Understanding coercion in Indian mental health care
from a multi-stakeholder perspective

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Chapter 1: INTRODUCTION

Coercion in the care of people with psychiatric illnesses is prevalent worldwide. Its history goes back to the earliest known mental health systems and continues as psychiatric care moves beyond mental health institutions into the community. Despite its prevalence, however, coercion – both as concept and practice – has remained understudied this discipline. Researchers, carers and psychiatrists have only recently begun to turn a critical eye on the systems of mental health-care that have long used coercive practices, and begun to raise questions about the long-term consequences of coercion, whether it is avoidable, and if so, how.

The answers to these questions, however, are as many and as varied as there are psychiatric practices around the world. Coercion is a complex phenomenon and the forms it takes are inextricably linked to cultural and social norms. For instance, individual autonomy is valued in most European and North American cultures, whereas Indian, Arab, African and Japanese cultures are more community and family-centred. This difference may affect the use of involuntary admission and informed consent, among other practices, in traditional versus modern Western societies (Shah & Basu, 2010). Medical paternalism (‘the doctor knows best’) is more acceptable to the patient in the latter societies. That does not, however, automatically and necessarily imply the right of the medical professional to assume the role of ‘do-gooder’ in the form of involuntary treatment and coercion. Due to this complexity and cultural dependency, it is unrealistic to expect straightforward directions about ethical considerations and normative claims about what should or should not be done. Even in high-income countries, where substantial research has been conducted on the subject, there are no conclusive answers, and debates are ongoing. In lower-income countries, on the other hand, there is a need for more research. In order to understand how mental health institutions and community-care systems can be designed with regard to the culture-specific issues that surround coercion, we need to understand the causes and consequences of coercion in different settings and the roles and perceptions of different stakeholders. In the following sections of this chapter, I explore some of these debates in order to understand the different perspectives and analyse their practical implications.
1.1 DEFINITIONS OF COERCION

 Despite the long history of the concept of coercion and its recognition in nearly every intellectual discipline – such as philosophy, psychiatry, law, sociology and literature – a comprehensive understanding of the full implications of coercion in a given context still prompts debate and discussion. Coercion is the act of exercising power, defined as one agent intentionally influencing the behaviour of others. The agent could do this by persuasion, but if this fails, can make the other do something/act against their will by deceit, intimidation, threats, force or extortion. It may involve inflicting physical or psychological pain in order to make the threat more credible, as in the extreme case of torture (Rhodes, 2000). The aim of coercion is to seek cooperation or obedience in those who are coerced as well as to send a message to those who support them. Coercion is closely related to the exercise of power (Dugan, 2003), which can be exercised in a threefold fashion: immanently, as a felt essence that is used to overcome resistance; implying the possible use of persuasion, manipulation, coercion, compulsion, pressure or constraints; or by resorting to the actual use of duress, force and violence (Arboleda-Florez, 2005).

 Sidman (2001) reminds us that we use coercion almost exclusively to control each other. He traces the origins of this idea to Patterson, who developed coercion theory to explain interactions in family dyads in which aversive action affects either the performance of the other person or that of the target subject. Patterson insisted that for behaviour to be coercive, it must not only be aggressive, but should consistently follow specific patterns, and produce a consistent reaction in the victim that serves the aggressor (Patterson, 1993).

 In law, being coerced is akin to acting ‘under duress’ or because of ‘undue influence’. More recently, it is also seen as equivalent to ‘extortion’. For a person subject to coercion, if the threat is substantial, coercion can be used as a defence with two possible meanings – when a person is compelled by force of authority to do something, or when actual force is used to cause the person to do something (compulsion) they would not otherwise do. Coercion could also be conceived as a form of exerting social influence via the use of international power exercised either through authoritative requests, persuasion, inducements, threats, offers, or actual use of force (Albrecht, 2016).
These definitions merely scrape the surface of the varied questions that the issue of coercion raises. How does coercion affect its victims? What are the ethical concerns when normative theoretical statements about coercion are made? How do people experience coercion? What gives rise to coercion in a given circumstance? How can we begin to address the conflict of interests that arise? The focus of this research in many ways is an attempt to move towards a deeper understanding of the reasons behind coercion in medical practice, specifically psychiatry, and how such an understanding can inform ongoing and future practices.

1.1.1 Coercion in Health Care

There has been growing attention paid to the use of coercion in health care by health professionals, managers, users/patients, researchers, and politicians. ‘Coercion’ in health care refers to formal, informal and perceived coercion. Formal coercion is regulated by legislation, while interventions that are often referred to as informal coercion are less regulated. Perceived coercion is how the person who is subject to coercion perceives it. Health professionals do not share the same opinions on use of coercion. The study conducted by Bigwood and Crowe (2008) describes bad conscience and fear among health workers as a result of physically restraining patients. Nurses stated that coercion ‘is part of the job, but it spoils the job’. Such ambivalence could easily lead to feelings of moral distress. Vatne and colleagues (2007) reported conflicting personal feelings concerning the ambiguity created by balancing the patient’s safety, dignity, and correction of abnormality. In order to cope with using coercion in their work, some employees tend to defend the need for it.

Debates surrounding definitions of coercion are more intense in the field of psychiatry, where coercive treatment, although controversial, is legally sanctioned in limited cases (Szmukler, 2008). Coercive measures always involve a conflict of medical ethical principles. Medical professionals need to balance beneficence (‘doing good’) and nonmaleficence (avoiding harm) with the prerequisite of respecting the patient’s autonomy, in order to justify coercion in extreme situations (Beauchamp and Childress, 2001).

In the context of health care, an exploration of the issue of coercive treatment focuses on patients in different contexts who are highly vulnerable to the use of coercive measures, such as general hospitals, old-age homes, or long-term care homes for chronically and severely ill or disabled persons (Kallert, 2008). It is difficult to establish a
comprehensive picture of coercion in health care even though health workers and patients are among the most likely to experience aggression and subsequent coercive interventions (Lepping et al., 2013).

1.1.2 Coercion in Psychiatry

In a psychiatric context, the term ‘coercive measures’ usually refers to coercive interventions occurring during hospitalisation in psychiatric wards (Kalisova et al., 2007). However, with the expansion of community care, coercion can also be experienced outside hospital settings. Coercion classically includes seclusion, restraints, and involuntary medication, but increasingly, community-based patients perceive the implied pressure to comply with treatment plans as coercive (Burns et al., 2011), even without the use of standard forms of restraint. Szmukler (2015) points out that coercion covers both compulsion and threat, in contrast to Wertheimer (1993) who distinguishes between threats and offers, and does not consider the latter to be coercive. In emergencies, when patients are at imminent risk of harming themselves or others, the need for coercion is less disputed (Swartz et al., 2002). The question is more difficult in non-emergency situations, but where aspects of safety or harm to health are the main consideration. Such situations commonly occur in geriatric medicine and psychiatry. In these cases, it is unclear whether the principle of acting in the patient’s best interest justifies the restriction of the patient’s autonomy.

There is, inevitably, a relationship between the freedoms and rights as described above and the extent of the use of powers, especially powers to restrict, and policies and procedures of a coercive nature as seemingly needed in psychiatric institutions and forensic psychiatry facilities. Coercion has been a constant in psychiatric interventions since antiquity, according to prevailing beliefs about the nature of mental illness (Neaman, 1975). There is a complex intersection of questions regarding permissibility and responsibility. There is a strong moral presumption against the use of coercion, and those who are coerced seem to be less responsible for the actions they were coerced to perform. When coercion is impermissible, this seems to be because it improperly constrains the person’s choice, and when coercion mitigates responsibility, this too seems to reflect the effect of coercion on the person’s choice. Physical coercion operates by taking physical control of at least some part of another’s body, e. g. being restrained to a
bed. The effect of physical coercion on personal choice is fairly clear because the person cannot move as s/he wishes (Pallikkathayil, 2011)

Perceived coercion in the context of mental health is defined as an individual's perception of being pressured to enter treatment for mental illness, from forces that are both internal and external to the person. It is a challenging clinical issue. Compulsory admission and other coercive interventions can be a complex and stressful experience for patients and family carers. Whether coercion is damaging to the patient's autonomy, liberty and dignity has to be understood on the basis of the clinical perspectives of the service provider, establishment and user.

Coercive interventions in mental health care do not come only from specialised services. Pressure to accept treatment can arise from family and carers who are often intimately involved in the treatment and care of severe mental illness. The family's role is vital and needs to be taken into account. Family members often deal with crises and are involved in general care. A person can feel coerced to accept treatment because of social and cultural expectations (Canvin et al., 2013). Moreover, family members' expectations and experiences of working with mental health professionals and services are unclear. A potential discrepancy between the wishes of family members and patients can present an additional complication. The role of family members in decisions and services regarding treatment tend to be poorly recognised in involuntary admissions and other coercive practices. A hospital stay will be stressful for the family members who are caring for a patient. A better understanding of their attitudes may help to address their needs more effectively and improve their involvement in care during and after an involuntary hospital admission made for the patient's benefit.

1.2 MENTAL HEALTH CARE AND COERCION IN THE INTERNATIONAL CONTEXT

The mental health system from the late 1800s to the 1970s in the United States (US) was based on two options – prison or a mental hospital. Such a situation was captured pointedly by Penrose, who in 1939 demonstrated that in European countries, crime rates and the number of psychiatric facilities were inversely related (Penrose Law). (Penrose proposed an inverse relationship between the number of psychiatric beds available to a population and its total number of prisoners, based on calculations from a cross-sectional study of 18 countries.) The ‘balloon theory’ proposed that as the number of mental hospital beds increased, the number of prison beds declined, and vice versa.
(Penrose, 1939). The asylums were a response to the abuses that ‘chronically ill persons with mental disorder’ suffered in the poorhouses. By 1955, however, there was an unprecedented rise in the population housed in public mental health hospitals in New York State and the US more widely. There were then over 500,000 patients in the nation's public mental institutions, including nearly 97,000 in New York. It was at about this time that the process, now known as ‘de-institutionalisation’, got underway, necessitated by the state governments’ realisation that they could no longer afford the asylums they had built. It was also made possible by the discovery of psychotropic drugs. In 1950, after the accidental discovery of narcoleptics, there were advances in psychiatric treatment. This situation gave impetus to the movement for community psychiatry in the 1960s and to a call to close the asylums and replace them with a more open and responsive system that considered patients’ perspectives (Rachlin, 1973).

In a study undertaken by Theodoridou and colleagues (2012), where they investigated the relationship between perceived coercion and the therapy, they found that ‘perceived coercion predicts the patients’ appraisal of the therapeutic relationship. Also, perceived coercion is related to a more negative patient-therapist relationship’, and perceived loss of autonomy is closely linked to a negative relationship between the clinician and the patient. Van den Hooff (2013) finds that whether or not patients are listened to is central in determining whether they feel respected as human beings in the case of coercive admission. Thus, the everyday question of how to relate positively with patients may sometimes be just as important as determining what treatment to start. It indicates the importance of communication between doctor and patient. Indeed, the qualities enabling clinicians to be effective in helping patients (clinical skills, knowledge, and attitudes) overlap with the very qualities that make them morally good.

These practices and theoretical interventions in the US and Europe emerged from a fundamental belief in individual autonomy and freedom of will. This belief, however, does not hold quite the same importance in a social context like that of India, which forms the base of this study, where society is primarily family-centred. The following section offers a brief examination of the background of mental health care and coercion in India.
1.3 MENTAL HEALTH CARE AND THE ISSUE OF COERCION IN INDIA

During British colonial rule, mentally ill patients were kept under custodial care in prisons and asylums. The Lunatic Asylum Act of 1856 was modified to form the Indian Lunacy Act (ILA) of 1912. The enactment of the ILA resulted in the opening of new asylums and improvements in their conditions. The name 'lunatic asylum' was changed to 'mental hospital' in 1920, and the control of mental hospitals was shifted from prison authorities to civil surgeons. Before India’s independence, the Bhore Committee was asked to survey mental hospitals in India. The committee recommended that the 1912 ILA was outdated and had outlived its usefulness (Mills 2001). The terminology used was obsolete. A draft of the Mental Health Act was prepared by the Indian Psychiatry Society in 1949, but it took nearly 40 years for this Act to be passed by the parliament. The Act finally received presidential assent on 22 May 1987. The central and state mental health rules were framed in 1990, and with effect from 1 April 1993 the Mental Health Act (MHA) of 1987 came into force. Even then, its real implementation occurred only after the ‘Erwadi tragedy’ (human rights violations in psychiatric and religious institutions were exposed by the media) (Sharma and Chadda 1996), in which 28 shackled inmates of a faith-based mental home burned to death.

India was the first post-colonial country to undertake mental health reforms. The national mental health programme (NMHP), created in 1982, established an integrated approach to mental health care, using specialist and non-specialist staff.

The National Human Rights Commission carried out two systematic examinations of mental hospitals in India in 1998 (National Human Rights Commission 1999) and 2008 (Nagaraja and Murthy 2008). Following the initial report, as part of the NMHP, funds were provided for upgrading the facilities of mental hospitals. This has resulted in some positive changes over the past ten years, as shown by the 2008 NHRC report. However, the NMHP model was not adopted by departments of health at the state level because they were expected to adopt the programme without adequate incentives or technical support. Certain systemic weaknesses were identified in internal evaluations (ICMR, 2009), which were largely ignored. Respondents acknowledged that there were no mechanisms to make authorities accountable for addressing the identified weaknesses. Government reports also highlighted that the system lacked mechanisms to penalise health workers’ non-performance (in any area of health care), or to make them legally accountable
This contributed to poor service provision. In the last three years, a group of experts has been commissioned to advise the government on priorities for the next funding cycle, the 12th Five Year Plan. This reflects a growing political commitment to dealing with mental health. The Government of India’s Ministry of Health and Family Welfare appointed a Policy Group to prepare a National Mental Health Policy and Plan. The experts from this group conducted intensive investigations into NMHP implementation across the country to prepare a situational analysis of the need for mental health care and current provisions, including issue of human resources, essential drug procurement and distribution, advocacy, prevention of mental illness, rehabilitation and care and promotion of mental health and rehabilitation (Mental Health Policy Group, 2012).

The present study aims to understand coercion in Indian mental health care from the perspectives of both the family carers or staff and the patients. It confronts the ethical dilemmas surrounding coercion by conducting an empirical study of the various issues and problems at stake. Most existing literature on coercion is from high-income countries (HICs); their findings may have limited relevance for a middle-income country (MIC) such as India in terms of planning and providing mental health services. In many Indian settings, dormitories with ten or more patients in one room are standard in government-run psychiatric hospitals. Moreover, one relative is expected to stay with the patient at all times to help with feeding, personal care and supervision. This creates different perspectives on coercion compared to those prevailing in Europe or North America, because the relative too can be a trigger, target and manager of a patient’s aggression, as well as a participant in the application of coercive measures.

Empirical research concerning coercion is quite limited in India. A number of researchers outside India have found mixed and inconsistent results regarding socio-demographics, primary psychiatric diagnosis and clinical predictors to coercion (Bindman et al. 2005; Rain et al., 2003; Swartz et al., 2004; Sheehan & Burns, 2011; Anestis et al., 2013).

In the following sections, I will define and analyse some of the issues that any study on coercion would inevitably need to address. I adopt an approach in which ethics and empirical research complement each other.
1.4 ETHICAL ASPECTS AND PATIENTS’ HUMAN RIGHTS PERSPECTIVE

The use of coercion in mental health raises many ethical questions and considerations. Defining coercion is in itself ethically challenging since it has consequences for how the power of health professionals is recognised and exercised. Defining and recognising coercion has to do with being morally sensitive and reflective. The Universal Declaration of Human Rights (UDHR) states that all human beings are protected from ill-treatment and improper detention. Using coercion against someone, depriving their freedom and placing restrictions on their life are usually violations of the person’s human rights. Heightening user involvement and participation may lead to a reduction in the use of coercive practices (Lillemoen & Pedersen, 2013). A Swedish study showed that only a minority of patients and relatives reported participating in treatment and care planning, both of which are legally regulated (Kjellin et al., 2004). This problem is clinically encountered in Indian mental health care and needs to be systematically analysed.

On the other hand, coercion is often used in psychiatry and in law for purposes of controlling human behaviour when it runs counter to social expectations or openly flouts the law. The key concept is human behaviour, which is seldom limited to one person and is inextricably linked to the human being within a society. Questions of human behaviour thus involve issues of personal responsibility and individual rights, including liberty. Any recourse to justice is an invitation to use coercive measures of control. Coercion works either through persuasion or through imposition, and it is the opposite of freedom, however defined, whether in positive or negative terms. Even when the patient enters into treatment voluntarily, there is always the open or veiled threat that the imposition of coercive measures is a possibility and, sometimes, even a probability. Coercion is an ever-present characteristic of psychiatric and medical interventions. Research shows that patients tend to accept the use of coercion if they feel they are treated with respect and are well taken care of (Kjellin et al., 1997). Coercion might involve extra care, attention, safety, and hence contribute to perceived dignity (Johansson & Lundman, 2002). If patients feel that staff attitudes are characterised by beneficence, that they are honest and open and feel that their mental health is improving (Bennett et al., 1993), it is more likely that they will accept the use of coercion.

Within a hypothetical continuous set of social circumstances, coercion would be found at the opposite end to freedom, as the latter is a state of not being constrained and of being able to exercise free will. In a state of complete freedom, there would be no
political forces that intimidate, threaten or use force to prevent such an expression of free will. However, if freedom is defined in positive terms as ‘consisting of being one’s own master’, then, by following orders, freedom is coerced. If, on the other hand, freedom is defined in negative terms as consisting of ‘not being prevented from choosing as others do’ (Berlin, 1969), then, again, orders to abstain from doing what one desires are coercive. While the expression of free will and the use of freedom are usually factors of state policies in democratic nations, their expression also depends to a large extent on entitlements and other social determinants such as social and economic arrangements that include education, shelter and health care (Sen, 1999).

1.5 POSITIVE AND NEGATIVE RIGHTS

From a rights perspective, it is relevant to make a distinction between positive and negative rights. Positive rights are those that the state guarantees to citizens, sometimes progressively according to circumstances, and the ability to pay for them. Negative rights are those held by the individual with a guarantee that the state has no right to prevent the person from their enjoyment, to interfere with them in any way or form, or to abrogate them unless there are good legal reasons; these rights are inalienable. Negative rights confront the issue of liberty, while positive rights pertain to aspects of being able to live as comfortably as possible. Negative rights include autonomy, bodily integrity, liberty and property along with equality and non-discrimination, freedom from inhuman and degrading treatment, and a least-restrictive environment. Such a list also includes positive rights such as to adequate food and shelter; the right to religious freedom; the right to health, together with timely access to quality mental and physical health care and services; the right to be involved in planning and decision-making and policy and management within the health system; the right to treatment and to refuse treatment; voting rights; the right to own and use property; right to expression of sexuality, marriage and to establish a family; the right to social inclusion and community integration; the right to housing or shelter, to employment and safe working conditions; the right to education and training; the right to control of personal and financial affairs and to insurance and social security; the right to information and participation; the right to legal counsel and access to courts; and appropriate protection, care and treatment of persons with a mental disorder (Weisstub & Diaz-Pinto, 2008). However, the limitation on the freedom to choose has impacts on people’s ability to exercise their individual rights, whether these are negative or positive (Helmchen & Sartorius, 2010).
1.6 THE IMPORTANCE OF THE CURRENT RESEARCH

Coercive measures are increasingly seen as human rights issues, and internationally binding documents like the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) emphasise this. The effects of protecting human rights in providing mental health care to ensure sound outcomes are an area of interest for this research.

International studies have shown that from 3% (Portugal) to 30% (Sweden) of all psychiatric in-patient episodes comprise involuntary hospital admission of general psychiatric patients (Salize & Dressing, 2004). As shown in another European multi-site study, approximately one-third of legally involuntarily admitted patients are currently subjected to individual coercive measures such as mechanical restraint, seclusion or forced medication within the first four weeks after admission. Here again, variation across clinical sites is enormous and rates can be as high as 60% (Raboeh et al., 2010). There is as yet no broad and robust base of empirical knowledge on such elements of service provision (Kallert et al., 2008). Ethical issues associated with clinical practice and research on coercive measures have become of utmost importance. They range from exploring undue influence on research, and questions of properly assessing the ability to give informed consent, to attitudes of professionals towards coercive measures (Steinert, 2007).

There is a lack of data on the effectiveness of coercive measures. The literature on coercive measures includes a long list of possible adverse effects and complications of being restrained. This includes problems with elimination, pneumonia, circulatory obstruction, cardiac stress, skin damage, poor appetite, dehydration, thrombosis, and accidental death. Other complications reported are getting out of restraints, vomiting, self-harm, injuring others and hostility or increased agitation (Mohr, 2006). Studies from outside India on this topic often conclude that the relationship between subjective and reported coercive incidents and the outcome of care are not yet fully understood and should be investigated (Kjellin & Wallsten, 2010).

The development and critical analysis of strategies to reduce the use of coercive measures in different settings are areas of major relevance for public mental health care and research. Coercive measures are not only critical for shaping public opinion regarding psychiatry, but are the main area in which this medical discipline faces increasing criticism,
particularly from the human rights perspective (Dudley et al., 2012) voiced by users of mental health services and prominent international political bodies such as the Council of Europe. Coercive measures constitute and symbolise a core element of the relationship between individual mental health professionals and their patients and of the dialogue with professional bodies.

The complex and internationally diverse linkages of all forms of coercive measures to mental health legislation is a field that must be assessed in much more detail, in particular when alternatives to coercive treatment are to be introduced and existing legal frameworks must be adapted to eliminate coercion.

In this chapter I have broadly outlined coercion in the field of mental health care. I have shown that coercive practices exist in different ways in health practices across the globe, including India. I have also outlined the legal and human rights interventions in the matter of coercive practices in mental health care with the trend to move from hospital settings towards community care. In the next chapter I present several theories and philosophical debates related to the issue of coercion and coercive practices – the range of definitions of coercion, factors influencing perceptions, conceptual models, the multidimensionality of patient behaviours and autonomy. Hence, my main aim is to comprehensively understand coercion in mental health care in India from a multi-stakeholder perspective in order to move towards zero coercion. Along with this main aim I present research questions in chapter 3, and describe the methodological approach, validity and ethical considerations.
Chapter 2: THEORETICAL CONCEPTS

This chapter presents the main concepts and theories that have informed the research. I start by conceptualising coercion in mental health care and elaborating historical and modern bio-ethical perspectives. The chapter continues with a discussion on the multidimensional behaviour model and causes of aggression, coercion as a spectrum of treatment pressure, types of coercive measures, areas where it is used and criteria for use of coercion. In the final section, I discuss autonomy and the role of autonomy in medical decision-making. I conclude by presenting the United Nations Convention on Rights of Persons with Disabilities on compulsory treatment.

2.1 CONCEPTUALISING COERCION IN MENTAL HEALTH CARE

Any consideration of coercion in mental health care requires an understanding of what it means. The attempt to understand coercion is seldom made in the empirical literature and debated in medical ethics. Coercion is a subjective experience of a particular intervention that is against a person’s will, either through force or by threat. It can violate the victim’s integrity or autonomy. It has different meanings in different contexts, situations and places and for different individuals. The most robust appraisal conceptualises coercion as a patient’s subjective state, which is reached after consideration of their environment and situation (Rhodes, 2000). As such, coercion can be considered as a subjective state that arises from compulsory actions in a similar way that autonomy is the subjective state that is necessary to allow objective informed consent.

In the empirical literature, this construct is often called ‘perceived coercion’ in order to differentiate it from objective interventions that may potentially increase or decrease the prevalence of coercion. This distinction is important as there is a so-called grey zone between interventions that may force an individual to follow a course of action and the subjective experience of being forced or threatened into such action (Eriksson & Westrin, 1995). For example, not all legally detained patients experience coercion in the act of detention; indeed, some describe the process in very positive terms as making them feel safe and increasing their access to care (Gibbs et al., 2005).
2.1.1 Historical perspective

The concept of coercion and compulsion are seldom the focus of in-depth philosophical debate outside their socio-political ramifications in Western philosophy (Schlosser & Markus, 2008). Nonetheless, classical philosophers set out the necessary conditions for coercion and its potential moral implications. Although these arguments are not made in relation to medical scenarios (and some even exclude the ‘mentally infirm’ from their reasoning), they have significant implications for how we conceptualise coercion and implement coercive acts. Aristotle, for instance, explores the conditions under which it is appropriate to hold a moral agent blameworthy or praiseworthy for particular actions. He argues that praise and blame are withheld from involuntary actions, that is, actions committed under duress or as a result of ignorance. Thomas Aquinas also discusses coercion in the context of a discussion of moral responsibility. He understands coercion in terms of necessity, where a person is forced to act in a way such that she or he cannot do otherwise. Aquinas here seems to understand coercion in terms of compulsion – coercion is linked to a lack of choice and violence. Aquinas recognises a distinction between compelled actions and those committed as a result of a threat. Hobbes clarifies the necessary conditions for coercion to occur, namely one person or group in having power over another individual or group. Locke argued that although state use of coercion is necessary, this depends on the state’s control itself reflecting the consent of the people (Warner, 1989).

Immanuel Kant emphasises the use of state coercion in securing citizens’ rights and freedoms. He argues that people are inclined to obey the law for two reasons. First, an ethical or rational motivation, such as a duty to obey the law so as to preserve an orderly society; and second, a judicial motivation, which applies to those who do not respect the law but follow it to avoid punishment. Although Kant acknowledges that coercion impinges upon freedom, he maintains that when the state uses it in a proper manner it also secures freedom. Impinging on the freedom of a few is justified to secure freedom for the majority (McCloskey, 1980). Nozick analyses coercion as comprising three central features: first, coercion uses threats rather than physical force; second, coercion is dependent on whether the coerer’s threat is credible to the coerced person (even if the coerer is bluffing, the crucial factor is whether the subject of coercion believes the threat to be
credible); third, the coerced person has to accept the proposal in order for coercion to take place; if not, then coercion, strictly, has not occurred (McCloskey, 1980).

2.1.2 Modern bio-ethical perspectives

All health interventions try to improve the well-being of patients who are considered competent to give consent and be fully informed. This is underpinned by the ethical principle of autonomy (Beauchamp & Childress, 2001). As medical practice has evolved, the principle of autonomy has become an essential guiding principle – not the health professional providing facts and figures but engaging in a dialogue that allows a patient to make an informed choice (McCloskey, 1980).

By definition, coercion and compulsion sit in opposition to autonomy and informed choice, by forcing patients to undertake a course of action over which they have little or no control. If this is the effect of a compulsory action, the question arises of whether such intervention may lead to immediate harm, so the principle of non-maleficence also becomes relevant. When considering the ‘harms’ of coercion and compulsion it is the requirement to do ‘good’ that balances these bio-ethical concerns. In other words, the consideration of any short-term coercive ‘loss’ is outweighed by the potential for ‘good’ to come in the medium to long term. This acts as justification for compulsory intervention that, in turn, increases the likelihood of coercion. As the ability to discuss options has been put to one side and the health professional is, essentially, deciding for the patient, there is an increased burden on the professionals involved to be clear what that good is.

There are three ways in which compulsion can be ethically framed (Owen et al., 2016):

- The patient’s autonomy is absent or reduced as a result of their illness, so that the principle of beneficence can operate relatively unencumbered: the patient is unable to exercise autonomy.
- The patient's autonomy can be weighed against the expected consequences of exercising it, and decided against: the benefits of autonomy are outweighed by the benefits of detention and treatment.
- When considering the patient’s autonomy from the perspective of their whole life, autonomy is most respected by treating the patient compulsorily: by restoring the patient to themselves, somewhat paradoxically, we try to maximise their real autonomy.
2.2 COERCION ON A SPECTRUM OF TREATMENT PRESSURE

Szmukler and Appelbaum have conceptualised a hierarchical framework of ‘treatment pressures’ commonly encountered in clinical practice (Szmukler & Applebaum, 2001) (Fig.1). The lowest level of pressure is persuasion, in which the benefits and risks of treatment are debated and the patient’s arguments are respected. A higher level of pressure may be exerted by using an interpersonal relationship between a clinician and a patient to exert ‘leverage’, perhaps by expressing disapproval or withdrawing emotional support. ‘Inducement’ describes the exertion of a positive pressure on the patient by offering benefits, financial or otherwise, in exchange for co-operation. The highest levels of pressure in the hierarchy are overt coercion. A threat could be made to withdraw services on which the patient normally relies (which is more coercive than simply failing to offer inducements over and above normal services) or to detain the patient in hospital. Finally, at the highest level of the hierarchy, patients may be compelled to take treatment against their will, by detention in hospital and, if necessary, by the use of physical force.

Figure 1: Hierarchy of treatment pressures

Mental health professionals play an active part in deciding the best course of treatment for patients who are admitted to hospital, and it is during the interaction between clinicians and the patient that coercion may be experienced. However, the extent
to which health professionals actually coerce (consciously or unconsciously) an individual to accept hospital admission is uncertain in a medical setting.

2.2.1 Types of coercive measures

There are different types of coercive practices used in different clinical settings (Lepping & Raveesh, 2013) (Fig.2). They include:

a) **Physical restraint**: direct physical contact between persons where force is positively applied against resistance, either to restrict movement or mobility or to disengage from harmful behaviour displayed by an individual.

b) **Chemical restraint**: involves the use of medication to restrain. It differs from therapeutic sedation in that it does not have a directly therapeutic purpose but is primarily employed to control undesirable behaviour.

c) **Mechanical restraint**: involves the use of equipment. Examples include specially designed mittens in intensive-care settings; everyday equipment, such as a heavy table or belt to stop the person getting out of their chair; or bedrails to stop a person from getting out of bed. Controls on freedom of movement – such as keys, baffle locks and keypads – can also be a form of mechanical restraint.

d) **Environmental restraint**: involves buildings designed to limit peoples’ freedom of movement, including locked doors, electronic key pads, double door handles and baffle locks. Seclusion is an important sub-type of environmental restraint. It is defined as ‘placing of a person, at any time and for any duration, alone in an area with the door(s) shut in such a way as to prevent free exit from that area’.

e) **Psychological restraint**: includes constantly telling a person not to do something, or that doing what they want to do is not allowed, or is too dangerous. It may include depriving a person of lifestyle choices by, for example, telling them what time to go to bed or to get up. It might also include depriving individuals of equipment or possessions they consider necessary to do what they want to do, for example removal of walking aids,
glasses, outdoor clothing or keeping the person in nightwear with the intention of preventing them from leaving.

### 2.3 AREAS OF APPLICATION OF COERCION

Figure 2: Types of coercive practices

These following areas of application of coercion can be distinguished:

**Patients with violent behaviour:** Coercion and violence are interrelated in day-to-day clinical care of a person suffering severe mental illness. Assessment of the risk of violence and reduction of coercion is a major challenge in psychiatry. These coercive measures are frequently used to control or prevent violent behaviour and thus often indicate a violent act that would have occurred in the absence of intervention. Statistically, seclusion and restraint are clearly correlated to in-patient violence rates. There is confusion about whether seclusion and restraint should be used as a predictor or an outcome (James et al., 1990). In-patient violence is not only determined by patient characteristics but also by the number, habits and specific interventions of staff and the characteristics of hospital organisation and even mental health care (Snyder et al., 2005).

**Patients with somatic disorders:** Coercion is used in:
- Patients in agitated states who resist treatment and pose a danger to themselves and others.
- Patients with clouding or loss of consciousness who cannot express their wishes, including possible opposition to treatment.
- Patients who calmly and clearly communicate that they are opposed to a medically indicated treatment, but who possibly lack mental capacity.

**Patients with communicable diseases:** If patients with communicable diseases refuse suitable medical treatment, coercive measures may be ordered – even for persons with capacity. In particular, these involve restrictions on freedom of movement (quarantine and isolation).

**Pregnant women:** Complications of pregnancy and childbirth may give rise to exceptional psychological states that compromise capacity. In such cases, coercive measures can be life-saving for mother and child.

**Patients with mental disorders:** In persons with a mental disorder, coercive measures may become unavoidable, first, in emergency situations where there is a serious danger to the patient or third parties as a result of the condition. Second, in non-emergency situations, longer-lasting coercive measures, generally drug treatment, may be ordered by a physician in the context of involuntary referral.

**Children and adolescents:** Children and adolescents with capacity have the right to consent to or refuse treatment. If a measure is carried out against the wishes of a child or adolescent, it is considered coercive even if consent has been given by the parents. In the case of patients lacking capacity, parental consent is legally sufficient.

**Patients in long-term care:** In the elderly, coercive measures are contemplated mainly in the event of a progressive loss of capacity due to dementia, or increasing frailty. Acute and fluctuating disturbances of consciousness (delirium) may also occur. In younger persons, capacity may be lacking as a result of a mental disability or a chronic physical or mental disorder, which may make coercive measures unavoidable in certain situations.

A number of factors determine the likelihood of a person behaving in a particular way which can be either modifiable or non-modifiable as shown in Figure 3. Figure 4
depicts the factors that influence how an individual perceives a situation. These factors are important to understand as to how an intervention needs to be planned and how it can be perceived positively by the individual receiving it and not feel being coerced.

Figure 3: Multidimensional behavioural model showing interaction of factors affecting patient behaviour (Braun & Kunik, 2004)
2.4 CAUSES OF AGGRESSION

Aggression among mental health in-patients has been of interest to researchers and a number of theories have been developed to explain the causes (Duxbury & Whittington, 2005). These can be narrowed down to three conceptual models: internal, external and situational/interactional (Nijman et al., 1999).

2.4.1 Internal model

The case for the ‘internal model’ has been strong and numerous studies have explored an association between aggression and illness (Linaker & Busch-Iversen, 1995). Steinert and colleagues (2000) found a strong association between thought disorders and violent behaviour during in-patient treatment. Severe psychopathology is a major source of in-patient aggression (Nijman, 2002). Intoxication with alcohol and other substances increase the potential for violence (Lanza et al., 1994). Morrison (1989) suggested that the particular combination of schizophrenia and substance abuse heightens the chance of aggression. This was supported by a study by the Royal College of Psychiatrists (1998), which reported that young men with a psychiatric illness and a history of substance abuse are most likely to be violent. As a result, age, gender and diagnosis are by far the most frequently researched demographic variables (Duxbury & Whittington, 2005).
2.4.2 External model

This model asserts that environmental factors contribute to the incidence of aggression. Issues that have been explored include provisions for privacy and space, location, type of regime and the impact of unit design (Nijman et al., 1999). Carmel and Hunter (1993) found that the location of an incident was generally the result of associated organisational routines such as medication rounds, handover periods or mealtimes (Vanderslott, 1998). Nijman (2002) suggested that assaults can also be triggered by the denial of services or liberty. Restrictions of this nature can affect the level and quality of interaction between staff and patients (Flannery et al., 1994). It has been argued that incidents are more likely to be preceded by a combination of environmental and interpersonal antecedents than by symptomatic behaviour (Shepherd & Lavender, 1999).

2.4.3 Situational/interactional model

A number of studies support the view that negative staff–patient relationships lead to patient aggression (Nijman et al., 1999; Duxbury, 2002). Sheriden and colleagues (1990) found that patients commonly saw conflicts with staff as a contributory factor. Whittington and Wykes (1994) suggested that certain staff are prone to being assaulted, indicating problematic rather than therapeutic relationships (Harris & Morrison, 1995). Limit-setting styles, coupled with a lack of opportunity for negotiation, are also reported to be problematic (Lancee et al., 1995), and some nurses have been accused of ‘going in strong’ (Whittington & Wykes, 1994). Professionals, it seems, are increasingly forced to act in controlling ways because of institutional pressures, despite controversy regarding the efficacy of these approaches (Gudjonsson et al., 2004).

