

## Staff and caregiver attitude to coercion in India

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### 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 analyzed 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 behavior, 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

### 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 and Basu, 2010). Coercive measures always represent an infringement of an individual's rights to self-determination and personal freedom. Coercive

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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 and 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; van Doeselaar *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 and 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 analyze 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 and Lepping, 2009).

Mental health services have been increasingly emphasized 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.

#### 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.

#### 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 and Chaturvedi, 2012; Dein and 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).

### 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 analyzed 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.

## 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 7<sup>th</sup> 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 1: Basic frequencies of the sample**

	Percentage of staff	Percentage of caregiver	Differences significant
<i>n</i>	210	210	
Age categories			
<18	-	3.8	<0.001
18-24	-	15.2	
25-34	28.6	11.9	
35-44	30.5	21.4	
45-54	18.1	11.4	
55-64	12.4	14.3	
>65	10.5	21.9	
Gender			
Male	80	54.4	<0.001
Female	20	45.2	
Experience of staff (years)			
1	11.4		
1-10	27.1		
>10	61.4		
Education of caregiver			
7 <sup>th</sup> standard		63.3	
High school		18.1	
Preuniversity		13.8	
Graduate		4.8	
Which caregiver			
Parents		26.2	
Spouse		27.6	
Brother or sister		15.7	
Children		27.2	
Others		3.3	
<b>Internal consistency SACS</b>	<b>Staff</b>	<b>Caregivers</b>	<b>Total sample</b>
Coercion as offending	0.44	0.13	0.25
Coercion as care and security	0.69	0.37	0.65
Coercion as treatment	0.57	0.25	0.37
Overall	0.58	0.07	0.44

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 analyzed 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. We observe higher scores in the group of female psychiatrists in the offending

**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 patients 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

**Table 3: Experience of the psychiatrist and coercion attitude**

	Response frequencies % yes			Comparisons (OR)		P		
	<1 year	1-10 years	>10 years	<1 year versus others	<10 years versus >10 years	All groups	<1 year versus others	<10 years versus >10 years
	Coercion as offending subscale-mean (SD)	4 (1.2)	3.9 (1.3)	4.5 (1.2)			0.002	0.245
Coercion could have been much reduced, giving more time and personal contact	83.3	96.6	96.9	0.25	1.56	0.014	0.017	0.138
Scarce resources lead to more use of coercion	91.7	86.0	87.6	1.55	0.98	0.773	0.403	0.585
Coercion violates the patients integrity	91.7	61.4	87.6	2.58	1.66	0.000	0.122	0.002
Too much coercion is used in treatment	16.7	40.4	37.2	0.36	1.07	0.108	0.028	0.337
Use of coercion can harm the therapeutic relationship	66.7	68.4	84.5	0.56	1.53	0.018	0.122	0.004
Use of coercion is a declaration of failure on the part of the mental health services	50	33.3	57.4	1.00	1.35	0.010	0.593	0.005
Coercion as care and security subscale-mean (SD)	4.4 (2.1)	4.9 (1.4)	5.11 (1.2)			0.082	0.037	0.097
For security reasons coercion must sometimes be used	83.3	89.5	84.5	0.83	0.91	0.603	0.459	0.336
Coercion may represent care and protection	66.7	71.9	76.7	0.69	1.14	0.521	0.249	0.193
Use of coercion is necessary as protection in dangerous situations	75.0	93.0	97.9	2.27	0.19	0.000	0.005	0.001
For severely ill patients, coercion may represent safety	75.0	82.5	86.8	0.56	1.23	0.311	0.15	0.140
Coercion may prevent the development of a dangerous situation	58.3	80.7	81.4	0.38	1.19	0.037	0.014	0.139
Use of coercion is necessary toward dangerous and aggressive patients	83.3	75.4	83.7	0.20	2.27	0.000	0.001	0.005
Coercion as treatment subscale-mean (SD)	1.1 (0.9)	1.2 (1.0)	1.1 (0.9)			0.836	0.889	0.648
Patients without insight require use of coercion	50	56.1	62.0	0.69	1.13	0.477	0.229	0.169
Aggressive patients require use of coercion	50	40.4	38.8	1.47	0.93	0.588	0.214	0.310
More coercion should be used in treatment	8.3	21.7	7.8	0.71	0.65	0.028	0.482	0.031

SD – Standard deviation; OR – Odds ratio

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. 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.

