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A Study to Assess the Effectiveness of Structured Teaching Programme on Knowledge Regarding Risk Factors and Prevention of Suicide among the Adolescents Studying in Selected College

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Abstract

Background of study: According to the WHO, more than 800,000 people die by suicide a year, making it the principal cause of death among people 1 5-29 years old. An annual global age-standardized suicide rate of 11.4 per 100 000 populations in which 15.0 are males and 8.0 are females. ***Objectives of the study:*** To assess the levels of knowledge regarding risk factors and prevention of suicide among the adolescents. To evaluate the effectiveness of structured teaching programme on knowledge regarding risk factors and prevention of suicide among adolescents. To find significant association between the pre-test knowledge score with selected socio-demographic variables. ***Methodology:*** One group pre-test and post-test design was used for this study. The independent variable in this study is planned teaching programme on knowledge regarding risk factors and prevention of suicide among adolescents. The study was conducted at selected college at Solapur. Sample includes 60 adolescents who fulfils the inclusion criteria were selected by non-probability purposive sampling technique. ***Result:*** The pre-test mean score is 13.41±2.64 which is 31.92% and post-test mean score is 17.58±3.08 which is 73.25% with a difference of 41.33%.The paired' test value is 7.35 which is significantly higher than the table value of 2.0009 at p≤0.05 level. Thus the structured teaching programme is effective in improving the knowledge regarding Risk factors and Prevention of suicide among Adolescents. There was no significant association found between the knowledge regarding Risk factors and Preventive measures of suicidal behavior among adolescents with their age, gender, and type of family, history of suicide or suicidal attempt, history of mental illness, history of substance abuse and source of information but there is significant association with area of residence at p≤0.05 level. ***Conclusion:*** This study intervention would help the adolescent to run healthy life without any distress, reduce the risk of suicidal behavior and also encourage them also to help those who have suicidal risk in the public or among friends.

Keywords: Structured Teaching Programme; Prevention of Suicide.

Introduction

Worldwide suicide is the second leading cause of death-following motor vehicle accidents-among teenagers and young adults. On average, adolescents aged 16 - 19 years have a per year suicide rate of about 1 in 10,000 people. Among them up to 10% of boys and 20% of girls death because of suicide.[1]

Approximately 0.5% to 1.4% of people die by suicide, a mortality rate of 11.6 per 100,000 persons every year. 800 000 people die due to suicide per year, which is 1 person in 40 seconds. In which 16-19 age group ratio is 52,060 which includes 27,060 are female and 25,000 are male.[2]

India has one of the world's highest suicide rates for youth aged from 15 to 29, according to Lancet 2011(7,696), 2012(6,654), 2013(8,423), 2014(8,068), 2015(8,934) and 2016(9,474). Student suicides in the India have increased 17% – 52% every day (6,248) in 2007 and 26% every day (9474) in 2016. In between 2007 -2016 around 75,000 students committed suicides in India. The statistic shows that reported the most - 1,350 - student suicides in 2016, which is 4 every day, followed by West Bengal (1,147) and Tamil Nadu (981). Kokan student suicide reported in 2016 is 420 in that Ratnagiri around 107.[3]

On April 3rd, 2017, a student committed suicide by jumping out of a 19th-floor hotel room in Mumbai. According to media reporting he had been depressed about failure in examination and repeatedly talked about ending his life on social media.

According to the American Foundation for Suicide Prevention, it is important to learn the warning signs of adolescent's suicide in order to prevent an attempt. Maintaining open communication with them and their friends provides an opportunity for helping as needed. If a teen is talking about suicide, he or she must receive an immediate evaluation.[4]

A retrospective study was conducted on trends in rate and methods of suicide in India in September 2013. The objective of this study was to evaluating suicide case in Lucknow which emphasis on the method of suicide as per the gender wise. There were 5204 samples was taken in which 2946 are male and 2258 are female although data was collected by using case sheet. The final result was the rate for males was 56.61% and for females was 43.38%. It shown that poisoning is the most common method of suicide in male (31%) as well as in female (48%).[5]

Objectives

- To assess the levels of knowledge regarding risk factors and prevention of suicide among the adolescents.
- To evaluate the effectiveness of structured teaching programme on knowledge regarding risk factors and prevention of suicide among adolescents.
- To find significant association between the pre-test knowledge score with selected socio-demographic variables.

Hypothesis

H_0: There is no significant difference between pre-test knowledge scores and post-test knowledge scores regarding risk factors and prevention of suicide among the adolescents.

H_1: There is significant difference between pre-test knowledge scores and post-test knowledge scores regarding risk factors and prevention of suicidal behavior among the adolescents.

H_2: There is significant association between pre-test knowledge scores with selected socio-demographic variables of adolescents.

Limitations

- The study will be limited to adolescence in higher secondary college.
- The study is limited to 60 samples.
- The data collection period is 4 weeks.

Research Methodology

Research Approach: The quantitative research approach was adopted in this study.

Research Design: The research design chosen for this study was Pre experimental (One group pre-test post-test design) research design.

Research Setting: The research setting selected for the present study were selected colleges.

Sample: The samples comprised of the Adolescents between 16-19 years and who fulfilled the inclusion criteria.

Sampling Technique: Non probability purposive sampling technique was been used for the present study.

Sample Size: The sample size was 60 adolescents.

Eligibility Criteria

Inclusion criteria

- Adolescents who are in age group of 16years – 19 years.
- Adolescents who are present on the day of study.

Exclusion criteria

- Adolescents who are not willing to participate in this study.

Variables

Dependent variables: Knowledge of adolescents regarding risk factors and prevention of suicide.

Independent variables: Planned teaching programme on knowledge regarding risk factors and preventive factors for suicidal behavior.

Socio-demographic variables

The socio-demographic variables in this study were as age, gender, type of family, area of residence, history of suicide or suicide attempt, history of mental illness, history of substance abuse and source of information regarding risk factors and prevention of suicide.