2.5 CRITERIA FOR USE OF COERCION

In some situations, carers may feel obliged to take urgent measures and introduce coercive procedures. It is extremely important that they do not use coercion as a matter of course. For this reason, it is imperative that they critically question every form of coercion and as far as possible discuss matters with the patient and the family. In the literature review, some researchers suggest that the essential criteria to justify coercive procedures are incapacity, harm and proportionality.
2.5.1 Incapacity

The first criterion insists that the patient should lack sufficient capacity to deliberate or to exercise control with respect to his or her behaviour. It is important that health professionals make a presumption of capacity. This presumption effectively lowers the threshold so that more patients would be expected to be deemed to have capacity. Concerns have been raised that clinicians may overestimate patients’ capacity (Lepping, 2011); and the process of assessing capacity has been criticised on the basis that the concept overlooks the inherent difficulties of comparing judgments about whether a patient is using or weighing information in the decision-making process in comparison to an ideal standard or model (Van Dellen, 2013). Coercion under such circumstances should promote, where possible, the restoration of such capacity. This criterion underlines the value of autonomy. However, on closer examination, it becomes clear that ‘disability’ as defined in the CRPD and ‘incapacity’ or similar legal terms, operates at different analytical levels. A person with a disability may be deemed incapable in some respects, but not necessarily so. A person without a disability may be deemed temporarily incapable or in need of protection at a certain time. The CRPD defines disability in Article 1 as ‘Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others’ (Office of the United Nations High Commissioner for Human Rights, 2009). The power of compulsion in psychiatry does not depend on the patient’s loss of autonomy as this is usually understood: psychiatric patients may be detained even if they have the capacity to make decisions for themselves, by virtue of having a mental illness. Though most would accept that protecting others is a necessary constraint on autonomy in an orderly society, this is unjustly applied to psychiatric patients. Thus, someone who is equally dangerous, but does not have a mental illness, cannot legally be detained unless they have committed a crime.

2.5.2 Harm

The second criterion determines that the physical or mental health or the integrity would be seriously harmed without the use of coercion. Here the value of inviolability is at stake. Two sub-criteria need to be explained. According to the first, serious harm would be inflicted on the patient’s physical or mental health in the absence of coercion. For this reason, coercive measures should focus on the treatment of the patient’s psychiatric
problem. According to the second sub-criterion, serious harm would be inflicted on the patient’s physical or mental integrity or that of other persons without the use of coercion. For this reason, the coercive measures employed must focus on the protection of the patient’s integrity or that of another person.

2.5.3 Proportionality

The third criterion means that there should be a ‘right’ proportion of, or a reasonable relationship between, the use of coercion and the harm that would otherwise be inflicted on health or integrity. Caregivers have to assess the values of autonomy and inviolability. This assessment implies that there should be a right proportion between the harm and the coercion, and hence that the coercion should not be more severe than necessary to avoid the harm. They are obliged to explore the possibility of employing the least coercive measures for the shortest time sufficient to guarantee health or integrity. Consequently, they should restrict the use of coercion to the degree and duration that is really necessary, no more and no longer.

The formulation of these three criteria leaves caregivers room for interpretation. Indeed, it remains impossible to determine strict boundaries between situations in which carers, patients and family would be best advised to continue the process of deliberation and situations in which coercion is justified. Caregivers should be careful not to opt for coercive procedures too quickly, but they should also take care to avoid situations in which the use of coercion to mitigate the threat of harm is too late.

2.6 AUTONOMY

Autonomy is widely accepted as one of the most important principles shaping current medical practice and is a central pillar of modern bio-ethics. The word ‘autonomy’ comes from the Greek ‘auto’ referring to ‘self’, ‘nomos’ meaning law, together giving ‘auto-nomos’ to self-govern. Within clinical medicine, autonomy focuses upon the idea of being able to make decisions about one’s own health.

Immanuel Kant was one of the earliest philosophers to comment on autonomy. In the 18th century, he stated that autonomy is one of the most important values in human society. Autonomy did not, however, always hold such importance. For the first few
thousand years of medical practice, it evolved under the umbrella of ‘beneficence’, whereby the physician was seen to know best. Physicians were portrayed as individuals with superior knowledge guided by the Hippocratic Oath requiring them to act in the best interests of the patient. The patient was expected to obey the physicians, who relied exclusively on their own judgment to treat the patient. In this model, the principle of beneficence was dominant. Its foundation relied on the obedience and trust placed by the patient in the treating physician. In some circumstances, this model extended to such concepts as ‘benevolent deception’, whereby information about the prognosis or treatment could be withheld if non-disclosure was considered in the best interests of the patient.

The transition from the beneficence to the autonomy model has occurred gradually over the last century, particularly in the last 50 years. A number of possible social factors have contributed to this evolution. First, contemporary society is more consumer-driven, and health care is regarded as another product. Second, greater media coverage has highlighted the frailties and problems in the medical system, which has, in turn, led to the erosion of public confidence in it. It is observed that with less trust, the desire to maintain more individual control regarding health-related decisions is more pronounced than ever before. Finally, patients now are better informed due to greater access to medical information through media such as the internet. In my opinion, these factors have led to greater expectation of individual self-determination and to patients’ wish to be more involved in decisions about their treatment promoting the concept of autonomy.

![Figure 5: Relationship between coercion and compulsion, autonomy and informed consent](image)

2.6.1 Autonomy and medical decision-making

Autonomy or the desire for self-determination is an important guiding ethical principle in medical practice. Enabling choice and attending to the wishes of the individual patient are understood to be central to good clinical care. At a theoretical level, the concept of retaining autonomy in a health-care situation seems to oppose the presence of coercion (Fig.5). There is no research that has investigated the relationship between the
preference for autonomy and the perception of coercion. There is also very little known about how patients might perceive medical coercion.

The way medical decisions are made in hospital is central to health care and directly affects a patient’s outcomes and experience of hospitalisation. The literature identifies three decision-making models. The first is the paternalistic model where the clinician is expected to take control of decisions. The second is the shared model where decisions are shared equally between the clinician and patient. The third is the informed model where the clinician is expected to provide adequate information to patients, who then make their own decision. The type of model used is dependent on the specific situation and influenced also by the patient and clinician in each case.

2.6.2 The United Nations Convention on Rights of Persons with Disabilities (UNCRPD) and Compulsory treatment

There is an important conceptual distinction between decision-making capacity for a time- and task-specific treatment decision as opposed to a ‘disability’. Furthermore, we need to recognise that there are circumstances of significantly impaired decision-making capacity where despite best efforts at supported decision-making, this is not possible. In such circumstances, treatment that is administered without the consent of the person might on occasion be justifiable (Szmukler et al., 2014). However, the UNCRPD seems unequivocal in marking a radical shift in the lawful grounds for deprivation of liberty under international human rights law (Office of the United Nations High Commissioner for Human Rights, 2009). More specifically, deprivation of liberty based on the existence of disability, including mental, is not compliant with the UNCRPD. The articles of particular significance and most pertinent to this area of jurisprudence are: Article 12 (Equal recognition before the law) – the right to enjoy legal capacity on an equal basis with others in all aspects of life, including the right to give consent for medical treatment; and Article 14 (Liberty and security of the person) – the right to be free from involuntary detention in a mental health facility and not to be forced to undergo mental health treatment.
Chapter 3: RESEARCH DESIGN

In Chapter 1, I outlined the significance and understanding of coercion in mental health care. I showed that coercive practices are present in widely differing manifestations in health-care practices across the globe. I outlined the relevant legal and human rights interventions and also traced the changes (subtle and explicit) in coercive practices, as mental health care moves from hospital settings towards community care.

In Chapter 2, I presented several theories and philosophical debates related to the allied concepts of coercion and autonomy. The range of definitions, categorisations and practical manifestations underline the complex nature of the concept of coercion and also reveal the complex interactions among different stakeholders. This theoretical discussion attempted to highlight the persistence of the problem and the inconclusiveness of the debates that surround it to date, which have subsequently brought to light a larger issue which forms the basis of this research: the importance of the local context in addressing practices of coercion. It is imperative to have an in-depth understanding of the context in which coercive practices take place in order to develop and make effective interventions.

In this chapter I outline the research design and the main objectives of this thesis. First, I present the main research question and sub-questions, followed by a description of the individual studies that constitute this research, each of which describes the methodology and the study area. This is followed by a discussion of issues of validity and ethical considerations.

3.1 AIMS AND RESEARCH QUESTIONS

The main research question of this thesis is as follows:

*How can we understand coercion in Indian mental health care from a multi-stakeholder perspective?*

To address this question, we formulated the following research sub-questions:

1. To what extent and in what way does coercion occur in (mental) health care in the Indian subcontinent?
As mentioned before, in India and in the Indian subcontinent, very little is known about the use and usefulness of coercive measures in psychiatry and other medical specialties. Coercion not only threatens the autonomy of patients and their health, but also threatens health care professionals’ perception of what constitutes good care and treatment. Some of the health-care treatment challenges seem to be dependent upon the context, such as in child and adolescent care, in intensive care and in geriatric care. Owing to the lack of health professionals to cater for a huge population in India, often family caregivers stay with in-patients, which can be both a protective and a precipitating factor for behaviours leading to coercion that need to be explored.

2. What are the prevalence, context and effects of patient and visitor violence towards staff in medical and psychiatric wards in India?

As yet, little is known about the frequency of violence committed by patients and visitors against staff, other patients and family caregivers. This sub-question examines the context in which these events occur, the effects of this violent behaviour on health care staff in general hospitals, and the resulting threat of coercion. Many patients admitted to wards worry about potential violence from other patients and visitors, and so they lose their sense of safety and security – a vital concern in health care. Often health care and mental health staff share the same concern about their safety. All violence has consequences for both the assaulted person and for the perpetrator. To date, there is no literature that compares violence in mental health care in general hospitals in India with its occurrence in other medical specialties.

3. What are the triggering factors for aggressive behaviour and the subsequent coercive measures in inpatient settings in mental health care?

Continuous monitoring of incidents in the ward may help in detecting typical triggers that precipitate violent behaviour, meaning that options to intervene will increase with knowledge of situations where patients are more likely to exhibit aggressive behaviour. The methods used for assessing aggression in persons with mental disorder comprise a self-rating questionnaire and observer aggression scales. However, aggression self-report measures have conventionally been taken only in recovered or co-operative subjects. Much of the existing scientific literature uses observation scales to assess the prevalence
of aggressive behaviour and coercive measures in psychiatric wards. In order to develop non-coercive measures, we need to better understand factors contributing to and resulting in coercion. This could not only help to protect staff and subjects from physical and psychological injury, but also contribute to more therapeutic work and treatment environments.

4. How is coercion perceived by patients, family caregivers and staff?

The purpose of this question is not to identify who has a 'correct' or 'incorrect' perception of coercion, but rather to identify whether there is a disparity between perceptions of patients, caregivers and staff that could have implications for eliminating coercion. It is important to acquire a better understanding of the association between therapeutic treatment and perceived coercion because of the complexities of the relationship between patient and clinician in mental health care. Studies of patients’ perceptions of coercion in psychiatric care are quite recent in India, and there is as yet little research that has investigated patterns of perception by patient, caregiver and staff. Any kind of practical improvement requires an understanding of perceptions about coercion among caregivers and staff, the ability to acknowledge the possible existence of alternatives and that established practices are not necessarily the only right or best ways of doing things. It becomes necessary to find out to what extent sex, age, professional background and other professional contexts are associated with staff and caregivers’ attitudes towards coercion.

5. What are the dilemmas in reducing coercion in mental health care?

In mental health care, promoting evidence-based alternatives to restraining patients is recognised as an important concern. However, there has been only limited research on this issue in the Indian context in relation to understanding and reducing coercive measures. The recommended treatment, in combination with the difficulties associated with trying to engage patients who are coerced, involves exorbitant costs. Also, many mental health professionals and relatives of persons with a mental disorder often see coercion as an essential tool. It is important to understand the factors which encourage therapeutic impatience and coercion in order to reduce coercion in mental health care.
3.2 RESEARCH APPROACH

A mixed-methods design was used in this thesis. Different research and methodological approaches were used to answer the different sub-questions. Thorough literature reviews were undertaken to understand coercion in mental health care both globally and in the Indian subcontinent in particular. Quantitative methods were used by administering various validated scales. An abbreviated version of the Survey of Violence Experienced by Staff (SOVES-A) was used to understand patient and visitor violence. I used the Staff Observation Aggression Scale-Revised Indian (SOAS-RI) to find out the prevalence of coercion in psychiatric wards. Different stakeholders’ perceptions of coercion was measured by the MacArthur Perceived Coercion Scale (MPCS) and Staff Attitude to Coercion Scale (SACS). A qualitative method was used in one study (study 7) to gain an in-depth understanding of the admission experiences of persons with mental disorders.

The methodology used for individual studies is briefly described sequentially below. The chapters that describe these studies provide more details of the methods for data collection and analysis (see Table1).

Study 1: Coercion in mental health services in the Indian sub-continent and the Middle East

This systematic literature review describes the provisions for mental health care, including the relevant legislation in India, and presents existing research data on coercion. Limited staff training and inadequate service provision across the country remain a problem. Anecdotal evidence suggests that coercion, restraint, and seclusion are common both in mental health facilities and in the home, but robust data are lacking. Despite the fact that family and friends are often intimately involved in patient care and often resort to coercion, criteria for coercion and restraint have not been defined. With a lack of international comparisons, it is even more important to be aware of patients’ rights and preferences regarding the need for, form of, and place of psychiatric treatment while also recognising the legitimate interests of family members.

Study 2: Patient and visitor violence towards staff in medical and psychiatric wards in India
This study is a quantitative survey of hospital staff's experiences of patient and visitor violence (PVV) in India, and aims to increase our understanding of the main causes of coercion in medical and psychiatric wards. We examined the relationship between reported levels of abuse and staff characteristics in order to inform further collaborative research to develop culturally acceptable and feasible interventions to reduce the levels of PVV and coercion in India. We administered an abbreviated version of the Survey of Violence Experienced by Staff (SOVES-A). SOVES-A is a staff questionnaire to investigate the prevalence of verbal abuse, threats and assaults against staff by patients, visitors, co-workers or others in the past four weeks. This validated tool includes questions about staff experience of violence within the last four weeks, as this timeframe yields the best results, and creates the least problems with recall bias. The SOVES-A also asks whether a staff member had a formal de-escalation and/or breakaway training in the last three years, and whether they have ever received training in the management of potentially violent individuals.

**Study 3: Aggressive behaviour and coercion on an Indian acute ward**

In this observational study, we

1. Examined the prevalence of in-patient aggression and subsequent coercive measures in a setting with non-professional family caregivers;

2. Analysed factors influencing the choice of immediate coercive measures as a reaction to aggression from patients; and

3. Explored the role of non-professional caregivers as instigators and targets of violence, and their participation in coercive measures.

An observational study of all levels of aggression and coercion was conducted in two acute psychiatric in-patient wards in Mysore in the Indian state of Karnataka. Trained mental health clinicians gave structured reports on all violent episodes and coercive measures during a 30-day period. The Staff Observation Aggression Scale - Revised, Indian (SOAS-RI) was used, and the severity of the SOAS-RI reports was independently analysed. In addition, patient data, including socio-demographic variables and ICD-10 diagnoses, as well as ward data including admission and discharge dates, were obtained from the patient case files and in-patient ward records.

**Study 4: Clinical correlates and predictors of perceived coercion among psychiatric in-patients: A prospective pilot study**
I conducted a prospective pilot study on the clinical correlates and predictors of perceived coercion among in-patients to find out:

1. Which coercive measures were taken;
2. The perceived coercion at admission and at discharge; and
3. Which patient and contextual characteristics were related to perceived coercion at admission and discharge.

The patients were selected through computer-generated random numbers on all working days: 170 randomly selected in-patients (aged 18 and above) participated in the study. In total, in 83 eligible subjects, all assessments, including the coercion assessment, were completed within three days of admission, and in 75 subjects, re-assessment was conducted within three days of discharge. Apart from socio-demographic details, data on the number of previous admissions, the duration of illness and the duration of in-patient care were gathered from medical records. A diagnosis of the psychiatric disorder was made according to the ICD-10 criteria, using Mini International Neuropsychiatric Interview (MINI 5.0). Clinical Global Impression (CGI) and insights were evaluated. The initial part of the interview was open-ended, as the patient was encouraged to describe the process of coming to the hospital.

**Study 5: Perceived coercion in persons with mental disorder in India**

This cross-sectional study was conducted to assess the subjective perception of coercion in involuntarily admitted patients, and to further identify links between this perception and socio-demographic variables, illness variables and former coercive interventions. Subjective perceptions of coercion were studied in all consecutive involuntarily admitted patients. They were interviewed and assessed for perceived coercion using the MacArthur Admission Experience Interview-Short Form (MAES) at the time of discharge. The MAES scale is useful as it takes into consideration key socio-demographic variables such as age, sex, educational status, marital status, family size, average family income, distance from the hospital, and illness variables such as duration, diagnosis, forensic history, and former coercive interventions.

**Study 6: Staff and caregiver attitudes to coercion in India**

Mental health professionals in India consider family members and caregivers as partners in the care of patients. The Staff Attitude to Coercion Scale (SACS) was administered to (staff) psychiatrists and caregivers in order to:
(1) Co-relate age, sex and experience of staff (psychiatrist) with SACS;
(2) Co-relate age, sex, education and relation of caregiver with SACS; and
(3) Compare both staff and caregiver attitudes with SACS.

SACS comprises a short, 15-item questionnaire on normative attitudes towards coercion, as follows: coercion as offending (critical attitude) – the view of coercion as offensive to patients; coercion as care and security (pragmatic attitude) – the view of coercion as needed for care and security; and coercion as treatment (positive attitude) – the view of coercion as a treatment intervention.

Study 7: Dilemmas in using restraint – use of restraints in older patients with mental illness: to do or not to do?

This study is a literature review on the use of restraints in older persons. Ethical dilemmas are presented for and against the use of restraint in this vulnerable population. Those with psychiatric and/or physically debilitating illnesses are doubly disadvantaged. Coercion in the older population is an issue in relation to common geriatric disorders like dementia but there are few published data in India on this aspect of coercion. European literature suggests that bedrails, belts and covert medication are common coercive practices used among elderly patients. They also suggest alternative measures to minimise coercion, as well as modest coercion as a temporary means to prevent harm. This review gives an account of the dilemmas involved in coercion and alternative practices to minimise it.

Study 8: Paternalism versus autonomy – are we barking up the wrong tree?

This study comprises a discussion which took place in collaboration with the Indo-European Symposium on Coercion and explores whether we can reduce paternalism by increasing patient autonomy. We argue that autonomy should not have any automatic priority over other ethical values. Thus, balancing autonomy with other ethical principles, and finding the optimal balance between the patient’s wishes and those of other relevant stakeholders, such as the patient’s family, has to be dynamic over time.
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3.3 RESEARCH VALIDITY

Standardised questionnaires were used in the qualitative studies. The instruments which were judged as relevant and with good content validity were chosen. The questionnaires were selected based on the analysis done for comprehensible, comprehensive and meaningful for actual practice in general hospitals (face validity). In study 2, we administered an abbreviated version of the Survey of Violence Experienced by Staff (SOVES-A) in English, which is well validated to be used in different setups. This is a staff questionnaire to investigate the prevalence of verbal abuse, threats and assaults on staff by patients, visitors, co-workers or others, in the past 4 weeks. For study 6 we used a revised version of the Staff Observation Aggression Scale, SOAS-RI (SOAS, Revised Indian). We adapted the SOAS-R report form to cater to the presence of non-professional caregivers. These adaptations include the presence of security staff, relatives and other caregivers in Indian in-patient mental health care and named it SOAS-RI. The advantages of systematising their observations are obvious; observers’ (and seldom the researcher) have the best opportunity to fully observe the patient throughout a 24 hour period.

The initial part of the interview in study 4 was open-ended (qualitative). Here, the patient was encouraged to describe the process of coming to the hospital. The interview focused on the patient’s perceptions of: 1. Coercion in the admission decision; 2. Being pressurised during hospital stay; 3. How others treated the patient during the process of coming to the hospital and being admitted; 4. Different pharmacological and non-pharmacological treatment measures; 5. Patient’s attitude towards hospitalisation. In this qualitative part, in order to cross-check research findings and researchers’ interpretations and so increase the internal validity, I used triangulation (Denzin, 1970). Triangulation of methods was attained by using complementary research methods including desk study, document analysis, interviews, group discussions and participant observation during meetings. In the involvement of multiple researchers from the team, who participated in all phases of this research, researcher triangulation was obtained. Also in the process of data analysis, multiple complementary strategies were deployed to increase the internal validity of this research project. All interviews and most group discussions were transcribed verbatim and extensive records were kept of participant observations. A thematic approach was used to code the data, followed by an inductive approach. The predefined concepts for the thematic analysis found their origin in the theoretical underpinnings of the individual studies.
Furthermore, in study 4, after personal interview, I followed up by administering the MacArthur Perceived Coercion Scale (MPCS), which covered perceived coercion among other admission experiences such as the reason or admission, application of coercion, pathway to care and various received treatment modules in the Admission Experience Interview. In study 8, the McArthur Admission Experience Interview Short form (MAEIS) was applied to a larger sample. The MacArthur contains four sub-scales covering a) perceived coercion; b) negative pressure; c) voice; and d) affective reaction. The scale has good internal consistency with respect to variation in site, instrument format, patient population, and interview procedure. In study 9 we applied the Staff Attitude to Coercion Scale (SACS), a short, 15-item questionnaire on normative attitudes toward coercion. These dimensions can be scored on a 5-point Likert-type scale, with 1 = disagree strongly to 5 = agree strongly or in dichotomous yes or no categories. The dichotomous version of the SACS was preferred over the Likert type as we included both staff and caregivers in a process of relative thinking in order to maintain consistency.

Studies 1 and 7 were designed as literature reviews with systematic search elements. I included all available literature to answer specific, research-relevant questions.

3.4 ETHICAL ISSUES

For Studies 2, 3, 5 and 6 ethical approval was obtained from the Institutional Ethics Committee (MMCEC 07/15) (MMCEC08/15) at the Mysore Medical College and at the Research Institute of Mysore, India. Study 4 was approved by the Institutional Ethical Committee (IEC) of the National Institute of Mental Health And Neuro Sciences (NIMHANS), Bangalore; Sl.No:03, Behavioural Sciences/NIMH/DO/SUB-COMMITTEE/2013, dated 1 June 2013.

Participants were informed about our background and our purpose in inviting them to participate in the research. They were informed that they could talk to anyone with whom they feel comfortable talking about the research, and that take time to reflect on whether or not they wish to participate. Participants were assured that if they did not understand any words or concepts, we would explain these as we went along, and that they could ask questions at any time. We also indicated clearly that participation was voluntary. Potential participants were also informed that they could withdraw at any time with no prejudice to the services they usually receive. It was clearly explained to that the research team would
maintain the confidentiality of data regarding information about the participant and information that the participant shared.

3.5 OUTLINE OF THE THESIS

Chapter 4 forms the background for this thesis, and has been published in the edited volume, *Coercion in Community Mental Health Care, International Perspectives* (Oxford University Press). This chapter sets the stage by answering the first sub-question. Chapters 5 and 6 answer research sub-questions 3 and 4 respectively by evaluating violent and aggressive behaviour in Indian in-patient care in psychiatric and non-psychiatric wards. Both these chapters are published in the *Asian Journal of Psychiatry*. I was involved in conceptualising, designing, analysing and drafting the topic. These chapters form the first part of the thesis, highlighting the existing conditions and parameters of coercion. I formed a team of like-minded researchers and undertook the pilot study to look at the subjective perception of coercion and its correlates, which constitutes chapter 7. This chapter is published in the *Asian Journal of Psychiatry*. Chapters 8 and 9 look into coercion from a multi-stakeholder perspective, and form the core of the thesis (Part II). These two chapters have also been published in the *Indian Journal of Psychiatry*. Part II covers sub-question 4, while Part III addresses sub-question 5, regarding the dilemma concerning the use of coercive interventions and the need to respect individual autonomy. Chapter 10, published in the *International Journal of Geriatric Care and Research*, takes an older population as an illustrative example. In Chapter 11, I compare autonomy-driven European experience with that of transforming mental health care in India. I explore whether paternalism can be reduced by increasing patients’ autonomy, and this is published as an editorial in the *British Journal of Psychiatry*. Chapter 12 comprises the discussions and conclusion, with recommendations for future research and practices that attempt to move towards zero coercion. In the epilogue, I present the Mysore Declaration, published in *International Psychiatry*, which is the outcome of the Indo-European symposium on coercion.
Part I

- Coercion and Mental Health Services in the Indian Subcontinent and the Middle East

- Patient & Visitor Violence towards Staff on Medical & Psychiatric Wards in India

- Observational Study of Aggressive Behaviour and Coercion on an Indian Acute Ward
Chapter 4: Coercion and Mental Health Services in the Indian Subcontinent and the Middle East

4.1 Introduction

Coercive practices are relatively common in mental health care, but coercion is ethically problematic because it involves acting against an individual’s autonomy (Sjöstrand & Helgesson, 2008). Ethical, legal, and clinical considerations become more complex when mental incapacity is temporary and coercive measures aim to restore autonomy (Prinsen & Van Dellen, 2009). It is contentious whether coercive actions are acceptable for the protection of others, since medical treatment is primarily meant for the individual. Coercive treatment may be required in order to promote the patient’s health interests, but health interests have to be balanced against autonomy (O’Brien & Golding, 2003). As elsewhere, coercive measures are controversial in India: although some have suggested that it may be acceptable if patients are a danger to others or to themselves, others are committed to eliminating it (Shah & Basu, 2010).

Mental health law in the Indian subcontinent and the Middle East has been evolving over the past few decades, in keeping with improved delivery of care, societal changes, and the demand for enhanced accountability from a population that is increasingly aware of its rights (Lepping & Raveesh, 2013). There have been rapid socio-economic, cultural, and psychosocial changes in the traditional, rurally oriented, and family centred societies of the Middle East and Asia. Despite the fact that family and friends are often intimately involved in patient care and often resort to coercion, criteria for coercion and restraint have not been defined. With a lack of international comparisons, it is even more important to be aware of patients’ rights and preferences regarding the necessity, mode, and place of psychiatric treatment while also recognizing the legitimate interests of family members. Many people with mental illness are abandoned by their families (Poreddi, et al. 2013) and their outcome is both unknown and a matter of grave concern.

In this chapter we review the provision of mental health care, including the relevant legislative developments, where available, in this region and present the very limited research data on coercion. There are common problems of limited resources and training and inadequate service provision across the entire region. Anecdotal evidence suggests that coercion, restraint, and seclusion are common, both in mental health facilities and within homes, but robust data are lacking.
4.2 India

During British colonial rule mentally ill patients were kept under custodial care in prisons and asylums. The Lunatic Asylum Act of 1856 was modified to form the Indian Lunacy Act (ILA) of 1912. The enactment of the ILA resulted in the opening of new asylums and improvements in the condition of asylums. The name ‘lunatic asylum’ was changed to ‘mental hospital’ in 1920, and the control of mental hospitals was shifted from prison authorities to civil surgeons. Before Indian independence, the Bhore Committee was asked to survey mental hospitals in India. The committee recommended that the 1912 ILA was outdated and had outlived its usefulness (Mills, 2001). The terminologies used were obsolete. A draft Mental Health Act was prepared by the Indian Psychiatry Society in 1949, but it took nearly 40 years for this Act to be passed by parliament. The Act finally got presidential assent on 22 May 1987. The central and state mental health rules were framed in 1990, and with effect from 1 April 1993 the Mental Health Act (MHA) 1987 came into force. Even then, the real implementation of this act only occurred after the ‘Erwadi tragedy’ (Sharma & Chadda, 1996) in which 28 shackled inmates of a faith-based mental home burned to death (see Figure 16.1). It became public that these inmates had been tied to trees during the day and then to beds at night and offered little if anything in the way of ‘therapy’.

![Candlelit vigil marking the ninth anniversary of the Erwadi tragedy in which 28 people died following a fire in a faith-based mental health facility.](image)

**Figure 4.1** Candlelit vigil marking the ninth anniversary of the Erwadi tragedy in which 28 people died following a fire in a faith-based mental health facility.
The development of community psychiatry resulted in the integration of mental health care in the community under the National Mental Health Programme (NHMP) in 1982. The NMHP was developed with the objective of ensuring the availability and accessibility of effective mental health care for all sections of the population. A very important development has been the recognition by the National Human Rights Commission (NHRC) of the human rights of the mentally ill. The NHRC carried out two systematic examinations of mental hospitals in India in 1998 (National Human Rights Commission 1999) and 2008 (Nagaraja & Murthy, 2008). Following these reports, funds were provided to upgrade facilities. This has resulted in positive changes over the past 10 years, as shown by the 2008 NHRC report (Nagaraja & Murthy, 2008): the percentage of admissions through courts has decreased from about 70% in 1996 to around 20% in 2008; long-stay patients have decreased from 80–90% to about 35%; and custodial care indicators such as staff wearing compulsory uniforms have decreased. While 20 hospitals used prison-like cells for seclusion in 1999, this had decreased to 8 in 2008. Recreation facilities increased and were present in 29 institutions in 2008 compared with 8 in 1999. Rehabilitation facilities were present in 23 institutions rather than the previously recorded 10. The budget had doubled in nine institutions, increased two to four times in thirteen, four to eight times in four and more than eight times in three institutions. The overall use of electroconvulsive therapy (ECT) had reduced and the use of modified ECT increased from 9 to 27 institutions. There were more changes in the 10 years between 1998 and 2008 than in the preceding 50 years. A persistent problem has been inadequate staffing, despite the creation of new positions (Murthy, 2011).

The recent Mental Health Care Bill (2013) shifted the focus to a rights-based approach to the protection of people with mental illness. The 2013 bill fills an important requirement of the UN Convention on the Rights of Persons with Disabilities (UNCRPD) by the right:

◆ to access to mental health care (including shelter homes, supported accommodation, community-based rehabilitation)
◆ to community living
◆ to live with dignity and protection against cruel, degrading, and inhuman treatment
◆ to equality and non-discrimination
◆ to information, confidentiality, and access to medical records
to personal communication, legal aid, and to make complaints about deficiencies in provision of services.

The Bill restricts and regulates the use of seclusion and restraints, and the parliamentary standing committee has suggested that the Bill be amended to ban seclusion completely on the grounds that it has no therapeutic purpose. The government has agreed to make this amendment. It is the first time that a law in India has guaranteed such rights to equality and non-discrimination and enshrined positive rights of access to basic services to people with mental illness. However, the recent draft proposal to amend the Indian MHA has not brought certainty to issues of coercion (Shah & Basu, 2010).

4.2.1 Coercion in India

Very little is known about the use and utility of coercive measures in psychiatry and other medical specialties in India. The existing evidence supports the view that informal coercion is widely used, although patterns of its use may differ. Some evidence suggests relatively high levels of cooperation between family members and clinicians in the use of coercive measures (Srinivasan & Thara, 2002). Covert medication is the practice of hiding medication in food or beverages so that it goes undetected, while covert prescribing is the practice of supplying a prescription to a family member or a health-care worker, knowing fully well that the medication is going to be used for an unwilling patient. The terms ‘surreptitious medication / surreptitious prescribing’ are sometimes used interchangeably with covert medication, but this may often indicate negative intent. Covert medication is commonly used in the context of patients with schizophrenia or bipolar disorder who refuse to take medication (Kala, 2012). Srinivasan and Thara (2002) reported that Indian families administered covert treatment under the supervision of a psychiatrist in half the cases of non-adherent patients studied. The treatment helped many patients to recover sufficiently from the illness to participate in further treatment voluntarily, with few reported negative effects and at a low cost. Delays in seeking treatment are often attributed to the choice of the caregivers, who may also make major decisions about treatments for patients who lack capacity (Rajkumar, et al. 2007). The family in India plays a major role in health-seeking for its members. Any intervention planned for the patient should take into account the family’s considerable influence over many aspects of patient management, including outpatient consultation and continuing care. There are many barriers standing in the way
of achieving the desired levels of care for people with mental disorder, such as lack of awareness, prejudice, lack of resources, and lack of adequate advocacy.

A study conducted by Rajkumar, et al. (2007) showed that all relatives signed consent for the administration of ECT. Many reported that the details of ECT were discussed with them and alternative treatments offered and they were happy with the outcome. However, many relatives also perceived that they were forced to provide their consent. Even the minority of patients who signed the consent form could not recall the details of the procedure. Many patients also reported coercion. Complete understanding and true voluntary acceptance of ECT are rarely attained in actual practice. A power differential between doctor and patient is often seen in Indian society and health care. In the context of a dependent therapeutic relationship, informed consent almost always contains an element of coercion. In India, the process is complicated by a reduced emphasis on personal autonomy and a lack of awareness of human rights. This may be compounded by illiteracy and poverty. In this situation the patient submissively yields to the physician’s authority: informed consent becomes a mere formality, given in order to maintain harmony in the doctor–patient relationship. In S.P. Sathe vs. State of Maharashtra the Bombay High Court regulated the prescription of indiscriminate electric shocks to people with mental illness. The directions included that reports must be made whenever electric shocks are given by a prison psychiatrist. A case in the High Court of Bombay challenged the practice of administering ECT without anaesthesia and without informed consent at the Institute of Psychiatry and Human Behaviour (IPHB), Panaji, Goa. The petitioner acted on behalf of patients and their relatives, since patients were in no position to approach the court and relatives were reluctant to come forward, given the stigma attached to mental illness. The court opined that the practice was barbaric, inhuman, and hence in violation of Article 21 of the Indian Constitution.

4.2.2 Mysore declaration

In February 2013 experts from India and Europe came together in Mysore, India, for an international symposium on coercion. A declaration was drafted, discussed, and ratified which defined coercive measures in the Indian context and outlined aims and possible ways to minimize coercion in medical settings in India. The declaration asserted that:

1 High Court of Bombay petition no. 1537 of 1984.
2 High Court of Bombay petition no. 357 of 1998.
There is an urgent need for the recognition and implementation of the rights of persons with mental illness, following principles with regard to equality, security, liberty, health, integrity and dignity of all people, with a mental illness or not . . . All parties responsible for the care and treatment of mental illness should work towards the elimination of all forms of discrimination, stigmatisation and violence, cruel, inhumane or degrading treatment. We affirm that disproportionate, unsafe or prolonged coercion or violence against persons with mental illness constitutes the violation of the human rights and fundamental freedoms and impairs or nullifies their enjoyment of those rights and freedoms.

The declaration recognizes the potential tension between the rights of patients who refuse medication and the benefits of potential restoration to normal functioning through involuntary treatment, as well as the wishes of family members, who often play an important role in the treatment of mental illness in India (Lepping & Raveesh, 2013).

4.3 Sri Lanka

Mental health services in Sri Lanka are integrated with primary care services in a bid to achieve equal standards. People with mental health problems are one of the most marginalized groups in Sri Lanka. The country has high suicide rates, increasing substance misuse, and many psychosocial problems (Weerasundera, 2011). After years of civil conflict, the 2004 tsunami, and with an estimated 2% of the population suffering from serious mental illness, the need for an effective policy has never been greater. Mental health services operate within a policy framework where services are community based, client centred, holistic, focused on rehabilitation, and sensitive to gender and age (Weerasundera, 2011). The education of health professionals and support workers in at least two institutions promotes a ‘rights- based approach' to caring for people with mental health problems (De Silva, 2002).

Sri Lanka has some archaic legislation dating back to the Lunacy Ordinance of 1873 when the country was a British colony. These laws still operate with minor amendments, most recently in 1956. The mental health policy sanctions involuntary treatment only at the country’s premier mental health facility, the National Institute of Mental Health. However, people with mental disorder are often treated at regional centres. Due to social stigma, lack of awareness, and financial constraints involuntary admissions are mostly
unchallenged. Mental health services continue to grow and services are moving towards greater, if not comprehensive, coverage (Weerasundera, 2011).

