

Caregivers' Attitude and Perspective on Coercion and Restraint Practices on Psychiatric Inpatients from South India

Guru S. Gowda, Channaveerachari Naveen Kumar, Sujoy Ray, Soumitra Das, Raveesh Bevinahalli Nanjegowda¹, Suresh Bada Math

Department of Psychiatry,
National Institute of Mental
Health and Neuro Sciences,
Bengaluru, ¹Department of
Psychiatry, Mysore Medical
College and Research
Institute, Mysore, Karnataka,
India

ABSTRACT

Background: Coercion and restraint practices in psychiatric care are common phenomena and often controversial and debatable ethical issue. Caregivers' attitude and perspective on coercion and restraint practices on psychiatric inpatients have received relatively less research attention till date.

Aims: Caregivers' attitude and perspective on coercion and restraint practices on psychiatric inpatients.

Methodology: This is a hospital-based, a descriptive, cross-sectional study. A total of 200 ($n = 200$) consecutive patient and their caregivers were chosen between June 2013 and September 2014 through computer-generated random numbers sampling technique. We used a semi-structured interview questionnaire to capture caregivers' attitude and perspective on coercion and restraint practices. Sociodemographic and coercion variable were analyzed using descriptive statistics. McNemar test was used to assess discrete variables.

Results: The mean age was 43.8 (± 14.9) years. About 67.5% of the caregivers were family members, 60.5% of them were male and 69.5% were from low-socioeconomic status. Caregivers used multiple methods were used to bring patients into the hospital. Threat (52.5%) was the most common method of coercion followed by persuasion (48.5%). Caregivers felt necessary and acceptable to use chemical restraint (82.5%), followed by physical restraint (71%) and electroconvulsive therapy (ECT) (56.5%) during acute and emergency psychiatric care to control imminent risk behavior of patients.

Conclusion: Threat, persuasion and physical restraint were the common methods to bring patients to bring acutely disturbed patients to mental health care. Most patients caregivers felt the use of chemical restraint, physical restraint and ECT as necessary for acute and emergency care in patients with mental illness.

KEYWORDS: Caregiver, coercion, India, psychiatry, restraints

INTRODUCTION

Escorting an unwilling patient to psychiatric care is always exhausting for the caregiver. The process often involves force, threat, or coercive measures in our social setting which further raise the antagonism in patients leading to refusal of care and violence.^[1,2] Unwillingness of patients for psychiatric care may due to multiple factors such as illness severity, poor insight, affective episode, psychotic disorder, young age, recent suicidal attempt, immigration, ethnic minority, male gender, and legal issue.^[3-12] This leads to involuntary admission and treatment under the mental health law.

Canadian study shows nearly 70% among the first episode psychosis needed involuntary admission and treatment, in general, have been accepted as a necessary step to protect patients, caregivers, and society.^[2] However, it remains a controversial ethical and legal dilemma, and sometimes, it becomes challenging to balance the rights of patients and the rights of the

Address for correspondence: Dr. Guru S. Gowda,
Department of Psychiatry, National Institute of Mental Health
and Neuro Sciences, Bengaluru - 560 029, Karnataka, India.
E-mail: drgsgowda@gmail.com

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community/family. The process of bringing the patient with psychiatric illness to care might involve various modalities such as the involvement of private health sectors, public health sectors, agencies, nongovernmental organizations (NGO), self-help groups, or neighbors. Carer closely associated with the patient, who sees patient in the time of need, may decide to contact support such as the neighbors, NGO, or police for the help. In few occasion, the patients with a wandering tendency might be brought to the facility without the knowledge of family members by police or different social work agencies.^[3,13,14] Unlike developed countries where there is an attempt to facilitate insight and verbally negotiate with the patients at different levels, the Indian sociocultural system does not always allow such privileges due to the lack of workforce, stigma, or understanding the problem faced by patients. Hence, it is very common for the patient to perceive a significant amount of coercion as they are often brought to the hospital by forceful means with the help of a lot of workforces or the police force. It is a sad state of affairs that often patients are not spoken to about the necessity of admission or the process involved in the way. They are often victimized physically or verbally due to the forcible ways of handling the situation. The coercive measures taken by family members might be verbal and physical abuse, humiliation, chaining, peddling, giving a large dose of sedatives, threatening by violent means such as sharp weapons or guns, and grooving by many people. It is an important phenomenon to explore as it has never been studied earlier and very important for clinicians, social activist, families, policy-makers, And in the context of the MHCA 2017.^[15] With this in mind, we are systematically studying attitude, experiences, and perspective of psychiatric inpatients caregivers on coercion and restraint practices.