Description of the tool: It consist of three section

Section I: socio-demographic data

The socio-demographic variables in this study were as age, gender, type of family, area of residence, history of suicide or suicide attempt, history of mental illness, history of substance abuse and source of information regarding risk factors and prevention of suicide.

Section II: Structured knowledge questionnaire to assess the knowledge regarding risk factors and prevention of suicide.

The Structured self-administered questionnaire was used to assess the knowledge. The questions were under the subheadings related to general information, risk factors and warning signs of suicide and prevention of suicide. There were 24 questions where each correct answer was given the score of 1 and each wrong answer was given the score of 0.

Section III: Structured teaching programme on risk factors and prevention of suicidal behavior.

Structured teaching programme includes definition of suicidal behavior, risk factors, warning signs of suicide, preventive measures of suicide and suicidal awareness.

Plan for Data Analysis

Descriptive statistics: Frequency, percentage and measures of central tendency (Mean, median and standard deviation).

Inferential statistics: Paired t-test and Chi square (χ^2).

Results

Table 1: Distribution of respondents based on the socio-demographic variables.

N = 60

Socio-demographic variables	N	%
Age (in years)		
16 – 17	39	65
18 – 19	21	35
Gender		
Male	24	40
Female	36	60
Type of family		
Joint	23	38.33
Nuclear	37	61.66
Area of residence		
With own family	34	56.66
With other's family	14	23.33
In hostel	12	20
Living alone	0	0
History of suicide or suicidal attempt in your family		
Yes	4	6.66
No	56	93.33
History of mental illness in your family		
Yes	8	13.33

Socio-demographic variables	N	%
No	52	86.66
History of substance abuse in your family		
Yes	25	41.66
b. No	35	58.33
Source of information regarding risk factors and prevention of suicide		
TV/Radio	21	35
Newspaper/Magazines/Books/Journals	32	53.33
Parents/Relatives/Friends/Neighbours	2	3.33
Information from health personnel	5	8.33

Table 1 shows that 39 (65%) samples are in the age group of 16 – 17 years and 21 (35%) are in the 18 – 19 years. Pertaining to the gender 24 (40%) are males and 36 (60%) are females. Concerning to the type of family 23 (38.33%) are from joint family and 37 (61.66%) are from nuclear family. Related to area of residence 34 (56.66%) are residing with their own family, 14 (23.33%) are residing with other's family, 12 (20%) are residing in hostel and no one is living alone. As per the history aspect first is history of suicide or suicidal attempt in family there is 4 (6.66%) yes and 56 (93.33%) no, second is history of mental illness in family for that 8 (13.33%) yes and 52 (86.66%) no and third is history of substance abuse in family 25(41.66%) yes and 35 (58.33%) no. Related to source of information regarding risk factors and prevention of suicide for that 21 (35%) are TV/Radio, 32 (53.33%) are Newspaper/Magazines/Books/Journals, 2 (3.33%) are Parents/Relatives/Friends/Neighbours and 5(8.33%) are Information from health personnel.

Table 2: Distribution of adolescents according to samples pre-test score.

N = 60

Level of knowledge	Pre test		Post test	
	F	Percentage	F	Percentage
Poor (0-12)	23	38.33%	5	8.33%
Average (13-18)	37	61.66%	32	53.33%
Good (19-24)	0	0.00%	23	38.33%

The above table shows that during pre-test, the adolescents scoring 23 (38.33%) have poor knowledge, 37 (61.66%) adolescents have average knowledge and none of them have good knowledge regarding Risk factors and prevention of suicide. Where as in the posttest 23 (38.33%) adolescents have good knowledge, 32 (53.33%) adolescents have average knowledge and 5 (8.33%) adolescents have poor knowledge regarding Risk factors and Preventive measures of Suicidal behaviour.

Table 3: Mean, standard deviation, paired 't' test value of effectiveness of panned teaching programme on risk factors and prevention of suicide.

N = 60

knowledge	Mean	S.D.	Calculated 't' Value	DF	Table 't' value
Pre test	13.41	2.64	7.35	59	2.0009
Post test	17.58	3.08			

Significant at p≤ 0.05 level

The above table 6 shows that the mean score during pre-test is 13.41 ± 2.64, and the mean score during post-test is 17.58 ± 3.08. The paired't' test value is 7.35 which is significantly higher than the table value of 2.0009 at p≤0.05 level.

Which shows that, t(cal.)> t(tab.)i.e. 7.35 > 2.0009, df = 59

The above table 7 shows the calculated chi-square value to test the association between the level of knowledge with selected socio-demographic variables. It indicates that there was a significant association between the level of knowledge and the selected socio-demographic variable such as area of residence ($\chi2$=10.69) whereas there was no association between the level of knowledge and the selected socio-demographic variables such as age ($\chi2$=3.43), gender ($\chi2$=2.33), type of family ($\chi2$=0.62), history of suicide or suicidal attempt in your family ($\chi2$=0.3), history of mental illness in your family ($\chi2$=0.003), history of substance abuse in your family ($\chi2$=0.19), source of information regarding risk factors and preventive factors for suicidal behavior ($\chi2$=2.15) at p<0.05 level of significance. Thus it shows that there was a significant association between the level of knowledge and the selected socio-demographic variables. Hence the hypothesis H1 was accepted.

Table 4: Chi-square test on pre-test knowledge regarding Risk factors and Preventive measures of Suicidal Behavior among Adolescents with their selected socio-demographic Variables.

