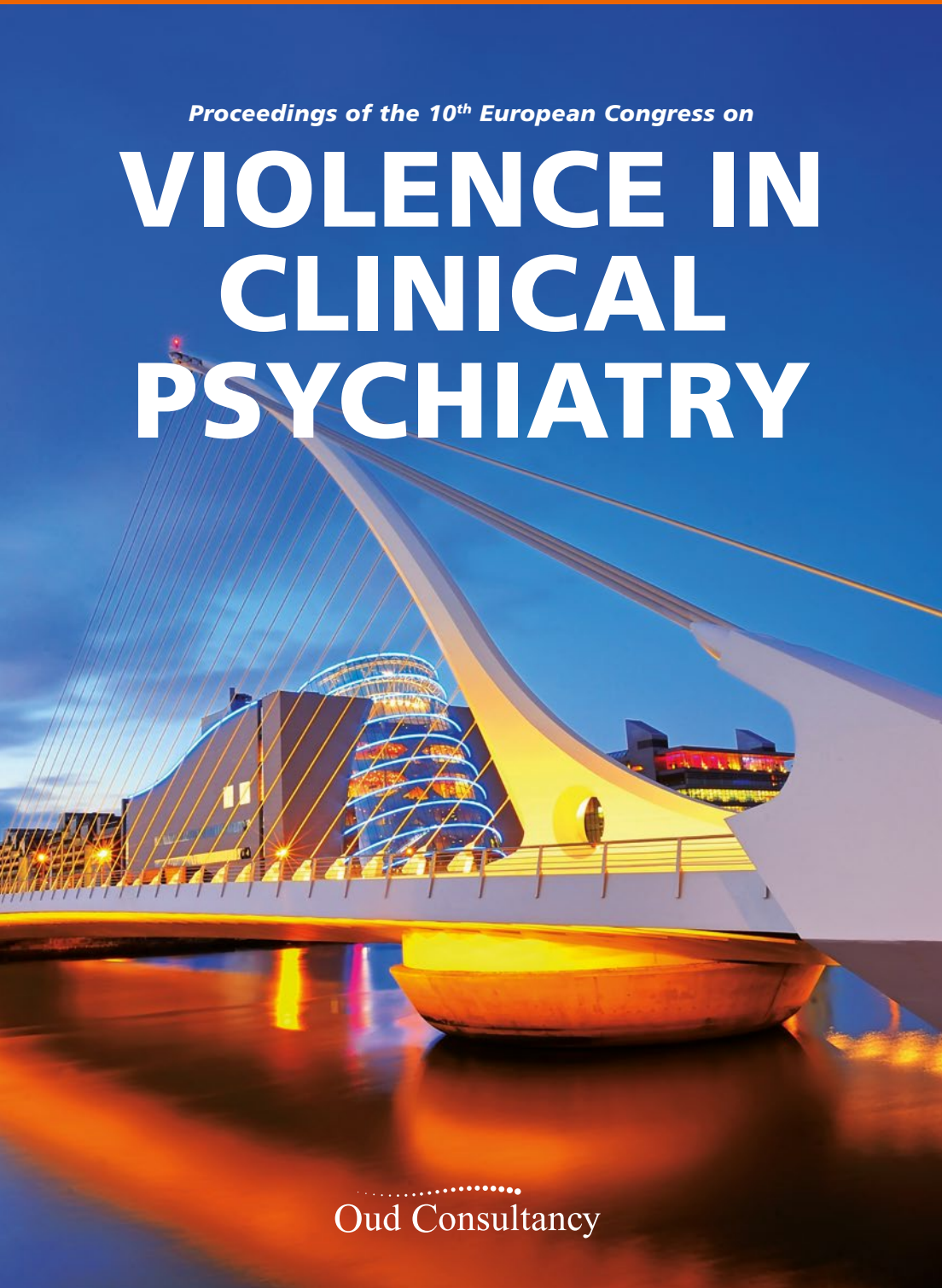
Patrick Callaghan - Nico Oud - Henk Nijman
Tom Palmstierna - Joy Duxbury

Proceedings of the 10th European Congress on

VIOLENCE IN CLINICAL PSYCHIATRY



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Violence in Clinical Psychiatry

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Preface

Invitation and historical background

A thousand welcomes to Dublin and the 10th European Congress on Violence in Clinical Psychiatry, 26-28 October 2017. In this, our silver jubilee year, the Congress is co-organized by the European Violence in Psychiatry Research Group (EViPRG), the European Network for Training in the Management of Aggression (ENTMA[08]), and is a World Psychiatric Association (WPA) co-sponsored meeting.

This year's Congress will focus strongly on clinically relevant and practically useful interdisciplinary scientific and practical knowledge on interventions aimed at treating and reducing violence and aggression. The overall congress theme: "Creating collaborative care: a multi-partnership approach" reflects our commitment to partnership working between clinicians, agencies, researchers, educators, service users and carers from across the globe.

The first congress, held in 1992 in Stockholm – Sweden, was an initiative by Prof. Börje Wistedt, the head of one of the larger psychiatric clinics in Stockholm at Danderyd Hospital / Karolinska Institute. He and his staff organized the congress with him as chairman and Prof.Tom Palmstierna as his scientific secretary. The Congress was held at the Swedish Medical Association and attracted 120 delegates who attended a series of lectures and seminars.

The second congress in 2001 was organized by the Addiction Center in Stockholm and its head Prof. Stefan Borg, and attracted 200 delegates. For the first time the Congress was a joint initiative with the European Violence in Psychiatry Research Group (EViPRG) founded in 1997 by Prof. Len Bowers and Prof. Richard Whittington. Following the success of this partnership all subsequent Congresses were co-organised with EVIPRG with the aim of bringing the latest science on violence and aggression to clinicians, researchers and managers.

London in the Summer of 2003 was the venue for the third Congress organized by Prof. Tom Palmstierna and Dr. Gerd Nyman, supported by the Addiction Center and Prof. Stefan Borg, and attracted 185 delegates.

From 2005 the Congresses have been organized by Oud Consultancy & Conference Management, chaired by Professors Henk Nijman & Tom Palmstierna in close collaboration with EVIPRG. Since 2011 the World Psychiatric Association (WPA) has co-sponsored the meeting. Since 2015 the European Network for Training in the Management of Aggression (ENTMA[08]) has been a collaborator in the organisation and delivery of the Congress.

Since the first European Congress on Violence in Clinical Psychiatry the meeting has expanded rapidly in terms of the number of scientific contributions and participants; the previous congress in Copenhagen in 2015 was attended by more than 600 participants from 36 countries, Dublin will be similar.

In line with previous congresses in Vienna (2005), Amsterdam (2007), Stockholm (2009), Prague (2011), Ghent (2013) and Copenhagen (2015) all contributions to the 10th European Congress on Violence in Clinical Psychiatry are published in this "book of proceedings" reflecting the current state of knowledge about, and research into the prevention and management of violence and aggression in mental health and intellectual disability settings and the training and education of staff.

The broad multi- and interdisciplinary scope of the 10th Congress is reflected in our varied programme encapsulating epidemiology and nature of inpatient violence against staff and patients, violence prevention and treatment, trauma informed care & practice, assessment of risk, prevention and protective factors, humane safe and caring approaches in and reduction of restrictive practices and the understanding of violence in specific populations. The training and education of (interdisciplinary) staff has featured consistently in all congresses. Despite twenty-five years of progress, throughout this time, we have remained true to our vision that the Congress will gather the best evidence and use this to transform care.

We are delighted that this year Congress is supported by the Department of Transport, Tourism and Sport, Fáilte Ireland (the National Tourism Development Authority), the Lord Mayor of Dublin, the Dublin Convention Bureau and the Irish industry suppliers.

Prof. Dr Patrick Callaghan
Mr Nico Oud, MNSc
Prof. Dr. Henk Nijman
Prof. Dr.Tom Palmstierna
Prof. Dr. Joy Duxbury

Supporting Organisations

- European Violence in Psychiatry Research Group (EViPRG)
- ENTMA[08]
- World Psychiatric Association (WPA)
  Section on Art and Psychiatry
  Section on Psychiatry and Intellectual Disability
  Section on Stigma and Mental Illness
- Oud Consultancy & Conference Management
- Altrecht Aventurijn
- British Institute for Learning Disabilities (BILD)
- The College of Psychiatrists of Ireland
- CONNECTING, partnership for consult & training
- Dundalk Institute of Technology (DkIT)
- Health and Safety Authority Ireland
- Irish Medical Organisation (IMO)
- Karolinska Institute
- Mental Health Commision (MHC)
- National Institute for the Prevention of Workplace Violence, Inc
- NGO Forum for Health
- Pflegenetz
- St. Olavs Hospital, Trondheim University Hospital
- The University of Nottingham
- The Mandt System
- The Psycho-Fysical Consultants

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Brodie Paterson (UK)(chair on behalf of ENTMA[08])
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Nico Oud (Oud Consultancy – Congress Organiser)
Kevin McKenna (Ireland)

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Vanessa Hetherington (Irish Medical Organization)

General scientific remark

Occasionally the congress organization receives queries, especially from academic Institutions, regarding the procedure for the selection of abstracts to be presented at the congress. Each abstract is submitted for peer review to members of the International Scientific Committee. Each abstract is anonymously adjudicated by at least three members of the committee. Abstracts are evaluated according to the following criteria:

- relevance to the conference theme,
- interest to an international audience,
- scientific and/or professional merit,
- contribution to knowledge, practice, and policies, and
- clarity of the abstract

Following the evaluation of each submission, the Organization Committee assesses the merit of each individual abstract and deliberates on the acceptance, the rejection or – occasionally – on provisional acceptance pending amelioration of the abstract. On applying this procedure, the Organization Committee endeavors to do justice to all submitters and to the Congress participants, who are entitled to receive state of the art knowledge at the Congress.

In total we did receive 208 abstracts from 34 different countries worldwide, of which 21 (10%) were rejected, 16 (8%) were withdrawn mainly due to financial reasons or not getting funding in time, and 20 (10%) were not included in the program and the proceedings due to not registering after all or not paying the fees in time. Together with the special workshops, special presentations and the keynotes in total 172 presentations from 30 different countries worldwide were presented.

ENTMA[08] Reception & Meeting

ENTMA[08] addresses issues related to training in the management of aggression and violence. The network involves a broad range of disciplines across health, social care, education and related sectors who are engaged in or associated with, designing, delivering, regulating, evaluating, researching or commissioning training. In order to meet and to discuss with members and interested non-members the steering group of ENTMA[08] has arranged an unique opportunity to network and meet during this congress by organising a special welcome reception and meetings:

- Special Welcome Reception on Wednesday the 25th of October 2017 from 19.00 – 21.00 in the Fahrenheit room
- 2 special ENTMA[08] meetings on Saturday the 28th of October 2017: (1) from 08.30 – 10.00 and (2) from 10.30 – 12.00 in room 18. Those meetings will be chaired by Brodie Paterson & Kevin McKenna

On behalf of the ENTMA steering group you are cordially invited to attend those events.

Dr Brodie Paterson (Chair) (Scotland)
Dr Kevin Mckenna (Deputy Chair) (Ireland)

Considering and Confronting Contentious issues

Brodie Paterson & Kevin Mckenna

While the evidence base supporting both the content and practice of training in the management of aggression and violence has grown very considerably in breadth and depth over the last twenty years, one challenge confronted by trainers, both in consultancy and classroom roles, is how to respond to 'contentious' issues. In the context of this workshop two circumstances are considered in which an issue is considered 'contentious'. The first of these is issues for which the evidence base is incomplete, ambiguous, contentious and/or conflicting, and the second is circumstances in which there is and incongruence or direct conflict between available evidence and mandates imposed by professional and/or regulatory bodies. Such 'contentious' issues are often framed dichotomously, with polarised positions characterised by sometimes impassioned arguments and proposals of actions which extend beyond and/or contradict available evidence. Three examples of such 'contentious' issues are:

- The adoption and value of 'Zero Tolerance' initiatives
- The use or prohibition of the use of 'Prone Restraint'
- The demand for 'Elimination' of coercive and/or restrictive interventions

This workshop will explore these contentious issues in an engaging and interactive forum which will place emphasis on gaining a considered understanding which might inform both consultancy and practice related to education/training in the management of aggression and violence.
The workshop will be structured in three components:

- The first component will provide a brief overview and synopsis of 'proponent' and 'opponent' propositions, arguments and evidence for each of these three issues.
- The second component will facilitate a highly interactive consideration of each of the three issues supported by consensus exercises using interactive technology.
- The final component will summarise key information with an emphasis on how the learning from the workshop can be readily applied within training/educational contexts.

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Chapter 1 – Keynote speeches and special presentations

Violence in clinical Psychiatry: adding the perspective of traumatization or a look through 'trauma glasses

Keynote 1

Eva Münker–Kramer (Austria)

Keywords: trauma and traumatization, trigger, types of traumatization and its impact on diagnoses and treatment

Introduction/background

Born 1961 in Germany, clinical psychologist, organizational psychologist, psychotherapist (BT, EMDR, traumatherapy), EMDR senior trainer, disaster and emergency psychologist.
Private practice in Krems/Donau and director of the EMDR-Institute Austria.
Lecturer in the fields of clinical psychology, psychotraumatology, disaster and emergency psychology, traumatherapy, EMDR nationally and internationally, e.g. in the Austrian Academy of Psychology, in national and international congresses (details www.emdr-institut.at/institut), in training of de-escalation management in Austria; author of journal and book articles in the above mentioned fields, latest book publication "Traumspezifische Psychotherapie mit EMDR, Reinhardt Verlag 2015.
Chair of the Austrian Association of EMDR since 2003, member of the executive committee of EMDR Europe Association, member of the standing committee of Disaster and Emergency Psychology in the European Federation of Psychology 2001-2017, member of the scientific committee of the post-graduate Academy of the Professional Association of Austrian Psychologists, member of the task force "Acute Trauma" of the German-speaking Association of Psychotraumatology and member of the Lower Austrian Ethics Committee by order the Lower Austrian Government, project coordinator of a Council of Europe funded train the trainers project for Eastern European Countries 2010-2012, coordination of training in psychotraumatology and EMDR in Ukraine (Lviv, Odessa) since 2006.

Abstract

Talking about aggression and violence in clinical psychiatry primarily means that the personel has to deal with the symptoms and the representation of something the patients are expressing.
The range of the background of these (re)-actions can go from extreme manifestations of psychotic symptoms or personality disorders to reactions to triggers within traumatized patients. This itself can – and in many cases does - cause new aggression and trauma to the offended person. Here the vicious cycle starts and often there is a dilemma to define what is the chicken and what is the egg.

Being aware of this, the question is whether intentionally looking through trauma glasses could bring an added value: preventive factors and hints daily practice to deal with it could be defined and integrated into clinical practice.

One crucial aspect might be going one step back into history taking and for example establishing a basic screening instrument on potentially traumatizing events. Having this information might open the chance to reduce the risk of additionally producing aggression and violence by – involuntarily – offering triggers to formerly traumatized patients, who then react agressively and violently again – thus perpetuating the vicious circle.

Other topics are behavioural aspects and also aspects of ward enviroment.
Furthermore, despite already existing and promising models more aftercare and professional coping for the personel after potentially traumatizing situations could be established following the existing models of CISM or adaptations of that.
To follow these ideas the keynote will at first provide an overview of different forms of traumatization, diagnoses and treatment approaches.
This contains a reference to the question on stabilization vs exposition which has an impact on treatment approaches in clinical psychiatry for the patients with trauma related disorders?

The main paper

Background
For many years this congress has sucessfully dealt with many aspects of clinical violence – reasons and consequences, prevention, counselling and treatment. There is already an extraordinary amount of knowledge and practical skills to deal with it professionally in many areas where violence and aggression in clinical psychiatry occurs.

In this key note another, I will conisider different perspectives on this complex topic:
the connection between trauma(tization) and aggression/violence. Each of them can act and be seen as a reason for the other on one hand and as a consquence of the other on the other hand. This resembles – using a daily life metaphor - the question of chicken and egg. It can also end up in a vicious cycle if there is no interruption anywhere in these dynamics.

So the main connection between the congress topic and psychotraumatology becomes evident
1. When considering reasons of aggressive behaviour related to traumatic experiences and how to prevent a bit of that and
2. when psychiatric personel experiences violence and aggression and suffers from consequenes and needs support. This can be done through prevention and cure.

To meet the mentioned topics and goals of the addtional perspective of trauma, this article will start with a brief introduction into definitions of trauma, neurobiological basics and an overview over the most important types of traumatization including their impact on reactions, diagnoses and treatment approaches. This will be supported by two figures which are self explanatory to a large extent in order not to exceed the maximum amount of words.

“Extreme stress” - Some basic remarks, clinical representation and neurobiology
As an introduction some basic definitions of extreme stress / pathological stress – besides “normal” so called “eu-stress - are needed to define psychological trauma more precisely.

Psychotraumatology as the underlying science deals with the reasons, the manifestations and the consequences of “toxic” stress in its acute and chronic manifestations is a relatively young science. Its findings as an integrative science are based on knowledge for example from psychology, medicine, history, neurosciences, sociology, ethnology, genetics.

An historical milestone was the acknowledgement of PTSD (Post traumatic Stress disorder) by the World Health Organization in 1981 (Huber, 2003, Shapiro, 1989, 2003), Münker-Kramer, 2015)).

This was the first time an exterior event was accepted as a potential reason for mental problems. Thus PTSD became the "mother of stress disorders". In the meantime a variety of different specifications and forms of stress disorders from acute stress to chronic stress has been defined (see below, Figure 1). This meets the necessity to describe the consequences of potentially traumatizing events ranging from single events like disasters (technical, natural…) and accidents happening to mentally healthy persons on one hand and on the other hand war, sequential trauma and developmental trauma occurring from all forms of (domestic) violence in so called "man made disasters" that "engrave" the personality from the very beginning (worst case) in its extreme.

So "traumatic" stress - to come back to the definition - itself is – going beyond just "distress" based on the pioneering work of Hans Selye (Herman, 2003, p. 17-51, Muenker-Kramer, 2005, p. 293f). Here we have the connection between the psychology of stress and the manifestation of the "trauma glasses" in the psychotraumatology as a discipline.

Brain imaging techniques like have made that possible. With their helpful experienes of daily life could be confirmed and verified in a fascinating way. This will be outlined later on in this paper when connecting some daily life sayings expressing the main clinical symptoms of stress disorders.

It is important to outline that not the event itself is the trauma but the mental, social, physical and behavioural consequences define the trauma within the affected person. The concrete individual ratio between the resources a person has and the amount and intensity of risk factors and other intevening variables that are connected with the event defines how much the event affects the person and can lead to a whole range of trauma related disorders and disturbances (see later in this text). This development is called the traumatic process by Fischer, Riedesser (2003, p. 61ff). A potentially traumatizing event they describe as an experience of a vital discrepancy between threatening situational factors and individual coping skills combined with feelings of helplessness and defenselessness that offends and shakes the perception of the self and the world.

The first part of this definition reflects a discription of what is noticeable in the body, then what affects feelings and emotions and finally the impairment of personal cognitions and beliefs.

As mentioned before – talking about neurosciences proving exactly daily life expressions of the impact on body, emotions and cognitions – that is described in a very clear way. It can be regarded as a translation between science and people´s personal experiences of psychotrauma symptoms in daily life and thus somehow these perspectives prove each other.

Concerning the body this can for example be felt and described as

- to be at a loss for words, to be paralysed,… one´s legs do not obey any more,
- to be thunderstruck, it gets on one´s nerves, to take it hard, it really hits one´s heart, to be like a punch in the stomach, to lose one´s appetite,
- to take one´s breath away, to be like a punch in the stomach.
- make one´s hair stand up (to make one´s hair fall out), to send cold chills down my spine, to be at a loss for words…

Neurologically this means that the stress-system, above all adrenalin and noradrenalin organize maximum of concentration, awareness, energy, muscle power – produce the fight and flight response as the first physical consequence in a situation of severe danger. Here the amygdala functins as a fire-alarm and blocks further ascension of perceptive informations higher up than the limbic system to avoid losing important time to react. Cortisol then tries to calm down again as soon as the danger has been overcome. But in the situation of ongoing threat, if there is no possibility to do anything the stress peak keeps on and – as an automatic natural protective mechanism start of the endorphin-system is switched on to produce an inner distance by anaesthetisation.

This clinically can result in dissociative symptoms and body memories, finally also in self injuring behavior if this protective mechanisms has to become a chronic reaction (to feel s.th. again).

With a look on emotions/feelings concerned persons may describe it as

- nameless anxiety
- naked horror
- to be at the mercy of someone or something
- to feel like having no clothes on, naked
- to feel like a caged tiger

The impact on the self-concept and one´s view of he world, one´s thoughts, attitudes, value systems, cognitions is maybe expressed by

- to be thrown really, to throw s.o. for a loop
- to feel like the rug has been pulled out from under s.o..
- nothing is like it was
- it will never be the same again
- it is like a part of me died
- here is no future in that
- life has no meaning any more
- everything is finished

As a neurobiological conqsequnece of the above mentioned alarm by the amygdala perceptions and affects belonging to the traumatic incidents are processed and stored in a disturbed way. This means that this storage different from non-traumatic events is unconnected and fragmented, loaded and stored in the context of a neuronal so called trauma-network: hence split up into behavioural (e.g. running around or the opposite) affective (anxiety, fear…), sensational (sensoric informations„body-memories“) and cognitive symptoms (I am dying now...).

Summarizing that means that we have strong, reflexive, knee-jerk reactions that are far beyond wilful control. These sensations, reactions and memories are stored in the so called implicit memory system amygdala based, hot, emotional, sensoric, non-conscious, non narrative, timeless, not under cortical control. It can can be triggered through any associated stimuls of which the concerned person maybe aware or – more often – not at all. *Here we have a very important impact on the topic of this article – the connection between traumatic experiences a person has – here unconsciously – stored and the danger to be triggered very specificlally. This person reacts with a reflex and this can also be a defense reflex. In a clinical setting this can occur as aggression or violence and can lead to various reactions itself and interpreations, consequences.*

Thus the most important goal of all efforts of trauma treatment – neurobiologically speaking is – to transfer these traumatic memories on all levels of representation into the so called explicit memory system or the cool storage, which works from 2 years on and is fully developed at 8. It seems to be located in the hypocampal-region and organized like a library - things can be found through hints, reachable for consciousness, biographic, modifyable. It is under cortical control and narrative. This means – in contrast to the contents of the implicit memory system it has a connection to the Broca area and can be connected to meanings and wording . Here we also have an impact for a recommendation to organizations that have to deal with the (consequences of) aggression and violence: to take care of the appropriate aftercare for their personell to avoid these disturbances become chronic by providing treatment that helps the memories to be stored properly.

These aspects have already been exposed in the daily living sayings that were mentioned above.

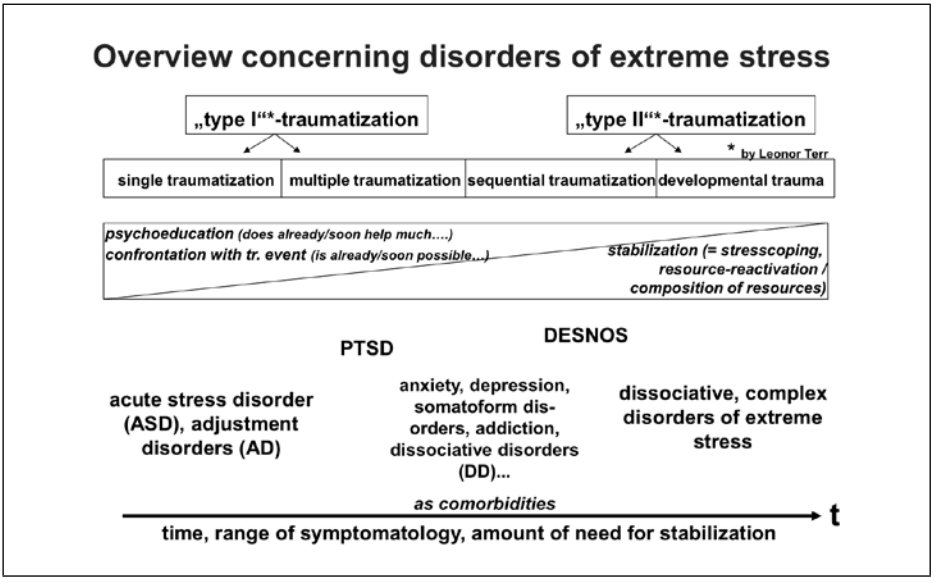
These fragments in the implicit memory system can be triggered by associated stimuli anytime, anywhere.In the moment they occur they are experienced as the already mentioned flash-backs without cortical control or the possibility for modification as the connections are interrupted. This potentially ongoing floating in trauma-networks means a high pressure for victims and they can show bizarre – and also aggressive – behaviour.

This brief introduction should make clearer that victims of extreme stress experiences can react to many kinds of (often unconscious) triggers unvoluntarily – among a wide range of reactions - also with aggression and so produce violence.

In these cases it might be helpful to understand more about potential triggers. This refers to the proposal later on to think about a brief non invasive screening instrument on stressful events in a patient's history. On the other hand the knowledge about the origin and the character of triggers help the staff in psychiatric wards in the field of diagnostics and in practical daily work to avoid triggers as much as possilbe once being aware of them dealing with special patients. These two aspects can already bring much effect.

Types of psychotrauma (L.Terr , 1989, J.of Traumatic Stress, Rothschild, B.,2002)
Lenore Terr, an Amerian child psychologist established a pragmatic scheme of different types of traumatization (I and II) people can suffer from gives a systematic idea also on subsequent diagnoses and thus what could be the background of seemingly aggressive behaviour from a psychotraumatological perspective?
In Figure 1 the potential types of traumatization are listed – from a single event to strike s.b. over several different (very important for the interpretation and the impact on the value system of the person) single events (both type I) to sequential traumatization where s.b. is exposed to ongoing similar traumatizing events caused by other persons that harm and deveolpmental interpersonal traumatization, often in the context of domestic violence, abusing attachment disorders and not seldom leading to structural disorders.

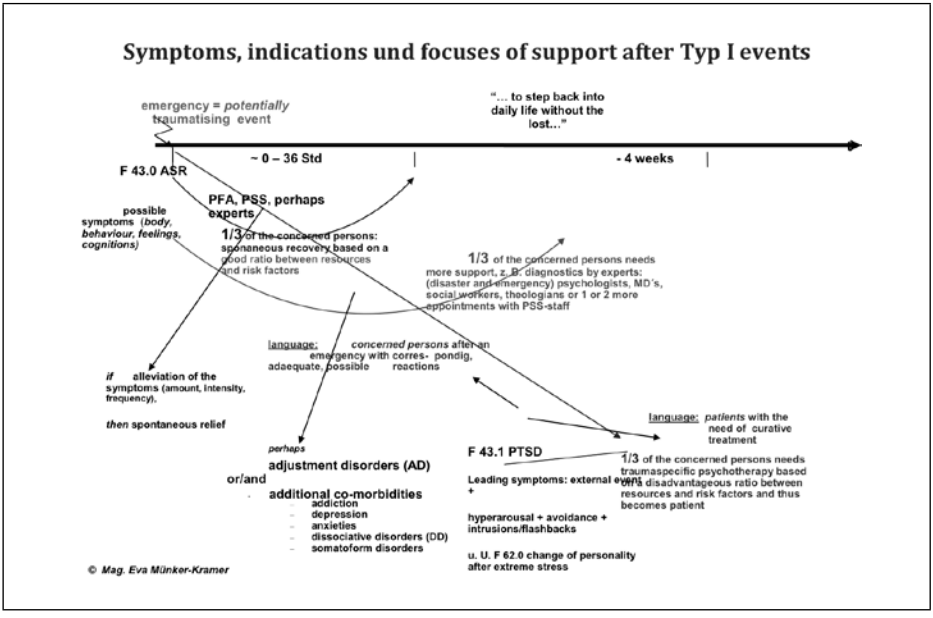
Figure 1: Overview disorders of Extreme Stress



As mentioned above since 1981 many important diagnoses have been described after only PTSD existed – a ratio between stabilization and exposure for the whole range of affected persons has been established and (see also figure 2 for type 1 events) a ratio of treatment and counseling methods have been developed and research has taken place. All these aspects will be addressed in the key note presentation.

The organization of aftercare after a single traumatic event

Figure 2: Symptoms, Indications and Focuses of Support After Type I events



In Figure 2 one potenial pattern how aftercare after a single traumatic event could be described is shown. If there is an incident where health staff has to experience aggression and violence (independent from the question where this has come from within the patient – this was another topic and perspective to prevent violence) this person has the right to receive adaequate and professional aftercare. Following the time line there are the different offers .

It is also called the pyramid of psychosocial support. This refers to the fact that following the epidemiology of PTSD after a single event there are many concerned persons that can – after a short phase of being affected – deal with it due to internal resources and mechanisms. On the other hand there are many people to support them. Following this rationale there are less concerned persons that need more support and less people can offer that because it needs at least a basic training. At step 4 there is only less than one third that really needs traumatherapy (according to a disadvantageous proportion of threat and resources) and this needs very specialised experts.

But this makes it manageable and the goal and the responsibility of the organization (health care instituions, task forces like fire brigade, police… but also banks, railway companies – all the fields where personel can be affected) is to really monitor the needs and meet them and provide support where needed.

1. Non-professional first psychological support (like 1st medical help2) by everybody. This means that colleagues, eye witnesses, anybody can refer to guidelines of reorientation, information on basic

reactions, giving instructions to reorient, try to prevent the person from unnecessary exposition to the traumtic event ….

2. Non-professional, basically trained first psychological support (like paramedics): specially trained laymen)

3. Professional psychological help (like medical doctors) emergency psychologists, other specially trained MPHs

4. Traumatherapy (like medical specialists): specially trained and experinced traumatherapists

Looking at the graph step 1 and 2 are provided in a phase where the concerned person experiences symptoms of an acute stress reaction up to a few days after the event. From then on – if there is no sponaneous relief or relief with the help of the support delivered up to about 4 weeks professional help should be made available to offer more detailed support and diagnostics. If despite this there is a chronicity – here the PTSD diagnosis comes into account as chronic - specialised traumatherapy by trauma focused CBT, EMDR and a few other methods is appropriate and shall be conducted by trained clinicians.
To take care of that is the responsibility of the organizations these events take place in and strike the people working there.

What does this mean for clinical psychiatry?
With of course humble recognition for what has already been developed and established to deal with the phenomenon and the consequences of violence and aggression in clinical psychiatry a few suggestions, recommendations, practical ideas for prevention and treatment shall finally be outlined as a result and a consequence of these remarks:

- the idea to establish and use a basic and short and non invasive (to avoid to trigger) screening instrument to identify areas of potentially traumatizing events of a patient as part of history taking (extended version see Münker-Kramer), 2015, p. 219
- to install adapted and practical CISM (Critical Incident Stress Managment) systems as a normal and well established matter of course in case of violence and aggression as an aftercare – not as an exception sceptically „allowed“ by decision makers, superior authorities and line managers
- to integrate basic lessons on trauma (causes, treatment) in basic education of professions working in psychiatric wards to build up knowledge and understanding and sensibility on one hand for the need to avoid triggers and on the other hand to protect onself

Summarizing my plea is just to put on the trauma glasses as another natural approach and use this as another natural source of awareness, draw consequences if needed an additional hints and understanding comes up this way and unexcitedly drop them again if they do not bring any additional perspectives to deal with the patient and the connected challenges.