METHODOLOGY

Setting and sample selection

The study was carried out at the Department of Psychiatry, National Institute of Mental Health and Neurosciences, Bengaluru – 29. A larger study that looked into the patient, family, and clinician's perspective on admission, treatment, and coercive experiences during psychiatric inpatient care (IP) was used as the source of data. A total of 200 ($n = 200$) consecutive patient and their caregivers were chosen between June 2013 and September 2014 through computer-generated random numbers sampling technique. Inpatients above the age of 18 were randomly selected and were approached with a request to participate in the study. Exclusion criteria included patients suffering from mental retardation, organic brain syndromes, delirium, dementia, developmental disorders,

and antisocial personality disorder since some cognitive ability allowing reflection on one's own experience was required for this study. Written informed consent was obtained. The attendants/family members were requested to provide consent when patients could not consent. The study was, therefore, performed in accordance with the ethical standards laid down in the 1964 Declaration of Helsinki (Declaration of Helsinki 1964). Patient caregivers' written consent was obtained to participate in the study in accordance with ethical approval. All patients and their caregivers were interviewed within 3 days of admission.^[4-6]

Study assessments

We used a semi-structured interview questionnaire to capture caregivers' attitude and perspective on coercion and restraint practices. This was prepared by culling out items emanating from an open-ended pilot interview of 15 participants chosen purposively and then face validated by senior consultant psychiatrists from the department of psychiatry. The initial part of the interview was open-ended. Here, the patient and the caregivers were encouraged to describe the process of coming to the hospital, their perception about coercive treatment, coercive measures and involuntary admission, deviation of patient's rights, and freedom during hospitalization. The second part of the interview focused on the patient's caregiver perceptions of (a) difficulties in the process of bringing the patient to the hospital, (b) attitude and practice toward coercive measure in hospital, and (c) perception about different treatment measures. This questionnaire captured the caregivers' attitude and perspective on coercive practices on psychiatric inpatients. The coercion ladder^[16] was rated on a 100-point visual analog scale, from zero corresponding to "no coercion" to a hundred being "maximal coercion."

Ethical considerations

The Institutional Ethical Committee approved the study.

Statistical analysis

Statistical significance was set at $P < 0.05$. Sociodemographic characteristics of the sample were analyzed using descriptive statistics. McNemar test was used to assess discrete variables.

RESULTS

Table 1 shows the sociodemographic profile of the caregivers. The mean age was 43.8 (± 14.9) years. About 60.5% of the caregivers were male and 69.5% were from low socioeconomic status. About 67.5% of the caregivers were family members and 43.5% had quit their jobs after the patient's illness.

Table 1: Sociodemographic profile of caregivers

	<i>n=200</i>
Age (years), mean±SD	43.8±14.9
Education (years), mean±SD	6.44±5.5
Sex, <i>n</i> (%)	
Male	121 (60.5)
Female	79 (39.5)
Occupation, <i>n</i> (%)	
Employed - currently	88 (44)
Unemployed - after the illness	87 (43.5)
Never employed	25 (12.5)
Marital status, <i>n</i> (%)	
Single	34 (17)
Married	129 (64.5)
Others	37 (18.5)
Relation to the patient, <i>n</i> (%)	
Spouse	33 (16.5)
Son/daughter	53 (26.5)
Parents	49 (24.5)
Brother/sister	36 (18)
Friends/other	29 (14.5)
Religion, <i>n</i> (%)	
Hindu	181 (90.5)
Muslim	12 (6)
Christian	7 (3.5)
Type of family, <i>n</i> (%)	
Nuclear	148 (74)
Extended nuclear	23 (11.5)
Joint family	29 (14.5)
SES, <i>n</i> (%)	
BPL	139 (69.5)
APL	61 (30.5)
Location, <i>n</i> (%)	
Rural	112 (56)
Semi-urban	24 (12)
Urban	64 (32)

SES: Socioeconomic status, SD: Standard deviation, BPL: Below poverty line, APL: Above poverty line

Table 2 depicts the attitude and perspective of the caregivers on the risk profile of patients. Caregivers used multiple methods were used to bring patients into the hospital. Threat (52.5%) was the most common followed by persuasion (48.5%). Reason for admission as per caregivers being a risk of harm to self, altered biological function, and risk of harm to others contributes the maximum percentages of 82.5%, 81.5%, and 64.5%, respectively.

