The perceptions and attitudes of Social Workers regarding their own mental health in Pretoria, South Africa

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DECLARATION

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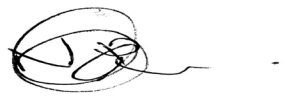
I declare that this dissertation is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

I declare that I submitted the dissertation to originality checking software and that it falls within the accepted requirements for originality.

I further declare that I have not previously submitted this work, or part of it, for examination at UNISA for another qualification or at any other higher education institution.



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SIGNATURE DATE

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This dissertation is dedicated to my late mother, Nomvuyiso Priscilla Mbhele. I wish you were here to witness my success. I also dedicate this project to my sister, Snenhlanhla Mbhele. I hope it will inspire you to further your studies.

DEDICATION

I thank Almighty God for strength, health, wisdom, inspiration and courage throughout the journey in pursuit of my studies. I wouldn't be done without Him (Proverbs 3:5: Trust in the Lord with all your heart, do not depend on your own understanding).

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ABSTRACT

Health care workers, including social workers, are exposed to high risk of mental health issues, increased anxiety, and depression symptoms due to the high caseload, emotional exhaustion, and depersonalisation associated with their work. This is because public hospitals in South Africa serve a large proportion of the population, often with constraint resources. Consequently, this qualitative study explored the perceptions and attitudes of Social Workers regarding their own mental health in Pretoria, South Africa. Descriptive, exploratory, and contextual research designs were thus adopted. A sample of social workers employed in Gauteng Department of Health, working in Pretoria, was selected using purposive sampling technique. Data was collected from participants by means of face-to-face semi-structured interviews with research questions embedded in an interview guide. The data collected was analysed using thematic analysis

Throughout the study the researcher adhered to ethical obligations such as informed content, confidentiality, anonymity, privacy, management of information, avoidance of harm and beneficent. The study contributes to new knowledge by bridging a literature gap identified in the scarcity of documented perceptions and attitudes of social workers regarding their own mental health. The study also identified that participants have difficulty in working with individual (colleagues) with mental illness as they feel they are unpredictable, aggressive and unable to control their emotions. The social workers are convinced that trauma debriefing sessions, team building, supervision, self-care should be promoted in the workplace to enhance mental health. Based on the findings, recommendations were made for social work practice, policy review and future research to improve the mental health of social workers in the hospital settings.

Keywords: Attitude, Mental health, Perception, social work and social worker

ACRONYMS

AMI	Any Mental Illness
CEO	Chief Executive Officer
DSM-5	Diagnostic and Statistical Manual of Mental Disorders
EST	Ecological System Theory
EAP	Employee Assistance Programme
EHWP	Employee Health and Wellness Programme
GPSA	Gauteng Province of South Africa
GDH	Gauteng Department of Health
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
HoD	Head of Department
IFSW	International Federation of Social Workers
KZN	KwaZulu-Natal
MHPFSP	Mental Health Policy Framework and Strategic Plan 2013-2020
NASW	National Association of Social Workers
NHRD	National Health Research Database
SACAP	South African Council for the Architectural Profession
SADAG	South African Depression and Anxiety Group
SAHRC	South African Human Rights Commission
SA	South Africa
SASSA	South African Social Security Agency
SACSSP	South African Council for Social Service Professions
UN	United Nations
UNISA	University of South Africa
WHO	World Health Organisation

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CHAPTER 1
INTRODUCTION AND BACKGROUND OF THE STUDY

1.1 INTRODUCTION

The burden of mental illness is increasing globally (Wu, Wang, Tao, Cao, Yuan, Ye, Chen, Wang, & Zhu 2023:63) and evidence suggests that an estimated 280 million people are living with depressive disorders in which “one in eight people” are suffering from mental illness such as depression and anxiety (World Health Organisation (WHO 2022:1). Mental health is a state of intractable internal balance that allows individuals to utilise their abilities effectively and in harmony with the known values of society. This includes basic cognitive skills, social skills and ability to identify, express and evaluate one’s own emotions as well as the ability to show empathy to others, flexibility, ability to cope with adverse life events and still be able to fully function in social roles, while maintaining a homonymous relationship between body and mind (Galderisi, Heinz, Kastrup, Beezhold &Sartorius (2015:231). Additionally, mental health can be viewed as the absence of mental disease and as a state of being that includes the biological, psychological or social factors which contribute to an individual’s mental state and ability to function within the environment (Manwell, Barbic, Roberts, Durisko, Lee, Ware & McKenzi (2015:6). In addition, the National Mental Health Strategic Framework and Strategic Plan of 2023-2030 by the Department of Health in South Africa, conceptualise mental health by putting more emphases to *a state of well-being* where individuals realise their abilities to cope with the normal life stressors, learn well and work well, and can make a meaningful contribution to their community.

From the preceding description, it is evident that view mental health is “a state of mind marked by healthy behaviour adjustments, emotional stability, absence of anxiety and depressive symptoms, and an ability to form positive relationships and the to have an ability to effectively manage stressful situation” (Gautam, Jain, Chaudhary, Gautam, Gaur and Grover 2024:66). This is to say, mental health is more than just the absence of disorder. It is a balance between a state of well-being and a state of resilience that is characterised by full functioning during adverse times, and enabling individuals to cope with life’s stressors, work productivity and effectively contribute to their

community. Against this backdrop, this study explored the perceptions and attitudes of social workers in Pretoria, South Africa, regarding their own mental health.

South Africa presents a high prevalence of mental health problems, with one in six south Africa being diagnosed with anxiety, depression and substance use problem. Research has shown that in South Africa, one in six people suffer from anxiety, depression, or substance-use disorders (Nguse & Wassenaar 2021:301). More recently research suggests that as many as one quarter of South African adults may suffer from probable depression, which varies according to provinces (Crain, Rochat, Naicker, Mapanga, Mtinsilana, Dlamini, Ware, du Toit, Draper & Narris (2022: 986531).

Similar research has shown that mental health also affects other countries such as North America, with an estimatimation that one in five adults or 51.5 million people had an emotional, behavioural, or mental disorder (National Institute of Mental Health, 2019). In 2023, research showed that about 57.8 million people in North America lived with mental health illness such as schizophrenia, bipolar disorder, post-traumatic stress disorder (PTSD), major depression, anxiety and inclinations towards suicide (Palay, Taillieu, Afifi, Turner, Bolton, Enns, Smith, Lesage, Bakal, Rush & Adair 2019: 761-769). This shows a general increase in diverse mental health issues. For instance, in Asia, an estimation of 150–200 million people diagnosed with various mental health disorders including anxiety, depression and substance abuse (Naveed, Wagas, Chaudlandy, Kumar, Abbas, Amin & Sallem (2020: 573150). A similar patten was identified also in Africa (Craig, Rochat, Naicker, Mapanga, Mtintsilana, Dlamini, Ware, du Toit, Draper, Richte & Norris (2022:986531). However, South Africa has predominantly shown a high rate of depression and anxiety (Perrotta 2019:042) and ranked third in their contribution to the burden of disease after HIV/AIDS (Meyer, Matlala and Chigome (2019:61). Surprisingly, some studies have shown that childhood trauma can predict adult trauma, depression and anxiety (Galvin, Scheunemann, Chiwaye, Luvuno, Kim, & Moolla 2025:2276). These studies collectively show that mental illness is prevalent in the society and work environments are a microcosm of the larger society.

Underscoring the significance of this study for social work profession, as social workers is one of the professions that is at high risk of experiencing mental health challenges such as burnout, anxiety, depression and post traumatic disorder due to the nature of the work they perform in their work environment. Previous research has consistently shown that social workers experience stress, putting them in great risk for job-related stress (Senreich, Straussner and Steen (2020:93), high levels of emotional exhaustion, stress, and burnout amongst social workers (Gomez-Garcıa, Alonso-Sangregorio & Llamazares-Sa´nchez (2020:463).

In South Africa, social workers are employed in a variety of settings including private practice, the non-governmental sector, the corporate sector and within governmental entities such as hospitals, which are the focus of this study. Social workers in hospitals are part of interdisciplinary medical teams that provide critical services to patients and their families with varying medical, psychiatric, social, and economic needs (Moore, Whiteside, Dotolo, Wang, Conley, Forrester, Fouts, Vavilala & Zatzick 2016:1348). They provide psychosocial support services to patients presenting with medical and psychiatric conditions. Their patients include those with chronic diseases, mental health issues and disorders, drug and alcohol abuse, physical disabilities, and those with terminal conditions (Bhagwan & Heerala 2024:107236).

For example, hospital social workers provide psychosocial support to patient diagnosed with mental illness to protect, respect and fulfil the right of mental health care service users to ensure that they are not being discriminated against, but are free to exercise their fundamental human right. Hospital social workers provide psychosocial support services in the form of counselling to patients and their significant others; facilitating access to multidisciplinary care for patients and their families; and connecting the patient with external resources to meet their needs (Kourgaintakis, Sewel, McNeil, Lee, Logan, Huehl, McCornick, Adamon & Kirvan 2022:123). They also provide psycho- education to patients and their families to ensure that they understand patient health challenges and wellness possibilities by addressing behaviour (Saxe Zerden, Lombardi & Janes 2019:142). Their roles further include crisis intervention, determination of accurate information, conducting or facilitating family conferences, and discussing discharge planning (Browne 2019-21).

The COVID-19 pandemic of 2020/2021 brought into focus some of the challenges experienced by social workers in hospitals. Some studies have reported that during the COVID-19 pandemic hospital workers were exposed to high risk of mental illness, increased anxiety and depressive symptoms and insomnia (Spoorthy, Pratapa & Mahant (2020:51). Numerous studies have confirmed that social workers in hospitals who worked during the peak of the Covid-19 pandemic experienced burnout, stress, and anxiety due to the nature of services they provided to patients and their families (Appiah, Sobiesuo, Obeng, Asamoah, Montey, Dwumah, Boampong, Boateng, Ofori, Nomoh & Nyarko (2025:8). This includes a study conducted South Africa, KwaZulu-Natal Province which recorded that more health care workers, including social workers, suffered from psychiatric symptoms (Seng, Subramaniam, Chung & Chong (2021:234) with some were experiencing depression, anxiety, trauma stress symptoms and signs and demonisation, poor functioning and an increase in irritability of fear of being infected or dying from COVID-19 (Mahlangu, Sikweyiya, Gibbs, Shair and Machisa (2023:20).

Ideally, when social workers detect traces of mental health challenges, they should address them because health care workers who avoid seeking help put themselves at risk of potentially developing more serious mental illnesses or mental disorders (Sovold, Naslund, Koasoulis, Saxena, Qaronfleh, Grobler & Munter (2021:9). For instance, schizophrenia, depression, obsessive-compulsive disorder, substance abuse, mania as well as anxiety disorder, depression disorder, and trauma and stress disorders Radden (2023). Social workers are not excluded from these, as they are confronted with challenges such as high case load, burnout, lack of resources, undiagnosed mental health challenges. Recently, the National Association of Social Workers (NASW 2021) urged social workers to consider taking serious measures for self-care both professionally and personally. However, researchers focus on the social workers' mental health challenges as they provide support to patients and their families, little is known about how they perceive themselves regarding their own mental health. It is against this backdrop that this study was conducted.

1.2 PROBLEM STATEMENT

Although social workers in South African public hospitals find themselves overwhelmed, over worked, emotionally fatigue, burnout due to the service in stressful

and complex situations, little is known on how they perceive and interpret their own mental health. Hence, it is important that social workers are aware of their own attitudes and perceptions regarding their own mental health. Failure to be cognisant of mental health issues and seeking help may lead to the development of mental illnesses that are among the most common health concerns in the world. This will also help in development of support system and organisational response to social workers experiencing mental health challenges in the workplace. It will also provide organisations with possible reasons that hamper social workers to communicate about their mental health issues. Research has shown that stigma may also contribute to fear of disclosure and seeking help from colleagues (Elraz, 2018:722; Waugh, Lethem, Sherring and Henderson (2017:457).

The impact of stigma in the work environment can also have adverse effects on performance, communication, and social interaction with colleagues (Elraz, 2018:722). Research has also shown that openness towards people or co-workers with mental health challenges or showing stigmatising attitudes towards co-workers also contribute to employees not disclosing their mental illness to colleagues and managers (Mitake, Iwasaki, Deguchi, Nitta, Nogi, Kadowaki, Niki, and Inoue, (2019). Additionally, failure to disclose does improve mental health, instead it exacerbates the development of other mental health illnesses. For instance, stigma around mental illness was found to be associated with a high degree of depersonalisation and burnout and the fear of disclosure (Zamorano, Gonzalez-Sanguino, Fernandez- Jimenez 7 Munoz 2024:812). Moreover, health care workers, including social workers who reported fear of stigmatisation and judgment by their colleagues and managers, also reported that they were not willing to find support for their mental health issues (Craig et al., (2022:10); Subramaniam, Chong, Allimadi & Chong (2021:234). Furthermore, these health care workers were found to be delayed or reluctant to seek help on their mental health issues as they fear being perceived as incompetent (Craig et al., (2022:10). Some reported having experienced embarrassment and shame after disclosing their mental health issues leading to a negative perception on career pathing (Zamir, Tickle & Sabin-Ferrell 2022:1712).

Therefore, investigating social workers' perceptions and attitudes regarding their own mental health is crucial because social workers are often employed in fast-paced

institutional and social service agency settings where they work with clients who have experienced significant trauma (Senreich, Straussner & Steen 2020: 93). Thus, they may be prone to secondary trauma, which may lead to mental health challenges. Social workers may also be prone to developing mental illnesses because they experience burnout, emotional exhaustion, depersonalisation, and fatigue due to their high caseloads, advocating for clients and sometimes with the lack of support from their supervisors, they tend to be worried about how they might be viewed by their colleagues (Kundra & Salzer 2019:462). Apart from this, mental health is, to date, considered a neglected area in the working environment due to a lack of knowledge, negative perceptions, and attitudes on mental health (Choudhry, Mani, Marg & Khon, 2016:12).

Even though several studies have been conducted focusing on stigma associated with mental health in the workplace (Miric 2022:2); attitudes towards mental illness, projective disclosure and disclosure (Waugh, Lethem, Sherring and Henderson (2017:457; Zamir,Tickly& Sabin-Farrell (2022:1712; Elraz (2018:722); relationship between burnout and mental illness related stigma among nonprofessional occupational mental health staff (Mitake, Iwasaki, Deguchi, Nitta, Nogi, Kadowaki, Niki & Inoue (2019:5921703); supporting social workers with mental health (Kundra & Salzer (2019:462); resilience and stressing frontline social workers during Covid-19 pandemic (Seng, Subramaniam, Chung, Alhmad & Chong (2021:234); factors impacting compassion satisfaction and workplace stress (Senreich, Straussner and Steen (2020:93 social work belief and perception about mental health issues (Choudhry, Mani, Ming & Khan (2016:2807-2818). There is limited research that has investigated social workers' perception and their attitude regarding their own mental health challenges.

These studies were mostly conducted at an internationally level, with few if any studies were conducted in South African. Of the studies conducted on the subject in South Africa, particularly with special reference to social workers, the researcher found that many focused-on employees' attitudes towards their colleagues with mental health challenges (Seng, Subramaniam, Chung, Alhmad & Chong (2021:234), Choudhry, Mani, Ming & Khan (2016:2807-2818). There were also those studies that explored social worker experiences in providing mental health services in health facilities, while

others focused on employees' experiences in working with employees with mental health (Miric (2022:2) "Health care workers fears of mental health stigma"; Waugh, Lethem, Sherring and Henderson (2017:457). However, there is a lack of studies conducted where social workers were prompted to look inwards at their own perceptions and attitudes of mental health in Pretoria, South Africa.

1.3 RATIONALE FOR THE STUDY

Health care workers are suffering from mental health challenges due to the nature of work to perform and the kind of work environment they work in (i.e., hospital setting). Various studies have been conducted on the mental health of health care workers including social workers, mostly focusing on their experiences in working with patients who are diagnosed with mental health conditions and in need of care. Some studies explored the fear of employees to disclose their mental health challenges due to stigma and discrimination. These studies shown that health care workers including social workers have opinions, different perceptions and interpretations about co-workers who experience mental health challenges. Other studies focused on social workers' experiences in working with employees who are diagnosed mental health disorders. It is known that social workers working in the hospitals provide psychosocial support services to patients and their families and that they are exposed to cases of violence and physical trauma which might have a negative impact on their mental health.

It is also known that social workers in health care settings have high caseloads of patients presenting with an array of health and mental health challenges and are constantly working under pressure. This could lead to mental health challenges such as compassion fatigue, burnout, anxiety and psychological distress. However, little is known about how they perceive and interpret their own mental health. For this reason, this study aimed to explore social workers' perceptions on their own mental health, to understand the attitudes social workers hold towards their mental wellbeing, to identify personal, organisational and contextual factors shaping these perceptions and attitudes and also to propose recommendations for policy and practice to support social workers mental wellbeing and proffer recommendations for future researcher. It is hoped that the study contributes to social work employers such as the Department of Health to have a nuanced understanding of mental health issues of social workers,

which could compel them to create conducive work environments tolerant of mental health issues and eliminate stigma and negative attitudes towards mental health illness.

1.4 RESEARCH PURPOSE, QUESTION AND OBJECTIVES

1.4.1 Research purpose

According to Maree (2016:31), a research goal or purpose must be clearly formulated to indicate how the research is conducted. Duggappa, Nethra and Sudheesh (2016:23) state that a research purpose gives an overall indication of what the researcher seeks to accomplish. From the preceding discussion, a purpose involves the dream the researcher wants to actualise by conducting a study. Following such hints, this study traces the following purpose, designed to: Explore the perceptions and attitudes of Social Workers regarding their own mental health in Pretoria, South Africa.

1.4.2 Research Question

A research question emanates from the need and rationale of the proposed research. A research question provides direction and guidance for a research project (O'Leary 2017; Kelly 2018). In essence, research questions are geared to keep the researcher focused during the study. Consequently, in this study the research question was formulated as follows: What are the perceptions and attitudes of Social Workers regarding their own mental health in Pretoria, South Africa?

1.4.3 Research objectives

Research objectives are specific statements about what the proposed project strives to accomplish (Du Plooy-Cilliers, Davis & Bezuidenhout, 2021:82). Sudheesh et al., (2016:632) view an objective as certain criteria a researcher utilises to achieve the goal of the study. In summary, research objectives comprise a list of activities undertaken by the researcher, one-by-one, which assist the researcher to achieve the research goal. For the study, the following research objectives were formulated to:

- explore social workers' perceptions of their own mental health
- examine the attitudes social workers, hold towards their mental wellbeing
- identify personal, organisational, and contextual factors shaping these perceptions and attitudes
- propose recommendations for policy and practice to support social workers mental wellbeing and proffer recommendations for future research

1.5 ETHICAL CONSIDERATIONS

According to Strydom and Roestenburg (2021:119), research ethics are a code of principles that bind the researcher to follow the professional code of conduct, to protect participant's rights and the community participating in a research study. Baikie and Priest (2019:52), emphasise that ethics are the norms and practices that are acceptable and required in conducting research. It can therefore be gathered from the preceding definitions that ethics are guidelines that govern the behaviour of the researcher, advising them on how to protect the dignity of participants. Owing to the preceding recommendations, the researcher thus adhered to the following ethical principles in the study: informed consent, confidentiality, privacy, beneficence, avoidance of harm, ethical management of data and anonymity.

1.5.1 Voluntary participation and informed consent

According to Creswell and Creswell (2018:103) when collecting data, the researcher should not coerce participants in the study; their participation should be voluntary where people can decide whether to participate or not. Radenkovic (2023) concurs that participants should not be forced to take part in a study, but they should be free to participate and withdraw their involvement at any time without penalty or consequence. In this study, the participants information sheet was thus formulated (Appendix D). In the informed consent form, details of the study such as goal and objectives of the study, risk and benefits of the study, the data collection and analyses processes, confidentiality and protection of identity were articulated. The freedom to refuse or withdraw from the study any time and without penalties was also articulated. In the study, before data was collected from each participant, they

read through the participant information sheet and thereafter were afforded an opportunity to ask follow-up questions about the study. The individuals who were keen to take part in the study were required to consent to participate in the study by signing the informed consent form attached as (Appendix D). This informed consent form is a legal document that can be produced in case of legal disagreements (Madondo 2021:198).

1.5.2 Confidentiality

Confidentiality refers to the practice of refraining from sharing sensitive information and identity of participants to unsanctioned individuals (Dhai & Ames 2019:102). Grinnell and Unrau (2018:646) support this definition and emphasise that confidentiality involves securing the private information collected from participants when conducting a research study. Consequently, before data could be collected, the researcher discussed the ethical issues of confidentiality with participants as contained in the participant information sheet. Moreover, the researcher ensured confidentiality by assuring participants that all information collected from them and records such as field notes would also be treated confidentially. Practically, this was achieved by ensuring the anonymity of participants.

1.5.3 Anonymity

Anonymity means there is no way to connect response data to the individual who provided it (Eyler 2020:49). Hwang (2023:1-7) concurs that anonymity involves keeping secure and private the personal information of participants, including their interest and well-being. To protect participants by ensuring their anonymity, the researcher did not use the names of participants during interviews and in the transcripts during data analyses. Instead, the researcher used pseudonyms, i.e., symbols as reflected in Table 4.1, to identify the participants when conducting interviews and presenting findings. The name of the institution where data was collected is also omitted from the data to ensure the anonymity of study participants.

1.5.4 Privacy

The privacy domain is about the personal information gathered and the expectations of the researcher to keep such information secure or, if shared, accessible information

about how and with whom data is shared (Panicker & Stanley 2021:43). Dhai and Ames (2019:102) define privacy as personal and sensitive information and that which an individual has a right to keep from others. According to Eyler (2020:48) privacy is important because participants are reluctant to disclose their personal information in a large group or in a place where they may be overheard. To ensure privacy in this study, the researcher held individual interviews with each participant in their offices and this way no one other than the researcher knew the social workers that took part in the study. In addition, the researcher did not indicate the personal information of participants such as their names and offices to ensure the privacy.

1.5.5 Avoidance of harm

Avoidance of harm is a primary principle governing the protection of research (Leavey 2022:33) and denotes that the prospective participants should be protected from harm. According to du Plessis-CilliersCilliers, Davis and Bezuidenhout (2021:304) avoiding harm may be eliminated by desisting from making participants recall emotionally painful memories, asking questions that may cause participants to be embarrassed, creating situations where participants' prospects may be harmed and making participants feel that their contributions to the study are less intelligent and less relevant than others.

This principle in the study was upheld as follows: the researcher created a conducive and safe environment for participants to feel comfortable to share their perceptions and attitudes regarding their own mental health. This was achieved by giving participants an option to select a venue for the interview. The researcher also ensured sincere sensitivity when asking questions during the interview to ensure that participants did not feel embarrassed and distressed about their responses. During the interview some participants developed some emotional discomfort, and as advised by McNallie (2018:386), their discomforts were assuaged. The researcher also informed participants that they could also go for comprehensive debriefing provided by a Clinical Psychologist. According to Leavey, (2022:33) and Hennessy, Dennehy, Doharty & O'Donoghue (2022:1197-1204) debriefing provides an opportunity to elicit feedback from the participants about their experiences after the interview.

1.5.6 Reflexivity

Reflexivity is a process of researchers engaging themselves in self-reflection about who they are as researchers, how their subjectivities and biases guide and inform the research process and how their worldview is shaped by the research. In qualitative research during data collection, Creswell and Creswell (2018:295) adds that researchers need to reflect about how their role in the study and their personal background, culture and experience affect the interpretation of data collected. Consequently, the researcher reflected about who she is in relation to the study and the reflection suggests that the researcher might have a conflict of interest since she herself is a social worker employed by the Gauteng Department of Health and is stationed at one of the hospitals in Pretoria. Therefore, to counteract this possible conflict of interest, the institution the researcher is employed was excluded from the study. The researcher acknowledges that data collection could have been tainted by friendships and difficult work relationships had she interviewed her immediate colleagues.

Furthermore, the researcher was fully conscious about her own values, belief system and views. Consequently, the researcher did not impose these on the participants during data collection and interpretation. During the data collection, the researcher captured truthfully information from participants which was accurately transcribed and presented though providing vignettes and quotations from the data generated in the final research report.

1.5.7 Management of information

Proper security measures need to be considered about storing of materials in a research study (Creswell & Poth 2018:55; Padgett 2017:83). Data management entails the practice of data storage, the sharing of data through the presentation of clear statements of adherence to encryption standards and compliance with existing regulations (Panicker & Stanley 2021:43). The researcher shares the view that keeping data is also protecting participant's anonymity and their dignity. The researcher followed the ethical guidelines and principles. The recordings, notes and transcripts have been kept secure; they are locked away in a cabinet, to which only the researcher has access to ensure confidentiality and anonymity of participants. The

informed consent forms, which contains the real names of participants are stored in a different lockable cabinet and all electronic files related to the research study are password encrypted.

1.5.8 Beneficence

The principle of beneficence speaks to factors that influence the welfare of research participants, but also the populations they represent in the study (e.g., individuals with a particular learning disability, individuals with compromised cognitive capacity or decision-making ability) and the down-stream societal implications (Panicker & Stanley 2021:338). According to Borrow, Brannan and Khandhar (2021:7) beneficence also denotes the behavior of the researcher in ensuring the benefits of others while promoting their welfare and safety of the participant's rights to freedom from harm, discomfort, and the rights of participants from exploitation. This is because in research it is an obligation to do no harm and to maximise any benefits while minimising harm (Barrios, Levy, Daiz-Anzaldua & Camarena 2022:389)). In this study, the following benefits were envisaged for the social workers and the social work field in general:

1) the participants gave voice to their perceptions and attitudes regarding their own mental health in the workplace, which might eliminate misconceptions around mental health in social work organisations.
2) it is hoped that the study eliminates negative attitudes by raising awareness about the prevalence of mental illnesses amongst social workers.
The findings of the study also encourage more researchers to conduct further studies on this topic, specifically about mental illness in the workplace, which could not only benefit social workers, but also the broader communities in working environments where robust mental health programmes may be instituted for staff.

1.6 CLARIFICATION OF KEY CONCEPTS

The following key concepts are overarching in the study:

- Attitude

The Merriam Webster Dictionary (2019) describes attitudes as the bodily state of an

individual's readiness to respond in a characteristic way to a stimulus such as an object, concept or situation. Fishman, Yang and Mandell (2021:87) define attitudes as "the sum of (positive and negative) beliefs weighted by evaluations of those beliefs." Drawing from the two preceding descriptions, for the purpose of this study, attitude is how social workers working in the hospital setting interpret their own mental health challenges.