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Victimised psychotic patients: can they be treated for co-morbid post-traumatic stress disorder?

Keynote 2

Prof. Dr. Mark van der Gaag (Netherlands)

Keywords: trauma, posttraumatic stress disorder, psychosis, eye movement and desensitization reprocessing, prolonged exposure.

Introduction

Many psychotic patients have been traumatized as a child and adult. Childhood trauma is causally connected with the development of a psychotic disorder in adulthood. Without childhood adversities the world would have a third less psychotic patients.

Methods

We screened a large group of the psychotic outpatients in The Netherlands and in a sample of 2608 patients we found that 16% fulfilled all the criteria of posttraumatic stress disorder. The patients were psychotic since 17 years and they had full symptoms of PTSD untreated during on average 20 years. A randomized controlled trial treated 155 patients with schizophrenia spectrum disorder and PTSD in three condition: Prolonged Exposure, Eye Movement and Desensitization Reprocessing, or Waiting List.

Results

Most patients lost the PTSD diagnose after eight sessions of therapy. There were no adverse events, nor symptom exacerbation. Therapy was safe to conduct.
The effect on PTSD was large and treated patients were less depressed, less re-victimized and at follow-up more often in remission of psychosis.

Conclusion

PTSD is underdiagnosed in people with a schizophrenia spectrum disorder. Treatment of PTSD in these patients has just started and is efficacious and safe to conduct.

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Schema Therapy, theory and practice: An evidence-based treatment for offenders with personality disorders

Keynote 3

Prof. Dr. David Bernstein (Netherlands)
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Abstract

Objective

In 2007, Bernstein and colleagues initiated a multicenter randomized clinical trial (RCT) to investigate the effectiveness of schema therapy for forensic patients with personality disorders (PDs) at 7 Dutch forensic hospitals ("TBS clinics"). The goal was to determine whether schema therapy (ST) could outperform treatment as usual (TAU) in reducing recidivism risk, PD symptoms, early maladaptive schemas, and schema modes, and promote the process of "resocialization" in which patients are gradually reintroduced into the community.

Methods

One hundred and three patients were randomly assigned to receive three years of either ST (N=54) or TAU (N=49). All patients had DSM-IV Antisocial, Narcissistic, Borderline, or Paranoid PDs, or significant Cluster B traits (PD NOS). Approximately 50% were considered psychopathic, based on a PCL-R score >= 25. Assessments were performed every 6 months for the duration of the study, using measures that were independent of patients' self-reports for all main variables. Data collection was completed in August, 2015.

Results

ST outperformed TAU for all primary and most (6 out of 9) secondary variables with small to medium effect sizes.

Discussion

Based on these findings, the Dutch government has officially designed ST an evidence-based treatment for forensic PD patients. In this presentation, we will discuss the ST conceptual model and treatment approach as adapted for forensic PD patients, and the findings of this study. The results have important implications for our ideas about the effectiveness of psychotherapy for this challenging population.

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From Risk Assessment to Needs Assessment: Triage, Safety and Recovery

Keynote 4

Professor Harry G. Kennedy (Ireland)
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Keywords: violence, schizophrenia, forensic, risk, causation, DUNDRUM

Introduction

Risk assessment

There is a crisis in risk assessment. For some time we have known that the preferred method for assessing risk assessment instruments, the receiver operating characteristic area under the curve, hits a "glass ceiling" at about 0.75. The recognition of protective factors has broadened the list of factors but a true protective factor must not only have a negative area under the curve, it must have a negative interactive effect with risk factors (Rutter). There are other challenges to the paradigm. Risk factors are often remote and indirect. Causal factors ought to be antecedent, proximate and explanatory. This approach has had major benefits, for example Coid's group has shown that delusions have a proximate and explanatory relationship with violence only when mediated by anger. The relationship between symptoms and violence may also be mediated by cognitive impairment (O'Reilly *et al.* 2016) and impaired judgement in schizophrenia. Current risk assessment instruments do not distinguish between serious violence and minor harmful acts. Nor do they distinguish between expressive, impulsive violence and instrumental, deliberative violence.

Risk assessment has improved practice in forensic psychiatry in many ways. It has enabled objective, transparent and evidence based assessments of risk (probability). Low scores on dynamic risk scales predict success on transferring from high security to medium security, or medium security to community; higher dynamic risk scores predict recall or reoffending. However the dynamic risk scales appear to be poorly responsive to change (O'Shea and Dickens) and they are difficult to map on to individual care programmes. Can non-causal factors guide us to reduce, ameliorate or manage risk? Increasingly structured professional judgement instruments place an emphasis on a final qualitative formulation and an overall risk judgement which arguably is as much intuitive as deliberative.

If the items in structured professional judgement risk assessment tools are indirect risk factors, what would constitute causal factors and what should be the basis for violence risk reduction, amelioration and management?

Needs Assessment: Triage

The decision to admit a patient to a secure forensic hospital is not based on the probability of further violence or harm; it is based on the seriousness of harm and the need to provide care and treatment in a therapeutically safe and secure environment. Over a ten year period we have been able to repeatedly validate a series of items on which clinicians base decisions regarding the need for therapeutic security. These are calibrated in clinically meaningful units. Not only do the items in the DUNDRUM-1 Triage Security Scale describe reasons why patients need various levels of therapeutic security, they also predict length of stay and they appear to be valid in different jurisdictions and different health services including Ireland (Flynn et al,), London (Freestone *et al.* 2016), the Netherlands (Eckert *et al.* 2017),

New South Wales (Adams *et al.* in press) and New Zealand. Further translations and validations are underway in Montreal and Belgium and are planned in Poland.

Safety

The management of patient violence in the acute hospital setting does not rely on SPJ instruments such as the HCR-20 or SAPROF. Instead, day by day risk assessment using the Brøset or DRILL can be used to assess short term imminence of violence and to trigger the need for immediate interventions to prevent violence. The item contents of instruments such as the DASA are not only proximate but obviously explanatory (imminent) and are likely to be causal factors not risk factors. In an explanatory system consisting of fixed risk factors, stable dynamic risk factors, acute dynamic risk factors and triggers, these imminent items are acute. The interventions used to prevent violence are notoriously lacking in the sort of scientific evidence required to meet the standards of Cochrane reviews or meta-analysis. Interventions such as seclusion and restraint are commonly condemned from the point of view of principled human rights. It is not uncommon to hear of policy initiatives to completely eliminate the use of seclusion. At the same time it is universally acknowledged that violence should be completely prevented also. There is often little reflection on how these two principles can be reconciled. For example eliminating seclusion would almost certainly lead to greatly increased use of prolonged manual or even mechanical restraint and forced medication by injection without consent. Seclusion is far safer than forced medication and far more dignified than prolonged restraint.

One reason why there is so little scientific evidence regarding clinical practice of restrictive, intrusive and coercive practices to prevent violence is the lack of a scientific nosology, a valid rating system and the tools to carry out such a study.

We have piloted a research tool, the DRILL (Dundrum Restriction and Intrusion Limiting Liberty Ladders) which codifies adverse behaviours (five 'ladders'), interventions (eight 'ladders') and consequences. In a preliminary retrospective study on a 12 bed forensic male admission ward over a six month period we have shown that these scales have good psychometric properties. We have shown that a short term risk assessment the DASA predicts subsequent adverse behaviours. We have shown that both the DASA and adverse behaviours predict preventions. We have also been able to show proportionality between these steps. Demonstrating proportionality is essential in demonstrating fairness, justice and ethical practice. Most high risk scores on the DASA end with low grade preventive interventions. Most adverse behaviours respond positively while still at a low level to interventions that are proportionate. Where higher scale interventions are used, such as restraint and seclusion and rapid titration by injection, these are in response to more serious, violent adverse behaviours.

For the future we believe that when used in real time on handheld devices, this tool offers the opportunity to conduct randomised positive controlled trials.

Forensic Recovery

Patients admitted to forensic hospitals spend much longer in hospital than it takes simply to get over the acute agitated aroused and hostile mental state. We have already discussed the distinction between risk factors, causal factors and needs. A research literature on "what works" for violent behaviour has taken an entirely different direction. Multimodal therapy with an emphasis on dose (intensity and duration) and on positive therapeutic relationships is effective. The effect size for very specific, manualised programmes, while significant, is relatively small compared to positive therapeutic relationship and other more general factors.

We have made a distinction between measures of treatment response under 7 broad headings (the DUNDRUM-3 Programme Completion Scale) which are measured in meaningful units of change and forensic recovery (the DUNDRUM-4) also measured under 7 broad domains and also measured in

meaningful units of change. We have shown that these predict moves from high to medium to low security and they predict conditional discharge. We have shown that these are sensitive to reliable clinical change with the RCI less than one unit of meaningful change (a transition between one level of therapeutic security and the next). We have shown that change in the "gold standard" measure of violence proneness, the HCR-20 is influenced by neurocognitive impairment mediated by change in the DUNDRUM-3.

Discussion

Much more needs to be done. We believe that in the future, randomised controlled trials (RCTs) in forensic mental health would not be valid unless they first describe a measure of case mix based on need for therapeutic security, (the DUNDRUM-1 scores) and neurocognitive function (MCCB) in order to allow other clinicians to know if the results are relevant to their patient group. RCTs should in the future compare "treatment as usual" (TAU) with TAU plus any new intervention. In this context, TAU is described by baseline scores on the DUNDRUM-3 scale and change in the D-3 over time. What interventions would improve the rate of change?
In conclusion, there is much more to structured professional judgement than risk assessment. There is also an obligation on us as clinicians to ensure that triage does not merely lead to quarantine. Triage should lead to treatment for which there is reasonable evidence of effectiveness – treatment is the way to recovery.

Finally, the emergence of functional neurocognitive ability should change the way we think about long term outcomes and quality of life.

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Safewards, and how it works in Germany

Keynote 5

Prof. Michael Löhr, Phd (Deutschland)

Introduction

The theme of verbal and non-verbal violence is omnipresent in psychiatric institutions. This situation has not changed for decades. Reliable figures for the whole of Germany are not available. Violence by patients on employees – depending on the institution and specific care setting for people in acute states of excitation due to an acute psychiatric disorder – are not rare. There is also, however, violence directed from institutions or employees toward patients. This violence can take different forms. The strongest form of this violence is coercive action. However, the violence and its containment are often the last link in the chain of an escalating crisis. This paper deals with the question of whether and how the Safewards model developed in England for acute psychiatric wards and how Safewards works in Germany.

Background

The question that employees have been tackling in all acute psychiatric settings is: what factors can lead to outbreaks of violence in patients? In a large-scale survey by Lozzino *et al.* (2015), various predictors of violent incidents in acute psychiatric admission wards were investigated. Altogether, 35 studies were included in this overview. A total of 23,900 patients were included, of which 17% became violent at least once. The following forecasts were made for this patient group: male, compulsory admittance, schizophrenic-type illnesses, alcohol abuse and violent behaviour in the past. It should be noted that this study focused exclusively on patient factors and that conditions such as environmental and relationship factors were not considered. As expressed by Long *et al.* "The number of coercive measures drop accordingly if the atmosphere in the ward is good, patients are handled with respect and the team has an individualised, non-rule-oriented approach, patients are appreciated, value is placed on prevention, the team can reflect on its practice, and the patients are given as much control as possible." (2016: 300)

If we consider the statement by Long *et al.* (2016), it becomes clear that compulsory measures and corresponding conflicts that precede the coercive measures can be reduced by modifying the environment and adapting professional relationships. These elements are of particular importance for prevention. The Central Commission for the Observance of Ethical Principles in the Field of Medicine and its Interdisciplinary Subjects (Central Ethics Committee) came to a similar conclusion at the Federal Medical Association: "Institutional conditions in hospitals have a significant effect on the use of coercive measures, and in some cases probably even more than the state of health of the patient." Federal Medical Association (2013: A1335). In an overview it was demonstrated that when looking at the results on the reduction of seclusion and restraint, broad-based programmes that look at the problem from different perspectives have proven to be valid (Scalan 2009). Considering this, the English nursing scientist, Len Bowers, was awarded an NHS-funded project with the aim of explaining all conflicts in acute psychiatric wards and developing an intervention programme based on current evidence. This task led to the development of the Safewards concept that has been available on the website www.safewards.net since 2013 and is therefore available for use. The overall concept was translated by the Diaconic University of applied science in Bielefeld and made usable for the German-speaking area.

The Safewards model

The Safewards model describes six areas in which conflicts and mitigation measures arise (Bowers 2014):

- Staff Team or Internal Structure Domain;
- Physical Environment Domain;
- Outside Hospital Domain;
- Patient Community Domain;
- Patient Characteristics Domain and
- Regulatory Framework Domain.

The good news is: employees can positively influence crises and conflicts and contain situations. This is done by reducing factors that can trigger conflicts. In so doing, the connection between flashpoint and conflict can be broken. Furthermore, employees can decide against restrictive measures. This creates a secure ward environment.
The Safewards model describes the factors very systematically and provides interventions to improve the safety of both employees and patients.
Patients who display a specific type of conflict behaviour also tend towards other conflict behaviours. There is a cumulation of behaviour patterns. Conflict and containment measures build up in the wards. Wards with a high rate of aggression also have a high number of incidents of absconding, forced medication and 1:1 care. It can therefore be concluded that the different incidents and actions have common causes (Bowers 2014; Löhr 2015). Within the model, various factors are described that can influence conflicts and containment measures.

The frequency of conflict situations and containment measures is largely affected by physical and social factors. The characteristics, conduct and attitudes of employees and teams that can affect the incidence of challenging situations and conflict containment measures are summarised under the term of "staff modifiers". The concept of "patient modifiers" refers to interactions between patients and employees or with fellow patients that affect the conflicts and containment measures and which employees are very likely to react to. The concept of flashpoints is defined in this model as the escalation of social and psychological situations that arise from originating factors and indicate a potentially imminent conflict behaviour.
The model shows that psychiatric staff can affect the frequency with which conflicts and containment actions occur at every level. This can happen by way of a variety of measures. If you approach factors appropriately and create a buffer, the flashpoint can be diminished or totally avoided. Staff must also ensure that the use of containment measures does not trigger new conflicts (Löhr 2015).

Safewards interventions

The Safewards model comprises ten interventions that lead to a reduction in conflicts and containment measures. Any intervention has at least one and preferably several intervention assignees. Their task is to plan exactly how to implement the intervention at ward level and carry it out. Safewards is a systemic intervention, so all employees should handle one or several interventions as intervention assignees. It has also been shown that if all professional categories are involved, the implementation result is better. Here are the 10 interventions explained in turn (Löhr 2015):

Clear mutual explanations:
Patients undergoing acute psychiatric therapy often display erratic behaviour. This has several reasons. One of them is that they often do not know exactly what is expected of them. Inconsistent expectations of employees also lead to uncertainties. In light of this, mutual expectations are clarified. This happens when employees engage with ward rules with dedication and check each point to ensure that it makes sense. After that, these rules are translated into expectations and discussed with the patients; then

important points are added that have meaning for the patients. This leads to agreed expectations. In total, these sub-interventions consist of seven steps.

The intervention assignees have the task of familiarising themselves with the expectations of the team and with those of the patients. This must be well-planned. The tasks also include visualising the new mutual expectations, creating a poster and reminding all employees to discuss mutual expectations with newcomers and to refer to the process of joint development.

Soft Words:

In full in-patient settings, it frequently happens that not all patient requests and wishes can be met. This is where flashpoints and conflicts can arise. It is extremely important to communicate perceptively and to intervene at an early stage. This intervention is based on two main elements of which the team should be made aware.

- The "Message of the Day" is hung up in the ward room and regularly replaced.
- Postcards with special notes and messages in interesting formats can be used to boost them.

The employees are made aware of the need to be respectful and polite at all times, to refuse a patient's request appropriately if no other solution is conceivable and to ask the patient respectfully to do something if this is necessary.

This is a demanding task for intervention assignees. It is essentially about discussing communication processes in the team. The intervention assignees use any suitable opportunities to point out good employee-patient interactions: "You have done well, because..." It is also about referring to less successful employee-patient interaction to foster clearer communication: "I have seen better from you, because..." This requires a high degree of personal and professional integrity on the part of the intervention assignees and a lot of self-reflection from the multi-professional team.

Talk Down:

It is very important that employees recognise a verbally escalating situation at an early stage. The methods with which they handle this situation will be conveyed in de-escalating interaction. A poster will also be hung up, depicting the most important steps and the process. In many acute psychiatric institutions, there are ward units with specially trained personnel for de-escalating interaction. This is an opportunity for trained employees also to work as intervention assignees.

When planning the introduction, they should think about how to train the multi-professional team in de-escalating interaction. Tools are available on the Safewards website. This intervention also works with visualisations. There is a poster that shows steps for de-escalating interaction and provides condensed information about this. This poster should be put up in the ward to remind everyone constantly about this intervention and the steps that should become routine. This is, however, only one part of this intervention. As indicated above, an originating factor is "conflicts within the patient community". To have an effect here, too, all employees are invited to inform their patients for whom they are the key worker about the principles of the de-escalation conversation. It is a good idea to put up posters in the patients' living area, so that they can also learn about this intervention and apply it.

Positive communication:

In handovers, the emphasis is often on patients that cause problems for employees or represent a danger to fellow patients. A negative image of patients quickly ensues. To counter this, an attempt should be made to say something positive about each patient and to appreciate positive aspects.

In this case the intervention assignees have the task of using rule communication structures (e.g. handovers, visits, etc.) to point out, if necessary, that the positive aspects of the patient should be stressed. This will help to get out of destructive communication spirals and appreciate even small positive things. Even the smallest positive aspect is worthy of mention (e.g., Mr. X got up on time this morning; Mrs Y smiled at me today).

Bad news mitigation:
Flashpoints can occur if patients get unpleasant news – e.g. a break-up with a partner, loss of their home, etc. – before employees know about it. If the team asks every day whether a patient has received any unpleasant news, it can be seen how the patient can be prepared for this situation and support can be given. This intervention should be initiated early on. Action is taken on the source factor directly.

After implementation, intervention assignees must remember to ask every day whether someone has received any bad news. If bad news is expected, a plan should be drawn up to decide what support can be given to the patient.

Know each other:
Employees often know very much about her patients. This knowledge helps employees to build up a relationship with the patient. This knowledge about the patient is shared with other colleagues so that all can build up a good relationship. This can also work the other way around. If patients know a little bit more about the team in their ward, they can find out whether they have any common interests or topics of conversation. In our everyday work, we gather a lot of information on individual patients, but hardly any of it seems appropriate "to establish a relationship, to chat, and to be friendly towards each other. Knowledge about the patient through the psychiatric history with illness, problems, incapacity and hospital stays is often perceived as negative." (www.safewards.net).

Good planning is essential for this intervention. The intervention assignees should present the intervention to the team. They can then discuss what information they want to reveal and how it can be made available (e.g. a folder in the patient's room). The information should be selected so that it arouses curiosity, without being too intimate. In addition to the intervention assignees, management of the ward teams is an important job. Experience has shown that this intervention is a source of many fears for employees. What can I reveal? Which information is not critical? Any fears are to be taken seriously and dealt with because an excessively timid attitude has an effect on the patients. Supervision and good self-reflection are essential.

Mutual help meeting:
The objective of this intervention is to see the ward with the patients and employees as a social community. Emphasis is placed on mutual support between patients. This meeting is a voluntary discussion with all patients and employees. At least three times, a week a discussion is held on how everyone can help each other. During each session, it is possible to say thank you for things that went well since the last meeting.

The intervention assignees decide which day would be best for the intervention. The mutual help meeting should take place on three days a week at least. Experience shows that even the weekend is a good time for the meeting to be held. Consideration should also be given to whether existing meetings, such as a morning round, could be replaced by a mutual support meeting. During planning, it is important to ensure that the intervention takes place regularly, that there are enough employees on site, and that they are able to lead such a group. For implementation in some general psychiatry clinics, it became clear that it cannot be assumed that all employees feel competent to lead such groups. Thus, at the beginning, employees (intervention assignees) who feel confident and comfortable instructing other employees should meet with each other.

Calming down Methods
If patients become restless, this can often be seen from facial expressions or tone of voice. At the appearance of these initial signs, methods such as aromatic oils, relaxation teas, an iPod with relaxing music, etc. can be offered to calm and relax the patients. These methods are preferable to PRN medication.

The intervention assignees for calming methods must plan well in advance which things should be placed in the box or boxes. It is also possible to offer several boxes – organised by theme – in which

items can be placed. This is where the intervention assignees can put their creative skills to good use. Things such as simple sport exercises, sudoku puzzles as well as arts and crafts activities can be organised. A ward employee who was responsible for implementing Safewards once said: "I could not imagine there being anything other than anti-stress balls in these boxes." Wards that already work with this intervention, approach the documentation of calming methods differently.

Reassurance:
For many people, being admitted to a psychiatric ward is a transformational experience. They react angrily or anxiously to situations with security measures such as locked doors. After each incident that can potentially trigger anxiety, patients should be spoken to individually or as part of a group. After these events, employees should also be more present and stay close to patients. This is not about surveillance, but about care and safety. If employees are not able to provide this security and respond without thinking, a crisis may arise.

The intervention assignees should plan a strategy for systematically dealing with security issues. This includes on the one hand making patients feel safe and on the other hand helping employees feel secure in difficult situations. There are many suggestions for this (www.safewards.net). In difficult situations that can trigger anxiety for everyone, it is important that all team members exude confidence and show the patients that the ward is a safe place. This can be a success if employees handle their fears and concerns professionally.

Discharge message:
Anger and aggression are often caused by the patients' frustration about their own state of health. This intervention should bring hope. The idea is to show the patient the purpose and the benefit of their stay in hospital. On the day of discharge, patients are asked to write a message on a card, to convey hope to those patients who have to stay. The cards are then put on the blackboard or displayed in other public places.

The intervention assignees plan the introduction of this measure and need to think about how the messages are presented. Experience shows that it is good to place them in a public and prominent position in the ward. Often graphical elements are used, such as a tree for display on a corridor wall. The cards can then take the form of leaves. Other possibilities can be used. This is how a ward works with an picture board on which discharge messages can be read.

State of research

The efficacy of the intervention was assessed in a randomised, controlled trial (RCT). The aim of the study was to assess the efficacy of a complex intervention to reduce conflict and containment in the ward. Bowers *et al.* (2015) looked at whether Safewards interventions were more beneficial than wards with interventions in the context of physical health. The key outcome parameters were the number of conflicts and containment measures. In total, 16 wards were allocated to the Safewards intervention group and 15 wards to the physical health control group. The control intervention was chosen, since better physical health of employees can reduce conflicts (Bowers *et al.* 2015). The basic survey was completed over a period of eight weeks. After that, there was an eight-week implementation phase, followed by an eight-week execution phase. On wards on which the Safewards interventions were used, the number of conflicts was reduced by 15% (95% CI 5.6-23.7). Compared with the control group, the containment measures were reduced by 23.2% (95 CI 9.9-34.3). This makes Safewards an effective intervention for reducing conflicts and containment measures. It should also be noted that this investigation by Bowers *et al.* (2015) has some limitations. Mustafa (2015) expressed criticism of some aspects (e.g. difficulty in achieving randomization, poor return rate for the patient staff conflict checklist, RCT as a difficult design for a complex intervention). It is, however, positive that the paper by Bowers is one of the few to study such a complex intervention using an RCT. For forensic psychiatry, there are currently only two scientific papers available.

Implementation experience

Around the world, many institutions are using Safewards implementations. For acute psychiatry, there is currently one RCT that has proven efficacy. For many other settings, proof of efficacy has not yet been given. However, the interventions used are based on interventions tested for efficacy. It seems that the complex Safewards intervention enjoys great popularity in other settings. In Germany, too, forensic institutions are introducing appropriate implementation processes. In this chapter, the experience of accompanied introductory processes by the author will be presented.

(a) Basic assumptions of implementation

Safewards is based on a theoretical model with associated interventions to reduce conflicts and containment measures. Safewards is, therefore, considered to fall within the notion of complex interventions. Safewards is consequently not an intervention for a specific professional group. The model and the interventions operate systemically. Thus all professional groups are to be taken into account for introduction and implementation. Without commitment from all professional groups and levels of hierarchy, implementation would hardly be possible.

(b) Implementation period

If we consider the implementation periods in the studies by Bowers *et al.* (2015) and Price & Leonard (2016), it is clear that very little time was dedicated to introduction. Experience with current implementation processes in Germany shows that careful planning with about a three-month lead time is required, with approximately 12 months for the actual implementation. The pre-implementation phase is of great significance and preparation for the actual implementation must not be underestimated.

(c) Pre-implementation phase

During this phase, focus is placed on two important elements.

1. All employees must be informed about the model and the interventions.
2. Commitment to the introductory process must be obtained from all management levels in all occupational groups.

All employees can be reached via a Safewards presentation, followed by a discussion of the concept and the interventions. All modern media such as webinars or videos are also available. For management levels, a check-list is available – Safewards pre-implementation check-list (SPIC) – that contains almost all pre-implementation stages. This check-list should be discussed and adapted to the specific aspects of the establishment. The SPIC is presented below:

Is top management on board?

- Has the nursing and the medical management been thoroughly informed about the Safewards model and Safewards interventions?
- Has the nursing and medical management explicitly agreed to the introduction of Safewards?
- Have the necessary funds been released for the introduction of Safewards (approx. €700 per ward)?
- Have the necessary funds been released for external assistance or supervision?
- Should an evaluation be included (if yes, an additional plan will have to be developed)?

Has the management (senior consultant and nursing service management) been involved in Safewards implementation?

- Has the departmental management been informed?
- Has the departmental management been involved in all training and information events?
- Does the departmental management handle the general project management?
- Have feedback loops been scheduled from operational project management to higher-level project management?

- Are bonus or penalty rules desirable for good and/or poor project progress?
- If yes, where will these be defined?
- How is Safewards to be integrated into the clinical procedure, so that in five years it can still be seen that the project existed (sustainability)?
- Have we decided how to ascertain in a year whether the intervention has been successfully implemented? (Adherence to SMART criteria)?

Have the operational project managers (ward manager and senior consultant) been appointed and their tasks determined?

- Has the operational project manager ensured that the entire multidisciplinary team has been involved in the introductory process?
- Have all the employees handled at least one intervention as an intervention assignee?
- Were employees able to be involved in the choice of the intervention?
- Is there a plan for dealing with problems?
- How long should implementation take?

Have the employees been able to discuss the interventions?

- Is it clear to every employee which intervention(s) he or she is responsible for?
- Have individual intervention assignees been able to look in detail at the Safewards model and the intervention(s) involved?
- Have intervention assignees decided on an implementation strategy?
- Has consideration been given to the materials required?
- How are other employees to be trained?
- What introductory steps are required?

During the pre-implementation phase, all important aspects should be discussed to ensure that the implementation process runs smoothly. Managers from the various levels should play a key role in this process. They will also bear most responsibility for the implementation phase. This means the nursing ward management and the senior consultant do not act as intervention assignees. As operational project managers, they should have an overview of the individual introductory steps and work closely with the intervention assignees and the strategic project manager. Problems should be dealt with immediately. It is also important that the intervention assignees should be appointed during this phase. They must be well-versed in the intervention so they can develop a plan for its implementation. It is recommended to have a team of two to three intervention assignees per intervention. Team members can also be involved as intervention assignees if there is more than one intervention. It is important that all team members should have the role of intervention assignees for at least one intervention.

(d) Implementation phase

This phase can take various forms. Time should be taken at the beginning, however, to develop an implementation plan together. Good experience was gained at a Safewards workshop. On this occasion, all members of the team (all professional groups and all management levels) in the ward come together for the day. The focus is not on talking about what Safewards is. It is about finding out which operational introductory steps need to be planned so that Safewards can be successfully implemented. It is important to complete the pre-implementation phase, otherwise difficulties could arise during the workshop if not all aspects have been discussed and decided. We assume that a ward will take a year to implement all ten interventions. Once this has been done, the individual interventions can be planned. As the intervention assignees are appointed during the pre-implementation phase and have familiarised themselves with the intervention, the sequence in which the interventions will take place can then be decided. It has proven to be feasible to implement each intervention within a month. During these four weeks, the task is to implement the intervention on the ward. The time needed to prepare depends on the intervention. For example, questions are asked about “clear mutual expectations” that will help to develop the implementation plan.

- How should the team be involved in developing clear mutual expectations?
- Is a meeting necessary and can a session of the rule communication committee be used?
- If everyone has agreed on mutual expectations, how do you communicate this to the patients?
- How can the patients express their expectations to the team?
- How can mutual expectations be viewed?
- Must things like corporate design be taken into account?
- Who, for example, prints the poster with the mutual expectations?
- How can we make sure that in the future all newcomers are informed of the mutual expectations and the development process?
- What is the timetable for all these preparatory activities?
- When can the intervention be started (when is everything complete?)?

The questions should give an impression of the tasks required for creating the operational implementation plan. The aim of the workshop is to create a full introductory plan in one day, which can then be used to schedule all possible operational implementation stages. This helps the intervention assignees implement the individual interventions.

Summary

Safewards is one of the few evidence-based models and interventions that lead to a demonstrable reduction in conflicts and containment measures. Safewards is more than the sum of its parts. It can be seen during the implementation processes that Safewards has a great impact on employees. The intervention encourages the self-reflection process and team building. At the moment, in Germany, many hospitals are involved in introducing it. We find the best results where Safewards is perceived and implemented as a multi-professional process. Implementation must be given at least as much attention as the actual intervention. It should be borne in mind that even Safewards cannot be reasonably expected to reduce all conflicts and ban all coercive measures from psychiatry. Safewards does, however, have the potential to turn acute psychiatric settings into healing places, also in Germany.

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Primum non nocere? Learning from consumer perspectives on aggression in psychiatry

Keynote 6

Dr. Bridget Hamilton (Australia)

Keywords: nursing, consumer experience, co-production, aggression, coercion, ethics

Abstract

Aim: This address brings to the foreground the perspectives of consumers in regard to everyday mental health care practices. It draws attention to associated harms that are usually underplayed in clinical research.

The professional healthcare workforce is committed to the ethical dictum: 'first do no harm'. The ethical and practical issues associated with overriding autonomy and using coercion in psychiatry are mostly considered separately from issues of aggression and violence. As a result of listening to consumers, the two topics of coercion and aggression are approached differently by this author.

Clinicians tend to focus on identifying when coercion may be necessary and determining how to use only the force that is considered necessary. Most research on the topic of aggression in psychiatry implicitly assumes that mental heath care is benevolent. Hence, research regarding aggression in psychiatry focuses attention on consumers as initiators, and assumes that the drivers of aggression are to be found in the patient. Little attention is paid to considering consumers' experiences of coercion as aggression by clinicians and the state.

Findings from several co-produced and consumer-led studies illustrate how partnering with consumers in research, and attending to both consumer and carer perspectives of mental health care, can broaden clinicians understanding of aggression and harm. A small but growing research stream explores consumers' own experiences of conflict and aggression in psychiatry, and questions the proposition that care providers do no harm. Consumers provide their own detailed accounts and analysis of a range of common interventions delivered without consumer consent, including: assertive outreaching treatment, medication by injection, detention in locked wards, coerced medications, several forms of restraint and seclusion. Quantitative and qualitative studies which pay serious attention to consumers' perspective of care shows how coercive interventions are experienced as aggression, with enduring, detrimental impacts.