4.4 Bangladesh

Bangladesh’s mental health policy, strategy, and plan were approved in 2006 as a part of an action plan for surveillance and prevention of non-communicable diseases. Community-based mental health care is the main approach of the policy. According to the national mental health survey of 2003–5 about 16% of the adult population in the country suffer from a mental disorder. Many fewer than this attend for treatment, however. Mental disorders are not covered by any social insurance schemes and there is no human rights review body in the country to inspect mental health facilities (World Health Organization, 2009a).

Bangladesh does not have a specific mental health authority. There are 50 outpatient mental health facilities but none provide follow-up care in the community. There are also no day treatment mental health facilities in the country. There are 31 community-based psychiatric inpatient units giving a total of 0.58 beds per 100,000 population, and on average patients spend 29 days in the facility. There are 11 community residential facilities in the country: 55% of the beds in these facilities are for children and adolescents, 81% of admitted patients are female, and 73% are children. There are no legislative or financial provisions to protect and provide support for mental health service users in respect of employment and rights. The spectrum of community mental health facilities is increasing, but the existing provision is inadequate. There are no mechanisms for supervision or protection of the human rights of mental patients in the country and no available data concerning coercion in mental health services. Special efforts are needed to make mental health services more accessible to the poor, tribal minorities, and the vulnerable (World Health Organization, 2005).

Essential psychotropic medicines are available in mental hospitals and the National Institute of Mental Health, but are not widely available in general hospital psychiatry units. There is only one small family association in the country and no consumers’ association. There is a lack of interaction between the family association and mental health service facilities. Initiatives have been taken around the capital city to develop community mental health services (Jacob et al. 2007).
Pakistan’s mental health policy was last revised in 2003 and mental health legislation was enacted in 2001. It focuses on access to mental health care including access to the least restrictive care, rights, family, capacity, and guardianship issues for people with mental illness. It also considers voluntary and involuntary treatment, the accreditation of professionals and facilities, mechanisms to oversee involuntary admission and treatment, and mechanisms to implement the provisions of mental health legislation (World Health Organization 2009a).

A national mental health authority exists which advises the government on mental health policies and legislation. This authority is also involved in service planning, service management and coordination, and in monitoring and quality assessment of mental health services. Five mental hospitals are available in the country and are organizationally integrated with mental health outpatient facilities. In the last 5 years the number of beds in mental hospitals has risen by 4% (Karim et al. 2004).

Policy and legislation, however, are not uniformly implemented (World Health Organization 2009a). The health system is not well established and lacks sufficient resources. Community services are limited to a few tertiary-care hospitals and only in big cities such as Lahore, Islamabad, and Karachi, and there are no community-based residential facilities or day treatment facilities. The density of psychiatrists in or around the largest city is over twice that outside it. None of the mental disorders are covered by social insurance schemes and only 0.4% of health-care expenditure by the government health department is devoted to mental health. The following legislative and financial provisions exist to protect and provide support for users: (1) provisions concerning a legal obligation for employers to hire a certain percentage of employees who are disabled; (2) provisions concerning protection from discrimination (dismissal, lower wages) solely on account of mental disorder; (3) provisions concerning priority in state housing and in subsidized housing schemes for people with severe mental disorders; and (4) provisions concerning protection from discrimination in allocation of housing for people with severe mental disorders. However, none of these provisions are enforced (World Health Organization, 2005). There are no mechanisms for monitoring coercive measures in the mental health services (Mubbashar & Saeed, 2001).

Patients in Pakistan are mostly looked after by their families. It is therefore important that training is focused on community-based psychiatry. Drug misuse is increasing and is
generally treated by non-psychiatric doctors. Psychological therapies are not readily available in Pakistan and there are currently no psychotherapists working in the national health system in Pakistan. Family is an important resource, and psychotherapies in this area could be used to improve patient care (Gadit, 2006).

4.6 Nepal

Nepal’s mental health policy was formulated in 1996. Key components include:

(1) to ensure the availability and accessibility of minimum mental health services for the whole population of Nepal;

(2) to prepare human resources in the area of mental health;

(3) to protect the fundamental human rights of the mentally ill;

(4) to improve awareness about mental health.

Less than 1% of government health-care expenditure is directed towards mental health. There is no human rights review body with the authority to inspect mental health facilities and impose sanctions on those facilities that persistently violate patients’ rights (Upadhyaya, 2009). Nepal has no community-based psychiatric inpatient units as such. Physician-based primary health care and non-physician-based primary health-care clinics are organized in the country. There is an unequal distribution of human resources between urban and rural areas (IASC Reference Group, 2012).

Whenever necessary, patients with medico-legal issues are admitted to mental hospital inpatient units for evaluation, court report, and treatment. There are no data on how many patients are detained or secluded each year in community-based psychiatric inpatient units, but 6–10% of the patients in mental hospitals had been detained or secluded (Jha & Adhikari, 2009).

4.7 Bhutan

The needs of people with mental illness who require care are increasing in Bhutan. The organization of mental health services in Bhutan is difficult due to a scattered population with diverse cultural practices, limited financial resources, a scarcity of mental health
personnel, lack of a comprehensive mental health policy, and the presence of conflicting healing systems and stigma (Nirola, 2010).

A National Mental Health Programme (NMHP) was started in July 1997 with the objective of ensuring the availability and accessibility of primary mental health care for all sectors of the population by integrating mental health into general health care. The NMHP integrates mental health care with the primary health-care system by training personnel in mental health at primary health-care centres. The integration of mental health into primary health care has helped to create an awareness of mental health in the community and reduce stigma. Patient admission may be voluntary or involuntary. None of the community mental health facilities have trained psychiatrists (Pelzang, 2012). The majority of patients are brought to the hospital by families and relatives. Only a few are referred from the criminal justice system or from prison. Bhutan does not have any mental health legislation to protect the rights of people with mental illness and there are no clear policies to prevent unlawful institutionalization, coercive medications/therapies, and/or inappropriate detention for psychiatric evaluation (Saxena, et al., 2007).

4.8 Afghanistan

The last mental health legislation in Afghanistan was enacted in 1997. The Ministry of Public Health is planning to revise the current mental health policy and legislation and to formulate a new national mental health programme. However, there is no regular budget allocation for mental health (World Health Organization, 2006). A national human rights review body exists (the Independent Human Rights Commission) which has the authority to inspect mental health hospitals. Only one review has occurred, in 2004, in response to a complaint by a family member (World Health Organization, 2005). Female users account for 47% of the population in all mental health facilities in the country. The proportion of female users is highest in day treatment and outpatient facilities. Less than 1% of medical doctors’ training is devoted to mental health compared with 2% of nurses’ training. Four per cent of primary-care doctors and 1% of nurses received at least 2 days of refresher training in mental health in 2004. There is no financial or legislative support for people with psychiatric problems (World Health Organization, 2006).

Although there have been efforts to promote equity of access to mental health services, these efforts have been inadequate. Limited resources are available for mental health and many of these resources are directed towards mental hospitals, leaving outpatient facilities
under-funded. Most of the resources are spent on the training of primary-care staff and no supervision and monitoring systems have been established (Saraceno, et al., 2007).

4.9 Iraq

Iraq and Iraqi society have been devastated by violence following the two Gulf wars. Many years of political and social repression, punctuated by wars, followed by a post-war period characterized by interrupted and insufficient basic services have taken their toll on the Iraqi people. According to the World Health Organization (WHO), mental health disorders are the fourth leading cause of ill-health in Iraqis over the age of 5 years and many studies have repeatedly shown a high prevalence of mental health problems in the Iraqi population (Hicks, et al., 2011).

In 2009, Médecins sans Frontières in collaboration with the Iraqi Ministry of Health launched a programme aimed at opening up access to psychological counselling and catalysing the integration of mental health care as a crucial component of the Iraqi health system. Iraq’s first national mental health survey in collaboration with the WHO in 2007 assessed the prevalence of common mental health disorders (such as anxiety, depressive, post-traumatic stress disorder, behavioural conditions, substance abuse) in the general population. It revealed significantly high levels of psychological distress in the population: one in five women and one in seven men were likely to suffer a mental disorder in their lifetime, with higher rates in those exposed to trauma. Almost 70% of those with any mental disorder reported experiencing suicidal thoughts. Fewer than 10% of these people, however, reported receiving care (Sadik, et al., 2010).

As with many countries in the region, the main component of Iraq’s mental health service has been institutionalized care for those suffering chronic psychiatric disorders such as schizophrenia. There are currently only four psychiatrists per million population, far below what is needed. Even fewer people are trained in the related mental health professions, including psychological counselling. As a result there is a significant gap for those experiencing conditions that are better resolved without hospitalization or medication, such as the commonly occurring anxiety and depressive disorders. While the security circumstances of Iraq have often complicated implementation, the challenges have also brought out innovative solutions which may help sustain services in future. For example, video conference links were trialled and then used extensively for training and technical support through case discussions and clinical supervision. When face-to-face visits have
not been possible, this has also been used for ‘intervision’— the personal support that all counsellors need to remain effective. While circumstances in Iraq may be considered to have improved to some extent since these surveys (at least until recent incursions and violence by ISIS), there is little reason to believe that the burden of mental ill-health has reduced and access to appropriate mental health care is still a critical issue (Tarantino, et al., 2009)

4.10 Iran

A mental health policy and programme was initially formulated in 1986. Its main components are advocacy, promotion, prevention, treatment, and rehabilitation. The strategy aims to integrate the mental health programme within the primary health-care system. From 1988 to 1990 successful pilot studies were implemented in Shahr- e- Kord and Shahreza in central Iran, resulting in significantly increased knowledge in health workers. There have been immense improvements in the provision of mental health services in rural areas over the last 15 years (World Health Organization, 2005).

A national mental health authority is involved in service planning, service management, coordination and monitoring, and quality assessment. In rural areas there is better implementation of the national guidelines compared with large urban areas. Residential facilities in Iran are run by the Social Welfare Organization (Noorbala, et al., 2004).

A lack of comprehensive and coherent mental health legislation is evident. Although available laws cover some areas such as competency, capacity, and guardianship, and despite the ratification of progressive laws in 1997 that provided legislative support for employment, many areas including involuntary hospitalization are not addressed (Patel, 2009). There is an urgent need to implement existing legislation as well as to monitor human rights. Outpatient services are available, and lack of medication is not an issue. The number of patients in community residential facilities providing long-term hospitalization and in mental hospitals is large and growing. Recently launched mobile services (a home visits initiative) are still essentially pilots and provide little coverage.

4.11 Jordan

Mental health services and activities in Jordan are provided by a range of stakeholders. There are four major providers (government, military, private, and non-governmental/
international), each with its own separate financing and delivery system. Jordan’s mental health system relies strongly on medical treatment, with few resources dedicated to recovery or bio- psychosocial treatment modalities. This is reflected in the high number of psychiatric versus psychosocial and allied medical staff in Jordan’s mental health system and the fact that the majority of mental health services are delivered through tertiary-level facilities, with virtually no primary, community-based, or self-care (World Health Organization, 2011).

Recent years have seen a growing commitment to improving mental health in Jordan. In 2010, Jordan was selected as one of six countries for the implementation of the WHO’s Mental Health Gap Action Program. Mental health is poorly integrated within general health structures, and until late 2011 there was no single policy-making and budget-holding mental health authority. The new authority will be responsible for service development, developing legislation and establishing mechanisms to protect and promote human rights and advocacy (Hijiawi, et al., 2013). There are no coordinating bodies overseeing any public education and awareness campaigns on mental health and mental disorders, although there have been limited and infrequent campaigns led by non-governmental organizations and professional associations. There are very few formal community mental health-care services in Jordan. Three Ministry of Health facilities have been transformed into community mental health centres, with the support of the WHO. One is a standalone mental health centre in the capital city Amman, and the other two are situated in comprehensive health centres in Amman and in Irbid. In Jordan there is a relationship between traditional healers and physicians which remains informal and disorganized (World Health Organization, 2011).

4.12 Saudi Arabia

Saudi Arabia had no psychiatric hospitals until the 1950s. In 1989, primary health-care centres were established throughout the country in order to improve the diagnosis and treatment of medical problems in the community (Okasha & Karam 1998). Primary care is regarded as the foundation of the health service and most patients are seen at this level—about 83% of public sector attendances occur in primary-care clinics (World Health Organization, 2009a).

Mental health law exists and helps to protect patient rights at local and national levels. Although mental health services are expanding, much of the care for those with mental
illness continues to take place in family settings. The family is sacred in Saudi Arabia, and caring for family members is considered a religious obligation. Children do not leave home until they are married, and elders are usually cared for within the family unit, not sent to a nursing home as in Western countries. This results in large extended families living together. Mental health care also takes place within the nuclear and extended family, and problems of mental ill-health are often kept secret. Due to guilt and shame, family members often refuse to discuss mental health problems with non-family members, including medical physicians and mental health professionals. Traditional healers constitute part of the household staff, using religious texts and recitation in management (Farooqi, 2006).

4.13 The United Arab Emirates (UAE)

There is no official mental health policy in the UAE, but mental health is specifically mentioned in the general health policy. A mental health plan exists and was approved or most recently revised in 2010. It includes a shift of services and resources from mental hospitals to community mental health facilities and the integration of mental health services into primary care. Dedicated mental health legislation exists and legal provisions concerning mental health are also covered in other laws (e.g. welfare, disability, general health legislation, etc.) (World Health Organization, 2011).

Despite recent improvements, mental health infrastructure and services are grossly insufficient for the large and growing needs. Prescription regulations authorize doctors in primary health care to prescribe and/or to continue prescription of psychotherapeutic medicines, but with restrictions. The Department of Health does not authorize nurses in primary health care to prescribe and/or to continue prescription of psychotherapeutic medicines and official policy does not permit them to independently diagnose and treat mental disorders within the primary-care system (World Health Organization, 2011).

There has been remarkable progress in the UAE in the recognition and treatment of mental health disorders, especially in the last 20 years. The UAE’s mental health system is making huge strides toward addressing the mental health needs of its people.
4.14 Egypt

Egypt has a mental health policy, legislation, and plan. All mental disorders and all mental health problems of clinical concern are covered in social insurance schemes. At least 80% of the population has free access to essential psychotropic medicines. There is a national human rights review body and a national mental health authority, which provides advice to the government on mental health policies and legislation (World Health Organization, 2009b). Most mental health facilities are in or near large cities. There is significantly more provision in urban areas but some areas have no mental health facilities. In order to promote equity of access to mental health services, Egypt is encouraging the development of community-based psychiatric units and outpatient facilities in each area throughout the country. Funding is insufficient to cover the costs of mental health services. Non-governmental organizations and community leaders share in the support and the improvement of mental health services. Resources from international organizations like the WHO and from other countries also help to support the mental health system in Egypt (World Health Organization, 2009a).

A national mental health authority is involved in service planning and coordination, monitoring and quality assessment of mental health services. However, residents in those areas that are not covered by basic mental health services have access to services in adjoining regions. It is difficult to gather accurate data regarding the length of stay of patients in mental hospitals due to a large patient population and high patient turnover (Okasha & Okasha, 2000). There are no consumer or family associations for people with mental disorders. There is a coordinating body, the General Secretariat of Mental Health, that oversees public education and awareness campaigns on mental health and mental disorders but there are no community residential facilities for patients with mental disorders—the reasons for this include stigma, lack of trained personnel and lack of funding (Okasha, 2004).

4.15 Conclusions

People with mental disorders are amongst the most vulnerable in society. They are often isolated, stigmatized, discriminated against, humiliated, and marginalized. They often end up in unhealthy or even inhumane living conditions either in the community or in mental hospitals, and experience an increased likelihood of human rights violations. Lack of understanding and poor management of mental illness by health professionals and people in the community may contribute to neglect. Allocation of resources to mental health care
and particularly community services, is grossly inadequate in many of the countries considered in this chapter, beyond that which might be expected from general health budgets.

There is, however, an increasing awareness of mental health in the general population, and the number of people seeking treatment is increasing. To ensure the availability and accessibility of mental health services for all of the population, and in particular for the most vulnerable and under-privileged groups, mental health services have to be integrated into the general health system of the region. Mental health resources have to be distributed in accordance with mental health policy and an adequate supply of essential psychotropic drugs should be maintained.

Improved training of workers and greater education of populations may help to reduce stigma and discrimination and eliminate damaging practices. Existing legislation first needs to be enforced and then improved upon to increase protection for those in need, both in hospitals and in the community. In this region there is little research evidence or detailed reports of formal or informal coercion conducted by services. It seems clear that coercion related to ways in which families attempt to help patients, covert medication, and widespread lack of resources is common and damaging. It is imperative that we work to improve our understanding of these issues and push for adequate treatment resources and good-quality basic legislation to protect the most vulnerable amongst us.

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Chapter 5: Patient and Visitor Violence towards Staff on Medical and Psychiatric Wards in India

ABSTRACT

Background: Patient and visitor violence (PVV) towards staff is common across health settings. It has negative effects on staff and treatment provision. Little data is available from the developing world.

Aims: To examine the prevalence of PVV in India and make comparisons with the existing data. Methods: We administered an abbreviated version of the Survey of Violence Experienced by Staff (SOVES-A) in English in Mysore on medical and psychiatric wards.

Results: 249 staff participated. 16% of staff in psychiatric wards were subjected to some form of PVV in the past 4 weeks which is lower than in the developed world. 57% of staff on medical wards experienced PVV which is similar to the developed world. Patients and Visitors were almost equal sources of this violence. Verbal abuse was more common than threats and physical assaults. Training in aggression management may be a protective factor.

Conclusion: PVV is a significant problem in India, especially on medical wards. Aggression management training may be a way to reduce the prevalence of PVV.

5.1 Introduction

Healthcare workers face patient and visitor violence (PVV) all over the world. A recent systematic review on PVV concluded that ‘patient and visitor violence is a serious problem for healthcare staff in general hospitals’ (Hahn, et al., 2008). There is consistent evidence from high income countries that violence towards healthcare staff is damaging on various levels: It negatively affects the psychological and physical well-being of healthcare staff as well as having a negative impact on job motivation and, more importantly, the ability to provide high quality care (Arnetz & Arnetz, 2001; Galatsch, et al., 2013; Needham, et al., 2005; Winstanley & Whittington, 2004). Workplace violence has a negative economic impact on organisations in terms of work days lost and sickness absence (Philbrick, et al.,
2003). The current evidence from high income countries indicates that the use of a rating scale for PVV like the Survey of Violence Experienced by Staff (SOVES) (McKenna, 2004) can reliably measure the prevalence of PVV and thus inform strategies to mitigate against it (Abderhalden, et al., 2008; van de Sande, et al., 2011).

Current data showed patient or visitor violence was commonly separated into three specific categories of incidents: verbal aggression, threats and physical assaults. In the largest nationwide prevalence study of PVV in psychiatric settings from the UK more than half of nurses but fewer doctors and non-clinical staff experienced PVV (Health Care Commission, 2007). Little data is available from South East Asia. One staff survey from Bangalore reported that 87% of staff on psychiatric wards had experienced some form of violence in their career (Balamurugan et al., 2012). Of the remaining studies from middle and low income countries, one Jordanian study amongst medical nurses reported 37% prevalence of verbal abuse and 18% of physical abuse in the last 6 months. Younger and less experienced staffs were more commonly affected. Half of the abused nurses considered leaving the profession (Ahmed, 2012). A nationwide survey amongst nurses in Kuwait reported that verbal violence had been experienced in the 6 previous months by 48% of the group, and physical violence by 7% (Adib, et al., 2002).

In medical settings percentage figures for verbal aggression range from 9% in a Swedish study to 97% in a Turkish study. The percentages for threats ranged from 5% in a Jamaican study to 70% in a US study. For physical assaults results ranged from 3% in an Israeli study to 58% in a US study (Hahn, et al., 2008).

The European Violence in Psychiatry Research Group (EViPRG) was founded in 1997. It is multi-disciplinary and aims to standardise research in psychiatric and other medical settings (including forensic and civil hospitals, nursing homes and other health care facilities), set standards, make international comparisons, bench-mark, and develop and research initiatives to reduce coercion. The Indian Forensic Mental Health Association (IForMHA) was founded in 2013 and headed by one of the authors (RBN), aims to achieve similar goals in India in collaboration with EViPRG. The first step in this direction is to collect the prevalence data in relation to hospital staff’s experiences of PVV in India. Therefore, we carried out a pilot study to examine the relationship between reported levels of abuse and staff characteristics to inform further collaborative research to develop culturally acceptable and feasible interventions to reduce the levels of PVV and coercion in India as outlined in the Mysore declaration (Lepping & Raveesh, 2013).
5.2 Methods

5.2.1 Setting

We investigated prevalence of PVV in general medical and psychiatric wards in 2 hospitals in South India. The medical wards were in the Holdsworth Memorial and Krishnarajendra Hospital, Mysore. It is a missionary hospital governed by the Church of Southern India. The hospital is situated in a busy quarter of Mysore city and provides low cost care to the less privileged. HMH has most specialities with 330 beds and an emergency department. It does not have separate psychiatry wards. At Holdsworth Memorial Hospital, there are two registered nurses for a 40–50 bedded busy ward. They are assisted by two nursing aids, but no volunteers. Each ward has a security guard whose primary work is to guard the entry and restrict ‘the family members and visitors’ outside the visiting hours. The guards have no formal training in de-escalation. The psychiatric state hospital of Mysore Medical College and Research Institute (MMCRI) was used for data collection on psychiatric wards. MMCRI is a state-run (free-to-patients) hospital that serves a catchment area of 1500,000 population, with 135 primary health centres. The hospital has most specialities with 1050 beds and a 10 bedded intensive care unit (ICU). 800–1000 patients attend outpatient departments daily. The department of psychiatry at MMCRI has 10 male and 10 female psychiatric inpatient beds. Staffing includes 6 psychiatrists in total and 2 registered nurses per shift. Thus, there will be one nurse for 10 psychiatry beds round the clock. There is one security guard for the inpatient care 24 h a day on shift, who manages the visitors and prevents inpatients from absconding from the hospital. The hospital policy is to admit a patient with an attendant, preferably a close relative. The nurse and the security guard have no formal training in de-escalation. Approximately 60% are involuntary admissions. Most patients come from lower middle to lower economic backgrounds and are severely ill on admission. The study was approved by the research and ethics committee at Mysore Medical College and Research Institute Mysore, India.

5.2.2 Instrument

We replicated a previous study conducted in North Wales (Lepping, et al., 2013). We administered an abbreviated version of the Survey of Violence Experienced by Staff (SOVES-A) in English, a staff questionnaire to investigate the prevalence of verbal abuse, threats and assaults on staff by patients, visitors, co-workers or others in the past 4 weeks.
This validated tool includes questions about staff experience with violence within the last 4 weeks, as this timeframe yields the best results, creating least problems with recall bias (McKenna, 2004). The SOVES-A also asks whether a staff member had formal de-escalation and/or breakaway training in the last 3 years, and whether they have ever received training in the management of potentially violent individuals. It takes 5 min to complete the SOVES-A.

5.2.3 Administration of the tool

Two of the authors (MK & RBN) distributed the tool by approaching staff on medical and psychiatric wards during a four week period in September 2013. Staff completed and returned the tool on the same day.

5.2.4 Analysis

We used Pearson’s Chi-square analysis on nominal data, with Fisher’s exact and trend analysis values used where appropriate. For continuous data t-tests and regression were used. All analyses carried out with SPSS (SPSS, 2004).

5.3 Results

We approached 141 and 101 number of staff from HMH and MMCRI, respectively, between September and October in 2013 to complete the SOVES-A. Of those, 136 (96%) from HMH and 81 (81%) from MMCRI returned the completed questionnaire. The total number of participants in the study was 249, 40 (16.1%) of which were male, and 62 (24.9%) female (missing data: 147 or 59%). 136 worked in a medical setting (67.5%), 81 in a psychiatric setting (32.5%). The study population consisted of 136 nurses (54.6%), 16 Healthcare social worker (HCSW) (6.4%) and 97 other professionals (39%) such as doctors, psychologists, research assistants, ward clerks and pharmacists. 44 (17.7%) of the participants worked part time, and 196 worked full time (78.7%) (missing data: 9 or 3.6%). The vast majority worked in hospital settings (186 or 74.7%), 42 in clinics (16.9%), and 13 (5.2%) in other settings (missing data 8 or 3.2%). The mean age was 31.3 years (range: 19–58). The average number of hours worked per week was 48.6 (range: 6–84). The mean percentage time spent each day with direct patient contact was 84.6% (range 1–100). The mean work experience in years was 5.7 (range: under 1 to 42). 14 staff (5.6%) has formal de-escalation training, 10 (4%) had PVV management training. Table 5.1 shows the prevalence of PVV for each type of abuse suffered. Table 5.2 shows the
source of abuse for the different frequencies and types. Table 5.3 shows the prevalence of PVV for different settings and professions.

Thirty-nine percent of staff reported some form of violence in the past 4 weeks; 57% of medical staff and 16% of psychiatric staff (Chi-sq. = 36.5, p < 0.001), a result that remained statistically significant across all three types of abuse. In addition, we found that in keeping with evidence from other countries (Hahn et al., 2008; Lepping et al., 2013), more time spent with the patient results in significantly more abuse of any kind (t = _2.40, df = 201, p = 0.017). This remained the case for all three types of abuse individually. We observed that the category 'others' were also at an

Table 5.1: Prevalence of PVV for each type of abuse suffered

<table>
<thead>
<tr>
<th>Type of abuse</th>
<th>Yes</th>
<th>No</th>
<th>Missing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suffered verbal abuse</td>
<td>97 (39.0%)</td>
<td>151 (60.6%)</td>
<td>1 (0.4%)</td>
</tr>
<tr>
<td>Threatened</td>
<td>42 (16.9%)</td>
<td>195 (78.3%)</td>
<td>12 (4.8%)</td>
</tr>
<tr>
<td>Suffered physical abuse</td>
<td>22 (8.8%)</td>
<td>144 (57.8%)</td>
<td>83 (33.3%)</td>
</tr>
</tbody>
</table>

Table 5.2: Source of abuse

<table>
<thead>
<tr>
<th>Source of verbal abuse</th>
<th>1–5</th>
<th>6–10</th>
<th>&gt;10</th>
<th>Missing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient</td>
<td>54 (21.7%)</td>
<td>5 (2%)</td>
<td>3 (1.2%)</td>
<td>187 (75.1%)</td>
</tr>
<tr>
<td>Relative</td>
<td>52 (20.9%)</td>
<td>8 (3.2%)</td>
<td>4 (1.6%)</td>
<td>185 (74.3%)</td>
</tr>
<tr>
<td>Other</td>
<td>21 (8.4%)</td>
<td>4 (1.6%)</td>
<td>3 (1.2%)</td>
<td>221 (88.8%)</td>
</tr>
<tr>
<td>Anonymous</td>
<td>10 (4%)</td>
<td>1 (0.4%)</td>
<td>3 (1.2%)</td>
<td>235 (94.4%)</td>
</tr>
</tbody>
</table>

Source of threat

<table>
<thead>
<tr>
<th>Source of threat</th>
<th>1–5</th>
<th>6–10</th>
<th>&gt;10</th>
<th>Missing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient</td>
<td>14 (5.6%)</td>
<td>3 (1.2%)</td>
<td>2 (0.8%)</td>
<td>230 (92.4%)</td>
</tr>
<tr>
<td>Relative</td>
<td>14 (5.6%)</td>
<td>3 (1.2%)</td>
<td>3 (1.2%)</td>
<td>229 (92%)</td>
</tr>
<tr>
<td>Other</td>
<td>7 (2.8%)</td>
<td>0</td>
<td>3 (1.2%)</td>
<td>239 (96%)</td>
</tr>
<tr>
<td>Anonymous</td>
<td>3 (1.2%)</td>
<td>5 (2%)</td>
<td>2 (0.8%)</td>
<td>239 (96%)</td>
</tr>
</tbody>
</table>

Source of physical abuse

<table>
<thead>
<tr>
<th>Source of physical abuse</th>
<th>1–5</th>
<th>6–10</th>
<th>&gt;10</th>
<th>Missing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient</td>
<td>7 (2.8%)</td>
<td>1 (0.4%)</td>
<td>2 (0.8%)</td>
<td>239 (96%)</td>
</tr>
<tr>
<td>Relative</td>
<td>3 (1.2%)</td>
<td>0</td>
<td>2 (0.8%)</td>
<td>244 (98%)</td>
</tr>
<tr>
<td>Other</td>
<td>3 (1.2%)</td>
<td>1 (0.4%)</td>
<td>1 (0.4%)</td>
<td>244 (98%)</td>
</tr>
<tr>
<td>Anonymous</td>
<td>3 (1.2%)</td>
<td>5 (2%)</td>
<td>2 (0.8%)</td>
<td>239 (96%)</td>
</tr>
<tr>
<td>Any recent abuse</td>
<td>Major</td>
<td>Minor</td>
<td>None</td>
<td>Missing</td>
</tr>
<tr>
<td>------------------</td>
<td>-------</td>
<td>-------</td>
<td>------</td>
<td>---------</td>
</tr>
<tr>
<td>6 (2.4%)</td>
<td>42 (16.9%)</td>
<td>99 (39.8%)</td>
<td>102 (41%)</td>
<td></td>
</tr>
</tbody>
</table>

Table 5.3: Prevalence of PVV for different settings and professions.

<table>
<thead>
<tr>
<th>Any abuse</th>
<th>Yes</th>
<th>No</th>
<th>Total</th>
<th>p-Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>95 (56.5%)</td>
<td>73 (43.5%)</td>
<td>168</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>13 (16%)</td>
<td>68 (84%)</td>
<td>81</td>
<td>$\chi^2 = 36.5$</td>
</tr>
<tr>
<td>Total</td>
<td>108 (43.4%)</td>
<td>141 (56.6%)</td>
<td>249</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Any abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse</td>
</tr>
<tr>
<td>HCSW</td>
</tr>
<tr>
<td>Other</td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Verbal abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>Medical</td>
</tr>
<tr>
<td>Psychiatry</td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Threat</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>Medical</td>
</tr>
<tr>
<td>Psychiatry</td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Threat</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse</td>
</tr>
<tr>
<td>HCSW</td>
</tr>
<tr>
<td>Other</td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>
increased risk of any kind of abuse (Chi-sq. trend = 11.1, p = 0.001). There is also a trend showing nurses subjected to less verbal abuse than the category ‘others’ or HCSW (Chi-sq trend = 5.6, p = 0.018). HCSW had zero threats compared to nurses who had 15 (11%) and ‘other’ that had 20 (21%) (Chi-sq. trend = 3.99, p = 0.046).

There were no differences in the proportion of any abuse experienced between men and women, full time and part time workers, and duration of their current job. Only nine staff (4%) had formal PVV management training, but this was associated with significantly fewer threats and physical abuse. 14 staff (7%) had formal de-escalation training. This was not associated with reported PVV.

5.4 Discussion

To our knowledge this is the first study to report the prevalence of PVV using a validated and standardised tool allowing for comparison with such data from high income countries. The response rates also illustrate that it is feasible to use structured questionnaires to measure PVV in the India subcontinent.

Our study highlights that PVV is a significant problem in south India. Similar to studies elsewhere (Hahn, et al., 2008) we found that verbal aggression was the most common occurrence followed by verbal threats, whilst physical assaults were relatively rare. However, given the significant negative impact and psycho-social trauma that can occur with verbal aggression alone, these prevalence figures are of a significant nature. The prevalence figures we found are lower than in comparative studies from high income countries for psychiatric settings, but not for medical settings (Hahn, et al., 2008). In a large UK audit (n = 3581) in psychiatric settings amongst nursing staff, nearly one-half said that they had been physically assaulted, and almost three-quarters said that they had been threatened or made to feel unsafe. The only psychiatric PVV study from India known to us reported much higher prevalence of whole career PVV (87%) (Balamurugan et al., 2012), which may explain the discrepancy with our findings. In medical settings, in a more recent largely community based Australian study of medical practitioners, 70.6% had experienced verbal or written aggression and 32.3% experienced physical aggression from one or more sources in the previous 12 months (Hills et al., 2012). In a study conducted in North Wales on high risk medical wards (geriatric, gastroenterology) 83% of staff experienced verbal aggression within the last four weeks, 50% were threatened and 63% were physically assaulted resulting mostly in no or minor injuries (Lepping, et al., 2013).
Interestingly, PVV was significantly more common on medical than on psychiatric wards. This is the first such comparison in any study. The most common sources of violence in our study were patients and relatives. Figures for both were almost the same, which is different to previous studies from high income countries where patients are by far the most likely source of violence with relatives a significant but smaller source of PVV. One explanation for this may be that relatives stay with patients in Indian hospitals, increasing the possibility of PVV. In settings like HMH where payments can be required, disputes about payments with relatives are common and can be a source of PVV. This needs further investigation, as it was suggested by participating nurses as a possible explanation.

The majority of participants were not willing to name the source of violence. The missing data in relation to the “perpetrator” of the abuse may represent the unwillingness and hesitancy by staff to name the individuals due to fear of personal consequences. In her systematic review Hahn and colleagues only included two papers from Asia (China and Taiwan) with two more from Kuwait, all others came from high income countries, including Turkey (Hahn, et al., 2008). Whilst figures for PVV are generally smaller in studies from Asia, they are not in any way negligible and very high in some individual studies. Similar to same studies from the high income world, it is encouraging to observe that those staff with aggression management training report lesser levels of exposure to abuse by PVV. However, in contrast to most psychiatric facilities in high income countries, aggression management training is not necessarily seen as an essential training component for hospital staff in India. Therefore, EViPRG members would like to develop and evaluate a structured PVV and risk management training that is culturally acceptable and meets the needs of Indian hospital settings (Lepping & Raveesh, 2013).

The findings from this study are encouraging and will inform our planned larger multi-centre prevalence study in India to determine the specific characteristics of the staff and hospital settings that are associated with higher levels of violence. Limitations: The study sample was randomly chosen but was collected from staff who were ‘physically’ present at work place from all settings where there is patient and staff contact. The numbers were not large enough to analyse site differences for subgroups of abuse. The English rather than a Kannada version of SOVES-A was administered. Despite this, we had a good response rate.
Appendix A

Based on—Survey of Violence Experienced by Staff (SOVES)

1. Please specify your job title

2. Please indicate status of post: Full time Part time/Job Share Relief Please state average weekly hours worked excluding overtime

3. Please describe your current workplace (e.g. medical unit, surgical unit, psychiatric unit, community care, emergency care, child care, care of the elderly, administration, etc)

4. Please estimate the percentage of your working time that involves contact with patients/clients:

5. Please indicate whether your post is primarily: Office Based Clinic Based Community Based Re-sidential/Hostel Hospital Based

6. Please state length of service working in health/social care: Years Months

7. Please state length of service in your current position: Years Months

8. Please indicate whether you are: Male Female

9. Please enter your current age in years in the box provided

10. In your current role have you ever been subjected to Verbal Abuse directed towards you in your workplace? (e.g. abusive or offensive language, personally derogatory remarks, profanity, or obscene comments):

   Yes  No

   If Yes, please indicate the categories which best describe the source(s) and frequency of that abuse within the past 4 weeks: (Please tick all applicable boxes)

<table>
<thead>
<tr>
<th>Source of verbal abuse</th>
<th>Frequency within past 4 weeks</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1–5</td>
</tr>
<tr>
<td>Patient/client</td>
<td></td>
</tr>
<tr>
<td>Relative/visitor</td>
<td></td>
</tr>
<tr>
<td>Co-worker</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

   If other, please specify.

11. In your current role have you ever been threatened in your workplace? (e.g. warnings of intent to injure, harassment, physical intimidation, threat with a weapon):

   Yes  No
If Yes, please indicate the categories which best describe the source(s) and frequency of threats directed towards you within the past 4 weeks: (please tick all applicable boxes)

<table>
<thead>
<tr>
<th>Source of threats</th>
<th>Frequency within past 4 weeks</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1–5</td>
</tr>
<tr>
<td>Patient/client</td>
<td></td>
</tr>
<tr>
<td>Relative/visitor</td>
<td></td>
</tr>
<tr>
<td>Co-worker</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

If other, please specify.

