CHAPTER I

BACKGROUND

Violence is a serious problem for those working in the health service. It is commonly encountered in caring for the mentally ill, particularly in hospitals. It has considerable implications for the organization of services, as well as for the individuals involved. Earlier reports suggest that the level of serious violence is low and that only a small proportion of patients are involved in violence of any kind. Yet, there is a growing body of evidence that levels of violence may be increasing. It is surprising in these circumstances that the literature on violence in psychiatric wards is sparse. (Fottrell et al., 1980; Lonno, 1983; Edwards& Reid, 1983).

Important differences in methodology and design between studies render comparison of their findings difficult (lonno, 1983; Hailer & Deluty, 1988). There is no generally accepted definition of violence. Some reports include verbal abuse or threatening behaviour (Bouras et al., 1992, Wernereta, 1993), others damage to property (Armond, 1982) and self-harm (Fottrell et al., 1978).Some investigators are concerned with physical attacks on persons (Shader et al., 1977; Dietz & Rada, 1982, Tardiff, 1983, 1984) while others limit their interest to attacks on staff (Ruben et al, 1980; Atkins, 1993, and Hodgkinson et al., 1985).Each study examines a different characteristics vary with size of hospital, specialization of facility, patient group and area served. There are also important differences in the methods used for collecting

data. A further problem with many studies is that violent patients have been examined collecting without reference to the non-violent group (e.g. Fottrell, 1980; Ruben et al, 1980, Armond, 1982).

It would not be surprising, for instance, to find more schizophrenics among the violent in a hospital where most patients are schizophrenics (Hailer & Deluty, 1988). Despite these difficulties some tentative conclusions may be drawn. Violence is more likely to be associated with younger patients (Tardiff & Sweillam, 1979; Hodgkin & Grunan , 1988), schizophrenics (Shader et al, 1987; Tardiff & Sweillam, 1982; Hodgkinson et al., 1985; Pearson et al. (1986), and those with a history of violence Before admission (Conn& Lion, 1983; Yesavage, 1993, 1994; McNiel et al., 1998).No consistent associations have been found with sex or race It has been suggested that increased violence may be associated with increased rates of admission (Adler et al., 1983) and overcrowding (Dietz & Rada, 1982; Edwards& Reid, 1983).This has not been demonstrated quantitatively, and one study reports an increase in violence as the ward population declined. No consistent association has been shown between length of stay and violence (Dietz& Rada, 1982).

Hostility and violence have long been a matter of concern in inpatient psychiatry. Violence of inpatient psychiatric units is a distinct character from outpatient violence. Of inpatients, 18% to 25% exhibit violent behavior while in the hospital, as per various studies. Of violent acts, most of it is directed at nurses, with other targets being (in descending order of frequency) fellow patients, property, self, physicians, psychologists, family members, and housekeeping staff. Ten to 45% of patients with schizophrenia exhibit aggressive or threatening behavior during hospitalization. Since violence is a complex behavior related to clinical as well as

social components and approaches of psychiatric care, it is particularly important to investigate the aggressive and violent behavior of psychiatric patients in different settings and countries in order to find out risky or protective factors The aim of the present study was to find out the characteristics of aggression and violence in psychiatric inpatients.

RATIONALE

Health research plays a major role in advancing science, in providing solutions for health problems and can contribute to growth, development, equity, global security and the fight against poverty. The massive imbalance in health research funding and output in terms of populations addressed has been referred to as '10/90'gap.Mental and neurological disorders are responsible for 13% and behavior related disorders for another third of the global burden of diseases. Despite the evidence, mental health is a neglected area within public health.

The South Asian region accounts for around one fourth of the world population and one fifth of psychiatrically ill patients in the world. Issues like community care, trained manpower, patient satisfaction and better legislation have been a focus of attention in recent years. As this region is fast developing, cooperation is needed in the field of mental health to keep pace with the other areas. Cooperation is needed to develop culturally acceptable forms of psychotherapy and new technologies for delivery of mental health services. Another area of potential cooperation is the development of a classification of mental disorders that is more informative in our setting. The development of a mental health programme and its inclusion at various levels of health care delivery has also gained precedence. New

research needs to be undertaken in the area especially to meet the local requirements and to understand diseases in a regional perspective

Most of the global burden of mental illness falls to the poorest nations, where 80% of world's population lives. According to the World Health Organization (WHO) "Most low/middle income countries devote less than 1% of their health expenditure to mental health. Health policies, legislation, community care facilities and treatments for mentally ill people are therefore dismally short of resources". Most evaluative research is conducted in high-income countries, and then applied to low and middle-income countries.