These studies encourage the research community and clinicians to confront harms that are otherwise under-recognised, contributing to cycles of conflict and aggression. This body of work offers more than a critique of service provision. Consumer knowledge can provide impetus and means for improving both the experiences and outcomes of care. Contributions include recommendations about how clinicians might acknowledge, take seriously and redress the harms done by use of force, even if coercion can be justified.

Conclusion

The presented findings and analysis may promote further discussions about how complex activities of containment and treatment are experienced, how they can provoke and perpetuate aggression, and what might be done to improve consumer outcomes.

Educational Goals

For conference participants to:
1. reconsider assumptions underpinning research and practice regarding aggression in psychiatry, in the light of consumer knowledge
2. consider how to explicitly account for and redress the harms associated with coercive intervention.

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Impulsive aggression: a dimension and a disorder

Keynote 7

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Keywords: Aggression, Impulsivity, Neurobiology, Treatment

Introduction

Human aggression can be defined as a behavior by one individual directed at another person or object in which either verbal force or physical force is used to injure, coerce, or to express anger. It is typically distinguished in two forms: instrumental or proactive and impulsive or reactive[1,2]. The former is premeditated in nature while the latter is characterized by a sudden discharge of anger in the context of a social threat or frustration. In addition, the former is largely dealt with in the context of the justice system while the latter is dealt with in the mental health system, if it is dealt with at all. Finally, while there is almost no data suggesting that premeditated aggression can be curtailed through standard mental health interventions, emerging data does suggest that impulsive aggression can be reduced through behavioral and/or psychopharmacologic intervention.[3] Accordingly, this paper will focus on impulsive aggression.

Over the years, aggression has been studied primarily as a dimensional construct. While the idea of dimensionality is currently being expanded to include other areas of psychiatry, interventions to reduce impulsive aggressive behavior in individuals can only be effectively developed in the context of a category that identifies individuals with severe and frequent enough impulsive aggressive behavior to warrant intervention. The remainder of this paper reviews the research in the area of impulsive aggressive behavior in humans in both dimensional and categorical terms.

Aggression as a Dimension

Bio-genetic studies involving human aggression as a dimension are fairly numerous and involve those related to behavioral genetics and neurobiology (i.e., central and peripheral neurochemistry, dynamic responsiveness to neurotransmitter-challenge), and neuroimaging.

Behavioral Genetic Studies.
As with many other behaviors, aggression is under both genetic and environmental influence. How much of either depending on the particular study and type of aggression, if specified, studied. In the most recent meta-analysis of twin studies of aggression, up to 50% of the variability in measures of aggression can be accounted for by genetic factors.[4] Our own twin studies using aggression and impulsivity measures that correlate significantly with neurobiological variables,[5,6] demonstrate significant genetic influence varying by type of aggression. Specifically, verbal aggression displays 28%, aggression against objects displays 35%, and aggression against others displays 45% genetic influence.[7] In addition, impulsivity is under similar genetic influence in these types of studies and the genetic correlation of impulsivity and aggression correspondingly substantial.[8]

Beyond genetic influence, environmental factors are also critical and these factors, together, account for more of the variance in measures of aggression than genetic factors. Environmental factors in aggression include, among others, history of childhood trauma, witnessing aggression, modeling of aggressive behavior observed in parents and caretakers, history of head trauma, and aversive social interaction in the "here and now".[9] The latter factor is particularly important in the context of clinical intervention because it relates how intra-personal factors directly lead to an aggressive encounter. If one

can understand these factors, one can develop an intervention to reduce impulsive aggressive behavior; we will return to this later in the paper.

Neurobiological Studies.
The neurobiological study of human aggression began by serendipity in the late 1970s when Brown and colleagues[10] were examining monoamine metabolites in cerebrospinal fluid (CSF) of putatively "healthy" subjects. As it happened, the investigators noted greater variability in the monoamine metabolite data than expected, particularly for serotonin (5-HT) metabolite, 5-hydroxyindoleacetic acid (5-HIAA). Knowing that 5-HT displayed an inverse relationship with aggressive responding in previous animal studies,[11] the investigators extracted a life history of actual aggressive events from the records of the subjects (i.e., navy recruits being evaluated for fitness of duty because of "aggressive" or "passive-aggressive" behavior) and reported a strong inverse relationship between CSF 5-HIAA levels and their lifetime measure of aggressive behavior. This relationship has also been reported in other studies of severely aggressive individuals[12-14] but not in those with less intense aggressive behavior.[15-17] In addition, to this inverse correlation between CSF 5-HIAA and aggression, inverse correlations with aggression have also been reported with the hormonal responsiveness to 5-HT selective agents[18] including fenfluramine[5,6] (indirect 5-HT agonist, ipsapirone[19] (5-HT1a agonist), and m-cholorphenylpiperazine[16,20] (5-HT-2c receptor agonist). These latter studies suggest that 5-HT receptors are sub-sensitive to 5-HT activation so that there is reduction in net 5-HT activity and, thus, in 5-HT mediated behavioral inhibition.

Other neurochemical systems may also be relevant in human aggression. At this time, there is preliminary data supporting positive relationships between aggression and catecholamines (norepinephrine[21], dopamine[22]), other amines (glutamate[23]), peptides (vasopressin[24]; substance P[25]; neuropeptide Y[26]), and circulating cytokines (e.g., Interleukin-6[27]). There is similar data supporting an inverse relationship between aggression and oxytocin.[28] However, with the exception of manipulating 5-HT as a strategy to reduce[29] or increase[30] impulsive aggression, few studies have been conducted to explore how manipulating non-5-HT systems reduces, or has no effect on, impulsive aggressive behavior in humans.

The site of action in the brain for these various neurotransmitter/modulators has only partly been explored in humans and again, mostly in regard to 5-HT. The first published study in this area reported reduced glucose metabolism on positron emission tomography (PET) in the in left orbitofrontal (OFC) and anterior cingulate cortex (ACC), in six impulsively aggressive, compared with five healthy control, subjects after d,l-fenfluramine challenge.[31] A similar finding was reported in a larger subject group using mCPP challenge.[32] In addition, a twelve-week course of treatment with fluoxetine normalized OFC function in a similar group of impulsively aggressive subjects supporting the idea that deficits in OFC function are at least partially accounted for by abnormalities in 5-HT function.[33] Other neuroimaging studies suggest that impulsively aggressive individuals have abnormal 5-HT synthesis and reuptake in medial frontal gyrus, anterior cingulate gyrus, superior temporal gyrus, and corpus striatum compared to healthy controls.[34] One PET study reported reduced availability of the 5-HT Transporter (5-HTT) in ACC in impulsively aggressive subjects[35] while another did not (van de Giessen *et al.*, 2014) though it did report a significant, positive correlation with 5-HTT availability in the ACC and trait callousness.[36] Among impulsive aggressive individuals in this study, a trend-level, negative partial correlation (with callousness and age as covariates) was observed between trait aggression and 5-HTT availability in the ACC.

Neuroimaging Studies.
In addition to neuroimaging studies relating to neurochemistry, more recent studies have reported on structural and functional aspects of the brain as it relates to aggression. The first published studies in this area reported reduced glucose utilization in prefrontal and temporal cortices in individuals a history of violence[37] and as well as an inverse correlation between glucose utilization in the prefrontal cortex with life history of aggression in personality disordered subjects.[38] Later studies suggested metabolic hypoactivity in frontal brain regions, and hyperactivity in subcortical regions, in impulsive

aggressive murderers compared with healthy controls.[39] Subsequent structural MRI studies have reported significant reduction of prefrontal volume in individuals with antisocial personality disorder compared with a control group.[40] Functional MRI studies of healthy subjects show that anger-inducing paradigms activate the prefrontal cortex[41-44] while similar studies report reduced activity in this area in typically aggressive individuals with borderline personality disorder.[45] In addition to the pre-frontal cortex, the amygdala is also involved in the regulation of aggression as demonstrated by the fact that electrical stimulation of amygdala increases aggression while amygdalectomy reduces aggression.[46] Despite this, both epileptic patients with episodic aggressive outbursts,[47] as well as individuals with antisocial personality disorder,[48] have been shown to have reduced amygdala volume, which might suggest reduced activation when stimulated.

Aggression as a Category: Intermittent Explosive Disorder

While it is clear that there is a neurobiological substrate underlying human impulsive aggressive behavior and that the relationship between the two is dimensional in nature, interventions designed to reduce impulsive aggression require criteria to identify who could, or should, be treated for problematic impulsive aggressive behavior. Typically, this is accomplished by using accepted diagnostic criteria for the disordered behavior in question. Until recently, however, neither the DSM, nor the ICD, contained an appropriate diagnostic criteria set for impulsive aggressive behavior. This changed with the development of research criteria[49,50] for Intermittent Explosive Disorder (IED) which were later adapted for inclusion in the DSM-5.

The essence of problematic impulsive aggression has always been in the DSM. However, in the third edition (DSM-III), this was renamed IED and defined as a diagnosis of exclusion. As a consequence, very few impulsively aggressive individuals received this diagnosis. The next DSM edition (DSM-IV) broadened IED criteria to correct this problem but remained problematic regarding what actually constituted an aggressive outburst, required frequency and time-frame, and the fact that DSM-IV IED criteria did not explicitly rule out premeditated aggression. The research criteria set was designed to address these issues and also allow a more complete characterization of what IED might be.

Clinically, IED is characterized by one, or both, types of impulsive aggressive outbursts.[3] First, frequent, but low intensity, outbursts occurring twice weekly for at least three months and infrequent, but high intensity, outbursts occurring three times per year). Second, the outbursts are out of proportion to stressors (i.e., provocation), impulsive and anger based (i.e., not premeditated), associated with distress and impairment, and not better accounted for by another disorder (i.e., outbursts do not only occur during the presence of another disorder). Lifetime prevalence of IED is in the range of 3-4%[51,52] and when other psychiatric disorders are comorbid with IED, the age of onset of IED typically precedes that of the other disorder by several years indicating that IED cannot be due to the presence of the co-morbid disorder.[52]

Behavioral Genetic Studies.
While there are no twin studies of IED, family studies of IED have been conducted. The one published, controlled, family history study of IED reported a significantly increased morbid risk of IED in first degree relatives of probands who met research criteria for IED (MR = 0.34) compared with the relatives of control probands without IED (MR = 0.10).[53] The increased morbid risk of IED in relatives of IED probands was not due to issues of comorbidity in either the probands or in the relatives. This was replicated in a follow-up direct family study conducted by our group (in preparation). This is consistent with the findings reviewed above that indicate that impulsive aggression if under significant genetic influence.

While family studies cannot speak to the role of the environmental factors discussed above, specific study of some of these have been conducted in individuals with IED. For example, individuals with IED are more likely to have a childhood history of perceived physical, and emotional, trauma[54] and altered

social-emotional information processing (SEIP[55]) which is partially mediated by the former. The latter factor is extremely important because it speaks to the intra-personal factors that lead to an aggressive outburst. For example, individuals with IED are less likely to process relevant information in a social interaction involving potential threat,[56] more likely to attribute hostile motives to the other person in the interaction, and more likely to get angry in these situations.[57] Further, the more an individual with IED thinks the other person is behaving in a hostile fashion (even when they are not) the more angry they become at that other person. Given that the threshold to engage in an impulsively aggressive outburst is regulated by the neurobiological substrate (e.g., reduced inhibition and enhanced activation by neurotransmitter systems and brain circuitry), deficits in SEIP relate to the proximal stimulus to an impulsive, angry, aggressive outburst.

Neurobiological Studies.
Studies of individuals with IED affirm the expected categorical differences in biological markers as a function of aggression. For example, individuals with IED display reduced 5-HT function as evidenced by a reduction in the prolactin response to both d,l-fenfluramine[5,58], and d-fenfluramine Challenge,[6] platelet 5-HT transporter binding,[59] 2009), and platelet 5-HT[60] itself. In addition, individuals with IED display elevated levels of inflammatory markers compared with both healthy and psychiatric controls.[27]

Neuroimaging Studies.
Similarly, studies of individuals with IED affirm categorical differences in structural and functional imaging studies. Individuals with IED display a reduction in gray matter volume in fronto-limbic circuits,[61] abnormalities in the shape of the amygdala and hippocampus,[62] and reduced fractional anisotropy in the superior longitudinal fasciculus (SLF),[63] all suggesting important structural deficits in critical emotion regulating areas of the brain. Functional fMRI studies also note hyperactivity of the amygdala to hostile social threat (i.e., anger faces) in IED compared with heathy controls, with either unchanged, or reduced, activation of prefrontal cortical regions.[64,65] Recently, we found that while the amygdala exhibits a hyperactive response to anger faces, amygdala responses to evoked emotion are not different in IED compared with healthy controls (in preparation). This suggests that heightened amygdala to hostile social threat may be an endophenotype for IED. Finally, we have found important differences in fMRI BOLD responses to videos displaying socially ambiguous situations in which one individual experiences a potentially aggressive event. In these studies we have found that individuals with IED display multiple deficits in cortico-limbic activation as a function of the different steps in SEIP. Specifically, compared with healthy controls, individuals with IED display reduced activation of medial prefrontal (mPFC) and anterior cingulate (ACC) cortices when watching aggressive versus non-aggressive videos, reduced activation of dorsolateral prefrontal cortex (DLPFC) and at the temporoparietal junction (TPJ) while evaluating if the person in the video was hostile in their actions, and reduced activation of superior prefrontal cortex (sPFC) and the periaqueductal gray (PAG) when estimating how angry they would be if the potentially aggressive event happened to them.

Treatment Studies.
Based on the 5-HT hypothesis of aggression, a few treatment studies comparing a serotonin specific reuptake inhibitor (SSRI) to placebo have been conducted in individuals with IED[66] or in individuals with problematic impulsive aggressive behavior.[67,68] In each study, fluoxetine was found to reduce the magnitude of overt aggressive behavior compared with placebo and a positive treatment response to fluoxetine may be most manifest in those with a functional (ll or sl), versus less functional (ss) genotype for the 5-HTT promoter polymorphism.[67] This latter observation is consistent with the idea that treatment responsiveness to an SSRI is dependent upon having an adequate number of functional 5-HTT receptors for the SSRI to engage. Two of three double-blind, placebo-controlled, studies of anticonvulsants in IED have also demonstrated anti-aggressive efficacy over placebo; one each with divalproex[69] and oxcarbazepine[70] but not levetiracetam.[71] Another anticonvulsant study in impulsive, versus premeditated, aggressive individuals found that phenytoin reduced aggression in impulsive but not in premeditated aggressive individuals.[2] Finally, treatment with an anger targeted cognitive-behavioral intervention in individuals with IED also found anti-aggressive effects compared with

those on "wait-list".[72] These data support the idea that the recurrent, problematic impulsive aggressive behavior seen in those with IED can be reduced by appropriate intervention.

Conclusion

Recurrent problematic impulsive aggressive behavior among human individuals is far from rare and can be described by the current DSM-5 criteria for IED. Individuals with IED display the behavioral genetic, environmental, and neurobiological features expected of those on the high end of the aggression spectrum. Thus, following along these lines preliminary treatment studies have confirmed that impulsive aggression can be reduced in individuals with IED. While none of the treatment studies demonstrate extremely robust anti-aggressive effects, many avenues remain for potential intervention in IED. For example, trials using agents that target other, Non-5-HT, neuronal systems such as vasopressin, glutamate, and oxytocin, among others have yet to be fully evaluated. So, too, would be a fuller evaluation of the possible role of inflammatory mediators in impulsive aggression.

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Special Symposium – EViPRG @ 20: looking back & looking forwards

Special Symposium

Moderators: Roger Almvik, Joy Duxbury & Richard Whittington

Friday 27th of October 2017, Room 18, 10.30 – 12.30

Abstract

The European Violence in Psychiatry Research Group (EViPRG) was established at a meeting in London in 1997 with the aim of bringing together researchers, practitioners and educators from around Europe with an interest in tackling violence and minimising coercion in mental health services. Members of the network have met regularly over the past 20 years to exchange ideas on best practice, to improve theory and evidence and to see if a consensus approach on ways forward can be developed. The ideas of 'Europe' and 'violence' have evolved significantly and differently across the continent over this period and this symposium will include reflections by the current and former chairs of the network on the achievements of the group, the challenges of developing evidence based best practice internationally and some potential next steps in this area.

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Special presentation – Supporting me through my communication passport
Workshop – My behavior has a function: a practical workshop in using the Communication Passport

Special presentation + workshop

Kate Sanger (UK)

Supporting me through my communication passport
1. Special presentation on Thursday 26th of October at the plenary session (12.50 – 13.05)

My behavior has a function: a practical workshop in using the Communication Passport
2. Special workshop on Friday 27th of October during parallel session 3 (Executive Boardroom)(10.30 – 12.30)

Background

I am a mother of three, my youngest daughter has a severe learning disability, complex communication disorder, and ongoing medical needs. My background is in nursing, having trained in Glasgow and worked within the NHS in Scotland and England, I gave up my career to become a full time carer for my daughter, who requires 24 hour care. My daughter can display self-injurious behaviour, and behaviours described as challenging, when trying to communicate to others that something is wrong and her needs are not being met.

This has led me to training myself and all those who support my daughter in understanding the function of "challenging behaviour" and supporting strategies to support change in a positive manner.

I became a trustee adviser to the Challenging Behaviour Foundation (CBF) and a co-presenter trainer. I have given presentation on "Behaviours that challenge Addressing the barriers to inclusion" as a family carer at The Royal Society of Medicine at their conference at Dundee University, I also gave a presentation on behalf of the CBF and Mencap at "Excellence out of Adversity" conference in Glasgow, and for the last five years I have been part of a team that gives workshops and presentation as part of a self- selective component course in caring for people with learning disabilities and complex needs to trainee doctors at Ninewells hospital. I have also sat on interview panels and parent forums, and was recently the co-creator (with Jennifer Sanger) of www.mycommpass.com

I have worked tirelessly over the past fifteen years to promote a better understanding of the reasons for challenging behaviour and it would be my dream that there would be mandatory training in 'positive behaviour support' for all those involved in the care of children and adults with severe learning disabilities.

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Special Dance Workshop – The Choreography of Catharsis: Recognizing, Responding, and Recovering from Violence in the Health Sector

Special Dance Workshop

Patricia P. Capello (USA)

Even before birth, human beings are sensitive to cues from their environment and respond to them on a body level. As we grow, our senses develop and are refined by both our physical surroundings and our emotional and relational connections to others. The "intuitive self" can access vital nonverbal cues that can be used to assess the world and people around us.

By practicing the basic constructs of DMT (dance/movement therapy) individuals can begin to hone the natural skills that are present in everyone. DMT exercises in attunement include elements that are fundamental to the health care professional: awareness of body position; body boundaries; engagement and disengagement on a body level; and the non-verbal communication of the physical self.

This experiential workshop will help participants recognize informational sensations in their own bodies and develop a kinesthetic empathy and awareness of those in others. Through practice of the movement elements of flow-weight-time-space, our responses to interpersonal situations (both aggressive and non-aggressive) will be better understood and regulated. Finally, exercising the body's innate recuperative abilities by exploring the power of breath, tension-relaxation, and strength, participants will learn how to activate their own recovery from incidences of violence.

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Chapter 2 – Epidemiology and nature of inpatient violence against staff

Evaluation of seclusion in patients with severe dual disorders

Poster

Arjen Neven, Nienke Kool, Jipke Kool & Joke Broelman (Netherlands)

Keywords :Seclusion, evaluation, dual disorder

Abstract

Introduction

Seclusion in mental health care is considered to be undesirable. Since 2002 a push has been made to reduce the number and duration of seclusion in the Netherlands. Learning about experiences of patients is an important way to gain more insight in the advantages and disadvantages of seclusion. In our study we analysed the evaluations of our patients with severe dual disorders who were secluded.

Method

Retrospectively we collected data from all patients who were secluded in our psychiatric ward specialising in treating patients with a severe dual diagnosis, in the period January 1st till July 1st 2016. Our ward has four units with 36 places in total. We have two seclusion rooms. The procedure is that, within one week, the seclusion is evaluated with the patient by a nurse using a questionnaire.

Results

In total, there were 29 seclusions, involving 21 patients during the study period. In the study period 144 patients were hospitalised. So 14,6% of all patients were secluded at some point in their hospitalisation. In total, the 21 patients were secluded for almost 944 hours, with a mean seclusion period of 44 hours 57 minutes (range was 45 minutes to 222 hours). On average, patients were secluded 0.6% of the hospitalisation period (36 places x 181 days x 24 hours).

Of the 29 seclusion episodes, 25 were evaluated (86,2%) (twice it was forgotten, twice an evaluation was not possible due to direct hospital discharge after the seclusion).Six patients refused an evaluation. So, in this study, we describe 19 evaluations (65,5%). The diagnoses and the results of the evaluations will be presented in the tables on the poster.

Discussion

Almost unanimously, patients were positive about the manner of the evaluation. Eight patients reported that they calmed down after seclusion. Two patients reported having problems because of the seclusion. They did not, unfortunately, report exactly which problems they experienced.

These positive data should be interpreted with caution. First, it is a small sample. Second, six patients refused the evaluation and in four cases the evaluation was missing. Possibly, negative experiences during seclusion caused the refusal to evaluate. Finally, we should be cautious because the results can be positively affected by the group of patients that agreed with the psychiatrist that seclusion was necessary.

Conclusion

Seclusion evaluation is a meaningful manner to discuss the seclusion with the patient and to improve mental health care for patients with serious dual disorders. This will aid our push to decrease the number and duration of seclusions.

Educational Goals

- To learn about the disadvantages of seclusion.
- To learn how to evaluate a seclusion with the patient.

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Inpatient violence in a Dutch forensic psychiatric hospital: prevalence and characteristics

Paper

Nienke Verstegen, Vivienne De Vogel & Michiel De Vries Robbé (Netherlands)

Keywords: Inpatient violence, forensic psychiatry, violence, gender, civil commitment, criminal commitment

Abstract

Background

Patients in forensic psychiatric hospitals usually have a history of severe (sexually) violent behaviour. They receive mandatory treatment to ensure they can safely return to society. However, violent incidents occur also during this treatment. These incidents may have a great impact on staff and patients in terms of traumatic experiences for victims and bystanders, an unsafe treatment climate, and high financial costs. The existing literature points at differences between settings, patient characteristics and contextual factors that may influence patterns of inpatient violence. Knowledge of these patterns can be vital in developing effective policies to decrease violent incidence rates. Therefore, this study aims to gain more insight into the frequency and nature of violent incidents that take place in a forensic psychiatric hospital in the Netherlands admitting both men and women and patients with different judicial statuses.

Methods

The study was conducted at the Van der Hoeven Kliniek, a forensic psychiatric hospital in the Netherlands admitting both male and female patients. All patients in this hospital are adults and sentenced by either criminal or civil court to mandatory inpatient treatment with the aim to reduce violence risk. Data on inpatient violence were extracted from hospital files on 503 patients between 2008 and 2014.

Results

A total number of 2434 violent incidents was recorded between 2008 and 2014. During this study time, 54.9% of all the patients (n = 276) displayed verbal aggression on at least one occasion, whereas 27.2% of all patients (n = 137) exhibited one or more incidents of physical violence. A gradual rise of the number of recorded violent incidents during the years was observed. A small number of patients was responsible for a large number of violent incidents. More violence was found to take place on the earlier days of the week. Some population differences were observed: female patients were responsible for more physically violent episodes than male patients and patients with a civil commitment exhibited more violent behaviour than patients with a criminal commitment. Finally, the relation between length of hospitalisation and inpatient violence was studied. For methodological reasons, this was done only for patients with a civil commitment. Violent patients with a civil commitment had a significantly longer length of stay than non-violent patients with a civil commitment. Causes and implications of this longer treatment duration are discussed.

Conclusion

This study points at important differences between groups of forensic inpatients in frequency and type of inpatient violent behaviour. Subsequently, differences in temporal factors are demonstrated. Interventions aimed at reducing the number of violent incidents should take these differences into account. Further research is necessary to gain more insight into the background of inpatient violence.

Educational Goals

- To gain more insight into patterns of violent behaviour in a forensic psychiatric hospital
- To learn more about differences between groups of forensic inpatients in frequency and type of inpatient violent behaviour

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Violent phenomenology, patient/staff disclosure and collaboration: Game theory analysis of inpatient and staff data

Paper

Keith Reid, Sandeep Rheel*, Evelyn Rogerson*, James Brotherston** (UK)*
*July 2017 *Northumberland Tyne & Wear NHS Trust, UK ** University College London, UK*

Keywords: game theory, payoff matrix, strategy, dominant strategy, maximin, collaboration, violent, violence, intent, idea, psychosis, utility, tell, positive, positive risk, relational security

Background

Game theory provides mathematical models of conflict and cooperation [1][2][3]. We model disclosure of violent ideas using estimates by patients and staff of decisional clinical interactions. Each 'player' estimates the benefit of outcomes arising from their own and their counterpart's choice options. This paper introduces game theory analytic approaches to clinical data, e.g. 'dominant strategies' which are always best choices.

Method

Twelve patients and twelve staff in a male secure forensic mental health unit completed questionnaires. Ethics was as a service evaluation. Respondents were told we would respect anonymity. We asked them to imagine a patient in their secure unit who had formerly been violent, then recovered, but once again had violent ideas or hallucinations to harm others. We proffered three patient choices to 'hide', 'admit' when asked or spontaneously 'tell' regarding violent intent. We proffered three choices for staff as 'carefree', 'positive' or 'careful'. 'Careful' represented relatively restrictive care. 'Positive' care tolerated risk but fostered recovery, with managerial support. 'Carefree' was relatively unrestrictive. We defined these approaches neutrally. We asked staff and patients to rate the nine possible combinations from their own perspective, and also predict expectations of the other player group. Ratings were *Very Bad (1) - Very Good (5)*. Each respondent therefore answered supplying a grid pair, two 3 x 3 grids or matrices, each comprising their estimates of nine scenarios from the viewpoint of two players, i.e. 18 values in all. For some analyses estimates were transformed to ordinal scores (1) – (5). A pilot study was performed to test the form. The questionnaire had two optional preparatory scenarios about takeaways and penalty shootouts. These were dropped from the procedure because respondents better understood the violence question. Lowercase subscript suffix '$_p$' denoted estimates in single boxes or whole grids regarding patients; '$_s$' denoted estimates regarding staff. The twelve patient grid pairs were successively labelled $P_{Ap,s}…P_{Lp,s}$ (P_L being the 12th patient) and the modal patient answer grid pair $P_{Mp,s}$. Twelve staff were labelled $S_A…S_L$ and their modal answer grid pair $S_{Mp,s}$. So if P_A estimated 'tell' vs 'positive' would turn out as 'Good' for patients and 'Very Good' for staff, this was annotated P_A('tell' vs 'positive')$_{p,s}$ = 4 vs 5. The game P_{Mp} vs S_{Ms} was the primary outcome modelling the typical interaction (Fig 1), and we committed a *priori* to a fair and conservative way of establishing the mode. We then present other summary data to demonstrate how real situations can be modelled, such as individual patients interacting with a staff group. For example, twelve single patient estimate grids regarding patients $P_{Ap}…P_{Lp}$, were played against staff estimates regarding staff $S_{As}…S_{Ls}$ creating 144 games to model trends in the likely choices of real people interacting. Games $P_{As}…P_{Ls}$ vs $S_{Ap}…S_{Lp}$ were discarded as not influencing behaviour. We hypothesised that (a) staff and patients would have preferences, (b) that there would good enough agreement of estimates to allow coherent interaction, (c) and solutions could be meaningfully summarised as a non-zero-sum game meaning that win-win outcomes are possible. We

thank Andrew Curran Higher Assistant Psychologist and Jo Brackley Principle SALT for viewing early questionnaires, and the staff and patients who responded.

Results

At first we asked consultants to identify patients who might be approached, all responded. Once we were visibly talking to these, other patients approached asking to respond. Some patients then declined once aware. Occasionally staff declined saying they were busy or awaited face to face explanation; we did not follow those up having enough responding staff. 12 male patients and 12 staff responded from three medium and one low secure wards. Patients completing had communication, engagement and/or compliance issues. Conditions of anonymity meant that we could not systemically describe patients. Patients were detained on forensic or civil sections for comorbid schizophrenia, schizoaffective, affective, cluster B, substance, and/or developmental disorders not requiring intellectual disability placement. They had been referred from high, medium, low, general adult or custody. Index offences included homicide, other violence, contact or non-contact sexual offences, and arson. Age ranged from twenties to seventies. Lowest known WAIS IQ was 69; highest attainment was university degree. Staff were from the whole team including cleaner, support worker, nurse, doctor, psychology and occupational therapy. Respondents overlapped between pilot and main studies. Primary data is available on request having no patient identifying characteristics. At the original n=5 seven point Likert scale, staff estimated patient preference and vice versa with a Spearman rank correlation p=0.0003 gained from http://vassarstats.net/corr_rank.html. We could not use Spearman with the later five item scale; it needed more ordinal points. Of the nine distributions of estimates in the grid P_{Mp} the most tightly dispersed mode from patients (8/12) was 'hide' vs 'carefree' = 'Very Bad'$_p$. Next were (7/12) that 'admit' or 'tell' vs 'positive' = 'Very Good'$_p$. The strongest modes in the grid S_{Ms} from staff (8/12) were that they estimated 'hide' vs 'carefree' = 'Very Bad'$_s$, and 'admit' vs 'careful' = 'Good'$_s$. Dominant strategy analysis implied it would be rational/self-interested for staff to be 'positive' vs any patient choice. Similarly it would be rational and self-interested for a typical patient to 'tell'. This would lead to the optimum outcome 'tell vs positive', predicted to be 'Very Good' by both, without collaboration. These options are shaded gray. Both players would rationally choose their own gray choice.

Fig 1 Modal estimates of the nine possible outcomes. Estimates regarding patients are by patients (P_{Mp}), and regarding staff are by staff (S_{Ms}). Rational decisions lead to the optimum.

Fig 1 the modal home game		Staff decide to be…		
		Careful	Positive	Carefree
Patient decides to…	Hide	Bad for patient; Very bad for staff	Bad for patient; Bad for staff	Very Bad for patient; Very Bad for staff
	Admit	Good for patient; Good for staff	Good for patient; Good for staff	(Very Bad or Bad) for patient; (Very Bad or Bad) for staff
	Tell	Good for patient; (Evens or Good or Very Good) for staff	Very Good for patient; Very Good for staff	Good for patient; Very Bad for staff

Each respondent had their own native estimate of patient and staff preferences contributing to the mode, 12 such grid pairs from patients and 12 pairs from staff. These were the 24 games implied by the paired grids $P_{(A…L)p}$ vs $P_{(A…L)s}$; and $S_{(A…L)p}$ x $S_{(A…L)s}$. Regarding 'admit' or 'tell', in all patient grid pairs but one (92%), a selfish/rational approach without collaboration would imply a choice of 'admit' or 'tell'. This achieved outcomes 'Good' or 'Very Good' for patients and/or staff. This patient P_C might rationally

choose to 'hide' and would then be uncertain of whether to expect 'hide' vs 'careful' = 'Evens'$_p$ or 'hide' x 'positive' = 'Very Good'$_p$; if they collaborated with staff as they saw them for tell vs positive, they could achieve 'Good'$_p$ vs 'Good'$_s$. Comments by patients about 'Carefree' staff were negative - e.g. 'F*ck that'. 'Carefree' staff were expected to be dismissive, uncaring and to foster patient-on-patient violence. Regarding 'carefree', staff preferences implied that rational staff would never choose 'carefree', with face validity. Regarding 'careful' one staff member had preferences that did not determine any independently derived rational self-interested solution but could use collaboration to agree on 'admit' vs 'careful' or 'tell' vs 'positive' to achieve 'Very good'$_p$ vs 'Good'$_s$. One outlying staff S_A had notably skeptical preferences and expectations. The rational outcome determined by his/her view was 'hide' x 'careful' giving 'Bad'$_p$ vs 'Very Good'$_s$, against the strongly stated patient estimate. His/her expectations could also not provide any collaborative improvement. 'Careful' was twice dominated, (n=2/12) so those two staff would never rationally choose 'careful', preferring 'positive'. Regarding 'positive', in 83% (n=10/12) of staff answers implied a selfish and rational approach without collaboration would imply 'positive' care. If collaboration were allowed 92% (11/12) staff estimates implied a 'positive' approach, all except the notable pessimist S_A. So variations arising from individual player expectations did not greatly make patterns of those games diverge from modal games. The strongest pattern of best strategies remained 'admit' or 'tell' for patients and 'positive' for staff.