- Mental health

According to Gautam et al., (2024:66) mental health is a state of equilibrium which enables individuals to utilise their ability in harmony with the universal values of society. Palumbo and Galderis (2020:1) specify that mental health is a state of wellbeing in which the individual realises their ability to cope with the normal stresses of life, work productively and fruitfully and contribute on their own community. However, for the purpose of this study, the definition by the National Mental Health Strategic Framework and Strategic Plan of 2023-2030 of mental health as a state of mental well-being that enables people to cope with the stresses of life, to realise their abilities, to learn well and work well, and to contribute to their communities (Department of Health 2023) is adopted. The latter definition is adopted in this study because it is pervasively used within the South African health fraternity.

- Perception

Perception is an individual interpretation of an object based on the information (Hooblaul, Cobbing & Daniels 2020:76). Perception is also described as information from the external world, which is structured in a way by finding certain meaningful patterns. It is described as a process of attaching meanings to selected objects or experiences Ou, (2017:3). For the study, perception is how social workers perceive their mental health challenges and how they perceive themselves in the process mental health discovery.

- Social Work

Social work refers to a practice-based profession and an academic discipline that promotes social change and development, social cohesion, and the empowerment

and liberation of people (International Federation of Social Workers (IFSW) (2021). This entails all the principles of social justice, human rights, collective responsibility, and respect for diversities that are central to social work. In this study, because of its universality, this definition of social work was adopted.

- Social Worker

In South Africa, a Social Worker is considered as a person registered by the South African Council for Social Service Professions (SACSSP) under section 28(1)(gD) of the Social Service Professions Act (No. 110 of 1978). The IFSW (2021) define a social worker as a trained professional who engages in a scientific relief, change, growth, and empowerment of people. For this study, a social worker was thus considered as a professional person registered with South African Council for Social Service Professions (SACSSP) as a social worker and employed by the Gauteng Department of Health in Pretoria to render social work services in hospital settings.

1.7 STRUCTURE OF THE STUDY

This research study is structured into the following five chapters:

- **Chapter 1**

This chapter introduces the research study and formulates the research problem, statement of the problem, rationale for the study, research question, research goals and objectives, clarification of key concepts, and terminates with an outline of the structure of the study.

- **Chapter 2**

Chapter two focuses on a comprehensive literature review with a theoretical framework adopted for the purposes of the study. The concepts mental health and mental illness are comprehensively described, followed by discussing the prevalence of mental health of employees in the workplace globally, including the regional context of Africa and thereafter localised to the South African context. Other topics covered in the chapter are the history of mental health in the workplace in SA the perceptions and attitudes of employees regarding mental health in the workplace, programmes available to promote mental health in the workplace, and social work strategies

designed to cope with mental health, the roles of social workers in the hospital, their challenges with mental health. The discussion in this chapter is framed within the theoretical framework of the ecological systems theory.

- **Chapter 3**

This chapter presents the research methodology adopted for the study. This entails a presentation of the actual application of the research process and methods. Some of the issues discussed include research approach, research design, study setting, population and sample, the methods and instruments employed to conduct the research study. Lastly, this chapter discusses the administrative methods on securing and maintaining data and ethical considerations.

- **Chapter 4**

This chapter presents the study findings derived from the data collection process undertaken. In the presentation of findings effort is also made to provide connections to the recent and relevant literature.

- **Chapter 5**

The chapter summarises the study, specifically the social work understanding of mental health and mental illness, working with individual diagnosed with mental illness, social work mental health challenges, social work perceptions on their mental health, effect of mental health on work, social life and at home, coping with mental health challenges, policies available in the workplace to support employees mental health, supportive services available for employees with mental health issues, suggestions to improve mental health services in the workplace. Lastly, the chapter proffers recommendations for social work practice, for policy developers and for future research to improve social work and mental health in the workplace.

1.8 LIMITATIONS OF THE STUDY

Limitations of the study concern possible weaknesses that are mostly out of researcher's control. These limitations are closely related to research design, funding constraints, literature review, research methodology, and the ultimate research findings. They are imposed restrictions that are essentially out of the researcher's

control (Theofonadis & Fountouki 2018:155). In this study, there are also research limitations with which the researcher needed to contend.

One of the inclusion criteria planned during the proposal stage of the study was to collect data from both female and male social workers. However, as mentioned in Chapter 4 (Data analysis), there were only two males who participated in the research study. Having few male participants could be viewed as biased because the findings may be reflective of the female social workers experiences, with minimal voice of their male counterparts. Pretoria is home to several hospitals, and the researcher had hoped to interview social workers from a number of them. Unfortunately, even though the National Health Research Database (NHRD) approved for the study to be conducted in the facilities, the researcher was faced with several hurdles, which resulted in only three hospitals forming part of the study. Firstly, there were delays in accessing the hospitals. This is because following approval by NHRD hospital CEOs and/or institutional research committees also needed to approve for the social workers in their institutions to participate in the project. From the CEO or institutional research committees, the application was then cascaded down to the social work department needing also, the social work managers to approve for social workers in him/her department to participate. Consequently, only three hospitals were included in the 0study from a possible 6 hospitals. This also resulted in the delay in collecting data.

There was a limited literature review in South Africa related to social work attitudes and perceptions regarding their mental health. Instead, the most available literature on the subject focuses on social workers' perceptions, attitudes, perspectives and experiences of social workers in working with mental health care patients or clients as well as in relation to their colleagues. Consequently, the study is based on literature from other countries. Lastly, some potential study participants could not be included in the study because the study was conducted during working hours and social workers work in a demanding and busy environment. Many who would have participated eventually could not for the same time constraints.

CHAPTER 2
LITERATURE REVIEW ON MENTAL HEALTH, SOCIAL WORK PRACTICE AND THEORETICAL FRAMEWORK FOR THE STUDY

2.1 INTRODUCTION

There is a seriousness of mental health in the workplace because it helps determine how people function, relate to others and how they handle stress. According to de Oliveira, Saka, Bone and Jacobs (2022:167-193), when the workplace prioritises and supports employee mental health, it decreases absenteeism and presenteeism and instead increases work productivity. Ahairwe and Atukunda (2025:76), share the same sentiment that mental health is an important aspect in the employee's well-being, which contributes to workplace productivity, organisational culture and employee retention. WHO (2024) also recommends organisation intervention that addresses challenges in working conditions, risks to mental health, flexibility in working arrangements implemented to improve employee's mental health in the workplace. In its 2023 Report, WHO (2023) revealed that a high number of employees suffering from mental illness such as depression and anxiety. Hoain, Hoosain & Plastow (2023:20) identify factors that contribute to employee mental illness may include lack of variety of work, worthless work, overload or underload, time pressures, inflexible work schedules, lack of control and decision-making abilities, poor environmental conditions, unsupportive work cultures, poor communication and toxic relationships at work, job insecurity and the conflicting demands of home and work.

It was against this backdrop that this study was constituted to explore the perceptions and attitudes of social workers in Pretoria, South Africa, regarding their own mental health. This chapter presents a literature review of mental health and mental illness in the workplace. In this regard, mental health and mental illnesses are comprehensively discussed followed by the history of mental health in South Africa. The global prevalence of mental health issues in the workplace as well as the prevalence of mental health issues in Africa and in South Africa is also covered. The discussion further highlights the social work strategies for coping with mental health. This discussion extends to social work practice in the hospital setting and delves into the social work roles and responsibilities, including the effect of mental health challenges

on social workers in hospital settings. In this regard, Bronfenbrenner's ecological system theory is adopted in this study.

2.2 MENTAL HEALTH AND MENTAL ILLNESS DEFINED

2.2.1. Defining mental health

The World Health Organisation (WHO 2019) defines mental health a state of wellbeing in which they become aware of their capability to be able to work productively and fruitfully, can handle stresses of life, and is able to have an impact in their communities. In the new definition of mental health by WHO (2025) the individual conditions have been extended to consider an individual regarding their emotional and psychological well-being. The Mental Health Strategic Framework 2023-2030 of South Africa also defines mental health as a state of mental well-being where people are able to cope with the stress in their life, realise their ability, learn and work well and have a positive contribution to their community. Mental health can also be defined as the absence of mental disease or a state of being that also includes biological, psychological, or social factors which contributes to an individual's mental state and ability to function within the environment (Manwell, Barbic & McKenzie 2015:45).

According to Galderisi, Kastrup, Heinz and Beezhold (2017:231) the WHO definition of mental health highlights two key components of mental health, which is a person's wellbeing and a person's productivity. He further discusses that wellbeing consists of emotional, psychological and social well-being and it involves positive feelings, positive attitudes toward own responsibilities and toward others and ultimately positive functioning. Consequently, mental health affects how people think, feel, and act, and helps determine how they cope with stress, relate to others, and make choices. Additionally, mental health can be defined as the absence of mental disease. This means that one's biological, psychological, and social factors are aligned and contribute to a healthy mental state and the ability to function optimally within the environment (Manwell, Barbiue, Robert, Dunvisko, Lee, Ware & Mckenzie, 2015:5). Values, culture, and social background should also be aligned for one to be mentally healthy. This, however, does not mean people with good mental health cannot experience some emotional turmoil such as sadness, unhappiness, and anger. What

is critical is that they can deal with those emotions constructively, because, echoing Galdorsi, Heinz, Kastrup, Beezhold & Sarforius (2017:407), mental health is a dynamic state of internal balance which enables individuals to use their abilities in harmony with universal values of society. For one to fully comprehend mental health, one should distinguish it from mental illness.

2.2.2 Mental illness defined

In the Mental Health Care Act No.17 of 2007, mental illness is referred to as "a disorder of thinking, mood, perception, orientation, or memory that completely harms judgment, behaviour, and capacity to recognise reality or ability to meet the ordinary demands of life." Mental illness can also be referred to as mental disorders. A mental disorder, according to Tse and Haslam (2023:224), involves harm in the form of stress that is due to failure of psychological mechanism to perform its functions. The clinical significant in an individual's cognitive, emotional regulation or behaviour that reflect disturbance in the psychological, biological, or developmental processes underlying mental functioning are the characteristics of mental disorder, according to the Diagnostic and Statistical Manual of Mental Disorder (DSM-5-TR). Mental illnesses also includes schizophrenia, depression, obsessive-compulsive disorder, substance abuse (Obdusoke 2021:4) and mania (Radden 2023) and the disorders also include anxiety disorder, depression disorder, and trauma and stress disorders (Odusoke 2021:4).

Mental illnesses differ in their form and degree; therefore their manifestation and symptoms differ (WHO 2019). Also, DSM-5-RT states that there are many options of treating mental health illnesses, which include psychotherapy when an individual seeks help from a therapist to assist them identify and change unhealthy emotions, thoughts and behaviours; and medication which is called antidepressant, is prescribed by a medical practitioner.

2.3 THE HISTORY OF MENTAL HEALTH IN SOUTH AFRICA

The developments that impact the wellbeing of South African people, including their mental health and the mental health services, can be traced back to 1952 and earlier, during the period of deep colonisation. Mental issues can also be traced to apartheid

laws that enforced inequality and oppression. Many people lived in poverty and experienced trauma due to dispossession, forced labour, and health challenges such as tuberculosis. According to Kleintes and Schenielder (2023:100206), mental health in this period was characterised by three phases: the first phrase was marked by a lack of recognition of mental illness as a medical condition, resulting in the absence of treatment plans. During this time people with mental issues were referred to as insane and mad, which contributed to the stigmatisation and discrimination of people living with mental illness.

The second phase was when there was a new establishment to build some psychiatric wards within the new Somerset Hospital in Cape Town in 1818. Between 1876 and 1922, nine specialised psychiatric hospitals were built around South Africa. Weskoppies hospital was built in 1892. However, there was still a challenge in accessing treatment for recovery and there was a limited effective treatment available, which resulted in hospitals becoming overcrowded. The third phase was finding the effective treatment, providing occupation therapy, rehabilitation, and outpatient services. During this phase around 1949, specialist training of psychiatrists was provided leading to a Diploma in Psychological Medicine that was offered at the University of the Witwatersrand. Psychiatric training was also included in the curriculum for health care professionals including nursing, clinical psychology, undergraduate medical and psychiatric social work training. During this period, institutionalisation of mental healthcare users served as a primary and dominant treatment approach but there was a change to improve the mental healthcare by implementing deinstitutionalisation and reintegration of mental healthcare users into the community (Madlala, Miya & Zuma 2020:1-2).

In 2004, the South African National Mental Health Policy came into effect, and put more emphasis on promoting deinstitutionalisation by treating mental health as an essential part of primary healthcare (World Health Organisation [WHO] 2014). Deinstitutionalisation initiatives were adopted as a global initiative, shifting long term mental health care users from institutional care to community care which aimed to promote social inclusion for all people living with mental illness (Sorsodahl, Peterson, Myers, Zingela, and Lund & van der Westhuizen 2023:100247). The implementation of this policy also enhanced the rights of people living with mental health disorders,

providing methods for the promotion and protection of their human rights. It also improved the accessibility and made mental health care the first contact of mental health care within the health system. This reform encouraged the integration of mental health care into general health care services and promoted the development of community-based services.

The deinstitutionalisation initiative has had both negative and positive results. For instance, integrating mental health into the primary health care system had a positive effect on the modernisation of psychiatric hospital services (Kleintjes & Scheider (2023:100206). A study by Madlala, Miya and Zuma (2020:1-8) shows that when the Province of KwaZulu Natal adopted Mental Health Care Act 10 of 2002 into their mental health care treatment model, this significantly improved the accessibility of mental healthcare services in the province. This also led to new challenges such as infrastructure, staffing and training, administration requirements which needed to be addressed. Moreover, in 2013, South Africa adopted the Mental Health Policy Framework and Strategic Plan 2013–2020 to manage, monitor and evaluate the implementation of Mental Health Care Act 10 of 2002. This created a need for tangible outputs in the deinstitutionalisation agenda. This had a negative impact as some mental health care residential facilities had to be shut down. For example, the Gauteng Province Department of Health decided in 2015 to terminate, for budgetary reasons, its contract with Life Esidimeni, a private residential facility for people with enduring mental illness due to their intellectual disability and chronic psychiatric disorders. This led to the death of 144 of the 1 711 residents of this facility between October 2015 and the end of June 2016 after they were transferred to other hospitals, their families, and in most cases, un-licenced and/or poorly equipped community-based centres with inadequately trained carers (Moseneke, 2018).

Deinstitutionalisation aimed to reintegrate people living with mental illness into their community. However, due to lack of community resources and some gaps in the policy, it exerted a negative impact on mental health care users. Kleintjes and Schenieder (2023:100206) identify some of the gaps in the South African National Mental Health Policy as follows: it focused on the traditional medical services re-organisation issues in the psychiatric care and did not address the broader special ills which impact on mental wellbeing of people. Hence, Kleintjes and Schenieder

(2023:100206) encourage that this policy should put more emphasis on the levels of care (e.g., all mental health care services should be provided equally and should be available at all levels of health care). This requires training of mental healthcare professionals with specialisation at different intervention levels, as well as clearly defined roles in governance.

The Mental Health Policy Framework and Strategic Plan MHPFSP (2013-2020) was again adopted in 2023 as it aligned with WHO (2012) plan Y as it emphasised strengthening mental health leadership and governance for mental health care services (Kleintjes & Schneider 2023:100206). Hence, NMHPFST 2023-2030 envisioned achieving high quality, integrated mental health promotion, prevention, care, treatment, and rehabilitation for all South African by 2030. However, it cannot be denied that it has been difficult to implement the NMHPFST 2023 due to lack of funding and the affordability of a successful mental health programme in the face of South Africa's social ills. Mental health cost and lack of funding for mental health services in South Africa makes it hard for individuals to access the care they need, and this negatively affects the quality of care available (Shiana, Stein, Zungu & Wolvaardt 2024:152458).

South African mental health care service providers receive funding from government, private insurers, and out-of-pocket payment by individuals and through donor funding to or from NGOs that provide mental health services (Shiana, Stein, Zungu & Wolvaardt 2024:152458). Docrat, Besada, Daviaud and Lund (2019:706-719) and Mental Health Situational Analysis: South Africa (2024) have confirmed that these funding models are insufficient to meet the urgent demand for care for mental health in SA. Another challenge is the shortage of mental health professionals such as social workers, occupational therapists' clinical psychologists, and trained mental health nurses. Most of the available mental health practitioners are concentrated in urban areas and neglected rural areas have insufficient and limited access to quality mental health care services. Marar, Breedt, Mdaka, Maarogante and Robertson (2024:1-3), the South African Human Rights Commission (SAHRC) suggest that underinvestment into mental health by government inhibits access to mental health. they contend that mental health is still only at a tertiary level and not at the primary care level as required by the NMHPFST (2023). This reality poses massive challenges on both policy

implementation and funding. The stigma surrounding mental health also presents a significant challenge because it creates a barrier to seeking help and receiving relevant mental health treatment. Research has repeatedly shown that individuals suffering from mental illness face discrimination and are maltreated by their employers, health care providers and others in the community, despite the constitutional emphasis that everyone must be treated with respect and dignity (Marar, Breedt, Mdaka, Maaroganye & Robertson 2024:1-3). WHO (2025) also reports that stigma and discrimination contribute to people being reluctant to seek help for their mental illness.

2.4. PREVALENCE OF MENTAL HEALTH ISSUES IN THE WORKPLACE

2.4.1 The global overview

Mental health issues have been on the increase year-on-year. Pascoe, Wood, Duffee, Kuo (2016:20160340) confirm the adult worldwide prevalence is estimated of 5% who suffer from depression and one in four individuals experiences mental health conditions at some point during their lifetime. WHO (2019) confirmed that 1 in every 8 people, or 970 million people around the world, were living with a mental disorder such as anxiety and depressive disorders. In 2020, there was also an increase in mental illness with initial estimates showing a 26% increase respectively for anxiety and major depressive disorders in just one year. This increase was also attributed to the Covid-19 pandemic (WHO 2022). Kayilesnanga, Sezibera, Mugabo and Iyamurenage (2022:1858) reported that globally about 450 million people are diagnosed and suffering from mental illness such as depression, anxiety and eating disorders.

In 2023 WHO (2023) reported that worldwide an estimated 3.8% of the population experienced depression, including 5% of adults (4% among men and 6% among women), and 5.7% of adults older than 60 years. Approximately 4.4 % of population in the world suffers from mental illness or mental disorders such as depression and anxiety disorder (Hogg, Moreno-Akaza, Toth, Serbanesce, Aust, Lueduc, Paterson, Tsantilla, Abdulla, Cerga-Pashaja & Cresswell-Smith 2023:739) and this constitutes 356.4 million people in the world.

According to Substance Abuse and Mental Health Services Administration (2023), in 2022 there was an estimated 59.3 million people aged 18 or older in the United States with Any Mental Illness (AMI). This number represented 23.1% of all U.S. adults. The observed prevalence of AMI was higher among females (26.4%) than males (19.7%). Young adults aged 18-25 years had the highest prevalence of AMI (36.2%), compared to adults aged 26-49 years (29.4%) and aged 50 and older (13.9%). A study conducted in the city of Ilam, Iran, also confirmed that Iram had a high prevalence of mental health illness, which consists of depression and anxiety as the most diagnosed conditions. This burden of disease has set alarm globally (Kakaei, Maleki, Biderafsh, Valizadeh, Mansournia & Pakzad 2023:115592). According to Mohammadi, Ahmadi, Khaleghi, Mostafavi, Kamali, Rahgozar, Hoosbvari, Alavi, Molayi and Sarraf (2019:1), who studied the same country, approximately 7 million people in Iram are affected by some form of mental disorder, with approximately 15%–20% of the population experiencing symptoms of depression ranging from mild to severe. Women were the affected gender, suffering from mental illness more than men due to their gender-specific experiences and vulnerabilities. Kakaei, Maleki, Biderafsh, Valizadeh, Mansournia, Pakzad & Pakzad (2023:1166692) confirm that the prevalence of depression, anxiety, and stress symptoms was significantly higher in women compared to men, with the prevalence of depression at 25% and 17.3%, anxiety at 31.15% and 23.3%, and stress at 18.6% and 13.6%, respectively. It is evident from the data that women suffer more from mental illness than males as often they are single mothers, divorced, widows and experience more domestic violence.

2.4.2 Prevalence of Mental Health Issues in Africa

According to Shifa, Adams and Demant (2025:151), there is 12.3 % of mental illness prevalence in Ethiopia. West African countries such as Ghana, appropriately 10% experience mental health conditions with limited access to mental health care services (Harden, Gyimah, Funk, Drew-Bold, Orrell, Maro, Cole, Ohene, Baingane, Amassah, Ansong &Tawiah 2023:142). A cross-sectional survey conducted by Ae-Ngibise, Sakli, Kamara, Lund and Weobong (2023: 280) found that the prevalence of suicidal behaviours and epilepsy was 11.8%, depression was 15.6% and 12% probable psychotic symptoms.

It is estimated that 87% of people in low-income countries who are diagnosed with mental illness do not receive treatment and the conclusion is that in African countries mental illness remains under prioritised (WHO 2025). Alloh, Regmi, Onche, van Teijlingen andTrenoweth (2018:12) share the same sentiment that in low and middle-income countries such as Iran, Ghana, Mali, Namibia, Nigeria, more than 70% of mental illness occur due to poor treatment and management of mental health, inadequate funding of mental health services, discrimination or stigma, poor financial resource allocations to mental health services. Kakaei, Maleki, Biderafsh, Valizadeh, Mansournia, Pakzad and Pakzad (2023: 1166692) also reported that there is a high prevalence of mental disorders amongst those with low economic status due to several factors, including insufficient income to meet even the most basic needs. Low-income groups are exposed to sparse if any entertainment. Their lives are characterised by relentless monotony, and hopelessness for the future is a key and consequential trait.

Research shows that mental illness affects both men and women, however, women are more affected to due to their different historical experiences (Kakaei at al2023:1166692). For instance, Abdeta, Birhanu, Kibret, Alemu, Bayu, Bogale, Meseret, Dechasa, Wondimneh, Abinew, Lami, Wedaje, Bete, Gemechu, Nigussie, Negash, Dirirsa, Berhanu, Husen, Eyeberu, Godana, Dessie, Sertsu, Hiko, Asfaw, Dereje and Nigussie (20231183797) conducted a study in Ethiopia and found that more women suffered from mental illness compared to males due to cultural beliefs that suppressed women from sharing their problems with others. Most females in Ethiopia are widows, single parents, divorced and or raising their children in the absence of the fathers. Historically and culturally women are expected to stay humble and silent resulting into normalising bottled pain and suffering. Moreover, the prevalence of depression, anxiety and stress symptoms was found to be significantly higher in women compared to men (Kakaei et al., 2023:14). More specifically, women in this study had a prevalence of 25% for depression (i.e., men at 17.3%), 31.15% for anxiety (i.e., men at 23.3%), and stress at 18.6% and 13.6% for men. In African countries, there is higher prevalence of mental health in the workplace. For example, Sudan showed an overall prevalence of 26.8% for depression among healthcare workers (Fodlalmola, Abdelmalik, Massad, Mariod, Osman, Youif, Adam, Ebrahim & Ellhusein 2022:17). Another study conducted among nursing staff in 2021 found that about 26.4% of African nurses suffered from severe depression. These statistics

significantly increased in 2022-2023 due to fear, uncertainty and social and economic disruptions associated with the COVID-19 pandemic, with prevalence of 76.6% for depression reported among health care workers (Mohamed, Mohamed, Ali, Gabow and Hilowle, 2024:2573-2585) and the overall prevalence of workplace related stress and anxiety reported at 59.3 % for women (Kefelew, Hailu, Teshome, Dewite & Abede (2023:103).

2.4.3 Prevalence of Mental Health issues in South Africa

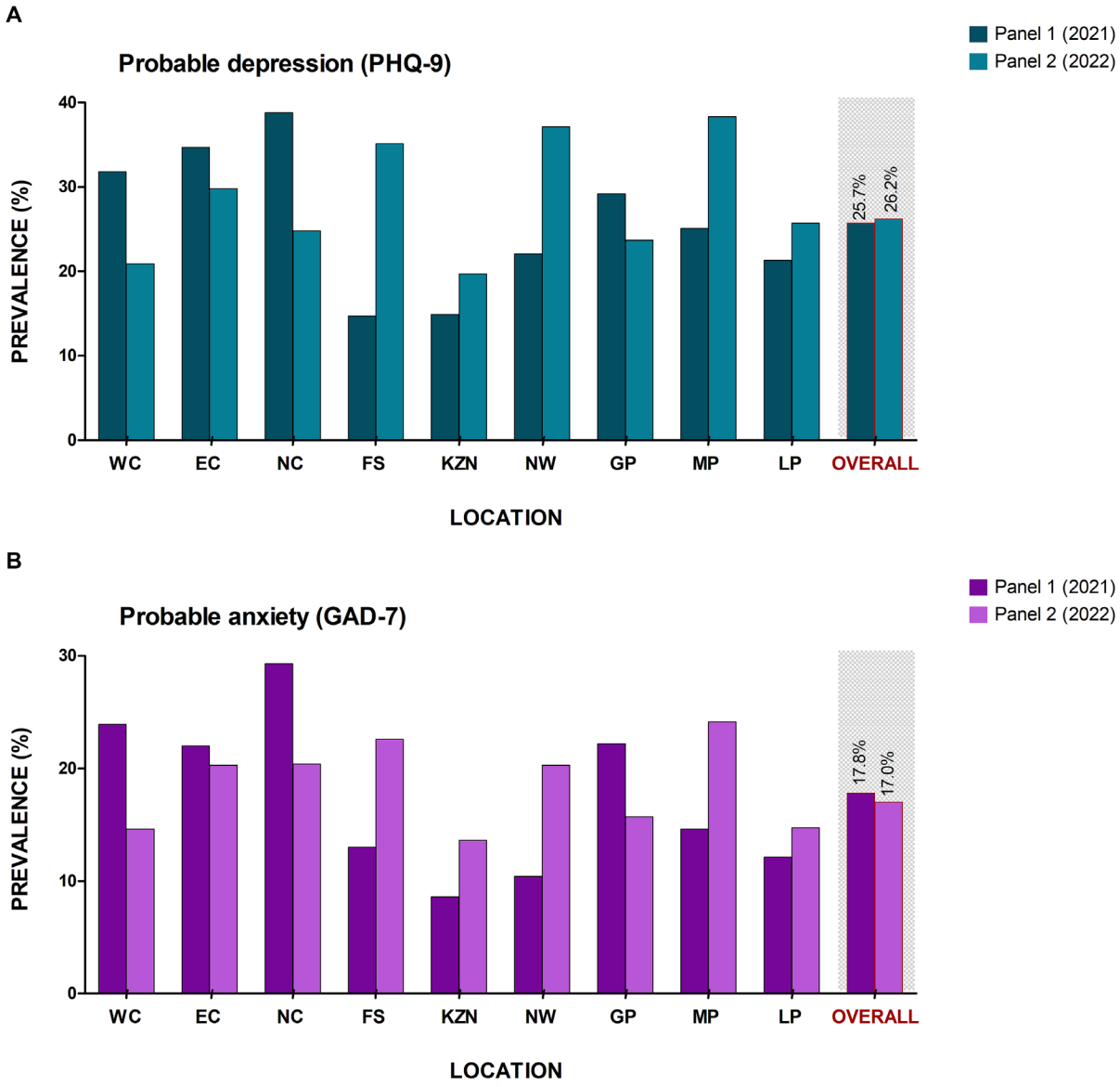
South Africa, classified as a low- and middle-income country, has high prevalence of mental illness in the workplace (/Booysen, Mahe-Polo & Grant 2021:1641). In 2017 SACAP (2018) reported that South Africans are suffering from mental health illness such as anxiety, depression, and substance use disorders. Research also found that neuropsychiatric disorder such as depression, anxiety, trauma and stress-related disorders and mood disorders are ranked third and these significantly add to the burden of disease after HIV/AIDS (Meyer, Matlala & Chigome 2019:25-29.). It is also estimated that 40% of South Africans with HIV and AIDS suffer from some version of mental illness, with 41% of pregnant women suffering from mental illness. When motor vehicle crashes and crime are considered, about 60% of South Africans could be suffering from post-traumatic stress which may result into mental illness if left untreated (SACAP 2018). Whilst there are many contributing factors to mental illness in South Africa, childhood trauma such as sexual abuse and emotional neglect before the age of 18 are clear factors contributing to mental illness (SACAP 2018). This high prevalence can also be attributed to “South Africa’s history of trauma resulting from discrimination, inequality and interpersonal violence” (Marchetti-Mercer 2023:119).