12. In your current role have you ever been physically assaulted in your workplace? (e.g. slapping, pinching, pushing, shoving, spitting, kicking, use of a weapon):

   Yes  No

If yes, please indicate the categories which best describe the source(s) and frequency of that abuse within the past 4 weeks: (please tick all applicable boxes)

<table>
<thead>
<tr>
<th>Sources of physical assault</th>
<th>Frequency within past 4 weeks</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1–5</td>
</tr>
<tr>
<td>Patient/client</td>
<td></td>
</tr>
<tr>
<td>Relative of patient/visitor</td>
<td></td>
</tr>
<tr>
<td>Co-worker</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

If other, please specify.

13. Following the most recent occurrence of physical assault in the workplace how would you classify any physical injury sustained?
    None—no physical injury of any sort
    Minor—injury required no treatment or first aid
    Major—injury required medical assessment and/or treatment

14. Have you had formal de-escalation and/or breakaway training in the last 3 years?
    Yes  No

15. Have you ever received training in the management of potentially violent individuals?
    Yes  No

Thank you for your valuable contribution to this study. All information in this questionnaire is confidential, and no individual responses will be identifiable.
References


Chapter 6: Observational Study of Aggressive Behaviour and Coercion on an Indian Acute Ward

ABSTRACT

Objective: We evaluated prevalence of aggressive behaviour and coercive measures on an acute Indian psychiatric ward where relatives are always present at the ward.

Method: Non-interacting, independent observers (specifically trained mental health clinicians) on an Indian acute, 20-bedded psychiatric ward gave structured reports on all violent episodes and coercive measures during a 30-day period. They used the Staff Observation Aggression Scale Revised, Indian (SOAS-RI). The severity of the SOAS-RI reports were independently analysed by one of the authors.

Results: 229 violent incidents were recorded, involving 63% of admitted patients. 27% of all admitted patients were subjected to intravenous injections. Relatives provoked 35% of the incidents and were the target in 56% of the incidents. Patients’ own relatives were involved in managing the aggression in 35% of the incidents. Relatives of other patients were involved in 14% of the incidents. The likelihood of a patient to be physically restrained and that a relative would be participating in the coercive measures was increased when medical staff was targeted.

Conclusion: Relatives are commonly triggers and victims of aggressions on the investigated acute Indian psychiatric wards. Doctors and nurses are less likely to be victims but aggression towards them leads more commonly to coercive measures.

6.1 Background

Violence and aggression at the workplace happens across all medical specialties (Sabine Hahn et al., 2008) and psychiatric inpatients wards are no exception. Significant interest has been shown in understanding patient violence as it has been shown to have a negative impact on staff motivation, job satisfaction and the quality of care delivered to
patient. More recently, intervention studies have shown effective ways to reduce violence and coercive measures in psychiatric settings (Abderhalden et al., 2008; van de Sande et al., 2011) paving the way for significant improvements.

Cornaggia et al. found a prevalence of 3%–15% of psychiatric inpatients displaying assaultive behaviour throughout a variety of high income countries (Cornaggia, et al., 2011). Beghi et al. report a prevalence of the use of restraint of between 3.8% and 20% from 49 included studies from high income countries (Beghi, et al., 2013). In the review of 15 years of research using the aggression reporting tool SOAS-R, Nijman, et al. conducted a meta-analysis of all studies that used SOAS and found a mean of 9.3 aggressive incidents per patient per year. The range varied between 0.4–33.2 incidents per patient per year. This study established SOAS-R as the standard instrument for reporting aggression, especially in Europe, and comparable across populations. (Nijman, et al., 2005) The Annual National Audit of Violence conducted by the UK Royal College of Psychiatrists in 2007 studied multiple details around aggression in 215 NHS hospitals across England and Wales, and remains the single largest data set on violence towards mental health staff. It reported that about 46% of mental health care workers were physically assaulted in the previous year and a significant 72% had felt threatened or unsafe in their career (RCPsych, 2007).

Data on aggressive inpatient behaviour on psychiatric wards from middle and low income countries are scarce. A recent study from India, looking into patient and visitor violence towards staff (n = 249) found that 57% of staff in medical wards and 16% of staff in psychiatric wards were victims of aggression in the previous 4 weeks. The study used an adapted self-report questionnaire, the so called Survey of Violence experienced by Staff (SOVES) (Raveesh, et al., 2015). One other study from Bangalore, India, reported patient violence experienced by 87% of psychiatric nurses (Balamurugan, et al., 2012).

Studies assessing violence in patients with psychiatric disorders are based on recall of aggressive incidents by staff using surveys or on incident reporting forms. Recall of the incidents by the staff is limited by recall bias. The Staff Observation Aggression Scale Revised (SOAS-R) is a validated instrument for reporting aggressive behaviour from patients in psychiatric institutions, and has become the standard instrument for aggression research in Europe over the past 30 years (Nijman & Rector, 1999; Palmstierna & Wistedt, 1987). Using a standard reporting scale like the SOAS-R allows for systematic reporting
and analysis. Reporting, however relies on staff being present everywhere on the ward at the time of an incident and having the motivation to report it (Lion, et al., 1981). Therefore, underreporting remains variable and limits a comprehensive reporting of incidents, especially when the severity of the violent incidents is low, which is why many previous studies using the SOAS-R use a cut-off that leaves the less severe incidents out of the analyses (Abderhalden, et al., 2008; Palmstierna & Olsson, 2007). Ideally, data should be collected by independent observers present on the wards at all times, but such research has so far been impossible to conduct for logistical and economic reasons (Brizer, et al., 1988).

The striking difference between psychiatric care in high income and middle and low income countries is the constant presence in the latter of a non-professional caregiver with every patient, mostly a close relative. They are practically involved in nursing care, but it is unclear to what degree this supports or hinders recovery. This classically happens in Indian governmental health care settings who often cater for patients from lower socioeconomic backgrounds. This setting brings the most important caregiver to the hospital ward, and allows observation of the dynamics between patients, relatives and professional staff. To the best of our knowledge, there has been no study from India reporting prevalence data on aggression and coercion in acute psychiatric wards.

The aims of the current study were to
i. Examine the prevalence of inpatient aggression and subsequent coercive measures in a setting with non-professional care givers (relatives) in attendance of the patient.

ii. Analyse factors influencing the choice of immediate coercive measures as a reaction to aggression from patients.

iii. Explore the role of non-professional care givers in being instigators and targets of violence and their participation in coercive measures

6.2  Materials and methods
6.2.1  Study design
We conducted an observational study of all levels of aggression and coercion on two acute psychiatric inpatient wards in Mysore, Karnataka, India. To guarantee continuous and independent observation, two psychologists and one social worker (PR, AKS & GH) observed the wards during the working hours (from 8 a.m. to 10 p.m.) without interfering in
any way. An intern doctor on duty continued the observation during the night. The observation period was 30 days in March and April 2015. Patient data including the socio-demographic variables and ICD-10 diagnoses, as well as ward data including admission and discharge dates. These data were obtained from the patient case files and ward inpatient records. The study was approved by the Mysore Medical College and Research Institute’s (MMCRI) institutional ethics committee.

6.2.2 Setting
The study was conducted in the psychiatric inpatient unit of Mysore Medical College and Research Institute (MMCRI), a tertiary care referral hospital located in southern India. This is a state run hospital serving a catchment area of 1,500,000 with 135 primary health centres. The department houses 20 beds, 10 each for male and female patients. The two wards for men and women are separated and comprised of dormitory accommodation. The wards are large rooms shared by 10 patients with nursing staff overlooking the wards. Though the wards are considered open wards, the main entrance leading on to these wards is gated. There is round the clock security available at the entrance. At least 2 nursing staff and one junior doctor working in shifts will be in the ward at any point of time apart from night shifts when nursing staff is reduced to one nurse for both wards. Psychologists and psychiatrists are present in the ward for at least 8 h a day and are available on-call out of hours. As a hospital policy one non-professional carer, preferably, and mostly a close relative has to be with the patient at all times. The vast majority of patients treated in the study setting come from lower socio-economic backgrounds, are severely ill at the time of admission, and are admitted against their will.

6.2.3 Standard medications used
As a standard operating procedure in the ward, whenever a patient needs parenteral medications, intravenous haloperidol 5 mg with lorazepam 4 mg are given. Haloperidol 5 mg with promethazine 25 mg are given when intramuscularly injections are required.

6.2.4 Instrument
The SOAS-R is a reporting form for aggressive incidents (Nijman, et al., 1999). It allows staff to report such incidents and includes information about provocation, means used, targets, consequences and immediate measures to stop the aggression. The observer subjectively judges whether the incident was provoked and by whom. The SOAS-R entails a scoring system to assess the severity of the incident. It is only used for patients’
aggressive behaviour. Examples of incidents classed as severe (score > 8) include: any physical attack resulting in a visible injury, physical pain or the victim feeling threatened, physical attack with a dangerous object resulting in the patient being restrained.

We adapted the SOAS-R report form to cater for the presence of non-professional care givers (SOAS-RI, see Appendix A). These adaptations include the presence of security staff, relatives and other care givers. It allows for the categorisation of the aggressor other than the patient. Furthermore, a column for reporting people involved in measures to stop the aggressive incident was added. In contrast to all other studies of inpatient aggressive behaviour using the SOAS-R, the reporting of aggressive incidents in this study does not rely on the nursing staff on the ward, but utilises independent and non-intervening observers. This observational technique, see e.g. Brizer et al. (1988) was tried out in the early 1980s, but was found to be too cumbersome and expensive. It was therefore abandoned in high income countries when techniques relying on staff observations were introduced (Nijman, et al., 1999; Kay, et al., 1988; Palmstierna & Wistedt, 1987). However, relying on the nursing staff’s reports inherently introduces the strong possibility of observer bias, which is seldom addressed in previous studies. By using reports from independent and non-intervening observers, it is much more likely to achieve more reliable reports on violent interactions in psychiatric wards.

6.2.5 Statistics
This study is an observational study from a psychiatric ward within a treatment and nursing context that is quite different from most other studies on violent behaviours. Most results are therefore purely descriptive in order to make comparisons with other studies.

Analyses of predictors of different kinds of coercive measures applied are performed with logistic regressions. Four separate logistic regression models were analysed. Each reported incidents as the observational unit for analyses. In the four separate models, the outcomes “Hands-on” coercive measure (i.e. physical intervention); intravenous coercion (i.e. the use of intravenous injections as a response to a violent act); patient's relative engaged in coercive measures and doctor or nurse involved in measures to stop aggression were used as dichotomous dependent variables. In the unadjusted models, the variables from the SOAS-R/Indian report form were used. Independent variables from the columns “provocation” and “target of aggression” were used as dichotomous variables. As independent variables from “means used by the aggressor” and “resulting injury”, we used
the predefined scores of severity, as defined by the original SOAS-R (Nijman, et al., 1999). A score of more than 8 in the SOAS-RI was considered a severe aggressive incident in line with previous studies using the SOAS-R (Nijman, et al., 1999). In the adjusted models, the significant variables from the unadjusted models were used in a stepwise forward model in order to determine the strongest predictors in an incident predicting the different outcomes of the four models. We performed a Kruskal Wallis Test to examine whether there are statistically significant differences between main diagnostic categories with regard to frequency of incidents and coercive measures. In these analyses, we used IBM SPSS Statistics, Version 21, release 21.0.0.0.

6.3 Results

6.3.1 Demographics
On the first day of the study, 16 patients were present in the ward. There were 47 patients admitted to the ward during the study period of 30 days. One patient was admitted twice during the 30 days study period. We had 387 occupied bed days, i.e. a mean occupancy of 12.9 beds with an occupancy rate of 64.5%. There were 19 women and 44 men, mean age 35.8 (SD: 11.2 range 17–69). The main diagnostic category (according to ICD-10) was psychosis with 44%, followed by alcohol dependence with 33%, mania with 19% and others with 4%. The mean observation time for mania patients was 6.42 days, for psychosis patients 6.25 days, and for alcohol dependency patients 4.71.

During the study period a total of 241 aggressive incidents were reported in the ward. In 229 of those the patient was the aggressor. In six incidents a relative was reported as the aggressor, in five it was security staff and in one a ward assistant. In eight of these incidents with an aggressor other than the patient, the target was a patient, in three a relative and in one staff was targeted. Five of the incidents with aggressors other than patients could be classified as severe. Table 6.1 summarises the characteristics of the aggressive incidents with patients as aggressors.

<table>
<thead>
<tr>
<th>Aggression by patients (N = 229)</th>
<th>N</th>
<th>% of incidents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of reported incidents with patient as aggressor</td>
<td>229</td>
<td>100.0%</td>
</tr>
<tr>
<td>Number of severe incidents (scoring &gt;8 on the SOAS-RI)</td>
<td>128</td>
<td>55.9%</td>
</tr>
<tr>
<td>Number of incidents resulting in “hands-on” coercive measures(^a)</td>
<td>77</td>
<td>33.6%</td>
</tr>
</tbody>
</table>
Of the 229 incidents from patients, 128 were severe (by scoring >8). This amounts to an average of 7.6 aggressive and 4.3 severely aggressive patient incidents per day. The frequency of physical attacks by patients was 3.4 incidents per day. This results in an average of 0.59 aggressive patient incidents per occupied bed day, and 0.33 for severe incidents. The number of incidents per 100 admissions per month is 487.2. The number of patients affected by physical restraint per 100 admissions per month was 51.1. The number of aggressive incidents per 100 occupied bed days per month was 59.17. 6.20 patients were affected by restraint per 100 occupied bed days per month. Table 6.2 gives the summary of the results for all parameters from the SOAS-RI report form.

Table 6.2: Detailed description of frequency of each of the variables of SOAS-RI.

<table>
<thead>
<tr>
<th>Provocation</th>
<th>Means used by the patient</th>
<th>Target of Aggression</th>
<th>Consequences of aggression</th>
<th>Measures to stop aggression</th>
<th>People involved in measures</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N %</td>
<td>N %</td>
<td>N %</td>
<td>N %</td>
<td>N %</td>
</tr>
<tr>
<td>No understandable provocation</td>
<td>51 22.3</td>
<td>Verbal aggression</td>
<td>200 87.3</td>
<td>None</td>
<td>27 11.8</td>
</tr>
<tr>
<td>Provoked by other patient</td>
<td>19 8.3</td>
<td>Ordinary objects on ward (e.g. glasses, chair)</td>
<td>14 6.1</td>
<td>Objects targeted</td>
<td>7 3.1</td>
</tr>
<tr>
<td>Provoked by relative of the patient</td>
<td>79 34.5</td>
<td>Bodily parts (e.g. hand, foot)</td>
<td>91 39.7</td>
<td>Patient self targeted</td>
<td>17 7.4</td>
</tr>
<tr>
<td>Provoked by other relative</td>
<td>5 2.2</td>
<td>Spitting</td>
<td>21 9.2</td>
<td>Other patient targeted</td>
<td>12 5.2</td>
</tr>
<tr>
<td>Provoked by security staff</td>
<td>39 17.0</td>
<td>Dangerous objects (e.g. knifes, strangulation)</td>
<td>0 0.0</td>
<td>Relative of the patient targeted</td>
<td>129 56.3</td>
</tr>
<tr>
<td>Provoked by ward assistant</td>
<td>0 0.0</td>
<td>Other relatives targeted</td>
<td>3 1.3</td>
<td>Need for treatment of the victim by physician</td>
<td>0 0.0</td>
</tr>
<tr>
<td>Provoked by doctor/ nurse</td>
<td>7 3.1</td>
<td>Security staff targeted</td>
<td>67 29.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provoked by help with ADL</td>
<td>1 0.4</td>
<td>Ward assistant targeted</td>
<td>5 2.2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provoked by being denied something</td>
<td>68 29.7</td>
<td>Doctor/ nurse targeted</td>
<td>35 15.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provoked by required to take medication</td>
<td>14 6.1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provoked by something else</td>
<td>3 1.3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

40 (63%) patients were responsible for the 229 incidents on the wards. 24 (38%) patients were subjected to any coercive measure; out of these, 17 (27%) patients were subjected to intravenous injections. The median number of coercive measures per patient was 1. One patient was subjected to 15 intravenous injections, thus skewing the overall numbers. It is worth noting that none of the incidents were associated with the use of dangerous or
harmful objects, a significant minority of the relatives of other patients were affected by aggressive incidents (3 incidents). Only three (1.3%) of the 229 incidents led to visible injuries, none required medical treatment.

### 6.3.2 Relatives in aggressive incidents

Patients’ relatives were involved in a significant number of incidents. Patient’s relatives provoked 35% of the incidents and 2% of the incidents were provoked by another patient’s relative. In 56% of the incidents the patient’s relative was the target of the aggression, in 1% another patient’s relative was targeted. When people were involved in stopping the aggression, the patient’s relative was involved in 35% of cases, other patient’s relatives in 14%. Relatives were involved in both cases of mechanical restraint and in 81% of manual restraints. In 54% of incidents of intravenous injections, relatives were involved in helping the medical staff administer the injection.

#### Table 6.3: Unadjusted logistic regressions of independent variables, variables significant in any of the regressions.

<table>
<thead>
<tr>
<th>Dependent variable</th>
<th>“Hands-on” coercive measures</th>
<th>Intravenous coercion</th>
<th>Patient’s relative involved in measures to stop aggression</th>
<th>Doctor/nurse involved in measures to stop aggression</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Odds ratio</td>
<td>95% CI</td>
<td>P</td>
<td>Odds ratio</td>
</tr>
<tr>
<td>Provoked by required to take medication</td>
<td>NS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scores of means used by aggressor, range 0–4</td>
<td>1.51</td>
<td>1.14</td>
<td>1.99</td>
<td>0.004</td>
</tr>
<tr>
<td>Security staff targeted</td>
<td>1.81</td>
<td>1.01</td>
<td>3.27</td>
<td>0.048</td>
</tr>
<tr>
<td>Ward assistant targeted</td>
<td>NS</td>
<td>6.31</td>
<td>1.02</td>
<td>39.0</td>
</tr>
<tr>
<td>Doctor/nurse targeted</td>
<td>2.78</td>
<td>1.34</td>
<td>5.79</td>
<td>0.006</td>
</tr>
<tr>
<td>Score of consequence of aggression, range 0–9</td>
<td>1.20</td>
<td>1.10</td>
<td>1.32</td>
<td>0.000</td>
</tr>
</tbody>
</table>

* “hand-on” means that the patient was restrained by physical interventions i.e. physical restraint, mechanical restraint, intramuscular or intravenous injection.

We conducted logistic regressions; see descriptions above and Table 6.3 for the significant unadjusted results. The following aspects were statistically significant in the four adjusted models, Table 6.4:

1. If the target of the aggression was a doctor or nurse, the likelihood of any chemical or physical restraint was increased (OR: 3.10 for any restraint; OR: 4.41 for intravenous injection)
2. If the target of the aggression was a doctor or nurse, the likelihood of a relative being involved in stopping the aggression increased (OR: 3.35).

3. An increase in incident severity led to an increased likelihood of any chemical or physical restraint being used (OR: 1.21 for any restraint; OR: 1.20 for intravenous injection), but not to an increased likelihood of relatives being involved.

Table 6.4: Forward stepwise multiple logistic regressions of the unadjusted significant independent variables.

<table>
<thead>
<tr>
<th>Dependent variable</th>
<th>&quot;Hands-on&quot; coercive measures</th>
<th>Intravenous coercion</th>
<th>Patient's relative involved in measures to stop aggression</th>
<th>Doctor/nurse involved in measures to stop aggression</th>
</tr>
</thead>
<tbody>
<tr>
<td>Significant Independent variables</td>
<td>Odds ratio 95% CI</td>
<td>Odds ratio 95% CI</td>
<td>Odds ratio 95% CI</td>
<td>Odds ratio 95% CI</td>
</tr>
<tr>
<td>Doctor/nurse targeted</td>
<td>3.10 1.43 6.72</td>
<td>0.004</td>
<td>4.41 1.96 9.81</td>
<td>0.000</td>
</tr>
<tr>
<td>Score of consequence of aggression, range 0-9</td>
<td>1.21 1.11 1.33</td>
<td>0.000</td>
<td>1.20 1.09 1.34</td>
<td>0.001</td>
</tr>
</tbody>
</table>

*a"hand-on" means that the patient was restrained by physical interventions including physical restraint, mechanical restraint, intramuscular or intravenous injections.

6.3.3 Diagnostic categories

We created 3 main diagnostic categories for the Kruskal Wallis test: Psychosis (n = 28), Mania (n = 12) and Alcohol dependence (n = 21). The remaining 2 patients could not be included into any of the above categories and were therefore not included in the analyses. We found no significant difference between diagnostic categories and the frequency of incidence per day, the frequency of physical attacks on a person per day and the frequency of severe incidents per day (SOAS-RI score > 8).

We did not find any statistically significant differences between diagnostic categories and the frequency of occasions when patients’ relatives were involved in coercive measures per day. For mania, we did find a trend towards a higher frequency of intravenous injections per day (Chi square = 5.361; df = 2; p = 0.069) and the number of “hands on” coercive measures (Chi square = 5.961; df = 2; p = 0.051).

6.4 Discussion

The current study looked into the frequency of aggression, the role of relatives and coercive measures in the inpatient ward of a general hospital psychiatric unit in India. The total number of incidents appears high compared to admission wards in high income countries (Nijman, et al., 2005). It is unclear whether this is a real difference or whether
under-reporting in comparable studies from high income countries is the reason for the difference. Studies from high income countries are dependent on staff motivation to report. They therefore often focus on more severe incidents, whereas our data includes all levels of incident severity with a preponderance of low level aggression and hardly any reported injuries. This indicates that under-reporting is unlikely in our data.

In Indian government settings, admission criteria focus on the need for additional care that cannot be provided in the patient's home by the family. There is therefore a selection bias towards more severely disturbed and unmanageable behaviour as compared to high income country admission wards. Our methodology is likely to cover a higher number of occurring incidents because of our use of independent persistent observation, thus eliminating underreporting bias. The low number of visible injuries supports the high coverage of real and less severe incidents.

6.4.1 Aggression towards hospital staff

Aggression towards doctors and nurses are seen in only 15% of the incidents. This is much lower than in high income countries and probably due to the fact there are far fewer nurses on Indian wards compared to staffing levels in high income countries. The low figure may also be explained by the fact that the patients’ relatives spend more direct time with the patient than staff (RCPsych, 2007). We have shown in a study from North Wales that direct contact time with patients is directly correlated with increased exposure to aggression and violence (Lepping, et al., 2013). Alas, the most striking observation in our study is about the patients' relatives. Relatives provoked about 35% of the incidents and were commonly involved in controlling aggression by either talking to the patient or participating in coercion. More severe aggressive incidents and attacks on nursing and medical staff are more likely to lead to coercive measure than incidents targeting relatives. This opens up questions about how to best minimise risk to relatives whilst they are caring for the patients on the wards. Relatives were more likely to get involved when such incidents occurred, thus effectively becoming members of the nursing team. Furthermore, our data shows that most interventions are reactive rather than proactive. Recent evidence-based measures to predict and reduce aggression and restrictive coercive practices on psychiatric wards could be adapted to reduce risk to relatives and staff as well as the reactive use of coercion (Abderhalden, et al., 2008; van de Sande, et al., 2011). These observations may become very relevant to psychiatric practice in high income countries too, as more relative involvement is considered in dementia care. Questions
about how to protect, but also how to potentially train relatives in order to have safe and meaningful involvement in the patient's care remain, and strategies need to be developed to facilitate good outcome.

6.4.2 Relatives of the patients in the ward

The other key outcome of the present study is the report of the role of the patient's relative in aggression as well as its management in acute psychiatric in-patient settings. Some possible explanations for our results are:

1. The obligation of caring for the patients partially shifts unknowingly and unintentionally from the nursing staff to the relatives. This shifts the target of aggression from the medical staff towards the relatives, who thus act as buffers.

2. The same change of obligation of caring increases the participation of relatives in coercive measures.

3. Relatives presence on the ward in acutely disturbed psychiatric patients may in itself increase aggressive incidents.

The presence of relatives on the ward therefore presents challenges and opportunities for the nursing and caring of the patient. Whilst on the one hand, the risk to relatives of being victims of violence has to be addressed, the presence of non-professional care givers on the other hand opens up the opportunity for continuous psycho-education and treatment once the patient has been discharged, taking into account the risk of violent altercations after discharge. This potentially allows for intense treatment to continue at home, led by family members, supervised and guided by staff. This may reduce risk of violence in the long term. Further studies are needed to examine the dynamics of the presence of relatives in relation to violence and coercion using a qualitative approach. Psycho-educational interventions could be investigated. This can include options hitherto not considered in high income countries.

6.4.3 Strengths and limitations

The current study has significant methodological strengths. This is the first ever study reporting of non-professional care giver involvement in hospital care. It is one of the first studies to incorporate an independent and consistent observer rating, giving a consistency in reporting. We believe, though this research method is resource intensive, it is unbiased as the observers are very rarely part of the violence or coercion, thus ensuring neutrality
and objectivity. It also prevents biased underreporting which is a basic methodological problem with the widespread use of the SOAS-R, staff reporting system. Also, we believe that the psychiatric ward in Mysore is typical of general hospital psychiatric units in middle and low-income countries in Asia. We therefore believe that the findings are generalisable to settings in the Indian subcontinent and beyond.

**Acknowledgements**

The authors acknowledge the inputs by Dr Manoj Mutalik, Dr Manjushree, Dr Melvin D’Souza, Dr Mohan Kumar Notagar, Dr Merin Babu, Dr Nagaraj Moger, and Dr Mohammed Shihab as non-interacting observers in the ward.

**Appendix A.**

Report form SOAS-R/Indian

<table>
<thead>
<tr>
<th>Category of aggressor:</th>
<th>Patient</th>
<th>Relative, if relative, relative to what patient?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Gender of aggressor:</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
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<table>
<thead>
<tr>
<th>Ward:</th>
<th>Male</th>
<th>Female</th>
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<tbody>
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</table>

<table>
<thead>
<tr>
<th>Date:</th>
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</table>

<table>
<thead>
<tr>
<th>Time:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>PROVOCATION</th>
<th>MEANS USED BY THE AGRESSOR</th>
<th>TARGET OF AGGRESSION</th>
<th>CONSEQUENCES FOR TARGET OF AGGRESSION</th>
<th>MEASURES TO STOP AGGRESSION</th>
<th>PEOPLE INVOLVED IN MEASURE(S)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No understandable provocation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PROVOKED BY:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other patient</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relative of the patient</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Other relative</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Security staff</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ward assistant</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doctor/Nurse</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Help with activities of daily life</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Being denied something</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient required to take medication</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (specify)</td>
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</table>

<table>
<thead>
<tr>
<th>OBJECTS:</th>
<th>Damaged, no need for replacement</th>
<th>Damaged, need for replacement</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>None</td>
<td>Talking to patient</td>
</tr>
<tr>
<td></td>
<td>None</td>
<td>Per oral medication</td>
</tr>
<tr>
<td></td>
<td>None</td>
<td>Intravenous medication</td>
</tr>
<tr>
<td></td>
<td>None</td>
<td>Mechanical restraint</td>
</tr>
</tbody>
</table>

<table>
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<tr>
<th>PERSONS:</th>
<th>Felt threatened</th>
<th>Felt short pain &lt; 10 min</th>
<th>Felt prolonged pain &gt; 10 min</th>
<th>Visible injury</th>
<th>Need for treatment of injury</th>
<th>Need for treatment by physician</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>PARTS OF AGGRESSOR’S BODY</th>
<th>Hand (e.g. hitting, punching)</th>
<th>Foot (kicking)</th>
<th>Teeth (biting)</th>
<th>Spitting</th>
<th>Other (specify)</th>
<th>Other person (specify)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>DANGEROUS OBJECTS OR METHODS</th>
<th>Knife</th>
<th>Strangulation</th>
<th>Other (specify)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
<td></td>
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</tbody>
</table>
References


Part II

- Clinical Correlates and Predictors of Perceived Coercion among Psychiatric Inpatients: A prospective pilot study

- Perceived Coercion in Persons with Mental Disorder in India: A cross-sectional study

- Staff and Caregiver Attitude to Coercion in India
Chapter 7: Clinical Correlates and Predictors of Perceived Coercion among Psychiatric Inpatients: A prospective pilot study

ABSTRACT

Background:

The current Mental Health Care Bill (MHCB) –2013 in India advocates least restrictive alternatives (LRA) in psychiatric treatment. However, we have little evidence on patient’s perspectives of coercion and LRA.

Methodology:

This was a hospital-based prospective pilot study. 170 subjects chosen by computer-generated random number sampling were screened. In 83 eligible subjects, all assessments including coercion assessment were completed within 3 days of admission and in 75 subjects reassessment was done within 3 days of discharge.

Results:

Perceived coercion as measured by the MacArthur Perceived Coercion Scale (MPCS) decreased significantly from 3.72 _ 1.98 at admission to 1.77 _ 1.8 (<0.001) at discharge. This was accompanied by significant increase in global functioning, insight score (from 1.5 _ 1.0 to 3.8 _ 1.1; p < 0.001) and as well as decrease in symptom severity (CGI-S) (from 5.9 _ 1.1 to 1.8 _ 1.9; p < 0.001). Coercion is predicted by family type, employment status, socio-economic status, severity of illness and level of insight. 87% patients reported that their admission was justified even though many felt coerced during hospital stay.

Conclusion:

Coercion is a dynamic state and changes with treatment and care. Clinical care may result in an improvement in global functioning, insight as well as in reduction in severity of illness consequently leading to less coercion. During the
time of discharge, majority of patients reported that their admission was justified, even though they felt coerced during hospital stay and agreed for treatment against their will within a safe, standardised coercive practice.

7.1. Introduction

Coercion is a subjective inner experience of a particular intervention performed against a person’s will, either through force or through threat of force. Ideally, no person should be coerced into treatment (Fears & Hackman, 2009). Use of coercive practice in mental health care has to balance between four different ethical issues representing interests, which are often controversial such as respect of the autonomy of patient, beneficence, non-maleficence and justice.

Perceived coercion has been studied in many of developed countries. Studies have shown that perceived coercion may be influenced by several socio demographic and clinical variables, such as higher age, being single, female sex and ethnicity (Rain, et al., 2003; Swartz & Swanson, 2004; Bindman, et al., 2005; Anestis, et al., 2013). In addition, diagnosis of psychotic illness, substance abuse problems, recent sexual abuse, poor insight, low scores on measures of functioning and more symptoms severity (eg. CGI –S) predicted a higher level of perceived coercion (Bindman, et al., 2005; Kjellin, et al., 2006; O’Donoghue, et al., 2014). Contrary to these findings, some studies have shown no clear influence of patient related variables on perceived coercion (Poythress, et al., 2002; Kjellin, et al., 2006; Sheehan & Burns, 2011). Individuals with hostile-dominant interpersonal style were also known to have higher levels of perceived coercion (Anestis, et al., 2013). Involuntarily admitted patients tended to perceive higher levels of coercion when compared with voluntarily admitted ones (Rain, et al., 2003; O’Donoghue, et al., 2014) though not exclusively as was shown by higher levels of coercion among those with severe psychotic symptoms (O’Donoghue, et al., 2014). Social factors like being admitted under reception order or by legal force also appeared to be important predictors of coercive treatment (Lidz, et al., 1998). Among prison populations, a higher perceived coercion was related to recent sexual abuse, having a drug charge, old age, males and higher symptoms severity (Cusack, et al., 2010). Patient under voluntary admission who perceived coercion had poor prognosis when compared with those admitted involuntarily who perceived coercion (Steinert, et al., 2010). Perceived coercion significantly decreased with improvement in global functioning and decrease in positive symptoms (Fiorillo, et al.,
Anestis, et al., 2013) and did not predict engagement with follow-up (Bindman, et al., 2005). Among prison populations, a higher perceived coercion was related to recent sexual abuse, being charged by drug-related issue, old age, males and higher symptoms severity (Cusack, et al., 2010).

In the Indian health context, society values medical and social paternalism more than individual autonomy. The family structure like belonging to nuclear, extended or joint family plays an important role by treatment of mentally ill person. The head of family makes decisions about treatment of beloved ones suffering from mental illness. Majority numbers of family members are responsible of supporting the patients by providing economical and psychological support in addition to staying with them during hospitalisation. The Indian Mental Health Act 1987 under Chapter IV Part II: No.19 also supports the family to admit the mentally ill person, who does not, or is unable to, express his/her willingness for admission as a voluntary patient (MHA, 1987). These are important protective factor for In India to treat person with mental illness. As such, absence of family support is expected to be a factor negatively associated course and outcome of mental illness.

In short, perceived coercion was found to be influenced by various socio demographic, clinical and social factors. It tended to improve during inpatient care and was predicted by parallel changes in insight, symptom severity and global functioning. In contrast, this issue has received relatively less research attention in developing countries. This is especially important in the background of the Mental Health Care Bill – 2013[MHCB-2013] of India that seeks for psychiatric treatment in least restrictive settings with provision for the least restrictive alternatives. Culturally relevant information could emanate from such a study and inform clinicians, patients, families and policy makers alike [MHCB-2013]. With this in mind, we set out to assess the clinical correlates and predictors of perceived coercion among psychiatric inpatients at two points in time: soon after admission and just before discharge.

The study was carried out at the Department of Psychiatry at NIMHANS. This psychiatric hospital is one of the oldest and largest in South East Asia, providing mental health service for more than 60 years through Outpatient Clinics and Inpatient Services. The Department has a large inpatient set-up with 550 beds, a De-addiction Service, a Family Psychiatric Centre, legal aid service and a Psychiatric Rehabilitation Day Care Centre. It caters a majority of both urban and rural population of south India and other parts of India. The catchment area may be estimated above 15 million inhabitants. In our Inpatient Services, commonly a family member has to stay in the ward to take care of the patient, which
implies double costs as they often miss an important provider of income. During ward stay, Family members were involved in persuasive and coercive treatment procedures like surreptitious treatment, involuntary medication and physical restraints. We report findings from a study investigating performed and perceived coercion. Main questions were:

1. Which coercive measures were taken?
2. What was the perceived coercion at admission and at discharge?
3. Which patient and contextual characteristics were related to perceived coercion at admission and discharge?

7.2. Methods and materials

This study was conducted from June 2013 to January 2014 at the Department of Psychiatry, National Institute of Mental Health and Neurosciences (NIMHANS), Bangalore -29. The patients were selected through computer generated random numbers on all working days. Randomly selected inpatients (aged 18 and above) were approached with a request to participate in the study. Patients suffering from mental retardation, organic brain syndromes, delirium, dementia, developmental disorders and antisocial personality disorder were excluded from the study as some cognitive ability allowing reflection on one’s own experience was required. After completely describing the study to the subjects and their relatives, written informed consent was obtained. When patients were not in a position to provide consent, their attendants/family members were requested to provide consent. The study was therefore performed in accordance with the ethical standards laid down in the 1964 Declaration of Helsinki (Declaration of Helsinki 1964). All patients were interviewed within 3 days of admission and re-interviewed within 3 days before discharge.

A sample of 170 patients were screened to enter the study. Out of 170 only 83 patients satisfied study criteria and were assessed at baseline (Fig.7.1: Flow Chart of the assessment). From the 83 selected patients 75 were re-interviewed at the time of discharge. The remaining eight patients either absconded or discharged against medical advice (DAMA).

7.2.1. Interview procedures

Apart from socio demographic details, data on the number of admission, the duration of illness and the duration of inpatient care were gathered from medical charts. Diagnosis of psychiatric disorder was made according to the ICD-10 criteria by using Mini International
Neuropsychiatric Interview (MINI 5.0) [MINI; Sheehan et al. (1998)]. A Clinical Global Impression (CGI) was used to assess illness severity and the global improvement of illness (Guy, 1976). Insight was evaluated using two scales. The Insight Scale-1 measured grades of insight as full, partial or no insight, based on awareness, attribution and acceptance about illness and willingness to take treatment (Sadock & Sadock, 2007b). The Insight Scale-2 was rated on a 5-point scale with a range of responses from one (complete denial of illness) through five (True emotional insight) (Sadock & Sadock, 2007a).