N = 60

Socio-demographic variables	N	%	≤ 14	> 14	χ^2 calculated value
Age in years					
16 – 17	39	65	28	11	3.43, df=1, p<0.05, NS
18 – 19	21	35	10	11	
Gender					
Male	24	40	18	6	2.33, df=1, p<0.05, NS
Female	36	60	20	16	
Type of family					
Joint	23	38.33	16	7	0.62, df=1, p<0.05, NS
Nuclear	37	61.66	22	15	
Area of residence					
With own family	34	56.66	22	10	10.69, df=3, p<0.05, NS
With other's family	14	23.33	12	2	
In hostel	12	20	4	10	
Living alone	0	0	0	0	
History of suicide or suicidal attempt in your family					
Yes	4	6.66	3	1	0.3, df=1, p<0.05, NS,
No	56	93.33	35	21	
History of mental illness in your family					
Yes	8	13.33	5	3	0.003, df=1, p<0.05
No	52	86.66	33	19	
History of substance abuse in your family					
Yes	25	41.66	15	10	0.19, df=1, p<0.05
No	35	58.33	23	12	
Source of information regarding risk factors and prevention of suicide					
TV/Radio	21	35	12	10	2.15, df=1, p<0.05
Newspaper/Magazines /Books/Journal	32	53.33	21	10	
Parents/Relatives/Friends/Neighbors	2	3.33	2	0	
Information from health personnel	5	8.33	3	2	

Significant at p≤0.05 level, NS – No significant, SA – Significant association.

Recommendations

- Similar study can be conducted as comparative study between male and female adolescents in different settings.
- Similar study can be conducted for various age groups.

- Similar study can be done by using various teaching methods.
- Similar study can be conducted after identifying suicidal ideation for the adolescents.
- A similar study can be conducted in different populations such as professional and nonprofessional students and workers.
- The study can be carried out to assess the quality of life among the adolescents.

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Feedback of COVID Survivors Regarding the Services Received from Hospitals

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Abstract

The outbreak of coronavirus disease 2019 (COVID-19) has become a pandemic. Till date, no antiviral treatment or vaccine has been explicitly recommended for this. Thus, preventive measures are the only most critical intervention. Health care workers (HCWs) are the primary sector in contact with the patients. They are struggling with issues such as social stigmatization, shortage of personal protection equipment supplies, frequent witnessing of death, fear of transmission of infection to self and to the family, and heavy workload. All these things put them in lots of stress, still they are providing care continuously. Being human sometime they may not be themselves and become the reason for poor feedback from the patients. The current study indicates that, almost all patients (above 90%) were satisfied with the admission and discharge procedures but an average of 50% only satisfied with the communication of the HCWs and involvement in the decision making process. Irrespective of the stress HCWs are trying their level best to provide good care and to achieve patient satisfaction, is appreciable.

Keywords: Feedback; COVID; Survivors; Services; Hospitals.

Introduction

COVID-19 is a deadly and uncontrollable pandemic with no known effective treatment. Currently there is the second wave going on in India that is hard to comprehend. As of May 4, more than 20 million cases of COVID had been reported with more than 222000 deaths. Hospitals are overwhelmed and health care workers are exhausted and becoming infected. High rate of infection, mortality, work overload, lack of sufficient PPE etc. provoke the feelings of anxiety and stress in health care workers.1-23 Social media is full of desperate people (public and health care workers) seeking medical oxygen, bed, medications and other necessities. Yet before the second wave also complaints were there on social media, though not the level as during the second wave. The current study attempted with the aim to identify the issues related to poor patient satisfaction during the first wave since the data collected before the second wave.

Methodology

A cross sectional study with quantitative approach was conducted among the COVID survivors across Odisha and Jharkhand, two states in the east zone of India from 1st of December 2020 – 30th of February 2021. A total of 112 COVID survivors were participated in the study aged between 14 to 76 yrs. with average age 36 yrs. with average hospital stay 12 days. Out of the 112 participants, 59 from Jharkhand and 53 from Odisha.

A structured survey questionnaire was constructed in Google forms and shared through link for self-administration. Convenient snowball nonprobability sampling was used to collect data from the relevant participants and the link was sent via Facebook messenger, WhatsApp and the participants were requested to share as much as they can within their connections. The questionnaire has 10 items, such as, whether pleased with the admission procedure, seen in a timely manner, communication with the nurses, communication with doctors, responsiveness of the hospital staffs towards the needs, care providers efforts to include them in the decision making about their care, amount of concern the care provider show for their questions or worries, friendliness/courtesy of the care provider, confidence in the care provider, pleased with the discharge procedure etc. with rating as satisfied, neutral and not satisfied. An informed consent briefly explaining the objective of the study was provided at the beginning of the questionnaire. Subjects who responded the survey were assumed to have willingness to participate. To maintain confidentiality, no personal details, or, potential identifiers are not collected.

To understand correct respondents and to ensure data quality, the link was shared with the HCPs fulfilling the

inclusion criteria (the doctors and nurses connected with the researcher and the snowball had started from there.

The collected data were analysed using descriptive analysis to determine the frequencies, and percentages.

Result

Table 1: Feedback of the COVID survivors.

N = 112

	Satisfied	Neutral	Not-Satisfied
Admission process	103 (92%)	-	9 (8%)
Seen in a timely manner	103 (92%)	-	9 (8%)
Communication with the nurses	92 (82%)	20 (18%)	-
Communication with doctors	87 (78%)	25 (22%)	-
Responsiveness of the hospital staffs towards the needs	87 (78%)	25 (22%)	-
Care providers efforts to include in decision making	73 (65%)	39 (35%)	-
Concerns by the care provider for the questions or worries	71 (63%)	41 (37%)	-
Friendliness/courtesy of the care provider	73 (65%)	39 (35%)	-
Confidence in the care provider	71 (63%)	30 (27%)	11 ()10%
Pleased with the discharge procedure	106 (95%)	-	6 (5%)

Discussion

The findings show on an average 78% COVID survivors were satisfied with the services they received in the hospital during hospitalisation due to COVID.