The high incidence of mental disorders in South Africa negatively contributes to “the burden of disease in the country (Booysen, Mahe-Polo & Grant 2021:1641). Nguse and Wassenaar (2021:304) also indicate that South Africans “are likely to experience a mental disorder, such as depression, anxiety, or substance use.

According to South African Depression and Anxiety Group (2024), most people in South Africa suffer from mental illness such as depression, anxiety and substance abuse with at least 52% of South Africans with severe mental illness receiving

treatment. A similar pattern was also observed in the workplace where more than 35 % of employees suffer from mental illness such as depression, anxiety and alcohol-use disorder. These were largely between the age of 20-29 years (Wijk, Martin & Meintjes 2023:164). This cohort was also found to have a 6.6% to 10.3 % more chances of developing major depression disorder and or substance abuse disorder, including alcohol-use disorder. Research also shows that across the nine provinces of South Africa, Mpumalanga reported the highest prevalence of 38% of depression and 22.6 % on anxiety. This is followed by the province of KwaZulu Natal (KZN) with prevalence of 19.7% on depression and 13.6 % on anxiety (Craig, Mapanga, Mtintilana, Dlamini & Norris, 2023:11). The graph below demonstrates the prevalence of mental health between 2021 and 2022 in South Africa: (A) Probable depression and (B) Probable anxiety.

Figure 1: Prevalence of mental health in South Africa by province between 2021 and 2023



Source: Craig, Mapanga, Mtintsilana, Dlamini and Narris (2023:11)

2.5. PREVALENCE OF MENTAL HEALTH IN THE WORKPLACE

Similar to global, regional and local communities' distribution of mental health, a high prevalence of mental illness was also recorded in the workplace (de Oliveira, Saka, Bone & Jacobs 2022:167; WHO 2023). In African countries, more than 80% of employees experience high and moderate levels of mental health challenges (Mental Health Hub Report 2023). The report states that in the workplace about 82.4% of women experience mental health challenges compared to 76.7% of men. According to Musanje, Flaxman, McIntosh and Kusujja (2024:127), in Uganda employees

experience common mental health challenges and over 78% has never received any form of mental health support. Mental health issues exert a negative impact on employees as it is estimated that 51.6% lost the ability to concentrate and keep focus and 48.3 % lost productivity and increased presentism in the workplace.

In 2024, the WHO (2024) reported that there are 12 billion cases of absenteeism reported every year due to depression and anxiety. This high number contributes to lost productivity in the workplace. Research has also shown that more employees are living with mental illnesses and depression and anxiety seems to be the leading ailment in the workplace (de Oliveira, Saka Bone & Jacobs 2022:167). Moreover, depression and anxiety are leading causes of overall disease burden amongst working individuals and increases cases of disability in the workplace (Hoosain & Plastow 2023:20; De Oliveira, Saka, Bone & Jacobs 2023:21; Strudwick, Gayed, Deady, Haffar, Mobbs, Malik, Akhtar, Braund and Bryant 2023:469). Hogg et al., (2023:273) reported that depression and anxiety are leading causes of disability in the work environment. According to the National Institute of Mental Health (2022), depression, anxiety, and substance use disorders are among the most diagnosed mental illnesses among adults, each of which are serious mental illnesses, depending on the severity of symptoms. de Oliveira at al, (2022:167) shares the same sentiments in his study and concludes that poor mental such as depression and anxiety contribute to loss of productivity, absenteeism, and presentism.

There are many factors that contribute to mental illnesses in the workplace including lack of variety in the work chores, worthless work, overload or underload, time pressures, inflexible work schedules, lack of control and decision-making limitations, poor environmental conditions, unsupportive work cultures, poor communication and toxic relationships at work, job insecurity and conflicting demands of home and work (Hoaiain, Mayet-Hoosain & Plastow 2023:5863). Similar to global, regional and local trends, mental illness in the workplace is also associated with stigma and discrimination, contributing to the lack of self-seeking behaviour to employees (Hampson, Watt &Hick 2020:288). Recent research confirms that employees suffering from mental illness are reluctant to seek help and delay recovering from mental illness due to stigma and discrimination (Hosain et al., 2023:288). Due to this, more employees are not diagnosed with their mental illnesses, and many do not receive any

treatment (Hosain et al., 2023:20). Self-labelled stigma also prevents employees from seeking help when suffering from mental illnesses in the workplace (Hosain et al., 2023:20).

2.6. PERCEPTIONS AND ATTITUDES OF EMPLOYEES REGARDING MENTAL HEALTH IN THE WORKPLACE

Perceptions refer to a process through which individuals manage sensory information and interpret it (Pupitasari, Garnisa, Sinuraya & Witrioni 2020:845). When people are diagnosed with mental illness, they are perceived and treated differently by others. In this study, Bronfenbrenner's ecological systems theory was adopted to understand the perceptions of employees regarding mental health. This theory was not designed to address mental health and mental illness; however, it offers an understanding of the challenges employees face and how these can influence employee's mental illness such as depression. For instance, the mesosystem relates to the interaction between the different employees and their workplace. Each social worker in South Africa has a high caseload, works overtime, lacks support from management and all these gaps may contribute to their mental illness. When colleagues have a misconception about mental illness, it hinders the help-seeking behaviour of the employee/ social worker. Previous research has established that mental illness in the workplace is associated with stigma and discrimination (Hampson, Watt & Hick 2020:288), and this study extends the evaluation of the mesosystem and its impact on mental illness.

Employees hold a negative perception of other employees suffering from mental illness. For example, a perception that when a person is diagnosed with mental illness they would never recover, or a perception that mental illness is not real, or a perception that employees suffering from mental illness are dangerous, incompetent, unpredictable and unreliable (White, Baldwin & Cang2023:481). Consequently, employees with mental illness are negatively labelled and perceived as unpredictable, aggressive, violent, dangerous, unreasonable, less intelligent, and lacking self-control (Hampson, Watt & Hicks 2020:288). Research also found that co-workers fear to work with an employee suffering from mental illness as they perceive them as unpredictable, dangerous, incompetent, and unable to establish collegial bonds with them (Shahwan, Yunjue, Satghane, Vaingankar, Manjam, Janrius, Lin, Roystonn & Sabramaniam 2022:50). Based on previous research, every employee has their own

perception that contributes to stigma and discrimination of employees suffering from mental illness.

Consequent to these perceptions and attitudes, people suffering from mental health s fear disclosing their anxieties to employers and colleagues as they feel they embarrassed and uncomfortable around their co-workers. They are essentially at risk of being stigmatised and discriminated against (Hampson, Watt & Hicks 2020:288) Moreover, the stigma has a negative impact on an employee's career, and they fear that "they might lose their professional standing" (Galbraith, Bovda, McFeeters & Hassan 2018:93). For instance, about 34.7 % of employees reported fearing negative career impact, 22.4% were concerned about stigma and 22.4 % indicated that these concerns are a barrier to disclosure. Hudson et al., (2021:147) also support that one of the contributing factors for employees' reluctance to seek help is that they are afraid they might lose their dignity at work, and it might affect their licencing to practice. these scholars further state that health care workers suffering from mental illness feel that their professional identity is threatened if they disclose their mental illness to their colleagues or managers. Social workers employed in the health care environment also suffer from mental illness, however, there are only a few studies that explore their attitudes and perceptions regarding their own mental health.

In contrast, Timming, French and Motensen (2021:100152) found that disclosing mental illness in the workplace helps employees enhance self-esteem and self-confidence in people suffering from mental illness. Given this information the work environment must be conducive, warm, safe, and supportive for workers to disclose their mental illness. McGrath, Krysinska, Reavley, Andriessen and Pirkis (2023:5548) support that "promoting workplace climates conducive to disclosures of mental health problems is within reach of all workplaces." The macrosystem carries values, cultural beliefs and religion that all exert an impact on the development of employee's perceptions and attitudes on mental health. Employees have different perceptions and attitudes toward others suffering from mental illness and these are shaped by their knowledge about mental illness, their experiences in working with individual suffering from mental illness, their cultural stereotypes based on their experiences of working with individual with mental illness. The stigma and discrimination impede seeking help when experiencing mental illness.

2.7. SOUTH AFRICAN WORKPLACE PROGRAMMES TO PROMOTE MENTAL HEALTH

Mental health in the workplace is the foundation of employees' wellbeing and for them to effectively function at work. Literature shows that there is stigma around mental health in the workplace. Mental health programmes are structured initiatives designed to promote mental well-being, prevent mental health disorders, and provide treatment and support for individuals affected by mental health conditions (WHO 2022). These programmes can be implemented in various settings, including schools, workplaces, healthcare facilities, and communities (WHO 2022). Mental health promotion in the workplace is defined as a strategy aimed to improve productivity of employees and the organisation, leading to better mental health and wellbeing, reduced levels of absenteeism and presentism, increased productivity, and job satisfaction (WHO 2022). Mental health intervention refers to programmes or intervention that aims to treat, prevent, and promote mental health and well-being of employees in the workplace (Peterson, Leduc, Maxwell, Aust, Amann, Cerga-Pashoja, Cappens, Couwnbergh, O'Connor, Arensman & Greiner 2021:41).

In South Africa employers and organisations are obliged by Mental Health Care Act 17 of 2002 to care for the wellbeing of their employees. Mental Health Care Act 17 of 2002 emphasises the rights of individuals with mental illness, even in the workplace, to equal access to healthcare and treatment without being stigmatised and discriminated. The policy promotes that mental health care uses should not be discriminated due to their mental illness; they have the right to human dignity and privacy, and they should receive care, treatment and rehabilitation services that improve their mental capacity to develop their full potential. The Labour Relations Act 66 of 1995 also contends that every employee has a right to fair labour practice, rights to fair treatment, safe environment, and protection against unfair dismissal, the right to participate in decision-making through the establishment of workplace forum. WHO (2022) recommends that employers should implement workplace interventions such as mental health promotions in the workplace to improve employee productivity and to better their mental health and wellbeing.

Workplace intervention focuses on working conditions and environments with the aim of preventing mental health challenges, improving physical health quality of life and workplace outcomes of employees (WHO 2022). Singh, Kumar and Gupta (2022:13) define workplace intervention as aimed to prevent mental illness and potential social and economic challenges. Such intervention assesses then eliminates and modifies the risks in the workplace that contribute to mental health problems. This includes organisational intervention programmes such as flexible working arrangements, fighting against violence and harassment at work (Singh, Kumar & Gupta 2022:13).

Organisational intervention programmes are designed to trace and identify the contributing factors to workplace stress such as high workload (Cohen, Pignata, Bezak, Tie and Chils 2023:1203). Organisational intervention focuses on primary and secondary prevention: *primary intervention* includes health promotion, which focuses on employees who are vulnerable to develop mental disorders due to their working condition and environment (Singh, Kumar & Gupta (2022:13). *Secondary* and *tertiary intervention* focuses on early diagnosis, treatment and measures to decrease disability. These also target employees who already have developed the mental illness and is aimed at reducing impairment (Singh, Kumar & Gupta (2022).

Organisation intervention programmes further encourage employees to fully participate in decision making, promotion of work-life balance, encouraging respect behaviours, creating opportunities for employees to be involved in training and capacity building (Luberenga, Kasujja, Vasanthan, Nyende, Tumwebaze & Leonard 2023-073012). Additionally, organisational intervention helps to reduce absence, stigma around mental health and support people with mental disorders while increasing productivity (Peterson, Leduc, Maxwell, Aust, Amann, Cerga-Pashoja, Cappens, Couwnbergh, O'Connor, Arensman & Greiner 2021:41).

Research confirms that effective organisational mental health programmes reduce the level of depression and increase productivity and effectivity of employees (Luberenga et al. 2023: 073012) and assist employers to reduce sickness, absenteeism, and the cost of healthcare at the workplace (Cohen, Pignata, Bezak, Tie & Childs 2023:1203). Research also confirms that mental health intervention programmes for healthcare workers can improve their well-being, work engagement, quality of life, and

mindfulness while reducing burnout, perceived stress, and symptoms of anxiety and depression (Cohen, Pignata, Bezak, Tie & Childs 2023:1203). Given this evidence, workplaces can collaborate with stakeholders responsible for employee health to enhance mental well-being through targeted interventions. Programmes such as Employee Assistance Programmes (EAPs), Employee Health and Wellness Programmes (EHWPs), and inpatient or residential mental health treatment are effective workplace initiatives that significantly impact employees' mental health.

2.7.1 EAP and EWP services

Employee Assistance Programme (EAP) is a work-based intervention programme provided to employees who experience life challenges such as substance abuse, stress, anxiety and depression, financial challenges and marital challenges. All these issues have an impact on employee's psycho-social functioning and productivity in the workplace. EAP programme offers counselling services, financial planning, career counselling and health and wellness promotion services to employees. EAP was established in SA in the early 1980s with an objective to enhance the psycho-social wellbeing of employees and their families, to adhere to the commitment and share responsibility of care, improve employees' productivity as well as to humanise the work environment and support employee wellbeing. The EAP intervention has been implemented in SA, according to Manganyi and Magorosi (2021:17384), who conducted a study in a tertiary hospital in Limpopo, South Africa. The study found that the utilisation of EAP services is very low and about 63 % of employees lack knowledge about the EAP services, 78% employees feel the service is not accessible to them. According to Mhangwani & Malindini (2023) found that in Gauteng, South Africa, the EAP objective is clear, however it is not well implemented and efficiently marketed. The conclusion is that this EAP only exists on paper as a majority of the employees do not utilise it. The study acknowledges the effectiveness of the services; however, some employees were not assisted.

The Employee Health and Wellness Programme (EHWP), on the other hand, focuses on rendering holistic services that address health, occupational safety and wellness. EHWP also focuses on employees and the organisation as a client system (DPSA 2023). DPSA (2023) also states that EHWP focuses on work-life balance programmes

such as flexibility in the workplace to accommodate work, family needs, personal life which can increase productivity in the workplace. Moreover, research verifies that the EHWP services/ programmes in the Gauteng government departments were effective as they are of good value to the employees (Mhangwani & Malindini 2023). The programme is voluntary, and clients are not forced, meaning that employees can access the programme when they feel stressed or sick due to challenges experienced in the workplace and even in their personal lives (Mhangwani & Malindini, 2023).

According to Dimoff and Kelloway (2019:4), mental health programmes promote mental health in the workplace. These programmes such as organisational intervention, workplace intervention, management intervention and individual intervention help to improve mental health in the workplace. The exosystem of the ecological systems theory views this layer of social workers as influenced by the policies and legislations promoting mental health. The availability of resources such as Employee Health and Wellness services, training, workshops, and stakeholder's involvement exert an impact on employee's mental health.

2.7.2 Inpatient or residential mental health treatment

Workplace intervention provides support to employees' mental health in the workplace, especially to help them cope with highly stressful and anxiety provoking situations. Inpatient or residential mental health treatment is one of the intervention programmes promoting mental health in the workplace (Pollock, Campbell, Cheyne, Cowie, Davis, McCallum, McGill, Elders, Hagen, McClurg, Torrens & Maxwell 2020:11). The inpatient mental health care is for individuals suffering from severe mental illness. This type of care aims to help patients acquire skills and confidence for successful community integration. It is provided by multidisciplinary teams including psychiatrists, psychologists, nurses, social workers and occupational therapists. The individual is offered assessment, monitoring and management of mental illness, psychological assessment, formulation, and psychological intervention including individual counselling, and group therapy. These activities help to improve interpersonal skills and provide support to families and carers (Killaspy & Dalton-Locke 2023:14). Inpatient care is about helping the patient to gain skills and confidence for successful community integration.

2.7.3 Management intervention

Mental health promotion is also about enhancing supervisors' and managers' ability to recognise and act on mental health conditions of supervisees. WHO (2022) thus recommends that managers be trained on mental health to enhance their ability to recognise and respond to employees experiencing distress in the workplace. Hence, managers are expected to recognise certain signs, struggles and behaviours resulting from poor mental health and negatively affecting the employee in question (Dimoff & Kelloway 2019:4). These signs include emotional distress, withdrawal (i.e., reduced social interaction at work, reduced effort in work task), attendance changes (i.e., absences and lateness), reduction in performance and showing reduced hygiene, substance use at work or expressing a desire to harm oneself or others (Kelloway, Dimoff & Gilbert 2023:363) and managers who can recognise these signs are able to support and protect their employees.

Research has shown that mental health literacy training is effective as it enhances the knowledge and attitude about mental health and reduces stigma on the employees (Bryan, Gayed, Milligan-Savilla, Madan, Calva, Glozier & Harvey 2018:464). EHWP 2012 outline steps that managers can take after recognition of warning signs. For instance, approach employees appropriately (i.e., showing respect and confidentiality) on the signs, provide appropriate support such as referral to Employee Assistance Programmes (Kelloway et al., 2023:363). It can thus be deduced from this preceding discussion that a mental health programme is essential in the workplace to help employees improve work productivity. This includes EAP and EHWP that provide counselling, and training on employees and their managers.

2.8. SOCIAL WORKERS' STRATEGIES TO COPING WITH MENTAL HEALTH

According to Miller and Grise-Owens (2022:674), social workers are at risk of suffering from work stress, secondary traumatisation, and burnout as well as compassion fatigue due to the high workload and lack of resources. Stanley and Sebastine (2023:1135), share the same sentiment that social work is a high-stress profession because social workers work deal with people suffering from distressing circumstances and difficult life situations such as domestic violence, abuse and crime.

The source of stress amongst social workers compared to other professions is that they have high workload or caseload, working overtime often without pay, dealing with the conflict between the clients and their families, and having to satisfy unmet personal expectations and negative public perceptions about their profession (Stanley & Sebastine 2023).

Previous research has found that social work stress is also the result of high demands of the nature of their work, uncontrollable workload and poor supervision and management support (Ravalier 2019:371). Moreover, high caseload makes social workers to intentionally put aside their emotions or feelings and prioritise giving their client a sense of feeling safe and secure (Quezada 2022:1467). To help them manage the stress, social workers should adopt effective coping strategies that enable them to work efficiently, provide optimal care, and enhance their personal well-being, professional performance, and physical health. These strategies may include supervision, self-care practices, peer supervision, boundary-setting, mindfulness, and resilience-building.

2.8.1. Supervision

Social Work supervision is a formal arrangement where supervisees reflect and review on their performance. It is an interactional process within an environment of anti-discriminatory relationships where the supervisor delegates by performing educational, supportive, and administrative work for promoting efficient and professional provision of social work services (Department of Social Development Supervision Strategic Framework 2012). Supervision is a professional relationship between a supervisee and supervisor to enhance responsibility and accountability for the development of competence and ethical practice takes place (National Association of Social Work (2022). Supervision is also an interpersonal relationship between the supervisor and supervisee with the focus on the supervisor enhancing social work knowledge, skills and monitoring for ensuring that the supervisees are ethically applying their capabilities (Tu, Huang, Sitar & Wang 2023:1764). Social work supervision involves the following: administrative supervision, educational supervision, and supportive supervision.

2.8.1.1 Administrative supervision

The administrative supervision primarily focuses on the correct, effective, and appropriate implementation of organisational policies and procedures (DSD_SSF 2012; G). NASW (2022) confirms that administrative supervision focuses on the implementation of administrative methods that allow social workers to be more effective when providing services to clients. It is oriented towards the organisation demand and focus on a supervisee level of functioning on the job description. Through administrative supervision, social workers are supported to streamline services provided to clients and their families (Bara 2022:84).

2.8.1.2 Educational supervision

NASW (2022) view educational supervision as a tool that enhances understanding of social work knowledge, self-awareness, and social work skills. The primary goal is to assist the supervisee to improve their knowledge, attitudes, and skills so that they can perform to their optimal level when executing their duties (DSD_SSF 2012). This includes staff development and training of social workers to a certain caseload. Bara (2021:84) states that educational supervision is determined by the supervisor in providing effective support to social workers to obtain knowledge about evaluating cases for better interventions to clients and their families. It is achieved through education and training social workers from a professional point of view and appreciating the knowledge and skills and fulfilling social work needs for ongoing training (DSD_SSF 2012; Angela 2021:84).

2.8.1.3 Supportive supervision

In the supportive function of social work, the primary focus is on worker morale and job satisfaction. The goal is to improve morale, job satisfaction and the quality of work (DSD_SSF 2012). Social workers face challenges that contribute to poor mental health, including heavy workload and emotionally draining environments such as vicarious trauma. The aim of supportive supervision is to eliminate occupation stress and burnout amongst social workers to enhance productivity and success in their intervention with their clients. Supportive supervision provides emotional support to supervisees which helps to decrease stress related to their work (NASW 2022). This type of supervision is intended to create a safe, protective and confident work

environment which requires supervisees to develop professional and personal skills and attributes (Bara 2021:84). Research has shown that supervision reduces psychological stress amongst social workers with high job demand (Tu, Huang, Sitar & Wang 2023:1764). More specifically, when job demand is high social workers receiving supervision garner emotional support and consequently have a lower negative effect and psychological distress. On the contrary, when supervision is low, this generally contributes to high levels of burnout amongst social workers (Losim, Rancan, Dan, Nadolu, Rancan & Petrescu 2022:160).

2.8.2 Self-care

Social work plays an important role in the lives of vulnerable individuals, families, and groups, providing them with care and support, yet with the high caseload, social workers experience high levels of burnout and stress due to the nature of their work (Ravalier, Wainwright, Clabburn & Loon 2021:1105). Self-care has been proposed as an empowering tool for employees to take ownership of their personal well-being (Rose, McCisker, Mittchell, Roesch-Marsh, Jian, & Petrova 2025:1455)

Self-care is a purposeful engagement in practice that promotes effective and proactive use of self in the professional role within the context of sustaining holistic health and well-being (Bressi & Vaden 2017:33). It is also defined as purposeful action when employees and the organisation contribute to wellness and reduction of stress amongst employees (Berkowits 2022:130). Self-care includes caring for one's body and mind through enough sleep, hygiene, good nutrition, exercise, positive relationship with the community, family or peers, creative activities that promote pleasure, rest, and relaxation (Bressi & Vaden 2017:33). Social workers thus have an ethical obligation to address their problems that may jeopardise their professional intervention and their performance to render quality services to clients and their families (NASW 2021). The value of integrity in this regard resides in the importance of social workers taking measures to take care of themselves professionally and personally to provide effective services consistent with ethical standards and practices (NASW 2021).

Self-care is beneficial to the social workers because it helps them to prevent stress, vicarious trauma and burnout which enhance high levels of compassion, and job satisfaction. When they care for themselves adequately, social workers can perform

their duties and handle the everyday stress in the workplace environment. They are psychologically and mentally fit (Berkowits 2022:130). Research has also shown that when social workers engage in self-care, they reported greater social, structural, economic, professional, and physical health (Bark, McKnley, Ka'apu & Figley 2023:914). Based on the evidence provided by the literature, self-care is an important practice that all social workers should adopt to prevent workplace stress. It also enhances productivity and the provision of quality services to clients and their families.

2.8.3 Ensuring boundaries

It is essential for social workers to establish and maintain boundaries because such efforts allow them, clients, and the organisation they work for to thrive. In the process, they also help to avoid emotional stress when there are clear boundaries (Marc, Dimeny & Bacter 2019:377). Professional boundaries are a set expectation, sets of guidelines and rules which define the ethical standards in the social care environment (NASW 2021). Research has shown that social workers who use professional boundaries as a strategy to enhance mental health in the workplace are able to leave their clients painful experiences behind their offices, not to take them home with them. Social workers also set boundaries with themselves and their colleagues to promote mental health in the workplace (Yi, Kim, Akter, Molloy, Kim & Frazier2018:667).

2.8.4 Mindfulness

Mindfulness has also been identified as a helpful coping strategy for social workers. Mindfulness has the potential to improve employees' well-being and address workplace stress (Miller & Griser-Owens 2022:674-691). Mindfulness is about an individual being conscious of what is happening to their life and staying there with an attitude of acceptance. It helps an individual to become more aware of their thoughts processes and their experiences on how they react to emotions and physical sensations and how these influence their behavior in their daily challenges in the workplace (McCuskey 2022:334-353). Research has shown that mindful social workers minimise stress and burnout in the workplace, enhance self-care and well-being, awareness of thoughts, emotions, and behavior to social workers and enhance social workers values and skills to handle their emotions and interpersonal skill (McCuskey 2021:334). Vonderlin, Biermann, Buhus and Lyssenko (2020:1579-1598)

adds that mindfulness also enhances psychological, physical wellbeing, reduces burnout and allows the social worker to be ultimately satisfied with their job in the workplace. Social workers who engage in mindfulness reduce anxiety, stress and self-compassion, self-awareness, self-care and also enhance sleeping patters (Kinman, Grant & Kelly 2020:758). There is also evidence that mindfulness enhances self-seeking behaviour by using techniques and strategies to address and deal with pressures that could negatively impact performance (Klockner, Craigie, Tsai &Hegney 2021:620).

Furthermore, Maddock (2023:54) shares the same sentiment that mindfulness assists social workers by enhancing attention, better self-awareness, improved psychosocial outcomes, wellbeing and their day-to-day functioning in the workplace. Based on this evidence, social workers need to be mindful of their emotions and their mental health. Self-awareness is also essential, enabling them to analyse their reactions toward traumatic experiences encountered while providing support to clients and their families.