![Fig. 7.1 Flow chart of assessment](image)

The initial part of the interview was open-ended. Here, the patient was encouraged to describe the process of coming to the hospital. The interview focused on the patient’s perceptions of

1. Coercion in the admission decision,

2. Perception of being pressurised during hospital stay,
3. How others treated the patient during the process of coming to the hospital and being admitted,
4. Perception about different pharmacological and non-pharmacological treatment measures,
5. Patient's attitude towards hospitalisation.

The second part of the interview included structured questions with predetermined answer sets. The MacArthur Admission Experience Survey (MAES) covered perceived coercion among other admission experiences such as reason of admission, underwent coercion, pathway to care and various received treatment modules in the Admission Experience Interview.

The MacArthur contains four subscales covering a) perceived coercion (MPCS), b) negative pressure c) voice and d) affective reaction. The scale has a good internal consistency with respect to variation in site, instrument format, patient population, and interview procedure (Gardner et al., 1993). In the current study, The Perceived Coercion Scale (MPCS) was also dichotomized. Scores of “0” were classified as “no perceived coercion” and scores of “1, 2, 3, 4, and 5” were classified as “perceived coercion present”. Four patient groups were identified allowing a contrast analysis, on behalf of the cut-off perceived coercion before and after treatment: not feeling coerced at all, coerced before not after, coerced after not before and feeling coerced before and after.

The coercion ladder (Cantrill, 1965) was rated on a 100-point visual analogue scale, from zero corresponding to “no coercion” to hundred being “maximal coercion”. Finally, a semi-structured interview was used to assess perception of different pharmacological and non-pharmacological treatment measures during the hospital stay. All above scales and questionnaires were used at admission and re-assessed at discharge.

7.2.2. Ethical considerations

The study was approved by Institutional Ethical Committee (IEC) of National Institute of Mental Health And Neuro Sciences (NIMHANS), Bangalore approved the study; Sl.No:03, Behavioural Sciences/NIMH/DO/SUB-COMMITTEE/2013, dated 01/06/2013.

7.2.3. Statistical analysis
Statistical analysis was performed using the level of statistical significance set at p < 0.05. Clinical and socio-demographic characteristics were analysed by descriptive statistics. Independent sample-t test and paired samples-t test were used to assess continuous variables. Chi-square and Mc-Nemar’s test were used to assess discrete variables. Differences between perceived coercion at admission and discharge were investigated by calculating residual gain (Steketee & Chambless, 1992; RG = Z2-Z1 * r1, 2; where Z = standardised z-score and r1, 2 = correlation between measurement 1 and 2). Binary logistic as well as linear regression models were used to determine predictors of coercion, comparing no coercion to any level of perceived coercion. The regression analysis was performed using stepwise forward and backward procedures. Each item was analysed separately and then fitted into the model. Interaction effects and collinear ties were checked for all significant main factors. Variable selection was based on likelihood ratio tests and model fit was assessed using McFadden pseudo R2 and plots of deviance residuals (McFadden, 1974). The final model was selected using variables contributing to the model according to the criteria of Hosmer and Limeshow (Hosmer & Limeshow, 2013). According to this procedure, variables with a p-value in of less than 0.2 remain in the final model. In all forced entry regression models, model fit was inspected. The final model was identified when between several steps of the de-escalation procedure the log likelihood parameter did not further decrease. Outcome of basic statistics as well as detailed listing of all modelling steps is available upon request from the second author. When appropriate, this analysis was also performed stratified over diagnostic categories. Two outcome variables were identified:

1. Perceived coercion above cut-off at admission and at discharge,
2. Change in as well as residual gain of perceived coercion between admission and discharge,
3. Results

The mean age of subjects was 33.0 (±10.7) years, mean of years of education was 9.66 (±4.67), 56.6% (n = 47) were males, 48.2% (n = 40) were married, 83.1% (n = 69) were from nuclear family, 62.7% (n = 52) earned below poverty line (BPL), 92.1% (n = 76) were never employed or unemployed following illness, 50.6% (n = 42) were from rural background. In 88% (n = 73) of the sample major mental illness like schizophrenia 43.4% (n = 36), bipolar disorder 32.5% (n = 27) and depression 12% (n = 10) were diagnosed. As much as 75.9% (n = 63) were admitted involuntarily. Only 20.5% (n = 17) were willing to stay. Almost all of the patients were marked to severely mentally ill. Mean CGI Severity
score at admission was 5.8 ± 1.2, 50.6% (n = 42) were severely ill and 25.3 % (n = 21) extremely ill. 73.5% (n = 61) had an absent insight at admission. 70% of the patients received some form of coercive measures during hospital stay. Chemical restraint was the most often imposed measure with 58% (n = 48), followed by orally administered involuntary medication (24%, n = 20), physical restraint (20%, n = 17), ECT (15%, n = 12), and seclusion by shifting in to closed ward (12%, n = 10).

Fig. 7.2 presents standardised observed differences in perceived coercion, CGI symptoms severity (CGI -S) and subjective coercive experiences between admission and discharge. As shown in the figure, from admission to discharge, there was an improvement in insight scores and illness severity and a decrease in all domains of coercion, both the total score as well as the domain scores. Perceived coercion decreased from 3.72 ± 1.98 to 1.77 ± 1.8 (p < 0.001). Subjective coercion scores decreased from 62.8 ± 3.6 to 13.5 ± 16 (p < 0.001). Insight score increased from 1.5 ± 1.0 to 3.8 ± 1.1 (p < 0.001). CGI–(S) symptoms severity decreased from 5.9 ± 1.1 to 1.8 ± 1.9 (p < 0.001). These differences were also reflected in several other questions. For example, 69% felt admitted against their will at admission, while only 16% felt admitted against their will at discharge. In addition, 58% felt treated against their will at admission, against 11% at discharge. All scores were significantly different. Perceived coercion at admission also showed to be related to insight (r = 0.43, p < 0.000) and CGI–S (r = 0.27, p < 0.000), where it proved to be inversely related to CGI-S at discharge (r = -0.356, p < 0.000).

Fig. 7.2. Standardised differences on CGI, insight, perceived coercion and subjective coercion experiences between admission and discharge Legend:
1. MPCS: Mcarthur perceived coercion scale score z-score standardised between 1 and 0
2. Insight scale score z-score standardised between 1 and 0
3. CGI Severity score z-score standardised between 1 and 0
4. Subjective coercion experiences like coerced admission, coerced medication, coerced treatment, coerced sedation, coerced sedation scores were (Z-score) standardised between 1 and 0.
5. Restriction of autonomy score z-score standardised between 1 and 0
6. Restriction of interpersonal relationship (contact) (IPR) score z-score standardised between 1 and 0
7. Restriction of dignity score z-score standardised between 1 and 0.

Subjects were assessed for subjective coercive experiences during the first 3 days of inpatients care. Here, above 50% of the subjects felt coerced in most domains, such as admitted against their will by 69%, treated against their will by 58%, sedated by 53%, 63% felt isolated, 63% felt they were restricted in interpersonal contact and 65% felt their autonomy was taken away. 44% felt heavily medicated and 44% felt their dignity was taken away. At discharge, respondents felt coerced in less than 20% in all domains. Even though many patients experienced some way of coercion, a vast majority agreed with treatment at discharge. Here, 87% reported their own admission was justified even if they felt coerced during hospital stay and as many as 73% felt it was right to treat any patient against his/her will. In addition, 67% felt that use of physical and chemical coercive measures at hospital are justifiable in acute emergency clinical services.

Tables 7.3 and 7.4 presents the baseline characteristics of the sample and their response to major issues in coercion compared to perceived coercion either at admission or at discharge, according to the four groups depicted in the methods section. It may be observed no background characteristics were distributed differently when the categories being coerced at admission or at discharge were compared. Willingness to stay, legal status, insight, care pathway, having been a risk to others and various coercion measures as may be expected did spread differently between the various categories presented.

Table 7.5 presents the findings of a logistic regression analysis comparing having felt coerced before and after to all other categories. The analysis showed having (employed) work and full insight were negatively related to Coercion. Being from a joint family or extended family, being of a higher social economic status were positively related to perceived coercion. Care pathway did not predict having felt coerced, implying this to be a confounder of these variables.

Table 7.7 presents the association between several characteristics and the difference (residual gain) between perceived coercion at admission and at discharge. Having work, not being married, inability to care for oneself before admission, being admitted against
will, having had bipolar or substance use disorders (alcohol, cannabis, or poly substance
use disorder), and having received chemical restraint proved to be associated to the
change in perceived coercion as expressed in the residual gain.

7.4. Discussion

This study was conducted at a psychiatric facility, which is one among the largest and
oldest government run facility. The study provides one of the first empirical data on
coercive measures in India. Main goal of the study was to investigate what coercive
measures occurred at the ward and how these were related to patient characteristics,
symptoms and perceived coercion.

In our study, physical, subjective and perceived coercion was highly prevalent at
admission. All this forms of coercion had decreased significantly at discharge when
compared to admission. This statistically significant decrement perceived coercion showed
a correlation to an improvement in insight scores, a reduction in symptoms severity by the
CGI–S, as well as an improvement in global functioning by the CGI–GI. This finding was
similar with studies in European samples (Fiorillo, et al., 2012; Anestis, et al., 2013)

A more important, interesting and surprising finding was, whilst most patients underwent
coercive treatment and experienced coercion during hospital stay, a majority felt their
admission was justifiable. The same majority of patients also felt that use of the physical
and chemical coercive measures was justifiable in acute emergency clinical services.
These findings were justifiable treat patient involuntarily (who doesn't have capacity to
consent for treatment) under beneficence, non-maleficence and justice of ethical ground
and temporary neglecting patient’s autonomy.

In uni-variate analysis, none of the background characteristics such as socio demographic
and clinical characteristics showed any association to perceived coercion at admission or
discharge. However, in multivariable analyses, perception of feeling coerced throughout
admission was associated with not having work, absent insight at admission, an extended
family rather nuclear family and being of a higher socio economic status. The decrease in
perceived coercion between admission and discharge was associated to unemployment,
marrried, inability to care for oneself, having had bipolar disorders or substance use
disorder, and having received chemical restraint. These detected associations are
remarkable, especially when we consider the relatively small sample size. However,
future study on larger samples is necessary for the better understanding of these detected
associations. The findings of this study confirm to some extent findings from the literature showing several variables to be related to perceived coercion (Bindman, et al., 2005; Rain et al., 2003; Swartz & Swanson, 2004; Anestis, et al., 2013; O'Donoghue, et al., 2014). In short, work, Socio Economic Status, marital status, family type, absent insight, severe illness episode or exacerbation showed an association to coercion. It also confirms the recent notion the extended or the transitional family may provide more support (Chadda & Deb, 2013) and therefore is related to less perceived coercion.
Perceived coercion and subjective coercive experiences tend to improve over time in our findings. This can be partly explained by either recall bias effect within a patient (Hassan, 2005) or patients may forget the coercion they had perceived in hospital, while feeling better. On the other hand, the positive effects of treatments during hospitalisation may influence coercion perception. In addition, other explanations could be a decrease in

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**Table 1**

Baseline characteristics and patient responses by being coerced (Perceived coercion).

<table>
<thead>
<tr>
<th></th>
<th>Perceived coercion before and after admission</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Totals</td>
</tr>
<tr>
<td>N=75</td>
<td>75</td>
</tr>
<tr>
<td>Age in years</td>
<td>33.6</td>
</tr>
<tr>
<td>Male sex</td>
<td>57%</td>
</tr>
<tr>
<td>Kannada Language</td>
<td>84%</td>
</tr>
<tr>
<td>Employed</td>
<td>12%</td>
</tr>
<tr>
<td>Hindu religion</td>
<td>89%</td>
</tr>
<tr>
<td>Nuclear family</td>
<td>81%</td>
</tr>
<tr>
<td>SES (APL = 20000 rupees/year)</td>
<td>39%</td>
</tr>
<tr>
<td>Married and living together</td>
<td>48%</td>
</tr>
<tr>
<td>Rural background</td>
<td>49%</td>
</tr>
<tr>
<td>Disorder</td>
<td>44%</td>
</tr>
<tr>
<td>Psychotic</td>
<td>44%</td>
</tr>
<tr>
<td>Affective</td>
<td>44%</td>
</tr>
<tr>
<td>Others</td>
<td>12%</td>
</tr>
<tr>
<td>Past admission</td>
<td>52%</td>
</tr>
<tr>
<td>Willingness to stay in months</td>
<td>77.5</td>
</tr>
<tr>
<td>Unwilling</td>
<td>67%</td>
</tr>
<tr>
<td>Ambivalent</td>
<td>13%</td>
</tr>
<tr>
<td>Willing</td>
<td>20%</td>
</tr>
<tr>
<td>Having legal case</td>
<td>12%</td>
</tr>
<tr>
<td>Absent Insight</td>
<td>75%</td>
</tr>
<tr>
<td>Care pathway (1st Contact to care)</td>
<td>22%</td>
</tr>
<tr>
<td>NIMHANS</td>
<td>37%</td>
</tr>
<tr>
<td>Faith healer</td>
<td>37%</td>
</tr>
<tr>
<td>Non-allopathic practice</td>
<td>3%</td>
</tr>
</tbody>
</table>

(Perceived coercion: No=0, Present=1–5 score in MPCS Scale).

---

**Table 2**

Baseline characteristics and patient responses by being coerced (Perceived coercion).

<table>
<thead>
<tr>
<th></th>
<th>Totals</th>
<th>No coercion begin &amp; end</th>
<th>Begin coercion end not</th>
<th>End coercion begin not</th>
<th>Begin and end coercion</th>
<th>Sig difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>N=75</td>
<td>75</td>
<td>11</td>
<td>2</td>
<td>18</td>
<td>44</td>
<td>n.s.</td>
</tr>
<tr>
<td>Risk to</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self</td>
<td>83%</td>
<td>64%</td>
<td>100%</td>
<td>94%</td>
<td>82%</td>
<td>n.s.</td>
</tr>
<tr>
<td>Others</td>
<td>56%</td>
<td>18%</td>
<td>100%</td>
<td>72%</td>
<td>57%</td>
<td>p &lt; 0.05</td>
</tr>
<tr>
<td>Health hazard problems</td>
<td>47%</td>
<td>36%</td>
<td>50%</td>
<td>50%</td>
<td>50%</td>
<td>n.s.</td>
</tr>
<tr>
<td>Inability to care for self</td>
<td>49%</td>
<td>27%</td>
<td>50%</td>
<td>50%</td>
<td>50%</td>
<td>n.s.</td>
</tr>
<tr>
<td>Risk to property</td>
<td>28%</td>
<td>-</td>
<td>50%</td>
<td>28%</td>
<td>34%</td>
<td>n.s.</td>
</tr>
<tr>
<td>Coercion - Physical restraint</td>
<td>21%</td>
<td>-</td>
<td>72%</td>
<td>27%</td>
<td>25%</td>
<td>n.s.</td>
</tr>
<tr>
<td>Chemical restraint</td>
<td>59%</td>
<td>-</td>
<td>100%</td>
<td>66%</td>
<td>63%</td>
<td>p &lt; 0.05</td>
</tr>
<tr>
<td>ECT</td>
<td>10%</td>
<td>18%</td>
<td>50%</td>
<td>11%</td>
<td>16%</td>
<td>n.s.</td>
</tr>
<tr>
<td>Seclusion (closed ward care)</td>
<td>13%</td>
<td>-</td>
<td>100%</td>
<td>22%</td>
<td>32%</td>
<td>n.s.</td>
</tr>
<tr>
<td>Involuntary medication</td>
<td>25%</td>
<td>-</td>
<td>50%</td>
<td>22%</td>
<td>26%</td>
<td>p &lt; 0.001</td>
</tr>
<tr>
<td>No coercive experience</td>
<td>28%</td>
<td>72%</td>
<td>-</td>
<td>22%</td>
<td>26%</td>
<td>p &lt; 0.001</td>
</tr>
<tr>
<td>Admitted against will</td>
<td>68%</td>
<td>9%</td>
<td>100%</td>
<td>72%</td>
<td>80%</td>
<td>p &lt; 0.001</td>
</tr>
<tr>
<td>ECT or medication given against will</td>
<td>52%</td>
<td>-</td>
<td>100%</td>
<td>50%</td>
<td>64%</td>
<td>p &lt; 0.005</td>
</tr>
<tr>
<td>Sedation was given against will</td>
<td>52%</td>
<td>-</td>
<td>100%</td>
<td>44%</td>
<td>65%</td>
<td>p &lt; 0.005</td>
</tr>
<tr>
<td>I want to leave hospital now</td>
<td>77%</td>
<td>18%</td>
<td>50%</td>
<td>83%</td>
<td>91%</td>
<td>p &lt; 0.001</td>
</tr>
<tr>
<td>I will receive treatment at home</td>
<td>50%</td>
<td>4%</td>
<td>100%</td>
<td>67%</td>
<td>53%</td>
<td>p &lt; 0.001</td>
</tr>
<tr>
<td>Admission justified</td>
<td>80%</td>
<td>55%</td>
<td>100%</td>
<td>100%</td>
<td>88%</td>
<td>p &lt; 0.005</td>
</tr>
<tr>
<td>Total against will of patient is acceptable</td>
<td>67%</td>
<td>55%</td>
<td>50%</td>
<td>94%</td>
<td>61%</td>
<td>p &lt; 0.001</td>
</tr>
<tr>
<td>Coercion is acceptable in treatment</td>
<td>73%</td>
<td>63%</td>
<td>100%</td>
<td>72%</td>
<td>74%</td>
<td>n.s.</td>
</tr>
<tr>
<td>Accepted Advanced directives for future</td>
<td>78%</td>
<td>81%</td>
<td>50%</td>
<td>89%</td>
<td>74%</td>
<td>p &lt; 0.005</td>
</tr>
<tr>
<td>Insight at admission</td>
<td>1.3</td>
<td>2.8</td>
<td>21</td>
<td>18</td>
<td>20</td>
<td>n.s.</td>
</tr>
<tr>
<td>Insight at discharge</td>
<td>3.8</td>
<td>4.2</td>
<td>4.5</td>
<td>3.8</td>
<td>3.7</td>
<td>n.s.</td>
</tr>
<tr>
<td>Duration of inpatient care</td>
<td>19</td>
<td>16</td>
<td>21</td>
<td>18</td>
<td>20</td>
<td>n.s.</td>
</tr>
<tr>
<td>CGI - Severi at admission</td>
<td>5.9</td>
<td>5.1</td>
<td>6.1</td>
<td>5.8</td>
<td>6.1</td>
<td>n.s.</td>
</tr>
<tr>
<td>CGI - Improvement at discharge</td>
<td>1.7</td>
<td>2.2</td>
<td>1</td>
<td>1.5</td>
<td>1.7</td>
<td>n.s.</td>
</tr>
</tbody>
</table>

(Perceived coercion: No=0, Present=1–5 score in MPCS Scale).

*Chemical restraint = Intravenous/intra muscular administrations of Neuroleptics against the patient will.
severity of symptoms, and improvement in global functioning leading to an improved patient’s insight into the illness and consequently less perceived coercion.

To place the data in the current study in an international perspective we may note in this Indian psychiatric hospital, a vast majority of the patients admitted were severely ill, had an absent insight and were admitted involuntarily by request of the family under special circumstances of MHA -1987. A majority of them received intramuscular or intravenous antipsychotics, ECT or involuntary medication during the initial part of their admission in order to control aggressive behaviour. It was observed that ECT was more often used as compared western countries. It may be due to extremely ill patient, very aggressive or suicidal nature of presentation and focussed on rapid recovery. In the ward, family members were also involved by alerting treating team (ward nurses and resident doctor)

### Table 3
Prediction of coercion (final model).

<table>
<thead>
<tr>
<th>Predictors</th>
<th>B</th>
<th>Ex (B)</th>
<th>Sig</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission justified</td>
<td>-1.0</td>
<td>0.35</td>
<td>0.19</td>
</tr>
<tr>
<td>Insight at discharge</td>
<td>-0.45</td>
<td>0.64</td>
<td>0.19</td>
</tr>
<tr>
<td>Age</td>
<td>0.05</td>
<td>0.96</td>
<td>0.12</td>
</tr>
<tr>
<td>CGI- Severity at admission</td>
<td>0.65</td>
<td>0.12</td>
<td>0.09</td>
</tr>
<tr>
<td>Other disorders</td>
<td>1.19</td>
<td>3.29</td>
<td>0.09</td>
</tr>
<tr>
<td>Married</td>
<td>1.64</td>
<td>5.16</td>
<td>0.06</td>
</tr>
<tr>
<td>Insight at admission</td>
<td>-0.81</td>
<td>0.48</td>
<td>0.05</td>
</tr>
<tr>
<td>Family type</td>
<td>1.27</td>
<td>3.57</td>
<td>0.04</td>
</tr>
<tr>
<td>Work</td>
<td>-3.01</td>
<td>0.04</td>
<td>0.02</td>
</tr>
<tr>
<td>Socio Economic Status</td>
<td>3.72</td>
<td>41.2</td>
<td>0.00</td>
</tr>
</tbody>
</table>

* Other disorders = Alcohol, cannabis, or poly substance use disorder.

### Table 4
Prediction of residual gain of perceived coercion (final model)***

<table>
<thead>
<tr>
<th>Predictors</th>
<th>Beta</th>
<th>Sig</th>
</tr>
</thead>
<tbody>
<tr>
<td>Past admission</td>
<td>0.14</td>
<td>0.19</td>
</tr>
<tr>
<td>Insight at admission</td>
<td>-0.21</td>
<td>0.10</td>
</tr>
<tr>
<td>It is right to treat against will</td>
<td>-0.19</td>
<td>0.10</td>
</tr>
<tr>
<td>Physical restraint</td>
<td>0.21</td>
<td>0.08</td>
</tr>
<tr>
<td>Reason for admission - inability to care *</td>
<td>-0.27</td>
<td>0.03</td>
</tr>
<tr>
<td>Married</td>
<td>-0.26</td>
<td>0.02</td>
</tr>
<tr>
<td>Admitted against will</td>
<td>0.29</td>
<td>0.02</td>
</tr>
<tr>
<td>Other disorders (Alcohol, cannabis, or poly substance use disorder)</td>
<td>-0.29</td>
<td>0.01</td>
</tr>
<tr>
<td>Chemical restraint</td>
<td>0.35</td>
<td>0.00</td>
</tr>
<tr>
<td>Bipolar disorder</td>
<td>0.40</td>
<td>0.00</td>
</tr>
<tr>
<td>Work</td>
<td>0.42</td>
<td>0.00</td>
</tr>
</tbody>
</table>

* RG = Standardised z-score of Perceived coercion at measure 2 minus Standardised z-score of Perceived coercion at measure one times the correlate of measure one and two, in symbols RG = Z2-Z1* r1,2.

*** Significant predictors in bold.
whenever patient shows aggressive, self-harm or erratic behaviour and were involved in providing (coerced) treatment such as, physical or chemical restraint.

In India, The Mental Health Care Bill – 2013 [MHCB-2013] advocates the duty to protect the fundamental rights, equality, security, liberty, autonomy, health, integrity and dignity of any citizen with mental illness. While on one hand the clinician needs to keep the patient’s rights on experiencing liberty this also may affect patient care and increase family caregiver burden, as well as community inconveniences and thus forthcoming danger for the patient. As such, custodial care for the mentally ill patient may be necessary where patient is risk to self, other, society or his/her own health and doesn’t have a capacity to consent for his/her treatment. During which patient is risk to self, other, society or his/her own health and doesn’t have a capacity to consent for his/her treatment. During which the clinician may need to impose coercion by neglecting temporary individual autonomy and rights.

7.5. Strengths and limitations

To the best of our knowledge, this is the first prospective study in South East Asia on clinical correlates and predictors of patient’s perceived coercion during hospital treatment. Furthermore, this is the first study where we looked at patients, family, clinician perspective on coercion, prepared, and standardised the subjective coercion experiences questionnaire. However, we focussed on the patients’ perspective in this paper. The study included all patients who are admitted which include both voluntary and involuntary admission. All patients were recruited and interviewed within the 3 days or at time of admission and assessed face-to-face interview by research student by using a validated scale for establishing clinical and coercion outcome. To assess changes, all coercion assessments were re-assessed within the 3 days or at time of discharge. Perceived coercion was also assessed on validated instruments.

The study also has some methodological limitations:

1) The study was conducted in a small number sample,

2) The Study was limited to inpatients, not included neither out patients nor a community sample,

3) Subjective bias could not be eliminated in this study,

4) The Population was predominantly from the south India, and may not reflect the completely Indian population.
5) The effects of different practices and treatment components on perceived coercion were not considered in the study.

7.6. Implications

Our study highlights about prevalence different types of coercive practice in clinical care. Decrease in coercive severity and frequency at discharge may be due the effective in-patient treatments and insight facilitation work done as part of treatment programme. It also highlights coercion as common measure and persist during discharge period, so MHC-B -2013 has to take into consideration on this aspect before implementing it. The current findings provide prevalence of perceived and physical coercion, knowledge improving coercive practice and developing treatment standardisation. A follow up of the current study on a far larger sample is underway, investigating not only patient’s perceptions, but also comparing these with professionals as well as caregivers perceptions. The findings of these studies may substantiate the development of guidelines, improve safety, develop training and support analyses on benchmarking practices and these guidelines could be developed regionally and based on evidence but especially be practical in the Indian context (Raveesh & Lepping, 2013).

Further research should explore patient’s experiences of coercion in more depth. The impact of family, clinician, staff, structure and ward-related factors, which may associated with coercion and can be reduced or controlled by specific interventions.

7.7. Conclusion

Coercion in psychiatric care is a common clinical scenario. Coercion is a dynamic state and may change treatment effect. Our study showed the majority of patients reported that their admission was justified even when they felt coerced during hospital stay. The same majority supported treatment against their will. Moreover, this pilot study underlines the need for a standardised protocol-based coercive practice, which involves taking clinical, cultural and ethical grounds into account. Hence, there is a need to consider it by MHC-B-2013 bill before implementing into legislation.

Role of funding source

None

REFERENCES


The New Mental health care bill (01.10.2013); Government of India.

The Mental Health Act -1987; Government of India.
Chapter 8: Perceived Coercion in Persons with Mental Disorder in India: A cross-sectional study

ABSTRACT

Background:

Little is known about how patients in India perceive coercion in psychiatric care.

Aims:

To assess perceived coercion in persons with mental disorder admitted involuntarily and correlate with socio-demographic factors and illness variables.

Materials and Methods:

We administered the short MacArthur Admission Experience Interview Questionnaire to all consecutive involuntary psychiatric patients admitted in 2014 in Mysore, India. Multivariate linear regression was used.

Results:

Three hundred and one patients participated. “Perceived coercion” subscale scores increased with female gender, nuclear family status, Muslim and Christian religion, lower income, and depressive disorder. It decreased with former coercion, forensic history, and longer illness duration. Drug use increased total scores; the extended family item decreased them. “Negative pressure” increased with male gender, extended family, lower income, forensic history, and longer illness duration.

Conclusions:

The study shows perceived coercion is a reality in India. Levels of perceived coercion and the populations affected are similar to high-income countries.

Key words:
Coercion, mental health, subjective perception
8.1 INTRODUCTION

Psychiatry is an area of medical practice where coercive treatment, although controversial, is specifically sanctioned by law under limited conditions (Szmukler, 2008). Increasing patient autonomy and decreasing coercion are frequently cited goals in mental health care (Heinz, et al., 2016).

Coercive measures always involve a conflict of medical ethical principles. Medical professionals need to balance beneficence ("doing good") and nonmaleficence (avoiding harm) with the requirement to respect the patient’s autonomy to justify coercion in extreme situations (Beauchamp & Childress, 2001). This includes best interest decisions for patients who lack capacity to make autonomous decisions. Patients who lack insights into their illness are of particular concern, as they often feel particularly strongly about being coerced (Newton-Howes, 2010). In addition, patients who regain insight into their illness are far more likely to approve of coercive measures retrospectively compared to those patients who do not regain insight (Owen, et al., 2013). Furthermore, the United Nation Convention on Rights of Person with Disability promote, protect, and ensure the full and equal enjoyment of all human rights and fundamental freedom. Coercion is defined as “any action or threat of actions which compels the patient to behave in a manner inconsistent with his or her own wishes.” In a psychiatric context, the term “coercive measures” usually refer to coercive interventions occurring during hospitalization on psychiatric wards (Kalisova, et al., 2007). However, with the expansion of community care, coercion can be experienced outside hospital settings, too. Coercion classically includes seclusion, restraints, and involuntary medication, but increasingly, implied pressure to comply with treatment plans can be perceived by community patients (Burns et al., 2011), without the use of standard forms of restraint. Szmukler points out that coercion covers both compulsion and threats (Szmukler, 2015), in contrast to Wertheimer who contrasts threats and offers, with the latter not being considered coercive (Wertheimer, 1993). In emergencies, when a patient is at imminent risk of harming him/herself or others, the need for coercion is less disputed (Swartz, et al., 2002). The question is more difficult in situations which are not emergencies, but where aspects of safety or harm to health are the main consideration. Such situations commonly occur in geriatric medicine and
psychiatry. In these cases, it can be unclear whether the principle of acting in the patient’s best interest justifies the restriction of the patient’s autonomy.

Even though a controversial area at the time, the first studies on coercion were conducted as early as the 1970s and 1980s (Shannon, 1976; Toews, et al., 1984 & Carpenter, et, al., 1988). These studies from Canada and Australia showed that patients were not always aware that they had been involuntarily admitted or felt that they were denied the chance of a voluntary admission. Starting in 1988, the MacArthur Coercion Study was designed to provide information to policymakers, clinicians, patients, and family members to broaden and deepen the conversation about the appropriate role of coercion in the provision of mental health services. This was arguably the beginning of systematic research into the use of coercion (Bradford, et al., 1986; Monahan, et al., 1995 & MacArthur Research Network, 2001). It showed that a substantial percentage of psychiatric patients feel coerced in the community, especially in the United States (MacArthur Research Network, 2001). A third of patients in the United Kingdom felt coerced in the community, which is substantially less than patients in the United States (Monahan et al., 2005), but still a significant minority. At the same time, differences in mental health legislation between countries were systematically examined (Röttgers & Lepping, 1999; Kallert, et al., 2005; Salzine, et al., 2005 & Steinert, et al., 2009). These analyses showed significant differences in legislation as well as standard practice. They revealed attend toward a steady increase of the number of people detained under mental health legislation in the European Union (Salize, et al., 2005).

Furthermore, substantial differences in the prevalence of coercive measures between countries emerged (Steinert, et al., 2014 & Noorthoorn, et al., 2015). Importantly, a recent study using whole country data from Wales, Ireland, Germany, and the Netherlands obtained very comprehensive coercion data, suggesting that there are still significant differences in the type of coercion used across Europe. However, the prevalence of coercion is remarkably similar across those four countries with big differences seen between hospitals in each of the four countries surveyed. It is interesting that big differences between hospitals persist (Noorthoorn, et al., 2015 & Steinert, et al., 2015), but differences regarding the prevalence of coercion between countries with similar health economies may be fewer than previously thought (Lepping, et al., 2016). These findings may seem surprising in an era of evidence-based medicine but demonstrate the extent to which coercive measures are still based mainly on local and national traditions rather than scientific evidence.
Because the majority of the literature on coercion is from high-income countries, their findings may have limited relevance for a middle-income country such as India in terms of planning and providing mental health services. In many Indian settings, dormitories with ten or more patients in one room are standard practice in government-run psychiatric hospitals. Moreover, it is normal that one relative is expected to stay with the patient at all times to help with feeding, personal care, and supervision. This creates different perspectives on coercion compared to European or North American settings because the relative can be a trigger, target, and manager of patient aggression as well as being part of the application of a coercive measure. The prevalence of coercion is understudied in India. We know of only one study that looked at the level of coercion systematically, and which used an instrument to record violence and coercion adjusted for the Indian setting (School of Oriental and African Studies-Rhode Island) (Danivas, et al., 2016). This study found a high level of coercive measures being used on psychiatric admission wards in Mysore, South India. The Mental HealthCare Bill (MHCB-2013 in India, which is likely to be ratified in autumn 2016, advocates least restrictive alternatives in psychiatric treatment. However, there are no published studies looking into the levels of perceived coercion patients experience in India. Understanding the patient’s coercion experience will help mental health professionals to respect patient experiences and improve staff and patient capabilities to participate in quality treatment.

8.2 MATERIALS AND METHODS

8.2.1 Aim

To assess the subjective perception of coercion in involuntarily admitted patients and to relate their subjective perception of perceived coercion with sociodemographic variables such as age, gender, educational status, marital status, family size, average family income, distance from hospital, and illness variables duration of illness, diagnosis, forensic history, and former coercive interventions.

8.2.2 Sample

The study was conducted over a period of 1 year from January 1, 2014 to December 31, 2014 at the Department of Psychiatry, Krishna Rajendra Hospital, Mysore Medical College and Research Institute, Mysore, South India. The hospital is a government institution and caters primarily for the middle and lower economic classes. After obtaining informed consent, all consecutive involuntarily admitted patients were interviewed and assessed for
their coercion experience using the MacArthur Admission Experience Interview Short-form (MAEIS) at the time of discharge. Ethical approval was obtained from the Institutional Ethics Committee (MMCEC 07/15). Inclusion criteria were patient age between 18 and 65 years, any psychiatric illness, and involuntary legal status on admission. Exclusion criteria were impaired cognitive function, inability to give informed consent as prescribed by the study protocol, presence of organic brain syndrome, learning disability, dementia, developmental disorders, and voluntary admission status. Out of total 310 samples, 9 were excluded (6 did not agree to participate and 3 were having alcohol dependence syndrome who got discharged against medical advice) with final 301 participants in the study.

8.2.3 Assessments

The MAEIS (Gardner et al., 1993) is a short version interview-based questionnaire with 15 items requiring “true,” “false,” or “do not know” responses. Inter-rate reliability is 0.89, test-retest scores are 0.81, and reliability as determined by Cronbach alpha is a very good 0.77 (Cronbach, 1951). The Kannada version was translated by Central Institute of Indian Languages at Mysore (Premier Institute for translation work in India) and back-translated to English. The back-translated version was compared with the original scale. The MAEIS contains four subscales covering (a) perceived coercion, (b) negative pressure (people putting pressure on patient to come into hospital), (c) voice (i.e., ability to voice own opinion),and (d) affective reaction. The interview has good internal consistency with regard to variation in site, instrument format, patient population, and interview procedure. In the domains, perceived coercion, negative pressure, and voice; the scale consists of a sum of all items. The subscale score for affect covers four negative and two positive affects (i.e., emotional responses to admission), which are inversely coded to construct the total score. In this domain, a higher score corresponds with a more positive affect. This is contrary to all other subscales of the MAEIS.

8.2.4 Analysis

Clinical and sociodemographic characteristics of the sample were related one by one to the separate item responses as well as the scale scores by descriptive statistics. Independent sample-\(t\)-test and paired samples-\(t\)-test were used to assess relevant differences over scores by groups. Chi-square was used to assess discrete variables. Statistical analyses were performed using the level of statistical significance set at \(P < 0.001\), using the Bonferroni correction (Bonferroni, 1936). A multivariate linear regression
was performed on the MAEIS total score as well as on all subscales. Perceived coercion, negative pressure, voice, and affective reaction to hospitalization were separately analysed to identify which variables contributed more or less to perceived coercion, pressure, and voice of the patient as the most important domains of the MAEIS. Items with a $P < 0.2$ were left in the final model, following recommendations by Hosmer and Limeshow on regression analyses (Paul, et al., 2013). The multivariate linear regression included all sociodemographic and diagnostic details, and the MAEIS and its sub-scales as outcomes and confirmed the results from the univariate analysis. Here, we set the significance at 0.05 with a sample size of 301. As the multivariate linear regression corrects for interdependencies, the main conclusions should be drawn from these. We first present plain frequencies [Table 1], followed by interview and subscale mean scores and univariate standardised beta and the final model betas [Table 2]. The significant final model betas represent the predictors. The explained variance of the model identifies to what extent the included variables explain outcome. In health care, an explained variance of above 15% is valued reasonable and above 30% as good (Achen, 1982).