Table 3 shows the caregivers' perspective on coercive practices. Chemical restraint had the highest acceptability of 82.5%, followed by physical restraint (71%) and electroconvulsive therapy (ECT) (56.5%) during acute and emergency care. Most caregivers felt that does not result in either a loss of autonomy, interpersonal contact, or isolation (percentages being 69%, 72%, and 73.5%, respectively).

Table 2: Caregivers' attitude and perspective on the risk profile of patients

	<i>n=200</i>
Methods used to bring the patient into hospital, <i>n</i> (%)	
With informed consent	33 (16.5)
Persuasion by family members	97 (48.5)
By restraining physically	51 (25.5)
By being threaten	105 (52.5)
With the help of police/community service	42 (21)
Who suggested the career, <i>n</i> (%)	
Patient	12 (6)
Family	116 (58)
Neighbor	33 (16.5)
Doctor	28 (14)
Police	5 (2.5)
Public media or others	6 (3)
Reason for current admission as per caregiver, <i>n</i> (%)	
Risk to self	165 (82.5)
Risk to other	129 (64.5)
Severe danger to health	98 (49)
Inability to care for self	91 (45.5)
Risk to public/personal property	51 (25.5)
Altered biological function	163 (81.5)

Table 4 shows the perspectives of the caregivers regarding the risk profile before and after the first 3 days of IP care. There have been significant changes in the perspective regarding risk to self, others, and public or private property. In all cases, perceived risk has reduced.

DISCUSSION

This study was conducted at a tertiary psychiatric training facility. This is one of the largest and oldest government-run facilities. The previous study from India using Staff Attitude on Coercion Scale (SACS) looked into the caregiver perspective and its comparison with the psychiatrist's attitude. It concluded that the lack of resources is one of the reasons for coercion in India.^[17] The drawback of the previous study was that it used SACS which was developed to look at the attitude of coercion among mental health professionals. It was not meant for caregivers, and it was not suitable to assess the ground reality and attitude of Indian caregiver population. In this study, we developed a semi-structured interview questionnaire capturing all coercive experiences. This was then administered and face validated using an open-ended interview. Later, the focused interview was conducted to capture caregiver attitude toward coercion. Our study provides one of the first empirical data on caregiver attitude and perspective on coercion and restraint measures in India.

In this study, the majority of caregivers are males and is middle-aged (mean age of 44 years), these findings are in line with the Mysore study findings.^[17] Caregivers, who stayed with patients during IP, are mostly family members and from low socioeconomic status. Our study shows that the patients suffering from a severe mental illness such as schizophrenia and other psychotic disorder

was 48% and those suffering from mood disorders was 43.5%. All of them very extremely ill according to the Clinical Global Impression-Severity scale, most had absent insight at the time of admission.^[6] Absent insight, involuntariness and severe psychopathology in patients were probably the factors that made the caregiver use multiple coercive methods to bring the patient to the hospital. It was not easy for caregivers to convince the patients. Only 16.5% of the patients agreed and consented for consultation. Caregivers described that when initially patients did not agree for consultation, they tried to persuade with him/her or else they used threats or the restraint to bring him to care. Most caregivers had felt it was necessary to bring the patient into the hospital. Some of the caregivers described they blackmailed the patients by saying (a) caregiver himself/herself was consulting for health problems and asked the patient to accompany the caregivers (role change for care), (b) caregiver brought the patients saying that they were visiting a hospital to see some other relative who was admitted, and (c) saying they are going for some social function. The most difficult thing a caregiver expressed is bringing the patient to health care than staying with the patient during IP. Most caregivers expressed the need for public service to take care of highly ill patients like 108 public ambulance service for the emergency medical condition in India. Usage of threat, persuasion, and restraint is also necessary because often the patients are in a state wherein they have no insight, are refusing food, or are dangerous to self and others. The context of events is to be given due consideration apart from patients' rights. Ultimately, if the coercive measure helps the patient achieve good health and functionality in the long run and also reduce the risk to self and society, it is not harmful.^[18] Therefore, Persuade him/her and when it failed they used threats as a method of coercion to bring him to care to achieve harmony of mental health in India.