Conclusion

The findings show irrespective of lots of stress due to fear of getting infection, stigma, lack of hospital supply, work overload etc. health care workers trying their level best to provide best possible care to the patients suffering from COVID.

Limitation

There are several limitations in the current study such as the study has self-response bias. The generalisability of the study finding is poor because of the small sample size.

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Sd/-

(Dinesh Kumar Kashyap)

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Assess the Attitude of Adults toward Mental Illness: A Pilot Study

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Abstract

Background: Awareness for mental illness is a key concept for good mental health in India. A good mental health completes the circle of health which not only includes physical but also includes mental health. ***Material & Methods:*** A non equivalent control group quasi experimental design was used. There were 40 adult of selected community were selected using purposive sampling technique. In this study 2 groups (20 experimental and 20 control group) were selected. During data collection information booklet were given to experimental group only. Reliability was calculated. Reliability of tool was established by Split Half method and Spearmen Brown prophecy formula and it was 0.83. The obtained data was analyzed and interpreted in terms of objectives and research hypothesis. Analysis was done by using descriptive and inferential statics. ***Result:*** Score of attitude assessed by structured attitude scale the mean score of structured attitude scale among experimental group was 124.4 with SD of +/- 8.22, among control group was 77.2 with SD of +/- 14.05 and the computed 't' value was 6.4 This indicates that there were significant difference in the post interventional score of attitude among experimental group and control group at the level of P< 0.05.

Keywords: Attitude; Information Booklet; Adult; Mental Illness.

Introduction

Mental illness is a neglected area which is found in all society in the world. Peoples belief that mental illness is incurable also misleading for referred for appropriate mental health care.[1] This implies that the stigma of mental illness frequently reported in the general public can be reduced by education and examination of attitude towards mental illness. People who are suffering from mental disorders also face stigmatizing and experience discriminating attitude from society. It is a great need to understand peoples attitude towards mentally ill people in order to develop positive and effective change for such attitudes.[2]

According to WHO report 2020 depression is one of the leading cause of disability worldwide whereas suicide is second leading cause among 15-29 of age group.[3] The new COVID 19 pandemic is greatly affect mental health worldwide. A survey conducted by WHO among 130 countries showing Eva stating impact of COVID 19 on mental health service.[4] WHO also estimated that about 7.5% people are suffering from some mental disorder, approximately 56 million are suffering from depression and about 38 million suffering from anxiety disorders. It is estimated that by end of 2021 about 20% India will suffer from mental illnesses.[5]

Mental health could be a major concern worldwide and India isn't way behind in sharing this. If we have a tendency to value developments within the field of mental state, the pace seems to be slow. Dr. Brock Chisholm, the first Director-General of the World Health Organization (WHO), in 1954, had cannily declared that "without mental state there is no true physical health."[6]

Awareness and health literacy are two sides of the same coin. Stigma and discrimination are negative consequences of ignorance and misinformation. There are a few studies which have measured mental health literacy in the Indian context. One study found mental health literacy among adolescents to be very low. These findings reinforce the need to increase awareness of mental health. Mental health literacy is a related concept which is increasingly seen as an important measure of the awareness and knowledge of mental health disorders.

The pilot study is a small preliminary investigation of the same general character as the major study. The main aim to assess the feasibility, practicability and assessment of measurement.[7]

Objectives

1. Assess the existing attitude regarding mental illness among adults of selected communities.
2. Assess post interventional attitude towards mental illness among adults of selected communities.
3. Compare between pre and post interventional level of attitude towards mental illness among adults of selected communities.

4. Associate the pre interventional attitude towards mental illness among adult with their selected demographic variables.

Hypotheses

H_1: There is a significant difference in pretest attitude scores of experimental and comparison group of selected community before administration of information booklet at 0.05 level of significance.

H_2: There is a significant difference in mean posttest attitude score of experimental group and comparison group of selected community after administration of information booklet at 0.05 level of significance.

H_3: There is a significant difference in mean pretest and posttest attitude score of, experimental group of selected community before and after the administration of information booklet at 0.05 level of significance.

H_4: There is a significant association of pre interventional attitude score among experimental and comparison group with their selected demographic variables at 0.05 level of significance.

Methodology

Research Approach: An Evaluating research approach was adopted for assessing the attitude of adults residing in selected community towards mental illness.

***Research Design*:** In this present study non equivalent control group quasi experimental design was used to assess the effectiveness of Information Booklet on attitude towards mental illness among adult of community. In this study 2 groups (experimental and control group) were selected. Experimental group was intervened with Information Booklet.

E $O_1 \longrightarrow X \longrightarrow O_2$

C $O_1 \longrightarrow O_2$

O Observation

E Experimental group

C Control group

X Intervention (Administered information booklet)

O_1 pre intervention score - attitude score before administration of information booklet.

O_2 post interventional score-attitude score after administration of information booklet.

Independent Variable: Information Booklet on mental illness was the independent variables in the study.

Dependent Variables: Attitude of community towards mental illness was the dependent variable in the study.

Setting of the Study

The pilot study was conducted in Godharmahu, Bhopal community.

Data from the pilot study were collected from 40 respondents who fulfil the inclusive criteria. An informed consent was obtained from respondent prior to the study. The purpose of the study was explained to the subjects and confidentiality was assured to all the subjects.

Population: In the present study target population was all adult between the age group of 21 and above residing in Godharmahu community, Bhopal city.

Target Population: The target population of the research study was adults who residing in Godharmahu community of Bhopal city.

Accessible Population: In this study accessible population was the adults residing in Godharmahu community who fulfil the inclusive criteria has been included in the study.

Sample: In the study the sample comprised of 40 adults residing in Godharmahu Bhopal fulfilling the inclusive criteria.

Sampling Technique: Purposive sampling technique was used to select the sample.