To make rational interacting decisions the patients and staff need to be reasonably aware of the preferences of the other player. Each respondent supplied eighteen values as explained in the method. We compared the eighteen modal values from typical patient answers with the eighteen modal answers from staff. This led to eighteen pairs to be analysed. Comparison was with Cohen's Kappa. The first comparison of eighteen starting in the top line of the top left box in the nine by nine grids was how 'hide' v s 'careful' turned out for patients, i.e. P_M('hide' vs 'careful')$_p$ = $\underline{2}$ compared to S_M('hide' vs 'careful')$_p$ = $\underline{2}$; the last of eighteen was S_M('tell' vs 'carefree')$_s$ = $\underline{1}$ compared to P_M('tell' vs 'carefree')$_s$ = $\underline{4}$. Staff estimated patient preferences with a fair agreement of K=0.2373. Patients estimated staff preferences with moderate agreement of K=0.5263. Overall the two groups achieved fair agreement of K=0.3127. The typical answer was the mode. If the mode was ambiguous e.g. having two equally frequent answers we tried to identify a median to choose the right mode. If use of the median did not resolve what the mode should be we used an intentionally conservative approach selecting estimates by patients to be low, but estimates by staff high. We analysed the twenty four games that arose from the interactions of each individual staff or patient against the modal answers for their counterpart group. When patient matrices $P_{(A...L)p}$ were individually played against the modal staff answer S_{Ms}, 92% determined a strategy of 'tell' or 'admit' vs 'positive'. The other implied 'hide vs 'positive'. When the individual staff matrices $S_{(A...L)s}$ were played against the modal patient answer P_{Mp}, 83% implied a 'positive' for staff and two implied a 'careful'. All determined a 'tell 'strategy for patients. The strongest pattern of best strategies remained 'admit' or 'tell' for patients and 'positive' for staff. We then analysed all of the 144 games $P_{(A...L)p}$ x $S_{(A...L)s}$ that arose from every patient interacting with every staff member based on their own preferences, if they communicated these, but did not yet collaborate. Again self-interested rational choices would have determined a patient choice of 'admit' or 'tell' in 92% of the 144 games, echoing the modal home games and a staff choice of 'positive' in 87% of the 144 games, close to the modal home games. Collaboration would have improved the outcome relative to a selfish approach in 8% of games.

Conclusions

In a secure unit disclosure of violent ideas is a non-zero-sum game. It can be rational and self-interested to be open and positive. Collaboration improves outcomes. We suggest that under 'positive' care 'admit' and 'tell' are equivalent. Patients' accounts were detailed, consistent and often heartfelt. Patients were better than staff at anticipating the other. Implications arise from treating this dilemma as a non-zero-sum which may have great clinical importance. Collaboration can be fostered, e.g. in repeated games players can tend to focus on status rather than objective benefit; but collaboration is increased by using positive terms [4][5]. This may explain why approaches that explain restrictions in terms of respect, recovery

and safety, rather than e.g. punishment and avoidance of harm, seem to foster collaboration. Playing styles represented as algorithms are successful in repeated competitive paradigms if they are 'nice', i.e. start collaboratively, 'provocable' i.e. respond to a non-collaborative moves by defecting briefly, 'non-envious' i.e. not responding to success on the part of their counterpart with defection, and 'not too clever' i.e. easy to understand or not devious [6]. We think this approximates good clinical relational style in secure settings. In repeated game paradigms players defect near the end of a series of repeated games [1] which may explain the anecdotal relational phenomenon of 'gate fever', where patients break rules near discharge. Also it may partly explain apparent better engagement and behaviour in indeterminate detentions such as treatment sections as opposed to determinate prison sentences, or the longer detentions of secure settings as opposed to acute general wards. We hope to research factors influencing estimates and playing style e.g. personality. Comparison of personality and style decades ago were tentative though intelligent players may vary their style more [7]. We hope to model and manage factors such as communication and simplicity of plans, in naturalistic and experimental games, to inform quantitative theoretical approaches to violence reduction.

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Student nurses perceptions and actual experiences of occupational violence whilst on mental health clinical practice

Paper

Phillip Maude & Michael Olasoji (Australia)

Keywords: Violence, Occupational Health, Student Nurses, Mental Health

Abstract

This study has compared Australian undergraduate nursing students perception of occupational violence they may encounter pre and post clinical placement in mental health. A survey questionnaire was developed using existing literature and content validity developed by expert review. University ethics approval for the project was obtained. Recruitment to the study was via a link to an online survey disseminated to Australian Universities that deliver undergraduate nursing Bachelor degree programs. Telephone interviews were conducted with individual participants (n = 15) who elected to be interviewed and two focus groups were conducted with nurse educators (n = 12). Findings from this study identified strategies to better orientate student nurses prior to undertaking clinical placement in mental health settings as well as ways staff in the mental health area can better support students. Pre training in de-escalation techniques and clinical resources was required prior to placement. Myths about working in mental health caused anxiety but once students experienced the mental health setting their attitudes improved.

Educational Goals

- To better understand nursing students pre-clinical perceptions of potential violence compared with the actual experience.
- To make recommendations for the development of best practice orientation for students and pre clinical training in de-escalating violence and supportive systems.

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Physical environment: staff perceptions of safety and aggressive incidents within UK mental health services (PESSA-UK)

Paper

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Keywords: mental health staff; workplace violence and aggression; ward environment; health geography

Introduction

Safety at work is a fundamental issue for mental health staff working on inpatient units, especially in the context of high levels of violence and aggression towards nurses. It has wide ranging implications for service user care, staff wellbeing and economics. Aggression and safety are multi-faceted phenomena, resulting from complex interactions between individual characteristics and contextual features, such as the ward environment (Abderhalden *et al.*, 2008; Bowers *et al.*, 2011). An employee's sense of safety is also likely to reflect organisational factors related to safety management and climate which interacts with the overall physical environment (Christian *et al.*, 2009).

The current theoretical base regarding factors that could affect staff perceptions of safety is limited and inconclusive (Papoulias, 2014). Research in this area is often conducted opportunistically, following ward or unit refurbishment and as such numerous variables are changed simultaneously and results are confounded. Despite this, certain ward characteristics have been identified as potentially associated with staff safety; these include ward occupancy rates (Nijman & Rector, 1999), crowding (Ng *et al.*, 2001) and lighting (Curtis *et al.*, 2007).
This study attempted to establish predictors of perceived safety amongst staff working on mental health wards. Areas under investigation included the physical and relational ward environment, as well as organisational climate and recorded violence.

Method

A cross sectional design was employed across 101 forensic and non-forensic mental health wards, over seven National Health Service (NHS) trusts in England. Independent variables included:

1. *The Ward Features Checklist (WFC)* – developed by the research team in line with expert consultations and recent academic literature. The WFC captures general and physical environment characteristics. This was completed by two researchers visiting the wards included in the study using a number of tools designed to capture the ward environment.
2. *Recorded incident data* – anonymised aggregated incident data captured by each NHS trust in their electronic patient record systems was requested for each ward. This included property damage, verbal and physical aggressive incidents recorded in the six months prior to the researchers' visit.
3. *The Work Safety Scale (WSS,* Hayes *et al.*, 1998) – a valid measure of five constructs of work safety. These relate to job role, colleagues and organisational policies and procedures.
4. A modified version of the *Perceptions of Prevalence of Aggression Scale (POPAS,* Nijman *et al.*, 2005a) - capturing individual experience of violence and aggression at work. This was modified to appropriately reflect the psychiatric environment.
5. *The Perceived Violence Climate Measure (PVCM,* Spector *et al.*, 2007) - capturing organisational violence climate. Outcomes include organisational attitude, policies and procedures.

The *WSS*, modified *POPAS*, and the *PVCM* were captured in an online survey completed by staff working on the wards which were previously visited by researchers to complete the WFC.
The dependent variable, *perceived safety at work (PSW)* was measured by an individual item included in the online survey, i.e. "Please indicate how safe do you feel while at work on the ward on a scale of 1 to 10".

Analysis

Categorical principal component analysis (CATPCA) and ordinal regression analyses were undertaken.

Results

In total 191 staff from 60 wards were included in the regression analysis. This includes the staff who completed the online survey and who worked on the wards which were visited by the researchers to complete the WFC. Of these, approximately half were female, a quarter were male and a quarter did not state. The majority were either qualified nurses (45.5%) or nursing assistants (30.4%). Of the staff that provided their age, the most frequent category was 25-34 (27.2%).
Non forensic wards reported statistically significantly higher levels of physical violence in the previous six months than forensic wards. The most frequent modes of violence experienced by staff were verbal aggression and aggressive splitting behaviour. Higher proportions of forensic staff reported feeling relatively unsafe at work (26.3% forensic staff compared to 20.5% non-forensic staff) and a much higher proportion of non-forensic staff reported feeling safe at work (30.1% of non-forensic staff compared to 17.8% of forensic staff). Organisationally, respondents across both forensic and non-forensic wards generally reported positive perceptions of their services violence prevention provision.

A number of factors were found to be significant predictors of staff perceived safety. Increased perceptions of safety predictors included positive views in the WSS (*OR* = 5.28); PVCM (*OR* = 1.85) and ward brightness level with the lights on (*OR* = 1.53). Unexpectedly, staffing and space (comprised of more beds; lower staff to patient ratios; less dayroom and bedroom space; and fewer toilets per patient) (*OR* = 0.65); and views of built-up structures (compared to greenery) (*OR* = 0.33) were predictors of decreased (lower) perceptions of safety. Perceptions of safety were lower on wards with higher reported levels of verbal incidents (*OR* = 0.98) and property incidents (*OR* = 0.90).
Other ward characteristics which common sense may have been assumed to be significant predictors of perceived safety at work were not. These included staff characteristics (gender age, role), type of ward (forensic vs non-forensic), and physical ward features such as number of windows and ward colour.

Conclusions

This study adds to a limited area of research and demonstrates that certain ward characteristics and the presence of aggression on the ward can affect staff perceptions of safety. A number of findings reflected positively on organisations including an overall positively reported safety climate and staff being encouraged to report aggressive incidents.
Some findings were counter-intuitive and contradicted existing research, highlighting a need for further research in this area. Qualitative research exploring staff and service user views and perceptions could aid further understanding of the results. Findings may have clinical implications for existing training initiatives aimed at reducing coercive interventions in the management of ward violence and aggression.

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Psychological Underpinnings to the Prevalence of Aggressive and Violent Behavior Encountered by Emergency Medical Technicians

Paper

Michael Wilds (USA)

Keywords: psychological, EMT, violent, aggressive behavior, emotional trauma, assault, battery, use of force

Abstract

Emergency medical technicians (paramedics) are being assaulted at an alarming rate not only by victims of domestic violence or their perpetrators, but also by intoxicated individuals and even individuals recovering from seizures. The assaults range from threats like "I'm going to kill you" to physical battery including broken arms and black eyes. In many cases, emergency medical technicians (EMT) lack adequate training for such aggressive and violent training. They are merely to wait for police to arrive if violence erupts. Similarly, most medical emergency services (EMS) lack support services for emotional and psychological damage that may occur after an EMT encounters violent and aggressive behavior.

This presentation will address inherent risks taken by EMT, the prevalence of aggressive and violent behavior, emerging psychology behind the violence, legislative solutions, and different violence awareness training designed to deescalate potentially explosive situations. The presentation will also address what use of force, including deadly force, may be justified by EMT in response to aggressive and violent behavior encountered during a medical response call. Finally, the presentation will conclude with an analysis of emotional trauma associated with being assaulted and battered while responding to an emergency medical situation.

Educational Goals

- Participants will be able to discuss the inherent dangers of responding to an emergency medical situation.
- Participants will be able to compare and contrast differing legal responses to assault and battery of EMT personnel.
- Participants will be able to identify psychological and emotional responses to EMTs who encounter violent and aggressive behavior.

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Managers' perception of Patient and Visitor Aggression (PERoPA). First results of an international research project

Paper

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Keywords: Patient aggression, visitor aggression, nurse managers, perception, management, prevention

Abstract

Introduction

Independent of clinical area, patient and visitor aggression (PVA) is a threat to the physical and psychological health and wellbeing of healthcare professionals worldwide. Furthermore, PVA reduces patient safety and quality of care and incurs substantial financial cost. Increasing numbers of patients with secondary psychiatric diagnoses such as dementia are being treated in general hospitals. Work processes and staff are often not geared towards caring for these patients, which increases the risk of PVA. Although the link between nurse managers, workplace safety, job satisfaction and quality of care has been recognized, little is known about how nurse manager experience and manage PVA. The PERoPA project aims to close this gap by exploring (1) how nurse managers perceive PVA, (2) address PVA and (3) the barriers and opportunities associated with its prevention and management.

Methods

PERoPA is an ongoing (2015-2018) international research project with a sequential mixed methods design. It comprises two studies. (1) A qualitative interview and focus group study with Swiss general hospital nurse mangers and (2) a quantitative international online survey including German- (phase 2a) and English-speaking (phase 2b) countries (all clinical areas). Interviews and focus groups (study 1) were conducted between Oct. 2015 and Jan. 2016. Data were analyzed in a qualitative content analysis. The survey (study 2a) comprising 86 items was conducted in German-speaking countries (Austria, Germany and Switzerland) between Nov. 2016 and Feb. 2017with data currently undergoing statistical analysis. Qualitative and quantitative findings will be triangulated on completion of the quantitative data analysis.

Results

Study 1: Thirteen individual interviews and 5 focus groups were conducted. Most participants perceived PVA to be problem. Three themes emerged: (1) Background factors: 'Patient and visitor aggression is perceived through different lenses'; (2) Determinants and intention: 'Good intentions competing with harsh organizational reality'; (3) Behaviours: 'Preventing and managing aggressive behaviour, and relentlessly striving to create low-aggression work environments'. Study 2a: A total of 646 managers took part in the survey, 410 completed the entire survey. Preliminary findings point towards differences in the perception of PVA across management levels. Although organizational support and environmental safety seems to be somewhat further developed in Switzerland compared to Germany and Austria, there is a need for increased organizational support in addressing PVA in German-speaking countries.

Conclusion

Nurse managers perceive PVA to be a problem that needs addressing, however, reducing PVA at an organizational level is a challenge for nurse managers due to competition for financial resources and lack of organisational interest in PVA. The extent of organisational support differs between the three German-speaking countries with nurse managers in Switzerland perceiving organisational support and safety to be more extensive compared to Austria and Germany. Nevertheless, PVA requires increased and on-going attention healthcare organisations.

Educational Goals

Participants will be able to
1. describe the differences in the perception of patient and visitor aggression in healthcare as per management level
2. discuss the implications of the different perspectives on prevention and management of patient and visitor aggression in healthcare

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Ten year follow – up Dutch data : coercive measures while developing intensive care units

Paper

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Keywords: Coercive measures , Psychiatric intensive care units, prediction, case mix correction

Abstract

Background

For ten years the Netherlands were engaged in the reduction of coercive measures. From 2006 to 2012 nationwide funding was provided (1) leading to a clear reduction of coercive measures (2).To assess these use coercive measures the Argus coercive measures scale was developed in three community mental health Centre's over a total of above 30 locations. Following 2009, a rising number of hospitals started using the scale. After 2011, the Argus scale became obligatory to all hospitals.

Methods

To evaluate the use of coercive measures we used the Argus coercive measures scale, covering seclusion, restraint and the use of involuntary medication. The use of these measures were counters, admission data and diagnoses of all patients admitted were denominators allowing case mix correction over time. In the database used for the analysis, each admission was one record. Patients could occur more often in de database when readmitted.

In this presentation we present ten year follow up data of these three hospitals, correcting for patient compilation by means of a multi-level logistic regression on the use of coercive measures against admission time and admission duration as offset. The first developed PICU in 2008, one of the first in the Netherlands. The second built a PICU in 2015. The third hospital has currently no PICU, but is developing two PICU's.

Results

Findings show in the first hospital a clear decrease of coercive measures from 2008 until 2011, followed by a slight increase over the years 2012, 2013 and 2014. In the second hospital findings show a continuous decrease in coercive measures as a whole, at first a decrease of seclusion against a rise of involuntary medication (3), a line bent down after opening of the PICU. The third hospital showed a clear decrease between 2006 and 2012, followed by slight increase in the findings after 2012. When correcting for change in patient compilation over time we observe in the first and last hospital an increase in the severity of psychiatric disorders showing a relative increase in number of SMI admitted. Admission days per year show in these two hospitals a drop due to bed closure. In the second hospital this change in admission days was observed too, but less powerfully. In the presentation we discuss the effect of organizational and policy differences explaining the differenc es in effect.

Conclusion

Implementation of PICU is not only about providing space, but also about embedding such change in hospital policy supported both at ward as well as hospital level.

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Educational Goals

- Investigation of factors effective in reduction of seclusion use.

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Prevalence of MID/BIF and trauma in patients in Functional Assertive Community Treatment teams in the Netherlands: association to Global functioning and Mental State

Paper

J Nieuwenhuis, H Smits, CL Mulder, EO Noorthoorn, P Naarding, B Te Boekhorst, EPM Penterman, and HLI Nijman (Netherlands)

Abstract

Little is known of the prevalence of Moderate Intellectual Disability and Borderline Intellectual Functioning (MID/BIF) in the chronic and serious mentally ill (SMI) patients. A recent study on two admission wards for general psychiatry in the Netherlands results showed 43.8% of the patients to be at risk of MID/BIF (Nieuwenhuis *et al.* 2017), as assessed with the Screener for Intelligence Intelligence Learning Disabilities (SCIL, Kaal, Nijman & Moonen, 2015). From the scarce literature we know people with MID/BIF living at home have more serious psychiatric problems those without MBID (Hasiotis, *et al.* 2008, Wieland et al, 2014). Several studies also show people with MID/BIF are more at risk to traumatic life experiences. Violence, sexual and physical abuse against people with a disability is widespread, especially to people with ID (Hatton and Emmerson 2004, Focht-New et al, 2008, Vadysinge A.N. et al, 2017, Lan-Ping Lin *et al.* 2009).

In a review Mauritz *et al.* (2013) concluded the prevalence of personal trauma and trauma related disorders were significantly higher in Serious Mentally Ill (SMI) than in general population. Several studies in the SMI using the Trauma Screening Questionnaire (TSQ, Brewin *et al.* 2002) showed a prevalence of being at risk of a traumatic stress disorder of 30% (20-47%) and an experience of physical abuse in 47% (range 25-72%), and sexual trauma in 37% (range 20-49%).

In outpatient psychiatric treatment, both intellectual impairment as well as experienced trauma may restrain recovery. Recovery as assessed in routine outcome measurement by means of the Health of the Nation Outcome Scale (Honos, Wing *et al.* 1996).

The current study aims at identifying the prevalence of intellectual disability (MID/BIF) assessed by the SCIL as well as the prevalence of experienced trauma as assessed by the TSQ. Main Questions are:

1. What is the prevalence of MBID (IQ 50-85) as determined with the SCIL in serious mentally patients treated in the community in Functional Assertive Community Treatment (FACT) teams?
2. What is the prevalence of trauma as determined with the TSQ and how often the diagnosis PTSS is set in patients treated in FACT teams?
3. What kind of trauma are most frequent in MID/BIF patients?
4. Is there an association between MBID and trauma?
5. What are the general characteristics of these patients?
6. What are the associations of MID/BIF and Trauma with global functioning and mental state as determined by the HONOS?

Methods and Materials

A cross sectional study was conducted in patients of two FACT teams in the mid-east and one team in the mid- south of the Netherlands (FACT team 1 and 2 in Apeldoorn and FACT teams in OSS

and Uden). The study was carried out and reported in line with the Strobe guidelines for reporting observational studies (Von Elm et al, 2007). Medical Ethical approval for the study was provided by the ethical board of the University of Twente, Enschede, The Netherlands. As the study is currently underway we report findings of the two teams in the mid-east of the Netherlands combined with some data of the team in the mid-south..

Assessments

Three assessment instruments were used in the current study: the SCIL, the TSQ and the HONOS. These assessments were related to medical chart information and service use.

MID/BIF screening using the SCIL

The SCIL is a test consisting of 14 questions and small tasks, which aims at providing a global insight in the cognitive abilities of a patient. The SCIL was specifically developed for detection of (a suspicion of) MBID (IQ 50- 85) in people in different social services, health care settings, jails, police offices and homeless settings.

Traumatic experiences screened by the TSQ

The Trauma Screening Questionnaire (TSQ) is a screener for Post-Traumatic Stress Disorder. This questionnaire consist of a 10-item symptom screening tool derived from the 17-item PTSD Symptom Scale. The TSQ items are answered by tick in 'yes'(symptom is present two weeks) or 'no' (symptom is not present); the minimum score is zero and the maximum score is 10. The reliability of the TSQ as expressed in Cronbach's alpha was good (α= 0.85). The optimum TSQ cut-off score was found to be 6, which demonstrated a sensitivity of 78.8%, a specificity of 75.6% (De Bont *et al.*, 2015).

General and social functioning measured by the HONOS

The HoNOS (Health of the Nation Outcomes Scales) was developed during the early 90s by the Royal College of Psychiatrists as a measure of the health and social functioning of people with severe mental illness. Its key purpose was to enable recording of progress towards the targets set within the Health of the Nation, the key health strategy document of the time.

Demographic data

Basic demographic data such as age, gender, marital status, ethnic background, psychiatric diagnosis (DSM-IV-TR) as well as information on admission history, previous (involuntary) admissions and current or previous coercion were extracted from routine hospital information in digital medical charts. In addition to this, the medical charts were read by a research assistant (a psychologist) to confirm the information and to screen on IQ data (if available) and the biography for potential information on MBID such as broken school career and diplomas.

Analyses

Differences in patients with scores below and above cut-off in the SCIL, the TSQ and the HONOS were analyzed by means of chi – square statistics. The association of the SCIL and the TSQ with Health and General functioning as measured with the HONOS was analyzed by means of logistic regression using the HONOS threshold (Nugter et al, 2009) as binary outcome variable.

Results

The response on the several questionnaires was an important issue in the current study. Of the potential 382 patients in the teams in Apeldoorn meeting the inclusion criteria, 282 (73%) completed the SCIL. 237 (62%) completed the TSQ, where 223 (59%) completed both. Table 1 presents the findings of comparisons between patients with scores above and below threshold on the SCIL.
The analysis of results of the team in the mid-south are not yet completed but the pooled data of all the teams could be extracted.

Table 1 Preliminary findings on comparisons between patients with and without SCIL above threshold

	Scil > 19 No MID/BIF	Scil < 19 MID/BIF	OR	95 CI OR	Differences Significant
Findings based on Apeldoorn data (n= 223)	122 (55%)	101 (45%)			
Male gender	42%	42%	1.011	0.626 – 1.635	-
Age below 35	27%	27%	0.633	0.372 – 1.181	-
Of ethnic minority	**5%**	**26%**	**7.103**	**3.119 – 16.175**	++
Low GAF at first assessment	43%	47%	1.167	0.720 - 1.891	-
Honos above threshold	**35%**	**53%**	**2.106**	**1.298 – 3.417**	++
Diagnosis PTSD reported in chart	7%	12%	1.978	0.864 – 4.529	-
MID/ BIF reported in chart	**5%**	**27%**	**7.155**	**3.120 – 16.407**	++
Trauma (Apeldoorn sample, n=223)					
Any trauma	84%	81%	1.234	0.612 – 2.487	-
Sexual trauma	42%	38%	0.812	0.474 – 1.392	-
Physical trauma	**36%**	**52%**	**1.962**	**1.143 – 3.351**	++
Emotional trauma	55%	63%	1.374	0.801 – 2.357	-
Prolonged neglect	27%	33%	1.309	0.735 – 2.330	-
Experienced disaster	40%	49%	1.461	0.858 – 2.467	-
Re-experience against will	**48%**	**62%**	**1.774**	**1.033 – 3.047**	++
Distressed dreaming	**25%**	**39%**	**1.845**	**1.037 – 3.283**	++
Having the felling the experience occurs again	35%	39%	1.181	0.681 – 2.050	-
Feeling disturbed by re-experiencing the occurrence	**51%**	**65%**	**1.823**	**1.056 – 3.147**	++
Experiencing physical reactions related	41%	50%	1.466	0.857 – 2.507	-
Difficulties falling asleep	40%	52%	1.688	0.957 – 2.854	-
Irritated	41%	46%	1.225	0.714 – 2.099	-
Concentration problems	56%	58%	1.063	0.622 – 1.817	-
Heightened awareness of danger	45%	46%	1.026	0.601 – 1.749	-
Sudden startle	53%	54%	1.003	0.589 – 1.709	-
6 or more items in the TSQ	45%	50%	1.180	0.694 – 2.008	-
Including the mid-south Netherlands Sample (pooled data) n=434	254 (58%)	180 (42%)			
Sexual trauma			**2.131**	**1.262 – 3.610**	++
Physical trauma			**1.702**	**1.010 – 2.800**	+
6 or more items in the TSQ (Both samples, n=434)	45%	55%	**1.570**	**1.061 – 2.825**	+

This shows that (the suspicion) of MID/BIF is highly prevalent in FACT teams as well as the prevalence of (the suspicion of) PTSD. Patients suspect for MID/BIF are more prone for sexual and physical trauma, especially when we combine data from both samples. Second, we observe an association of ethnic minority and a HONOS above threshold to lower SCIL scores in the Apeldoorn sample. Next to that, cross tabulation of the above threshold scores of the TSQ with above threshold scores on the HONOS showed an increased risk (61% as opposed to 36%, OR=2.784, 95 CI=1.631 – 4.753) for higher HONOS scores in the patients with more than 6 items on the TSQ.

Table 2 presents the findings of a regression analysis on patient characteristics with the threshold of the HONOS as outcome. Bipolar disorder, a SCIL below 19 and a TSQ above threshold predicted higher HONOS scores.

Table 2 regression analysis

Outcome = HONOS above threshold		Wald statistic	OR	95% CI OR	p
Depressive disorder	1.335	3.412	3.798	0.923 – 15.632	0.064
Bipolar disorder	-1.099	4.603	0.333	0.122 – 0.909	0.032
Developmental disorder	0.510	1.771	1.666	0.786 – 3.531	0.183
SCIL < 19	0.777	6.841	2.175	1.215 – 3.894	0.009
TSQ> 6	0.808	7.155	2.242	1.241 – 4.052	0.007

These preliminary findings show some substantial differences between patients with low and high SCIL scores, implying a lower SCIL score is associated to more symptoms of PTSD. Also, MID/BIF and trauma prove to be related to a worse outcome as measured in the HONOS.

Conclusions

Both (the suspicion of) MID/BIF and trauma are highly prevalent in SMI patients treated in FACT teams in the mid-south and the mid-east in the Netherlands. This was hardly known or reported in the medical charts. As expected SMI patients with also MID/BIF are more vulnerable to develop PTSD. The HONOS above threshold of both groups – MID/BIF<19 and TSQ>6- as a measure of worse health and social functioning proved to be significant, with odds ratios above 2.

This means that more attention should be payed to the experienced trauma and PTSD as well as cognitive functioning in daily practice. PTSD in SMI patients can be treated very well, as in patients with a lower intellectual functioning. This may lead to in improved wellbeing in patients and their family.

We expect the findings to be completely analyzed at the conference, and provide more in depth findings combining data of both locations.

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A Systematic Review of the Efficacy of Harmful Behaviour Programmes for Patients in Forensic Mental Health Settings

Poster

Gerry Farrell, Ruth Ryan, Jan McCarthy & Margaret Graham (Ireland)

Keywords: Mental health, forensic, interventions, treatment, cognitive behavioural approaches.

Abstract

Introduction

This systematic review guided by Wakefield's seven step approach aims to assess the efficacy of harmful behaviour programmes for forensic mental health patients within secure environments. Forensic mental healthcare is an emerging speciality that crosses boundaries between health and judicial systems.

Objective

The rationale for this review was based on the growing concerns and needs of patients and service providers as the unique and individual challenges for patients have been unmet in the past. Therapeutic modalities based on cognitive, behaviour and social learning theories have application within this context for forensic mental health nursing. Such interventions include the Reasoning and Rehabilitation Programme R&R3 and Enhanced Thinking Skills (ETS)4 aiming to reduce the incidence of harmful behaviours.

Methodology

The data for this study was gathered through in-depth systematic searches of electronic databases, from 2005-2015, to answer the question: What is the efficacy of harmful behaviour programmes for patients in forensic mental health settings? The databases Medline, Academic Search Complete, AMED, Biomedical Reference Collection, Cinahl, PsychArticles, Social Sciences, Embase and The Cochrane Library yielded 189 articles. Limiters and examination through inclusion and exclusion, in addition to quality appraisal tool CASP identified seven studies as appropriate to meet the aim of the review.

Results

Data extraction identified seven studies which were undertaken in the United Kingdom. All studies used a quantitative approach with various sample sizes ranging from 35 to 121. Three study utilised the 'R&R'; three R&R2'MHP and another ETS. Findings provide an increasing evidence base for cognitive behavioural therapeutic approaches in reducing harmful behaviours.

Benefits of specific intervention programmes in reducing harmful behaviour within forensic settings were detailed.

Furthermore, engagement in these programmes enhances wellbeing and impacts on symptoms. In addressing the question regarding the efficacy of harmful behaviour programmes for patients in forensic mental health settings this review demonstrates the complexity of providing a nursing service within custodial and legal constraints.

Conclusion

To conclude, these specific intervention programmes contribute to reducing harmful behaviour and increase wellness for patients in forensic mental health settings.

Educational Goals

- An understanding of the cognitive approaches to addressing harmful behaviours in forensic mental health patients
- An understanding of the systematic evidence base underpinning interventions for forensic mental health patients

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Can user involvement, by allowing patients to choose their own contact person during weekends, reduce aggression and violence?

Paper

Lene Haugaard Bonnesen & Rasmus Bo Greve Pedersen (Denmark)

Keywords: Psychiatric unit, Violence, user involvement, Patients, staff, contact person.

Introduction

Having had very good results involving our patients in hiring new staff, we heard several of our patients asking for additional ways to be involved, and generally increase their influence in their daily lives as patients.
Subsequently, we therefore looked at possible opportunities to involve the users of our forensic psychiatric unit. We identified and decided to initiate a project where users could choose their personal contact person during weekends.
The concept was nested in an idea that choosing your own contact person, based on personal chemistry and interests, whom you primarily wanted to spend your weekend with, could reduce aggressive behaviour.
We introduced the idea to the patients. They responded positively but provided concrete proposals how to adjust and optimize the concept, and with them in mind it was decided to start the project from the first weekend of 2017.