**Table 4: Age and gender of the caregiver and coercion attitude**

	Age categories (years)							Difference significant	Gender		Difference significant
	<18	18-25	26-35	36-45	46-55	56-65	>65		Male	Female	
Coercion as offending subscale-mean (SD)	3.4 (0.7)	3.6 (0.7)	3.9 (0.7)	3.9 (0.7)	4.1 (1.2)	4.3 (1.2)	3.8 (1.5)	0.075	3.9 (1.2)	3.9 (1.2)	0.693
Coercion could have been much reduced, giving more time and personal contact	75	96.9	100	100	100	93.9	95.7	0.013	96.5	96.8	0.605
Scarce resources lead to more use of coercion	75	65.6	76	64.4	70.8	63.3	50	0.379	69.6	56.8	0.039
Coercion violates the patients integrity	62.5	53.1	56	66.7	62.5	70	43.5	0.256	58.3	57.9	0.534
Too much coercion is used in treatment	12.5	43.8	40	40	41.7	56.7	39.1	0.443	39.1	45.3	0.225
Use of coercion can harm the therapeutic relationship	62.5	59.4	52	48.9	50	56.7	47.8	0.934	48.7	56.8	0.150
Use of coercion is a declaration of failure on the part of the mental health services	50	46.9	52	31.1	45.8	56.7	34.8	0.284	46.1	38.9	0.184
Coercion as care and security subscale-mean (SD)	4.1 (1.2)	3.6 (1.4)	4.4 (1.8)	4.4 (1.5)	4.2 (1.6)	3.4 (1.9)	4.1 (1.7)	0.000	4.2 (1.8)	4.2 (1.5)	0.341
For security reasons coercion must sometimes be used	75	50	56	73.3	58.3	60	52.2	0.346	55.7	64.2	0.132
Coercion may represent care and protection	62.5	46.9	56	62.2	50	43.3	43.5	0.555	51.3	50.5	0.510
Use of coercion is necessary as protection in dangerous situations	75	68.8	52	57.8	66.7	60	52.2	0.661	53.9	66.3	0.046
For severely ill patients, coercion may represent safety	62.5	65.6	60	48.9	50	76.7	34.8	0.014	48.7	61.1	0.049
Coercion may prevent the development of a dangerous situation	62.5	65.6	60	53.3	62.5	50	34.8	0.128	53.9	51.6	0.421
Use of coercion is necessary toward dangerous and aggressive patients	75	59.4	56	55.6	50	60	43.5	0.608	51.3	57.9	0.208
Coercion as treatment subscale-mean (SD)	1.1 (0.9)	1.1 (0.6)	1.1 (0.9)	1.2 (1.0)	1.3 (0.9)	1.3 (1.1)	1.3 (0.9)	0.715	1.1 (0.9)	1.4 (0.9)	0.007
Patients without insight require use of coercion	50	34.4	44	46.7	66.7	46.7	45.7	0.432	45.2	48.4	0.373
Aggressive patients require use of coercion	37.5	28.1	28	33.3	45.8	36.7	45.7	0.609	39.1	33.7	0.251
More coercion should be used in treatment	25	46.9	40	55.6	45.8	40	50	0.659	40	54.7	0.023

SD – Standard deviation

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.