The relevance of existing research to the world's poorer nations is questionable. Only 10% of the total spent on health research is directed towards the diseases which are responsible for 90% of the global burden of disease. Health funding is generally provided by higher income countries whereas much of the global burden of disease is in the less rich nations. In fact, expenditure on health research in many low and middle-income countries is largely unaccounted for. Interventions evaluated in trials conducted in high-income countries tend to be unaffordable or unavailable to those in poorer countries. For the world to derive maximum benefit from health research, the balance of research between rich and poor countries needs to shift radically.

In mental health, the number of trials conducted in any one country seems to be correlated with the wealth of that nation: Gross Domestic Product (GDP) has been shown to be more correlated with the number of schizophrenia trials than with population size, GDP per capita. If this correlation is extended to other areas of mental health, the number of mental health trials would be considerably lower in poor

countries than in rich nations. Furthermore, there is evidence that lower income countries are under-represented in psychiatric literature. In one survey of high impact journals, 90% of the literature was derived from "Euro-American" societies; in addition a search of the ISI Web Science database showed that lower and middle-income countries contributed only 6% of the mental health literature. It is subsequently likely that less mental health research activity takes place in poorer countries and, in addition, that reports of these trials are less accessible.

Aggression and violence of inpatient psychiatric units is a distinct character from outpatient aggression and violence. This thesis aims to find out the characteristics of aggression in psychiatric inpatients in India and to compare these with studies conducted in high-income countries; and to assess their relevance for the needs of low and middle-income countries and if possible make recommendations for controlling preventable factors in problem causation.

The majority of research on this subject has been in the developed countries. Aggression and Violence have long been a matter of concern in psychiatric inpatients but unfortunately very little information about this from developing countries like India. This study may come up with the useful and relevant information of some of the preventable factors which can be controlled by public health interventions.

RESEARCH QUESTIONS

- What are the factors related to aggression and violence in psychiatric inpatients?
- Which of these factors can be controlled by public health interventions?

STUDY HYPOTHESIS

- There is relationship between aggression and violence and demographic factors
- There is relationship between aggression and violence and clinical factors

OBJECTIVES

- To investigate the characteristics of aggressive and violent behaviour amongst psychiatric inpatients
- To make recommendations for controlling preventable factors associated with aggression.

BRIEF DESCRIPTION OF THE STUDY AREA

Dr. Ram Manohar Lohia Hospital is a central government hospital, formerly known as Willington Hospital, was established by the Britishers for their own staff in 1954. After independence, its control was again transferred to the central government of independent India.

It has grown over the years and is currently having about 984 beds, spread over in 30 acres of land. It caters to the population of New Delhi and Central District, apart from patients from other areas and even from out side Delhi. It is having 71 beds in a Nursing Home for the C.G.H.S beneficiaries, including Maternity Nursing Home.

This hospital has round the clock emergency services in Medicine, Surgery, Orthopedics and Pediatrics. The facilities in other specialties are also available on call basis. The hospital has laid down disaster action plan & disaster. In a year hospital provides services to about 12 lakhs patients as OPD cases, admits about 46,000 patients in Indoor and about 1.5 lakhs patients are attended in

the Emergency. Similarly about 5,000 CT Scan, 1.70 lakhs X-Ray cases, 28 lakhs laboratory tests and about 17,000 Ultrasound are done. Hospital conducts about 9,000 Major and 40,000 Minor operations during a year. Free medicines are made available to the OPD patients as per the prescribed list and almost all essential medicines to indoor patients.

Hospital has two Incinerators, one Micro Wave Machine and two Plastic Shredders for sound hospital waste disposal system.

Hospital has separate psychiatric ward with separate male and female wards. There are 29 beds in the male ward and female ward is 11 bedded. It has out patient department, emergency and liaison psychiatry, psychotherapy, ECT therapy and also ward. There were two wards, one for male and other for female patients. There are 5 psychiatrists, 1 psychologist, 18-20 nursing staff and up to 5 interns and 2 house officers at a time. Family members actively participate in the assessment and management of their relative. Around 350 outpatients are seen daily by 10-15 doctors. The department serves a catchment area that covers large parts of the state, but people with acute psychiatric emergencies are largely referred by general practitioners or acquaintances from the neighboring towns and villages, or from emergency services of this and other hospitals.

VARIABLES

DEPENDENT:

- Aggression
- Violence
- Aggression and violence together

INDEPENDENT:

- Age
- Gender
- Diagnosis
- Income
- Residence
- Employment status
- Education
- Suicide risk
- Alcohol abuse
- Substance abuse
- Marital status
- Length of admission

OPERATIONAL DEFINITIONS

Aggression: For this study, aggression was defined as verbal aggression which could be demanding or argumentative, shouting, yelling or screaming, swearing or using abusive language. Other things include generally in a bad mood, irritable or quick to fly off handle critical, sarcastic or derogatory, saying some one is incompetent, Impatience or anger if something does not suit him/her or for that matter being angry with him/her are also included.

Violence: For this study, I used this definition for Violence' any act of actual physical harm involving physical contact, irrespective of outcome.