2.8.5 Resilience

Resilience has been identified as a coping strategy for mental health for social workers in the workplace. Koh, Hum, Khoo, Ho, Chong, Ong, Neo and Yong(2020:105) () define resilience as a dynamic evolving process of fostering positive attitudes and effective strategies when experiencing stress. It is one of the strategies to lower burnout and enhance compassion amongst social workers. Resilience can also be defined as a skill on how individuals manage their everyday stress and anxiety that arises from the nature of the job (Rose & Palattiyil 2020:23). Resilience can further be defined in a metaphor as an individuals' ability to keep their head above water and manage the stress that comes with the workload (Rose & Palattiyil 2020:23). Resilience is affected by empathy since social workers must be able to turn-off their empathic concern than being over-involved with clients (Rose & Palittiyil 2020:23). Empathy is the capacity of a "social worker to understand the emotions of other people and to regulate one's own emotions" (Rose & Palittiyil, 2020:30). The study confirmed that becoming too empathic when providing support to clients gives rise to negative emotions and that being a resilient social worker does not mean they are not

experiencing difficulties in their lives. Empathy does not mean that social workers do not experience negative feelings such as being angry, frustrated, and anxious but they are able to manage and balance them (Kinman & Grant 2017:1979).

The benefits of resilience include helping social workers to have a high level of self-awareness, enthusiasm and hope. Quite often, resilient social workers are open to new experience and helps to learn limitations. Resilient social workers also exhibit a positive attitude towards the future and adapting to the transition of life, including in the workplace and its challenges (Rose & Palittyil, 2020:23). Research has shown that social workers with higher resilience adapt easily when experiencing stressful life events; it helps social workers to enhance sense of control, emotional intelligence, self-efficiency, persistence, and the ability to look at the problem as a challenge. Equally, resilience helps social workers to manage their role and responsibilities in the workplace (Grant & Kinman, 2017:1979).

It is evident that resilience is an important strategy for social workers to enhance their mental health and to cope with stressful working environments. If resilience is mustered effectively, social workers can set boundaries on their roles and responsibilities which can eliminate being overwhelmed. It is necessary to discuss social work practice in the hospital setting for better understanding of their role, responsibilities, and their mental health challenges.

It can thus be deducted from this preceding discussion that social workers experience stress due to the high workload, working overtime, and working in a demanding working environment. Social workers need to use different coping strategies to deal with mental health challenges in the workplace. It is evident from the literature that supervision serves social workers in coping with stress. Self-care has been recommended to social workers as coping strategy which includes rest, enough sleep, relaxation and good nutrition. As discussed above social workers need to develop coping strategies that gel with their self as they are unique and experience stress differently. In the ecological systems theory, the chronosystem accommodates individual experience changes which influence their development over time. Social workers live in a constantly changing work environment and they need to develop a coping strategy to deal with their mental health over time.

2.9. SOCIAL WORK PRACTICE IN A HOSPITAL SETTING

Social workers function in various fields such as in the hospital setting wherein, they are referred to as medical social workers or hospital social workers. Medical social workers are employed to provide psychosocial services to patients and their families Medical social workers provide services to in- and out-patients and they deal with a variety of social problems including abandoned babies, psychiatric and homeless patients (Ikpeme, Ede& Ikpeme 2024:15). It is the responsibility of medical social workers to ensure that patients are informed about external stakeholders who provide service that are relevant to their needs. They connect patients and their families to their nearest resources available and support in the community, providing psychotherapy, supporting counselling, grief counselling or assist patients to strengthen their connection to social support structures (Ikpeme, Ede & Ikpeme 2024:15).

Moreover, medical social workers provide frontline services to the patient's families to help them alleviate the social, financial, psychological hardships related to difficult conditions. Their major role is to assess the psychosocial functioning of patients and their families where it is needed (Kodom 2023:1567). Furthermore, medical social workers help patients, and their families have a better insight into their diagnosis, work through the emotions of the diagnosis, providing counselling based on their needs (NASW 2016). For instance, social workers provide grief counselling to individual or families after the loss of their family member (Fox, McIlveen & Murphy 2021:131).

Medical social workers form part of multidisciplinary teams including doctors, nurses, speech and rehabilitation therapists, optometrists, psychologists, and occupation therapists. Medical social work is regarded as the soul of the hospital, providing support, understanding, and caring at a person-to-person level. Unfortunately, in some Africa countries medical social work is not recognised and this compromises holistic treatment to patients and their families (Dako-Gyke, Boateng & Mills 2018:107). Medical social work empowers patients with coping strategies to maintain the recovery after being discharged from the hospital.

2.9.1 The role of the social work in the hospital

Social workers in the hospital settings play a variety of roles including the following: assessment of the needs of the patient and their families, psychosocial support to patient and their families, and discharge planning.

2.9.1.1 Assessment of the needs of the patient and their families

Medical social work role is to assess patients and their family through biopsychosocial assessment tool to holistically understand and explore patient needs and design an intervention plan to meet the needs of the patient and their families (Ikpeme, Ede & Ikpeme 2024:15). Medical social workers conduct assessment of the patient's social (i.e., family composition, position and family role), emotional (i.e., coping mechanisms, adapting to stress, trauma, or adversity, managing intense emotion, understanding the link between emotions, thoughts, and behaviors), environmental (i.e., assessment of living circumstance), and financial (i.e., economic support) needs. All these aspects have an impact on patient diagnosis and treatment plan (Ikpeme, Ede& Ikpeme 2024:15). Research has shown that medical social workers assess patient holistically to understand patient experiences, including their physical (i.e. probing on symptoms and related emotions) and mental health which ultimately determine the best course of treatment and identify specific treatment goal and intervention that is relevant to the patient and their families (Khalid & Naz 2020 : 171-173). Medical social workers can understand patient and their family needs through a biopsychosocial assessment, and this enables them to provide relevant and effective services to the patient and their families.

2.9.1.2 Psychosocial support to patient and their families

Medical social work provides psycho-educational support to patients and their families by educating them on the illness and treatment plan, the available resources that meet the patient needs, the importance of treatment adherence to sustain the recovery (Muhingi & Machani 2022:2). This helps the patients and families to cope with the emotional and social response to illness and treatment. Medical social workers facilitate and conduct family conferences with patients, families, and MDT members for the patient to receive holistic services including, providing counselling to the patient and family. These medical social work interventions help towards establishing a firm

foundation for treatment and promotion of positive living to patient and their families (Muhingi & Machani 2022:2).

Psycho-educational counselling to patients and their family provides insight into the illness and the treatment plan, especially adherence to the plan (Nistor 2024:143). This gives patients and their families the opportunity to share their perceptions with the multidisciplinary team on the diagnosis, treatment plan and after care. In certain instances, medical social workers advocate for the patients to ensure that they adhere to the diagnosis and treatment plan. Thus, this discussion highlights the critical role of medical social workers in developing discharge plans to ensure patients are released into a safe environment that supports their recovery and prevents unnecessary readmission. Discharge planning should actively involve patients and their families, allowing them to share their perspectives on the process and discuss potential post-discharge challenges.

2.9.1.3 Discharge planning

Discharge planning is a process that is crafted by the medical social worker which involves different tasks and activities to ensure that patient home care is conducive enough and thereby guarantees the effectiveness of discharge planning which largely depends on the availability of community services, family support system (Dimla, Parkinson, Wood & Powell 2021:20). Hence, the aim of discharge plan assists with reintegration of patient into their community, provides the support relevant for the patient to maintain the progress of the recovery of the patient during their hospitalisation, coordinates the care and treatment of the patient and family, provides support that satisfies the patient needs for the community, reduces the possibility of relapse or unnecessary return to the hospital for the same condition, strengthens family support system for the patient, and ensures early intervention during crisis and relapse (Gowda, Gajera, Srinivasa & Ameen 2019:706).

The role of a medical social worker at this stage is to re-assess patient home circumstances through biopsychosocial assessment to identify the needs of the patient and family and collaborate with the multidisciplinary team in developing a discharge plan. According to Dimla et al., (2021:20) a discharge plan is crafted through

assessment of patient family support system, assessing the patient's home circumstances and the impact on their health and design. There must be a clear linkage between the patient and the community resources relevant to their needs. It is done collaboratively with a multidisciplinary team, families and patient for decision making and in discharge planning. Dimla et al., (2021:20) point out that medical social worker's role in discharge planning is educating and informing patients and their families of the community resources they need, conducting family meetings for the multidisciplinary team to discuss patient illness and the treatment plan for adherence.

It is, however, critical to note that the medical social worker often depends upon patient and family decisions for a successful discharge plan. Gowda, Gajera, Srinivasa, and Ameen (2019:706) emphasize the importance of involving patients and their families in discharge planning. Their study found that including patients and families in decision-making enhances satisfaction with discharge services (Ward-Stockham, Omonaiye, Darzins, Kitt, Newnham,Taylor & Considine 2024:1097). Additionally, research confirms that families engaged in discharge planning are more likely to participate fully in aftercare services compared to those not involved in the process. Considering the above, it is evident that discharge plan ensures that the patient is discharged into a safe environment that caters for the patient's needs, helps with their complete recovery and avoids unnecessary re-admission.

2.9.2 Sections, units, and wards where medical social workers operate

Social workers work in all sections, units, or hospital settings and they are responsible for the treatment of patients in the hospital. However, because hospitals are big, a few of the wards wherein social workers work and their responsibilities are discussed.

2.9.2.1 Emergency care units

The Emergency unit services patients facing different challenges due to their health condition which leads to emotional distress and Kamrujjaman, Demetriou, Alvarez and Delgado (2023:629) point out that social workers in the emergency unit are responsible to provide counselling for emotional support for posttraumatic stress disorders. They provide grief counselling, and trauma as well as debriefing counselling to patients and their families. Some patients are admitted in the emergency unit after

car accidents. The social workers advocate for the patients and also help them in decision making regarding their medical condition and treatment plan, assisting patients with social support, providing information based on the needs of the patient and family, connecting the patient with available resources for continuous support to the patient and their families (Kamrujjaman, Demetriou, Alvarez & Delgado 2023: 628-635).

The medical social worker also arranges family meetings and cooperates with practitioners, mental health experts and other care teams along with the family for discussion of patient health condition and the treatment plan. For instance, Ogundipe, Kadiri, Etonyeaku and Aduloju (2020:126-129) explored the role of medical social workers in the management of patient with burn injuries. The study demonstrates that when patients experience burns injuries, they develop psychological challenges with adapting to life due to the physical limitations and permanent changes. Unable to cope with the loss, such patients experience trauma, anxiety, pains depression and body image concerns. The study reports that the responsibility of the medical social worker in this regard entails going beyond providing psychosocial support but also assisting patients to recover by liaising with community support for the burn patient, assisting with reintegration into the community and providing coping skills for the patient and to reclaim life once again. Considering the above, it is evident that the social work role in the emergency unit is vital as most patients suffer from trauma, say after experiencing gender-based violence, patients need counselling and psychosocial support from the medical social worker.

2.9.2.2 Paediatric unit

According to Mosquera, Avritscher, Pedroza, Bell, Samuel, Harris, Eapen, Yadav, Poe, Parlar-Chun, Berry andTyson (2021:175), a paediatric ward is an area in the hospital where children receive medical care from different health practitioners such as nurses, doctors, physiotherapists, social workers. Social workers are trained to treat and provide care to children admitted for different reasons. Children can be admitted in a paediatric ward for specific or acute medical illness, injury or chronic condition such as asthma, mental illness, cancer and other illnesses (CDC 2023). Bhagwan & Heeralal (2024:107236) stresses that in paediatric critical care for families of patients

(children) become stressed because of their child's medical condition or illness and the treatment they receive (Bhagwan & Heeralal, 2024: 107236). Children also feel upset, angry and depressed when they are hospitalised and sick hence, they need psycho-social support from medical social workers. In the hospital, medical social workers at paediatric unit provide psycho-education support on health and wellness. Bhagwan et al., (2024: 107236), point out that social workers' role in paediatric wards includes crisis intervention, providing information related to the child health condition, discussing discharge planning with family and referring the patient to local community resources for care. Social workers in paediatric units are responsible to care and protect children and ensure that they are safe when discharged from the hospital.

2.9.2.3 Oncology wards

Oncology department is a specialised department for the diagnosis and treatment of cancer. The oncology department includes medical, radiation and surgical oncology (Nation Cancer Institution). According to Liliehorn, Isaksson & Salander (2019:494) many patients who are diagnosed with cancer cope well with challenges related to cancer when they receive psychosocial support from professional psychosocial support including social work. Medical social work in oncology plays an important role for patients and their families. When patients are diagnosed with cancer, they experience psychological distress which needs social work intervention (Fereidouni, Abnovi, Ghanbori. Gashmard, Zarepour, Samani & Ghasemi 2024: 3327). In this regard, social work provides psychosocial support to patients and their families to enhance their ability to cope with the stressors due to the illness, trauma, treatment plan, and the transition of life due to cancer.

Guan, BrintzenhofeSzoc, Middleton, Otis-Green, Schapmire, Rayton, Nelson, Grignon and Zebrack (2024:1310) suggest that work in oncology plays a critical role that includes therapeutic intervention for individual, couples and families, facilitating patient care, decision-making, care coordination, assessment, and emotional support. There is the necessary palliative care support services for patients and their families. These services include helping patients and their families to cope with body disfigurement and sexual health. Patients and their families sometimes lack insight into the diagnosis and treatment plan and the social worker must ensure that they facilitate family

meetings for members to have a better understanding of the diagnosis and treatment plan or options available for them (Radu, Moldovan & Baban 2022:293-302).

Perlmutter, Herron, Rohan and Thomas (2022:137) confirms that it is the role of the medical social work in oncology to prepare cancer patients by facilitating access to the community and public resources such as financial assistance programs and disability grants from (SASSA), including home base care services to assist families to take care of the patient at home after discharge. Social work is also involved to provide palliative care support services and end-of-life services to patients with cancer. Palliative care is a holistic approach that improves quality of life for patients and their families facing the problems associated with life-limiting illness (Karunarathna, Godage, Rodrigo, & Rathnayak, 2024). When a patient is at the end of life due to cancer, it has an impact on their finances, physical, spiritual, and psychological distress. Consequently, medical social work intervention is essential as they work in an interdisciplinary team in the hospital. According to Lawson and Snow (2021:109-118) medical social work in palliative care is responsible for the final assessment of psychosocial needs, adjustment to illness and side effects of the treatment. Subsequently, the need to connect the patient with available community services. Medical social work provides psychoeducation support services to patients and their families which reduces the misconception and misunderstanding of the diagnosis and treatment plan or options. Essentially, they enhance the coping skills and empower the patient to take ownership in decision-making regarding their treatment plan (Karunarathna, Godage, Rodrigo, & Rathnayak, 2024).

The table below by Lawson & Snow (2021:109) illustrates the psychosocial interventions used for oncology patients and their families.

Table 2.2: Psychosocial intervention for patients and families in oncology wards

Intervention	Description	Outcomes
Cognitive behavioural therapy	Helping patients and families to identify maladaptive thinking and behaviours for them to eliminate negative emotions	It reduces anxiety, increases problem-solving skills, and understanding of stress while also enhancing coping.

Supportive counselling	Focus on assisting patients and their families to cope with distressing emotions, promoting coping skills	Enhancing coping skills by establishing a therapeutic alliance and decreasing anxiety.
Relaxation techniques	Encompasses different techniques to calm the thoughts to enable patients to take ownership and feel more in control and at ease.	Increasing sense of control, reducing anxiety and enhancing coping skills
Psychoeducation	Utilises education resources and provides information to decrease feelings of helplessness while increasing the patient knowledge and sense of control and ownership	Enhances decision making, reduces anxiety, and increases sense of control.
Crisis intervention	Focuses on symptoms reduction, encouraging patients and family to express their feelings and emotions and provide counselling.	Reduce psychosocial symptoms, mobilise social support, enhance the sense of self-competency.

2.9.2.4 Renal unit

A renal unit hosts patients diagnosed with kidney failure. When a patient is diagnosed with kidney failure, they face a multitude of psychological stressors that have a negative impact on their health outcome. The prevalence of kidney failure is increasing globally, and it is higher in disadvantaged communities. Those diagnosed have a high need for social work intervention (Francis, Harhay, Tummalapalli, Ortiz, Fogo, Fliser, Roy-Chaudhury, Fontana, Nangaku & Wanner 2024: 473).

The social worker is one in a interdisciplinary team that provides support the patients and their families. According to Hansen, Tesfaye, Sud, Sewlal, Mahta, Kairaitis, Tarafdar, Chau, Zaidi andCastelino (2022:16), the roles of nephrology social work are as follows:

- They conduct psychosocial assessment holistically with patients and family
- They provide crisis intervention
- They provide psychoeducational support services to patients and their families which helps patient have insight into their diagnosis and treatment plan and for them to enhance adjustments to the diagnosis
- They provide counselling to patients and their families, so as to have a better adjustment to illness and treatment
- They are part of interdisciplinary care planning and collaboration
- They advocate for psychosocial needs of patients and their families.
- They identify patient challenges and strengths and recommend relevant strategies to improve patient wellbeing
- Social workers provide psychosocial support to patients and their families at an early stage of their diagnosis which helps their ability to cope and strengthen that capacity before it deteriorates

The above discussion has evidenced that social workers function in different units within a hospital and their major role is to provide support to patients and their significant others. There is, therefore, a need for adequate employment of social workers in hospitals to render effective services.

2.10 THE EFFECT OF MENTAL HEALTH CHALLENGES ON SOCIAL WORKERS IN THE HOSPITAL SETTING

Social workers experience several challenges within their profession including mental health issues. Research shows that health care workers, including social workers, suffer from mental health (Moses, Dreyer & Robertson 2024:4163). According to Kostka, Borodzicz and Krzeminska (2021:705), some of the reasons or triggers for health care workers' mental health issues include the death of patients in their care, high caseload, secondary traumatic stress, and burnout as discussed below.

2.10.1 The death of patients affects the mental health of social workers

It has been established that health care practitioners working with patients who died while providing care exerted a negative impact on their mental health (Kostka, Borodzicz & Krzeminska 2021: 705-717). They may experience sadness, compassion, shock, anxiety, fear, and a feeling of hopelessness after the death of the patients in hospital (Finlayson & Graetz Simmonds 2018:23). Social workers witness the suffering and death of patients during their practice. Clark (2018:24) states that witnessing suffering is difficult for social workers, regardless of self-awareness, self-care and support. Death is an overwhelming experience and exerts a negative impact on their mental health, placing high demand on their psyches. The death of a patient has a negative impact on emotional distress, symptoms of panic attach, nightmares and compassion fatigue (Hanna, Jolanta, Katarzyna, Kornelia & Mariusz 2024: 25634). Social workers spend time with patients when providing psychosocial support services and even more time with patients' families therefore, when a patient dies, social worker's mental health may also be significantly affected.

2.10.2 High caseload

Many social workers perform multiple roles, responsibilities, and this has put a strain on them (Ntshongwane & Tanga 2022:42). Research has shown that the high workload for social workers due to the nature of their work (e.g., monitoring community projects, doing home visits, doing group work, providing therapy to patients while they are also expected to provide therapeutic services to their family members triggers stress and fatigue (Fuseini 2024:107939). Moreover, medical social workers experience stressors such as high volume of work from patients and families, pressure for the delivery of efficient services which often leads to demoralised social workers (Trowbridge, MischeLawson, AndrewsPecora & Boyd 2017:207). However, emotional exhaustion, depersonalisation on social workers, feeling devalued by employers, lack of organisational support (including peer support), role clarity and ambiguity, and the professional's role not corresponding with their professional values are the main drivers of stress (Evans et al., 2006; Maddock, 2015; McFadden et al., 2018; Ravalier et al., 2021).

2.10.3. Secondary traumatic stress

Social work is perceived as a rewarding profession with many challenges such as providing support to high numbers of clients experiencing ongoing trauma and violence. In many instances, medical social workers are required to provide psychosocial support to sexually abused clients or chronically ill patients which contributes to secondary trauma (Armers, Lee, Bride & Seponsa 2020:104540). Secondary traumatic stress is defined as the emotional stress and behavior of an individual who had an indirect experience of another individual's direct traumatic experience (Kelty, Green, Ribaux & Robertson 2023:209). Secondary traumatic stress is viewed as a natural behavior and emotion resulting from realising the traumatic experience of the significant others and the stress after assisting someone suffering from trauma (Senreich, Straussner & Steen 2020:93).

Research has shown that secondary traumatic stress has a negative impact on social workers which affects their mental health (Lee, Gottfried & Bride 2018:228). More specifically, secondary traumatic stress negatively impacts physical health, increases unhealthy behavior and generates a negative perception of oneself, affect sleeping patterns, and often leads to the development of stomach ulcers (Lee, Gottfried & Bride 2018:228). Furthermore, research has shown that secondary traumatic stress leads to the development of burnout, compassion fatigue, vicarious traumatisation in those who work directly with clients and patients who have traumatic experiences (Schiff & Lane 2019:454). Research on social work interventions during COVID-19 confirmed that both social workers and mental health professionals experienced loss and trauma while supporting emotionally distressed clients affected by the pandemic, while simultaneously dealing with similar personal trauma (Holmes, Rentrope, Korscch-Williams & Kind 2021:495). These professionals were regarded as 'wounded healers' (Holmes, Rentrope, Korscch-Williams and King 2021:495), meaning helping professionals whose own traumatic experiences enabled them to better understand and relate to their patients' trauma. Similarly, social workers providing psychosocial support to patients who are admitted in hospital and suffering from severe illness are also affected by secondary traumatic stress.

2.10.4 Burnout

Social work profession is perceived as a thankless profession that is highly stressful due to the nature of the services provided to clients, including advocating for clients and their families, and still performing administrative duties such as managing daily appointments, writing reports, and attending MDT (Ikpeme, Ede& Ikpeme 2024:15)... (Ikpeme, Ede& Ikpeme 2024:15).., found that medical social workers tend to consistently find themselves overwhelmed, overworked, and emotionally fatigued which leads to burnout. Research shows and confirms that medical social workers providing services to traumatised and psychologically unstable patients experience a more severe burnout when compared to those working in other organisations (Ikpeme, Ede& Ikpeme 2024:15)

Burnout is chronic stress that is experienced by employees in the workplace, and it is characterised by emotional exhaustion, depersonalisation, and a lack of a sense of personal accomplishment (Alobayli, O'Conno, Holloway and Creswell, 2023:9). Moreover, burnout is an emotional breakdown that normally results from chronic stress of employees related to their job-related roles and responsibilities. WHO (2019) states that burnout results from chronic workplace stress that has not been managed successfully by the employee. It is also characterised by emotional exhaustion, increases mental distance from the role and responsibilities or feeling negative to the job. Such stress leads to a significant reduction of professional worth of employees. According to Ratcliff (2024:26) it can be divided into different scopes which include the following:

- Emotional exhaustion when employees feel emotionally and psychologically drained.
- Depersonalisation when withdrawal can be the result and when employees feel a low sense of job satisfaction and accomplishment.
- Reduced personal achievement - when employees reflect self-doubt about the ability to perform their job effectively or developing a tendency to evaluate results negatively. Employees display low morale, low coping skills and low productivity at work.

The mental health challenges on social workers' personal and professional lives are related to the death of a patient, providing support to the patient's family. This experience is overwhelming, especially when coupled with the high caseloads involving providing therapeutic services to individuals with their families, groups and communities and administration thereof. Such exhaustive tasks lead to chronic exhaustion and in some cases secondary trauma from violent and criminally inclined cases. Lastly, they also experience burnout due to the urgent services provided on constant basis. Hence, social workers in microsystems are involved in stress work-related issues that has an impact on their mental health.

2.11 THEORETICAL FRAMEWORK UNDEPINNING THE STUDY

In this study, the researcher adopted the ecological systems theory, established in 1979 by psychologist Urie Bronfenbrenner. It focuses on the quality and context of individuals' life as viewed through developmental phases that occur within the context of complex interconnected systems (Crawford 2020:170). Bronfenbrenner noted that individual development and behavior is influenced by the environment and ecological realities (Rus, Salas, Parris, Webster, Lobo, Ecaterina & Popa 2020:237). Consequently, "The ecological system theory focuses on how a person adapt to the demands of the environment, opportunities, capacity of a person and the needs for both development and the person capacity to adjust to changing external demands are provided for, met, and challenged by the environment (Crawford 2020:170).

The ecological systems theory specifies that an individual interacts within four layers in their environment categorised as microsystems, mesosystems, ecosystems, and macrosystems that exert an impact on their general development. The microsystems are the group and institutions that direct mostly and generate varied impact in the life of a person, such as the settings in with a person have a direct interaction. This is the first system that surrounds social workers on a personal level with families, colleagues, and friends (Ettekal & Mahoney 2017:230). Social workers in this level are also involved in work-related issues that contribute to their mental health, thereby shaping their perceptions on and attitudes to their mental health (Ettekal & Mahoney 2017:230).

The mesosystem consists of interaction between the different parts of a person's microsystem. These interactions form a microsystem and interaction creates a mesosystem that emphasise on middle-size system, including support networks and groups that might influence Social Worker's productivity at work. Lakhan and Ekúndayò (2013:104), confirm that the mesosystem of ecological systems theory incorporates distinctive microsystems that serve these micro systems, formally and informally. They incorporate families and groups (peers, associations, work facilities, and services). The researcher perceives social environment as one of the important aspects influencing a social worker's perceptions and attitudes on their mental health in the work environment. Therefore, in this study, from data collection until interpretation, the researcher considered the effects of the interaction between prospective participants (social workers) and their families and work environments. The researcher posed probing questions in this regard because, according to Waugh, Lethem, Sherring and Henderson (2017:457), when employees have misconceptions surrounding mental health in the workplace and in their families, they are bound to develop negative attitudes, which in turn inhibit them from seeking help for fear of stigmatisation.

The macrosystem refers to a society's overarching set of beliefs, values, and norms evidenced in religious, socio-economic, and cultural organisations within communities (Crawford (2020:170). For the purposes of this study, the researcher examined features like the cultural background, which surrounds the social workers' perceptions and attitudes on their mental health in the work environment. In this study, the macrosystem also assisted the researcher to understand the effect of belief norms and values on mental health in the work environment.

The exosystem equally influences an individual. It is the next ultimate level that includes the microsystems where the individual is involved but not directly embedded (Ettekal & Mahoney (2017:230). This means that within the exosystem, the social worker may be influenced by dynamics like accessibility to resources that might contribute to their attitudes on their mental health in the workplace. The decisions by stakeholders such as the hospital administrators in addressing mental health issues and to enhance knowledge on employees about mental health comprise an example of an exosystem. This system assisted the researcher to understand the impact of lack

of resources and/or preventive programmes on mental health and their impact on the employee's attitudes and perceptions regarding their mental health in the workplace.