Background

R6 is a Danish forensic psychiatric unit with nine patients. The average patient hospitalized in Sct. Hans Forensic Hospital is hospitalized for more than 2 years. The staff is divided into teams, so each team at R6 consisting of 5-6 personal normally has the responsibility for 3 patients.

We aim to have a member of each team on duty on every day- and evening shift, so patients experience continuity in their cooperation with staff.

Based on the concept that user involvement and being responsible for one´s own care, can reduce the use of violence and threats, a project was developed where patients in a psychiatric unit choose their own contact person during weekends. The thesis is that the patients, based on their knowledge about individual staff members, would choose a contact person who matches their desire for how they would spend their weekend/spare time. I.e., a patient with an interest in playing pool, table tennis or running would choose a staff member with similar interests and competencies, where a patient who wishes to relax, watch movies, play backgammon during weekends would chose a staff member who could facilitate such wishes.

The weekend would subsequently be partially planned and structured accordingly, which hopefully would cause fewer conflicts and thereby reduce violence and threats.
At the same time, we hoped to learn our patients to plan their weekends in advance. So when they will be discharged they already know that weekends mean time of, and time of means spending time with people you like, and hopefully that means they will seek out the company of friends, family, fitness or similar, instead of returning to old habits and ending up in the criminal environment and/or starting drug abusing again. However, we have yet to find a way to measure to what extent this trial had have any impact on our patients.

Methodology

Patients are offered the opportunity to choose their own contact person from Friday afternoon at 3 PM until Sunday evening at 11P M. Nightshifts not included
The project runs throughout 2017, beginning 1 January. The number of SOAS (staff observation aggression scale) registrations is measured during weekends. To get an overview to what extent this causes changes in the number of SOAS registrations compared to 2016, these two periods are compared at the same unit for weekends only.

Results

The results this far, from the 1 January until the 1 May 2017, show a significant development. 20 SOAS registrations in the first four months of 2016 versus 1 SOAS registration in the same period of 2017.

Conclusion

Concurrent with the implementation of the project to involve patients and offer them active participation via choosing their own contact person during weekends, a significant reduction in SOAS registrations has been recorded. A linkage between patients being involved in their own care and the reduction in the number of SOAS registrations cannot be excluded. Additionally, indications are that the project has a positive effect on the units´ general environment and results in more satisfied patients and staff.
However, it cannot be excluded as an explanation that other circumstances may have influenced the results as well,though no particular circumstances have been identified as a possible explanation thus.
A logical explanation could be a change in the patient population. However, of the 20 SOAS registrations from 2016, 11 was caused by patients still in the ward in 2017.
Similarly, absence from or changes in the drug abuse levels in the ward might have had a big influence as well identified data support such theory.

Discussion

What if all patients chose the same staff member in a shift? We have noticed that certain members of the staff were “favourites” amongst patients. No one have been chosen to support all nine patients, but we have noted shifts where 5-6 patients have chosen the same staff member. There are typical 3-4 members at work at the same shift.
After a while some of the patients adjusted their wishes, and started choosing other members of the staff. As one patient expressed. “Optimally, I would have chosen you but I am cognisant that you won’t have the time for me, if we all do”.
We have not observed any increase in SOAS registrations after the patients pragmatically began adjusting their desires.
One of the unanswered questions remains to be: “Would it make a difference if we implemented the system so patients could choose their contact person every day, all year around?

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Which patients are in highest risk of coercive measures after admission to a general psychiatric ward?

Poster

Mikkel Højlund, Lene Høgh & Anne-Mette Nørregaard (Denmark)

Keywords: coercion, reduction, mechanical restraint, substance abuse, intervention, BVC

Abstract

Background

Coercive measures, especially mechanical restraint, are more frequently applied to some patients in general psychiatry. In order to tailor an intervention to reduce mechanical restraint we sought to create an evidence base specific to our population in general psychiatry.

Aims

To identify possible predictive markers for coercion among general psychiatric inpatients.

Methods

Systematic analysis of all coercive episodes at ward P2, Department of Psychiatry Haderslev, Denmark during 2015. Data regarding admission, psychiatric diagnosis, substance abuse, type and time of coercive measures were sampled from case records.

Results

We identified 18 coercive episodes in 16 different patients (admissions) from approximately 300 admissions to ward P2 during 2015. Of these 13 episodes (72%) happened within the first 24 hours following admission. In all episodes the patients were involuntarily admitted, and in 11 episodes (61%) the patient suffered from a psychotic condition. In 9 episodes (50%) the patients were under the influence of psychoactive substances. Eight patients (44%) had not been taking psychotropic medication in prescribed or sufficient doses, and the same 8 patients had not had regular contact with psychiatric outpatient services prior to admission.

Conclusions

The majority of coercive episodes happened within the first 24 hours after admission, and in patients with concurrent psychotic disorder and substance abuse. We propose an intervention based upon these data which includes: Systematic evaluation of violence risk, individual plans for patients in increased risk of violence, systematic analysis of all episodes and near-episodes of coercion, group therapy during admission dedicated towards substance abuse, better staffing levels and continuous training of staff. This intervention is currently being tested at the Department of Psychiatry in Aabenraa, Denmark and has until now lead to a decrease in episodes with mechanical restraint from 18 in 2015 to 9 in 2016, and only 1 episode in the first half of 2017.

Educational Goals

- Presentation of real-life data on patients in risk of coercive measures.
- Example of an tailored intervention for decreasing coercion in a general psychiatric ward.

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In the heat of the moment: PAUSE - Patient Advice Used for psychiatric intensive care Safety and de-Escalation

Paper

Paul Doedens, Jentien Vermeulen, Corine Latour & Lieuwe de Haan (Netherlands)

Keywords: Nursing, violence, aggression, de-escalation, advice, qualitative study, phenomenology

Abstract

Background Prevention of coercion in mental health care is a major, international challenge for mental health professionals. The Dutch government aims to diminish seclusion of psychiatric inpatients by 2018. Since the main reason for seclusion is violent behaviour, there is a need for understanding aggressive behaviour.

Aims

We conducted a qualitative study to explore the complex phenomena of aggression in psychiatric inpatients from a multidimensional point of view. The objectives of our study were1) to explore similarities and differences in perspectives on aggressive incidents of patients and involved professionals and 2) to describe advice from all directly involved stakeholders in an incident to prevent aggression.

Methods

We used a phenomenological design with open-ended focused interview questions. Patients and staff members were invited to participate after an aggressive incident occurred on the closed admission ward of the Academic Medical Centre in Amsterdam. One of the authors, who had no treatment or working relationship with the patients and staff members, conducted all interviews. The interviews were digitally recorded, electronically transcribed and coded electronically in MAXQDA. Two researchers expressed all transcriptions independently by open coding and these concepts were transformed into categories by axial coding.

Results

We included 15 aggressive incidents and conducted 32 interviews. 15 of our interviewees were patients, 17 were nurses of the closed admission ward. The majority of the patients were diagnosed with the psychotic disorders. In 80% of the cases, the aggressive incident resulted in seclusion. We found that patients and nurses had notable agreement on the course of events during the incident. The difference in perspective was primarily on the severity of the incident and hence the appropriateness of the intervention. Most patients judge the incident to be less severe than the nurses and often rated the intervention as coercive. We found this phenomenon primarily with patients with psychotic disorders. Patients without psychotic disorders evaluated the severity of the incident similar as the nurse. Patients' advice reflected mostly on their own situation and gave highly personal advice. The advice of nurses was mostly directed to medication and ward facilities. Patients highly appreciated the evaluation of the incident with an independent staff member.

Conclusion

We found two different types of incidents, the first had differences in perspective between the patient and nurse on the severity of the incident, the second had similar perspectives of the patient and nurse. Evaluation of aggressive incidents should explore the perspective of both parties and use this as input for restoring the therapeutic partnership.

Educational Goals

- The participant understands the importance of evaluation after aggressive and violent incidents on psychiatric wards (cognitive)
- The participants understands the role of patient-staff alliance to prevent aggression on psychiatric wards (affective)

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Violence and threats of violence in Swedish inpatient care: A Critical Incidence Technique analysis

Paper

Lars Kjellin, Lars-Erik Warg & Veikko Pelto-Piri (Sweden)

Keywords: Violence, Psychiatry, Inpatient care, staff, Critical Incidence Technique

Abstract

Background

Workplace violence (WPV) against healthcare workers employed in psychiatric inpatient wards is rightly considered to be a serious occupational issue involving both staff and patients. The consequences can include increased service costs and impaired or lower standards of care as well as a bad psychosocial work climate for the staff. The working definition of WPV used in this study is "….. any incident in which a person is abused, threatened or assaulted in circumstances relating to their work".

Aim

The aim of this study was to ascertain how staff in psychiatric inpatient care perceive and describe their workplace pertaining to 1) situations that led to threats and/or violence, 2) the type of threats and violence they were subjected to, and 3) the kind of events, thoughts or actions that followed these incidents.

Methods

A questionnaire required each member of staff in 10 inpatient psychiatric wards, located in four different counties in central Sweden, to describe two incidents they perceived as most threatening or violent during the last two years. All the staff were working either in general psychiatric wards, forensic psychiatric inpatient units or in one psychiatric addiction centre. In total, 319 reported incidents were analysed according to a critical incident technique by classifying the descriptions as subcategories, then categories, and finally main areas.

Preliminary results

For each of the three foci, two main areas emerged: 1) before the incident: patient and situation, 2) during the incident: aggression and response, and 3) after the incident: thoughts and measures. Pre-incident factors were related to diagnosis, drug abuse and/or patients being denied something. The incidents themselves circulated around aggression and threats in a variety of situations, some of them tied to staff responses. The aftermath of the incidents involved staff debriefings, individual thoughts, the healing of injuries and also preventive measures being taken on an organizational level.

Conclusions

This study gives insight into what precedes threats and violence within psychiatric inpatient care. This is important since it gives some clues about what possible preventive measures could be taken. Moreover, the study provides information about the impact these types of incidents can have on individuals, as well as the units themselves. Finally, as the critical incident technique was conducted in this study, it

will be possible to pinpoint on a case level, what factors tend to lead to what type of violence and how these incidents are dealt with afterwards.

Educational Goals

Readers of the poster will be able to

- account for how violent incidents may be described by psychiatric inpatient care staff with regard to what happened before, during and after the incident
- reflect upon possible associations between situations leading to violence, type of violence, and thoughts or actions that followed.

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Early Monitoring of Aggression early warning signs in a Portuguese Forensic Psychiatry Unit

Poster

Sara Ribeiro, Maria Marques & Amorim Rosa (Portugal)

Keywords: Aggression, early warning signs, FESAI, Psychiatry, Forensic Psychiatry.

Abstract

Introduction

In the psychiatric context, the resolution of the problem of aggressive behaviors implies the use of different prevention and control responses (Irwin, 2006). Usually, in the control of patient-related factors, therapeutic responses of a biological and psychosocial nature are offered. The adequacy of therapeutic responses depends on a correct evaluation. In forensic psychiatry, among the various clinical assessment tools in this field, the Forensic Early Signs of Aggression Inventory (FESAI) (Frans *et al.*, 2011) seems to be an instrument that favors the understanding of the dynamics of aggression alert signs and provides early involvement of the patient in their monitoring and recovery. In this sense, and in order to effectively use this inventory in Portugal, it was considered useful to conduct a quantitative, exploratory and correlational study, with the following objectives: To analyze / monitor the prevalence of early warning signs of aggression and to assess the influence of Clinical diagnosis.

Method

Aquantitative, exploratory and correlational study, which was carried out in a Forensic Psychiatry Unit of the Center area and involved 45 hospitalized patients, who presented with the medical diagnosis schizophrenia (n = 46.7%). The Forensic Early Signs of Aggression Inventory (FESAI) was used and the different procedures of an ethical-formal nature were fulfilled.

Results

Overall mean values of 6.75 episodes of aggression were observed, ranging from zero to a maximum of twenty-two aggression alert signs per patient; (1.56) and 'social isolation, diminished social contact' (1,31). Patients with a main diagnosis of schizophrenia are those with the lowest mean scores on the scale and most of their dimensions (except for 'social isolation, decreased social contact' and 'extreme sexual fantasies, needs, behaviors'), on the other (Eg, delusional disturbance, personality disorder, alcoholism, and epilepsy) present higher mean orderings in most dimensions, with differences between these groups being statistically significant ($p < 0.05$), The dimensions 'physical changes' and 'discouragement and anxiety', lead us to affirm that the diagnosis only has explanatory power on early warning signs of aggression in these two dimensions.

Conclusion

In terms of conclusion, we can say that the FESAI enables the identification and detection of individual aggression alert signals through a broad view of patients' behaviors and perceptions. It is a valuable aid to nurses to assist in the management of disruptive behavior, regardless of the clinical diagnosis of the patient.

Educational Goals

- Identify some signs of early warning signs of aggression evaluated in a Portuguese forensic psychiatric service using the FESAI.
- Recognize the importance of monitoring the early warning signs of aggression in the management of disturbing behaviours in the context of forensic psychiatry.

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The Diet and Aggression study: reducing aggression among chronic psychiatric inpatients through nutritional supplementation

Poster

Nienke de Bles, Nathaly Rius-Ottenheim, Bert van Hemert & Erik Giltay (Netherlands)

Keywords: aggression, nutritional supplements, long-stay psychiatric inpatients

Abstract

Background

Aggressive incidents are highly prevalent among chronic psychiatric inpatients. Previous studies have already demonstrated the potential of multivitamin-, mineral-, and n-3 fatty acids (n-3FA) supplementation to reduce aggression in maladjusted children and forensic populations.

Aims

The aim of the current study is to test the hypothesis that multivitamin-, mineral-, and n-3FA supplementation reduces the incidence and severity of aggressive incidents, while simultaneously increasing quality of life among chronic psychiatric inpatients.

Methods

The Diet and Aggression study is a pragmatic, multicenter, randomized, double-blind, placebo controlled, intervention trial with an intervention period of 6 months. As the wash-out period of nutritional supplements is in some cases unknown, a parallel design was chosen. Eligible for the study are psychiatric inpatients aged 18 years or older, who are residing in open and closed long-stay psychiatric wards. During 6 months one group receives 3 supplements daily: 2 Orthica Multi Energie (containing vitamins and minerals) and 1 Orthica Fish EPA Mini (containing n-3FA: eicosapentaenic acid and docosahexaenic acid). The control group receives 3 placebo capsules.

Outcome parameters

The main parameter is the number of aggressive incidents as registered with the Staff Observation Aggression Scale-revised (SOAS-R). At three points during follow-up questionnaires will be administered: the Aangepaste Versie van de Agressievragenlijst (AVL-AV), a 12 item self-report questionnaire about feelings of aggression; the World Health Organization Quality of Life Questionnaire (WHOQOL-BREF), a 26-item observer rated quality of life instrument; and a 25-item observer rated instrument that includes the Montgomery Asberg Depression Rating Scale (MADRS). Also, at the start and the end of the intervention, blood samples will be taken to determine nutritional status. Lastly, at four time points, nursing staff will complete the Social Dysfunction Aggression Scale (SDAS), measuring observed levels of aggression and social dysfunction.

Educational Goals

A poor dietary intake of vitamins, minerals, and n-3 polyunsaturated fatty acids (from fatty fish) has been associated with more aggression, irritability, and anger.
Dietary supplements may reduce aggressive incidents and can be implemented easily and at low-cost.

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Chapter 3 – Epidemiology and nature of violence against patients / patients as victims

Victimisation in a sample of severely disabled psychiatric out-patients in psychiatric institutions and in the community

Paper

Tilman Steinert & Verena Rossa-Roccor (Germany)

Keywords: Victimization, mental illness

Background

Representative studies from the US, UK and Australia showed that mentally ill people are victimized by physical violence, sexual violence, and offences against property more frequently than the general population (Frueh *et al.* 2005, Khalifeh *et al.* 2015, Morgan *et al.* 2016). This refers to both violence by strangers and domestic violence. Even after adjustment for characteristics of the social environment there remains a considerably increased rate of victimization, particularly for women. The risk of being victimized by any kind of violence was increased more than six-fold among mentally ill women in comparison to the general population after adjustment for age, civil status, ethnicity, work status, living environment, and substance abuse. The risk for men was also increased, but to a smaller extent (Khalifeh *et al.* 2015). Risk factors for victimization of people with severe mental illness in Australia were female gender, younger age, substance abuse, homelessness, disadvantaged living environment, childhood sexual abuse, conviction by police within the last year, and self-harm, but not cognitive functioning and psychopathological symptoms (Morgan *et al.* 2016). People who have been victimized outside psychiatric hospitals have an increased liability to be re-victimized by coercive measures in psychiatric hospitals (Steinert *et al.* 2006, Steinert *et al.* 2007). The aim of the present study was to survey a sample of patients with severe mental illness who receive support in terms of social psychiatric services on their victimization rates and emotional distress resulting from victimizing events.

Methods

We developed an extensive questionnaire (Weissenau Victimization of People with Mental Illness Questionnaire (W-VIPMIQ)on adverse experiences in psychiatric institutions as well as in the community and for the assessment of the subjective emotional distress of these experiences. We recruited participants with severe mental illness through out-patient institutions in a defined region in two administrative departments (Landkreise) in a rural region in Southern Germany..The inclusion criterion was that participants should receive state-funded disability support such as nursing homes, assisted living, sheltered workshops, or regular contacts by social psychiatric services. Participants were contacted via the respective institutions and received the W-VIPMIQ which they were asked to answer anonymously.

Results

We received responses from 170 individuals with a mean of 11.2 previous psychiatric admissions. Rates of reported victimization were high for each kind of adverse event, both in the community and in psychiatric institutions. A significant minority of female respondents reported sexual molestation by staff, which caused a maximum of helplessness, fear, and distressful memory. Results will be published in detail in a journal article.

Conclusions

The prevalence of victimization among people with mental illness is frequently underestimated. With the W-VIPMIQ, there is now , a comprehensive instrument for the assessment of victimization in mentally ill people available.

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Trait anger and anger attacks in depressive and anxiety disorders

Poster

Nienke de Bles, Laura Pütz, Nathaly Rius-Ottenheim, Bert van Hemert, Willem van der Does, Brenda Penninx & Erik Giltay (Netherlands)

Keywords: trait anger, anger attacks, psychiatric disorders

Abstract

Introduction

Trait anger and anger attacks are common in psychiatric patients. However, there is a lack of research investigating the relationship between anger and types of psychiatric disorders.

Aims

The aim is to explore the prevalence of anger and its correlates in order to better understand how anger should be viewed in a clinical context.

Methods

In a cross-sectional analysis of the NESDA (Netherlands Study of Anxiety and Depression) cohort study, 2,291 participants (aged 18-65 years) were categorized into controls, patients with remitted anxiety and /or depressive disorder and patients with a current depressive, anxiety or comorbid disorder. They completed the Fava's Anger Attack Questionnaire, the Spielberger's Trait Anger Scale, the Beck Anxiety Inventory (BAI), and the Inventory of Depressive Symptomatology (IDS).

Results

High trait anger and anger attacks were present in respectively 28.4% and 42.6% of patients with a co-morbid disorder compared to 2.6% and 5.1% of controls.

Conclusion

Anger is a prevalent emotional state and trait in patients suffering from psychiatric disorders. Anger is most prevalent in male patients suffering from co-morbid disorders and is strongly associated with depression severity.

Educational Goals

- Anger attacks frequently occur in young male depressed patients, and especially those with high trait anger.
- A history of depression or anxiety may permanently increase anger traits and the risk of anger attacks, after remission from depressive or anxiety disorders (i.e. scaring effect).

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Chapter 4 – PTSD & Violence prevention and treatment

Treating anger and aggression in U.S. combat veterans with Posttraumatic Stress Disorder

Paper

Elizabeth Van Voorhees, Paul Dennis, Lydia Neal, Patrick Calhoun, Eric Elbogen, Kelly Caron & Jean Beckham (USA)

Keywords: combat veterans, posttraumatic stress disorder, anger, aggression, cognitive behavioral therapy, allostatic overload

Abstract

Managing anger and aggressive urges are among the top priorities of U.S. veterans of the wars in Iraq and Afghanistan seeking treatment in the Department of Veterans Affairs (VA) (Crawford *et al.*, 2015). This is particularly the case for veterans with Posttraumatic Stress Disorder (PTSD) (Olatunji *et al.*, 2010). Treatment options for anger and aggression in the VA are largely limited to isolated referrals to group cognitive behavioral therapy (CBT), with little consideration of how group CBT might fit into a larger plan of recovery. Yet there is limited empirical evidence supporting the long-term effectiveness of group CBT for reducing aggression or other anger-related functional impairment in this population (Shea *et al.*, 2013).

There are likely several reasons for this. First, research has documented that PTSD has a far-reaching and profound impact on emotional and interpersonal functioning (Pietrzak *et al.*, 2010); and U.S. veterans commonly present with complex trauma histories that began in early childhood and span across several phases of development (Van Voorhees *et al.*, 2012). Given the longevity and depth of trauma-related disturbance with which many veterans struggle, it may be dubious to expect that even the most powerful treatment will afford broad and lasting effects if administered in a vacuum.

Second, the exposure to uncontrollable stress that leads to the behavioral symptoms of PTSD manifests on a physiological level as "allostatic overload", or disruption of the body's capacity to effectively self-regulate upon exposure to subsequent stressors (McEwen, 2004). Chronic stress-related hyperarousal is one of the hallmarks of PTSD on both emotional and physiological levels (Dennis *et al.*, 2016), and PTSD hyperarousal cluster symptoms in particular have been linked to problems with aggression (Kachadourian *et al.*, 2013). Yet most CBT approaches to anger management emphasize cognitively-mediated strategies: Physiological self-regu lation strategies, if mentioned at all, are given only perfunctory attention.

Finally, female veterans have rarely been included in research on therapy on anger or aggression in U.S. veterans, and group CBT within the VA is almost exclusively implemented in mixed-gender groups. Preliminary findings from our own research suggest that female veterans differ from their male counterparts in the experiences they see as contributing to their anger and anger-related problems, as well as in the therapeutic approaches they find most helpful in supporting their recovery. Therefore, a

"one-size-fits-all" approach to group interventions runs the risk of neglecting the needs of an increasing number veterans with PTSD, leaving them vulnerable to a sense that they have "failed" at treatment and encouraging their further retreat into isolation and despair. Here we will review the current research on cognitive behavioral therapies for anger and aggression in combat veterans, including the results of our pilot randomized clinical trial comparing group CBT to an active control condition. We will discuss future directions for understanding and treating PTSD-related anger and aggression in combat veterans.

Educational Goals

- Describe current frontline approaches to treating anger and aggression in combat veterans with posttraumatic stress disorder, and discuss potential reasons for the relatively disappointing findings thus far regarding their long-term effectiveness.
- Discuss factors that need to be considered to develop more effective approaches to treating anger and aggression in combat veterans with PTSD.

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Post-traumatic stress disorder and resilience in substance-related disorder patients in the south Thailand insurgency

Poster

Chonnakarn Jatchavala, Arnout Vittayanont & Adisak Ngamkajornviwat (Thailand)

Keywords: Post-traumatic stress disorder, resilience, Substance, Southern Thailand, insurgency

Abstract

Background

Since 2004, the south Thailand insurgency has continuingly deteriorated, generating violence in the 3 most southern provinces of Thailand: Patani, Yala and Narathiwat. Local civilians, who live in these restive areas, have undergone psychological distress (e.g. PTSD), and the increasing prevalence of substance abuse in these areas has been the highest Thailand has seen. However, some studies have revealed that the resilience of adolescents and widows in these areas is still high compared with other Thai populations from different areas.

Aims

1. To study the clinical representation of PTSD symptoms and resilience quotient. 2. To examine the association between PTSD disorder symptoms and resilience among patients with substance-related disorders living within the areas affected by the Southern Thailand insurgency

Methods

This study is a descriptive cross-sectional survey. The single assessment was obtained by self-administered questionnaires conducted by psychiatric nurses. The questions relate to: Personal information, Thai version of PTSD check-list (Thai PCL), and Thai resilience questionnaires (Thai-RQ). The subject group was patients with substance-related disorders at Thanyarak Pattani Hospital: the only center of excellence for addiction located in the restive area of Southern Thailand. Data This was gathered from the 1st of April to 30th of June, 2016. R software package was used to perform descriptive statistics and Pearson's correlation.

Results

Of the 92 male patients, aged between 18 to 54 years old, most were single, Muslim and used methamphetamines and opioids heavily. It was reported that the most serious PTSD symptoms among all patients was avoidant and numbing symptoms, the same as in the positive PTSD screened group (4.3%). The patients were mostly within the normal range of resilience quotient (59.0%). The overall highest mean score was at the part of emotional stability (28.42+ 4.65) and the lowest one was coping strategy (14.45 + 2.86). However, the group with positive PTSD symptoms had more coping strategies (14.75) than the negative group (14.44). The symptoms of PTSD and resilience among patients with substance-related disorders in the areas of the south Thailand insurgency were not statistically significant.

Conclusion

In the restive area of the south Thailand insurgency, the most common symptoms of PTSD found among patients with substance-related disorders were avoidant and numbing symptoms, while the highest resilience quotient was found on the part of emotional stability. However, PTSD symptoms and resilience were not significantly correlated by statistical analysis.

Educational Goals

- Cognitive and affective domains of learning (on subject of positive psychiatry)

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How 'the urge to kill' feels: Articulations of emic 'appetitive aggression' experiences and its individual and social implications among former forcibly recruited children and youth in post-war northern Uganda

Paper

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Keywords: 'Appetitive Aggression'; war; `cen´; resilience; killing, children associated with armed forces.

Abstract

Based on ten months of ethnographic fieldwork in northern Uganda among Acholi who were forcibly recruited into the Lord's Resistance Army (LRA), this article provides emic, qualitative details from research on 'appetitive aggression.' Through two case-stories the article unfolds first person articulations of how 'appetitive aggression' is experienced as 'the urge to kill' and how it relates to the emic Acholi spiritual concept of 'cen.' The analysis illuminates what the individual and social implications of 'the urge to kill' and 'cen' entail for two Acholi men in first a militant and then a civil post-war context. While the analysis supports the findings in 'appetitive aggression' studies whereby appetitive aggression serves as a protective factor against developing PTSD, this study documents that once the former mobilized return to civilian life, 'appetitive aggression' and 'the urge to kill' precipitate individual and at times lethal social and moral complications in a fragile post-war community. Thus, the article argues that appetitive aggression and the emic perceptions related to it among the local population are essential to take into account in studies, processes and programs targeting demobilization, rehabilitation, reconciliation and re-integration.

"Death is their trade at all hours, death is a habit because, precisely, 'one either goes mad on the first day or becomes accustomed to it.'"

Primo Levi 1986: The Drowned and the Saved p. 12

Introduction

So far, appetitive aggression research comprises quantitative research on the prevalence and distinction of appetitive aggression (Hecker et al, 2013; Köback *et al.* 2015a; Nandi *et al.* 2015). This paper contributes with qualitative research about how appetitive aggression is experienced as "an urge to kill", and how this urge in the local post-war Acholi cosmology is understood as a possession by evil spirits called `cen´. The paper shows how appetitive aggression has individual, social and societal consequences overlooked in rehabilitation, and peacebuilding activities in conflict and post-conflict settings – and based on interdisciplinary analysis, I argue, the findings I am about to present also has implications for how we receive and interact with soldiers who return from deployment to societies in Europe, and in the US.

The study

The data comprise life-story interviews, follow up interviews, the results from the AAS scale and combatant questionnaire (Weierstall and Elbert 2011) and participant observation among 36 former forcibly recruited children, youth and adults from the rebel movement, the Lord's Resistance Army (LRA) in northern Uganda. This paper analyses the data from conversations with Martin and Genesis, two former forcibly recruited men, I followed over a four-year period. When I first met Martin and Genesis in northern Uganda in 2013, it had been 17 years since Martin came home from the LRA, and around 10 years since Genesis came back. Martin was 24 when he was abducted by the LRA during night-time and Genesis was 7 years old, when he was abducted by his uncle into the ranks of the LRA.

Appetitive aggression research (SLIDE)

Based on experimental and interview research among soldier and veteran-populations from state- and non-state armies, Weierstall, Elbert and Schauer and their neuro-traumatology colleagues at Konstanz University arrived at the hypothesis that a distinct type of aggression existed, which needed to be researched further. In their article from 2010 they coined the term 'appetitive aggression' and formulated the theory behind it (Elbert, Weierstall and Schauer, 2010). Appetitive aggression is defined as: "The perpetration of violence or the infliction of harm on a victim, with the aim of experiencing violence-related enjoyment through an exposure to violent cues, such as the struggling of the victim" (Hecker, *et al.*, 2015, p. 2-3). This definition resembles accounts of how numerous soldiers in WWI and WWII as well as veterans from the Vietnam War experienced "combat high" (Hecker, *et al.*, 2015; Weierstall *et al.* 2013), "the unspeakable joy-full slaughter" (Bourke, 1999), and "joy-full killing" (de Man 1919). The main point in the theory behind appetitive aggression research, which aligns with studies and theories of psycho-traumatology (Schaal *et al.*, 2014, Duntley *et al.*, 2005), is that relating violent events to the hunter network, as opposed to the fear network, is a *resilient* response, which serves as a protective factor against developing trauma related disorders, including PTSD (Elbert, Weierstall and Schauer 2010; Köback *et al.* 2015a, b; Nandi *et al.* 2015; Weierstall, *et al.*, 2013, 2012, 2011; Moran *et al.*, 2014). Empirically, this hypothesis has been confirmed: Appetitive aggression correlates negatively with PTSD (Weierstall *et al.* 2012; Köbach 2015a). Appetitive aggression in the majority of the articles on the topic, is not viewed as "pathological *per se* but as an adaptation in a very bloody, cruel, and violent environment" (Hecker, *et al.*, 2013, p. 2). Thus, appetitive aggression and its connection to the hunter network is categorized as a common "approach behaviour, whereas fearful responses associated with the fear network can be seen as avoidance behaviour" (Ibid).

Findings

The theme of killing (either perpetrating or witnessing) stood out as a general theme raised by 35 out of the 36 former forcibly recruited children, youth and adults who participated in the study. 'The urge to kill' was raised as a theme by Martin and Genesis in our very first conversation: Martin expressed concern about not being able to control his urge to kill and both men felt unable to manage intrusive memories from "the bush." The data consolidate the under-researched, and crucial finding that: a) appetitive aggression can continue after leaving the violent environment, b) the continuation of appetitive aggression in the civil context produces alienation, stigmatization and thus an embroilment of social relations and processes of re-integration and rehabilitation. These circumstances pose an emotionally taxing threat to security and reconciliation in war and post-war contexts.

Experiences with "the urge to kill" across cultural contexts and time

De Man's words about the "supreme joy of killing" (1919) and testimonies in Joanna Bourke's book (1999) by veterans from WW1 and 2 and the Vietnam war, are enthrallingly similar to how Martin describes his experiences with "the urge to kill". Martin for instance shared in conversations that what

he misses the most about being with the LRA "is killing" and elaborated without encouragement during the AAS assessment about his reactions to seeing the blood of the enemy:

(SLIDE) Martin: "Yes! It is very good, it is very interesting when you see their blood. That one… if we have got them it is not only their blood that we like seeing… if we have won them then we have to "ululululululate" (make a war cry) and our moral goes up and we continue fighting and win them the more and if possible we kill many of them." (Martin, April 22nd, 2013)

Bodily experiences of "the urge to kill" during and after war.