Development and Description of the Tool

Section A: *Socio Demographic Variables (6 items)*

Section A consist of socio demographic variables of adults residing in selected community such as age, sex, education, occupation, religion, family member with mental illness.

Section B: *Structured Attitude Scale*

Section B It consists of 30 items on attitude towards mental illness. Structured attitude scale.

Section C: *Information Booklet*

Information booklet was developed on the review of the literature and the objectives state for attitude, the title of the booklet was "mental health and mental illness". The investigator prepare information booklet on mental health, mental illness, common mental illness, cause of mental illness, myths related to mental illness, rights of mentally ill.

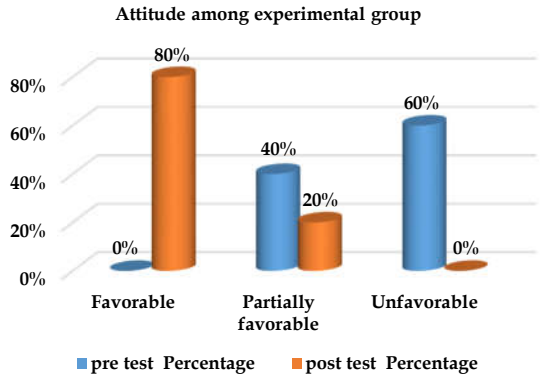
Result

Section I: Socio Demographic Data

Table 1: Frequency and percentage distribution of experimental group and control group.

N= 40

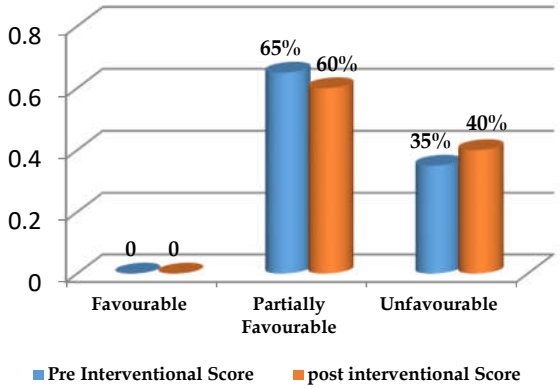
Demographic variables	Experimental Group		Control Group	
	Frequency	Percentage	Frequency	Percentage
Age (in years)				
21-30	4	20%	8	40%
31-40	12	60%	12	40%
41-50	4	20%	0	0%
51 and above	0	0%	4	20%
Sex				
Male	8	40%	12	60%
Female	12	60%	8	40%
Education				
Middle school				
High school	4	20%	4	20%
Higher secondary	4	20%	4	20%
Graduates and	4	20%	4	20%
above	8	40%	8	40%
Occupation				
Government job				
Private job	0	0%	4	20%
Self employee	12	60%	8	40%
Other please	8	40%	4	20%
specify	0	0%	4	20%
Religion				
Hindu	12	60%	12	60%
Muslim	8	40%	8	40%
Christian	0	0%	0	0%
Other	0	0%	0	0%
Mental Illness in family				
yes	4	20%	8	40%
No	16	80%	12	60%
Not sure	0	0%	0	0%



Section II: Assessment of Attitude towards Mental Illness Measured By Structured Attitude Scale.

Cylindrical diagram shows the attitude among experimental group measured by structured attitude scale. It depicts the majority 12(60%) of participants had unfavourable attitude, and less than half 8(40%) of them had partially favourable attitude towards mental illness. After giving self instructional module there was change in attitude as most of 16(80%) were develop favourable attitude, and only 4(20%) were develop partially favourable attitude towards mental illness.

Cylindrical diagram showing distribution of attitude level among control group. It depicts the majority 12(60%) of participants had unfavourable attitude, and less than half 8(40%) of them had partially favourable attitude towards mental illness. In post test there were no change found in attitude majority 11(65%) of participants had unfavourable attitude, and less than half 9(35%) of them had partially favourable attitude towards mental illness.



Section III: Effect of Information Booklet (Structured Attitude Scale).

Table no 2: post test scores of experimental and control group.

(n=40)

Group	Mean	Mean Difference	SD	DF	't' value
Experimental	124.4	47,2	8.22	18	6.76 S
Control	77.2		14.05		0.043NS

*P≤0.05 **P≤0.01 ***P≤0.001, S-Significant, NS-Not Significant

Data in table 2 depicts mean score of attitude assessed by structured attitude scale the mean score of structured attitude scale among experimental group was 124.4 with SD of +/- 8.22, the computed' value was 6.76 at degree of freedom 18. This indicates that there were significant differences in the post interventional score of attitude among experimental group at the level of P< 0.01, 0.05.

Conclusion

Majority 12 (60%) of participants had unfavourable attitude among experimental group & majority 12(60%) of participants had unfavourable attitude among control group, prior to the administration of Information Booklet. Most of 16(80%) were develop favourable attitude among experimental group & majority 4(20%) of participants had unfavourable attitude among control group, after the administration of Information Booklet.

Summary

The present study was undertaken by the investigator to evaluate the effect of information booklet on attitude towards mental illness, among adults of selected community. Mentally ill are seen by most as incurable, because of repetitive nature of the episode of illness. The current trend is complete integration of the mentally ill patient into the normal pattern of medical care with continuity of care from his family doctors, society.