Incidents of violence were categorized into four groups:

- those directed against fellow patients

- Staff
- Visitors
- Property

Diagnosis: diagnosis is based on DSM-IV criteria and for analysis purpose according to DSM-IV it was divided into five groups which include moods disorders group, psychotic group, abuse group, personality disorder group and lastly miscellaneous (OCD and others like Munchausen syndrome).

Socio-economic status: socioeconomic status is based on five different factors which included:

- Family monthly income
- Education level
- Employment status
- Residence

Suicide Risk: For my study, Suicidal risk was assessed by a questionnaire including 5 yes/no answers. At least two yes answers were considered to be necessary to define the suicidal risk present. Questions were:

- history of previous suicide attempts
- history of self harm
- low self-esteem
- hopelessness
- Family history of suicide.

CONCEPTUAL FRAMEWORK

INDEPENDENT VARIABLES

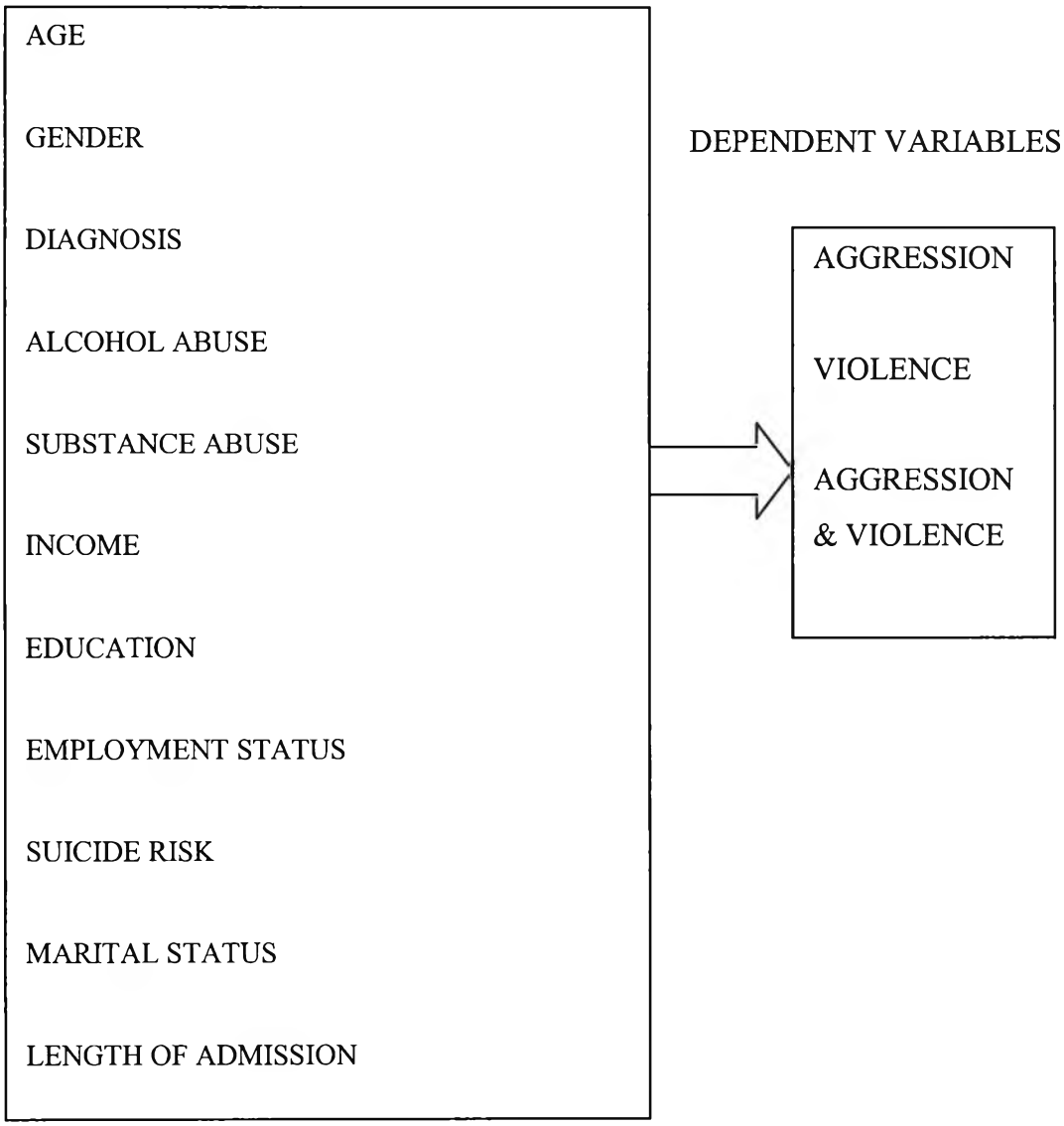

Figure1: Conceptual framework