## 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),

**Table 5: Education and relation of the caregiver and coercion attitude**

	Caregiver education				Difference significant	Caregiver relation					Difference significant
	7 <sup>th</sup> standard	High school	Preuniversity	Graduate		Parents	Spouse	Brother or sister	Children	Others	
Coercion as offending subscale-mean (SD)	3.5 (1.1)	3.5 (0.9)	3.6 (0.9)	3.8 (1.3)	0.866	3.5 (1.1)	3.6 (1.3)	3.6 (0.9)	3.5 (0.8)	4 (1.2)	0.765
Coercion could have been much reduced, giving more time and personal contact	96.2	97.4	96.6	100	0.923	100	93.1	100	94.7	100	0.183
Scarce resources lead to more use of coercion	60.9	57.9	75.9	90	0.119	63.6	67.2	51.5	66.7	71.4	0.586
Coercion violates the patients integrity	60.2	50	58.6	60	0.736	49.1	60.3	51.5	66.7	57.1	0.463
Too much coercion is used in treatment	47.4	36.8	31	20	0.144	38.2	46.6	57.6	33.3	28.6	0.172
Use of coercion can harm the therapeutic relationship	51.1	60.5	48.3	50	0.726	54.5	48.3	57.6	47.4	85.7	0.337
Use of coercion is a declaration of failure on the part of the mental health services	36.8	52.6	51.7	60	0.134	43.6	44.8	42.4	38.6	57.1	0.892
Coercion as care and security subscale-mean (SD)	3.2 (1.5)	3.7 (1.3)	3.3 (1.5)	3.5 (1.8)	0.221	3.1 (1.5)	3.3 (1.5)	3.8 (1.4)	3.2 (1.4)	3.9 (1.3)	0.122
For security reasons, coercion must sometimes be used	59.7	65.8	55.2	70	0.694	47.3	60.3	60.6	66.7	85.7	0.155
Coercion may represent care and protection	47.4	52.6	58.6	70	0.414	43.6	60.3	60.6	43.9	42.9	0.216
Use of coercion is necessary as protection in dangerous situations	57.1	68.4	58.6	60	0.666	67.3	44.8	69.7	63.2	42.9	0.058
For severely ill patients, coercion may represent safety	51.1	71.1	48.3	50	0.149	60	51.7	63.6	45.6	57.1	0.435
Coercion may prevent the development of a dangerous situation	48.9	57.9	65.5	50	0.372	43.6	53.4	66.7	50.9	71.4	0.242
Use of coercion is necessary toward dangerous and aggressive patients	55.6	57.9	44.8	50	0.702	43.6	55.2	63.6	54.4	85.7	0.166
Coercion as treatment subscale-mean (SD)	1.4 (0.9)	1.2 (0.9)	1.2 (0.9)	1.2 (1.0)	0.491	1.4 (0.9)	1.3 (0.9)	1.1 (0.8)	1.3 (0.9)	1 (1)	0.503
Patients without insight require use of coercion	48.1	55.3	31	40	0.234	50.9	50	33.3	47.4	42.9	0.547
Aggressive patients require use of coercion	38.3	36.8	27.6	40	0.744	40	41.4	21.2	38.6	28.6	0.342
More coercion should be used in treatment	51.1	26.3	55.2	40	0.038	50.9	43.1	54.5	43.9	28.6	0.642

SD – Standard deviation

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

**Table 6: Differences between professionals and caregivers on coercion attitude**

	Psychiatrist	Caregiver	OR	P
Coercion as offending subscale-mean (SD)	4.28 (1.23)	3.56 (1.41)		<0.0001
Coercion could have been much reduced, giving more time and personal contact	95.2	96.7	1.22	0.311
Scarce resources lead to more use of coercion	87.6	63.8	0.56	<0.0001
Coercion violates the patients integrity	81	58.1	0.61	<0.0001
Too much coercion is used in treatment	35.7	41.9	1.14	0.115
Use of coercion can harm the therapeutic relationship	78.1	52.4	0.59	<0.0001
Use of coercion is a declaration of failure on the part of the mental health services	50	42.9	0.86	0.085
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

(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 experience 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 caregivers 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 and 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 patients, caregivers, and professionals make. 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 and Basu, 2010). The chance of being subject to coercion is 36% in India, which is fairly high compared to Europe with 5%–10% (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 colors the opinion as expressed in the SACS, primarily of staff and to a lesser extent of caregivers.

### 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.

### 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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