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An Exploratory Study to Assess the Occurrence, Pattern and Impact of Workplace Violence and Misconduct on Nurses in Selected Hospitals of Hyderabad

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Abstract

An assault on health professionals in the workplace is a public health and legal problem. Violence against nurses is a silent epidemic. Until relatively recently, little attention had been paid to this problem. ***Objectives:*** The objectives of the study were to assess the pattern & impact of workplace violence and misconduct on nurses and to seek out the association between selected demographic variables and impact of workplace violence and misconduct on nurses. ***Materials and Methods:*** Quantitative research approach with non-experimental exploratory survey design was selected for the present study. The sampling technique chosen was purposive sampling technique for a sample size of 60 nurses who fulfilled the criteria through structured questionnaire. The sample chosen was nurses from General hospitals of Hyderabad. The tool consisted of Part A demographic profile with 10 variables. Part B consisted a three-point Likert Scale to assess the pattern of workplace violence. Part C consisted of a three-point Likert Scale to assess the impact of workplace violence and misconduct. Part D consisted of a Checklist to assess the Pattern of misconduct on nurses. We analysed the scores using descriptive and inferential analysis. Association between them was performed using Pearson correlation. Statistical significance was taken to be $p < 0.05$. ***Results:*** The study results revealed that majority of the nurses were under the age group of 21-30 years and most of them were females, also they had 2-3 years of work experience followed by larger portion of them pursued Post Basic BSc nursing and surprisingly study subjects reported that they have been suffered from workplace violence from colleagues and patient's attenders. The study subjects have undergone workplace violence and misconduct at workplace such as bullying (100%), physical (28.3%), verbal (100%) and sexual violence (50%) followed by official (100%) and sexual misconduct (55%). The study subjects also revealed that major proportion of the nurses experienced bullying, verbal violence, sexual violence and physical violence under the pattern of workplace violence and suffered from mild, moderate and severe impact due to workplace violence. Of the 60 nurses, all of them had suffered from official misconduct at workplace followed by 33 of the study subjects had experienced from sexual violence at workplace and faced mild, moderate and severe impact from misconduct. There was a no significant association between impact of workplace violence with selected demographic variables like age, gender, religion, years of work experience, marital status, education, department, designation, shift timings, relationship with abuser. Also, there was no significant association between impact of misconduct and the selected demographic variables. Conclusion: Implementing prevention programmes will help the nurse to be free from difficulties and can reduce the statistics of workplace violence and misconduct.

Keywords: Attitude; Information Booklet; Adult; Mental Illness.

Introduction

Today, concerns are rising about the escalating levels of violence against nurses. Nurses are the frontline personnel's and are more likely to encounter violence because of the amount of time spent in direct patient care. Most nurses are not trained to manage explosive situations. Also, the nurses are not vocal about violence experienced in the workplace due to fear of their employers because the employers may reciprocate their action in the form negligence or poor job performance on the part of the reporting employees. In addition, some nurses consider violence as part of their job. Violence against nurses impairs job performance after the incident. It also reduces job satisfaction and may compel nurses to quit their jobs.[1]

The Indian Medical Association has reported that 75% of healthcare workers face verbal or physical abuse in hospital premises and fear of violence was the most common cause for stress for 43% of the health care workers. The highest number of violence was reported at the point of emergency care and 70% of the cases of violence were initiated by the patient's relatives.[2]

In hospitals, nursing homes, and other healthcare settings, possible sources of violence include patients, visitors, intruders, and even co-workers which include verbal threats or physical attacks by patients, a distraught family member who may be abusive or even become an active shooter, gang violence in the

emergency department, a domestic dispute that spills over into the workplace, or co-worker bullying.[3]

Since there was substantial evidence of workplace misconduct occurring in the hospital and nurses were severely affected. The investigator developed interest in carrying out research to explore the incidents, patterns and its effect on the nurses. The investigator through empirical evidences found that Indian Nurses were hesitant of reporting the same and were not being assertive presumably due to the fear of job loss or reprimands. So, researcher found this as a topic that needs to shed more light.

The objectives of the study were to assess the pattern & impact of workplace violence and misconduct on nurses and to seek out the association between selected demographic variables and impact of workplace violence and misconduct on nurses.

Materials and Methods

Quantitative research approach with non-experimental exploratory survey design was selected for the present study. The sampling technique chosen was purposive sampling technique for a sample size of 60 nurses who fulfilled the criteria through structured questionnaire. The sample chosen was nurses from selected General hospitals of Hyderabad.

The tool consisted of Part A- demographic profile with 10 variables.

Part B consisted of a tool to assess the pattern of workplace violence marked on a 3-point Likert Scale.

- 1-16: mild pattern of workplace violence.
- 16-33: moderate pattern of workplace violence.
- 32-48: severe pattern of workplace violence.

Part C consisted of a tool to assess the impact of workplace violence and misconduct on a 3-point Likert Scale.

- 1-6: Mild impact of workplace violence.
- 7-12: Moderate impact of workplace violence.
- 13-18: Severe impact of workplace violence.

Part D: consisted of a Checklist to assess the Pattern of Misconduct on Nurses. 0 indicated absence of occurrence of misconduct.

- 1-2: Mild occurrence of misconduct.
- 3-4: Moderate occurrence.
- 5-6: Severe occurrence of misconduct.

The analysis was done using descriptive and inferential analysis.

Results

Table 1: Frequency and percentage distribution of nurses by their sample characteristics.

n=60

Sample Characteristics	Frequency	Percentage
Age		
20-31 years	49	81.6%
31-40 years	11	18.4%
41-50 years	-	-
>51 years	-	-
Gender		
Male	1	1.6%
Female	59	98.4%
Others	-	-
Religion		
Hindu	39	65%
Muslim	7	11.6%
Christian	14	23.4%
Others	-	-
Work experience		
0-1 years	14	23.4%
2-3 years	22	36.6%
3-4 years	12	20%
>4 years	12	20%
Marital Status		
Married	26	43.4%
Unmarried	33	55%
Widowed	-	-
Divorced	1	1.6%
Highest Education		
GNM Nursing	17	28.4%
Post Basic BSc Nursing	25	41.6%
BSc Nursing	15	25%
MSc Nursing	3	5%
Designation		
Staff nurse	44	73.4%
Ward in charge	15	25%
Nursing superintendent	-	-
Nurse educator	1	1.6%
Department		
In-patient department	34	56.7%
Out-patient department	4	6.6%
Psychiatric department	6	10%
Emergency department	16	26.7%
Shift timings		
8 am to 2pm	15	25%
2pm to 8pm	20	23.4%
8pm to 8am	19	31.6%
I don't remember	9	10%
Relationship with abuser		
Patient	10	16.6%
Patient's attenders	24	40%
Doctor	2	3.6%
Colleagues	24	40%