The last system is the chronosystem and includes major transitions of life that influence an individual development over time. This transition includes family, employment status as well as large society changes like wars and civil rights movements (Crawford 2020:170). For instance, the Covid-19 pandemic had a worldwide impact on people, individually and collectively, and can thus be classified as a chronosystem, which contributed to mental illness of employees globally. Consequently, the researcher probed prospective participants about their major life transitions that might have had an influence on their perceptions and attitudes of mental illness. From the description of the theory above, it can therefore be deduced that the ecological systems theory emphasises observing people in different settings and questioning their interactions with various systems to fully gain an insight of their behavior. In this regard, the researcher examines and explores the effect of various systems of prospective participants in relation to their perceptions of metal health.

2.12. Chapter summary

This chapter defined mental health and mental illness. It also comprehensively discussed the background on the prevalence of mental health globally, regionally and nationally. Also covered in the chapter is the prevalence of mental health in the workplace, perceptions, and attitudes of employees. Mental health programmes are also and so are social work strategies to cope with mental health Lastly a discussion of the impact of mental health challenges on social workers practising in the hospital setting was done, covering the overall impact of the death of patients on the mental health of social workers, high case load, secondary traumatic stress amongst medical social workers and burnout of social workers.

CHAPTER 3

RESEARCH METHODOLOGY

3.1 INTRODUCTION

This chapter presents the research methodology adopted in conducting this study exploring the perceptions and attitudes of social workers on their own mental health in Tshwane, Pretoria. The following topics are discussed in the chapter: research approach, research design, study setting, population and sample i, including the methods and instruments employed to conduct the study. In the ultimate section of this chapter, we cover the ethical considerations.

3.2 STUDY APPROACH AND DESIGN

3.2.1 Research approach

A qualitative research approach was adopted in this study. According to Hennink, Hutter and Bailey (2020:10), qualitative research examines people's experiences in detail by utilising specific research methods chosen by the researchers such as in-depth interviews, focus groups discussions and observations. A qualitative inquiry is "a broad approach" that qualitative researchers utilise to examine social circumstances (Rossman & Rallis 2017:5) and assumes that people apply "what they see, hear, and feel" to interpret their social experiences. Qualitative research is also conducted when there is a necessity to understand a multifaceted issue in greater detail and when the details can only be obtained by 'talking directly with people, going to their homes or places of work, and allowing them to tell the stories unencumbered by what we expect to find or what we have read in the literature' (Creswell & Poth 2018:45). Furthermore, the approach is also inductive in that the researcher develops concepts and theories from data that are 'contextualised from social interaction with research participants rather than predisposed or deductive hypotheses to prove' (Ravitch & Carl 2019:7).

The approach was thus applicable to the study because, firstly, the researcher longed to gain an in depth understanding of the phenomenon under study. Secondly, echoing Madondo (2021:47), the researcher sought to answer the "what, how and why" questions regarding the phenomenon. Thirdly, the researcher hoped to gather data

through direct engagement with participants. Furthermore, the approach was chosen because it allows the researcher to ask open-ended questions and allows participants to express their perceptions regarding their mental health in their own words, as espoused by Bryman (2016), Padgett (2017), Creswell and Poth (2018), Laiamputtong (2016), Erickson (2018). Lastly, the qualitative research was deemed appropriate to understanding the meanings, interpretations, and subjective experiences of individuals. It is also a humanising research approach owing to its focus on personal, subjective and empirical evidence.

The researcher offered an opportunity to participants for them to share their perceptions and attitudes on their mental health in the workplace. This was done by conducting in-depth face-to-face interviews to generate data to answer the research question. The researcher ensured that participants felt respected and with the sense of humanity by adhering to the ethical principles adopted on the study. Participants were provided with consent forms, treated participants' information with confidentiality and anonymised participants by using pseudonyms. According to Alam and Asmawi (2024:126), qualitative research takes a holistic approach in considering the whole context in which the individuals reside and work in to generate a full understanding of the world problems that they experience. The researcher intended to collect data to get a full picture regarding the phenomenon investigated. Hence the researcher asked social workers open-ended questions and gained an understanding into social work perceptions and their attitudes towards their mental health. The researcher also used theoretical frameworks to consider the impact of the hospital environment on social workers and their mental health. The researcher collected data from social workers herself and transcribed all the collected data and analysed it. The study anticipated a full description of social work coping strategies, policies that support social workers to promote mental health in the workplace and the coping strategies developed for them to deal with mental health.

3.2.2 Research design

A research design is a comprehensive plan that a researcher chooses in solving problems logically and as clearly as possible. It gives guidelines to researchers on how to carry out their plans (Rezaul 2018:3). Moreover, it can be explained as a

stepwise technique that monitors what is chosen by the researcher when planning a study (Wisenthige 2024:74). A research design also permits the researcher to channel the research methods that are suitable for the research project and set their studies for success (Khanday & Khaman 2023:06)). In literature there are different types of qualitative research designs, however in this study, an exploratory, descriptive, and contextual research design was adopted.

An exploratory design is usually conducted when relatively little is known about the phenomenon or an event; when the goal is to determine whether a relationship exists amongst several variables under scrutiny (Olawale, Chinagozi & Joe 2023:1384). The exploratory research design also explores topics that are unusual to create a new understanding into the underlying conundrum (McNabb 2020:98). The advantage of exploratory research design is that it allows the researcher to use semi-structured interviews and open-ended questions to obtain an in-depth understanding of the phenomenon. The researcher utilised an exploratory design because little is known about the perceptions and attitudes of social workers regarding their own mental health in South Africa. This can be attributed to the fact that in literature most studies focus on experiences of social workers and how employees perceive other colleagues who experience mental health challenges. The exploration was thus achieved by using semi-structured interviews and open-ended questions to obtain an understanding of social workers' perceptions and attitudes regarding their mental health in Pretoria, South Africa.

During data collection, the interaction with participants was recorded and following the interviews, the audio recorded data was transcribed and the description is presented as Chapter 4 of this report. In undertaking this task, the researcher employed the descriptive research design because, according to McNabb (2020:58), a descriptive research design provides an explanation of an event or helps to define a set of attitudes, opinions or behaviors at a given time and environment. The design was further suitable in the study because, echoing Bezuidenhout et al., (2021:85), it purposes is to describe as accurately as possible the characteristics of phenomena in relation to the context. He further explains that it aims to describe a situation, problem or phenomena under investigation such as individual experiences in a specific environment. Frey (2022:72) concurs that descriptive research design describes a

group of people, a phenomenon, or an event. It is designed to understand social problems and issues; it describes who is experiencing the problem, how widespread the problem is, and how long the problem has existed.

The final design implemented was the contextual research design. The contextual research design strives to generate comprehensive knowledge and in-depth understanding of the context in which the experiences of participants occur (Duda, Warburton & Black 2020:33). The contextual research design takes into consideration the experiences of the research participants within their environment, namely, physical, geographical, social, cultural, economic and religious aspects (Malagon-Maddonado 2014:120). In the study, the researcher thus hopes to understand how the work, the social, the cultural, the economic and the religious contexts of prospective social workers shape their perceptions and attitudes on their own mental health. The context of this study was Gauteng Department of Health government hospitals located in Pretoria. The data collected from the participants was contextual because the perceptions and attitudes on mental health was influenced by their work experiences at these hospitals in Pretoria. For instance, the economic context in a form of the resources availability to supporting mental health issues as well as the organisational culture of the hospitals influenced the perceptions of social work participants regarding how to handle their own mental health issues.

3.3 RESEARCH METHODS

3.3.1 Study setting

According to Maree (2016:46) it is important for the researcher to choose the site where the research study is conducted. In this study, the research was conducted in Pretoria, in the City of Pretoria of the Gauteng Province of South Africa. The area of City of Pretoria is small, stretching from Centurion in the South to Soshanguve in the North. According to Statistics South Africa (2011), Pretoria has an estimated population of 2 921 500 residents and consists of seven regions, which are Pretoria North, Far North, Central, Western, Southern, Pretoria Far East, Eastern, and Bronkhorstspruit. The study thus targeted hospitals located in the said locations.

3.3.2 Population

A target population constitutes the totality of individuals within a particular group (Azeh 2015:63). A target population consist of a subset of the broader population being investigate, characterised by the specific criteria directly relevant to the research inquiry (Alvi 2016:34). According to Hossan, Dato'Mansor and Jaharuddin (2023:209) population as the entire group of persons or objects that the researcher is interested on which meets the criteria for the study, while Babbie (2020:199) describes it as 'the theoretically specified collection of the elements of a study', thus the elements (people or artefacts) from which a sampling unit is selected. The population for this study thus comprised all the social workers (i.e., managers, supervisors and practitioners) employed by the Gauteng Provincial Department of Health but located in the Pretoria region. According to the Statistics of Social Work in Gauteng Department of Health (2022), the number of social workers employed by the Pretoria region of the Gauteng Department of Health are as depicted in Table 3.1

Table 3.1: Social work employees in Gauteng Department of Health in Pretoria

Name of the Hospital	**Social Work Manager**	**Social worker supervisor**	**Social workers**	**Total**
Dr George Mukhari Hospital	1	4	17	22
Jubilee Hospital		1	4	5
Odi Hospital		1	2	3
Pretoria West Hospital		1	2	3
Steve Biko Academic Hospital	1	2	8	11
Pretoria District Hospital			3	3
Totals	2	09	37	47

Table 3.1 above shows that there is a sizeable number of social workers employed by the Gauteng Department of Health in Pretoria and this made the study feasible because the researcher had a good pool of prospective study participants. It is also crucial to note that in this study, echoing Pope and Mays (2020:52), the researcher could not include the entire population of social workers in Gauteng when conducting

the study due to time and financial limitations. The researcher thus selected a subset of the population drawn by means of sampling.

3.3.3 Sampling

Army and Eyler (2021:78) states that researchers must decide on the sampling method used, and it should be related to the research question and study objectives. Sampling is aimed at determining the exact number of units from the whole population for investigation in order to organise and describe the features of the whole population, if needed, to draw interferences about the population from the small subset of data (Bezuidenhout at al. 2021). Amy and Eyler (2021:79) describe sampling as analysing a portion of a large group of individuals in the research to gain an in-depth insight about the whole population.

There are two categories of sampling methods, which include probability and non-probability sampling (Amy et al., (2021:79). Quantitative researchers use of probability sampling when conducting research while qualitative researchers prefer non-probability sampling techniques. Probability sampling is used to estimate the extent to which the sample represents the larger population (Amy et al., 2021:79) while non-probability sampling does not claim representativeness and a complete sampling frame (Makwana, Engeneer, Dabhi & Chadasama 2023:3).

In this study the researcher adopted non-probability sampling techniques, i.e., purposive sampling to be exact. Purposive sampling is sometimes regarded as purposeful sampling or judgmental sampling. It is a methodology in which elements of the population are selected strictly on their fit with the goal of the study (Bezuidenhout at al, 2021). Purposive sampling gives a researcher an opportunity to choose the sample for a purpose, providing an understanding into an issue that that is related to the study focus (Alston 2018). According to Cohen, Manion and Mortison (2019:219) through “purposive sampling a researcher is given a chance to select the case included in the study based on their judgment of their typical of certain characteristics.” Purposive sampling was suitable for the study because the researcher wanted to collect in-depth information from the social workers. The technique is also relevant because it is cost-effective, can be executed quickly and it is personalised to fit the

research study as alluded to by Bezuidenhout at al. (2021). The study participants were subsequently selected by means of the following inclusion and eligibility criteria:

- Social workers employed by the Gauteng Provincial Department of Health who provide psychosocial support services to patients and their families.
- Social workers working in the Pretoria region
- Those with at least 1-year experience in the social work field
- Social workers who showed willingness to be part of the study by signing the informed consent form.
- Social workers between the age of 18 and 65 years of age with no limitation regarding gender.
- Social worker who can speak and understand English.

It is thus clear from the inclusion criterion that not all social workers were included in the study and an exclusion criterion was developed. The exclusion criteria refer to features of the potential study participants that have a potential of interfering with the outcomes of the research study or those that may pose risk for an unfavorable result of the research study (Patino and Ferreira 2018:44). Against the backdrop, the following exclusion criteria was developed for the study:

- Participants who are not interested to be part of the study
- Participants with less than one year's experience in working in the health field
- Social workers operating in the Pretoria region but employed by other government entities or employed in the NGO and private sectors.

It is worth noting here that the number of participants included in a study was unknown to the researcher prior to data collection because, according to Malterud, Siersma and Guassora (2016:26), in qualitative research, the sample size is not strictly determined by set formulae since data collection continues until no new information emerges from the participants (Pope & Mays 2020:52). According to du Plooy-Cilliers, Davis and Bezuidenhout at al. (2021:153), this process is called data saturation. The principle was utilised in this study where data saturation helps the researcher identify when to

stop collecting data, was adopted in the study to determine the number of participants (Pope & Mays 2020:52).

3.4 DATA COLLECTION METHODS AND PROCEDURES

Data collection is a procedure of applying specific techniques to gather information from participants in an organised manner for answering the research questions (Creswell & Poth 2018:148). In qualitative studies, data can be collected in many forms "including interviewing individual participants, focus group interviews, taking field notes of shared experiences, journal records, interview transcripts, observations, storytelling, letter writing and autobiography" (Creswell & Poth 2018:140). In this study, the researcher used interviews for collecting data. The process of data collection in this study thus unfolded as follows:

3.4.1 The preparations for collecting data

The researcher requested ethical approval to conduct the study from UNISA College of Human Sciences Ethics Review Committee, allowing the researcher to embark on a recruitment drive to gain access. The researcher applied online to NHRD (National Health Research Database) to request conducting a study in the Gauteng Department of Health in hospitals situated in Pretoria and the required permission was granted. Following the NHRD approval (the researcher submitted a request to conduct a study in the hospitals in Pretoria for approval and to collect data from social workers). The request was accompanied by a permission letter to conduct the study, consent form, and ethical approval letter from UNISA. Gaining access to the study site was another undertaking because only three institutions replied positively to the request. Creswell and Poth (2018:172) also warns that gaining access to participants can be an overwhelming task.

Following approval by each of the hospitals, the researcher contacted social work managers in the social work departments of the hospitals to request to conduct the study with the social workers. Through the managers, the researcher then went to the hospitals wherein meetings were held with social workers to orientate them about the study. Padgett (2017:73) concurs that gatekeepers must be informed about the nature of the research study, as well as the duration.

After the presentation (orientation), the researcher requested email addresses and office numbers of social workers. The researcher then communicated with the social workers about the study via emails. The researcher provided details on what the study wished to accomplish, how data would be collected and the type of contact and length of contact with participants. The researcher made a copy of the informed consent form (Addendum B), which outlined the ethical aspects complied with and steps taken by the researcher to ensure the protection of the participants. The emails were then followed up by contacting participants who expressed willingness to participate in the study. Subsequently 14 social workers participated in the study. After participant's consent, the researcher arranged the interviews for data collection in an environment safe and conducive for the participants and where the participants felt comfortable to participate in the study as advised by Creswell & Poth (2018:57).

3.5 DATA COLLECTION METHODS

In qualitative studies, data can be collected in many forms including interviewing individual participants, focus group interviews, taking field notes of shared experiences, journal records, interview transcripts, observations, storytelling, letter writing and autobiography (Creswell & Poth 2018:140). In this study the researcher used interviews to collect data from participants. Qualitative research interviewing is a form of social interaction in which the interviewer must listen to, and encourage, the accounts of others so that they feel safe to tell their stories or share their views (Pope and Mays 2020:49). According to Taylor, Bogdan and Vault (2015:102) qualitative interview is the face-to-face engagement wherein the participants and researcher meet with the purpose of understanding the participant perceptions on their experiences as expressed in their own words. There were thus several qualitative data interview instruments at the researcher's disposal but for the purpose of the study, data was collected by means of semi-structured face-to-face interviews with participants.

Semi-structured interviews employ flexibility to gain more in-depth information from interactive communication with the participants (Pathak & Intratat 2016:8). During data collection in semi-structured interviews, the researcher used an interview guide but was flexible in encouraging the participants to share and talk freely with the researcher

(Pope & Mays 2022:44). Army & Eyler (2021:199) adds that semi-structured interviews are conducted using a list of broad and open-ended questions, but with some flexibility to obtain full information from the participants. The researcher thus compiled the research questions before conducting interviews and at the beginning of the interview the researcher elicited biographical information. The questions are contained in Appendix C of this report. In this regard, the researcher asked open-ended questions as opposed to closed-ended ones because, echoing Pope and Mays (2020:220), the former questions allow the participant to give different perspectives and responses that are not influenced by predetermined cues provided by the researcher. Amy and Eyler (2021:199) advise that interviews should be conducted in a quiet and comfortable place that is convenient for the participants and the researcher complied with the suggestion. The interviews were therefore conducted in the offices of the social workers, privately. The interviews were also recorded. It is important for qualitative interviews to be recorded so that they can be transcribed for detailed analysis and keeping a record of what is said during interviews (Eyler 2021:199). The researcher also alerted participants about the audio recording when they signed an informed consent form. Audio recording the interviews was of great help in the study because, echoing Amy and Eyler (2021:199) it enhanced the reliability and clarity in analysis.

During the interview, the researcher applied interviewing skills such as building rapport, active listening, and probing. For the researcher to get to know participants, building rapport and sharing of information and similarities was applied. According to Pathak & Intratat (2016:5), building rapport can perfectly be done before the interview and when a good foundation on which to build the topic-related conversation has been laid.

Probing was also used to obtain detailed information from participants and to help the researcher gain more details about what the participants said for clarification Army and Eyler (2021:199). The researcher probed when participants voiced their perceptions and attitudes regarding their own mental health. The researcher used probes such as “I hear you; mmm; I see; go on; and also non-verbal responses such as nodding her heard during the interview.” This ensured that participants kept sharing or talking without being distracted, garnering in the process their deep understanding

of their thoughts. Additionally, probing helped to motivate participants to share their experiences.

Furthermore, the researcher actively listened to participants when sharing their views regarding their own mental health. According to Pope and Mays (2022:46) active listening skill involves listening attentively and thinking about what participant is saying during interview and assisted the researcher to capture their thoughts and opinions. When listening, the researcher observed non-verbal cues - facial expression, tone of voice, eye contact, gestures and posture when participants shared their attitudes and perceptions regarding their mental health (Pope and Mays, 2022:46). This skill was applied because a qualitative interviewer is an actor during the process of collecting data and should ensure that her position does not influence the study.

3.6 PILOT TESTING

Before data collection, the researcher conducted pilot testing. Castillo-Montoya's (2016: 811) state that interview protocols could be supported through piloting the interviews to identify if there are flaws, or limitations within the interview design that allow necessary changes in conducting the major study. According to Dikko (2016:532), before conducting the main research study, it is compulsory for the researcher to test the questions with specific participants who can alert the researcher on doubts and other problems related to improving the clarity and precision of questions for collecting data. Tate, Beauregard, Peter and Morotta (2023:20) also add other advantages of conducting a pilot test, which includes: getting a sense of time it would take participants to respond to all of the questionnaire items, confirming clarity of instructions, in both the case of face-to-face and questionnaire-based interviews, testing whether any questions are unclear or confusing, determining whether there is any questions respondents feel uneasy to answer, checking whether the design is clear and attractive. Piloting also helps in checking if problems are experienced in the recording and capturing of responses.

Owing to the preceding description on pilot testing, a pilot study was conducted, and the following procedure was followed: The researcher already received ethical clearance from (Addendum A) as well as NHRD clearance certificate (Addendum F) to conduct a study to social workers in Pretoria, South Africa. One hospital was

identified, social worker manager in Social Work department was contacted requesting to conduct the research study with social workers, the approval was granted and three social workers who met the study's inclusion criteria were recruited and interviewed. As part of research interview, participants were orientated on the study, and the consent was obtained through the signing of the consent form (see Addendum D). Only participants who signed the consent form were informed about the date, venue and time for the interview.

The interviews were conducted in the hospital, in social worker department as it was conductive and private environment enough for them to share freely their perceptions and attitude regarding their own mental health. On the day of the interview with the participants, they were reminded about the recording and were given hard copies of the consent form before the start of the interview (see addendum E). The researcher reflected on the issues related to confidentiality, and data management (i.e., data will be kept safe in the locked cabin). The researcher also explained the purpose of piloting, requested permission to record the interview, and it was granted.

Piloting was conducted through the semi-structured using interview guide. This granted the researcher an opportunity to clarify and modify interview questions for the main study. After the interview the participants were given an opportunity to give feedback about the questions and feedback about their perception about the interview. From piloting, one question was modified *from* "Describe your experience in working with an individual with mental health illness" *to* "Describe your experiences in working with individuals (employees) with mental health challenges." The participants indicated that when answering the question, they answered based on their experiences of working with patients with mental health challenges as opposed to referring to their colleagues. Hence, question was then rephrased. Rephrasing the question gave the participants a clear understanding that the question refers to their experiences in working with their colleagues who experience mental health challenges. This rewording process assisted the researcher to enhance the quality of the study.

The researcher also realised that after the interview, participants were overwhelmed by emotions as they got an opportunity to self-introspect and realised that they might be experiencing mental health challenges, which required their attention. This was an

important discovery for the researcher proceeding with the main study and the contact details of the Clinical Psychologist who specialises in employee health and wellness were given to the participants. Participants were encouraged to contact this Clinical Psychologist for debriefing and further intervention when necessary. Finally, participants interviewed for the pilot study were not included in the actual study.

3.7 METHOD OF DATA ANALYSIS

Data analysis is a process of minimising data gathered from participants and transforming it through an iterative process of interpretation, transferring and construing meaning from the collected data (Padgett 2017:141). Data analysis is a technique of modeling information to get useful data through consolidation and minimising responses and to answer the research question (Grinnell and Unrau, 2018:648). In analysing the collected data, the researcher employed thematic data analysis to assess and weigh the data. Thematic analysis is used for identifying, analysing and reporting patterns or themes derived from participants' experiences, meanings and their reality (Groenland & Dana, 2019:186). According to Gupta, Sheheen and Reddy (2019: 203), thematic analysis allows data interpretation to reach the broader perspective of significant social contexts. In this study, the following steps described by Gupta, Sheheen & Reddy (2019:206) are followed in analysing data:

Phase 1 (Getting familiar with data)

In phase one the researcher familiarised herself with the collected data in its entirety by listening attentively to the audio recording and thereafter transcribed all the interviews. Following that, the researcher read and re-read the transcripts and listened to the audios several times to thoroughly immerse herself with the data.

Phase 2 (Generating initial codes)

Once familiar with the data, the researcher generated initial codes. The researcher attended to each data item to create preliminary codes based on themes emerging from the data. Different text colours were used to highlight and circle significant information and categorise them to form a code. This reduced and organised collected data.

Phase 3 (Searching for theme)

At this stage, the researcher sorted, analysed, identified the codes, and combined them according to central themes. The researcher then populated the data on a spreadsheet. The researcher then managed to reduce the data into themes.

Phase 4 (Reviewing themes)

On reviewing themes, the previously generated themes and sub-themes can merge, develop, break down or collapse through the modification process (Gupta, Sheheen & Reddy, 2019:206). And likewise in this study the researcher also analysed, adjusted and modified the themes. At this juncture, subthemes also emerged.

Phase 5 (Defining, refining, and naming themes)

The researcher analysed each individual theme and subtheme and where necessary refined them according to need, ensuring that they were linked to the overall study purpose. Thereafter the researcher gave themes short, clear, and functional titles as advised by Gupta, Sheheen & Reddy (2019:206).

Phase 6 (Producing final report)

The final phase of the data analysis process involved compiling the final research report. The themes and sub-themes developed in Phase 5 was used to structure the discussion of Chapter 4 (i.e., Findings of the study) of this research report.

3.8 METHOD OF DATA VERIFICATION

Data verification is also referred to as trustworthiness, which Madondo (2021:203) defines as the acceptability of research outcomes which includes credibility, transferability, dependability, and confirmability. In this study, data verification was also considered by employing the trustworthiness principles of confirmability, transferability, credibility, and dependability espoused by Kaka, Rasheed, Rashid & Akhter (2023:45)

3.8.1 Credibility

According to Army and Eyler (2021:199) credibility refers to observing the research protocols, which involves dependent variables and giving precise and truthful feedback

of the findings from participants to ensure trust in the interpretation. The researcher ensured credibility by applying certain strategies such as audit trail, spending more time in the field, peer debriefing and member checking (Strydom, 2021:395). To ensure credibility of the finding, the researcher followed the aspect of triangulation,

3.8.2. Reflexivity

Reflexivity denotes that a researcher should acknowledge their personal biases and preconceptions throughout the research process (Stahl and King 2020:28). The researcher in this study confronted her possible biases prior to data collection and through introspection she predetermined that her possible preconceptions and biases in the study could stem from the fact that she herself is a social worker working in the Department of Health, at the Steve Biko Academic Hospital in Pretoria. Secondly, she also needed to reflect on her own perceptions about her own mental health, ensuring that this did not cloud her judgment during the data collection, analyses and presentation of findings in the study and this minimized potential distortion in the findings.

3.8.3 Dependability

Dependability refers to the technique used to determine the credibility of the amalgamation of data collection methods, data analysis procedures and the knowledge derived from the data in the study (du Plooy-Cilliers, Davis, & Bezuidenhout 2021:296). According to Army and Eyler (2021:199) dependability validates the outcomes from the information gathered from the participants. For ensuring the dependability of the research study it requires the researcher to carefully describe the research process, to ensure audit trails, and to make documentation easily accessible to others (Strydom 2021:394; Bless et al., 2013:237). Another method for ensuring dependability is triangulation (Madondo 2021:152). Drawing from the preceding views, in this study dependability was assured by describing comprehensively the research process undertaken as advised by Strydom (2021:394) and Bless et al., (2013:237). This Chapter 3 of the research report is thus dedicated to discussing the research process followed in the study. The researcher also used a voice recorder during data collection, which assisted in ensuring that the described data is a correct

representation of the views of participants to ensure dependability as advised by Strydom (2021:152).

3.8.4 Transferability

According to Stahl and King (2020:28), transferability pertains to the degree to which the research findings can be extrapolated to alternative contexts or situations. Qualitative researchers aim to offer comprehensive and intricate depictions of the study's environment, participants, and procedures to enhance the potential for transferability. By providing detailed and comprehensive explanations, researchers allow readers to evaluate how applicable the findings are to similar situations, thus improving the study's transferability. According to Madondo (2021:143), transferability includes a component of assessing the external validity of the research findings and conclusions. In this study, the researcher provided detailed information about the findings of the study as advised by Army and Eyler (2021:199)The findings are a comprehensive, rich, and thick description of the participant's perceptions on the studied phenomena as contained in Chapter 4 of this report and in their current format anyone can read it to have an in-depth understanding regarding the study.

