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CLINICIAN ATTITUDE AND PERSPECTIVE ON THE USE OF COERCIVE MEASURES IN CLINICAL PRACTICE FROM TERTIARY CARE MENTAL HEALTH ESTABLISHMENT

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Abstract: Use of coercive measures in mental health care is an important issue for research. There are scarce data available on perception and attitudes toward coercion among Indian psychiatrist..

Key words: Clinician attitude, coercion, India, least coercive alternative, psychiatry.

The study was conducted at the Department of Psychiatry, National Institute of Mental Health and Neurosciences, Bengaluru, India. Psychiatrist in charge of the inpatients was asked about their general opinion on coercion and was administered Staff Attitude to Coercion Scale questionnaire. Findings were compared to previously published studies on patients' opinion and family opinion in the same sample. Data were analyzed using descriptive statistics. Coercion proved to be a common measure applied in nearly 70% of the patients studied. The 189 psychiatrists participating in the study almost all perceived coercion as care, protection and safety, and as protection from dangerous situations. About 66% of psychiatrists perceived physical and chemical restraint (sedation) as necessary and acceptable in acute emergency care. One-third of the psychiatrists felt their patients lost autonomy, dignity, and the possibility of interpersonal contact. The same amount agreed that some patients could have been treated with less restriction and fewer coercive measures.

Coercion is defined as the intentional overriding of one person's known preferences or actions by another person, where the person who overrides justifies the action by the goal of benefiting or avoiding harm to the person whose preferences or actions are overridden.[1,2] In the modern era of psychiatric care, coercive measures are legally sanctioned under certain circumstances.[3] They are common in clinical care and include involuntary medication administration, isolation, seclusion, physical restraints, and chemical restraint.

Reasonably good data exist for the following areas of coercion: prevalence of coercive measures,[5,6] influence of diagnosis and severity on coercion,[7] patients' subjective perception of coercion, factors influencing that perception,[6,8] and its dynamic nature.[9] Gender of the patient also plays a role.[10] Factors influencing coercive experiences and differences across cultures have also been studied.[11,12] Most studies showed nurses to be instigators of coercion after being targets of aggression.[13] In India where relatives usually stay with psychiatric patients on the ward, they were found to be both triggering factors and targets of aggression. Doctors are less likely to be targeted, but targeting a doctor leads to an increased likelihood of coercive measures.[14] Indian psychiatrists believe coercion to be a treatment modality, but their attitude to it is as yet almost unexplored.[15] Most studies so far have been patient centered and very few studies are available on staff attitude to coercion. Studies also observed that coercion in the admission process had different role-dependent perspectives. Individual staff level factors including their personality are an important factor in implementing coercive measures.

In India, society places a relatively lower value on individual patient autonomy compared to some European and American societies.[3] However, Indian society is complex and fast changing.

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Perception and attitude toward coercion vary among patients, patient's family, and clinicians. The recent Indian Mental Health Care Act of 2017 (MHCA-2017)[18] advocates compulsory treatment in the least coercive setting and as a least coercive alternative. However, India lacks studies to help us understand clinician attitudes toward coercive practice. In this context, we assessed clinicians' attitude and perspective on the use of coercive measures in psychiatric practice.This study was carried out between June 2013 and September 2014 at the Department of Psychiatry, National Institute of Mental Health and Neurosciences, Bengaluru – 29. For the purpose of this paper, data were derived from a larger study that looked into the patient, family, and clinician's perspective on admission, treatment, and coercive experiences during psychiatric inpatient care. The details about patient, family, and clinician selection were provided elsewhere.[8,9] Patient, family, and clinicians' written consent was obtained in accordance with the ethical approval obtained for the study, after a comprehensive description of the study. A total of 189 clinicians (psychiatrists) in charge of patients consented to the study.

Study assessments

We studied clinician attitudes and perspectives on coercion in psychiatric inpatients using a semistructured interview questionnaire covering six questions on opinions about the use of coercion, together with the Staff Attitude to Coercion Scale (SACS).[16] The initial part of the interview was open ended. Here, the clinicians were encouraged to describe the process of using different coercive measures for the respective patient during admission. These questions were also posed to the families of the patients.

In the second part of the interview, we asked clinicians to complete the SACS short, 15-item questionnaire on staff Attitude to Coercion.[16] It captures (a) coercion as offending (critical attitude), (b) coercion as care and security (pragmatic attitude), and (c) coercion as treatment (positive attitude). These dimensions were scored as dichotomous yes or no categories in our study. This scale showed an overall Cronbach's alpha of 0.58 in the staff sample in a recent Indian study. In other words, these dimensions can be scored in items scored on a 5-point Likert-type scale, with 1 = disagree strongly up to 5 = agree strongly. 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.

Ethical considerations

The study was approved by the Institutional Ethical Committee (Sl. No: 03, Behavioural Sciences/NIMH/DO/SUB-COMMITTEE/2013, dated 01/06/2013)

Statistical analysis

Statistical analysis was performed using descriptive statistics. Furthermore, reliability was calculated to investigate the scale consistency of the SACS in the current sample..

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In society places a relatively lower value on individual patient autonomy compared to some European and American societies. However, Indian society is complex and fast changing. Perception and attitude toward coercion vary among patients, patient's family, and clinicians. The recent Indian Mental Health Care Act of 2017 (MHCA-2017) advocates compulsory treatment in the least coercive setting and as a least coercive alternative. However, India lacks studies to help us understand clinician attitudes toward coercive practice. In this context, we assessed clinicians' attitude and perspective on the use of coercive measures in psychiatric practice. This study was carried out between June 2013 and September 2014 at the Department of Psychiatry, National Institute of Mental Health and Neurosciences, Bengaluru – 29. For the purpose of this paper, data were derived from a larger study that looked into the patient, family, and clinician's perspective on admission, treatment, and coercive experiences during psychiatric inpatient care. The details about patient, family, and clinician selection were provided elsewhere.[8,9] Patient, family, and clinicians' written consent was obtained in accordance with the ethical approval obtained for the study, after a comprehensive description of the study. A total of 189 clinicians (psychiatrists) in charge of patients consented to the study. We studied clinician attitudes and perspectives on coercion in psychiatric inpatients using a semistructured interview questionnaire covering six questions on opinions about the use of coercion, together with the Staff Attitude to Coercion Scale (SACS).[16] The initial part of the interview was open ended. Here, the clinicians were encouraged to describe the process of using different coercive measures for the respective patient during admission. These questions were also posed to the families of the patients.

Conclusion: Psychiatrists felt that physical and chemical restraints are necessary and acceptable in acute emergencies. Most psychiatrists considered coercion as a caring protective and safety attitude but also acknowledged its potential negative impact on patient dignity and therapeutic relationship

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