Table 1 shows that 49 nurses were under the age group of 21-30 years and 11 of them were aged between 31-40 years. Majority of them were females i.e., 98.4% and only 1.6% were males. Most of the nurses were Hindu by their religion (65%), followed by Christians (23.4%) and Muslims were (11.6%). Many of the nurses i.e., 22 had 2-3 years work experience, 14 nurses were having under 1-year work experience, followed by 12 nurses had 3-4 years of work experience and 12 nurses were having >4 years of work experience. Of all the study subjects, 26 nurses were married, 33 of them were unmarried and 1 of the study subjects was divorced. Out of 60 nurses 17 nurses pursued GNM as highest education, 25 of them pursued Post Basic BSc nursing, 15 nurses pursued BSc nursing and 3 of them pursued MSc nursing as highest educational qualification. Majority of the nurses were staff nurse (73.4%), ward in-charge (25%), nurse educator (1.6%) according to the designation. According to the department wise categorisation, out of 60 nurses, 34 nurses were working under inpatient department, 16 were in emergency department, 6 of them were working in psychiatry department and 4 of them were working in out-patient department. Major number of nurses i.e., 33.4% encountered workplace violence in the shift timings of 2pm-8pm, 31.6% nurses encountered workplace violence in 8pm-8am shift, 25% of them in 8am-2pm shift, followed by 10% of the nurses don't remember the shift timings in which they encountered workplace violence. Under the category of relationship with abuser 24 nurses reported workplace violence from their colleagues, 24 of them reported workplace violence from patient's attenders, 10 of them reported workplace violence by patients and 2 of the nurses reported workplace violence by doctors.

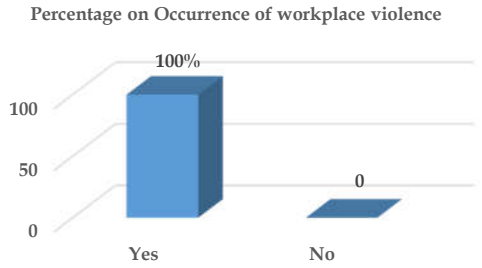

Fig. 1: Frequency and Percentage on Occurrence of workplace violence.

Figure 1 shows that all the 60 study subjects (i.e., 100%) had undergone workplace violence.

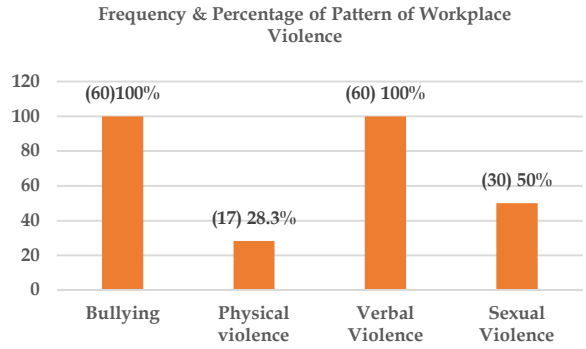

Fig. 2: Frequency and Percentage on Pattern of workplace violence.

Figure 2 shows that larger portion of the nurses reported bullying (100%) and verbal violence (100%), followed by (50%) of the nurses reported sexual violence and the least percentage (28.3%) of the nurses reported physical violence under the pattern of workplace violence.

Table 2: Domain wise Mean of Pattern of workplace violence and Rank Order of Nurses.

Pattern of Workplace Violence	Mean	Modified Mean	Rank Order
Verbal Violence	6.05	1.21	1
Bullying	3.8	0.76	2
Sexual Violence	1.41	0.176	3
Physical Violence	0.5	0.083	4

Table 2 shows the Mean score of Pattern of workplace violence and further Rank order of the pattern of workplace violence. The highest modified mean score was found to be Verbal violence with domain (1.21) whereas the least modified mean was found in Physical violence with domain of (0.083). The descending order of Pattern of workplace violence domain wise order was Physical violence (0.083), Sexual violence (0.176), Bullying (0.76), Verbal violence (1.21).

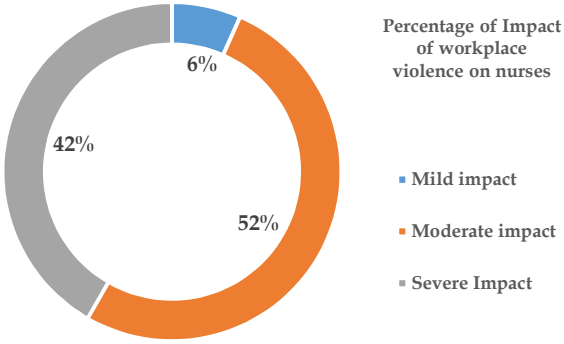

Fig. 3: Percentage of Impact of workplace violence on nurses.

Figure 3 represents that 6.6% of nurses had mild impact of workplace violence, 51.7% of the nurses suffered from moderate impact of workplace violence and surprisingly 41.7% of the nurses had severe impact of workplace violence.

Table 3: Impact of Workplace violence on Nurses.

n=60

Group	Possible Range of Score	Obtained Range of Score	Mean	Median	Mode	Standard Deviation
Nurses	1-18	4-16	11	11	14	3.23

Table 3 highlights that the impact of Workplace violence on nurses with possible range of scores were from 1-18, obtained range of scores were from 4-16 with average mean score of 11, median was 11, mode was14 and Standard deviation was 3.23.