3.8.5 Confirmability

According to Creswell (2018:134), the aim of confirmability is to ensure that the researcher shows they have acted in good faith and set aside their personal values and theoretical inclinations to influence the research. Madondo (2021:143) concurs that conformability refers to the fairness between the participants and the researcher during data collection and developing of the research report. Creswell (2018:134) further advises that good qualitative research contains comments by the researchers about how their interpretation of the findings is shaped by their background, such as their gender, culture, history, and socioeconomic standing. Against this backdrop, the researcher adhered to conformability by making sure that the research outcomes are truly from participants' responses. The researcher did not allow her emotions and values as well as her experiences to interfere with participants' responses. The researcher also utilised quotations and vignettes from participants as recommended by Santos et al., (2021:186) to eliminate researcher bias.

3.9 SUMMARY OF THE CHAPTER

This chapter elucidated the research methodology that was utilised to explore the topic and the attendant research questions. Its outlined how the research was conducted. The purpose, research question, research objectives, data collection, data analysis, data verification were presented and defended. The next chapter is a narrative and comprehensive report of the findings of this study.

CHAPTER 4
DATA PRESENTATION AND ANALYSIS

4.1. INTRODUCTION

Whether in a qualitative research or quantitative research, the findings of a study present what has been achieved after the data collection and analysis (Raibow, 2024). This chapter thus focuses on reporting and analysing the data that were obtained by means of face-to-face semi-structured interviews. The interviews were conducted with social workers employed by the Gauteng Department of Health in the Pretoria South Africa. The study explored their perceptions and attitudes regarding their own mental health. The findings thereof are discussed and evaluated. For the sake of authenticity, verbatim statements of the participants are presented in italics. In keeping with the ethical considerations of anonymity, the participants are not identified by name but by pseudonyms which are alphabetic symbols. While many of the themes overlap, the discussion is clustered with reference to the objectives and research questions as outlined in Chapter 1. In this study, ten themes emerged from the data derived from the interview questions posed by the researcher during the semi-structured interviews. The discussion thus commences with the analysis of participant biographical question.

4.2 BIOGRAPHIC PROFILE OF PARTICIPANTS

Participants in the study were required to answer the following biographical questions: How old are you? What is your highest qualification? How long have you been working as a social worker? Describe your responsibilities as a social worker within the Gauteng Department of Health and the participants responded as follows:

Table 4 .1: the biographic profile of the participants

Participants	Age	Social work experience	Gender	Qualifications
P1	30 years	1 year	Female	Bachelor of Social Work
P2	30 years	5 years	Female	Bachelor of Social Work
P3	32 years	2 years	Female	Bachelor of Social Work and registered for Master of Social Work.

P4	35 years	10 years	Female	Bachelor of Social Work
P5	35 years	1 year	Female	Bachelor of Social Work
P6	36 years	10 years	Female	Master of Social Work
P7	37 years	9 years	Female	Bachelor of Social Work
P8	39 years	15 years	Male	Bachelor of Social Work
P9	40 years	6 years	Female	Bachelor of Social Work
P10	42 years	2 years	Male	Bachelor of Social Work
P11	42 years	10 years	Female	Bachelor of Social Work
P12	43 years	14 years	Female	Bachelor of Social Work
P13	45 years	9 years	Female	Bachelor of Social Work And Honours in community development studies. Registered for Master of social work
P14	52 years	10 years	Female	Bachelor of Social Work

4.2.1 The age of participants

The inclusion criterion of the study was that participants should be above 18 years to 65 years of age and in keeping with this the study consisted of participants age 32 years to 52 years. Eight participants are in stage 6 (intimacy vs isolation) of Erik Erickson in stages of development and 6 in stage 7 (generativity vs stagnation) of Erik Erickson stages of development. Stage 6 includes young adults that need to be in a loving relationship with other people, their success contributes to strong relationships, failure leads to loneliness and isolation stage 7 individuals. During adulthood, and adult continues to develop their lives, determined in their career and family. Adults who are successful during this stage feel that they are making a positive impact on the world, are active in their families and community, those who fail to achieve this feel unproductive and uninvolved in the world.

4.2.3 The participants' social work experience

The participants in the study had 1 to 15 years social work experience in Gauteng Department of Health. Five of them had one to five years and seven participants had nine to fifteen years of experiences working as social workers.

4.2.4 Social work roles the hospital

The participants were asked to describe their duties in the hospitals as social workers, and they reported that they generally provided psychosocial support services to patients and their families, connected patients and their families with local resources, provided grief counselling, provide psychotherapy to patients and their families, discussed discharge planning, and equally psychoeducation support counselling. According to Bhagwana and Heerala (2024:156) there is a great need for social workers to provide psychosocial support services to patients and their families to deal with emotional and psychological challenges due to their hospitalisation. Social workers in the hospital also have a role and responsibility on crisis intervention, psycho-educational support counselling, family meetings, discharge planning and refer patient to community services that are relevant to their needs (Browne:2019: 21-37).

4.2.5 The gender of participants

Gender refers to the socially constructed characteristics of women, men, girls and boys (WHO 2024). This encompasses norms, behaviours and roles associated with being a woman, man, girl or boy, as well as the relationships with each other. As a social construct, gender varies from society to society and can change over time. Kaufam, Eschliman and Karver (2023:666) confirms that gender is a social construct of roles, behaviours, activities, and attributes that a society considers for men and are learned through socialisation processes. Consequently, in this study, the gender variation of the study participants is as follows: 12 female social workers and 2 male social workers. This gender representation is in keeping with the profession because, according to Galley (2020), social work is largely a female–dominated profession, while males occupy senior roles. Vilka and Baha (2018:51) share the same sentiment that social work profession is not popular amongst men than women. Thobela(2020) also found that as much as social work in South Africa is dominated by women, men are slowly joining the field.

4.2.6 The qualifications of participants

Thirteen (13) participants reported to be in possession of the minimum social work qualification, and only one reported had a postgraduate qualification, which is a Master of Social Work degree, while another participant has an honour in community development studies. Two other participants are currently registered for postgraduate and studying towards a Master of Social Work qualification in different institutions. The participants thus meet the basic criterion of practising social work in South Africa because in South Africa, a social worker is considered as a person who possess a social work qualification and registered by the South African Council for Social Service Professions (SACSSP) under section 17 of the Social Service Professions Act (No. 110 of 1978). The IFSW (2021) also defines a social worker as a trained professional who engages in a scientific relief, change, growth and empowerment of patients.

4.3 Presentation of findings

The findings herein are presented thematically. Thematic analysis is a qualitative research method that systematically organises and analyses complex data sets (Dawadi 2020:62-71). Savacool, Iskandarova and Hall (2023:97) concurs that thematic analysis is a type of qualitative analysis that is used to analyse classification and presentation of themes (patterns) that relates to the data collected. Naeem, Ozuem, Howell and Ranfogni (2023:22) concur that themes in qualitative research are active patterns derived from data collected to answer the research question and they represent the meaning within the data collected from participants. In this chapter, themes were derived from interview guide attached as (Addendum E). It is also critical to note that in this presentation, codes are used, and according to Kiger and Varpio (2020:846), codes comprise the basic element of raw data collected assessed in a meaningful way regarding the phenomenon. Below is a summary of themes, sub-themes that emerged from the interview with the participants.

Table 3.2 Overview: Themes, subthemes and categories

THEMES	SUB-THEMES
Understanding the difference between mental health and mental illness	Participants' understanding of mental health

	Participants understanding of mental illness
Participants' experiences on working with individuals with mental illness.	
Participants' own mental health challenges	
The participants' perception of their own mental health	
Effects of mental health on the participants	Work pressure Lack of social life Home life
Participants' coping strategies with own mental health challenges	Supervision and consultations Self-care Spiritual support
Workplace policies and services to promote mental health.	Policies that promote mental health in the workplace Services available to promote mental health.
Suggestion on how to improve mental health services in the workplace	

Theme 1: Understanding of the difference between mental health and mental illness

Poopedi and Bila (2023:357), mention that mental health is a growing area of concern worldwide with a lot of people presenting with mental illness complications. It was thus deemed important in this study to establish if participants understood the difference between mental health and mental illness because it is only when they can identify signs and symptoms of mental health challenges that they can seek help. It is also only if participants have insight into themselves that they can utilise mental health resources and support available to them. The following sub-themes emerged from the responses of the participants:

Subtheme 1.1: Participants' understanding of mental health

According to National Mental Health Strategic Framework and Strategic Plan of 2023-2030, mental health is a state of mental well-being that enables people to cope with the stresses of life, to realise their abilities, learn and work well, and contribute to their

communities. On the other hand, mental illness includes a range of disorders such as anxiety disorder, depression disorder and trauma disorder. In this study, when asked to describe mental health, most participants mentioned that mental health refers to emotional wellbeing; being able to cope with stress and being mentally healthy. This is attested to by their following utterances:

"Mental health is being mentally healthy, like everything is balanced, your health is good mentally" (P9)

The next participant extended this understanding:
"Mental health is a broad spectrum, it includes social wellbeing, and how you cope with life experiences. It's about how you handle problems and life challenges" (P2)

P8 offered a generic understanding of mental health:
"Mental health is mental well-being. It will encompass feeling well mentally, like addressing your stressors to avoid mental illness" (P8)

Similarly, P4 brought in the need for therapy:
"Mental health is about emotional wellbeing; it requires therapy when not emotionally well" (P4)

Coping comes through strongly in P3:
"A mentally healthy individual is able to do daily activities, work or home and adjust to any environment. An individual is able to cope with any circumstance that may emerge" (P3)

P5 specifically recognises the dimensions of mental health:
"Mental health is about our health. The way we take care of ourselves, and our well-being, which can be in our work hard in terms of physical, mental, emotional, spiritual well-being. That's what mental health is about. How we take care of ourselves" (P5)

P10 endorses the following in terms of the difficulties and opportunities related to mental health:

"*Mental health refers to out how a person feels. How you relate to others, how you deal with opportunities, difficulties, and challenges of everyday living. That's mental health" (P10)*

Upon analysing the above data, it is clear that social workers understand the meaning of the concept of mental health. The participants asserted that mental health is a state of being mentally sound and being able to manage life challenges and stressors as well as being able to seize the opportunities.

Subtheme 1.2: Participants' understanding of mental illness

Regarding the participants' understanding of what mental illness means, the participants explained this in relation to its causal factors. They asserted that mental illness is caused by extreme stress and that when mental illness is diagnosed, this must be followed by immediate treatment. The participant's utterances are as follows:

"Mental illness is when a person suffers through some form of mental illness in terms of depression, bipolar disorder, that is mental illness. The people probably exhibit symptoms of psychosis, and they can't cope with their depression, and they need further care, treatment, and rehabilitation. For me, that's mental illness and that's when we need to seek help" (P6)

P1 was rather curt in their understanding:
"Mental illness when the person doesn't have a capacity to cope with life stresses. It's when stress escalate to depression, schizophrenia and bipolar" (P1)

P2 focused on the diagnosis:

"Mental illness is diagnosed by a psychiatrist and requires treatment, and its example are bipolar and schizophrenia" (P2)

P3 stressed the impairments arising from mental illness:
"*Mental illness refers to an inability or the impairment in cognitive function. Cognitively there is an impairment" (P3)*

For P4, the pathology requires medication:
“Mental illness such as schizophrenia, bipolar required medication because an illness is the presence of disease. It would mean that now there is a mental pathology. That's how I understand it” (P4)

Equally, for P5 it is the imbalance that characterises the disease:
“Mental illness is any health condition that may destabilise one’s mind, affecting ones thinking and behaviour, and requires to be diagnosed by psychiatric doctors” (P5)

P7 recognises the new understanding of the ailment:
“Mental illness is now called mental disorder to eliminate the stigmatisation. It is about something is wrong with a person” (P7)

In P9’s understanding, another generic conceptualisation emerges:
“Mental illness is when you have an illness, having something that disturbs your mental health, and causes you to be mentally ill” (P9)

The participant’s comments are confirmed by the Diagnostic and Statistical Manual of Mental Disorder (DSM- 5), which define mental disorder as a syndrome characterised by clinically significant disturbance in an individual’s cognition, emotion regulation, or behaviour that reflect a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. The participants’ descriptions also concur with the description of mental health espoused by the Mental Health Care Act No.17 of 2007 that defines mental illness as a disorder of thinking, mood, perception, and memory that completely form judgment, behaviour and the capacity to recognise reality or ability to meet the ordinary demands of life. From the vignettes, it is clear that participants fully understand the concept of mental illness as most shared that mental illness is when an individual is unable to function mentally and subsequently gets diagnosed by a psychiatrist and treats the condition with medication. Against this backdrop, the ecological system theory is applied to understand mental illness by examining the interpersonal relationships between the individual and the different environmental systems.

Theme 2: Participants' experiences in working with individuals with mental illness

This theme was derived from the following question: Describe your experience of working with individual diagnosed with mental illness. The question was important to establish the extent to which participants have been exposed to mental illnesses. Most of the participants voiced their experiences of working with colleague(s) with mental health challenges. The following responses reflect the experiences of the participants:
"I did have a colleague previously who was diagnosed with a bipolar mood disorder. She unfortunately … had relapsed. It seemed like she was not adhering to her treatment, so it created so much burden on us as colleagues like all of us who were working with her in the department. Her absenteeism increased, and it meant that the workload on our side increased too. She had to constantly be admitted and seeing that other colleagues were unable to understand her condition; she was stigmatised. She was treated differently from others" (P12)

P8 regaled her frustrations:
"I had one colleague who was dealing with a mental illness, and it was very frustrating to deal with her. It felt like everything was about her. So, it took a lot out of me to be supportive, to be there for her because when she went through a phase of relapse, I would become the enemy in her stories" (P8)

P7's experience was quite elaborate:
"It was not easy to work with a colleague who was diagnosed with mental illness. It was a challenge because they are unpredictable and even aggressive at times in the workplace. So, it's more about identifying that you know what, this colleague is going through something, you go and basically talk to that person and say, I've noticed that you're not yourself, what is happening? You notice by their physical appearance, you notice about how they're dressing up, their neglect, also not being attentive, not listening, sometimes it's isolation. So, you pick up all these triggers and then you need to go and identify. It was tough because she herself comes from a family where the father is diagnosed with bipolar disorder and then she herself was going through depression and I want to say depression and anxiety" (P7)

P9's experience focused on the emotional drain:
"I feel they want attention, you know, making things about them. I feel like it's something that has been a very draining experience because, yes, you want to be supportive, but to what extent?" (P9)

The challenges of dealing with a colleague suffering from this illness was even more telling in P10:
"So, yeah, it can be challenging. It's challenging, it's not easy. No, it's not. Because they would have outbursts. I once experienced an outburst in one ward. It's a colleague that I know very well and have worked with for many years. I've known her to be very friendly and easy to work with. One day, we just had this argument and she burst out. But I could see she was not herself" (P10)

P11 dwelt on the signs and symptoms:
"But it gets difficult if someone is mentally ill, you can see the signs and symptoms, but they are not formally diagnosed, and they don't even admit to themselves that they are not well, so working with those people, it gets very difficult. So being aware of their illness, it gets better. Working with them is very difficult" (P11)

Whereas P12's account shows brevity, it still shares the same aspects of abnormality:
"I have a very bad experience with working with colleagues with mental illness as they tend to behave abnormally" (P12)

The participants shared different experiences of working with colleagues with mental illnesses. There were participants who reported that working with colleague(s) with a mental illness is very difficult as they are unpredictable and can also be aggressive in the workplace. Others shared that because often they (participants) often do not know their diagnosis, then they are stigmatised in the workplace. These findings are confirmed by Hampson, Watt and Hicks (2020:288) who also reports that employees with mental illness are labelled and perceived as unpredictable, aggressive, violent, dangerous, unreasonable, less intelligent, and lacking in self-control in the workplace. Shahwan, Yunjue, Satghane, Vaingankar, Manjam, Janrius, Lin, Roystonn, Sabramaniam (2022:50) also found that co-workers fear to work with employees

suffering from mental illness as they perceive them as unpredictable, dangerous, and often they are unable to get along with them.

White, Baldwin and Cang (2023:481-495) also concur that employees hold a negative perception of other employees suffering from mental illness as they believe that when a person is diagnosed with mental illness, they are likely never capable of recovering; they believe that mental illness is not real, employees suffering from mental illness are dangerous, incompetent, unpredictable and unreliable.

From the findings above and following Poppedi and Bila (2023:356), people with mental health illnesses have various bio-psychosocial needs and meeting these depend largely on social workers and specifically mental health social workers. It is therefore the view of the researcher that when working with a colleague battling a mental illness, social workers must have a complete understanding of client and be guided by professional values, have non-judgmental attitudes, and allow client self-determination (Gale et al., 2022). Social work colleagues ought to extend the same grace to their colleagues albeit it may not be easy.

The findings also fit in with the microsystems of the ecological systems theory, which denotes system that surrounds social workers on a personal level with families, colleagues, and friends (Ettekal and Mahoney 2017:230). This may include institutions and groups that have the most direct and generate varied impact in someone's life. The microsystem is thus applicable herein because social workers have a direct contact with their colleagues who have mental health challenges and as such the interaction has an impact on their lives including shaping their perceptions and attitudes on their mental health. This is because the first social workers in this level are also involved in the work-related issues that contribute to the shaping of their mental health.

Theme 3: Participants' mental health challenges

Herein, the participants were required to discuss their own mental health challenges. Many of the participants reported experiencing mental health challenges, indicating that trauma is one of their major mental health challenges associated with working in

a hospital a setting. Burnout and anxiety brought forth by their high workload were also mentioned as factors contributing to their mental health challenges. The participants also experienced anxiety due to high expectations from the multidisciplinary team (MDT). These are some of the participant's vignettes in this regard:

"Patients' experiences are traumatic. I am also experiencing anxiety and insomnia from the high workload and the demand of social work services. There is also a lack of understanding of social work services from Multi-Disciplinary Team (MDT)" (P1)

P3 states similar experiences and specifically talks of the MDT:
"I experience burnout because of lots of irreverent referrals from the MDT. Burnout emerges because there are not enough social workers. There is also a misrepresentation of social work services from MDT" (P3)

The high workload recurs as a critical cause in the following:
"We do get burned out because of the high workload and at times when you go home you are emotionally exhausted, and this leads to stress. In fact, high workload as well as the high expectations of social workers leads to mental health challenges" (P6)

"And the burnout also, like every day hearing the same social dysfunction of families, every single day being frustrated at times with the limitation of resources, that issues are not resolved. You see the same patient that you didn't know where to refer, they keep coming back, the family keep pleading for help, you are unable to help them" (P8)

"I experience anxiety, due to workload. Anxiety may also be caused by Physical pressure and constantly feeling empathy towards patients and their families. And not being able to do enough, the lack of support system in the department also impacts on me" (P5)

"I will say for me I experience burnout because we have a lot of caseloads here in the hospital. It is also being too emotionally involved with your patients' problems. Sometimes you take those problems home and they affect your functioning when

you're at home. So yeah, sometimes it's impossible to separate social work duties and your personal life" (P10)

"I experience anxiety, often having panic attacks in terms of, did I do it right?" (P2)
"The high workload creates anxiety. This is because there is a lot of expectation from MDT and sometimes, we end up not seeing other patients referred and sometimes we leave the hospital around 18h00 because of the high caseload. This negatively impact my mental health as sometimes I don't sleep at night, having anxiety about cases" (P13)

The findings attest to the fact that stress and burnout are universal risks for the wellbeing of social workers (Maddock 2024:1-16). Stanley and Sebastine (2023:11353) concurs that the source of stress amongst social work compared to other profession is associated with high workload or caseload, working overtime often without pay, dealing with the conflicts between the clients and their families, and having to satisfy unmet personal expectations and negative public perceptions about their profession. According to Hoosain, Mayet-Hoosain and Plastow (2023:5863) contributing factors of mental illness on employee's include lack of variety of work, worthless work, overload or underload, time pressures, inflexible work schedules, lack of control and decision-making abilities, poor environmental conditions, unsupportive work cultures, poor communication and relationships at work, job insecurity and conflicting demands of home and work. The ongoing stress and burnout thus reduce work performance (Fukui, Salyers, Morse & Rollins 2021:204). Jones (2022:2) also confirms that there is prevalence of high stress and burnout among social workers worldwide and that it is noticeable that there is barrier in understanding the effects of burnout in job performance. In conclusion, it can thus be deduced from these findings that social workers are individuals who are at high risk of suffering from work stress, secondary traumatisation, and burnout as well as compassion fatigue (Miller & Grise-Owen 2022).

Theme 4 Participants' perceptions and attitudes of their own mental health

For this theme, the participants were asked to share their perceptions and attitudes regarding their own mental health. Wagani & Gaur (2023:1-11) and Klussman, Cartin, Langer and Nichols (2022:120) state that self-awareness on mental health is important

because it helps a person understand how they feel, think, their emotions and how these can affect their mental health. This recognition also helps them to manage own emotions and to better communicate. In the study of the 14 participants, they confirmed that they are mentally not well. In responding to the question, the participants alluded to some of their mental health challenges as per the following utterances.

“So, we are expected to have this balanced life and be strong and be able to handle whatever that comes your way. So, in that way, even if you experience challenges such as maybe depression or maybe you are overwhelmed or all those things, you act as if you are okay even though you know that you are not okay” (P5)

“I feel like I am too weak. Maybe this profession, this speciality of mental illness is not for me. I’m not resilient enough or strong enough to deal with such challenges when it comes to my patients. So yeah, it makes us do an introspection a lot” (P9)

“When I am experiencing burnout, I see myself as a failure and failing myself, not capable enough to work, and I blame myself for not completing the task and I feel this profession is not for me’’(P1)

“I feel inadequate to provide quality services to patients and their families” (P7)

Ratckiff (2024:26) shares the same sentiment as the participants, as his study reports that social workers experience mental health challenges, and they view themselves as inadequate and incompetent. The above comments also suggest that social workers are at risk of work-related stress, and that if the situation is not addressed or no actions taken, then burnout remains a massive challenge. resulting in emotional exhaustion, depersonalisation and low self- esteem, a warning highlighted by (Lombardero-Posada, Mendez-Fernandez, Aguiar-Fernandez, Murcia-Alvarez & 2022:195). Maddock (2024:1-16) shares a similar sentiment that ongoing stress and unresolved feelings of burnout may lead to risk of secondary traumatisation, hopelessness, and poor job performance. Social workers are change agents, but when they experience mental health challenges, they perceive themselves as failures, inadequate and weak. The ecological systems theory purports that social environment

is one of the important aspects influencing the individual and in relation to the study, social workers experienced mental health challenges due to the nature of their work and the working environment, and this contributes to their perceptions and attitudes on their mental health in the work environment.

Theme 5: Effects of mental health challenges on the participants

Most of the participants reported that mental health issues affect three areas of their lives: work pressure, social life and home life and these areas were classified as subthemes as explicated below:

Sub-theme 5.1: Work pressure

Work is defined as an activity such as a job where an individual exerts mental and physical effort usually for money (van der Laan, Ormsby, Fergusson and McIlveen 2023:252). Most of the participants mentioned that they felt anxious about work. They cited that the administrative aspect, especially report writing, was the most strenuous. Participants also mentioned that they come to work with no job interest, not willing to submit their reports, felt that the environment is not conducive, and work productivity reduced. The following verbatim quotes are representative of participants' responses:

"I cannot meet deadlines anymore; I conduct short counselling sessions because I'm too tired to listen to them for long" (P8)
"I come to work with no job morale, sometimes I take unnecessary leave" (P9)

"Obviously work productivity becomes affected because I either have to take a day off or I won't come to work, sometimes when I experience burnout, it affects my work productivity negatively" (P10)

"I'm not willing to give my reports for quality assurance because I know if I submit them, I'm going to get criticism" (P7).

"Sometimes I feel burned out. Sometimes I feel sick. I constantly feel sick. I know I should take sick days off from work because I am not really coping but unfortunately

there is no time to be off work and as a result this affects my productivity at work" (P12.)

The voices above make it evident that social workers do face mental health and psychological issues that affect their work life, hindering them from doing their job efficiently. From the discussion, it is evident that negative effect of ongoing stress or unresolved feelings of burnout contribute to lower productivity, reduces organisational commitment, absenteeism, presenteeism on social workers (Maddoc, 2024:54). Lombardero-Posada, *et al*., (2024:135) concurs that extreme working conditions, together with difficulties of detachment and self-care, leave social workers helpless, frustrated, and exhausted. Stanley and Sebastine (2023: 1135) confirm that stress in social work is frequently experienced by practitioners and is attributed to a collection of work-related influences.

Sub-theme 5.2: Lack of social life

Laursen and Veenstra (2021:21) define social life as a time spent by the individual with peers, friends and family in a relaxing and entertaining manner. Acoba (2024:1330720) share the same sentiment that social life and socialising with other people help to ease anxiety, depression, decrease stress and provide comfort, prevent loneliness. In this study, most participants reported that they do not have a social life. Apparently, they stopped watching television, distanced themselves from community gatherings, and lost their relationships. The participants' below verbatim quotes affirm this:

"I experience a lot of traumas due to the nature of my work and it affects my mental health. Consequently, I withdrew myself from the whole community because of my mental health" (P1)

"I am always emotionally drained. I don't get time to watch TV especially all the murder drama which I love because I am always tired. I also don't want to go out with my husband and friends because I am always tired and mentally drained" (P7)

“I stopped going to events, eateries and get together because of mental health challenges in my workplace. When I am burnout, I am always tired and emotionally exhausted” (P8)

“I am always emotionally drained; I no longer socialise with other people because I get so tired of listening and talking with people and prefer being alone. I avoid conversations with neighbours. I no longer go to church. I have limited my availability” (P9)

“But the social life is definitely affected because I isolate and don't want to socialise with anyone” (P10)

According to Stanley and Sebastine (2023:1135), social support and work-life balance are significant predictors of burnout and as such the participants in this study can be said to be burnt out. Based on the research finding, socialising might assist social workers to have time to share their stressful life experiences and thereby support each other. According to Brandt, Liu and Heinz (2022:398) states that socialisation can reduce depression symptoms, by decreasing the feelings of loneliness, isolation and anxiety. Stanley and Sebastine (2023:1138) also add that sharing stressful events with others and talking about the emotions associated with them is likely to aid positive psychological adjustment when supportive social networks are available. Social support can improve mental and physical health, and emotional wellbeing and in the organisational context, social support is associated with better work engagement.

Sub-theme 5.3: Home life

The participants reported that work stressors do affect their home lives negatively. Some also reported that they scream at their children for no reason while there were those who said to deal with their work pressures, they prefer to isolate themselves from their families. The following verbatim quotes are representative of the participants’ responses confirming this sub-theme:

“I experience mental health challenges and they affect my family life because when I am burnout, I am become an angry, unhappy, tired, exhausted mother and unable to

engage fully with my family. I also carry the thoughts and dram about the painful and traumatic experiences of patient" (p1)

"I bring my frustrations to my family. Sometimes I shout at the children" (p6)

"When I go home, I don't have energy, I don't want to cook, I don't want to clean, I don't want to go to the gym, I just want to do nothing. So, in that sense, it affects my life because the stressfulness of the working environment" (p7)

"I get home tired and feel like sleeping" (p8)

"Due to mental health challenges, I neglected my family, unable to be a supportive wife and mother. I also lost interest to engage with my family, consequently my husband divorced me" (p9)

***"**When I am depressed and burnt out, I arrive at home tired and exhausted emotionally then I isolate myself from the rest of the family and not interested to interact with them. This has affected my family because I don't spend enough time with them due to mental health challenges" (p10)*

Evidently, the participants in the study are overworked and stressed. In fact, their mental health is at risk. This risk suggests that social workers do not deal with their work pressures effectively. Kaczor (2017:) asserts that social workers should have strategies to deal with their stressors. In Kaczor (2017:51) suggests that physical action or activities such as running, floorball, yoga, and cycling can assist because such activities eliminate increased blood pressure and other negative consequences.