In additional accounts Genesis and Martin describe the "urge to kill" as a vivid, intense bodily sensation. According to both, the urge comes suddenly, and it "leaves you" suddenly. While in the LRA, both Martin and Genesis describe how they would feel contemplated, happy and completely at ease in the body during the act of killing. The restlessness related to the urge to kill would, when the urge had been satisfied, be rewarded with a blissful calm. After the war, for some not until several years after coming home from the LRA, `cen´ starts visiting, and is experienced as "a coldness covering the body", "inability to move arms and legs", and "if you do not win over the spirits, you will die" (Conversation with Martin 2015).

The urge to kill is not welcomed home

In Acholi tradition 'cen' is defined as "the vengeful spirit of a dead person". Such spirits are capable of possessing places where killings have been carried out and anyone involved with the killing, including family members to the one who has killed and the one who killed (Harlacher, *et al.*, 2006, p. 59), and can lead to "madness" *(apoya or bal pa wic)* (p. 63). Notably, 'cen' is considered contagious (Meinert and Whyte 2017, 2016) - a characteristic which makes 'cen' something to fear and respect among the Acholi as well as it makes `cen´ a topic of stigmatization for "those rebels who came back from the bush" (notes from fieldwork conversations). In other words, `cen´ heavily influences interpersonal relations and everyday life in the post-war Acholi region today.

In the LRA during the war 'the urge to kill' was perceived in the LRA environment as socially desirable, and as "skills" and "strengths" of soldiers and heroes. Now, however, the civil home community refers to 'the urge to kill' and `cen´ as something which is "in the hearts of 'the rebels' who returned from the bush", as life threatening - and as a chilling reminder that the past atrocities of war do not feel at a safe distance. Thus, sticking to the aggressive strategy that worked in the soldier-environment to men like Martin and Genesis now is associated with undesirable behaviour (Wessells 2006) and means social death (Card, 2003; Vigh, 2006) in civil post-war life, and ultimately, in some communities in the Acholi region, physical death too: During fieldwork, Martin under great unease told about incidents in neighbouring villages where the civil community had engaged in "mob-justice" and lethal violence against men like Martin and Genesis who had returned home from the LRA. In addition, he shared the following account where fierce stigmatization had led Martin to experience urges to kill and `cen´:

(SLIDE) Martin: That thing comes and covers you like something has just fallen on you... so sometimes it happens, but when it is not your own will it happens, but you just find yourself doing that…… Afterwards you begin to worry now about all the things you have done."

(SLIDE) Appetitive aggression and the DSM V

There are several similarities between 'PTSD' in veteran populations and 'cen' in the Acholi ex-combatant population (Bayer *et al.*, 2007; Bhetancourt, *et al.*, 2009; Neuner, *et al.*, 2012; Pham, Vinck and Stover, 2009; Okello, Onen and Musisi, 2007). Furthermore, in a western psychiatric approach and vocabulary, Martin's appetitive aggression experiences resemble a dissociative state

(Neuner et al, 2012) where Martin is not aware of what he is doing while the spirit "comes and takes his heart completely," as he says.

Martin speaks as if outside of himself: "You just find yourself doing that" and as if something is taking control of him and he ends his narration of the incident with "I was a normal person once again." In Martin's account, he does not become "a normal person" until that which is controlling him has left him.

(SLIDE)

Helle: But what about… you say you still have that urge to kill today… in what… in what situations does that happen?
Martin: Because it removes the fear that you have in you… that when you go there you kill the people, so that they do not kill you…

Here we see a very specific empirical expression of the 'hunter vs. the fear' network theory behind appetitive aggression; when facing threats, one can respond either with the fear-related response network to threat – or the hunter-network, i.e. an aggressive response to threat. Martin experiences that choosing the aggressive, violent and proactive response removes the fear of death.
Despite difficulties in the bush, Martin and Genesis and many other like them, miss being soldiers. Martin misses killing the enemy soldiers, and several other things about being with the LRA: Coming home is difficult for many reasons.

Discussion

Despite the similarities in the experiences the two men have narrated about the urge to kill, one crucial difference needs to be underlined: Martin was twenty-four when he was forced to carry out his first killing. Genesis was seven years old. After his first killing Genesis became an active child soldier after only six months with the LRA and was a captain in the LRA by the age of 8 with the responsibility of leading a group of 12 soldiers.

Punamäki in her studies of children and youth who grow up in war-affected contexts describes social adaptation processes where aggressive behaviour is promoted, while other emotions and behaviours are numbed, or avoided. Several scholars (Polman *et al.*, 2007; Wainryb 2011) align with Punamäki, when she goes on to describe with what costs these social adaptation processes are learned, and a rather bleak looking prognosis for traumatized adults and children "who numb their feelings often exhibit uncontrollable and impulsive behaviour" (Punamäki, 2009, p. 67).

Inspired by Bordonaro and Payne's question 'what agency is good agency?" (2012) I wish to draw attention to how research and interventions addressing children and youth who grew up in adverse, violent contexts across disciplines perceive anger/aggression as something which needs to be "replaced" (Amendola *et al.*, 2013), "managed" (Turcotte-Seabury, 2010), and associated with delinquency (Sigfusdottir, *et al.*, 2008, Schultz *et al.*, 2004). Such approaches fail to explore and acknowledge the resilient protection, agency and survival skills, which *also* are inherent in aggression (Draijer and van Zon, 2013, Wessells 2016, 2006).

Summary of findings

1. The first important finding is that, as the theory of appetitive aggression suggests, the fascination of and the appetite for violence was not there from the beginning of entering the extremely violent environment of the LRA. The fascination emerged *gradually*.
2. Appetitive aggression, aggressive behaviour in general, and violent perpetrations against enemies are considered pro-social behaviour within the group while at war – but upon homecoming the

aggressive behaviour is considered dangerous, antisocial and morally unacceptable. This leads to alienation, and stigmatization. As my analysis showed, similar challenges are seen among soldiers from the US and Europe coming home from wars.

3. The clear theoretical, and empirical distinction in appetitive aggression theory between reactive and instrumental (appetitive) aggression is blurry in this empirical study. Experiences of appetitive aggression can start as both reactive and appetitive impulses – the findings in this study thus promote the most recent tendency to acknowledge this co-existence in appetitive aggression studies.
4. According to studies of children and youth who grow up in violent environments, one of the most detrimental effects is dysfunction in emotion regulation, which can lead to aggressive behaviour (Colasante, *et al.*, 2015; Punamäki in Barber, 2009; Kempes *et al.*, 2005). In the LRA however, children and youth very effectively regulated their emotions: In the LRA the enforced emotion regulation leads children and youth, as well as Martin who entered the LRA as an adult, to suppress sorrow, fear/anxiety, and any other emotion related to vulnerability – whilst promoting aggressive behaviour. This points to a potential dilemma in the theory and studies of appetitive aggression: In some accounts researchers explain appetitive aggression through a deficit model arguing that appetitive aggression occurs when frontal centres in the brain that control emotion regulation are blocked. In other accounts the researchers perceive 'appetitive aggression' as a hedonic, natural instinct – resembling the references in my analysis to De Man (1919) and his "slumbering instinct" and Zimbardo's perception that inflicting harm and enjoying it are dispositional traits, which can be evoked in certain situations (2007). At the same time, the deficit explanatory model in appetitive aggression research is perceived as a protective factor against traumatization and mental health pathologies, and thus a resilient response to potentially traumatizing events. My analysis suggests, with caution, that appetitive aggression might not emerge due to *deficits in functioning* of emotion regulation, but due to *well-functioning* adaptation skills and emotion regulation that ensures survival and improves safety and social recognition in extremely violent, threatening and coercive contexts. The present study is qualitative and unable to test this empirically generated hypothesis via experimental studies, but we encourage further research that can explore this hypothesis.

Recommendations

Based on the findings I end with the following recommendations:

1. The fact that appetitive aggression studies document the prevalence of an appetite for violence in both child soldier, ex-combatant, soldier and veteran populations points to the fact that issues of appetitive aggression are absolutely essential to address in interventions targeting rehabilitation from war-related trauma and re-integration and reconciliation processes of former child soldiers, ex-combatants and veterans into their home communities.
2. The individual, social, and moral implications of appetitive aggression illuminated in this article call for a careful approach to communicating with former child soldiers, ex-combatants, and veterans - and their families and surrounding communities. Clearly, not only former ex-combatants from a war in Acholiland struggle with reintegrating back into civil society; so do soldiers in state armies in Europe and the US (Howell, 2012; Litz, *et al.*, 2009). We need to develop comprehensive ways of dealing with the taboos related to war, aggression and to the "unspeakable joyful-slaughter" (Bourke, 1999). Loved ones and home-communities are unlikely to accept that violent activities, including killing, and war-experiences can entail positive emotions and even create a longing in the demobilized/veteran population. If addressed, this should be done with empathic caution and ideally drawing on research that illuminate how such joyful emotions seem to be a common, adaptive response to violent conditions.
3. DDR programs must take emic, spiritual and bodily notions into account when interacting with participants in addressing issues of aggression and violence in order to optimize the effects of their interventions.

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Examine the possible correlation between violence and compassion satisfaction and fatigue and experience with traumatic life events among mental health professionals working in a forensic department

Paper

Jacob Hvidhjelm, Jesper Bak & Christian Delcomyn (Denmark)

Keywords: Violence, threats, aggression, Trauma, Compassion Satisfaction, Compassion Fatigue, Burnout

Abstract

Background

Violence and threats of violence are a widely recognized problem, particularly in Mental Health services. No research is available investigating the possible relationship between compassion satisfaction, compassion fatigue and experience with traumatic life events with experienced violence and threats of violence. A better understanding of these complex relationships may offer insight into a way to reduce violence and threats of violence on forensic psychiatric wards.

Aim

This study aimed to assess the possible correlation between violence and compassion satisfaction and fatigue and experience with traumatic events in life.

Methods

A Cross-sectional design was used to survey health professionals at a mental health center in Denmark. The survey included questions regarding exposure to violence and threats, demographic questions, the Professional Quality of Life: Compassion Satisfaction and Fatigue v. 5 tool (Stamm, 2010) measured compassion satisfaction, and compassion fatigue (secondary traumatic stress and burnout) and Brief Trauma Questionnaire (BTQ) (National Center for PTSD, 1999).

Results

Two hundred and seventeen mental health professionals (nurses, nurses-aid, psychiatrist, psychologist, social works, physiotherapist and occupational therapist) returned their questionnaires giving rise to a response rate of 74.8%. Sixty-seven percent of the respondents were females and 25.8% reported to have been exposed to violence during the last 12 months and 71% have been exposed to threats of violence. Descriptive statistics demonstrate that 33.2% of the staff showed low Compassion satisfaction, 30.4% high Burnout, and 28.1% high Secondary traumatic stress.

There were no significant differences between sex and age in exposure to violence and threats of violence. Compassion satisfaction were significantly lower among nurses (p=.036) and nurses-aids (p=.034) compared to other groups (psychiatrists, psychologists, social workers, physiotherapists and

occupational therapists), there were no significant differences on Burn-out and Secondary traumatic stress. There were no significant differences in sex and age.

There were no significant relationships between sex, age, and education and experiences with trauma earlier in life, but we found a significant relationship between violence and trauma (p=.011), and threats of violence.

Conclusion

Mental health professionals working in a forensic settings experience a considerable amount of stress suggesting psychological risk to the staff's wellbeing and possible impairments to patients´care. Our results support this, but more research needs to be done on this issue.

Educational Goals

Participants will…

- Learn that violence and threats of violence in a forensic setting contribute to staffs' stress and strain.
- Learn that trauma plays a part in which staff members will experiences violence and threats of violence.

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Assessment and Treatment of Youth at Risk for Violence Using the CARE-2

Paper

Kathryn Seifert (USA)

Keywords: youth, violence, prevention, assessment, treatment, behavior, trauma, aggression

Abstract

The CARE-2 was developed to assess the high, medium or low risk for future violence and to provide a treatment plan using evidence based practice to reduce the risk of future acts of violence. In phase I of the study ROC's for CARE-2 scores and violent behaviors by youth were: pre-teen males, ROC = .86; pre-teen females ROC = .91; teen males ROC = .82 ; teen females ROC = .86.

Various researchers have found associations between childhood trauma and aggressive behaviors. Phase II of the study also found significant associations between aggressive behavior of youth and childhood trauma among youth in the sample: teen male violence and childhood trauma ROC = .77; Pre-teen females ROC = .87; teen females ROC = .75.

Lipsey *et al.* (2010) found that family therapy is effective and improved outcomes among severely delinquent youth. Phase III of this study will measure the effectiveness of various treatment modalities such as family therapy and skill building to improve outcomes for youth with assaultive behaviors.

Background

The CARE-2 was developed to assess the risk for chronic violence among youth and to help the practitioner to form a treatment and risk reduction plan using evidence based practice. The validity of the CARE-2 to perform this task has been demonstrated in Phase I of this research project and cross validated by the work of Drs. Tossey, Becker and Venable at Salisbury University, a part of the University of Maryland system.

The CDC Ace's study verified that childhood trauma is associated with a multitude of physical and behavioral health problems, including aggression, throughout the lifespan (Centers for Disease Control and Prevention, n.d.). More than 50% of people that commit violence have histories of abuse and/or neglect in their families of origin. Additionally, the Crossover Practice Model out of Georgetown University found in one study that 82% of the youth that had been arrested also had some involvement with the child welfare system. Also, the youth involved in both systems (child welfare and juvenile services) had more severe and chronic offense histories, and were involved with juvenile justice earlier and longer that single system youth. These youth went deeper into the system, as well.

In addition to findings of trauma histories among youth with violent behaviors, there have been findings of immature coping and interpersonal skills (Van der Kolk, 2014). This is associated with using violence as a means to an end, a belief which is common among aggressive persons with extensive trauma histories (Seifert K. , Youth Violence: Theory, prevention, and intervention, 2012). Phase II of this project demonstrated a significant association between histories of trauma and aggressive behaviors in a sample of 1026 young people.

Lipsy and colleagues (2010) have written on improving outcomes for youth involved with the Juvenile Services systems by using treatment modalities such as family therapy and skill building (Lipsy, 2010).

Such practices can improve recovery rates for this population from 30% to 70%. Treatment modalities for youth at risk for violent behaviors will be assessed in Phase III of this study.

Methods

There are several phases to this research. Phase I involved examining correlations between risk scores of the CARE-2 and actual acts of violence before and after the administration of the CARE-2. This would demonstrate the ability of the CARE-2 to discriminate between youth at risk for violence and those not at risk for violence (Seifert K. , CARE-2 Assessment: Child and Adolescent Risk/Needs Evaluation, 2003-2011). Phase II involves the examination of associations among histories of trauma, skill deficits, and aggressive behavior. Phase III will involve examining comprehensive and coordinated treatment of risk factors to increase functioning and reduce aggression. This presentation will focus on Phase II.

Sample

Anonymous data from the CARE-2 (Seifert K. , CARE-2 Assessment: Child and Adolescent Risk/Needs Evaluation, 2003-2011)were collected from various agencies in the US and analyzed. There are 1026 youth in the sample. Of that number, 369 were children (ages 2 to 12), 636 were adolescent (ages 13 to 19), and 21 with missing data. From the sample, 677 were male and 328 were female, and 21 of the profiles were missing data. In terms of estimated intelligence, 72% of the sample (739) had average intelligence, 19% (195) had above average intelligence, 5% (51) had below average intelligence and 4% had missing data. Data were collected from youth in outpatient treatment programs, residential settings, juvenile detention settings, group home facilities, and school settings. For comparison purposes data were also collected from a subset of youth with no reported behavioral problems.

The main locations for data collection were the Mid-Atlantic and the Midwestern regions of the United States. Youth placement varied as well, with 72% (739) living at home, 6% (62) in detention, 7% (72) in residential treatment placement, 4% (41) split between all other placement locations (e.g., foster care, independent living, group home placement, hospital, or prison), and 5% (51) had data missing. In terms of ethnicity, the sample was primarily Caucasian (544, 53%) and African-American/Black (380, 37%). Other ethnic groups included Hispanic (26, 2.5%), Hispanic and Other ethnic (75, 7.5%), and 2.5% were missing data. To determine if the ethnic composition of this sample was similar to the U.S. population of youth with serious behavior problems, the national statistics were reviewed. Nationally, Caucasian juveniles constituted 71% of all juvenile arrests and African American juveniles constitute 26%. Other ethnicities account for an additional 3% of the population. Fifty-five percent of violent crimes were committed by Caucasian youth and 43% were committed by African American youth (Snyder and Sickmund, 1999).

Measures

The CARE-2 was used to measure characteristics of the sample. The CARE-2 is a combination risk and treatment needs assessment, delineating the estimated short-term risk for violence and the treatment and structure needs of the client. The sample includes 1026 youth from the East Coast and Mid-West. It can be used for youth ages 6 to 19. There are rural, suburban, and urban youth in the sample. Additionally, the youth have a full range of behavioral problems. One unique feature of the CARE-2 is that interventions are listed with each item of the instrument. The risk score states that the “youth is (not, mildly, moderately, highly, or very highly) similar to youth with chronic (a history of more than three) assaults on others.” The scaling was made using means and standard deviations and scatter plots of the particular group being evaluated. Youth who are highly similar to young people with chronic (more than three) assaults are two standard deviations above the mean for the total group. The mean for the low risk group is two standard deviations below the mean for the total group. The “not similar group” was determined by the score below which there were no cases for which there were assault

histories. The moderate group contained both youth with and without histories of assaults. The "highly and very highly similar" groups contained only youth with histories of chronic (more than 3) assaults.

Procedures

This study examined de-identified archival data of a sample of 1026 youth. This sample was the original data for the development of the CARE-2. Data was collected and then analyzed.

Results

In Phase I of the study associations between CARE-2 scores and aggressive behaviors. Significant correlations were demonstrated among the variables in the expected direction for the 1026 youth. CARE-2 scores were associated with chronic acts of violence: Pre-teen males, R = .77, F = 72.32, p = .00, ROC = .94; teen males, R = .52, p = .00, ROC = .82; pre-teen females R = .57, P = .00, ROC = .91; teen females, R = .51, p = .00, ROC = .86.

Phase II of the study also found significant associations between aggressive behavior of youth and childhood trauma among youth in the sample: teen male violence and childhood trauma ROC = .77; Pre-teen females and trauma, ROC = .68; teen females and Trauma, ROC = .75.

Phase II anecdotal evidence. Family therapy has been found to be effective in treating youth with histories of trauma and aggressive behaviors by the author of this study. Phase III will involve collecting data to support or invalidate the hypothesis.

Conclusions & Discussion

The CARE-2 was shown to have significant validity statistics when determining which teens were at High, Medium, or Low risk for future violence. Additionally, there is growing body of evidence that trauma histories as well as skill deficits are significantly associated with aggressive behaviors among youth. The examination of this sample demonstrated significant correlations between trauma history and aggression among youth in the sample. Lipsy (2010) found that family therapy improved the outcomes for severely delinquent youth. Phase III will examine the hypothesis that family therapy improves outcomes for youth at high risk for violence.

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Educational goals

1. Demonstrate the association between CARE-2 scores and violent behaviors of a sample of youth
2. Identify trauma histories associated with aggressive behaviors.
3. Demonstrate how to assess and treat the risk factors of aggression through evidence based practice such as family therapy.

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Chapter 5 – Trauma informed care & practice

The pros and cons of implementing trauma informed care in Danish psychiatry

Paper

Jesper Bak & Jacob Hvidhjelm (Denmark)

Keywords: Mental health, nursing, trauma, trauma informed care

Introduction

Trauma informed care could be defined as: A strengths-based service delivery approach that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment

Background

Principals of Trauma Informed Care (TIC) are implemented at many mental health hospitals across the US. In Denmark there are no such principals implemented. That might be because patients and staff don't experience trauma to the same extent as in the US. The OECDs social indicators ranked Denmark in top with a score on safety at 85% (safe walking alone at night), and life satisfaction on 7.5 on a scale from 0 to 10. The US is ranked lower, with a safety score on 74%, and life satisfaction on 6.9 (2).

Objectives

This study explores to what extent patients and staff in Denmark, has been exposed to traumatic experiences earlier in life, compared to patients and staff in US.

Methods

A cross sectional survey on trauma experiences among patients admitted to a psychiatric ward and staff-members working at two psychiatric wards (one forensic and one dual-diagnostic), using the Brief Trauma Questionnaire (BTQ) (3) were conducted. The BTQ was translated to Danish, back translated to English, compared and revised accordantly, by the two authors. The questionnaire was distributed electronically, using Enalyzer (4), and handled anonymously, so that the researchers were blinded to who the respondent were. All analyses were performed using IBM SPSS Statistics for Windows, Version 22.0 (Released 2013; IBM Corp., Armonk, NY).

Results

The sex distribution of the respondent showed 27% were men, the average age was between 41 and 50 years, the education was distributed with 44% nurses aids, 31% nurses, 12% psychologists/ psychiatrists, and 13% others, and the response rate was 69.4% (respondents, N=309).

Table 1. Distribution of traumatic life events among staff in two mental health wards in Denmark

Traumatic life events (N=309)	%	(n)
1. Experiencing war (life in danger/seriously injured)	2	(5)
2. Serious accident (life in danger/seriously injured)	23	(70)
3. Natural or technological disaster (life in danger/seriously injured)	6	(17)
4. Life threatening disease (life in danger/seriously injured)	7	(23)
5. Childhood trauma (physically punished or beaten - life in danger/seriously injured)	8	(26)
6. Childhood trauma (attacked, beaten or bullied - life in danger/seriously injured)	22	(68)
7. Unwanted sexual contact (life in danger/seriously injured)	4	(13)
8. Seriously injured (seriously injured)	7	(20)
9. Close persons death after a violent incident	20	(62)
10. Witnessed other person seriously injured or killed	25	(76)
At least one incident	63.7	(197)
At least two incidents	34.3	(106)
At least three incidents	16.8	(52)
At least four incidents	6.1	(19)
At least five incidents	1.6	(5)
Six incidents	0.3	(1)

Note. Descriptive statistics of traumatic life events. N = number of all respondents. % = percent of respondents in the group. n = number of respondents in the group.

Table 1, the most common traumatic life event was "Witnessed other person seriously injured or killed" 25%, the next was "Serious accident (life in danger/seriously injured)" 23%, followed by "Childhood trauma (attacked, beaten or bullied - life in danger/seriously injured)" 22%. Regarding the number of traumatic life events, 64% of the staff members had experienced at least one traumatic life event, 34% at least two events, 17% at least three events, 6% at least four events, 2% at least five events, and last 0.3% equal to one person six events, out of ten possible events.

Table 2. Associations between traumatic life events and background variables

Background variables	B	95% CIs of B	p
Ward (forensic ward vs. dual-diagnostic ward)	0.10	[-0.24, 0.45]	.55
Sex (male vs. female)	-0.23	[-0.59, 0.14]	.23
Age (five, 10 years groups)	-0.07	[-0.20, 0.07]	.31
Education (nursing aids/nurses vs. psychologists/psychiatrists)	-0.61	[-1.08, -0.15]	.01

Note. The parameters (B) were estimated using a linear regression, and all background variables were analysed together. The parameters should be interpreted as, e.g. education; there is a difference between the two groups of 0.6 traumatic life events in average.

Table 2, the only background variable significantly associated with number of traumatic life events was education. We found higher educated staff (psychologists and psychiatrists), in average had experienced fewer traumatic life events (B = -0.61, p = .01).

Preliminary results from the survey where the respondents were patients with a dual-diagnostic diagnose will be presented at the congress.

Conclusions

Quit a large amount of the staff had experienced traumatic life events, and a few had experienced several.
Conclusions from the patient survey will be presented at the congress.

Discussion

The use of BTQ to collect data on traumatic life events was chosen because it is brief, and easily understood by respondents. Schnurr (5), found Kappa coefficients for the presence of trauma that met DSM criterion A1 were above .70 (range .74-1.00) for all events, except for disease (.69) and "other persons seriously injured or killed" (.60). So the BTQ would find trauma in a good or almost perfect way.

Using an electronical system (Enalyzer) to collect the questionnaires, which was able to hide the identity of the respondents to the researchers, could be one of the reasons why so many answered the very private and sensitive questions, and thereby strengthen the representativeness of the study. The response rate of 69.4% would in many cases be described as acceptable (6), and the likelihood of response bias rather low.

The amount of staff that experienced traumatic life events was not very different from earlier findings of population samples in the US, Kessler (7) found 56%, and Breslau (8) found 61% had experienced at least one traumatic life event. Also, the level of education has been found earlier to be associated with the number of traumatic life events (9). So even though we score higher on safety, and life satisfaction, on the OECDs social indicators, this seems not to be connected to experiencing lesser traumatic life events.

It seems that we can (before we know how many traumatic life events the patients experience) deduce, that it is not because the staffs in Denmark experiences fewer traumatic life events, that we have not implemented principals of TIC. And because the amount of traumatic life events is as high as in the US, it is an area we as staff (and patients) probably should be more interested in, and paying more attention to.

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Physical restraint use: an integrative review about the potential psychological and physical harm for mental health in-patients

Workshop

Pauline Cusack, Frank Cusack & Susan McAndrew (UK)

Keywords: Physical restraint, in-patients, service user, mental health, harm, hospital

Abstract

Aim

The aim of the Integrative review was to explore the physical and psychological harm of physical restraint upon mental health in-patients'

Objective

To appraise and summarise the available literature regarding physical restraint practice, highlighting any physical or psychological harm caused to mental health in-patients, as a result of its use.

Methods

An integrative review was used to identify experimental and non-experimental research on physical restraint practice relating to the psychological and physical harm caused to mental health in-patients

The databases searched were CINAHL, EMBASE, Psych Info, MEDLINE and Cochrane. Terms were defined and an inclusion/exclusion criteria applied, based on the research aim. Professional networking, Author Searching, Hand and Journal searching were also employed. Studies published from 2000 to April 2016 were included in this review.

In total, eight articles were included in the final analysis; one quantitative, two mixed methods and five qualitative. Papers that met the inclusion criteria were then appraised using the Critical Appraisal Skills Program (CASP) tools. Papers were then evaluated using Walsh and Downe's, 2006 Quality Summary Score; this gives ratings from A to D against any flaws in the papers. D rated papers are considered of poor quality and therefore a decision was made to remove any papers which were assessed as D rating at this stage. No papers were rated as D, meaning that all papers at this stage were included in this review. Three reviewers' quality assessed and appraised the papers, using constant comparison to allow for themes, patterns and variations to emerge.

Results

In total eight main themes emerged, which were significant to this review and focused on physical or psychological harm for mental health in-patients who have experienced physical restraint. These were: - Trauma/re-traumatisation; Distress; Fear; Feeling ignored; Control; Power, Calm; and In-humane conditions. The findings were discussed as part of the review. Although individual themes emerged, several were found to be inter-related and the subtle nature of this inter-play was also explored within the review.

Conclusion

Overall the emerging themes from this review suggest that physical restraint can and does lead to physical and/or psychological harm for mental health in-patients. The harm is experienced before, during and following restraint, and in the latter for some significant time. Being restrained can intensify tension and fear about future interventions, and additionally the staff-patient relationship becomes compromised. Coercive practices such as this, are highly controversial and raise questions about the cultures of organisations, as well as the attitudes of staff.

Educational Goals

By the end of the workshop individuals will:-

- Have gained an understanding of physical restraint from a mental health in-patient perspective
- Be able to consider different interventions in restraint reduction

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Responding to trauma: An analysis of chart documentation in a psychiatric inpatient setting

Paper

Merrick Pilling & Andrea Daley (Canada)

Keywords: trauma, structural violence, marginalization, chart documentation, qualitative

Abstract

Background

Research indicates that many clients in inpatient settings are trauma survivors and there is a growing awareness of the importance of effectively addressing patient experiences of trauma in such settings (Elliott, Bjelajac, Fallot, Markoff, & Reed, 2005; Muskett, 2013). It is therefore important to gain a better understanding of how inpatient mental health care practitioners conceptualize and treat patient experiences of trauma.

Aims

To understand how mental health care practitioners conceptualize trauma, as evidenced in chart documentation in an inpatient setting.
To explore the potential impact of such conceptualizations on practice.

Methods

This qualitative study employed critical discourse analysis and institutional ethnography to examine 120 inpatient charts from a large psychiatric institution in Toronto, Ontario in Canada. The charts of 15 women and 15 men were reviewed from four inpatient programs with discharge dates between January 2013 and January 2014.

Results

Findings indicate that patient trauma histories are often documented but treated as incidental in shaping experiences of mental distress. Further, many inpatient service providers characterize traumatic experiences as individualized occurrences that are unrelated to larger structural conditions such as colonization, violence against women, and poverty. Chart documentation suggests that this can result in the use of individualized intervention strategies that minimize or ignore the impact of trauma and ongoing marginalization.

Conclusions

Chart documentation suggests that current inpatient practices at a large psychiatric institution in Toronto, Ontario tend to minimize the impact of trauma and ignore the larger context in which it occurs. A wider range of interventions may be necessary to adequately address the impact of trauma, especially those that consider structural oppression.

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Educational Goals

- To gain a better understanding of the ways in which inpatient mental health care practitioners conceptualize trauma in chart documentation.
- To examine how practitioners' assumptions about trauma inform inpatient practice and explore possible alternatives.

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How we create the perfect storm: The intersection between trauma, power and models of practice

Paper

Indigo Daya (Australia)

Keywords: Trauma, power, consumer, lived experience

Abstract

Consumers comment that acute psychiatric services have become 'like a war zone', with each side, consumers and clinicians, heaping ever-greater destruction upon each other. Yet from the social experience of war it is clear that this is no pathway to sustained peace. Certainly it is no pathway to recovery and healing for consumers, or to a safe workplace for clinicians. These things require trust, truth-telling, compassion and genuine human connection.

This position paper is a presentation of reflections on violence in clinical psychiatry from the author's lived perspectives as consumer/survivor, mental health worker and educator, and government policy advisor in mental health. Reflections in this paper will consider how the three factors of power, trauma and models of practice intersect to create a perfect storm for violence that can seem difficult to escape, and how the potential solutions are also inherent in these same topics.

Educational Goals

- Participants will be able to explain how violence is experienced and understood from different perspectives, including clinical, consumer and government perspectives, and to consider this explanation in weighing the pros and cons of different responses to violence in their own work setting/s
- Participants will be able to explain the roles of trauma and power as mediators in incidents of violence, and discuss the use of trauma-informed practice and consumer participation as strategies to reduce violence.

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Trauma Informed Practice Education for Psychiatric Nursing Students: A Canadian Model

Poster

Susan Power (Canada)

Keywords: trauma, informed, care, psychiatric, nursing, education

Abstract

Patients who are receiving treatment for mental illness and addictions are often victims of historical or current trauma. They may be experiencing symptoms of acute trauma or complex post-traumatic stress disorder (PTSD). Psychiatric Nurses practicing with knowledge of Trauma Informed Care (TIC) can enhance the quality of care for patients in all settings and this paper will discuss the importance of providing education in TIC for psychiatric nursing students to enhance quality of care for patients. A specific trauma informed care approach was developed for Bachelor of Psychiatric Nursing program curriculum of Kwantlen Polytechnic University.