Table 4: Occurrence of Misconduct on nurses.

n=60

Occurrence	Frequency	Percentage
Yes	60	100%
No	0	0

Table 4 shows that all study subjects had experienced misconduct at workplace.

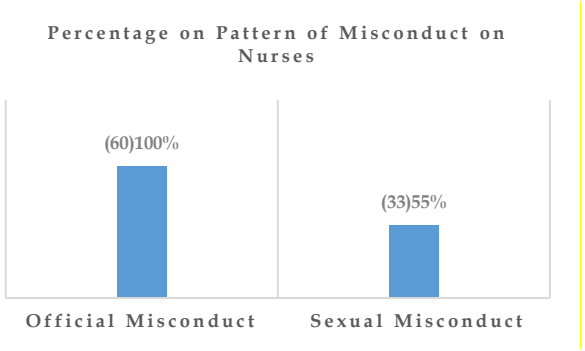

Fig. 4: Frequency and percentage on Pattern of Misconduct on nurses.

Figure 4 represents those 60 nurses (100%) had suffered from official misconduct at workplace and 33 of the study subjects (55%) had suffered from sexual violence at workplace.

Table 5: Findings related to Frequency and Percentage on Impact of Misconduct.

n=60

Impact of Misconduct	Frequency	Percentage
Mild Impact	29	48.4%
Moderate Impact	27	45%
Severe Impact	4	6.6%

Table 5 represents that (29) 48.4% of nurses had mild impact related to misconduct, (27) 45% of the nurses suffered from moderate impact due to misconduct and surprisingly (4) 6.6% of the nurses reported severe impact as a consequence of misconduct.

Table 6: Impact of Misconduct on Nurses.

Group	Possible Range of Score	Obtained Range of Score	Mean	Median	Mode	Standard Deviation
Nurses	1-18	3-13	7.1	7	5	3.73

Table 6 illustrates that the impact of Misconduct on nurses with possible range of scores from 1-18, obtained range of scores were from 3-13 along with average mean score of 7.1, median was 7, mode was 5 and Standard deviation was 3.73.

Table 7: Association between the Impact of Workplace violence with selected demographic variables.

n=60

Demographic Variables	Chi Sqaure	Degree of Freedom	Table Value	Level of Significance
Age	4.717	6	12.59	NS
Gender	1	4	3.84	NS
Religion	0.948	6	12.59	NS
Years of work experience	10.495	6	12.59	NS
Marital status	1.374	6	12.59	NS
Education	3.52	6	12.59	NS
Designation	8.59	6	12.59	NS
Department	1.86	6	12.59	NS
Shift timings	1.75	6	12.59	NS
Relationship with abuser	2.45	6	12.59	NS

Table 7 highlighted there was no significant difference between impact of workplace violence, the selected demographic variables like age, gender, religion, years of work experience, marital status, education, department, designation, shift timings, relationship with abuser as the Chi square value is lesser than the obtained table value.

Table 8: Association between the Impact of Misconduct with selected demographic variables.

N=60

Demographic Variables	Chi Sqaure	Degree of Freedom	Table Value	Level of Significance
Age	0.22	6	12.59	NS
Gender	0.57	4	9.49	NS
Religion	6.116	6	12.59	NS
Years of Work Experience	6.09	6	12.59	NS
Marital Status	0.917	6	12.59	NS
Education	4.198	6	12.59	NS
Designation	0.841	6	12.59	NS
Department	2.28	6	12.59	NS
Shift Timings	9.56	6	12.59	NS
Relationship With Abuser	1.885	6	12.59	NS

Table 8 shows that there was no significant difference between impact of misconduct and the selected demographic variables like age, gender, religion, years of work experience, marital status, education, department, designation, shift timings, relationship with abuser because the table value was greater than the obtained Chi square value hence there was no association and results illustrated that it was Not Significant.

Discussion

The present study revealed that majority of the nurses reported bullying 60 (100%) and verbal violence 60 (100%). Additionally, (30) 50% of the nurses reported sexual violence and the remaining percentage 17 (28.3%) of the nurses reported physical violence at workplace which are in line with the study of Teris Cheung & Paul S. F. Yip[5], he highlighted that the most common forms of Work Place Violence were verbal abuse/ bullying (39.2%), then physical assault (22.7%) and sexual harassment (1.1%).

The current study also assessed the perpetrator of violence on nurses were mainly their colleagues (40%), patient's attenders (40%), doctors (3.6%) and patients (16.6%) which is in accordance with the study of Asmaa Alyaemni et al[6] where perpetrator of violence on nurse found to be their recipients of care that is patients (82.4%) and their relatives (64.8%) who proved to be the instigators of violence.

The present study shows that, there was no significant association between impact of workplace violence with selected demographic variables. Also, the present study revealed that there was no significant association between impact of misconduct and the selected demographic variables.

Conclusion

Workplace violence is normally associated with mental disorders, and it can be limited by factors such as job control, social protection and justice[4]. Despite the importance of the role of nurses, health systems and specially hospitals, have been unable to ensure the safety of frontline nurses against workplace violence, which is important since they are in close proximity with the patients and their relatives.

So, every hospital should have a separate workplace violence prevention programme and follow legal acts in order to deal with the problems that nurses are facing in delivering nursing care. Implementing prevention programmes will help the nurse to be free from difficulties and reduce the statistics of workplace violence and misconduct.

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Article in supplement or special issue

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Corporate (collective) author

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[9] National Statistics Online—Trends in suicide by method in England and Wales, 1979–2001. www.statistics.gov.uk/downloads/theme_health/HSQ20.pdf (accessed Jan 24, 2005): 7–18. Only verified references against the original documents should be cited. Authors are responsible for the accuracy and completeness of their references and for correct text citation. The number of reference should be kept limited to 20 in case of major communications and 10 for short communications.

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- Abbreviations spelt out in full for the first time. Numerals from 1 to l0 spelt out
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