Further to the above, the link between work pressure, lack of social life and home life speak to the need for one to strike a work-life balance. Stanley and Sebastine (2023:137) confirms that the concept of work-life balance (WLB) is important for the social work professional. WLB is the separation of work life from one's personal life and has been considered as the ability to satisfactorily manage responsibilities relating to both work and family matters. Isa and Indroyiti (2023:1910) share the same sentiment that WLB is a state of an individual who can manage the demands of

different roles between work and personal life using their time and energy to achieve self-fulfilment. This implies that work life and personal life complement each other. The study by Merc, Bacter and Buhas (2023:241) confirms that when social workers have an imbalance between professional and personal life, there are negative consequences including increased fatigue and stress, physical and emotional health problems, while at work it includes decrease in the quality-of-service delivery, deterioration of relations with colleagues and being demotivated. It is, therefore, important to understand that work-family conflict role impact work withdrawal and exit behaviour that could positively impact depersonalisation and work withdrawal.

Theme 6: Participants' coping strategies to deal with mental health challenges

Coping strategies are an effort where both the thoughts and behaviour that an individual adopts to manage internal and external stressful challenges an individual encounter in their lives. These strategies help an individual to manage and deal with demands of everyday life as well as traumatic experiences. Desalegn, Zeleke, Shumet, Mirkena, Kassew, Angaw and Salelew (2023:20) states that when an individual encounters a stressful situation, they adopt thoughts and behaviours to reduce, master and minimise stressful events. In this study, the participants cited different coping strategies of dealing with their mental health challenges. There were participants who reported that when in distress they consult their supervisors and managers. Some reported that what helps is that they work as a team with colleagues, while others reported that they attend debriefing with colleagues to deal with mental health challenges. The following verbatim quotes are representative of participants' responses confirming this sub-theme:

Sub-theme 6.1: Supervision and consultation as a coping strategy

"*Usually I speak with my supervisor, my supervisor supports me, so I'll tell her today this is how I'm feeling, I feel like I'm not okay emotional" (P6)*

"I talk to my supervisor and head of department (HOD). I attend my weekly supervision, and I get guidance from her" (P2)"

"When I am feeling burnout and overwhelmed, I consult my supervisor for guidance and support maybe to discuss the challenging cases or any other work-related challenge and he will give me support and guidance" (P5)

"My supervisor is very supportive to us as social workers; therefore, I attend supervision to discuss challenging cases and after a session I feel less overwhelmed, and this helps me to cope with mental health challenges" (P9)

From these submissions, it can be deduced that social work supervision is regarded as emotional support mechanism by social workers helping them deal with their work-induced mental health challenges. The National Association of Social Work (2022) defines supervision as a professional relationship between a supervisee and supervisor to enhance responsibility and accountability for the development of competence and ethical practice in South Africa. According to the South African Council for Social Services (2012) it is mandatory for social workers to be supervised. Tu, Huang, Sitar and Wang (2023:1764) confirm that in China supervision reduces psychological stress amongst social workers with job demand. When job demand is high, social workers receiving supervision garner emotional support and consequently have a lower negative effect and psychological distress. On the contrary, when supervision is low, it contributes to high levels of burnout to social workers (Losim, Runcan, Dan, Nadolu, Runcan & Petrescu (2021:160)). Considering this finding, it is clear that some social workers receive effective supervision, and it helps them to cope with mental health challenges in the workplace.

Sub-theme 6.2: Self-care as a coping strategy

Self-care is one of the coping strategies articulated by the participants that helps them cope with their mental health challenges. Self-care includes caring for one's body and mind through enough sleep, hygiene, good nutrition, exercise, relationship with the community, family or peers, creative activities that promotes pleasure, rest, counselling, and relaxation (Bressi and Vaden 2017:33). Self-care in social worker is usually associated with reducing stress, burnout and other mental health challenges

and empowering wellbeing (Rose, McCucker, Mitchell, Roesch-March, Jian &Petrova 2025:1455-1573). Below are verbatim responses of participant regarding self-care:

“I love to run long distance, and it helps me to refresh my mind and my psychologist confirmed that it I good for my health and will improve my mental health” (P3)

“I separate work with my personal life. I take lunch breaks out of the office and sometimes just sit in my car. I also attend debriefing with my colleagues and exercise after work” (P4)

“In our hospital we have a clinical psychologist that is available for employees to provide counselling, therefore when I utilise their services as my coping strategy. I also consult social work supervisor and head of the department when I attended a traumatic case that contribute negatively to my mental health challenges” (P1).

It can be deduced from the preceding discussion that social workers do have self-care regimes that serve as their coping strategies in dealing with mental health challenges. The participants highlighted the following self-care strategies that they found useful: exercising, maintaining relationships, yoga and music. According to Ratchiff (2024:234), self-care is a way to find balance for oneself while serving other people in need and it should be given sincere consideration.

Sub-theme 6.3: Spiritual support as a coping strategy

There was another participant who cited spiritual support as a coping mechanism. Spirituality can be defined as “one’s religious beliefs and practices as well as one’s sense of purpose and meaning in life” (Gale *et al.* 2022:1). Spirituality is an essential aspect in people’s lives, health and in their well-being as it addresses issues of hope, meaning and purpose in life. It is also a personal way that an individual resorts to in seeking meaning and connection (Milner, Crawdorf, Edgley, Hare-Duke & Slade 2020:34). According to the participant she uses spiritual counselling, going to church and praying to cope with her mental health challenges. The participants confirm this stance] below:

“I go to church on Sundays and the church leaders offers spiritual support. Women activities in church also helps me to cope with my mental health challenges. Also, I don't take work to my home. I make sure that I have a vision board, I plan my day, try by all means to be organise at work, so those are my coping mechanisms as an individual” (p7)

In the study it has thus been established that spirituality, self-care and supervision and/or consultation are coping strategies used by participants to cope with their mental health challenges. Desalegn, Zeleke, Shumet, Mirkena, Kassew, Angaw & Salelew (2023:20) concur that that when an individual encounters stressful situation they adopt thoughts and behaviours to reduce, master and minimise stressful events. According to Guy-Evan (2024:254), these coping strategies can thus be referred to as the macrosystem that represents overarching cultural elements which affect individual development, consisting of cultural ideologies, attitudes, religion and social conditions in which the individual are immersed.

Theme 7: Workplace policies and services available in the workplace to promote mental health.

The study participants gave varying responses in this regard. Some of the participants reported three policies, the Employee Health and Wellness Programme (EHWP) policy, the Basic Condition of Employment Act and the Occupational Health Act while others mentioned that they are not aware of any polices available for employees. The following verbatim quotes are representative of participants’ responses confirming this sub-theme:

“I know the policy in DPSA called employee health and wellness policy. I also know Basic Conditions of Employment Act, 1997 (Act No. 75 of 1997) and Occupational Health and Safety Act, 1993 (Act No. 85 of 1993)” (P5)

“The policy is called Employee Health and Wellness Policy that and the policy is part of the occupational health care act” (P6)

“Honestly speaking, I'm not sure of policies. But we need to be aware of those things. We need to be aware because there are policies. You know policies for patients” (P2)

“I’m not aware of specific policies for supporting staff members. I think need to find out policies that are supporting social worker” (P1)

“There is a policy but I cannot name it but policy says whenever an employee experiences a problem, the supervisor has to be involved first. The supervisor will refer you to a wellness officer and that's when your issues can be addressed with a wellness officer” (P 8).

According to Employee Health and Wellness Programme Strategic Framework (2019), EHWP is a unique approach to addressing workplace productivity issues and employees’ concerns affecting their work productivity. One of its core functions is consultation with training of, and assistance to managers, supervisors, and shop stewards seeking to manage the negative effect of stress on employees, enhance the work environment, and improve work productivity. On the other hand, section 20 of the Basic Conditions of Employment Act, 1997 (Act No. 75 of 1997), promulgate employees’ rights to sick leave and annual leave ensuring fair labour practice. These subsections thus promote mental health in the workplace because by taking the said leave, workers avoid fatigue and burnout. In addition, section 20 of the Occupational Health and Safety Act, 1993 (Act No. 85 of 1993) proposes that employees should work in safe and conducive environments which include protecting employees from mental health risk and promoting well-being, respectively.

In addition to the above, the participants were aware of the Employee Health and Wellness services in the hospital services available for them. They reported that they attend training sessions and trauma debriefing sessions. The participants’ utterances included the following:

“We have an employee health and wellness that is conducted by a clinical psychologist. So usually if you can consult personally, but sometimes the supervisor refers us, maybe your manager is he realise that you need assistance with the EHWP services, then they will take you through it” (P2)

“There are training sessions that are provided in the hospital. They're just there to reshape our skills. We have Employee health and wellness Practitioner in the hospital, I heard it's there, but I've never utilised it because I've learned to cope on my own” (P3).

“I know there is EHWP, but I don’t feel confident enough to utilise their services, however there is support from supervisor” (P4)

“We have supportive supervisors, they attend trainings that we attend though not often, whereby we are provided with skills on how to be resilient in the workplace, on how to deal with burnout or stress, things like that. So yeah, but like I said, the trainings happen after a while. But it helps to support us” (P7)

“We also attend training such as stress management, stress and emotional burnout in workplace, self-care and self-awareness, financial management and pre-retirement and OHS” (P5)

Some participants asserted that they attend training and workshops as these are supportive services for their mental health issues in the workplace. According to Achackzai, Siddig and Khishkai (2024:2349), training is a learning experience to an individual aimed at enhancing individual skills, knowledge and attitude or social behaviour for them to become efficient in the workplace. WHO (2024) shares the same opinion that training for employees in mental health literacy and awareness helps to enhance knowledge of mental health and to reduce discrimination around mental health. The training sessions and the EHWP services can thus be referred to as the exosystem for the patients because they have an impact on the way that social workers in the hospitals address their mental health challenges.

Theme 8: Suggestions on how to improve mental health services in the workplace

The participants mentioned that they wished supervisors and managers were fully trained on mental health, such that EHWP services could be rendered more

confidentially by the designated practitioners. Participants also suggested provision of debriefing sessions. The following utterances confirm the views of participants:

"*I think employee wellness should be at a core of every institution's functioning. It should be among their priorities, especially in the health department. I think if employee's wellness is prioritised and provided by qualified professionals who are specifically trained and appointed to run wellness, there will be a lot of information sessions" (P4)*

"I suggest that there should be a compulsory employee wellness or a therapist that engages employees monthly, in a private space, in a confidential space, not necessarily on the employee's request. Because I may think that I'm okay, but not knowing that I'm not okay" (P3)

"Okay, basically we have supervisors who are supposed to support, guide and mentor us, so that when you're having a mental health issue or a personal issue, you can go to them for assistance. I also wish we should attend trauma debriefing sessions in the social worker department and more training especially on mental health in the workplace" (P6)

"I wish there could be more training for supervisors and managers on mental health" (P1)

"I wish we can have more outings as colleagues, have lunch together, talk about our experiences and debrief and relax, that can assist a lot. Because yeah, I believe it will also assist with team building, whereby we'll be strengthening our working relationships there" (P9)

These findings make it clear that working at a hospital can take its toll on one's mental health. The above comments confirm that the participants need trauma debriefing because although some do receive support and guidance from their supervisors/managers, the support is inadequate. The participants thus thought it would be beneficial to them if supervisors attended compulsory training sessions on how to attend to subordinate mental health issues. The participants also recognised

that when faced with challenges they can approach their supervisors, but they equally advocated for getting trauma debriefing from a different therapist. Poppedi and Billa (2023:371) are also of the view that social workers providing mental health services should have access to regular supervision, to support social workers' emotional resilience as well as their physical wellbeing. Jones (2022:14) concurs that low pay, paperwork frustrations, task variety, and autonomy create a sense of joy among mental health employees. Further to the above, Tu, Huang, Sitar and Wang (2023:20) also indicate that job satisfaction can be increased when there is a perception of support among co-workers and supervisors. The National Mental Health Suff and Sherwood (2022) in their study on health and mental wellbeing at work also recommended that organisations should provide a combination of wellbeing benefits to provide support, promote good health and protect income. Social workers do have access to counselling services and employee assistance programmes but normally do not focus on their financial need.

4.4 Conclusion

This chapter presented the findings of the study. The chapter explicated the participants profiles and identified themes and subthemes which emerged from the data collected from 14 study participants. The themes included the following: understanding the different between mental health and mental illness, participants experiences working with individual with mental health illness, participants mental health challenges, participants perception and attitude of their mental health, the effect of mental health on work pressure, home life and lack of social life, participants coping strategies with own mental health challenges workplace policies and supportive services to promote mental health and lastly participants suggestions on how to improve mental health services in the workplace policies. In presenting the findings, quotes were used and corroborated by literature. Chapter 5 makes conclusions and recommendations derived from the study.

CHAPTER 5
SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1 INTRODUCTION

The purpose of the research study was to explore and gain an in-depth understanding of the perceptions and attitudes of social workers regarding their own mental health in Pretoria, South Africa. This chapter presents a summary of all the chapters that constitute this research report. The summary is followed by establishing if the study goal was achieved using the specified objectives. It also establishes in this regard if the research question has been adequately answered. Karunarathna, Alvis, Gunasena and Jayawardana (2024) also share similar sentiments that a summary provides the reader with comprehensive understanding of the study. Following a summary, conclusions about the study are presented. These conclusions are based on the research process and the data findings. To end the chapter, recommendations are also proffered in this regard. This include recommendations based on the findings of the study, recommendations to policy makers, and those pertaining to future research.

5.2 SUMMARY OF THE STUDY

The study is structured as follows:

5.2.1 Chapter one: General introduction

This chapter is an overview of the introduction and background to the study. In it the concepts of mental health and mental illness are defined. A brief background on mental health was also presented. The significance of the study phenomenon in social work was also established. The research problem was also articulated and justified. The discussion in the introductory chapter thus revealed that whilst there were numerous studies on the phenomenon (i.e., of mental health in the workplace) such studies focus largely on employees' perceptions, attitudes, and experiences in working with employees with mental illness as well as in servicing mentally ill patients. It was thus against this backdrop that a gap on the perceptions and attitudes of social workers regarding their own mental health was identified. Other topics discussed in the chapter include the rationale for the study, research question, goal, objectives and the

research paradigm, research design, study population, sampling, sample size, data collection methods, data analysis and ethical considerations The following key words for the study, i.e. social work, social worker, mental health, mental illness, attitude, and perception are also defined.

5.2.2. Chapter two: Literature review

Chapter two focuses on a comprehensive literature review of other studies conducted on the mental health of employees in the workplace globally. The discussion was also articulated within the regional context of Africa and thereafter localised to the South African context. The discussion centered around the history of mental health in the workplace in South Africa with a particular focus on health care workers. The intention was to give an overview of the prevalence of mental health in the workplace, the perceptions and attitudes of employees regarding mental health in the workplace, programmes that are available to promote mental health in the workplace, and the social work strategies to cope with mental health. Social workers are designated in different departments in the hospital, and they provide psychosocial support services to patients and their families and as the effect of mental health challenges on social workers in the hospital was also included in the chapter. The discussion was framed within the theoretical framework of the ecological systems theory.

5.2.3. Chapter three: Study methodology

This chapter presents the research methodology adopted in conducting the study. It includes the research approach, research design, study setting, population and sample. The techniques and instruments used were postulated with the ethical considerations for conducting the study. The significance of the ecological systems approach adopted in the study is also explicated in Chapter 3.

5.2.4 Chapter Four: Data analysis and findings

The chapter presents the findings of the study. These findings were drawn from the thematic analysis and the interpretation of the data collected from participants. The findings were presented by means of themes and sub-themes supported by quotes and vignettes of participants' responses and literature review. The researcher also draws conclusions from the overall study as presented in this current chapter.

5.3 THE STUDY GOAL, OBJECTIVES AND RESEARCH QUESTION

5.3.1 The goal of the study

According to Duggappa, Nerthra & Sudheesh (2016:23) a research goal gives an overall indication of what the researcher strives to achieve. In this study, the research goal was formulated as exploring the perceptions and attitudes of social workers regarding their own mental health in Pretoria, South Africa. The research goal was accomplished in the study because the researcher explored the perceptions and attitudes of social workers regarding their own mental health. The social workers were interviewed in this regard, and they then shared their perceptions and attitudes regarding their own mental health and their responses were then analysed thematically. Chapter 4 of this research report thus serves as the evidence for the explorations and recurrent thematic patterns.

5.3.2 Research objectives

Research objectives are statements about what the proposed project strives to accomplish (Bezuidenhout, Corne & Du Plooy-Cilliers 2021:82). In defining the objectives, Sudheesh et al., (2016:632) view an objective as certain criterion a researcher utilises to achieve the goal of the research study. In summary, the research objectives are a list of activities undertaken by the researcher, one-by-one, which steer the researcher to achieve the research goal. In this study, the objectives were designed to:

- To explore social workers' perceptions of their own mental health
- To examine the attitudes social workers, hold towards their mental wellbeing
- To identify personal, organisational, and contextual factors shaping these perceptions and attitudes
- To propose recommendations for policy and practice to support social workers mental wellbeing and proffer recommendations for future research

All four objectives were achieved in this study. The first objective of the study of describing the phenomenon of mental health is achieved in Chapter 2, the literature

review. The researcher delineated literature focusing on the meanings of the concept of mental health and during the data collection, the participants also defined the concept of mental health in their understanding. The second objective of exploring empirically the social workers attitudes and perceptions regarding their mental health was also achieved. This study successfully collected data through one-on-one interviews with 14 social workers working in hospitals in Pretoria, South Africa. The social workers shared their perceptions and attitudes regarding their mental health and their shared data was synthesised into meaningful experiences as discussed in Chapter 4 (data analysis). The last objective to proffer recommendations to improve practice, policy and future research was also accomplished as this present chapter presents the said conclusions and recommendations as articulated from subheading 5.4 below.

5.3.3 Research question

Research questions begin with the rationale of the proposed research. A research question provides direction and guidance for a research project (Kelly 2018). In essence, research questions are designed to keep the researcher focused during a study. Consequently, in this research study, the researcher sought to answer the following research question on the perceptions and attitudes of Social Workers regarding their own mental health in Pretoria, South Africa. Drawing from the findings in Chapter 4 of this report as well as the discussion below, the answers to this question were articulated in Chapter 4 where personal experiences and attitudes resonated with responses to social workers regarding their own mental health in Pretoria, South Africa.

5.4 THE CONCLUSIONS

Conclusion aid in understanding why the study is essential to them and it is a synthesis of critical elements, not just a description of the points or a re-statement of a problem statement (Zaid & Tsagem 2022). In this study through data analysis eight themes were captured and discussed using participants' verbatim submissions and literature. The conclusions are thus based on the main outcomes from the themes of the study.

In keeping with the themes of the study, the discussion commences with presenting conclusions based on the biographic information of study participants.

5.4.1 Conclusion on biographic information of the research participants.

In this regard, the participant's biographic profile information on their age, years of experience, gender and their highest level of qualification was sought. The biographic information allowed the researcher to gain a comprehensive background of the participants. The biographical information also enhanced the credibility and validity of the research study because it confirmed that the study participants were indeed social workers employed in hospitals in Pretoria, South Africa. Regarding the age of the participants, most social workers are all above thirty years and below 55 years. Regarding their years of experience, most participants have above two years of experience working in the hospital setting. The participants thus met the inclusion criteria of the study because as articulated in Chapter 3 the study sought to interview participants with more than two years of experience working as a social worker in the hospital in Pretoria.

Based on the gender component, most participants were female than male social workers and this can be attributed to the fact that social work in South Africa is a female dominated profession. Vilka (2018:14) and Zakhele (2020) share the same sentiment that in South Africa is dominated by women, men are slowly occupying female dominated field including social work and nurse. Finally, with regard to their qualification most of them held the required Bachelor of Social Work degree and only one social worker holds a master's in social work degree, which suggests that social workers rarely pursue a postgraduate social work degree.

5.4.2 Conclusion on the social workers' understanding of mental health and mental illness

Under this theme most participants differentiated between mental health and mental illness. It is thus concluded that participants understand the concept of mental health. The transcripts confirm that participants defined mental health as a broad spectrum that includes social being of how an individual cope with life experiences and how the

individual handle problems when faced with life challenges. The participants also defined mental health as being able to perform their daily activities at work and at home and the ability to adjust to any environment mentally and to be able to cope with any stressful circumstances that emerge. They believe that dealing with stressful challenges helps to avoid being diagnosed with mental illness. The participants' understanding of mental health thus enabled them to adequately respond to the questions posed to them during data collection in this study.

Participants also showed a clear understanding of the concept of mental illness. They defined mental illness as a mental disorder. The participants shared that mental illness, or disorder eliminates is diagnosed by a psychiatric. Other participants defined mental illness based on the type of mental illness, as they mentioned schizophrenia, bipolar, and depression as mental illness as a presence of disease of mental pathology while others defined mental illness as when an individual is unable to cope with life stresses that escalate to depression, schizophrenia, and bipolar and that they probably have symptoms of psychosis, and they can't cope with the condition thus needing disease care, treatment, and or rehabilitation. Participants' definitions for mental illness as supported by Mental Health Care Act no, 17 of 2007 as a disorder of thinking, mood, perception and memory that completely form judgment, behavior and the capacity to recognise reality or ability to meet the ordinary demand of life.

5.4.3 Conclusion on the experiences of participants on working with individual (colleagues) with mental illness

The participants confirmed having worked with individuals living with mental illnesses before. The participants' responses indicated that individuals with mental illness are not easy to work with. Apparently, they can be unpredictable because they sometimes behave aggressively and may also lack self-control. They can have unprovoked outbursts. They largely attributed the behavior to sometimes not adhering to their treatment. Apparently, non-adherence to treatment can be burdensome because those at work must cover the work for the individual who is not at work. The participants, however, seemed optimistic about working with colleagues dealing with mental illnesses. This is because they were of the view that they learn to understand them and minimise discrimination towards them.

Against this backdrop, it is concluded that social workers do have a direct contact with their colleagues living with mental illnesses and this has shaped their perceptions and attitudes on their mental health. Also, although they may have had difficult encounters with them, they have not stigmatised and discriminated against them because they understand mental illness since they too provide psychosocial support services to patients with mental illnesses. Those with mental illnesses in the hospital can thus be regarded as the microsystem, which in ecological systems theory are institutions and groups that are direct and generate varied impact in someone's life.

5.4.4 Conclusion on participants' mental health challenges

The findings in this study established that the social work participants in this study did experience mental health challenges of burnout, anxiety, and trauma which they attributed to high caseloads, lack of resources as they endeavor to assist patients, and unrealistic expectations of social workers by the multi-disciplinary teams (MDT) in the hospitals. The high caseload was mentioned as contributing to the mental health challenges since high caseloads compel participants to leave the hospital after hours as they ought to complete their workload for a particular day and this contributes to burnout and anxiety. Participants also stated that consequent to the misconceptions and unrealistic expectations of the MDT they sometimes refer irrelevant cases which increase their workload and contribute to their mental health challenges.

The self-awareness of participants on their mental health challenges is thus commendable because it helps a person understand how they feel, think, and their motive and where they are not well which can enhance help-seeking behavior. Self-awareness is also critical because social workers have an ethical responsibility to ensure that they are psychologically well for them to provide quality services to patients and their families.

5.4.5 Conclusion on participants' perceptions and attitudes on their own mental health

Most participants perceive themselves as failing when they experience mental health; they cannot understand why as social workers they are unable to deal decisively with

their own mental health challenges. In fact, they view it as not being capable enough to provide quality services to patients and their families. Then they tend to blame themselves.

5.4.6 Conclusion of the effect of mental health on participants' lives

It is concluded in this study that mental health challenges have a negative effect on the social workers' lives. This is because the participants reported that mental health challenges have negatively impacted their social life, work life and home life. The participants concurred about their work productivity and how mental health challenges has affected it. They reported not being able to provide quality services to patients and their family because they are emotionally exhausted and burnt out. It can thus be logically deduced that mental health challenges contribute to poor work productivity and should be attended to.

The findings also confirmed that mental health also affected the participants' social lives. Stanley and Sebastine (2023:1135) state that social support and work-life balance are significant predictors of burnout. in this study the participants mentioned that due to trauma, anxiety, and burnout, they have withdrawn themselves from community gatherings, going out with their friends, and watching their favorite TV shows due to their mental health challenges. They reported being emotionally and physically exhausted and unable to engage with other people as they used to. Participants stopped even going to church and were no longer available for events with friends due to mental health challenges. They isolated themselves from society. Mental health challenges have a negative impact on the participants' social lives. The social exclusion thus robs participants of an opportunity to form meaningful relationships. Socialisation can help social workers spend time with their significant others and to share their stressful lives with their loved ones. Social life is an importance aspect on an individual life as social support and work life balance are taking out as significant predictors of burnout.

The participants' mental health challenges have also affected their families negatively. The study has shown that participants find it hard to strike a balance between work and family life due to mental health challenges. Participants indicate that when they

are burnt out, emotionally drained they become frustrated and shout at their children for petty mistakes. The participants also reported not having enough time and energy to spend with their families as they are always tired and emotionally drained. Participants indicated that they feel they have unintentionally neglected their families, support their spouses emotionally and this has apparently led to divorce for some. There is thus a need for social workers to develop coping mechanisms in dealing with mental health challenges constructively so as to prevent it from infringing on their family life.

5.4.7 Conclusion on coping strategies used to deal with mental health challenges

Participants did have coping strategies to deal with their mental health challenges, which included using self-care, spiritual support, and social work supervision. The study verified that some participants use supervision as a coping strategy to address their mental health challenges as they believed it helps them to manage the psychological stress associated with their work demands. The supervision was also not adequate because it focuses more on the administrative component of their work instead of supportive supervision, making them feel that their mental health is not adequately addressed. Literature also underscores the importance of supervision for social workers in the workplace. Tu, Huang, Sitar and Wang (2023:20) findings confirm that in China supervision reduced psychological stress amongst social workers with job demand. When job demand is high, social workers receiving supervision as emotional support have a lower negative effect and psychological distress. On the contrary, when supervision is low it contributes to high levels of burnout to social workers (Losim, Rancan, Dan, Nadolu, Rancan & Petrescu 2022:19). Considering the result, it is clear that some social workers dos does not receive effective supervision, and this leads to burnout amongst social workers.