Table 3: Caregivers' perspective on coercive practices

Variable	n=200
Physical restraint in IP care, n (%)	
Yes - It is acceptable in acute and emergency care	142 (71)
No - It is a crude way of treating	15 (7.5)
Don't know	43 (21.5)
Chemical restraint in IP care, n (%)	
Yes - It is acceptable in acute and emergency care	165 (82.5)
No - It is a crude way of treating	9 (4.5)
Don't know	26 (13)
ECT in IP care, n (%)	
Yes - It is acceptable in acute and emergency care	113 (56.5)
No - It is a crude way of treating	11 (5.5)
Don't know	76 (38)
Restriction/loss of individual autonomy/dignity, n (%)	
Yes	60 (30)
No	138 (69)
Don't know	2 (1)
Restriction/loss of interpersonal contact, n (%)	
Yes	54 (27)
No	144 (72)
Don't know	2 (1)
Isolated/secluded from other, n (%)	
Yes	51 (25.5)
No	147 (73.5)
Don't know	2 (1)
Family coercion ladder, mean±SD	11.0 (16.88)

ECT: Electroconvulsive therapy, SD: Standard deviation, IP: Inpatient care

Table 4: Caregivers' perspectives on the risk profile of patient before and first 3 days of inpatient care

Variables	Before admission (n=200), n (%)	First 3 days of inpatient care (n=200), n (%)	χ^2 (df)	P
Risk to self				
Yes	165 (82.5)	36 (18)	6.59 (1)	<0.05
No	35 (17.5)	164 (82)		
Risk to other				
Yes	129 (64.5)	36 (18)	14.15 (1)	<0.001
No	71 (35.5)	164 (82)		
Risk to public/private property				
Yes	51 (25.5)	18 (9)	13.20 (1)	<0.001
No	149 (74.5)	182 (91)		
Inability care				
Yes	91 (45.5)	50 (25)	0.168 (1)	0.682
No	109 (54.5)	150 (75)		

As per caregivers, most had a risk of harm to self, others, and public or private property, and those were the main reasons to bring the patients to acute and emergency psychiatric care. Apart from these reasons, an inability to take care of the patients and the patient not taking the medication are also associated with psychiatric admission in previous studies from Norway and other countries, which were not assessed in our study.^[18-20] Before reaching the hospital, most of the families waited to resolve the problems, went to multiple religious places, and secluded the patient in their house. The majority got suggestions from their own family members and neighbors to seek psychiatric care when they noticed imminent danger associated with the behavior. Most caregivers were there during acute and emergency care and most of the caregivers perceived that the use of chemical restraint; physical restraint and ECT were necessary during acute and emergency psychiatry care and also felt that they did not result in either a loss of autonomy, interpersonal contact, or isolation. As per caregivers, most patients who had a risk of harm to self, others, and public or private property behavior got better within 3 days of IP.

Most caregivers consented for the use of chemical restraint; physical restraint and ECT during acute and emergency psychiatric care when a patients' decision-making capacity was lost. However, the previous study reported that the involvement of the relatives in treatment and care planning of the patient has been found to be less than required.^[21] Hence, the involvement of caregivers can be increased by proper communication and joint decision-making between caregivers and health-care providers.^[22] Engagement of the family in care and further initiatives like group conferences can help deal with a reduction in the experience of coercive treatment.^[23] This is good for not only the patients but also their family members and friends as well as the mental health professionals themselves. It will in turn help to reduce the medicolegal litigation problems with health-care professionals. Most patients' caregivers felt that coercion does not result in loss of dignity, autonomy, and interpersonal contact. This raises one more question that, whether caregivers have adequate knowledge about restraints or them under the pressure to provide psychiatric treatment to their belonging one. This question was answered by a recent study from Nepal on family's attitude to restraint saying majority had a lack of knowledge on risk and consequence of restraints.^[24]

Strengths and limitations

Our study gives a comprehensive picture of caregivers' attitudes and perspective on the use of coercion and

restraint measures in mental health establishment setting. However, the population may not be representative of the entire Indian population and limited to South India.

Future directions

There is a need for studies looking at knowledge and attitude of caregivers of patient with mental illness on coercion and different restraint measures.

CONCLUSION

Threat, persuasion and physical restraint were the common methods to bring patients to bring acutely disturbed patients to mental health care. Most patients caregivers felt the use of chemical restraint, physical restraint and ECT as necessary for acute and emergency care in patients with mental illness.

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Conflicts of interest

There are no conflicts of interest.

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