A Trauma Informed Care teaching module was created for fourth year psychiatric nursing students as a class project. Delivery of the module transformed student attitudes to TIC. TIC includes making sure patients are assessed for trauma exposure; that nurses use evidence-informed practice; that resources on trauma are available to psychiatric nurses.

This article reviewed how trauma informed practice education can increase trauma sensitivity of nurses to clinical interventions that will improve the care that patients receive from nurses.

The aim of this study was to evaluate the effectiveness of TIC education for psychiatric nursing students. Following brief TIC education package students described the changes in their clinical practice.

The TIC education module was delivered to a group of 30 psychiatric nursing students. There was an informal pre and post evaluation for students to determine the level of comfort, competency, and awareness of TIC.

The aim of this study was to evaluate effectiveness of a three-hour module of theory of Trauma Informed Care delivered to Psychiatric Nursing Students. The education module included lecture, discussion, and case study. Evaluation was based on student feedback of their theoretical learning and their clinical application of the information.

Educational Goals

Learners who participate in the presentation will

- Develop awareness of educational theory of Trauma Informed Care.
- Have knowledge of a model of Trauma Informed Care and be able to teach the model to other practitioners and front line health care professionals.

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Chapter 6 – Assessment of risk, prevention & protective factors

Development and validation of the "Mechanical Restraint – Confounder, Risk, Alliance Score" among forensic mental health clinicians

Paper

Lea Deichmann Nielsen, Frederik Alkier Gildberg, Lise Hounsgaard & Per Bech (Denmark)

Keywords: Risk assessment, Mechanical restraint, forensic psychiatry

Abstract

Background

The duration of mechanical restraint (MR) is particularly prolonged among forensic psychiatric inpatients in Denmark. Use of a structured risk assessment instrument has shown to to reduce the duration of isolation. However, no instrument exists for use during MR to support the clinical decision-making process among clinicians on whether the patients are ready to be released from MR with the aim of reducing the duration of MR.

Purpose

This project focusses on the development of a clinically and psychometrically validation of a new short-term risk assessment instrument: Mechanical Restraint - Confounder, Risk, Alliance Score (MR-CRAS) among forensic psychiatric clinicians.

Design

Phase 1 served to develop MR-CRAS based on existing research literature and risk assessment instruments as well as focus group interviews among clinicians with rich first-hand experience.

Phase 2 served to clinically validate MR-CRAS through 1) face validation among clinical experts within forensic psychiatry; 2) content validation of MR-CRAS among a panel of researchers and clinical experts within the field; 3) Pilot testing of MR-CRAS within two closed forensic psychiatric inpatient units.

Phase 3 served to further evaluate the psychometric properties of MR-CRAS through a multicenter field study to gain insight into the instruments dimensionality and deciding on the definitive content of MR-CRAS

Results

Phase 1
- A one page scheme + user manual
- Three subscales containing factors identified as reasons for prolonged MR: Confounders, Risk and a Parameter of Alliance
- Observation and assessment each hour (eight hours per scheme)

Phase 2
- All subscales showed excellent content validity with a total of 18 items
- MR-CRAS was perceived and experienced as comprehensible, relevant, comprehensive and usable in clinical practice
- Was easy to complete
- Formed a quick overview of essential observations
- Created a common basis for continuous assessment of the patient´s readiness to be released from MR

Phase 3
This phase is currently being undertaken and the results will be available at the presentation

Future research

Risk management interventions targeted at specific scores in MR-CRAS will be developed. Subsequently the effect of MR-CRAS combined with targeted risk management intervention will be tested on the duration of MR.

Implications

The results will lead to further testing of the reliability and validity and implementation of MR-CRAS in other psychiatric settings. MR-CRAS as a short-term risk assessment instrument could be an effective element in a SPJ approach and extend the traditional preventive use of risk assessment with a unique framework for use during MR.

Educational Goals

Participants will:
- realize that when MR is used as a last resort the duration of MR should be kept at a minimum
- become acquainted with the new short-term risk assessment instrument MR-CRAS to support clinicians' clinical decision-making process on when the patient is ready to be released from MR or not with the aim of reducing the duration as soon as safely possible

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Response Crisis Intervention Model for Conflict Management - RCIM: A quick scan scale for fidelity assessment in psychiatric care

Paper

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Keywords: Violence in Psychiatry, Response Crisis Intervention Model, Confict Management, Quick-Scan, Fidelity, Crisis Situation Intervention, Intervention in Psychiatry

Abstract

The Response Crisis Intervention Model for Conflict Management in Psychiatric Care – RCIM (Windcaller, 2010), has been successfully applied for many years, aiming to prevent and deal with aggression in crisis situations in psychiatry. The RCIM protocol was also used as a guideline to train staff in the attitudes and behaviours to be conducted in the case of violence in psychiatric care. In order to respond adequately to these violent crisis situations, it is important that the RCIM is implemented well, following its guidelines. To assess the RCIM protocol application in mental health organisations, a fidelity scale, based on interviews, was developed and applied to managers, staff and clients, which although useful, showed it to be very long and complex. Aiming to improve the assessment of the RCIM protocol, a quick scan scale of its fidelity was developed and validated.

The research methods included: a literature review on the topics of aggression, fidelity, and quick-scans; development of a quick scan fidelity scale for the RCIM protocol based on its large fidelity scale; a pilot study of interviews with experts; adjustment of the final version of the quick scan fidelity for the RCIM (with 10 questions) in consultation with experts; application and validation of the quick scan fidelity scale for the RCIM. The results of the research will be presented and discussed in this presentation.

Educational Goals

- The goals regarding the cognitive, affective and psychomotor domains of learning, are reached when the participants understand the Response Crises Intervention Model for Conflict Management protocol - RCIM, and the application of the quick scan to measure its fidelity, in preventing and dealing with violence in psychiatric care. The cognitive domain is related to developing a knowledge and understanding of the protocol, the affective domain refers to the development of an adequate psychological attitude towards violence as proposed by the protocol, and the psychomotor domain indicates the physical behaviour indicated by the RCIM.

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Interprofessional collaboration in criminal justice/ mental health services transitions-theoretical considerations, working models and the HCR-20

Workshop

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Keywords: Collaboration, interagency working, interprofessional working, risk assessment

Abstract

The demand on services when offenders make the transition from prison back into society is complex and demanding, and calls for the development of new interagency collaboration arrangements. This workshop explores with participants some of the tools with which to enhance these collaborations.

In part 1, the Change Laboratory Model (CLM) of workplace transformation, as a means of managing interagency collaborative practice, is presented. The presentation focuses on cultural historical activity systems theory as a theoretical perspective underpinning this model, that offers a framework with which interactions between the services can be better understood. The theoretical framework is illustrated through its application to case studies of offenders making the transition between prison and the community.

In part 2, interprofessional collaboration is described as a complex phenomenon, needing conceptual models that capture different aspects of the collaboration processes. One such model and associated measurement tool is the Perception of Interprofessional Collaboration Model (PINCOM). It contains 12 facets of collaboration on the individual-, group- and organizational level. It is suggested that the model could be used within a larger social innovation framework (such as the CLM), and as a reflective tool during or after structured clinical assessment (see HCR-20).

In part 3, the potential of using a risk assessment tool, the HCR-20, to enhance collaborative processes will be discussed. The HCR-20 (Historical, Clinical, Risk Management-20) is the most commonly used structured professional judgment tool for violence risk assessment. It comprises 10 historical factors, 5 dynamic factors, and a risk management scale with 5 items about adjustment to future risk-related circumstances. A conventional use of the tool means personnel in charge of the patient or inmate at the time of assessment, do the assessment and present the results to personnel in the services that will engage with the inmate later on. Often this causes interprofessional misinterpretations, disagreements, and complications in the transition process. The presentation will address the pros and cons of doing a shared assessment of the risk management items.

In Part 4, participants are encouraged, in group discussions and interactive exercises, to apply each the above models to their own work experiences and explore the utility of these approaches in enhancing their own understanding and practice of interagency collaborations.

Educational Goals

On completing the workshop, participants will be able to:

- Learning objective 1: apply the theoretical models underpinning the Change Laboratory Model (CLM) of workplace transformation and the PINCOM conceptual model to reflect and analyse their own interagency working practices.

- Learning objective 2: explain the utility of interprofessional joint shared risk assessment in their own working practices.

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Qualitative research of violent incidents between young paramedics in Czech Republic

Paper

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Keywords: Emergency medical services. Qualitative research. Paramedics. Violence.

Introduction

Violence towards prehospital emergency professionals is often neglected. There is no complete understanding of the incidence of violence in the Czech Republic or recommendations for specific professional communities in problems of violence and how to solve the problem of violence in prehospital emergency medicine. Prehospital and emergency medical professionals are the first ones who respond to the urgent needs of people. A high prevalence of violence has been reported in a few studies, indicating the extent of the problem. Also it seems that inappropriate patient behaviour may be caused by unprofessional behaviour of prehospital emergency professionals.

The rate of occupational injuries among paramedics and other emergency medical professionals is eight times higher than the national average for all workers and twice as high as the rate for police officers; it seems there is no occupational group with a higher injury or fatality rate than paramedics and medical professionals in emergency medicine. The basic theories of violence include frustration, social learning, and general pattern of violence, violence vs. nonviolence, inequality, subcultural and ecological theory. Theories of violence, including the "remaining marked for life", "direct correlation between organizational effects and creating a safe environment", managers' self-awareness, and the contributing factor toward moderating violence must be taken into account, too. Although, some safety measures are designed to reduce violence in hospital emergency departments, few studies have focused on pre-hospital emergency settings, with its principally unpredictable and unstructured environment. Studies that explain the process of violence are yet to be carried out. Quantitative research cannot explore real causes/roots of violence against paramedics and professionals in emergency medicine properly and so qualitative approach is needed to understand the phenomenon and consequently provide a basis for the promotion of safety, health and efficiency of the EMS personnel.

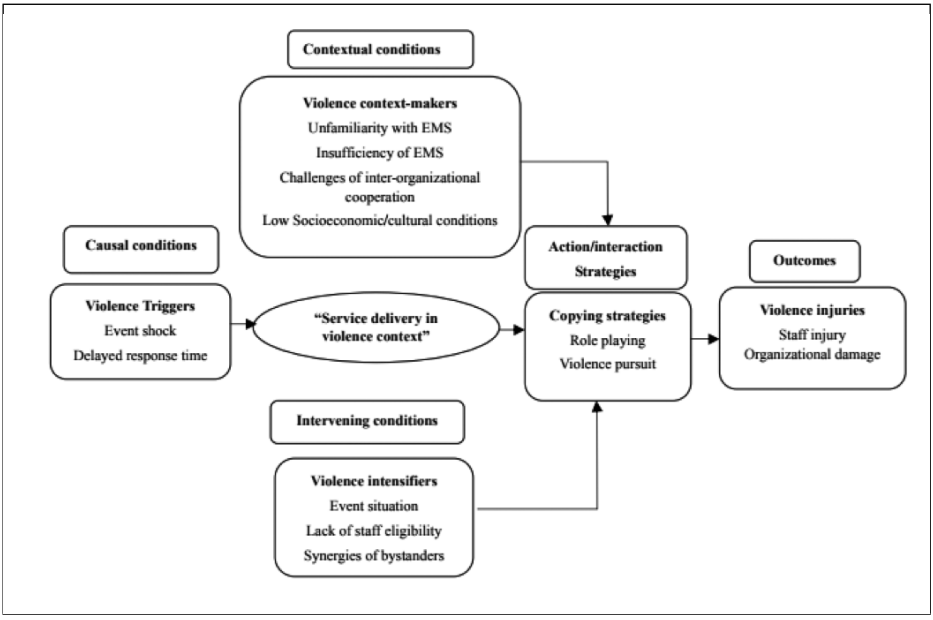
Methods and research samples

This study was conducted to explore the process of violence in emergency medical services using the Strauss/Corbin systematic approach grounded theory of providing the Paradigm model. Such methods are often followed when there is no theory that defines a social phenomenon (such as violence). The participants in this research included EMS staff with at least two years of work experience in the Prague Emergency Medical Services or in the Emergency Medical Services of the Central Bohemian Region and who were victims of violence. Our sample included 10 registered paramedics and 10 Emergency medical technicians (EMTs) between 23 and 33 years of age (mean±SD: 27.7). The educational level of the participants included 11 high school diploma (EMTs), 9 bachelor's degrees (Paramedic), and two master's degrees (paramedics). All participants of the study were the victims of violence when deployed to the scene to provide EMS to traumatic or non-traumatic patients.

The face-to-face interviews lasted from 20 to 50 minutes (mean±SD: 36,5) and were conducted in a location chosen by the participants. Data was collected utilizing a semi-structured interview. All

sessions were audio-recorded. The collected data were transcribed and analysed using content analysis according the Strauss/Corbin approach and constant comparative method (The Paradigm Model of Workplace Violence, Figure 1). The questions focused on the way violence occurred, how they have respond to violence, and the consequences. Also, observation, notes from documents and EMS medical record were used: circumstances of the event (e.g. transporting a patient to the hospital); identity of perpetrator´s role (e.g. patient, patient family member, etc.); if the victim knew the perpetrator prior to the event; if the respondent reported the assault to his or her employer, and, any other conditions (e.g. perpetrator was intoxicated), possible prevention of incident.

Figure 1. The Paradigm Model of workplace violence process in EMS setting



Results

In this study, "impact of communication of emergency medical services delivery in the context of violence from patients or their relatives" emerged as the core category and the main focus. The five main groups of the paradigm model of violence against EMS staff included causal, contextual and intervening conditions, strategies, and consequences (Figure 1).

Causal Conditions

The main category of causal conditions was "triggers of violence" that included two groups: "event shock" and "delayed response time".

Event shock: Prevalence of severe unexpected events such as illness or trauma may cause anxiety and agitation, resulting in unpredictable and uncontrollable behaviour such as violence *(„The father of the victim could not control and keep calm anymore. His son had a collapse and he wanted to transport him fast to the hospital. He attacked verbally the paramedics and he couldn't keep calm." Participant 7)*.

Delayed response time (RT): One of the major causes of violence in the EMS conditions is the delay in response, which can be due to delay in requesting for help, the imagination of delay, unrealistic

expectations and actual delays in the arrival of EMS. Further delayed due to staff negligence and the lack of resources including the availability of an ambulance („People want us to be there immediately after the accident. That's impossible. We arrived 10 minutes after the accident on the scene and the relative of patients was waiting for us before their home. He was very angry, he was threatening with fists to us and he was very rude, because we were late." Participant 5).

Contextual Conditions

This category, entitled „Context-makers of violence" includes four subgroups as follows: unfamiliarity with the EMS duties, insufficiency of the EMS organization, challenges of inter-organizational cooperation, and poor socioeconomic and cultural conditions.

1. *Unfamiliarity with EMS duties* - the inadequate knowledge of EMS duties by clients; occasionally, the request for transferring non-emergency patients or request to transfer to hospital resulted in WPV: *„85 year old man called an ambulance for his hypertension. I checked his blood pressure and it was ok (130/75). Patient showed us his homemade monitor for blood pressure control. The monitor had showed normal parameters (120/80, 130/80, 125/70 - this was last measuring). I tried to explain him that his blood pressure is normal and everything is ok. He called for his wife and he wanted his stick. Then he was started to banging with his stick to his table and he was shouting: 'You are only taxi drivers and I need to the hospital. Scoop me and transfer me to the hospital!!' Participant 4).*

2. Insufficiency of the EMS organization: One of the contextual factors of violence in the EMS (VEMS) is the Insufficiency of EMS organization, regulations and how to manage the organization. Communication between ambulance staff and the relevant centres can cause violence (overload of staff in the ambulance medical equipment's). Participant 1: *„We cannot take care of people and their things. We were looking after 36old man who fell down in his drunkenness. He was violent verbally but at last he agreed with transport to the hospital. In the courtyard of hospital he started to stand up and he want to take down his seatbelt. I asked him that he would stay in calm. He took out his knife from his jacket and cut the seat belt and he went to me. In this moment my colleague (EMT) stopped the ambulance, I opened the door of ambulance and locked the man inside of ambulance. Then we called the police."*

3. The challenge of inter-organizational cooperation: The performance of other organizations, (ministry or police). The police are effective in safeguarding emergency medical services. In some situations we need police cooperation to calm down the patient. *(„We wanted the help of police, yes. But these police men started to humiliate our patient and one of them wanted to hit him. We wanted only to cooperate for our safety with police during the transport to the hospital. The presence of police sometimes contributes to more violence from patients." Participant 2)*

4. Low socioeconomic and cultural conditions: The incidence of public reactions (such as violence) is more common in social environments with poor culture, educational, socioeconomic status, and greater social ills. Also, lack of interest of governmental health system in prevention of VEMS: *„Most staff says- this is only part of the job, but I disagree. One 20 old man wanted to accompany our ambulance in his car. I had a suspicion that he is drunk. I pointed out him that if he accompanied us by his car I'd call the police. Then he went to me and hit me in my face." (Participant 17).*

Intervening Conditions

Intervening conditions are a series of conditions that impact violence strategies - situation of the event, lack of staff eligibility and synergies of bystanders.

1. Situation of the event: We tried to found out when the prevalence of VEMS is the highest. From 20 respondents' experienced 18 participants the attack during the night shifts (2 - 6 a. m.); 10 participants experienced violence at the street, 10 in the ambulance.
2. The incompetence of EMS staff: In some cases, due to environmental conditions and anxiety of the clients we observed inappropriate behaviour in our staff. This significantly increases violence against staff. Thanks to grounded theory we have found out that all 20 participants had an opportunity to prevent their conflict.
3. Synergies of bystanders: There are some studies (Gormley *et al.*, 2016; Gülen *et al.*, 2016; Rahmani *et al.*, 2012) that pointed high risk groups with context of VEMS such as people with history of drug abuse, alcohol, psychedelic agents and aggressive and irresponsible people with criminal records, are involved in fomenting violence. On the other hand, we found that in 10 out of 20 participants the attack was caused by people in stress (these people were decent, with good family function and a good job).

Action/Interaction Strategies

In this study, "coping strategies" were identified as the main category with two groups: "role playing" and "the pursuit of violence".

1. Role playing: EMS staff focused on providing optimal services by ignoring violence against them, exhibit self-control and managing violence by strategies, including explaining, convincing, relaxing, confidence and self-defence techniques, such as leaving the scene, keeping away, and building trust, accepting demands of the clients, taking refuge in people and seeking the cooperation of the perpetrator. Another strategy involves cooperation with the police, which plays an important role at the scene to prevent violence or reduce injury: „We heard the insults *('We're gonna kill you!!'), but did not reply. We saw one man whom tried to stand up and three people around him. We were still in an ambulance and driver started to move backwards and then we went away and turned the corner. Then we called the police and cooperated with them." Participant 16.*
2. Follow-up violence: These strategies include reporting violence and protecting victims of violence. In some cases, victims of violence, especially in cases of physical injury, report violence to their supervisor for follow-up and expect support which depends on the sensitivity of the supervisor and policy of EMS organization. Also, in some cases, violence is not reported for various reasons. The strategy of EMS management is to advise staff not to confront violence, and in the event of violence, support the staff in their decision. Judicial support for violence victims is another strategy used to follow-up violence.

Outcomes

Exposure to physical and verbal violence puts EMS staff and organizations at risk of significant consequences.

Staff injuries: The EMS staff injuries include a variety of physical and psychological injuries:

„I am very careful now. After one year of incident (A man in unconsciousness kicked me to the face when I tried to check him; I was 10 minutes in unconsciousness and I was three months out of duty?) when I am now in contact with addict people during night shift I remember for it. Participant 20.

„I wanted to call the police for violent man and after my words he hit me into my face. He lives nearby our base. Always we go around I remember at this accident." Participant 9

Conclusion

This study was conducted to explore the process of violence in emergency medical services using the Strauss/Corbin systematic approach grounded theory of providing the paradigm model. Such methods are often followed when there is no theory that defines a social phenomenon (such as violence). The collected data was transcribed and analysed using content analysis according the Strauss/Corbin approach and constant comparative method (The paradigm model of workplace violence). In this study

we reported on the impact of communication of emergency medical services delivery in the context of violence from patients or their relatives. The five main groups of paradigm model of WPV against EMS staff included causal, contextual and intervening conditions, strategies, and consequences (Figure 1). In general, we can state that the paramedics and EMTs were exposed to verbal violence and physical violence. From 20 participants interviewed, 18 attacks occurred during the night shift. 10 participants experienced violence on the street, and, 10 in the ambulance. The perpetrators were men in 18 cases. The crucial role of violent conflict is the behaviour of medical staff – unprofessional behaviour with drunken or addict patients increases the possibility the violence by 70 % (Pekara, 2015). On the other hand, we found that in 10 cases the attack was caused by people in stress. Thanks to grounded theory we have found that all 20 participants had an opportunity to prevent their conflict.

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An Exploration of the Protective and Risk Factors Related the Escalation of Extremist Violence

Workshop

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Keywords: extremism, radicalization, violence, threat assessment

Abstract

In the wake of recent escalations and attacks in the United States and abroad, the authors explore a specific and detailed investigation of how an individual's radical ideologies can move from strongly held beliefs to extremist violence. This paper examines risk factors for violent extremism and protective factors that reduce the potential for violence. This research is useful foundation for a risk assessment model for violence risk assessment evaluators.

From Radical Thoughts to Extremist Actions

When a radicalized individual or group embraces violence as a justified pathway to achieve their political, religious or social goals, this can transform to extremism and terrorism (Pressman., 2016). There is a progressive connection from radicalism to extremism to terrorism. Extremism is the vocal and active opposition to the essential values which potentially escalate to terrorism where violence is used to achieve the desired goals and ends (Scarcella, Page & Furtado, 2016). Terrorism is then defined as the unauthorized or unofficial use of violence and intimidation in pursuit of political, religious or ideological goals (Scarcella, Page & Furtado, 2016). Here, the individual is interested in the attack itself as well as the impact of the attack on others and the larger community. This can occur as a lone terrorist without command and control from a group, or with support or inspiration from other individuals.

While many individuals may feel marginalized, treated unfairly, discriminated against, and unengaged in society, only a small number move toward violence to express these frustrations or to bring about change. Radical thoughts and ideas are not, in and of themselves, dangerous or problematic. There are many examples throughout history of positive contributions from radical individuals and groups. Unfortunately, there are other examples where an individual's radical thoughts and ideas transform to embrace violence and intimidation as reasonable actions to reach their political, religious, or ideological goals. One of the central goals of this research is to better define the tipping point toward violence.

Dr. Adam Lankford shares some important insight here regarding the interplay between suicidality and terrorism. Prior to his work, there were some assumptions that the desire for change based on the religious, political, or social ideology was paramount. Following his research (Lankford, 2010; 2013), the issue of suicidality – the sense of hopelessness, depression, isolation and failure – came forward as an initial catalyst rather than the desire to achieve some larger societal message or culture shift. Likewise, other research has identified the identity crisis and struggles often associated with those vulnerable to radicalization (Pressman, 2009; Horgan, 2008; CEGEVR, 2008).

This distinction here, regarding suicidality as primary motivation rather than an unfortunate price to pay for the cost of achieving a larger mission goal, is critical. The motivating factors must be understood prior to an attack. Plainly stated, a suicidal individual may look for a justification to take their own life, rather than losing one's own life as an ultimate sacrifice for the cause. As we move into exploring the research with a focus on risk, protective factors and underlying motivations, suicidal thoughts and

ideations, a desire to escape a life of chronic disappointments and pain, is an important construct to understand.

In analysis of research on additional risk factors, multiple and complex processes have been identified as related to violent extremism. In their seminal meta-analysis, Scarcella, Page and Furtado (2016) suggest that given the multi-faceted nature of extremism and terrorism, a diverse team of professionals from psychology, criminology, law enforcement and law would better be able to discuss the nature of these factors. It is our hope that these risk and protective factors summarized here may assist team members and evaluators in the task of better understanding the inter-play between risk and protective factors.

Risk Factors (RF)

Risk Factors (RF) are the concerning thoughts or behaviors that have been shown by research and past attacks to be present. There are ten Risk Factors (RF) that are highlighted here to better understand the escalation from radicalization to extremist and violent behavior.

1. **Hardened point of view, injustice collecting.**
   An individual with a hardened point of view begins to selectively attend to their environment, filtering out material or information that doesn't line up with their beliefs. Stances begin to harden and crystalize (Van Brunt, 2012; Glasl, 1999; Turner & Gelles, 2003). These views are beyond a strongly held belief and contain a passion and emotion that rejects other points of view or hardened ideological positions, and they are reinforced through other personal experiences and networks (Sageman, 2007). Within a hardened point of view, an individual may begin injustice collecting (O'Toole, 2002; Calhoun & Weston, 2009; Van Brunt, 2012; 2015). O'Toole described this individual as "a person who feels 'wronged,' 'persecuted' and 'destroyed,' blowing in- justices way out of proportion, never forgiving the person they felt has wronged them" (O'Toole & Bowman, 2011, p. 186). Injustice collectors keep track of past wrongs committed against them and are often upset in a manner that exceeds what would typically be expected.

2. **Marginalization and perceived discrimination.**
   Here the individual exists within a marginalized state in society. This marginalization may be based on social factors, ethnic or racial differences, cultural dissimilarities, or diverse gender expression. The margination may be related to differences in religious involvement, records of past crimes, the presence of mental illness, or divergent political ideologies. The marginalized individual feels out of step with the greater society and experiences being an outsider (Bhui, 2012).

3. **Connection to extremists.**
   The individual seeks contact with extreme subcultures within their local community (Sinai, 2012) or through friends, family, lovers or a political event to learn more about the extremist movement (Gill, 2007; Schmid, 2013; McCauley & Moskalenko, 2008; Her Majesty's Government, 2011). There may be an interest in extremist narratives that manifest with an individual seeking information on the internet (Pressman, 2009; Weimann, 2006) or attending group meetings (Bhui, 2012). In some cases, the individual may travel abroad for more than six months and have contact with extremist networks (Horgan, 2008; Travis, 2008; Pressman, 2009).

4. **Affiliation seeking.**
   Here the individual has a strong desire to identify with a like-minded group (McCauley & Moskalenko, 2008; CEGEVR, 2008; Pressman, 2009). They are motivated by the experience of the group and the sense of community and solidarity that is offered (Her Majesty's Government, 2011). They may seek coalitions that share their viewpoint and strengthen their resolve to action. They seek supporters to their viewpoint, often within the peer/social group or through online connections. The individual seeks to find those that confirm existing beliefs and reinforce a villainized target (Van Brunt, 2012; Meloy & Hoffman, 2014; Randazzo & Plummer, 2009).

5. **Expressions of polarized thinking and ideology.**
   The underlying distinction between other types of violence and violent extremism or terrorism is the presence of a political, social, or religious ideology. When considering the element of risk associated with a radical ideology and the potential for movement to violence, the focus must be on the individual's willingness to engage in thinking that is different from their own as well as any underlying messages in the ideology that justify violent acts. Consider the example of religious ideologies. Religious doctrines that have an overly legalistic, orthodox, black/white view of the world can empower those seeking justification or a license to kill in the name of religion (Slootman & Tilley, 2006; Sinai, 2012). This doctrine or teaching is reductionist and limiting, referring to a singular concept of truth and encouraging trust for only those religious authorities who conform to their existing beliefs (Borum, 2011).

6. **Cognitive bleakness.**
   This occurs when the individual's thinking is full of dissatisfaction and disillusionment, wrought with anger, disenfranchisement and emotional vulnerability (Horgan, 2008; Goli & Rezaei, 2010). Depressive symptoms create sympathies for violent protests and terrorism. They are occupied with thoughts of disconnection, isolation and rejection of the values and society around them (Pressman, 2009; Horgan, 2008; Her Majesty's Government, 2011). They may struggle to feel connected to their social group, reject societal values, feel alienated and disengaged from others (Taarnby, 2005; CEGEVR, 2008), or they may feel caught and lost between cultural expectations or between generations (CEGEVR, 2008).

7. **Personal failures.**
   The individual's environment around them is in freefall. They experience a powerful loss or difficulty integrating with their community, school, work, primary support group and/or social circle. Examples include chronic unemployment, a financial crisis, death of a loved one, problems adjusting to a new life circumstance like a birth of a child in a perceived unjust world, dismissal from an academic program or internship, a sudden loss of a job, or a sense of blocked upward mobility based on their personal characteristics such as race, ethnicity, religious beliefs or appearance (Bhui, 2012; Schmid, 2013; Travis, 2008).

8. **Societal disengagement.**
   The individual begins to feel separated from larger societal values and experiences social or political frustrations. They distrust those in the established order and may have experienced a history of violence at the hands of an unjust authority in the past (CEGEVR, 2008; Pressman, 2009, Slootman & Tilley, 2006). In a society that they feel is endorsing negative attitudes toward religious or other groups, the individual actor's willingness to buy into state legitimacy is reduced (CAGE, 2016).

9. **Justification for violent action.**
   Prior to committing to violence, it is necessary for the individual to achieve a sense of peace and larger justification for their actions (Moghaddam, 2005). As with soldiers, there is period of moral disengagement and adherence to the mission where the enemy is depersonalized and dehumanized (O'Toole & Bowman, 2011; O'Toole, 2002; Van Brunt, 2012; 2015). There is often a pervasive sense of anger and frustration toward the target and a desire for revenge (Pressman, 2009).

10. Predisposing characteristics.
    There are several characteristics in the literature that are correlated with extremists. These include:
    a. easily manipulated, impressionable, a sense of low self-esteem (CEGEVR, 2008; Pressman, 2009);
    b. religious naivety (Travis, 2008);
    c. depressive symptoms (Bhui, 2016; Her Majesty's Government, 2011);
    d. early exposure to violence in the home or community, negative social backgrounds, military or paramilitary training at home (Pressman, 2009);

e. a serious criminal past, history of incarceration (Travis, 2008; Her Majesty's Government, 2011; Christman, 2012); and
f. thrill-seeking, chasing fantasies of glory (Sageman, 2008; Bhui, 2012).

Protective Factors (PF)

Protective Factors are those stabilizing, social or environmental supports that balance and gird the risk factors. These protective factors are reducing and mitigating the impact of risk factors. As with the risk factors, these protective factors are supported by research in radicalization, extremism and terrorism as well as lessons from previous attacks.

1. **Social connection.**
   A central protective factor involves the individual's connection to family, friends and community. These connections include positive experiences with social support and attachment to others, those who have positive attachments to the community and a sense of social bonds (BHUI, 2016; Pressman, 2009). There is support from a societal level of group belonging and integrated cultural respect and identity (Kurzman, 2011).

2. **Pluralistic inclusivity.**
   This phrase describes an individual who can balance various opposing viewpoints simultaneously. In many ways, this is a hallmark of an ideal college student experience – the ability to hold differing points of view without advancing to harmful debate or contentious argument (Sokolow, 2014). The individual has been exposed to positive experiences with counter-ideological narratives (Kurzman, 2011) through their primary support, community and societal influences.

3. **Non-violent outlets.**
   Individuals have access to non-violent outlets for expressing frustrations and resolving grievances (Bhui, 2012; Kurzman, 2011). This occurs in peer and family groups as well as within community and society. They have access to democratic means for negotiating how to meet their individual needs, explore options related to opportunities to improve their situation (social mobility), or to change a decision impacting them (Moghaddam, 2005).