The study also verified that self-care was one of the coping strategies participants utilised to deal with mental health challenges in their workplaces. Apparently, they have debriefing sessions with their colleagues where they share their challenges and solutions to overcome those challenges regarding their work issues. Some participants also shared that they exercise, eat lunch every day and strive to separate work from

their personal life. There was also a participant who uses therapy with a clinical psychologist as a coping mechanism. The researcher observed that participants use self-care to deal with mental health challenges in different ways and they chose it based on their ability and preference which is inconsistence with their self-structure. Self-care is an individual, family and community's ability to enhance their health, maintain their health, use prevention methods for their health and to cope with their illness without and without support from care workers.

Additionally, the study confirmed that people place high moral values on spirituality which helps them with their health and well-being. Spirituality addresses issues of hope, meaning and purpose in their lives. The participants shared that when they experience mental health challenges, they go to church where spiritual leaders offer emotional support, pray for them, and by participating in church activities it also helps them to cope with mental health challenges. Listening to gospel songs also helped some of the participants to distress.

5.4.8 Conclusion on workplace policies and services to promote mental health

The study established that there are policies and services available from the employer for use by participants in hospitals to support and promote mental health in the workplace. The participants mentioned the following prescripts: Employee Wellness Management Policy for the Public Service, the Basic Conditions of Employment Act, Act No. 75 of 1997 and the Occupational Health and Safety Act, Act No. 85 of 1993. While there were participants who are aware of these prescripts, there was also a cohort of participants who were not aware of them. The participants who were aware of the prescripts also mentioned that the prescripts advocate for the employment of more employee wellness practitioners to service employees in hospitals.

Regarding services, the participants reported to be exposed to the training sessions covering various topics including stress management, that are held from time to time which they attend. The training sessions apparently help them to be resilient and enhances their coping strategies. It is also critical to note herein that of these participants some stated that the programmes are not well structured, lack resources to accommodate employees and they are available in written form only but more not

in operation. On the other hand, whilst participants were aware of the services, some did not feel confident to utilise the service

5.4.9 Conclusion on suggestions on how to improve mental health services in the workplace

Participants suggested several strategies that could be employed by the Gauteng Provincial Department of Health to improve the mental wellbeing of their employees. The participants voiced that the Department of Health should hire more employee health and wellness practitioners and recommended that social workers be hired to conduct wellness services with employees. According to the participants, there was also a need for more continuous training sessions and trauma debriefing sessions to employees and they suggested they be conducted monthly. The participants also expressed a need for managers and supervisors to receive trainings on how to support subordinates dealing with mental health challenges. Team building exercises were also touted as a strategy that could enhance relations amongst colleagues.

5.5 RECOMMENDATIONS

Recommendations are exclusively based on the research findings. Research recommendations are solutions and suggestions by the researcher for a certain situation based on the r findings. Recommendations call for action on procedures to improve and enhance in the future based on the research findings. Likewise in this study, recommendations are also made, which include recommendations for social work practice, policy review and further future research based on the afore-mentioned conclusions. It is therefore recommended that:

- The South African Council for Social Service Profession (SACSSP) introduce a policy fora mandatory psychological screening and debriefing at least once a year for all social workers to promote their mental health. This is because the study found that mental health challenges experienced by participants contribute to poor work productivity, exerts a negative impact on their significant others, hence the need for concerted effort to help social workers deal with their mental health challenges.

- Team-building excursions were also highlighted in the concluding remarks in this study. To address these, it is recommended that institutions should establish mandatory team-building sessions for social workers to help maintain a good working environment and trust-building which is opportunity to reduce stress, improve confidence and foster a positive mind set. Where possible,
- Social work departments or units within the hospitals should be encouraged to hold them frequently.
- Social Workers should engage in self-care activities to enhance their own mental health. These activities should be built into their supervision contracts at the beginning of each year.
- Managers and supervisors should undergo training on mental health and on how to deal with mental health challenges of their subordinates for them to effectively support social workers when they experience mental health challenges.
- There is a need for future research on the topic which should solely focus of male social worker because the study saw a large representation of the female social workers,.
- the employers (i.e., the Gauteng Department of Health) should embark on an educational drive to alert their employees of the services because it was found in this study that there were social workers who were not aware of policies that promote mental health in their workplaces. In the same breath it was also established that there were some social workers who are aware of the EHW programmes made available by their employer and that this cohort did not feel confidence to utilise the services.
- more practitioners must be employed to reach all the social workers, including all other deserving employees. This is because the study revealed a lack of EHWP counsellors within the Gauteng Department of Health.
- supportive supervision should also be formalised and built into the supervision contact of social workers with the supervisors because the participants called for supportive supervision. The findings verified that social workers regarded supervision as one of the possible mechanisms for coping with their mental health challenges but that unfortunately they were mostly exposed to administrative supervision. By formalising supportive supervision social work supervisors could be deliberate in speaking to social workers about their work and personal

challenges which hinders their productivity, which in turn could enhance the mental wellbeing of social workers.

- there is thus a need for a nationwide quantitative study to establish the mental health of social workers in the health field in South Africa so as to influence policy developers to craft and implement plausible strategies to enhance their wellbeing.

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ADDENDUMS

COLLEGE OF HUMAN SCIENCES RESEARCH ETHICS REVIEW COMMITTEE

04 December 2023

NHREC Registration # :
Rec-240816-052
CREC Reference # :
48990086_CREC_CHS_2023

Dear Ms Noluthando Proude Mbhele

Decision:
Ethics Approval from 04 December 2023 to 04 December 2024

Researcher(s): Name: Ms. N. P. Mbhele
Contact details: 48990086@mylife.unisa.ac.za
Supervisor(s): Name: Dr. G. B. Bhuda
Contact details: bhudag@unisa.ac.za

Title: The perception and attitude of Social Workers regarding their own mental health in Pretoria, South Africa

Degree Purpose: Masters

Thank you for the application for research ethics clearance by the Unisa College of Human Science Ethics Committee. Ethics approval is granted for one year.

The ***medium-risk application*** *was reviewed by* College of Human Sciences Research Ethics Committee, in compliance with the Unisa Policy on Research Ethics and the Standard Operating Procedure on Research Ethics Risk Assessment.

The proposed research may now commence with the provisions that:

1. The researcher(s) will ensure that the research project adheres to the values and principles expressed in the UNISA Policy on Research Ethics.
2. Any adverse circumstance arising in the undertaking of the research project that is relevant to the ethicality of the study should be communicated in writing to the College Ethics Review Committee.
3. The researcher(s) will conduct the study according to the methods and procedures set out in the approved application.
4. Any changes that can affect the study-related risks for the research participants, particularly in terms of assurances made with regards to the protection of participants' privacy and the

confidentiality of the data, should be reported to the Committee in writing, accompanied by a progress report.

5. The researcher will ensure that the research project adheres to any applicable national legislation, professional codes of conduct, institutional guidelines and scientific standards relevant to the specific field of study. Adherence to the following South African legislation is important, if applicable: Protection of Personal Information Act, no 4 of 2013; Children's act no 38 of 2005 and the National Health Act, no 61 of 2003.
6. Only de-identified research data may be used for secondary research purposes in future on condition that the research objectives are similar to those of the original research. Secondary use of identifiable human research data require additional ethics clearance.
7. No fieldwork activities may continue after the expiry date**(04 December 2024).** Submission of a completed research ethics progress report will constitute an application for renewal of Ethics Research Committee approval.

Note:

*The reference number **48990086_CREC_CHS_2023** should be clearly indicated on all forms of communication with the intended research participants, as well as with the Committee.*

Yours sincerely,

Signature: 

Signature: PP 

Prof. KB Khan
CHS Research Ethics Committee Chairperson
Email: khankb@unisa.ac.za
Tel: (012) 429 8210

Prof ZZ Nkosi
Exécutive Dean: CHS
E-mail: nkosizz@unisa.ac.za
Tel: 012 429 6758

ADDENDUM B: PARTICIPANT INFORMATION SHEET

Research title:
The perception and attitude of Social Workers regarding their own mental health in Pretoria, South Africa.

Researcher:

(Noluthando P. Mbhele)

Ethics clearance reference number: Rec-240816-052

Research permission reference number : 48990086_CREC_CHS_2023

Dear Prospective Participant

I, Noluthando P. Mbhele I am doing research with Dr Gladys B Bhuda (Senior Lecture) in the Department of Social Work towards a Masters in Social Work at the University of South Africa. We are inviting you to participate in a study entitled: The perception and attitude of Social Workers regarding their own mental health in Pretoria, South Africa.

WHAT IS THE PURPOSE OF THE STUDY?

The aim of the study is to explore the perception and attitude of Social Workers regarding their own mental health in Pretoria, South Africa.

You have been selected to take in the study because you are employed as a Social Worker in Gauteng Department of Health to provide psychosocial support services to patients and their families and because the nature of your work has a bearing on mental health issues. Data will thus be gathered from social workers by means of a face -to-face semi-structured interview. The interviews will be conducted at the venue you agree to, which will be comfortable to you such as your office. The interview will take approximately one hour.

Participating in this study is voluntary and you are under no obligation to consent to participation. If you do decide to t ake part, you will be given this information sheet to keep and be asked to sign a written consent form as a proof of your willingness to participate in the research study. You are also free to withdraw the consent and to discontinue your participation at any time and without given a reason, without any loss of benefits.

WHAT ARE THE POTENTIAL BENEFITS OF TAKING PART IN THIS STUDY?

Please note that there is no financial benefits for participating in the study, but the aim of the research study is to explo re the perception and attitude of Social Workers regarding their own mental health in Pretoria, South Africa. The researcher aims to make an important contribution to social worker knowledge with regard to metal health services and to contribute to the improvement of mental health care programmes for staff in the department.

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ARE THEIR ANY NEGATIVE CONSEQUENCES FOR ME IF I PARTICIPATE IN THE RESEARCH PROJECT?

There is not anticipated risk or harm that would arise from participating in the study, however if after sharing information you are left emotionally charged, the researcher, with your consent, will refer you to qualified and registered Social work to provide psycho-emotional support.

WILL THE INFORMATION THAT I CONVEY TO THE RESEARCHER AND MY IDENTITY BE KEPT CONFIDENTIAL?

You have the right to insist that your name will not be recorder anywhere and that no one, apart from the researcher and identified members of the research team, will know about your involvement in this research. Your answers will be given a code number or a pseudonym and you will be referred to in this way in the data and in any other publications, or other research reporting methods such as conference proceedings.

Furthermore, the researcher will ensure that the information and digital recordings with the information collected from you during the interviews will be kept in a lockable cabin in the researcher's office and records that identify you will be available only to people working on the study, unless you give permission for other people to see the records.

The researcher will also store hard copies of your answers for a minimum period of five years in a locked cupboard/filing cabinet in the office for future research or academic purposes; electronic information will be stored on a password - protected computer. Future use of the stored data will be subject to further Research Ethics Review and approval.

This study has not yet received written approval from the Research Ethics Review Committee of the UNISA but once approved A copy of the approval letter can be obtained from the researcher if you so wish.

Should you have questions regarding the study or if you would like to be informed of the final research findings, please contact Noluthando Proude Mbhele on 071 3498 551/ 48990086@mylife.unisa.ac.za . Furthermore, s hould you have concerns about the way in which the research has been conducted; you may contact Dr Gladys B Bhuda at 012 429 4807, bhudag@unisa.ac.za.

Thank you for taking time to read this information sheet and for participating in this study.

Thank you.

Noluthando Proude Mbhele

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ADDENDUM D
CONSENT TO PARTICIPATE IN THIS STUDY

Research title: The perception and attitude of social workers regarding their own mental health in the city of Tshwane, South Africa

Researcher: Noluthando P Mbhele

I, _____ (participant name), confirm that the person asking my consent to take part in this research has told me about the nature, procedure, potential benefits and anticipated inconvenience of participation.

I have read (or had explained to me) and understood the study as explained in the information sheet.

I have had sufficient opportunity to ask questions and am prepared to participate in the study.

I understand that my participation is voluntary and that I am free to withdraw at any time without penalty (if applicable).

I am aware that the findings of this study will be processed into a research report, journal publications and/or conference proceedings, but that my participation will be kept confidential unless otherwise specified.
I agree to the recording of the <insert specific data collection method>.

I have received a signed copy of the informed consent agreement.

Participant Name & Surname…… (please print)
Participant Signature……..Date……
Researcher's Name & Surname……(please print)
Researcher's signature……..Date……

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ADDENDUM E: Data collection tool(s) (including questionnaire/ interview guide/checklist)

Biographic questions:

1. How old are you?
2. What is your highest qualification?
3. How long have you been working as a social worker within the Gauteng Department of Health?
4. Describe your responsibilities as a social worker within the Gauteng Department of Health

Topical questions:

5. Distinguish between mental health and mental health illnesses
6. Describe your experience of working with individuals diagnosed with mental health illnesses
7. Describe your own metal health challenges
8. How has mental health challenges affected your work, family and social life
9. How do you cope with the said challenges?
10. What policies are available in your institution to support employees experiencing mental health issues?
11. What supportive services are available for employees with mental health issues in your institution?
12. What suggestions do you have to improve mental health services in the workplace?

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ADDENDUM F :NHRD CLEARANCE CERTIFICATE

GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

Enquiries: Dr. Manei Letebele-Hartell
Tel: +27 12 451 9035
E-mail: Trov.Mashabela@gauteng.gov.za

TSHWANE RESEARCH COMMITTEE: CLEARANCE CERTIFICATE

DATE ISSUED: 06/03/2024
PROJECT NUMBER: 21/2024
NHRD REFERENCE NUMBER: GP_202401_017

TOPIC: The perception and attitude of Social Workers regarding their own mental health in Pretoria, South Africa.

Name of the Lead Researcher:	Ms Noluthando Proude Mbhele
Name of the co-researcher:	Dr GB Bhuda
Facilities:	Tshwane Health Facilities (***annexure 1 attached***)
Name of the Department:	University of South Africa

NB: THIS OFFICE REQUEST A FULL REPORT ON THE OUTCOME OF THE RESEARCH DONE AND

NOTE THAT RESUBMISSION OF THE PROTOCOL BY RESEARCHER(S) IS REQUIRED IF THERE IS DEPARTURE FROM THE PROTOCOL PROCEDURES AS APPROVED BY THE COMMITTEE.

DECISION OF THE COMMITTEE: APPROVED

.....
Dr. Manei Letebele-Hartell
Chairperson: Tshwane Research Committee

Date: 07/03/2024

.....
Mr. Mothomone Pitsi
Chief Director: Tshwane District Health

Date: 2024/03/07

GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

Annexure 1

DECLARATION OF INTENT FROM THE PHC MANAGER FOR TSHWANE PROVINCIAL CLINICS

I give preliminary permission to **Ms Noluthando Proude Mbhele** to do his or her research on **"The perception and attitude of Social Workers regarding their own mental health in Pretoria, South Africa."** In

ADELAIDE TAMBO CLINIC	NEW EERSTERUS CLINIC
BOEKENHOUT CHC	PHEDISONG 1 CHC
BOIKHUTSONG CLINIC	PHEDISONG 4 CHC
BOPHELONG (REGION C) CLINIC	PHEDISONG 6 CLINIC
DASPOORT POLI CLINIC	PHOMOLONG CLINIC
DILOPYE CLINIC	RAMOTSE CLINIC
EERSTERUST CHC	REFENTSE CHC (ODI)
GARANKUWA VIEW CLINIC	SEDILEGA CLINIC
HOLANI CLINIC	SKINNER STREET CLINIC
JACK HINDON CLINIC	SOSHANGUVE 2 CLINIC
JUBILEE GATEWAY CLINIC	SOSHANGUVE BLOCK JJ CLINIC
KEKANASTAD CHC	SOSHANGUVE BLOCK TT CLINIC
KGABO CHC	SOSHANGUVE BLOCK X CLINIC
KT MOTUBATSE CLINIC	SOSHANGUVE CHC
LAUDIUM CHC	STANZA BOPAPE CHC
MANDISA SHICEKA CLINIC	SUURMAN CLINIC
MARIA RANTHO CLINIC	TEMBA CHC
MERCY NGO CLINIC	TLAMELONG CLINIC
NELLMAPIUS CLINIC	WINTERVELDT CLINIC

DECLARATION OF INTENT FROM THE PHC MANAGER FOR TSHWANE PROVINCIAL CLINICS

I know that the final approval will be from the Tshwane District Research Committee and that this is only to indicate that the clinic/hospital is willing to assist.

Other comments or conditions prescribed by the PHC Manager to the Researcher are:

The researcher to have an entry meeting with potential facilities before starting with the data collection.

Mr M. Makhudu
Primary Health Care and Wellness: Tshwane
Date: 15/2/2024

ADDENDUM G: RESEARCHER ACKNOWLEDGEMENT FORM

CONFIDENTIALITY AGREEMENT WITH RESEARCH THIRD PARTIES

Hereby, I, Phindile Mbatha in my capacity as debriefer/ transcriber/ independent code r/ data capturer/ language editor, am aware of and familiar with the stipulations and contents of the conditions of ethical clearance specific to this study of which the title is: The perception and attitude of Social Workers regarding their own mental health in Pretoria, South Africa.

I shall conform to and abide by these conditions. Furthermore, I am aware of the sensitivity of the information collected and the need for strict controls to ensure confidentiality obligations associated with the study.

I agree to the privacy and confidentiality of the information I am granted access to in my duties as debriefer/ transcriber/ independent code r/ data capturer/ language editor . I will not disclose or sell the information I have been granted permission to gain access to, in good faith, to anyone.

I also confirm that I have been briefed by the research team on the protocols and expectations of my behaviour and involvement in the research as a debriefer/ transcriber/ independent coder/ data capturer/ language editor.

Title	Signature	Date
Researcher		28/11/2023
Supervisor		28/11 /2023
Debriefer/ Transcriber/ Independent coder/ Data capturer/ Language editor		28/11/2023

University of South Africa
Preller Street, Muckleneuk Ridge, City of Tshwane
PO Box 392 UNISA 0003 South Africa
Telephone: +27 12 429 3111 Facsimile: +27 12 429 4150
www.unisa.ac.za

GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

MAMELODI HOSPITAL

Private Bag x 0032 P O Rietvlei 0122
Tel no. 127 12 541 8000/8001

DECLERATION OF INTENT FROM THE CLINICAL MANAGER

I do give permission to: Ms. N. P. Mhhele GP 202401_017

to do research on: The perception and attitude of Social Workers regarding their own mental health in Pretoria, South Africa.

Other Comments or Conditions prescribed by the Clinical Manager:

1.The research outcome to be reported to the institution.

.....

Signature:
Clinical Manager

Date: 21 / 02 / 2024

Addendum: **c**

UNISA university of south africa

PERMISSION LETTER

Research title: The perception and attitude of Social Workers regarding their own mental health in Pretoria, South Africa

Researcher

Noluthando P. Mbhele

24 June 2024

Kalafong Provincial Tertiary Hospital

Department of Health (Social work Department)

Dear Manager

I, Noluthando P. Mbhele, I am doing research with Dr Gladys Bhuda (Senior Lecture) in the Department of Social Work towards a Masters in Social Work at the University of South Africa. We are hereby requesting permission to conduct a research study entitled: The perception and attitude of social workers regarding their own mental health in Pretoria, South Africa. The aim of the study is to explore the perception and attitude of Social Workers regarding their own mental health in Pretoria, South Africa.

The Kalafong Provincial Tertiary Hospital has been selected for the proposed study because it employs Social Workers who are providing psychosocial support services to patients and their families and the researcher has an interest to interview them to explore their perception and attitude regarding their own mental health on the subject matter. This is also because the social workers, owing to the nature of their work, they may themselves encounter some mental health challenges to their working environment and the nature of their work.

The target populating for the study are thus social workers working in health settings in Pretoria, South Africa. Data from the prospective study participants (i.e. social workers) will thus be collected by means of semi-structured interviews. The interviews will be conducted with those who

consent to participate in the study and will be conducted within the social workers' offices. The interview will take approximately one hour per social worker when collecting data.

During data collection, the researcher will thus follow the University guidelines and will also adhere to ethical practice. In so doing, the researcher will adhere to inform consent, will uphold confidentiality, anonymity and the privacy of participants; she will also ethically manage the information obtained, and will also ensure that participants bear no harm, amongst other ethical issues

The benefits of the study are that social workers will give voice to their knowledge on their mental health illnesses in the workplace, which might eliminate misconceptions about mental health within the social work fraternity. It is also hoped that the study will raise awareness about the prevalence of mental health amongst social workers and enhance seeking behavior. These findings could also bring about more research on this topic specifically on mental health issues in the work environment, which could benefit not only social workers, but also broader society in the working environment in that robust mental health programmes may be instituted for staff.

It is not anticipated that participants may encounter any negative consequences for participating in the study. However, should it happen that participants experience any emotional discomfort during the interview, you will be debriefed. If their discomfort continues, you will be referred to Social Work for further therapeutic support.

Furthermore, the researcher will also provide the copy of findings to the Department upon completion of the research report. Should the institution have concerns about the way in which the research has been conducted, you may contact Dr Gladys B Bhuda at 012 429 4807, bhudag@unisa.ac.za.

Yours sincerely

Noluthando Proude Mbhele

UNISA Social Work Masters Student

GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

Weskoppies Hospital

Private Bag X 113
PRETORIA
0001
Enquiries: Ms M Magolego
Tel: (012) 3199719
eMail:
Mmethapelo.Magolego@gauteng.gov.za

Name of researcher: Ms Mbhele NP
NHRD No.: GP_202401_017
Project title: The perception and attitude of Social Workers regarding their own mental health in Pretoria, South Africa.

Approval of research to be conducted at Weskoppies Hospital:

Your application was evaluated by the Weskoppies Hospital Research Committee (WHRC).

Decision: Approved.

The approval of all research conducted at Weskoppies Hospital is subject to:

1. The hospital's records not being compromised, removed, duplicated, nor disclosed.
2. The submission of bi-annual reports and the final outcome of the research (i.e., published article, final dissertation/thesis or a full research report) to Ms Magolego (email above) for the benefit of Weskoppies Hospital and its stakeholders.

Mr M. Motaung
CEO: Weskoppies Hospital

Date: 2024-03-01

GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

Dr. George Mukhari Academic Hospital

Office of the Director Clinical Services
Enquiries : Dr. C Holm
Tel : (012) 529 38767
Fax : (012) 560 0099
Email:Christene.Holm @gauteng.go.za
keitumetse.mongale@gauteng.gov.za

To Ms NP Mbhele
Department of Health Sciences
University of South Africa

Date :31 January 2024

PERMISSION TO CONDUCT RESEARCH:GP_202401_017

The Dr. George Mukhari Academic Hospital hereby grants you permission to conduct research on "The perception and attitude of Social Workers regarding their own mental health in Pretoria, South Africa " at Dr George Mukhari Academic Hospital

This permission is granted subject to the following conditions:

- ☑ That you obtain Ethical Clearance from the Human Research Ethics Committee of the relevant University
- ☑ That the Hospital incurs no cost in the course of your research
- ☑ That access to the staff and patients at the Dr George Mukhari Hospital will not interrupt the daily provision of services.
- ☑ That prior to conducting the research you will liaise with the supervisors of the relevant sections to introduce yourself (with this letter) and to make arrangements with them in a manner that is convenient to the sections.
- ☑ Formal written feedback on research outcomes must be given to the Director: Clinical Services
- ☑ Permission for publication of research must be obtained from the Chief Executive Officer

Yours sincerely

DR. C. HOLM
DIRECTOR CLINICAL SERVICES
DATE: 31/1/24

GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

STEVE BIKO ACADEMIC HOSPITAL

Enquiries: Dr JS Mangwane
Tel No: +2712 3452018
Fax No: +2712 354 2151
E-mail: joseph.mangwane@gauteng.gov.za

For attention: Noluthando Proude Mbhele

NHRD Ref Number: GP_202401_017

Re: REQUEST FOR PERMISION TO CONDUCT RESEARCH AT STEVE BIKO ACADEMIC HOSPITAL

TITLE: The perception and attitude of Social Workers regarding their own mental health in Pretoria, South Africa.

Permission is hereby granted for the above-mentioned research to be conducted at Steve Biko Academic Hospital. This is done in accordance to the "Promotion of access to information act No 2 of 2000".

Please note that in addition to receiving approval from Hospital Research Committee, the researcher is expected to seek permission from all relevant department. Furthermore, collection of data and consent for participation remain the responsibility of the researcher.

The hospital will not incur extra cost as a result of the research being conducted within the hospital.

You are also required to submit your final report or summary of your findings and recommendations to the office of the CEO.

STATUS OF APPLICATION: Approvec

Date: 2024-02-06

Dr. J S. Mangwane
Manager: Medical Service

GAUTENG PROVINCE
IPHUMA
REPUBLIC OF SOUTH AFRICA

Annexure 1

Declaration of intent from the hospital CEO

I give preliminary permission **Ms NP Mbhele** to perform his research on

"The perception and attitude of social workers regarding their own mental health conducted in Tshwane District Hospital" .

I know that the final approval will be from the Tshwane Regional Research Ethics Committee and that this is only to indicate that the hospital is willing to assist.

Other comments or conditions prescribed by the hospital CEO:

Once research is completed kindly send a copy to the hospital CEO so that the hospital can improve services based on research findings.

MS M S. MOGASHOA
TSHWANE DISTRICT HOSPITAL
CEO

Ms Monene Mogashoa
Chief Executive Officer
Tshwane District Hospital
0832698002

01/04/2024
Date

ADDENDUM I: EDITORIAL CERTIFICATE

Office: 0183892451

FACULTY OF EDUCATION **Cell: 0729116600**

Date: 25th October, 2025

CERTIFICATE OF EDITING

I, Muchativugwa Liberty Hove, confirm and certify that I have read and edited the entire dissertation, **The perceptions and attitudes of Social Workers regarding their own mental health in Pretoria, South Africa,** submitted by **NOLUTHANDO PROUDE MBHELE,** in accordance with the requirements for the degree of **MASTER OF SOCIAL WORK** at the **UNIVERSITY OF SOUTH AFRICA.**

Noluthando Proude Mbhele was supervised by Dr. G.B. BHUDA.

I hold a PhD in Literature and Language Education and am competent to edit and advise on research practices, specifically coherence, cohesion and grammatical concord.

Yours sincerely

Professor M.L. Hove (PhD, MA, PGDE, PGCE, BA Dual Honours – English &Mathematics; C2 NRF Rated Researcher; 2024 Visiting Scholar-University of London, SOAS)

ADDENDUM J :TURNITIN RESULT

Similarity Report

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NOLUTHANDO PROUDE MBHELE

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45847 Words

CHARACTER COUNT
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PAGE COUNT
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Sources overview