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Observational study of aggressive behaviour and coercion on an Indian acute ward

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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 inverstigated acute Indian psychiatric wards. Doctors and nurses are less likely to be victims but aggression towards them leads more commonly to coercive measures.

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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

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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 and Rector, 1999; Palmstierna and 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 and 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 socio-economic 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

2. Materials and methods

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.

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.

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.

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

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