8.3 RESULTS

In our study, 301 involuntarily admitted patients participated in the study. Two hundred and fourteen (71%) were male, 146 (49%) were under 35 years, 142 (47%) between 35 and 55 years, and only 13 (4%) between 55 and 65 years. One hundred and seventy-nine (64%) belonged to a nuclear family, 169 (58%) had a family income of 50,000–100,000 Indian Rupees a year (in September 2016), and 162 (59%) were Hindu. Eighty-nine (30%) patients were admitted with a substance misuse disorder, 65 (23%) with psychosis, 67 (25%) with depression, and 35 (13%) with a bipolar disorder. Two hundred and thirty-five (85%) had an illness duration of 1–10 years, 202 (73%) had past experiences with coercion, and 46 (16%) had a forensic history, i.e., having been in contact with either police or the court.
| Item description percentage true is presented | <25 | 25-55 | >55 | Male | Female | Nicker | Extended | Hindu | Muslim | Christian | ≤10 | 11-40 | >40 | Yes | No | No | Yes | <1 | 2-10 | >10 |
|-----------------------------------------------|-----|-------|-----|------|-------|--------|----------|-------|--------|-----------|-----|--------|-----|-----|---|---|---|---|-----|-----|-----|
| I felt free to do what I wanted about coming into the hospital | 61  | 66    | 56  | 63   | 59    | 66     | 74       | 35    | 57     | 61        | 60  | 51     | 19  | 32  | 59 | 45 | 54 | 46 | 49 | 67 | 11  | 57  | 74  |
| People tried to force me to come into the hospital | 52  | 43    | 62  | 39   | 57    | 35     | 48       | 38    | 52     | 39        | 66  | 61     | 60  | 51  | 19 | 32 | 59 | 45 | 54 | 46 | 49 | 67 | 11  | 57  | 74  |
| I had enough chance to say I wanted to come in the hospital | 43  | 45    | 42  | 39   | 53    | 26     | 42       | 39    | 54     | 71        | 24  | 50     | 32  | 56  | 38 | 49 | 49 | 30 | 42 | 48 | 32 | 48 | 27 |
| I chose to come into the hospital | 57  | 60    | 53  | 62   | 54    | 64     | 64       | 44    | 48     | 75        | 62  | 61     | 62  | 81  | 76 | 46 | 75 | 62 | 45 | 58 | 51 | 75 | 57 | 27 |
| I got to say what I wanted about coming into the hospital | 64  | 68    | 59  | 69   | 60    | 73     | 70       | 52    | 57     | 71        | 72  | 67     | 33  | 75  | 94 | 88 | 53 | 78 | 67 | 55 | 65 | 56 | 72 | 65 | 38 |
| Someone threatened me to get me to come into the hospital | 28  | 26    | 31  | 23   | 34    | 14     | 25       | 35    | 32     | 18        | 27  | 24     | 45  | 24  | 0  | 18 | 37 | 10 | 27 | 31 | 26 | 41 | 11 | 30 | 48 |
| It was my idea to come into the hospital | 58  | 68    | 48  | 54   | 55    | 66     | 67       | 41    | 51     | 75        | 62  | 47     | 29  | 71  | 75 | 76 | 48 | 75 | 63 | 44 | 59 | 50 | 80 | 57 | 28 |
| Someone physically tried to make me come into the hospital | 35  | 25    | 45  | 31   | 41    | 19     | 27       | 50    | 41     | 18        | 35  | 33     | 59  | 26  | 14 | 12 | 48 | 15 | 33 | 40 | 67 | 54 | 9  | 36 | 74 | 114 |

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<td>Totals</td>
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<td>I was threatened with commitment</td>
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<tr>
<td>They said they would make me come into the hospital</td>
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<tr>
<td>No one tried to force me to come into the hospital</td>
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<tr>
<td>My opinion about coming into the hospital did not matter</td>
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<tr>
<td>I had a lot of control over whether I went into the hospital</td>
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<td>I had more influence than anyone else whether I came in the hospital</td>
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Contd...
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<td>Sad at admission</td>
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<td>Pleased at admission</td>
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<td>Relieved at admission</td>
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<td>Confused at admission</td>
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<tr>
<td>Frightened at admission</td>
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*Percentages expressed in bold figures are statistically significantly different across categories at P<0.001 using Bonferroni correction.
<table>
<thead>
<tr>
<th>Categories within the independent variables</th>
<th>Mean scores MacArthur</th>
<th>MacArthur total score</th>
<th>Perceived coercion</th>
<th>Negative pressure</th>
<th>Voice</th>
<th>Affect</th>
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Table 2: Contd...

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<th>Categories within the independent variables</th>
<th>Mean scores MacArthur</th>
<th>MacArthur total score</th>
<th>Perceived coercion</th>
<th>Negative pressure</th>
<th>Voice</th>
<th>Affect</th>
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<tbody>
<tr>
<td></td>
<td>Response</td>
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<td>Negative pressure</td>
<td>Voice</td>
<td>Affect</td>
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<td>12</td>
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</table>
| $R^2$ adjusted (explained variance)         |                       | $R^2$ total score      | $R^2$ perceived coercion | $R^2$ negative pressure | 0.162 | 16% | $R^2$ voice | 0.109 | 11% | R2 affect | 0.159 | 16%

*The left side of the table presents response and mean scores of the separate dimensions per item category. Means expressed in bold figures are statistically significantly different at $P<0.001$ using Bonferroni correction. **The right side of the table, below "regression analysis" shows the association between determinants (age, gender, ...) and the total scale score and the scores of the four dimensions of the MacArthur scale. In all variables, the last category is the reference category. In religion, it is Hindu. Hindu (Coded 0) is compared with Muslim (Coded 1) and Christian (Coded 2). A positive beta of 0.17 implies a higher score on perceived coercion in Christians and Muslims as compared to Hindus. Variables in the final models fulfill the relevance criterion of Hosmer and Lemeshow
Table 1 shows the raw data for each item of the MAEIS across the basic demographic data, diagnostic, and illness history details. Diagnosis was left out of this table to improve readability. It showed a pattern of lower scores in patients with depression compared to all other diagnostic categories. Table 2 first presents the mean scores on the main interview and subscales before showing regression findings.

At first, we present results regarding patient sociodemographic variables, focusing on statistically significant results. We observe more negative pressure experienced by patients between 35 and 55, compared to younger and older patients. Male patients showed more negative pressure. Patients with nuclear family rather than extended family support felt less own choices and more perceived coercion but less negative pressure. Muslims perceived more coercion but less negative pressure. In all patients, results showed that the higher the income, the lesser the scores on perceived coercion and negative pressure. Marital status did not discriminate between items and was also left out of the table. Table 1 confirms that patients with high-income score were lower on most items measured throughout the MAEIS. Distance to the hospital showed an inconsistent association with the subscales measuring perceived coercion and negative pressure.

A legal history was associated with more perceived negative pressure. The longer the illness duration, the less coercion was perceived. Female had more positive affective responses than males. Patients with higher income had more positive affect scores. Patients with previous coercion have more negative affective responses than those without, as do patients with a legal history. Muslim and female patients felt more relieved at admission than men and Hindu or Christian patients.

Regarding diagnosis as shown in Table 2, patients with a psychotic disorder felt less coerced, but more negative pressure than those with other diagnoses. Patients with a depressive disorder felt less coerced into being admitted than patients with psychosis, substance misuse disorder, or bipolar disorder. Former coercion was associated with a higher total score, more perceived coercion, and a higher voice scale score, but not negative pressure.

Table 2 summarizes the multivariate regression. It is important to notice the differences in the associations of the predictors with regard to the total score and the four MacArthur Admission Experience Interview sub-scales:

• We observed only two significant associations in the final model regarding “total scores,” with a limited explained variance of 16%: Total score decreasing by being from an
extended family type ($\beta = -0.19; P < 0.001$). Drug abuse increases total score ($\beta = 0.12; P < 0.05$)

- “Perceived coercion” increased with female gender ($\beta = 0.15; P < 0.001$), with being either of Muslim or Christian religion ($\beta = 0.17; P < 0.001$), having a lower income ($\beta = 0.21; P < 0.001$), and a depressive disorder ($\beta = 0.12; P = 0.02$). It decreased with extended family type ($\beta = -0.21; P < 0.001$), in case of former coercion ($\beta = -0.24; P < 0.001$), forensic history ($\beta = -0.11; P = 0.03$), and with larger illness duration ($\beta = -0.21; P < 0.001$). The model showed a good explained variance of 31%

- “Negative pressure” decreased with female gender ($\beta = -0.25; P < 0.001$), with higher income ($\beta = -0.21; P < 0.001$), and the category “other diagnosis” ($\beta = -0.12; P = 0.02$). It increased with extended family type ($\beta = 0.12; P = 0.02$), forensic history ($\beta = 0.09; P = 0.05$), and longer illness duration ($\beta = 0.28; P < 0.001$). Again, the model showed a satisfactory explained variance of 27%

- “Voice” (being heard) increased by female gender ($\beta = 0.15; P < 0.001$), being of extended family type ($\beta = 0.17; P < 0.001$), and being of either Muslim or Christian religion ($\beta = 0.14; P = 0.01$). It decreased by former coercion ($\beta = -0.21; P < 0.001$). This model showed a low explained variance of 11%

- “Affect” (emotional response) showed an increase with female gender ($\beta = 0.17; P < 0.001$), higher income ($\beta = 0.14; P = 0.01$), and former coercion ($\beta = 0.12; P < 0.04$). It decreased with longer illness duration ($\beta = -0.19; P < 0.001$), with a limited explained variance of 16%.

In short, perceived coercion as well as negative pressure showed associations with a number of patient characteristics. Total score, affect, and voice showed looser associations.

8.4 DISCUSSION

In our study, higher total scores for perceived coercion were associated with drug abuse, while lower total scores were associated with being from an extended family. Higher scores in the subscale of “perceived coercive experience “were associated with female gender, coming from a nuclear family, not Hindu, lower socioeconomic status, depression, former coercion, forensic history, and a longer duration of illness. “Negative pressure” proved to be associated to male gender, being of an extended family, having a higher
income, not having a diagnosis of depression, having a diagnosis categorized as “other,” having a forensic history, and longer illness duration. “Total score,” as well as the subscales “voice” and “affect” showed fewer associations with the variables included in the analysis. There was a substantial to good explained variance in the subscales “perceived coercion” and “negative pressure” in contrast to the subscales “voice,” “affect,” and the total scores. This shows that in the sample items mentioned in the first two subscales are associated with a number of predictors.

This association is far more powerful than associations of determinants in the subscales “voice” and “affect.” This implies that patients in this Indian setting provide more consistent responses in the first two domains than in the last two.

Furthermore, it means that coercive experiences are associated with several sociodemographic and clinical variables, especially with respect to perceived coercion and negative pressure. Our findings were consistent with most studies from high-income countries (Bindman, Tighe, Thornicroft & Leese, 2002; Rain, et al., 2003; Swartz & Swanson, 2004; Kjellin, et al., 2006; Sheehan & Burns, 2011; Berkg, Einsiedler, Flammer, & Steinert, 2011; Anetis, et al., 2013 & O’Donoghue, et al., 2014). They confirmed early studies by Gardner et al. (1993) showing subscale scores can be of more importance in some patient groups than the total scale scores of the MAEIS (Hoge, et al., 1997 and 1998).

To the best of our knowledge, there is only one other Indian study investigating the correlation between patients’ sociodemographic and clinical variables and their relationship with coercive experiences. This Bangalore study was a pilot study with a limited sample size of \( n = 83 \) (Gowda, et al., 2016). Our study is very important in the current Indian context because of the new MHCB-2013 (Chadda & Deb, 2013). India has been characterized as being a traditional and family-centered society, with traditionally higher respect for collective decisions over individual ones and at least in theory, more acceptance of medical paternalism (“the doctor knows best”) (Shah & Basu, 2010). Nevertheless, our findings show few differences in comparison with similar studies from high-income countries. This suggests that the current rapidly changing social, economic, cultural, and psychosocial profile in India may have made changes to medical practice with fast diminishing differences between Indian and high-income cultures. The daily practice steadily moves away from a medical paternalistic model of doctor-directed care toward a model of information sharing and autonomous decision-making by patients (Burns, et al.,
Our findings suggest that the more autonomy-based MHCB-2013 for India is in keeping with these developments.

Our study has shown that perceived coercion is a significant problem in Indian psychiatric settings and certain at-risk groups have emerged, while other factors may be protective. One of the important aspects of current psychiatric practice includes improving autonomous decision-making capacity by sharing, discussing, offering, and repeated disclosure of information to patients through individual counselling, information booklets, group therapy, and involvement of carers. The main way of achieving this is by training personnel in skilled communication that is two-way, open, repeated, empathic, and accommodative. Our results allow staff to focus, especially on at-risk groups. One way of potentially reducing perceived coercion is advanced planning for the possibility of future incapacity. However, evidence for advanced directives and joint crisis plans from high-income country studies remains ambiguous; some authors advocate their use, whereas others find little evidence for their efficacy to reduce readmission rate or coercive measures. In India, the use of advanced directives has a number of advocates (Thornicroft, et al., 2013; Raveesh & Lepping, 2013). Their effectiveness in the Indian context, however, needs further exploration.

8.5 STRENGTHS AND LIMITATIONS

To the best of our knowledge, this is the first cross-sectional study in India with a large sample size. It presents consecutive sample but included only involuntarily admitted patients. All patients were recruited and interviewed during admission and assessed by face-to-face interviews using a validated scale. The study has some methodological limitations. It was limited to inpatients, while we know that coercion is a significant problem in the community, too. The study was from a single center in the south of India. The population was, therefore, predominantly from South India and from lower socioeconomic backgrounds and may not represent the entire Indian population. The effects of different practices, resources, treatment facility, and treatment components on perceived coercion were not considered in this study.

8.6 CONCLUSIONS

The results of our study highlight that clinical and sociodemographic characteristics influence the coercive experience of patients. Developing standardization in how to deal with difficult situations in aggressive patients may help develop guidelines, improve safety,
develop training, and start analysing and benchmarking current practices of coercive measures. Guidelines should be developed regionally or nationally, they should be based on evidence, and they should be practical in the Indian context. Clinicians in India should develop appropriate ways to reduce coercion; this study allows them to identify specific at-risk groups. The study shows that perceived coercion is a reality in India. Our data suggest that the level of perceived coercion and the populations affected are similar to high-income countries. It suggests that a move is required from socio-political models to modern bioethical models in Indian clinical practice.

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Chapter 9: Staff and Caregiver Attitude to Coercion in India

ABSTRACT

Objectives: The objective of this study was to assess attitudes of Indian psychiatrists and caregivers toward coercion.

Materials and Methods: The study was conducted at the Department of Psychiatry, Krishna Rajendra Hospital, Mysore, India. Staff Attitude to Coercion Scale (SACS), a 15-item questionnaire, was administered to self-selected psychiatrists across India and caregivers from Mysore to measure attitudes on coercion. Data were analysed using descriptive statistics and investigating differences in subgroups by means of Chi-square test, Student’s t-test, and analysis of variance. Reliability of the SACS was tested in this Indian sample.

Results: A total of 210 psychiatrists and 210 caregivers participated in the study. Both groups agreed that coercion was related to scarce resources, security concerns, and harm reduction. Both groups agreed that coercion is necessary, but not as treatment. Older caregivers and male experienced psychiatrists considered coercion related to scarce resources to violate patient integrity. All participants considered coercion necessary for protection in dangerous situations. Professionals and caregivers significantly disagreed on most items. The reliability of the SACS was reasonable to good among the psychiatrists group, but not in the caregiver group (alpha 0.58 vs. 0.07).

Conclusion: Caregivers and psychiatrists felt that the lack of resources is one of the reasons for coercion. Furthermore, they felt that the need on early identification of aggressive behaviour, interventions to reduce aggressiveness, empowering patients, improving hospital resources, staff training in verbal de-escalation techniques is essential. There is an urgent need in the standardized operating procedure in the use of coercive measure in Indian mental health setting.

Key words: Attitude, caregiver, coercion, staff

9.1 INTRODUCTION

The term “coercive measures” usually refers to coercive interventions occurring under hospitalization in psychiatric wards (Kalisova, et al., 2007). This includes seclusion,
physical restraint, chemical restraint, mechanical restraint, and covert medication. Covert medication is commonly administered in India by many caregivers often in consultation with a psychiatrist (Shah & Basu, 2010). Coercive measures always represent an infringement of an individual’s rights to self-determination and personal freedom. Coercive measures involve a conflict of medical-ethical principles. On the one hand, there is the principle of “doing good” or “avoiding harm,” while on the other hand, there is the requirement to respect the autonomy of the patient as far as possible.

In emergencies, the use of coercive interventions is common where the patient is at substantial risk of harming him/herself or others; in such cases, professionals may feel a need for coercive measures (Swartz, et al., 2002). The question is more difficult in situations that are not emergencies but where aspects of safety or harm to health are foremost, notably in geriatric medicine and psychiatry. In such cases, it is often unclear whether the principle of acting in the patient’s best interest really justifies the resulting constraints of the rights and freedom of the individual, that is, the violation of the patient’s autonomy (Steinert & Lepping, 2009).

Early studies on restraints were conducted in the US between the 1970s and 1980s. Researchers noted an important variation in frequency of use of restraints across US cities. New York City and large-town hospitals had the highest rates of seclusion and restraint (Carpenter, et al., 1988). Differences in ward culture, treatment ideology, composition of patients, size of ward, and number of staff per patient are some of the factors mentioned. Staff attitudes are often mentioned as a possible influence on the use of coercion (Alem, et al., 2002; Klinge, 1994 & vanDoeselaar, et al., 2008).

Hoge, et al., (1993) and Bennett, et al., (1993) interviewed patients, staff, and family members at the same hospital used in the Lidz, et al.,’s study (1995) and observed that they had different role-dependent perspectives on the use of coercion in the admission process. Attitude toward coercive measures depends on external factors such as individually experienced treatment such as emotional exhaustion and therapeutic optimism (Happell & Koehn, 2011).

It showed that the number of people detained for treatment in England and across Europe rose steadily during the 1990s (MacArthur Research Network, 2001). It has also been shown that the rates of detention are highly variable from place to place, to an extent that is only partially explained by levels of social deprivation (Wall, et al., 1999) probably because criteria for admission – such as “risk to others” – allow wide interpretation in
practice. The EUNOMIA research group has investigated the themes of outcomes, ethics, and epidemiology related to the use of coercion (Bindman, 2002). In 2009, they investigated differences in the use of seclusion and restraint rates in 12 European countries. They concluded that there were huge differences in the amount of use that the quality of national health register data was poor and that efforts should be made to improve the quality of national statistics on the use of coercion (Kallert, et al., 2005). This large variation was, however, not confirmed in a recent study covering nationwide data in four European countries. This study was able to analyse large data sets rather than data from individual hospitals. It found that restraint prevalence was very similar across Ireland, Wales, The Netherlands, and Germany although the types of coercion remain vastly variable across countries (Steinert & Lepping, 2009).

Mental health services have been increasingly emphasised over the past decade, and there is a wide consensus that clinicians should see family caregivers as partners in the care of patients (Wynn, 2003). Our current Mental Health Care Bill – 2016 advocates that family members and psychiatrist should be members of the District Mental Health Review Board. There are no formal studies in India that assess the attitude of psychiatrist (staff) and caregivers toward coercion and coercive practice. More than any one person’s account is necessary to estimate reliably what actually transpired in the hospitalization process.

**9.2 AIMS AND OBJECTIVES OF THE STUDY**

The main goals of the study were:

- To study the sociodemographic correlates of psychiatrists attitudes toward coercion
- To study the sociodemographic correlates of caregivers attitudes toward coercion
- To compare staff and caregiver attitude toward coercion.

**9.3 MATERIALS AND METHODS**

Staff Attitude to Coercion Scale (SACS) (Husum, Finset & Ruud, 2008) was used. We applied the SACS, a short, 15-item questionnaire on normative attitudes toward coercion. They were as follows: In coercion as offending (critical attitude) – the view of coercion as offensive toward patients; coercion as care and security (pragmatic attitude) – the view of coercion as needed for care and security, and coercion as treatment (positive attitude) – the view of coercion as a treatment intervention.
These dimensions can be scored in items scored on a 5-point Likert-type scale, with 1 = disagree strongly up to 5 = agree strongly or in dichotomous yes or no categories. In the European sample using the Likert scale, the three subscales showed a Cronbach’s Alpha coefficient of 0.70, 0.73, and 0.69, while the total scale showed an alpha of 0.78 (Husum, et al., 2011).

In our sample, we decided to use yes or no response categories for a number of reasons:

- First and most importantly, research has shown that providing too many options in response categories may not necessarily reflect underlying opinions in an Indian context but produces a regression to the mean (Harzing, 2006; Viswanath & Chaturvedi, 2012; Dein & Bhui, 2013)
- We were primarily interested in the association between patient and caregivers’ characteristics and their attitudes to coercion. We were interested in the difference between psychiatrists and caregivers, which can be more robustly calculated with dichotomous answers.

This study was conducted from January 1, 2015, to March 31, 2015, at the Department of Psychiatry, Krishna Rajendra Hospital, attached to Mysore Medical College and Research Institute (MMCRI), Mysore. After obtaining informed consent, all caregivers of consecutive involuntarily admitted patients were approached to complete the SACS. Psychiatrists of MMCRI and across the country were approached to complete the SACS either on a one-to-one basis or through survey monkey. Ethical approval was obtained from the Institutional Ethics Committee (MMCEC08/15).

9.3.1 Statistical analysis

Statistical analyses were performed using the level of statistical significance set at \( P < 0.05 \). Clinical and sociodemographic characteristics of the sample were analysed by descriptive statistics. Independent sample \( t \)-test, analysis of variance, and paired samples \( t \)-test were used to assess continuous variables. Chi-square was used to assess discrete variables. The reliability of the SACS was tested in the current sample, as opinions may vary across cultures, and because we chose different response categorizations.

9.4 RESULTS

A total of 210 psychiatrists (staff) from the Department of Psychiatry, MMCRI (6 psychiatrists), involved in the study, and email was sent to all members of Indian
Psychiatry Society (204 psychiatrists) across India participated by completing survey monkey [Table 1]. Nearly three-fourth of the psychiatrists (n = 162) were aged between 26 and 55 years. Of 210, 168 (80%) of the psychiatrists participating in the study were male and 129 (61.4%) had more than 10 years of experience in clinical psychiatry. Caregivers were attendants of involuntary patients admitted to the Department of Psychiatry, MMCRI, during the study period, who were willing to participate and gave consent. Caregivers were from all age groups, with a significant number (18%) above 55 years. A slight majority were male (54%), and the overall education level was low (64% had only 7th grade education). Caregivers were parents (26.2%), spouse (27.6%), children (27.2%), or siblings (15.7%).

When we look at the reliability of the SACS in the current samples [Table 1], we observe an overall Cronbach’s alpha of 0.58 in the staff sample, against a Cronbach’s alpha of only 0.07 in the caregiver sample. Taking the sample size into account, the figure in the psychiatrist group is reasonable.

<table>
<thead>
<tr>
<th>Table 1: Basic frequencies of the sample</th>
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<td>Percentage of staff</td>
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<td>Age categories</td>
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<td>Experience of staff (years)</td>
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<tr>
<td>Education of caregiver</td>
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<td>High school</td>
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<td>Preuniversity</td>
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<td>Graduate</td>
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<td>Which caregiver</td>
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<td>Parents</td>
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<td>Spouse</td>
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<td>Brother or sister</td>
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<td>Children</td>
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<td>Internal consistency SACS</td>
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<tr>
<td>Coercion as offending</td>
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<tr>
<td>Coercion as care and security</td>
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<td>Coercion as treatment</td>
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<tr>
<td>Overall</td>
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</table>

SACS – Staff Attitude to Coercion Scale
The subscale results were offending subscale: alpha of 0.44, security subscale: alpha of 0.69, and treatment subscale: alpha of 0.57. In the caregiver sample, these figures were 0.13, 0.37, and 0.25, respectively. This shows that the SACS measures opinions of professionals, which are not necessarily shared or understood by caregivers. Reflected by a higher internal consistency, there is a better agreement on coercion among psychiatrists than among caregivers. The findings imply that the scale scores for the psychiatrists ‘opinions, but not the caregivers’ opinions, can be analysed with a good degree of reliability. However, when the caregivers are divided into groups, the consistency in response is higher among siblings, and to some extent, children as caregivers compared to parents or spouses.

Table 2 relates the psychiatrists’ age and gender to the items in the SACS, while Table 3 highlights the association of the psychiatrists’ experience with the items measured in the SACS. In the subscale “coercion as offending,” we observe an association between increased scores and age and experience of the psychiatrist.

| Table 2: Age and gender of the psychiatrist and coercion attitude |
|-----------------------------|-----------------------------|-----------------------------|
|                             | Age categories (years)      | Difference significant      | Gender                      | Difference significant |
|                             | 26-35 36-45 46-55 56-65 >65 |                             | Male Female                 |                             |
| Coercion as offending subscale-mean (SD) | 3.9 (1.2) 4.1 (1.1) 4.3 (1.4) 4.7 (1.2) 5.1 (1.0) | 0.000 | 4.2 (1.2) 4.7 (1.2) 0.015 |
| Coercion could have been much reduced, giving more time and personal contact | 90 | 100 | 94.7 | 100 | 90.9 | 0.060 | 94 | 100 | 0.102 |
| Scarce resources lead to more use of coercion | 90 | 87.5 | 78.9 | 92.3 | 90.9 | 0.449 | 84 | 100 | 0.002 |
| Coercion violates the patient's integrity | 73.3 | 84.4 | 78.9 | 92.3 | 81.8 | 0.284 | 81 | 81 | 0.579 |
| Too much coercion is used in treatment | 30 | 25 | 47.4 | 46.2 | 50 | 0.050 | 35.7 | 35.7 | 0.567 |
| Use of coercion can harm the therapeutic relationship | 70 | 75 | 94.2 | 76.9 | 100 | 0.046 | 76.2 | 85.7 | 0.128 |
| Use of coercion is a declaration of failure on the part of the mental health services | 36.7 | 42.2 | 47.4 | 61.5 | 100 | 0.000 | 45.8 | 66.7 | 0.012 |
| Coercion as care and security subscale-mean (SD) | 4.7 (1.6) 5.1 (1.2) 5.1 (1.3) 4.9 (1.7) 5.1 (0.9) | 0.626 | 4.9 (1.5) 5.2 (0.8) 0.230 |
| For security reasons coercion must sometimes be used | 90 | 90.6 | 84.2 | 69.2 | 81.8 | 0.082 | 84.5 | 90.5 | 0.235 |
| Coercion may represent care and protection | 70 | 71.9 | 78.9 | 76.9 | 81.8 | 0.745 | 75.6 | 69 | 0.248 |
| Use of coercion is necessary as protection in dangerous situations | 86.7 | 96.9 | 100 | 92.3 | 95.5 | 0.061 | 93.5 | 95.2 | 0.498 |
| For severely ill patients coercion may represent safety | 80 | 87.5 | 78.9 | 92.3 | 86.4 | 0.480 | 81.5 | 95.2 | 0.012 |
| Coercion may prevent the development of a dangerous situation | 68.3 | 87.5 | 78.9 | 76.9 | 81.8 | 0.139 | 76.2 | 88.1 | 0.066 |
| Use of coercion is necessary toward dangerous and aggressive patients | 80 | 76.6 | 89.5 | 86.4 | 81.8 | 0.577 | 81 | 83.3 | 0.458 |
| Coercion as treatment subscale-mean (SD) | 1.1 (1.0) 1.0 (0.9) 1.1 (0.9) 1.3 (1.1) 1.1 (0.7) | 0.773 | 1.0 (0.9) 1.4 (0.9) 0.017 |
| Patients without insight require use of coercion | 51.7 | 57.8 | 57.9 | 69.2 | 72.7 | 0.376 | 57.1 | 66.7 | 0.172 |
| Aggressive patients require use of coercion | 41.7 | 34.4 | 47.4 | 38.5 | 45.5 | 0.726 | 37.5 | 52.4 | 0.058 |
| More coercion should be used in treatment | 16.7 | 9.4 | 5.3 | 23.1 | 0 | 0.047 | 8.3 | 23.8 | 0.008 |

SD – Standard deviation
We observe higher scores in the group of female psychiatrists in the offending subscale as well as the treatment subscale. We observed a significant difference in the security subscale and the care and security subscale with lower scores in psychiatrists with less experience.

Tables 4 and 5 relate the caregivers’ characteristics to the items in the SACS. The clear patterns observed in the professionals are not observed in the caregivers.
Table 5: Education and relation of the caregiver and coercion attitude

<table>
<thead>
<tr>
<th>Caregiver education</th>
<th>Difference significant</th>
<th>Caregiver relation</th>
<th>Difference significant</th>
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<tbody>
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<td>Standard</td>
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<td>Preuniversity</td>
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<tr>
<td>Coercion as offending</td>
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<td>subscale-mean (SD)</td>
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<td>Coercion could have</td>
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<td>been much reduced,</td>
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<td>lead to more use of</td>
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<td>coercion</td>
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<td>Coercion violates the</td>
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<td>patients integrity</td>
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<td>Too much coercion is</td>
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<td>Use of coercion can</td>
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<td>mental health services</td>
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<td>Coercion as care and</td>
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<td>security subscale-mean (SD)</td>
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<tr>
<td>For security reasons, coercion must sometimes be used</td>
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<td>39.7</td>
<td>63.8</td>
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<tr>
<td>Coercion may represent care and protection</td>
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<td>47.4</td>
<td>52.6</td>
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<tr>
<td>Use of coercion is necessary as protection in dangerous situations</td>
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<td>57.1</td>
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<td>For severely ill patients, coercion may represent safety</td>
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<td>51.1</td>
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<tr>
<td>Coercion may prevent the development of a dangerous situation</td>
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<td>57.9</td>
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<td>Use of coercion is necessary toward dangerous and aggressive patients</td>
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<td>55.6</td>
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<tr>
<td>Coercion as treatment subscale-mean (SD)</td>
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<td>1.4 (0.9)</td>
<td>1.2 (0.9)</td>
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<td>Patients without insight require use of coercion</td>
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<td>48.1</td>
<td>55.3</td>
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<tr>
<td>Aggressive patients require use of coercion</td>
<td></td>
<td>38.3</td>
<td>36.8</td>
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<tr>
<td>More coercion should be used in treatment</td>
<td></td>
<td>51.1</td>
<td>26.3</td>
</tr>
</tbody>
</table>

SD = Standard deviation

On some items, female caregivers tend to identify more problems and show higher scores; on others, they identify fewer problems than their male participants. Neither education nor relationship to the patient is associated with coercion attitudes. However, the large inconsistency, especially in parents and spouses as caregivers, impairs this association.

If we select only siblings as caregivers – who show a reasonable reliability – we observe a significantly higher score on coercion on the care and security subscale, while they show lower scores in the treatment subscale. Education shows no association in any subscale.
Table 6 presents the responses of professionals and caregivers alongside each other; odds ratio are presented to illustrate the degree of difference. At a scale level, the professionals score higher on the offending subscale and the security subscale. Concerning the treatment subscale, the psychiatrists score higher. More often than caregivers, psychiatrists voice the opinion that scarce resources lead to more coercion. They also see coercion as a violation of the integrity of the patient which may harm the therapeutic relationship. Concerning the security subscale, the psychiatrists agree far more often than the caregivers with the item statements, with a response generally much higher than in the European samples, perhaps reflecting differences in the context of the ward, with relatively more severely mentally ill. The psychiatrists are in general more reluctant than caregivers to agree that coercion is an acceptable treatment option. In short, the psychiatrists show a completely different opinion to coercion than the caregivers on most items.

| Table 6: Differences between professionals and caregivers on coercion attitude |
|-------------------------------|-------------------|-------------------|------|
| Coercion as offending subscale-mean (SD) | Psychiatrist | Caregiver | OR  |
| Coercion could have been much reduced, giving more time and personal contact | 4.28 (1.23) | 3.56 (1.41) | <0.0001 |
| Scarse resources lead to more use of coercion | 95.2 | 96.7 | 1.22 | 0.311 |
| Coercion violates the patients integrity | 87.6 | 63.8 | 0.56 | <0.0001 |
| Too much coercion is used in treatment | 81 | 58.1 | 0.61 | <0.0001 |
| Use of coercion can harm the therapeutic relationship | 35.7 | 41.9 | 1.14 | 0.115 |
| Use of coercion is a declaration of failure on the part of the mental health services | 78.1 | 52.4 | 0.59 | <0.0001 |
| Psychiatrist | Caregiver | OR  |
| Coercion as care and security subscale | 4.98 (1.41) | 3.31 (1.47) | <0.0001 |
| For security reasons, coercion must sometimes be used | 85.7 | 59.5 | 0.55 | <0.0001 |
| Coercion may represent care and protection | 74.3 | 51 | 0.62 | <0.0001 |
| Use of coercion is necessary as protection in dangerous situations | 93.8 | 59.5 | 0.45 | <0.0001 |
| For severely ill patients coercion may represent safety | 84.3 | 54.3 | 0.53 | <0.0001 |
| Coercion may prevent the development of a dangerous situation | 78.6 | 52.9 | 0.59 | <0.0001 |
| Use of coercion is necessary toward dangerous and aggressive patients | 81.4 | 54.3 | 0.56 | <0.0001 |
| Coercion as treatment subscale | 1.11 (0.97) | 1.30 (0.94) | 0.041 |
| Patients without insight require use of coercion | 59.0 | 46.7 | 0.78 | 0.007 |
| Aggressive patients require use of coercion | 40.5 | 36.7 | 0.92 | 0.241 |
| More coercion should be used in treatment | 11.4 | 46.7 | 2.14 | <0.0001 |

SD – Standard deviation; OR – Odds ratio

9.5 DISCUSSION

This is the first cross-sectional study from staff and caregiver attitude on coercion. Our study shows that most psychiatrists feel that coercion violates the patients’ integrity and may harm therapeutic relationships. The attitudes of the psychiatrists are in line with the findings in the European samples and a recent Australian survey (Kinner, et al., 2016). In our Indian sample, both psychiatrists and, to a slightly lesser extent, caregivers see limited resources as the most important factor underlying coercion. Coercion could be reduced, given more time and personal contact in the opinion of all participants. Psychiatrists agree more often than caregivers to the statements regarding the use of coercion for safety
reasons. Furthermore, psychiatrists have a more negative view of coercion and see it as more “offensive” and violating the integrity of the patient than caregivers.

Furthermore, caregivers are much more likely to support the more frequent use of coercion as part of the patient’s treatment. The current finding is similar to recent Indian data from NIMHANS, Bengaluru, on clinicians’ attitudes on coercion and coercive practice (Gowda, et al., 2016). The caregivers’ relatively benign attitude on coercion, especially compared to the recent Australian study (Harzing, 2006), may be linked to difficulties Indian caregivers experience with mentally ill relatives in the community where they are largely responsible for them without much help from state agencies.

Older psychiatrist (above 46 years), with more experience, felt more often that coercion could harm the therapeutic relationship and may represent a failure on the part of the mental health services than a younger psychiatrist. Older caregivers and male, more experienced psychiatrists (more than 10 years) believed more than the other participants that coercion was due to scarce resources, violating the patient’s integrity, and should not be used in treatment. This finding is in line with the Norwegian study by Wynn (Wynn et al., 2011). Female caregivers felt that the use of coercion as protection in dangerous situations represents safety and should be used in treatment. No association was found between caregiver education level and relation to the patient and attitude toward coercion. Age, gender, and experience of the psychiatrist showed an association on the offending subscale. In addition, female psychiatrists agreed somewhat more than their male colleagues that coercion could be a treatment option.

Both psychiatrists and caregivers agreed that coercion should not be used more often in treatment, but almost half of all caregivers did want to see more coercion in treatment. Agreement only existed in the judgment about the necessity of coercion in cases of aggression and lack of insight. They also agreed that coercion could be reduced significantly, given more time and personal contact. These findings are similar to a Norwegian study by Wynn on staff attitude (Wynn, et al., 2011).

That experience is relevant to one’s opinion of coercion which is reflected in a number of European studies. In a Swedish study by Karlsson, et al., (2001), a significant relationship was found between staff attitudes and the use of restraint. The nursing staff, who did not use restraint, had more negative attitudes toward using it and more knowledge about the regulations for restraint use (Janssen, Noorthoorn, Linge & Lendemeijer, 2007). The Norwegian study showed male staff and unskilled staff to be significantly more prone to
choosing a coercive intervention than others (Wynn, et al., 2011). In two Dutch studies, a personnel mix of more and less experienced staff (Janssen et al., 2007) and the availability and application of clear treatment protocols (Verlinde, et al., 2016) predicted less use of coercion.

We hypothesize that differences in normative attitudes between caregiver's and psychiatrists could be attributed to the following:

• The attitude of caregivers toward patients may be different, because in the Indian context, caregivers are often confronted first and for some time with a patient's symptoms. They feel a need for fast recovery as the economic costs of the illness may lead to significant financial distress

• The overall education among caregivers is by and large less than that of staff, and in some areas, caregivers may have hardly any experience with mental illness and associate it with negative outcomes

• Normative attitudes and opinions of psychiatrists could be different to caregivers because of the position of the caregivers to the patients

• Psychiatrists have greater experience with various treatment interventions than caregivers. They may also internalize different normative ethical attitudes during their medical education

• The caregiver's perception about outward or inward directed aggression or suicidality may differ from psychiatrists as they are emotionally involved

• The staff's attitude may be influenced by knowledge of the hospital resources, their training in coercive practices, locally supervised operating procedures for coercive interventions and cultural factors, such as acceptance of doctor's decisions (Viswanath & Chaturvedi, 2012).

Recent Indian data from our group showed high ward prevalence of coercive measures during psychiatric hospital admissions with one or more types of restraint used in 38% of admitted patients. In the same observational study, 63% instigated a violent incident during their admission (Danivas, et al., 2016). Gowda, et al., (2016) investigated perceived coercion as measured by the MacArthur Perceived Coercion Scale in Bengaluru. They found that it decreased significantly between admission and discharge. This was accompanied by significant increase in global functioning, insight score and decrease in
symptom severity. 87% patients reported that their admission was justified even though many felt coerced during their hospital stay (Gowda, et al., 2016).

Another survey of 278 Indian psychiatrists on the use of physical restraint and seclusion in psychiatric practice showed that most of them (80%) practice restraints as a treatment modality and believe that they are integral to the management (Khastgir, et al., 2003).

In an international perspective, our findings need to be placed against the background of the mental health context of a country and the experience of patients, caregivers, and professionals. Whereas in Europe, coercion consists primarily of either seclusion or mechanical restraint with or without medication, coercion in India is predominantly chemical restraint accompanied by physical restraint. Seclusion is infrequently used, if at all (Shah & Basu, 2010). The chance of being subject to coercion is 36% in India, which is fairly high compared to Europe (Noorthoorn, et al., 2015 & Lepping, et al., 2016).

Patients in Indian acute settings are also severely ill, with mean CGI scores of around 5 (Gowda, et al., 2016). It is likely that the experience in coercive measures colours the opinion as expressed in the SACS, primarily of staff and to a lesser extent of caregivers.

**9.6 STRENGTHS AND LIMITATIONS**

To the best of our knowledge, this is one of the few studies that look at caregivers’ and psychiatrists’ attitudes to coercion, comparing the two groups. The study included consecutive caregivers of involuntarily admitted patients.

All caregivers and staff were recruited and interviewed during the admission period, and attitude on coercion was assessed with validated instruments. The study has some methodological limitations: It was conducted with a relatively small sample and limited to inpatient caregivers, including neither outpatients nor a community sample. We had poor consistency among the caregiver sample, putting into question the reliability of the SACS for Indian caregivers. It did not invalidate the total scores presented in Table 6.

The dichotomous version of the SACS (yes and no answers) produces high levels of consistency among psychiatrists but not caregivers. We, therefore, recommend the dichotomous version for future research in India among clinicians. More research is needed to explore how caregivers’ attitudes can best be captured.
9.7 CONCLUSION

Caregivers and psychiatrist perceived a relative lack of resources as the main reason for coercion and believe that it could be reduced in clinical practice by giving more time and personal contact to patients. Hence, interventions to reduce coercion should take into account organizational, training, and legal issues in the respective country.

Caregivers and professionals have very different attitudes toward coercion, and future research should focus on how this gap can be bridged. Psychiatrists’ normative attitudes toward coercion are remarkably similar to attitudes of psychiatrists in European countries.

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There are no conflicts of interest.

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Part III

• Use of Restraints in Elderly with Mental Illness: to be or not to be?

• Paternalism v. Autonomy – are we barking up the wrong tree?
Chapter 10: Use of Restraints in Elderly with Mental Illness: to be or not to be?

Abstract

Elderly people are one of the most vulnerable populations in society. Those with psychiatric illness and/or physical debilitating illness are doubly disadvantageous. Coercion in psychiatric practise is a concept much talked about in the recent years in the perspective of maintaining the rights of the patients. Coercion in elderly is an issue with regards to common geriatric disorders like dementia. However, few published data exists amongst the Indian population on this newer aspect of coercion in elderly population. Western literature suggests that bedrails, belts and covert medications are the common coercive practices amongst elderly. They also suggest alternative measures to minimise coercion as well as modest coercion as a transient option to prevent harm out of problem behaviours in dementia. The existing laws in developed nations address coercion along with elderly abuse where as in India it is predominantly focussed on elderly alone. The current review gives an account on these dilemmas involved in coercion and alternative practices that can minimise the same.

Key words

abuse, coercion, dementia, elderly, mental illness, restraints

10.1 INTRODUCTION

Reducing the use of seclusion and restraint has been identified as a major practice change initiative across globe. Despite moves to enhance the autonomy of clients of health care services, the use of a variety of physical restraints on the freedom of movement of frail, elderly patients continues in nursing homes in western countries.1-3 The situation is not very different in India. Despite the fact that family and friends are often intimately involved in patients’ care in India, standards of coercion and restraint have not been defined. With a lack of international comparisons it is all the more
important to be aware of patients’ individual rights and preferences regarding the necessity, mode and place of psychiatric treatment and also to recognise the legitimate interests and wishes of family members.

Restraint is defined as ‘the intentional restriction of a person’s voluntary movement or behaviour.’ In this context, ‘behaviour’ means planned or purposeful actions, rather than unconscious, accidental or reflex actions. An alternative plain English definition is ‘stopping a person doing something they appear to want to do’.4

10.2 INDIAN CONTEXT

Mental health policies and laws in low- and middle-income countries often fail to incorporate current international human rights and best practice standards to prevent violation of human rights.5 Article 21 of Indian constitution (Right to life) defines that ‘No person shall be deprived of his life or personal liberty except according to procedure established by law’.6 The right to life is interpreted as more than mere existence and includes the right to live with human dignity and decency.

In the Chandan Kumar vs. State of West Bengal,7 the Supreme Court heard of the inhuman conditions in which mentally ill persons were held in mental hospital at the Mankundu Hospital in the Hooghli district of West Bengal state. The Court denounced this practice and ordered the cessation of the practice of tying up the patients who were unruly or not physically controllable with iron chains and ordered medical treatment for these patients.

In India, refusal to consent and incompetency to consent are included in the section on 'admission under special circumstances' in the Mental Health Act (MHA) 1987.8 It has been strongly criticized that 'competence' has not been defined in the purview of the MHA. In the MHA, 1987 there is no separate provision for forced treatment. The act delineates the procedure and the circumstances under which a person with mental illness can be admitted to a hospital against his wish; however there is no mention on the treatment process. It assumes that a person is treated against his wish in good interest of the patient. The new Mental Health Care Bill 2013 brings about a rights-based protection of mentally-ill persons. This was never the focus of the MHA 1987 and the 2013 Bill fills this requirement of the UN Convention on the Rights of Persons with Disabilities by guaranteeing to all persons the right to access mental healthcare, and a range of services for persons with mental illness including shelter homes,
supported accommodation, community based rehabilitation; the right to community living, the right to live with dignity, protection against cruel, degrading and inhuman treatment, the right to equality and non-discrimination, the right to information, confidentiality and access to medical records; right to personal communication, legal aid and the right to make complaints about deficiencies in provision of services in addition to other similar legal remedies. It is for the first time that any law has guaranteed such rights to equality, non-discrimination and the positive rights for provision of basic services to persons with mental illness. However, the recent draft proposal to amend the Indian Mental Health Act has not brought certainty to issues of coercion.9

The common forms of coercion in India are chemical, physical and mechanical restraint. These are described below.

10.3 TYPES OF RESTRAINT

There are different types of restraints. Restraint, whether it is chemical, physical, or environmental, is a limitation of a person’s autonomy and freedom of movement.10

10.3.1 Physical restraint:

Direct physical contact between persons where force is positively applied against resistance, either to restrict movement or mobility or to disengage from harmful behaviour displayed by an individual.11 Broadly speaking, the need to use restraint, particularly physical restraint, arises from two distinct circumstances: those which are planned and those which are unplanned. Unplanned physical restraint refers to those incidents requiring restrictive physical interventions which are unforeseen and unexpected. Under these circumstances immediacy does not allow time to plan ahead. Staff are guided by best practice guidelines and training. Planned physical restraint refers to restrictive physical interventions which have been planned via risk assessment and where there is an expectation that predicted circumstances are likely to occur. There is time for planning and restraint plans are structured and documented in health care records.

10.3.2 Chemical restraint:

It involves the use of medication to restrain. It differs from therapeutic sedation in that it does not have a directly therapeutic purpose but is primarily employed to control
undesirable behaviour.

10.3.3 *Mechanical restraint:*

It involves the use of equipment. Examples include specially designed mittens in intensive care settings; everyday equipment, such as using a heavy table or belt to stop the person getting out of their chair; or using bedrails to stop a person from getting out of bed. Controls on freedom of movement – such as keys, baffle locks and keypads – can also be a form of mechanical restraint.

10.3.4 *Environmental restraint:*

It involves buildings designed to limit peoples' freedom of movement, including locked doors, electronic keypads, double door handles and baffle locks. Seclusion is an important sub-type of environmental restraint. It is defined as ‘placing of a person, at any time and for any duration, alone in an area with the door(s) shut in such a way as to prevent free exit from that area’.

10.3.5 *Psychological restraint:*

It includes constantly telling a person not to do something, or that doing what they want to do is not allowed, or is too dangerous. It may include depriving a person of lifestyle choices by, for example, telling them what time to go to bed or to get up. It might also include depriving individuals of equipment or possessions they consider necessary to do what they want to do, for example removal of walking aids, glasses, outdoor clothing or keeping the person in nightwear with the intention of preventing them from leaving.

Though there has been discussion about the restraint and coercion in patients with psychiatric disorder, there is a significant void when it comes to geriatric population. At present, to the best of our knowledge, there has been no publication from India in indexed journals focussing on coercion in elderly. There are some western studies throwing light on this issue. But our day-to-day practise definitely indicates coercion in both psychiatric and medical settings either due to behavioural and psychological symptoms associated with dementia or as a result of delirium secondary to any medical causes. Though this is done with harm reduction (to prevent elderly from having falls and sustaining injuries) to patient as a primary motive, there has been no research looking at the extent of coercion, practices used as part of coercion
and guideline for use in India.

A recent study done in Norway, which involved interviewing the nursing home staff infers that in Europe, patients suffering from dementia are subjected to different coercive practices like bedrails, belts and covert medication. The two main reasons being: the patients’ incompetence to give consent for treatment and prevention of harm to patient.12

There have been acts and bills in place in the developed nations like the United Kingdom and United States of America. Protection of vulnerable adults (POVA) recognised the extent of elderly abuse and the need to prevent them. As part of that, no one previously involved in the abuse of the recipient of care/sexual act with persons with learning disability/mental retardation are allowed to work in institutions where caregiving for elderly is involved. Similarly in the USA, an act to address the issue of protection of elderly - Older Americans Act is in place. All these acts mention restraint (physical or chemical) as a form of abuse. It is predominantly in the context of care of elderly in institutions and not in hospital settings when they are ill. Even in India, there exists a “The Senior Citizen’s Bill 2005” which address the issue of elderly neglect as a social issue and not talk about the coercion or restraint in treatment settings.

10.4 LEGAL AND ETHICAL DILEMMA

In mental health, there is a delicate balance between the need to prevent and manage aggressive behaviour so that staff, consumers and visitors are safeguarded, and the need to promote the health and welfare of consumers in the least restrictive manner.14 Medicating people with disabilities and elderly people is a contentious issue, particularly in situations that involve aggression. Some experts argue that medication can have a calming effect, and may help to “normalize” the individual (which means absence of aggression or problem behaviour). On the other hand, critics argue that medication only masks the symptoms; it does not address them.15 The issue becomes even worse when the evidence suggests that mental health workers may be over medicating their patients. Many experts challenge the assumption that use of restraints is necessary to protect the welfare of frail, elderly patients by drawing on a range of data indicating the limited efficacy of restraints. They argue that the duty to respect individual autonomy extends to a duty to respect the autonomy of patients.
who are elderly, frail and living in nursing homes.\textsuperscript{16}

Here is a case illustrating the medico-legal implications. A patient with Alzheimer's disease was hospitalized and within 24 hours, after she was restrained, found dead. The county coroner called her death an accidental asphyxiation. A lawyer was obtained by the family to represent the family in a ‘wrongful death suit’.\textsuperscript{17} In addition, the Department of Justice alleged that the hospital violated the False Claims Act by collecting Medicare payments without “following federal rules on the use of chemical and physical restraints.” The hospital agreed to pay the government $200,000 and to hire a consultant to review restraint usage at the hospital as part of the agreement. The settlement focused upon financial fraud of government funding rather than the actual harm/danger to the patient.\textsuperscript{18}

A balance has to be struck between patients’ autonomy and the suffering that absence of treatment may cause. The Hawaii declaration of the World Psychiatric Association provided guidelines for treating a patient who cannot express his or her own wishes regarding treatment and cannot see what is in his or her best interest because of their psychiatric illness. A compulsory treatment may or should be given provided it is done in the best interests of the patient. Patients should be encouraged to participate as fully as possible in all decisions about their care.\textsuperscript{10}

\textbf{10.5 STRATEGIES TO MINIMISE THE USE OF RESTRAINT}

A recent qualitative study explains the strategies to prevent and avoid the use of coercion in elderly. Strategies like ‘deflection and persuasion’, ‘limiting choices by conscious use of language’, ‘flexibilities’ like trying later, change of personnel and one-to-one care with respect to patient’s temperaments and ‘seclusion’ have been explained in detail. The study also lists some prerequisites to avoid coercion. These include knowing the patient, resources in nursing home, adequate staffing and competence of staff. These are discussed exclusively in case of elderly patients.\textsuperscript{12}

Another European study has tried to answer some critical questions in relation to coercion in dementia patients. These questions include: When should people with dementia be submitted to coercive care? Who should decide about this? Within what legal framework should the medical personnel who are practicing coercive care operate? The study indicates coercion as a mode of treatment when it is modest. The study explains that ‘modest’ coercion is one which is exerted where the patient is
incapable of autonomous decisions for his treatment. It also discourages ‘meddlesome’ coercion which is imposed even when the patient is capable of autonomous decision. The author concludes that one has to choose between two options: a law giving too much licence to health care personnel and a hypocritical system that gives no licence at all, but takes for granted that they will take action when they should do so, but not otherwise.\(^\text{13}\)

Mental health clinicians should be trained in skilled communication that is two-way, open, repeated, empathic, and accommodative. Along with communication, detailed documentation is necessary to explain why a particular action (e.g. involuntary treatment, seclusion or restraint, etc.) was felt necessary under the specific circumstances. Facilities should be available for advanced planning for the possibility of future incapacity, for example, by the use of joint crisis plans and advance directive. This can help reduce compulsory admissions and treatment in patients with severe mental illness, and may affect the amount of perceived coercion.\(^\text{11}\)

The doctrine of the 'least restrictive alternative' ('least' in terms of modality, severity, and duration of the action taken) should be used. Positive approaches, such as persuasion, should be the strategies of choice and negative approaches, such as threats should be avoided. Professionals should be explicit about what they are doing and why, should allow patients to tell their side of the story, and should seriously consider this information.

\textbf{10.6 CONCLUSION}

Elderly people with mental disorders are one of the most vulnerable populations in society. They often end up in unhygienic and inhumane living conditions either in the community or in the mental hospitals with increased likelihood of human rights violation. Mental health legislation acts as an important means of protecting the rights and dignity of persons with mental disorders. However, mental health care providers and hospitals should implement strategies for adequate staff, infrastructure and effective staff training on management of aggression and violence safely for staff and patients. This needs to include evidence base and safe de-escalation, as well as restraint techniques that have to be implemented only when alternative strategies like persuasion and one-to-one care fail.
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Chapter 11: Paternalism v. Autonomy – are we barking up the wrong tree?

11.1 Summary
We explore whether we can reduce paternalism by increasing patient autonomy. We argue that autonomy should not have any automatic priority over other ethical values. Thus, balancing autonomy v. other ethical pillars and finding the optimal balance between the patient’s wishes and those of other relevant stakeholders such as the patient’s family has to be dynamic over time.

Many attempts have been made across the world to reduce paternalism in medicine. In psychiatry these attempts have arguably been most pronounced because psychiatry has traditionally used legislation to sanction coercion and detention, thus reducing patient autonomy.1 For England and Wales the Mental Capacity Act 2005 explicitly sanctions the use of coercion in order to facilitate investigations and treatment that is in the patient’s best interest while the patient lacks capacity. Traditionally the argument has been that doctors and nurses have made too many decisions for patients, which has compromised patient autonomy, and recent court interpretations of the Mental Capacity Act have reinforced the importance of patient autonomy.2

11.2 Pillars of Medical Ethics
The question that arises from these developments is primarily whether we will actually be able to reduce medical paternalism by increasing patient autonomy and whether the legislation route is the best way forward in this regard. Patient autonomy is an ethical value that is important and has developed over decades. There is, however, no a priori reason to focus on any one particular ethical value above others. Beauchamp & Childress first defined the four pillars of medical ethics and included beneficence (do good), non-maleficence (do no harm), autonomy and justice.3 In medical ethics it is very clear that patient autonomy should be seen as a value of equal status to the others, not prioritised as a value of higher order. Beauchamp & Childress point out that society has a legitimate interest in good outcome and ‘doing good’. Simply put, in medical ethics doing the right thing for the patient has equal value to patient autonomy.
Other medical ethics theories such as the ethics of care focus on the dilemmas patients have to navigate within complex relationships and environments. They consider care and empathy to be primary objectives of medical and nursing input. Again, they particularly recognise the complexity of human relationships that people live in and the fact that relatives and friends may well play an important role for the patient’s decision-making and continuous treatment. An example of this different focus is seen in many societies in the developing world where more collegial decision-making processes within the family are preferred, and beneficence for the family as a whole may be seen as more important than the immediate autonomy of the individual at a particular point in time. It should be emphasised that any overruling of the patient’s autonomy is not necessarily permanent. By a temporary overruling of this principle, for example in psychotic states, the patient can regain capacity to exercise ‘true’ autonomous decisions once recovered. By focusing on patient autonomy to the detriment of beneficence, nonmaleficence and justice, we create the potential for services to become unjust as a whole and for individual decisions to regularly not turn out to be in the patient’s interest. Some may argue that this is a legitimate price to pay if it overcomes paternalism but this implies the fundamental assumption that by strengthening patients’ expressed wishes, autonomy will in fact overcome medical paternalism.

11.3 Shifting the Balance In Doctor–Patient Relationships

However, this assumption has a number of serious flaws. Paternalism is a description of a particular type of doctor–patient or nurse–patient relationship that implies that the doctor or nurse knows what is best for the patient and enforces that opinion on the patient. The patient in this type of relationship is not equal but in a subordinate position. Modern medicine has rightly argued that this has to change and that the patient not only has to be in an equal position to the doctor but he or she is also the ultimate decision-maker. Many attempts have been made to facilitate the change in the doctor relationship by educating doctors and nurses as well as patients and, in the UK, the General Medical Council has played a major role in this. Other countries have had similar drives to alter the balance towards the patient. Recent court cases about consent and autonomy in England and Wales have established the principle that even the consent process and the choice of side-effects mentioned has to be individualised towards each patient. The argument used by the judges who passed those judgments was always to reinforce autonomy in order to overcome paternalistic behaviours by doctor’s and nurses.
However, the fundamental problem with this approach of using a legalistic focus on autonomy to battle paternalism is that paternalism is about the doctor–patient relationship whereas autonomy is an ethical value. These relationships in healthcare exist in parallel to principles of ethics.⁵ Fundamental relationships can and need to change over time if we want to improve healthcare and the way we treat patients, but are we barking up the wrong tree if we think we will achieve this by compromising fundamental ethical values such as beneficence, non-maleficence and justice?

Although there is always a tendency to use legislation when desired developments do not happen quickly enough there is little evidence to suggest that this approach works to change behaviours. Furthermore, by meddling with important ethical values we run the serious risk of jeopardising good outcomes and justice within the healthcare system. This is because a constant rather than a dynamic focus on autonomy is likely to increase the number of poor outcomes, especially as clinicians regularly overestimate patients’ capacity to make decisions.⁶, ⁹ In addition it requires additional resources to facilitate individual healthcare wishes that may then have an impact on the overall ability of the system to deliver just healthcare, especially in times of austerity and limited resources. If we create an imbalance between fundamental medical ethical values, we are likely to jeopardise outcomes without addressing the fundamental problems of paternalism. Paternalism can only be changed by changes to the doctor–patient relationship that are fundamentally about equality and communication and not autonomy.⁷ Balancing autonomy vs. other ethical pillars and finding the optimal balance between the patient’s wishes and those of other relevant stakeholders such as the patient’s family has to be dynamic over time, depending on the course of the patient’s mental condition. However, a reasonable first starting point to finding solutions would be an acceptance that the primacy of the immediate expressed wish of autonomy can cause potential problems for the patient’s recovery. If we accept that there is no prima facie case that any ethical principle should trump any other in all cases, re-balancing the different interests and ethical principles in psychiatric practice could focus on outcomes that are important for the patient and his or her immediate environment. This would have to be done with a clear knowledge of important ethical principles other than autonomy and what they mean in current practice in different socioeconomic contexts.¹⁰ Different countries, different socioeconomic contexts and different cultures need to develop ways to optimise this re-balancing process so that any limitations to patient autonomy are for the shortest possible time and in the least restrictive way.
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Chapter 12: CONCLUSIONS AND DISCUSSION

There is meagre literature and data on the issue about coercion, coercive practice, standard measures on coercion and restraint from India. This thesis therefore set out to examine coercion in practices of mental health care in India. In this chapter I discuss the findings of my research (guided by the research questions), its clinical implication, and further outline an agenda for future research.

12.1 Findings on the research questions

To what extent and in what way does coercion occur in (mental) health care in the Indian subcontinent?

In study 4, I have extensively reviewed about this research sub question. Over the past few decades, mental health law in the Indian subcontinent has evolved in keeping with improved delivery of care, societal changes, and the demand for enhanced accountability from a population that is increasingly aware of its rights (Lepping & Raveesh, 2013). There has been rapid socio-economic, cultural, and psychosocial changes in the traditional, rurally oriented, and family centered societies of the Indian subcontinent. Despite the fact that family and friends are often intimately involved in patient care and often resort to coercion, the criteria for coercion and restraint have not been defined. Many people with mental illness are abandoned by their family caregivers (Poreddi, et al., 2013) and their outcome is both unknown and a matter of grave concern. As such, other than in India, there is no formal research conducted on coercion in the subcontinent. Study 4 has extensively reviewed about this research sub question. Here I would like to give a brief overview of status of mental health care in different countries in the subcontinent.

In Srilanka, the mental health policy sanctions involuntary treatment only at the country’s premier mental health facility, the National Institute of Mental Health. However, people with mental disorder are often treated at regional centers. Due to social stigma, lack of awareness, and financial constraints, involuntary admissions are mostly unchallenged (Weerasundera, 2011). In Bangladesh, mental disorders are not covered by any social insurance schemes and there is no human rights review body in the country to inspect mental health facilities (World Health Organization 2009). There are no legislative
or financial provisions to protect and provide support for mental health service users in respect to their rights. In Pakistan, mental health care includes access to the least restrictive care, rights, family, capacity, and guardianship issues for people with mental illness. It also considers voluntary and involuntary treatment, the accreditation of professionals and facilities, mechanisms to oversee involuntary admission and treatment, and mechanisms to implement the provisions of mental health legislation (World Health Organization, 2009). Nepal has no human rights review body with the authority to inspect mental health facilities and impose sanctions on those facilities that persistently violate patients’ rights (Upadhyaya, 2009). Our current research is the gateway for the need to focus on the sensitive issue of coercion across the Indian subcontinent.

What are the prevalence, context and effects of patient and visitor violence towards staff in medical & psychiatric wards in India?

To answer this question we looked into patient and visitor violence towards staff in medical and psychiatric wards in India (study 5) and observed a correlation between patient aggression and coercive practices. Our study compared the frequency of aggression, by patient and family caregivers in the inpatient ward of a general hospital psychiatric unit with that of medical and surgical ward in India. It was found that 16% of staff in psychiatric wards were subjected to some form of patient and visitor violence (PVV) in the preceding 4 weeks, and 57% of staff in medical wards experienced PVV. Patients and visitors were almost equal sources of this violence in both cases. The total number of incidents appears high compared to admission wards in high income countries (Nijman, et al., 2005). Aggression towards doctors and nurses is seen in only 16% of the incidents in our study which is much lower than in high income countries. This may be explained by the fact there are far fewer nurses in Indian wards in all specialties compared to staffing levels in high-income countries. The low figure may also be explained by the fact that the patients’ relatives spend more direct time with the patient than with the staff (RCPsych, 2007). We further observed the incidences of violence in study 6 (Observational study of aggressive behaviour and coercion on an Indian acute ward) for objective non-biased neutral observer reporting and found that family caregivers provoked about 35% of the incidents, and were also involved in controlling aggression by either talking to the patient or participating in coercion. We found that more severe aggressive incidents and attacks on nursing and medical staff are more likely to lead to coercive measures than incidents targeting relatives. Our data shows that most coercive interventions by staff are reactive rather than proactive. Even though the same observation study could not be conducted in
medical (non-psychiatric) wards for logistical reasons, we found a significant number of aggressive incidents with coercive measures in medical wards, which is a concern in health care in general.

Furthermore, studies most often discriminate between verbal and physical violence (Hahn et al., 2008). In this study too, the distinction proved to be significant. We found that verbal aggression was the most common occurrence followed by verbal threats, whilst physical assaults were relatively rare. PVV and coercive interventions were significantly more common in medical than in psychiatric wards. The most common sources of violence in our study were patients and relatives. One explanation for this may be that family caregivers stay with patients in Indian hospitals, irrespective of the sub-specialty of health care. Health care professionals working in general hospitals are at high risk of experiencing various forms of violence at some point during their career. Interactions in which patient or visitors endure frustrating experiences also contribute to violence in general hospitals (non-psychiatric wards). Examples include procedures that induce pain and/or anxiety and procedures that encourage the patient to feel as though he or she is not being taken or treated seriously (Winstanley, 2005).

To understand why coercion is more prevalent in medical wards, it is important to note that the patient’s health state can also contribute to violent incidents. For example, patients with reduced cognitive abilities (patients in intensive care, post-operative and geriatric units) often have difficulty understanding situations adequately. This may lead health care professional to believe that some violence is inevitable. This could also imply that the risks for violence are higher in some wards. However, instead of simply accepting violence as a reality in these wards, health care professionals should assess the extent to which patients or family caregivers have problems understanding the situation and then attempt to increase this understanding. These situations require specific interventions and the temporal resources of staff (Winstanley & Whittington, 2004). In our study 5, I found only 4% of the staff had formal PVV management training, but this was associated with significantly fewer threats and physical abuse, and 7% of the staff had formal de-escalation training. Researchers have reported that health care professionals including mental health professionals should also consider the characteristics of the workplace, characteristics of patient-provider interaction, and the patients’ current health state to prevent violence and intervene in a professional way (Whittington & Wykes, 1996; Duxbury, 2002; Duxbury & Whittington, 2005). One of the main goals of this thesis in its
move towards zero coercion was identifying precisely these multifarious characteristics in the context of health care in India.

*What are the triggering factors for aggressive behaviour and subsequent coercive measures in Indian inpatients mental health care?*

In study 5, I looked at the triggers of coercion; specifically from whom coercion was triggered. The findings were as follows: from the patient 7.6%; from the family caregivers 8%; and from others (family caregiver for other patients, security personal and ward atmosphere) 8%. This is a significant finding in clarifying and dismissing the stereotype that patients are the main source of coercion. Yet, the fact remains that in spite of understanding some of the triggering factors for coercion, there are still some difficulties in predicting it. A major reason for this is the often exclusive focus on patient’s properties alone, e.g., their history of violence, psychopathology, and impaired impulsivity control. Most causal and predictive research isolates these attributes and attempts to build individualistic models out of them. In our observational study (Study 6), I found no significant difference between diagnostic categories and the frequency of incidence per day, the frequency of physical attacks on a person per day and the frequency of severe incidents per day. In the study 6 I observed that if the target of aggression was a doctor or nurse, the likelihood of any chemical or physical restraint increased. An increase in incident severity led to an increased likelihood of chemical or physical restraint being used. It has been reported that aversive stimulation, the use of coercion, limit setting and an authoritarian nursing style have all been reported as precursors leading to coercive interventions (Lancee, et al., 1995 & Cheung et al. 1997). Negative staff interaction in particular, is increasingly identified as an antecedent to non-therapeutic relationships (Duxbury, 2002). The problem may be exacerbated by staff who distance themselves after assault, thus increasing the risk of future assaults and restrictive practices (Whittington & Wykes, 1994).

In addition to interpersonal interactions and behaviour as key factors contributing to aggression, researchers have also shown that ward design, ward architecture, ward regime and the overall ward atmosphere and culture can act as an aversive stimulation. An over-controlling and over-sanctioning atmosphere, which may be justified by the hospital policy, will certainly increase the aversive stimulation of the patient and subsequently also increase the potential for violence and coercive intervention (Ritcher & Whittington, 2006). As with the ward atmosphere in our setting depicted in study 6, our in -
patient set up in this research was also found to have an insufficient number of beds in relation to the population of the catchment area. In such a circumstance, with family caregivers often residing with the patient, balancing safety poses a much greater challenge. Moreover, non-psychiatric nursing staffs who do not have any training in management of aggression are posted to psychiatry wards. Training in physical and nonphysical techniques for aggression management is now a prerequisite for all mental health staff, especially those in acute care setting in high income countries (Richter & Whittington, 2006). Yet, in our findings we found that this was lacking.

*How is Coercion perceived by Patient, Caregiver and Staff?*

I have tried to discuss the perception of coercion from the points of view of different stakeholders in study 7 (Clinical correlates and predictors of perceived coercion among psychiatric inpatients: A prospective pilot study), study 8 (Perceived coercion in persons with mental disorder in India: A cross-sectional) and study 9 (Staff and caregiver attitude to coercion in India).

Coercive experiences as understood from our above three studies are associated with several socio-demographic and clinical variables, especially with respect to perceived coercion and negative pressure. I found in our study 8 (conducted in Mysuru) that perceived coercion by patients was higher among females, among Muslims and Christians rather than Hindus, and among those from lower income groups. Perceived coercion decreased with former experiences of coercion, forensic history and a longer duration of illness. It showed that despite the fact that India is a more community oriented society compared to high income countries, coercion is a reality for Indian patients. In study 7 conducted at Bengaluru, I found the factors that increase perceived coercion include poor insight, poor global functioning, and a lack of reduction in illness severity. In keeping with studies from the UK, 87% of patients reported that their admission was justified even though many felt coerced during their hospital stay. Wynn (2003) interviewed patients who had been restrained and reported that some felt the use of restraint had been warranted, while others were more critical. Many thought that the use of restraint could have been avoided. A study on forced medication found that patients and staff did not share the same views of what patients experienced when forcibly medicated. Also, a minority of patients, and not as many as the staff thought, retrospectively approved of the use of forced medication (Haglund, Von Knorring, & Von Knorring, 2003). We also observed in our findings that perceived coercion and subjective coercive experiences tend to improve over
time. This can be partly explained either by recall bias effect within a patient (Hassan, 2005) or by the fact that patients may forget the coercion they had perceived in the hospital while feeling better. It may also be the case that the positive effects of treatments during hospitalisation influence coercion perception. In addition, other explanations could be a decrease in severity of symptoms, and improvement in global functioning, leading the patient to an improved insight into the illness and consequently less perceived coercion.

Our study shows that most psychiatrists feel that coercion violates the patients’ integrity and may harm therapeutic relationships. Psychiatrists have greater experience with various treatment interventions than family caregivers. They may also internalise different normative ethical attitudes during their medical education. The attitudes of the psychiatrists are in line with the findings in the European samples and in a recent Australian survey (Kinner, et al., 2016). In two Dutch studies, a personnel mix of more and less experienced staff (Janssen, et al., 2007) and the availability and application of clear treatment protocols (Verlinde, et al., 2016) predicted less use of coercion. This emphasises the need for a clear no-coercive-treatment protocol in the Indian mental health care setting. The staff’s attitude may be influenced by knowledge of the hospital resources; their training in coercive practices, locally supervised operating procedures for coercive interventions, and cultural factors such as acceptance of doctor’s decisions (Viswanath & Chaturvedi, 2012).

Psychiatrists agree more often than family caregivers to the statements regarding the use of coercion for safety reasons in our study. Both psychiatrists and family caregivers agreed that coercion should not be used too often in treatment. But, almost half of all family caregivers did want to see more coercion as an intervention, probably as family caregivers often face difficulty in bringing the person with mental disorder to the hospital. Agreement only existed in the judgment about the necessity of coercion in cases of aggression and lack of insight. Staff and family caregivers agreed that coercion could be reduced significantly, given more time and personal contact. These findings are similar to a Norwegian study (Wynn, et al., 2011) in which researchers found a significant relationship between staff attitudes and the use of restraint. The nursing staff, who did not use restraint, had more negative attitudes toward using it and more knowledge about the regulations for restraint use (Janssen, Noorthoorn, Linge & Lendemeijer, 2007).
The attitudes of family caregivers towards patients may be different, because in the Indian context, family caregivers are often confronted extensively with the patient’s symptoms. They feel a need for fast recovery as the economic costs of the illness may lead to significant financial distress. The family caregiver’s perception of outward or inward aggression or suicidality may differ from that of the psychiatrist’s as they are emotionally involved. Moreover, the overall education among family caregivers is by and large less than that of staff, and in some areas, family caregivers may have hardly any experience with mental illness and associate it with negative outcomes.

What are the dilemmas in reducing coercion in mental health care?

The experience of coercion is common, as I found from our studies in part II of this thesis. In our observational study (Study 6), I found high ward prevalence of coercive measures during psychiatric hospital admissions with one or more types of restraint used in 38% of admitted patients, of which 27% were subjected to intravenous injections when the target of their aggression was a doctor or nurse. From study 7 I understand that coercion is a dynamic state and it can change with treatment and care. Clinical care may result in an improvement in global functioning and insight, as well as in a reduction in the severity of illness, consequently leading to less coercion. This makes way for the possibility of developing a standard clinical guideline in mental health care in India focusing on the mentioned variables without any coercive measures. Recent studies have indicated that the use of restraint can exacerbate mental health issues and ironically, contribute to an increase in behaviours of concern (Webber, McVilly, & Chan, 2011; Chan et al., 2012).

Contrarily, in our study 7, during the time of discharge, a majority of patients reported that their admission was justified, even though they felt coerced during hospital stay and agreed to treatment against their will within a safe, standardised coercive practice. A possible explanation for decrease in coercive severity and frequency at discharge maybe due to the effective in-patient treatments and insight facilitation work done as part of the treatment programme.

The evidence to date emphasises the importance of the attitudes of mental health workers towards their patients as a key factor that may be amenable to change. A combination of listening and respecting the patient’s view is likely to minimise any experience of coercion, even if the outcome is compulsory treatment (Newton-Howes,
Although mental health professionals have worked hard to minimise the negative attitudes towards mental health in the community, these negative attitudes remain present even within services, suggesting a need to remain focused on the interactions of all clinicians (Newton-Howes, Tyrer & Weaver, 2008). They need to be reflective about how they can work with individuals to maximise the chances of a positive outcome from a patient perspective, and to eliminate coercion in day-to-day care. In a context of commitment and care in mental health, communication has been pivotal, whether before, during or after the use of coercion or pressure. In the existing situation in Indian mental health care, no agreements are made beforehand with persons with mental disorders. When coercion or pressure is used, the family caregiver and the patient each holds different views as I have found in study 8 and study 9.

12.2 Summary of findings and conclusion

1. Patient and visitor violence (PVV) is a significant problem in India, especially in medical wards. Aggression management training may be a way to reduce the prevalence of PVV.
2. Family caregivers are often triggers and victims of aggression in the investigated acute Indian psychiatric wards.
3. Doctors and nurses are less likely to be victims, but aggression towards them leads more commonly to coercive measures.
4. Perceived coercion is a reality in India. Levels of perceived coercion and the populations affected are similar to those in high-income countries.
5. Coercion is a dynamic state, and changes with treatment and care. Clinical care focusing on improvement in global functioning and insight, as well as in a reduction in the severity of illness, consequently leads to less coercion.
7. At the time of discharge, a majority of patients reported that their admission was justified, even though they felt coerced during hospital stay.
8. Family caregivers and psychiatrists perceive a relative lack of resources as the main reason for coercion, and believe that it could be reduced in clinical practice by having more time and personal interactions with patients.
9. Family caregivers and professionals have different attitudes toward coercion from clinical and socio-demographic perspectives respectively.
10. Psychiatrists’ normative attitudes toward coercion are remarkably similar to attitudes of psychiatrists in European countries.

12.3 Implications of coercion in mental health care

A majority of in-patient mental health care hospitals in India admit persons with mental disorders along with family caregivers. The obligation of caring for the patients, thus, shifts unknowingly and unintentionally from the nursing staff to family caregivers. This shifts the target of aggression from the medical staff towards the relatives, who act as buffers for medical professionals. Indeed, it remains impossible to determine strict boundaries between situations in which family caregivers, the patient and his/her family would be best advised to continue the process of deliberation, and situations in which coercion is justified. Caregivers should be careful not to opt for coercive procedures too quickly, but they should also take care to avoid situations in which the intervention to mitigate the threat of harm is too late.

In study 7, I attempted to understand issues such as restriction of autonomy, interpersonal relationships and dignity from the perspectives of persons with mental disorders. I can imply from the findings that in Indian mental health care practice, it is more important, from the perspective of treatment, to enable a patient to identify with a concrete situation. This means that actual autonomy is attributed to a dynamic character, and is not something that is present or absent—rather, it has to be developed through interaction with ever changing circumstances. Within the family caregiver-patient relationship, autonomy is a challenge. It is not only the patient who decides after having received and understood the family caregiver’s information. Rather, the patient decides together with the family caregiver (supportive decision making). The patient is stimulated to regain his identity, and to make decisions that fit this identity. If the development of an identity is an interpersonal process, then autonomy too is intrinsically linked to others.

While the autonomy and dignity of the person with a mental disorder are taken into consideration, the therapeutic relationship also needs to be improved. The promotion of therapeutic relationships is necessary if aggression is to be handled more effectively (Duxbury 2002). While this clearly involves a change in policies and targeted training, it must also address philosophies of care and negative organisational cultures (Whittington 2003). Since the beginning of the 21st century, successful initiatives to reduce the use of coercive interventions have started to emerge at the individual hospital level, mostly
reported from the United States (Gaskin, Elsom, & Happell, 2007). Programmes contain individually planned influential factors, which have been systematically targeted to produce changes at different levels of organisation. Common factors typically included in these programmes comprise emphasising the impact of leadership on organisational change, systematic and rigorous monitoring of the use of coercive measures, staff education and a change in the therapeutic environment. Reduction efforts may be accompanied by an increase in violent incident rates, if the staff have not been given specific training or experience in the management of violent patients except by using coercion (Khadivi, Patel, Atkinson, & Levine, 2004). Evidence indicates that reduction in the use of coercion is possible without increasing assaults by the patients (Hellerstein, Staub, & Lequesne, 2007; Steinert, et al., 2008).

Recent evidence-based measures to predict and reduce aggression and restrictive coercive practices in psychiatric wards could be adapted to reduce the reactive use of coercion and also reduce the risk to relatives and staff (Abderhalden, et al., 2008 & van de Sande, et al., 2011). These observations may become very relevant to psychiatric practice in high income countries too, as more family caregiver involvement is considered in dementia care. In places where there is limited visiting from families and others and care decisions are made by clinicians alone (often doctors alone), there is the potential risk of coercion being extended in terms of both intensity and duration, especially if that is part of the culture of practice (Fiorillo, et al., 2011). Questions remain, in Indian mental health care, about how to protect and potentially train family caregivers in order to have a safe and meaningful involvement in the patient’s care, and strategies need to be developed to facilitate good outcomes.

12.4 Alternatives to coercive interventions

It needs to be recognised that individuals have died from being restrained in extreme cases. In Australia, deaths have resulted from asphyxia and cardiac arrest during the use of bodily force. There have been cases of deaths from overdoses resulting from the use of medication to control behaviour, and the use of a wheelchair restraint strap on an elderly person (McSherry, 2017). The United Nations’ Special Rapporteur on Torture has called for a ban on the use of restraint in health care settings because of its adverse effects, although it appears he is referring to physical and mechanical restraint rather than chemical restraint (Special Rapporteur on Torture, 2013).
A successful healthcare intervention needs to be understood from these two perspectives: does it work and is it acceptable? Coercive interventions have difficulties on both these tests. Use of restraints can be a stressful and humiliating event both for patients and staff members who impose these measures. This can traumatise patients and staff members, damage the therapeutic relationship, and hinder patient recovery. It would be more humane, just and effective to implement alternatives that serve to reduce experienced and actual coercion, promote the wider involvement of people in their care, and potentially improve outcome. Therefore, health care staff members should attempt alternative strategies or interventions prior to the use of any restraints. Alternatives to coercion strategies play a significant role in preventing the use of restraints and avoiding the potential harmful outcomes associated with the use of restraints (coercive practice). Restraint reduction programs focus on symptom management, safety measures, supportive techniques and structural techniques.

Managing aggressive and violent behaviours has become an essential skill important to those who are involved with psychiatric patients. A large amount of evidence has been collected that demonstrates that behavioural approaches to care can provide effective alternatives to reliance on restraint (Richter & Whittington, 2006). Successful strategies such as clear guidelines and a comprehensive reporting requirement; commitment by management; adequate staffing levels; and staff training in the safe use of, and alternatives to restraint are keys to prevention. Proper training increases the behavioural competence of all direct care staff while administrative structure encourages the competent application of behavioural skills and ensures effective management of the behaviour by those who are relatively more competent.

The National Association of State Mental Health Program Directors in the United States has developed Six Core Strategies to Reduce the Use of Seclusion and Restraint (2005). These strategies are:
1. “Leadership towards Organizational Change”— articulating a philosophy of care that embraces seclusion and restraint reduction;
2. “Use of Data to Inform Practice” — using data in an empirical, ‘non-punitive’ way to examine and monitor patterns of seclusion and restraint use;
3. “Workforce Development” — developing procedures, practices and training that is based on knowledge and principles of mental health recovery;
4. “Use of Prevention Tools” — using assessments and resources to individualise aggression prevention;
5. “Consumer Roles in Inpatient Settings” — including consumers, carers and advocates in seclusion and restraint reduction initiatives; and
6. “Debriefing Techniques” — conducting an analysis of why seclusion and restraint occur and evaluating the impacts of these practices on individuals with lived experience.

In study 5 I observed that only a few of the nursing staff (4%) had formal training in debriefing and de-escalation methods. They reported less threats/assaults and were able to handle aggression without any coercive measures.

12.5 Validity of the findings

12.5.1 External validity

The applicability of the findings to the broader Indian context and also to other low and middle income countries is a question that needs to be addressed. We believe that the psychiatric ward in Mysore is paradigmatic of general hospital psychiatric units in middle and low income countries in Asia. We therefore believe that the findings are generalisable to settings in the Indian subcontinent and beyond. Moreover, the Bengaluru centre is an exclusive mental health institution which is managed by the federal government of India, which runs similar institutions across country, all having similar staff recruitment and patient care policies. Chapter 4 specifically included reviews about coercion in mental health services in the Indian subcontinent and the Middle East. Chapter 10 discussed the clinical and ethical dilemmas taking an older population as a sample and attempted to learn from the findings in this review. Chapter 11 was a comparison of the experiences between the west and Indian mental health, with a focus on autonomy. We developed the Mysore Declaration, recognising the rights of the persons with mental disorder and restoring these rights without indulging in coercive measures. This can act as a guide not only to India and other developing nations but to developed nations as well.

12.5.2 Internal validity

Reliable and time-efficient methods of recording aggression and coercion were used in our psychiatric wards in order to get complete and factual information on the
magnitude of the problem of coercion. In study 5 we tried to compare inpatient patient and visitor violence and use of coercive interventions from a government hospital in both medical and psychiatric wards with a privately run hospital to minimise the selection bias. In study 6, Non-interacting, independent observers (specifically trained mental health clinicians) conducted 24 hour observations and gave structured reports on all violent episodes and coercive measures during a 30-day period. By using reports from independent and non-intervening observers, it is much more likely to achieve more reliable reports on violent interactions in psychiatric wards. Observers are not part of the violence or coercion, thus ensuring neutrality and objectivity. We focused on the patients’ perspective in study 7 conducted at Bengaluru, which was a pilot for the larger study that was done in Mysuru (Study 8). We extended the focus from the patient to staff and family caregivers in study 9 to understand coercion from a broader perspective of all the stakeholders. In study 7 we included all patients who are admitted, which included both voluntary and involuntary admission, to know the internal consistency. In this study, all persons with mental disorder were recruited by computer-generated random number sampling and interviewed at time of admission, with consent from a family caregiver. Assessments about perceived coercion were done, first, within three days of admission, when the persons with mental disorder co-operated for a face-to-face interview by a primary investigator using a validated scale for establishing clinical, socio-demographic and coercion outcome; then to look for any changes, all coercion assessments were re-assessed at time of discharge.

12.6 Strengths of this research

1. To our knowledge this is the first study in India to report the prevalence of patient and visitor violence using a validated and standardised tool allowing for comparison with such data from high income countries.

2. The observational study is one of the first Indian studies examining non-professional care giver involvement in hospital care. Also, it is one of the first studies to incorporate an independent and consistent observer rating and a consistency in reporting.

3. To the best of our knowledge, this is the first prospective study in South East Asia on clinical correlates and predictors of patient’s perceived coercion during hospital treatment.
4. This is the first study from the region comparing attitudes between family caregivers and psychiatrists.

12.7 Limitations

1. In the Indian public mental health setting, admission criteria focus on the need for additional care that cannot be provided in the patient’s home by the family. There is therefore a selection bias towards more severely disturbed and unmanageable behaviour, as compared to high income country admission wards.

2. Reliance on hospitalised data may lead to an overestimation of the prevalence of aggressive behaviour in the psychiatric population as a whole.

3. In the study on Patient and Visitor Violence, a majority of the participants were not willing to name the source of violence. The missing data in relation to the “perpetrator” of the abuse may represent the unwillingness and hesitancy by staff to name the individuals due to fear of personal consequences.

4. The study conducted is limited to inpatient mental health care, and includes neither outpatients nor a community sample.

5. The study was conducted mainly in a government set up which predominantly caters to a low socio-economic population. Perceptions among high income population visiting private/corporate mental health care establishments may differ.

12.8 Future Recommendations on Research

Competence in behavioural rehabilitation or behavioural competence among psychiatric direct care staff can be assessed by addressing quality measures such as internal consistency, temporal stability, content validity, construct validity and criterion related validity. These measures directly assess situations that direct care staff encounter in their daily practice, and demonstrate that staff members who practice behavioural competence recognize how the environment, including their own behaviour, can influence the behaviour of others. Such measures need to be used by clinical administrators to establish staffing patterns and plan programming changes to attain zero coercion in mental health care in India.

Whilst on the one hand, the risk to relatives of being victims of violence has to be addressed, the presence of nonprofessional care givers nevertheless opens up the
opportunity for continuous psycho-education and treatment once the patient has been
discharged, taking into account the risk of violent altercations after discharge. This
potentially allows for intense treatment to continue at home, led by family members,
supervised and guided by staff. This may reduce risk of violence in the long term.
Further studies are needed to examine the dynamics of the presence of relatives in
relation to violence and coercion using a qualitative approach. Psycho-educational
interventions could be investigated.

The differences between relatively comparable wards, hospitals and geographical
areas in the amount and type of coercion used need to be studied across health care. It is
harder to understand the large differences in the use of coercive measures within
one country with one legal system, than it is to understand the differences between
countries. Corroborative findings from larger multi-centre, multi-disciplinary Indian
studies can help us develop clear strategies to eliminate coercive interventions.

Testing the feasibility and outcome of six core strategies by United States National
Association of State Mental Health Program in the Indian setting.

Furthermore, the effectiveness of advanced directives which may reduce perceived
coercion as prescribed in the new Mental Health Care Act 2017 in the Indian context
needs exploration.

Caregivers and professionals have very different attitudes toward coercion, and
future research should focus on how this gap can be bridged to attain zero coercion.

Finally, future research projects should aim to develop a complex model that includes
organisational policies and structure, situational variation between wards, and
personnel and interaction related factors.
Summary: Coercion is recognised as a problem in health services around the world. Very little is known about the use and utility of coercive measures in psychiatry and other medical specialties in India, although the existing evidence supports the view that coercion is widely used. In February 2013 experts from India and Europe came together in Mysore, India, for an international symposium on coercion. A declaration was drafted, discussed and ratified which defines coercive measures for the Indian context and outlines aims and possible ways to minimise coercion in medical settings in India. This paper outlines the main points of the declaration.

Coercion is recognised as a problem in health services around the world. There is a growing body of evidence analysing the prevalence of coercive measures as well as randomised controlled trials comparing various types of coercion (Abderhalden, et al., 2008 & Steinert, et al., 2010). Recent leverage studies have opened up the field to include soft pressures exerted on patients by services (Monahan, et al., 2005 & Burns, et al., 2011). Almost the entire current literature comes from higher-income countries. Very little is known about the use and utility of coercive measures in psychiatry and other medical specialties in India. The existing evidence supports the view that coercion is widely used, although patterns of its use may differ. Some evidence suggests relatively high levels of cooperation between family members and clinicians in the use of coercive measures (Srinivasan & Thara, 2002).

There has been a rapid change in the socioeconomic, cultural and psychosocial profiles of the traditional, rurally oriented and family-centred societies of India and Asia in general. Despite the fact that family and friends are often intimately involved in patients’ care in India, standards of coercion and restraint have not been defined. With a lack of international comparisons it is all the more important to be aware of patients’ individual rights and preferences regarding the necessity, mode and place of psychiatric treatment, but also to recognize the legitimate interests and wishes of family members. The recent draft proposal to amend the Indian Mental Health Act has not brought certainty to issues of coercion (Shah & Basu, 2010).
Drafting of the declaration

In February 2013 experts from India and Europe came together in Mysore, India, for an international symposium on coercion. The experts included members of the newly founded Indian Forensic Mental Health Association and the European Violence in Psychiatry Research Group. The meeting was supported by senior staff from Betsi Cadwaladr University Health Board and Bangor University (North Wales, UK). A declaration was drafted, discussed and ratified which defines coercive measures for the Indian context and outlines its aims, as well as ways to minimise coercion in medical settings in India.

The declaration

The declaration asserts that:

- there is an urgent need for the recognition and implementation of the rights of persons with mental illness, following principles with regard to equality, security, liberty, health, integrity and dignity of all people, with a mental illness or not.

It goes on:

- All parties responsible for the care and treatment of mental illness should work towards the elimination of all forms of discrimination, stigmatisation and violence, cruel, inhumane or degrading treatment. We affirm that disproportionate, unsafe or prolonged coercion or violence against persons with mental illness constitutes the violation of the human rights and fundamental freedoms and impairs or nullifies their enjoyment of those rights and freedoms. We will strive to uphold the human rights of persons with mental illness. We will work towards the prevention of violation, promotion and protection of their rights.

The declaration recognises the potential tension between the rights of patients who refuse medication and the benefits of potential restoration to normal functioning through involuntary treatment, as well as the wishes of family members, who often play an important role in the treatment of mental illness in India. The declaration states that:

- "Notwithstanding this debate, persons with mental illness are entitled to the equal enjoyment and protection of all human rights and fundamental freedoms in the political, economic, social, cultural, and civil or any other field".

It further reiterates rights and responsibilities of patients as well as society towards persons with mental illness. This includes an emphasis on capacity and patient rights, but
the declaration also focuses on facilities and least restrictive treatment. It suggests that a balance has to be struck between patients’ autonomy and the suffering that no treatment may cause. The Hawaii declaration (see http://www.codex.vr.se/texts/hawaii.html) suggests that compulsory treatment may (or even should) be given provided it is done in the best interests of the patient. Patients should nonetheless be encouraged to participate as fully as possible in all decisions about their care.

The role of the family in caring for people who are mentally ill in India needs due consideration. The declaration takes into account this specific Indian context:

“The family in India plays a major role in health seeking for its constituents. Any intervention planned for the patient should take into account the family’s considerable influence over many aspects of patient management, including outpatient consultation and continuing care”.

The declaration names possible barriers standing in the way of achieving the desired standards. Barriers are partly of a legal nature because the Indian Mental Health Act does not, for example, define when a patient is competent to make decisions. There is no separate provision for enforced treatment. However, there are clear rights for people with mental illness under the Indian Constitution (Pyle, 2004). Additional barriers include lack of awareness, prejudice, lack of resources and lack of adequate advocacy. The declaration sets out measures that are needed to overcome such barriers and in so doing describes a potential road map to achieving less coercion in India:

- raising awareness
- benchmarking, using validated tools to count and document the use of coercive measures
- agreeing a definition of restraint and other coercive measures.

Standardisation and benchmarking are internationally recognised as ways to drive forward quality improvements. In addition, guidelines for the use of medication should be developed regionally or nationally. They should be based on evidence, and be practical in the Indian context. Guidelines for restraint and rapid tranquillisation can improve safety and avoid idiosyncratic practice (Lepping, 2013). Staff training both to reduce the use of coercive measures (including training in control and restraint that emphasises physical restraint as the intervention of last resort) and to introduce safer methods of restraint has proved an effective measure in many parts of Europe. Comparisons of benchmarking results have been another important tool in Europe. This allows the identification of areas
where practice is outside the norm, which can then be prioritised for intervention. The declaration defines various types of restraint for the Indian context. An agreed definition of restraint allows better communication without misunderstandings between various stakeholders. The declaration asserts that the phrase ‘violence and/or coercion against a person with mental illness’ means an act of violence that results in or is likely to result in physical, sexual, economic or psychological harm or suffering to a person with a mental illness, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life. The definitions cover physical restraint, chemical restraint, mechanical restraint, environmental restraint, seclusion and psychological restraint. The declaration broadly separates unplanned and planned restraint.

Legal and policy reform is a key strategy identified to promote human rights. Mental health Policies and laws in low- and middle-income countries often fail to incorporate current international human rights and best practice standards to prevent violation of human rights (Drew, et al., 2011). The Mysore declaration should stimulate advocacy and education campaigns, and it suggests establishing legal and oversight mechanisms to prevent human rights violations.

In order to achieve these goals the declaration calls upon healthcare providers in India to develop strategic plans. Benchmarking, regular analysis of data, regional, national and international comparisons and transparency can help to raise awareness and allows key stakeholders to prioritise funding where deficiencies are identified. Organisational strategies will be needed to implement training and raise awareness. This will require the support of senior management in stakeholder organisations. Raising awareness among patients and their families will be an important aspect of any national strategy.
REFERENCES


Epilogue: Mysore Declaration on Coercion in Psychiatry

13.1 Introduction

Coercion is recognized as a problem in health services around the world. There is a growing desire to explore the reasons for the use of coercion and develop an evidence base of research to inform debates and discussion as well as change in practice. At a recent international symposium in Mysore, India a group of experts from Europe and India articulated a set of best practice principles to support the minimization of the use of coercion. We urge health practitioners and policy makers in government and medical education to consider these principles and translate them into clinical practice.

13.2 The Indian context

There is rapid change in socioeconomic, cultural, and psychosocial profiles of the traditional rural-oriented and family-centered societies of India and Asia in general. Despite these changes, family and friends are intimately involved in patients’ care in India. For example, covert administration of antipsychotic medication by family members under medical advice to noncompliant patients with schizophrenia is observed to be common practice. Various standards on coercion and restraint have been defined in Europe with varying degrees of success in implementing them. There is a lack of data in India regarding the use of coercive measures and other forms of leverage in medical practice. This makes international comparisons difficult. It is therefore all the more important to be aware of the patients’ individual rights and preferences regarding the necessity, mode, and venue of psychiatric treatment, along with the recognition of the legitimate interests and wishes of family members.

The draft proposed amendments to the Mental Health Act of India 1987 (MHA 1987) classifies “admissions” as patients being ‘independent’ and able to decide for him/herself, without support or requiring minimal support. “Supported admissions” are those where the patient needs substantial or high levels of support, although the draft proposals remain vague about provisions for assessing and implementing admissions. High levels of support (bordering on 100% support) are to be viewed as a temporary phenomenon and as soon as the person is judged to be able to make independent decisions, he or she should be allowed to make his or her own decisions.
13.3 The declaration

There is an urgent need for the recognition and implementation of the rights of persons with mental illness, following principles with regard to equality, security, liberty, health, integrity and dignity of all people, with a mental illness or not. All parties responsible for the care and treatment of mental illness should work towards the elimination of all forms of discrimination, stigmatization, and violence, cruel, inhuman or degrading treatment. We affirm that disproportionate, unsafe or prolonged coercion or violence against persons with mental illness constitutes a violation of the human rights and fundamental freedoms, and impairs or nullifies their enjoyment of those rights and freedoms. We will strive to uphold the human rights of persons with mental illness. We will work towards the prevention of violation, promotion and protection of their rights.

13.4 What are the barriers to achieving these standards?

Refusal to consent and incompetency to consent are included in the section on 'admission under special circumstances' in the MHA 1987. It has been strongly criticized that 'competence' has not been defined in the purview of the MHA. In the MHA, there is no separate provision for forced treatment. Involuntary treatment is thus presumed to be authorized under the section on admission under special circumstances and involuntary admission. As a 'mentally ill' person is defined as a person who needs treatment because of his mental disorder, it is commonly extrapolated that under Sections 19 and 20, it is the psychiatrist's duty to treat the mentally ill person. In other words, the clauses of the Act do not set out or help to resolve the dilemmas that treating clinicians face. Specific guidelines, thresholds or criteria as to the circumstances where involuntary treatment or admission is justified are woefully missing from the existing MHA.

Other barriers to achieving the expected standards include

☐ Lack of awareness in the patient (or the family) about the treatment and the outcomes to be achieved.

☐ The assumption that mental illness is always and necessarily accompanied by lack of capacity.

☐ The lack of provision for advanced planning (including advanced directives) in the event of future incapacity, compulsory admissions and treatment in patients with severe mental illness.
Continuing prevalence of perceived coercion and negative approaches to lack of compliance, including threats and other forms of leverage.

Lack of resources, which encourages therapeutic impatience and coercion.

Lack of training and support to clinical staff on safe management of disturbed behaviour and treatment refusal

Lack of adequate advocacy and representation of patients’ wishes

13.5 What measures are needed to overcome these barriers?

The initial phase to achieve a reduction of coercive measures and coercive leverage involves:

- Raising awareness, Benchmarking, using validated tools to count and document coercive measures
- Agreeing a definition of restraint and other coercive measures.

13.6 Definitions

We recognize the following definitions:

The term "violence and/or coercion against person with mental illness" means an act of violence that results in, or is likely to result in, physical, sexual, economical or psychological harm or suffering to person with mental illness, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life.

**Physical restraint**: direct physical contact between persons where force is positively applied against resistance, either to restrict movement or mobility or to disengage from harmful behaviour displayed by an individual.

**Chemical restraint**: involves the use of medication to restrain. It differs from therapeutic sedation in that it does not have a directly therapeutic purpose but is primarily employed to control undesirable behaviour.

**Mechanical restraint** involves the use of equipment. Examples include specially designed mittens in intensive care settings; everyday equipment, such as using a heavy table or belt to stop the person getting out of their chair; or using bedrails to stop a person from getting out of bed. Controls on freedom of movement – such as keys, baffle locks and keypads – can also be a form of mechanical restraint.

**Environmental restraint** involves buildings designed to limit peoples' freedom of movement, including locked doors, electronic key pads, double door handles and baffle locks.
Seclusion is an important sub-type of environmental restraint. It is defined as ‘placing of a person, at any time and for any duration, alone in an area with the door(s) shut in such a way as to prevent free exit from that area’.

Psychological restraint includes constantly telling a person not to do something, or that doing what they want to do is not allowed, or is too dangerous. It may include depriving a person of lifestyle choices by, for example, telling them what time to go to bed or to get up. It might also include depriving individuals of equipment or possessions they consider necessary to do what they want to do, for example removal of walking aids, glasses, outdoor clothing or keeping the person in nightwear with the intention of preventing them from leaving.

Broadly speaking, the need to use restraint, particularly physical restraint, arises from two distinct circumstances: those which are planned and those which are unplanned.

Unplanned physical restraint refers to those incidents requiring restrictive physical interventions which are unforeseen and unexpected. Under these circumstances immediacy does not allow time to plan ahead. Staff are guided by best practice guidelines and training.

Planned physical restraint refers to restrictive physical interventions which have been planned via risk assessment and where there is an expectation that predicted circumstances are likely to occur. There is time for planning and restraint plans are structured and documented in health care records.

13.7 Standardization and benchmarking

Standardization describes the attempt to develop guidelines, improve safety, develop training and analyse benchmarking results. Guidelines should be developed regionally or nationally. They should be based on evidence and they should be practical in the Indian context. Existing evidence-based guidelines from Betsi Cadwaladr University Health Board, for example, can be used as a template for adaptation. Guidelines for restraint and rapid tranquilization will improve safety and avoid idiosyncratic practice. Staff training on the reduction of coercive measures (including control and restraint training that emphasizes physical restraint as the intervention of last resort) was fundamental and effective measure in parts of Europe. The comparisons of benchmarking results have been another important tool in Europe. This allows the identification of areas where practice is outside of the norm, which can then be prioritized for intervention.

13.8 Rights and responsibilities
There is an ongoing and appropriate debate over the tension between the rights of patients who refuse medication in contrast to the benefits of restoration to normal functioning through involuntary treatment. Notwithstanding this debate, persons with mental illness are entitled to the equal enjoyment and protection of all human rights and fundamental freedoms in the political, economic, social, cultural, and civil or any other field.

States should condemn violence against persons with mental illness and should not invoke any custom, tradition or religious consideration to avoid their obligations with respect to its elimination. States should pursue by all appropriate means and without delay a policy of minimizing violence and coercion against persons with mental illness. States should exercise due diligence to prevent, investigate and, in accordance with national legislation, punish acts of violence against person with mental illness, whether those acts are perpetrated by the State or by private persons.

A balance has to be struck between patients’ autonomy and the suffering that no treatment may cause. The Hawaii declaration of the World Psychiatric Association provided guidelines for treating a patient who cannot express his or her own wishes regarding treatment and cannot see what is in his or her best interest because of their psychiatric illness. The guidelines suggest that compulsory treatment may or should be given provided it is done in the best interests of the patient. Patients should be encouraged to participate as fully as possible in all decisions about their care.

The role of the family in caring for the mentally ill in India needs due consideration. The family in India plays a major role in health seeking for its constituents. Any intervention planned for the patient should take into account the family’s considerable influence over many aspects of patient management, including outpatient consultation and continuing care.

A thorough assessment of the patient’s decision-making capacity should take place before coercive measures are considered. Decision-making capacity can and should be improved by means such as repeated discussion of information, group sessions, videotapes and computer programs, and involvement of family members.
Mental health clinicians should be trained in skilled communication that is two-way, open, repeated, empathic, and accommodative. Along with communication, detailed documentation is necessary to explain why a particular action (e.g., involuntary treatment or seclusion/restraint, etc.) was felt necessary under the specific circumstances. Facilities should be available for advanced planning for the possibility of future incapacity, for example, by the use of joint crisis plans and advance directive. This can help reduce compulsory admissions and treatment in patients with severe mental illness, and may affect the amount of perceived coercion.

The doctrine of the 'least restrictive alternative' ('least' in terms of modality, severity, and duration of the action taken) should be used. Positive approaches, such as persuasion, should be the strategies of choice and negative approaches, such as threats should be avoided.

Professionals should be explicit about what they doing and why, should allow patients to tell their side of the story, and should seriously consider this information.

Health care providers and hospitals should implement strategies for effective staff training on management of aggression and violence safely for staff and patients. This needs to include evidence based and safe de-escalation, as well as restraint techniques.

13.9 Long term plans/goals

The most important 3 long term goals are:
1. Active involvement of patients in decisions made about them
2. When coercive measures are necessary, they should be undertaken by trained staff in a safe manner.
3. Long term reduction in prevalence of coercive measures

In order to achieve these goals health care providers will need to develop strategic plans. Benchmarking, regular analysis of data, regional, national and international comparisons and transparency can help to raise awareness and allows key stake holders to prioritize funding where deficiencies are identified. An agreed definition of restraint allows better communication without misunderstandings between various stakeholders. Organizational strategies will be needed to implement training and raise awareness. This will need
support from a senior level in stakeholder organizations. Raising awareness amongst patients and their families will be an important aspect of a national strategy.

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SUMMARY

Introduction

Coercive practices are often encountered in mental healthcare. The issue of coercion with its many facets is one of the oldest problem of psychiatry. The most fundamental ethical conflict in psychiatry exists between the ethical principles of respect for the patient’s autonomy and dignity and the duty to avoid harm for the patient and others. The undesirable result of this conflict sometimes is the use of coercion, which can occur in many different aspects of psychiatric treatment – coercive admission to psychiatric hospitals, safety measures within psychiatric institutions, coercive treatment inside and outside psychiatric hospitals, referral to forensic psychiatric units, and more. All of these measures are increasingly under regulation of laws, court decisions, guidelines, and ethical considerations, and have repeatedly been a subject of concern in the public and in the media in many developed countries. However, empirical knowledge on usage, attempts to reduce and barriers to abolish is very limited and non-existing in developing countries like India. Coercive practices are now perceived as a human rights issue and international human rights conventions such as the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) (which are binding on countries that have ratified these conventions) emphasize the need to respect the autonomy of persons with mental disorder. Hence this thesis work to understanding coercion in Indian mental health care from a multi-stakeholder perspective was taken up as an initiative to move towards zero coercion.

Theoretical concepts

In the theoretical background, the main concepts and theories used in this thesis are introduced by by conceptualising coercion in mental health care and elaborating historical and modern bio-ethical perspectives. The chapter discussess on the range of definitions, categorisations and practical manifestations underline the complex nature of the concept of coercion and also reveal the complex interactions among different stakeholders. This theoretical discussion highlight the persistence of the problem and the inconclusiveness of the debates that surround it to date, which have subsequently brought to light a larger issue which forms the basis of this research: the importance of the local context in addressing practices of coercion. It is imperative to have an in-depth understanding of the context in which coercive practices take place in order to develop and make effective interventions. Autonomy and the role of autonomy in medical decision-making are
explained and the chapter is concludes by presenting the UNCRPD on compulsory treatment

**Research design**

The main research question of this thesis is:

> How can we understand coercion in Indian mental health care from a multi-stakeholder perspective?

Based on the main research question the following five research sub-questions are formulated:

1. To what extent and in what way does coercion occur in (mental) health care in the Indian subcontinent?
2. What are the prevalence, context and effects of patient and visitor violence towards staff in medical and psychiatric wards in India?
3. What are the triggering factors for aggressive behaviour and the subsequent coercive measures in inpatient settings in mental health care?
4. How is coercion perceived by patients, family caregivers and staff?
5. What are the dilemmas in reducing coercion in mental health care?

A mixed-methods design was used in this thesis. Different research and methodological approaches were used to answer the different sub-questions. Thorough literature reviews were undertaken to understand coercion in mental health care both globally and in the Indian subcontinent in particular. In study 7 personal interview was conducted and in quantitative studies various validated scales were administered.

The thesis consists of three parts.

Part I is on Background: violent, aggressive behaviour and coercion in India includes, study 4: Coercion and Mental Health Services in the Indian subcontinent and the Middle East, study 5: Patient and Visitor Violence towards Staff on Medical and Psychiatric Wards in India and study 6: Observational Study of Aggressive Behaviour and Coercion on an Indian Acute Ward which answers research sub-questions 1, 2 and 3 respectively.

Part II of the thesis describes the Perception and attitudes towards coercion by different stakeholders. It includes study 7: Clinical Correlates and Predictors of Perceived Coercion among Psychiatric Inpatients: A prospective pilot study, study 8:
Perceived Coercion in Persons with Mental Disorder in India: A cross-sectional study and study 9: Staff and Caregiver Attitude to Coercion in India that answers the research sub-question 4.

Part III of the thesis deals about the Ethical dilemmas of using coercion which includes two studies. Study 10 discusses the Use of Restraints in the elderly with mental illness: to be or not to be? And study 11 debates on Paternalism v. Autonomy – are we barking up the wrong tree? This part of the thesis answers sub-question 5 of the research.

Conclusion

Patient and visitor violence (PVV) is a significant problem in India, especially in medical wards. Aggression management training may be a way to reduce the prevalence of PVV. Family caregivers are often triggers and victims of aggression in the investigated acute Indian psychiatric wards. Doctors and nurses are less likely to be victims, but aggression towards them leads more commonly to coercive measures.

Perceived coercion is a reality in India. Clinical and socio-demographic characteristics of persons with mental disorders influence subjective coercive experience. Levels of perceived coercion and the populations affected are similar to those in high-income countries and psychiatrists’ normative attitudes toward coercion are remarkably similar to attitudes of psychiatrists in European countries.

Coercion is a dynamic state, and changes with treatment and care. At the time of discharge, a majority of patients reported that their admission was justified, even though they felt coerced during hospital stay. Clinical care focusing on improvement in global functioning and insight, as well as in a reduction in the severity of illness, consequently leads to less coercion. Family caregivers and psychiatrists perceive a relative lack of resources as the main reason for coercion, and believe that it could be reduced in clinical practice by having more time and personal interactions with patients. Future research projects should aim to develop a complex model that includes organisational policies and structure, situational variation between wards, and personnel and interaction related factors.
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Prof Rob Poole, Prof Catherine Robinson from Centre for Mental Health and Society within Betsi Cadwaladr University Health Board in partnership with Bangor University to compare and raise the research awareness among the local setting.