4. **Social safety.**
   Here the individual has a sense of safety and security within their family, community and social structures (BHUI, 2012). They have family support toward non-violent action (Schanzer, Kurzman, Toliver, & Miller, 2016; Pressman, 2009) along with other significant peer support. They feel connected and able to have their voice heard in political action movements.

5. **Emotional stability.**
   This is the opposite of vulnerability and emotional instability. There is a psychological steadiness, wellbeing and constancy as well as sense of empathy and understanding of other's points of view (Pressman, 2009). They have the capacity to process cultural ideals in contrast to their personal beliefs and have a sense of self-esteem, empowerment and an integrated cultural identity (BHUI, 2012).

6. **Professional/academic engagement.**
   The individual is engaged in or has achieved professional, career or academic success. They are a part of these communities and possess a sense of connection, commitment and progress in their academic or professional lives (BHUI, 2012). They engage in critical thinking, have a sense of empowerment and engage in activism related to counter-violent ideologies (Schimd, 2013). They have a high sense of self-esteem and view their place in the professional and academic world on stable ground (Pressman, 2009).

7. **Global competence.**
   A sense of global competence implies an empathetic acceptance and tolerance to diverse viewpoints, religions and philosophies. This does not imply a commitment to these various perspectives, but rather an emphasis on equal and inclusive participation (Moghaddam, 2005). Individual's with a sense of global competence often have a multi-faceted and cohesive view of society (Kursmann, 2011) and a respect for the potential shifts in various ideologies over time (Pressman, 2009). They are willing to investigate the world and recognize the variety of perspectives that exist across cultures and religions (Jackson, 2017).

8. **Empathy.**
   The ability to empathize with other's perspectives stands against the dangers of objectification, dehumanization and depersonalization (Van Brunt, 2012; 2015a; O'Toole & Bowman, 2011; O'Toole, 2002; Turner & Gelles, 2003). Jackson (2017) writes, "Willingness of one group to harm another group often stems from a lack of accurate information about the other's history, cultural motivation and behavior" (p. 19). Empathy fosters a sense of community and perspective-taking that promotes understanding, tolerance and acceptance and leads to a shared sense of attainment, opportunity and positive prospects.

9. **Sense of Identity.**
   Here the individual has a well-defined sense of self (Higgins, 1994; Richardson, Neiger, Jensen & Kumpfer, 1990; Taylor & Wang, 2000; Christmann, 2012). They are progressing towards or have achieved a sense of self-actualization. They are morally engaged have a sense of critical decision-making (Kohlberg, 1973; Bandura, 1999). There is a cognitive resistance to extremist narratives, and they have acquired the skills needed to balance their doubts, and engage constructively in society without the need for violence (UNESCO, 2016).

10. **Consequence of actions.**
    The individual has a sense of moral engagement and awareness of how their choices result in positive or negative actions (UNESCO, 2016; Kohlberg, 1973; Bandura, 1999). They avoid negative action to avoid negative consequences for their social circle, primary support group, career and financial status.

Final Thoughts

Violence and threat assessment teams and evaluators need tools to better understand the risks associated with violent extremism. This paper identified some of these risk and protective factors associated with the movement from radical thoughts and perspectives to extremism and violence. Future research looking towards mobilization and catalyst factors such as direct threats, reactivity to others, escalation, suicidal commitment, access to lethal means, group pressure to act, narrowing on target, leakage of attack plans and evaporating protective inhibitors would be useful as well as the development of a scoring mechanism, or structured professional judgement tool, to better quantify the risk of an attack.

The intent of this research is not to create obstacles to progressive social movements, free speech, and activism and non-conventional ideas. In fact, the hope is that by understanding a more objective set of factors related to extremism, this can be a first step in identifying more appropriate prevention strategies and interventions for those at-risk for violence.

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Prevalence of Violence in Nursing practice in the Czech Republic - first survey

Paper

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Keywords: Violence, Nursing, Czech Republic, Prevalence, Communication.

Introduction

Violence in nursing care is a complicated and dangerous risk, especially for general nurses. The incidence of violence has been rising in the past few years. Out of all job groups, health care professions is the most likely to experience violence at work. It is not being addressed well enough in the Czech Republic. The issue is not transparent; there are no standard procedures, nor preventive measures. The causes of violence are diverse, influenced not only by the profession of the healthcare workers, but also by the type of violence, educational attainment (high school versus university) and last but not least previous experience with violence. When focusing on the occurrence of violence in health care regarding the type of wards, the largest incidence was identified for urgent admissions (Ferns, 2012), intensive care and emergency wards (Hahn, 2012). General nurses are the most common targets of violence. They are the ones most frequently in contact with the patients, in contrary to other health care providers. It is on this level the violent incidents are most frequent (Weinreb, 2014). Violence in healthcare is not solely perpetrated by the patients (or their relatives). There are situations when health care providers become violent towards patients (Hahn, 2010). Some health care providers can by their behaviour, become unsuitable or unprofessional, and provoke potential attackers to violence. The provider needs not be primarily misbehaving, however, due to insufficient knowledge of the diagnosis, wrong words or formulations or indeed his behaviour, he\she can evoke in the patient unpleasant feelings stemming from previous, unpleasant, experiences which can potentially lead to violence (Fluttert, 2007). Provocations from the health care provider can therefore often be unintentional (Bártlová *et al.*, 2010). Furthermore, the incidence of violent behaviour evokes strong feelings of danger which increases the probability of inadequate reaction (Dynáková, 2005). The main sources of violence during encounters between patients and providers is the environment (stress), people in connection to the process (their inability to control emotions in stressful situations) and the care itself (misunderstanding of the roles between the provider and the care recipient). Also, interconnection of individual impulses can provoke violence. Lastly, particular cases of violence are represented by organic causes where violence is an intrinsic part of an illness (epilepsy, hypoglycaemia, stroke, intoxication).

This paper brings research findings dealing with the issue of violence during mutual contact between patients and nurses in the Czech Republic. Its main aim is to map violence which appears during mutual contact between general nurses and patients. Secondary aims were to identify the most common problems in these situations, and to find possible solutions. The aims were tested by four hypotheses and met by one research question.

Methods and research samples

Mixed design - a combination of quantitative methods, qualitative in-depth interviews, and ex-post evaluation of teaching method - was used in this research. The quantitative sample included 896 respondents (500 general nurses, 92 doctors, 151 paramedics, 25 ambulance drivers, 60 physiotherapists, 18 safety workers and 50 auxiliary health care workers). In order to verify the hypothesis, contingent

tables with various degrees of freedom were used in combination with $\chi 2$ test– for independence. Qualitative research was based on ten in-depth interviews with nurses (from various departments including outpatient care and emergency pre-hospital care) who had experienced a violent incident. Interviews were analysed by coding according to Glaser and Strauss's Grounded theory. Unlike quantitative research, in-depth interviews were carried out on a smaller sample of respondents. Originally, 50 interviews were carried out, although as some attributes were being repeated, only 10 interviews were chosen to show the most important aspects. Ex-post evaluation included evaluation of practical training of 550 non-medical health care workers (general nurses, porters, auxiliary workers) in 14 workshops that were organized during 11 months. The total number of non-medical health care workers in the project was 550. After 12 months, 239 questionnaires were returned, a 42% response rate.

Results

From the total amount (896 respondents) involved in the research, 641 respondents (71.5%) had experienced verbal abuse during the last 12 months and 165 respondents (18.4%) had experienced physical violence. Only 90 respondents (10%) had not experienced any violence within the last 12 months. Out of the 806 respondents that had experienced violence, 638 were women (79.1%) and 68 men (7.9%). Based on statistical testing (independence $\chi 2$ test) we tried to find out ($p = 0.005$), if more women than men working in healthcare were subjected to violence in the CR. This hypothesis was not confirmed. Regarding the most frequent occurrence of violence in a healthcare profession, general nurses were the most exposed (physical violence 53.3% and verbal abuse 60.2%). Further, detailed research has revealed that high school educated nurses are more often subjected to violence than university educated nurses ($p = 0.005$).

As our qualitative study shows, the behaviour of the providers is more significant than the type of ward they are working in, as violence can generally occur anywhere regardless the type of patient ward. The aim of this qualitative study was verification that general nurses indeed can contribute to the occurrence of violence by their behaviour. This hypothesis was confirmed. The behaviour of health care providers has been shown as the most significant factor influencing the prevention of conflicts and potentially violent situations. Each failure, whether or not from the side of the professionals, is justifiable on two sides, both the side of the patient and the often exhausted provider. Health care personnel are not machines and they are entitled to emotions.

In 2010 the project of Czech-Moravian confederation of trade unions and Health care and social services trade union of CR showed that 60% work providers introduced steps preventing violence at their facilities. It was however also concluded that measures such as adjustment of working environment, development of human resources, increase in personnel or education in communication skills are still very much lacking. Most respondents thus answered that the greatest reason for violence is not overworking but insufficient communication (Pekara, Trešlová, 2011). The fatigue of the personnel is mirrored in the satisfaction of the patients (Lanctôt and Guay, 2014) monitored also by questionnaires conducted by Healthcare ministry of CR. Their results show that patients in Czech hospitals have an array of reservations to the behaviour of doctors. Particularly, patients mind the lack of privacy while going through their health status, the fact that the doctors do not introduce themselves and they do not give their patients enough attention (Vašek, 2007). Research during the last 20 years has shown a positive impact of education and training in communication skills for health care providers. Similarly focused seminars have significant results and health care providers themselves describe them as beneficial (Brown and Bylund, 2008). It can be concluded from the above that the most interesting information regarding prevention is the fact that violence is closely connected to communication between professionals and patients. However, most projects aimed at communication in CR is designed as a one-day course without a follow-up or feedback and the demanding profession makes reading books, even interesting ones next to impossible.

In relation to the last part of the research (ex post evaluation of the efficiency of own teaching method) practical re-schooling was conducted through 14 seminars during 11 months. Each seminar fitted the maximum of 40 heath care professionals and lasted 120 minutes. Among the used didactic methods were exchanging knowledge through experiences, real situations - case studies, reflexions and problem solving. The seminars were designed to enable the participants to follow up – no longer with our help – by practicing the recommended techniques at work. After twelve months, 239 completed questionnaires were returned (response rate: 42%). Our verified group was comprised 210 general nurses (87.9%) and 29 (12.1%) auxiliary health workers (scrub nurses, care takers) with 92% women and 8% men. The respondents found the greatest benefit in development of their communication skills in contact with violent patients, practical examples of de-escalation and simple defensive moves when encountering physical violence. Didactics communication techniques (that were particularly emphasised) were evaluated by 237 respondents as appropriate (99.2%), the respondents classed the methods and models of communication techniques as suitable for understanding the given issues. The respondents evaluated positively practical examples, well-chosen model situations (31.8%), the interactive approach (9.2%), the use of humour as a relaxation aid in conflict situations (3.8%). 217 respondents (90.8%) were satisfied with the time span of the seminars (120 minutes). Key information was the way the respondents were able to use their communication skills during encounters with patients during the last 12 months. 121 respondents (50.6%) used their new skills successfully in practice (particularly respondents aged 55-64). 23 respondents (9.6%) tried unsuccessfully to use the techniques and 95 respondents (39.7%) did not get the opportunity to try and solve a conflict. The respondents (only 144 that had used the learned skills answered) did so most often in everyday situations dealing with clients (44 respondents; 30.6%), managing aggressive patients (28 respondents;19.4%), 23 respondents (16%) in order to justify long waiting hours, 23 respondents (16%) during non-communication from the other party, 10 respondents (6.9%) used assertive communication techniques, 8 respondents (5.6%) helped themselves to better self-confidence by the newly learned approach and 8 respondents (5.6%) applied the techniques while dealing with patients in distress. Despite an initial failure to use de-escalation techniques in a small number of respondents, 170 (71.1%) are planning to proceed in using the techniques in the future. We have therefore shown that communication techniques can be taught to health care professionals in relatively short time period. The output of this effort is a bespoke education model for teaching communication skills for prevention of violence - health care professionals can practice their communication skills automatically when in contact with a violent patient or his relatives in real life situations.

Conclusion

Based on the reported results we can conclude that violence in health care concerns general nurses in particular. The consequences fall on health care workers irrespective of gender, mostly in the form of physical violence. The highest incidence was found for general nurses with high school education compared with university educated nurses. Besides education, another significant protective factor is communication. We have shown that it is possible to educate health care providers by a short seminar with significant results – nurses could by themselves after a year from participating in the seminar, practice their communication skills at work. The behaviour of the professionals remains a significant factor despite the learned preventive methods that can unnecessarily foment violence. Regarding corrective and preventive measures, we recommend examples of good practice. Much has been written on violence in healthcare. However, CR is still only touching the surface of the subject. With the knowledge now gained, we are standing before a new challenge. It is time to stop dealing with the problem as such and start instead to look for ways to solve individual problems by taking constructive measures – to try to find individuals capable of deescalating even very unruly, violent individuals and thus work towards a positive trend and show a good example. Prevention and an illustrative example are always better than finding consequential solutions. The results of qualitative and quantitative research have also shown a lack of reporting of violent situations and poor support from the management of health care facilities.

The main recommendation for the practice is to educate future health care workers efficiently and at all levels of the educational system. It is necessary to implement compulsory reporting and active support by the management of health care facilities. It is also necessary to use the power of media and strive for violence prevention through professional literature and model case studies. It is important to actively find individuals who have not experienced violence during their long professional careers and use them as model examples for both students and workers in practice. Only engaging real scenarios and using simulation in education can show nurses the reality of a violent situation which will always be burdened with large amount of stress.

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The relationship between treatment progression and violence risk reduction over a 3 year period in a cohort of forensic mental health patients

Paper

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Keywords: Violence risk assessment, Treatment progression, Dundrum Toolkit, HCR-20, structured professional judgement, recovery, progress

Abstract

Introduction:

The truest form of progression within forensic mental health is the movement of a patient from a higher secure environment to a lower secure environment or to the community. Furthermore, there are many clinical factors that may be considered by multidisciplinary teams in making clinical judgements about moving a patient to a lesser secure environment. For instance, structured professional judgement tools that measure violence risk (HCR-20) and treatment progression (DUNDRUM Toolkit) are now widely used to contribute to clinical decisions in forensic mental health.Previous research has shown that both of these instruments independently predict moves to lesser secure settings and conditional discharge from hospital to the community. However, little research has shown how treatment progression relates directly to violence risk over time. Therefore this study aims to determine if treatment progression (DUNDRUM Toolkit) predicts reduction in violence risk (HCR-20) over a 3 year period in a cohort of forensic mental health patients.

Methods

Data were collected with 66 forensic mental health patients. Both the HCR-20 and DUNDRUM 3 were completed by multidisciplinary teams as part of usual treatment in 2012 and 2015. Multiple regression was used to determine associations between change in treatment progression scores (DUNDRUM Toolkit) and change in violence risk scores (HCR-20) over a 3 year period, whilst controlling for baseline scores on the DUNDRUM Toolkit and HCR-20 in 2012.

Results

Treatment progression predicted reduction in violence risk over a 3 year period F (3,63)= 21.45, p

Conclusion

Progression of treatment within the framework of the DUNDRUM toolkit may be important in reducing risk of violence.

Educational Goals

- To develop a greater understanding about the use of structuered professional judgement tools and their influence on making clinical judgements.
- To explain associations between treatment progression and violence risk reduction.

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Aggressive behaviour presented by patients voluntarily and involuntarily hospitalized in Psychiatry: 1-year retrospective comparative study

Poster

Rosaria Di Lorenzo, Paola Ferri, Laura Vecchi & Cecilia Artoni (Italy)

Keywords: Aggressive behaviour, patients voluntarily and involuntarily hospitalized, Italian acute psychiatric ward

Abstract

In Italy, involuntary hospitalizations are regulated by Law 180 of 13 May 1978 (later included in Law 833 of 23 December 1978) that establishes the following 3 criteria: 1) acute psychiatric conditions which require urgent treatment, 2) refusal of treatment clearly expressed by patients capable of consent, 3) treatment required is necessary, unavoidable and cannot be given in outpatient services. The same Law established the definitive closure of psychiatric hospitals and the opening of new acute psychiatric 15-bed wards, so-called Service of Psychiatric Diagnosis and Treatment (SPDT), located in a General Hospital, which cater for patients with acute mental disorders requiring voluntary and involuntary hospitalizations.

The purpose of this study was to analyse the variables associated with patients who require compulsory treatment in order to highlight the risk factors for this compulsory treatment.

We retrospectively collected all hospitalizations in the SPDT of a northern Italian town (catchment areas of 520,000 inhabitants) from 1-1-2015 to 31-12-2015. We collected demographic and clinical variables related to voluntary and involuntary patients and their hospitalizations. We statistically analysed the comparisons between them.

We divided our sample, composed of 396 patients, into voluntary (VP=236) and involuntary (IP=160) patients according to the regimen of their hospitalizations: voluntary (n=304) and involuntary (n=197). We found that our IP were statistically significantly different from VP for mean age (IP were 43.73 years old on average vs. 38.9 for VP, t=-3.32, p=0.001), family and home environment (IP more frequently "lived alone", Pearson chi2=43.24, p=.000) and work activity (IP more frequently worked or were retired, Pearson chi2=37.07, p=0.000). The reason for involuntary hospitalizations more frequently was "acute psychopathology imbalance" whereas the reason for voluntary hospitalizations was "suicidality" (Pearson chi2=32.93, p=0.000). The mean duration of IP hospitalizations (13.32 days on average) was longer than others (8.82 days on average, t=-2.99, p=0.002) and the diagnosis at discharge more frequently was "schizophrenia and other psychosis" followed by "manic episode" (Pearson chi2 =52, p=0.000). IP more often presented aggressive behaviour, both mild (verbal) and severe (needed to be controlled and contained by professionals) during their hospitalizations (Pearson chi2=26.64, p=0.000). At discharge, IP were more frequently sent to another psychiatric ward and/or facility (Pearson chi2= 14.81, p=0.000) with a long-acting anti-psychotic therapy (Pearson chi2=49.17, p=0.000).

Our results highlight that patients who required compulsory treatments were affected by the most severe psychiatric disorders with social maladjustment, needing complex therapeutic and rehabilitative

strategies in order to counteract aggressive behaviour, poor therapeutic compliance and prolonged hospitalizations.

Educational Goals

- In a psychiatric ward, aggressive behaviour is related to the severity of illness.
- Complex health care strategies are necessary to counteract the regression behaviour induced by severe psychiatric disorders

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Co-production with staff, service users and carers to develop post-incident support after incidents of violence

Paper

Brian Littlechild, Tony Storton & Andrew Cashmore (UK)

Keywords: Mental health, violence, aggression, service user and staff support, co-production

Introduction

This paper is based on work being undertaken in the UK's Hertfordshire Partnership NHS Foundation Trust (HPFT) in collaboration with staff, service users and carers to develop policies and practices which best support the needs of each of these groups when there have been incidents of violence, addressing how service users and carers might best be included in policy and practice development (e.g. Littlechild and Hawley, 2009).

Violence and aggression was found by the National Institute for Health and Care Excellence (NIHCE, 2015) to be relatively common and to have serious occurrences in health and social care settings (NICE 2015). The 2015 NIHCE guideline found that *"the manifestations of violence and aggression depends on a combination of intrinsic factors, such as personality characteristics and intense mental distress, and extrinsic factors, such as the attitudes and behaviours of surrounding staff and service users, the physical setting and any restrictions that limit the service user's freedom"*. It also concluded that the impact of violence and aggression is significant and multi-facetted, *"adversely affect(ing) the health and safety of the service user, other service users in the vicinity, carers and staff"* (NIHCE, 2015).

Renwick *et al.* (2016) states that violence within UK mental health trust has both an impact psychologically and physically for all involved, reflecting that 40% of inpatients show aggression during admission, the highest reported in Europe.

Holmes *et al.* (2012) concluded that the consequences of workplace violence in the health care sector are far–reaching, including how the service user and the service user's network, e.g. partners, family members or the wider patient group, may be affected.

Stenhouse argues that research for service users is limited, which highlights a challenge from all perspectives (Stenhouse, 2011). Despite the evidence of the experience affecting both service users and staff, there appears to be much less work published on issues and support services for service users, a key focus of this chapter.

Aims of the project

The project described here is based on the 2015 NIHCE Guideline, where HPFT is developing a co-produced strategy for post-incident support after incidents of violence by use of a 360-degree review of experiences and support needs of all who have been involved. This is taking place following a review of the relevant literature, and ongoing consultation with service users, carers and staff in order to formulate a plan to co-produce policies and procedures.

The aim of post incident support for service users is to respond to the needs of those impacted upon by events relating to restraint or assault. This approach aims to cover three areas:

1. A co-produced approach based on the involvement and views of experts by experience
2. To develop an approach that relates to Trust values which reflect an approach which is: Welcoming, Kind, Positive, Respectful and Professional
3. To develop a method that allows those involved in supporting service users to use a shared approach of reviewing and revisiting 'traumatic events' in a consistent manner, with a range of options.

Such co-production of services is not only recommended by the NIHCE guideline, but also in UK government health bodies' policies. NHS England, the main government body for setting policy overall for the UK government, set out in 2016 how co-production is now acknowledged as a key issue for mental health agencies: *"Services must be designed in partnership with people who have mental health problems and with carers"*. (NHS England, Mental Health Taskforce, 2016:20).

The project's approach considers varying stages based on presenting / requested needs so that events are responded to in terms of basic welfare needs, and that the process is kind and directed towards support.

Musket *et al.* (2014) advocates the principles of trauma-informed care, generating caring organisations, where patients/service users are connected, valued, well informed and included, reflecting the suggested approach being proposed in the project.

As an outcome of conflict, Cockerton (2015) reports the risk of restrictive interventions that can relate to physical harm, which combined with the trauma history for some people as having an impact on the dignity on all those involved. For restrictive practices, this has been shown to cause compromise, with nurses describing feelings of conflict, anxiety and distress (Bigwood and Crowe, 2008). A value based approach of support, which is co-produced and reviewed in context to re-visiting events that may traumatise further is therefore suggested.

Options considered in the project are how best to provide:

a. Information
b. Key support
c. Review of support plans (where relevant)
d. When jointly agreed, external post incident support
e. Further options, to include development for future restorative justice

Key issues in developing effective plans for supporting service users, carers and staff

Holmes and colleagues (2012) concluded that the consequences of workplace violence for staff were far-reaching and included absenteeism related to illness, injury and disability, staff turnover, decreased productivity, decreased satisfaction at work, and decreased staff commitment to work. A similar review of the psychological impact of violence found by previous research reported that the 3 most common responses to injury were anger, fear and guilt (Needham *et al.*, 2005). Thus, incidences of violence and aggression may also affect the perception by staff of services and service users in a manner that has a strong negative impact on service users and carers on the overall experience of care (De Benedictis *et al.*, 2011). Clarke *et al.* (2010) suggest fear of aggressive behaviour or violence from service users may impact on the quality of the care provided. As such a process of insight, reflection or review is required as a constant.

Experts by experience perspectives

Initial exploration of the key issues from experts by experience perspectives in HPFT suggests that a more proactive, preventative approach is required for a reduction in violent incidents by service users leading to restrictive intervention, by medication or physical restraint; and avoiding abusive

practices and minimising trauma to service users and staff, thereby humanizing service users' experiences particularly during episodes of acute illness. Part of the aims of the project are to address prevention of any possible human rights abuses; minimization of isolation and distress; improvement of communication between service providers and service users; and promotion of attitudinal changes which reflect respect for other people's dignity (Mayers et al, 2010).

Service users report to peer experience listeners inadequate communication between themselves and service providers, and perceive that their human rights had been infringed during acute episodes of illness. Service users have often reported that increased communication with staff could have prevented restraint.

Service users have described having had various negative emotional states and responses during restraint events, including fear and rejection, and not as a therapeutic intervention. Sedation was considered to be least distressing. Observing methods of forced/involuntary containment caused further distress. Service users reported feeling sad and angry, whereas staff mentioned feeling anxious. It was concluded that debriefing sessions with service users and staff may help minimize negative consequences (Merineau-Cote and Morin, 2014).

The project

The project team is looking at developing a full 360 degree review of incidents to involve experts by experience, e.g. by use of peer experience listeners, to include the staff involved in the restraint, service users witnessing the restraint, and offering counselling. This involves service users and staff in collaborating to develop plans of care, identifying unique triggers and comfort measures, and possibly involving the use of advance decisions or advance statements, with the aim of preventing the need for restrictive intervention in the future and reduce the incidence of violence and aggression.

The NIHCE Guidance expects that there is dialogue with service users about the reviews of and interventions to deal with this matter, and their preferences about this for them, to help them to reach fully informed decisions about these plans. This should not only be a key feature/goal of any effective set of responses to violence and aggression, but also that any policies/procedures need to take into account what might prevent such effective processes taking place, and how to facilitate this aim of including service users and carers fully in the aftermath of and forward planning for such aggression and violence. It is this emphasis on service user and carer involvement in policy development and review that underpins the project set out here.

The team are examining the use of the involvement of service user trainers who have experience of being physically restrained in acute mental health settings in training courses in physical restraint for mental health professionals. A study by Obi-Udeaja *et al.* found that service user involvement has boosted the quality of physical intervention training by adding realism to it (Obi-Udeaja, et al, 2010).

It is also examining how valuable debriefs are, particularly when documented, for gathering information about mental health inpatient experiences of restraint, and can be used to re-establish the therapeutic relationship and to inform plans of care (Ling et al, 2015). Where restrictive interventions take place, post incident actions should address not only trigger factors from the perspectives of all, but also environmental factors likely to increase or decrease the need for restrictive interventions, and involve and empower service users and their carers, including post-incident debrief and review.

The NIHCE guideline in section 1.1, recommends that to improve the service user experience/inclusion, staff and agencies should:

- work in partnership with service users and their carers
- adopt approaches to care that respect service users' independence, choice and human rights, and as part of this, if willing and capable, that service users and carers are involved in decision-making whenever possible.

In addition, service users and carers should be involved in adjustments to services, e.g. provision of particular types of support, modifying the way services are delivered, any environmental factors, the approach to interactions with the service user, or making changes to facilities. These deliberations and decisions should then be recorded, as agreed between the service user, the carer where appropriate, and staff in the service user's care plans and care notes.

The Guideline recommends that:

"The results from such reviews with the service user and carer where appropriate, should lead to a risk assessment and risk management plan, which may need to be shared with other circumstances of the client, the carer and the agency.", which should evaluate the physical and emotional impact on everyone involved, including witnesses; help service users and staff to identify what led to the incident and what could have been done differently (this could be done by way of a critical incident analysis, for example). Such reviews/assessments should determine whether alternatives, including less restrictive interventions, were discussed; determine whether service delivery issues make it difficult to avoid the same course of actions in future; potentially recommend changes to the service's philosophy, policies, care environment, treatment approaches, staff education and training; and try to avoid a similar incident happening in future.

It is recommended that a service user experience monitoring unit or equivalent service user group should be involved in carrying out such reviews, and give a report to the agency/setting that is based on a formal external post-incident review. The learning from such processes should not only be for individual service users/staff/teams, but also for the organisation as a whole, to report and analyse data on violence and aggression and the use of restrictive interventions.

These recommendations about service user involvement at a high level are welcome, but we do need to take into account our knowledge of the difficulties of including service users and carers.

The importance of service user inclusion is essential to understand this perspective, which emphasises the need for a co-produced approach in evaluating any approach for post incident support.

Therefore, a key area of concern is how we empower service users and carers to the greatest possible to participate in these ways, and how we might judge the effectiveness of this.

Arnstein (1969) developed a widely quoted model of a ladder of citizen participation, and whilst there are some criticisms that this model is too hierarchical and that there are other issues more to take into account (see e.g. Tritter and McCallum, 2006), it is valuable as a way to gauge levels of participation, with at the highest (best) rung of the ladder level experts by experience leading from the outset, to at the bottom rung (worst) where there is lip service is given to the inclusion or manipulation of experts by experience solely to give the impression that experts by experience coproduction has taken place. Ocloo and Matthews argue that progress to achieve greater involvement in health services is patchy, slow and often concentrated at the lowest levels of involvement of the Arnstein ladder (Ocloo and Matthews, 2015).

Conclusion

The relevant research and NIHCE evidence-based guidance recommends involving service users in all decisions about their care and treatment, and the development of care and risk management plans jointly with service users and/or their carers; checking whether service users have made advance decisions or advance statements about the use of restrictive interventions, and if not, discussing this with them so that they can make an informed choice about how such matters are dealt with if the need arises.

In this project, we are attempting to work up our co-production at the highest end of the ladder, including policy and practice development and review, and 360% review of all involved- staff, service users, carers- of their views of the causes, and effects of the incident, and subsequent recording, in order identify the trigger factors for that service user and staff attitudes and responses can be taken into account in future by workers, including by way of jointly produced advance decisions.

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Post incident debriefing: A must, should or could ?

Paper

Rosalyn Mloyi (UK)

Keywords: Restrictive Practice, Debrief

Abstract

Following extensive media coverage of Winterbourne View's use and misuse of restrictive interventions which the organisation's leaders were unaware of and failed to govern (DoH, 2010); there have been numerous statutory and national publications with guidance aimed at reducing these practices. Responsibility for this is placed squarely on organisation leaders' shoulders calling for the need for more robust governance structures. Among a number of reduction strategies, they all point to the importance of post incident debrief (DoH, 2012; RCN, 2014; DoH, 2014, 2015, NICE 2015).

Many organisations such as health & social care, the police, emergency responders, banks, etc. offer debriefing as part of an organisational response to incidents in a bid to reduce psychological distress and exposure to subsequent litigation. In some instances, such interventions are compulsory (Wessely and Deahl, 2003). In health & social care, a number of studies show debriefing as being one of a number strategies that when used in combination can successfully reduce restraint and seclusion (Huckshorn, 2004; Azeem *et al.*, 2011; LeBel, Huckshorn & Caldwell, 2010; Lewis et al, 2009) however, despite the intuitive, professional, moral, ethical and cultural soundness and the theoretical grounding of post incident debrief, its effectiveness is far from clear (Raphael and Wilson, 2000). Conflicting research shows that there are widely varying attitudes and opinions about its efficacy. The use of debrief as currently used is complicated, fraught with difficulties and needs to change.

To aid discussion and analysis 'critical incident' and 'debriefing' need to be understood. A critical incident is an event that has enough emotional power to overcome the usual coping abilities of an individual, is traumatic, unexpected, a serious threat to well-being, contains an element of loss and involves disruption of that individual's values or assumptions about their environment (Mitchell and Bray 1990; Nielsen 1986 cited by Kurke & Scrivner,1995). It is defined by the impact it has on the individual rather than event (Gentz 1990 cited by Kurke & Scrivner, 1995). In a context specific to violence reduction, according to Sutton *et al.* (2014); debriefing involves the facilitation of purposeful conversations with staff and services users involved in an incident in order to review the event and develop strategies to avoid it reoccurring. Other agencies such as the police state that they use debriefing to alleviate the painful effects of the incident, prevent subsequent development of PTSD and restore the individual to their pre-incident level of functioning as soon as possible (Sutton *et al.*, 2014). These aims although not specified in the definition above are part of the debriefing process in mental health services.

Currently and historically, there are very strong drivers for debriefing some of which are included in legislation such as the Mental Health Act Code of Practice (MHA CoP) (2015) which states that after any incident of disturbed behavior that has led to the use of restrictive interventions, a debrief should be undertaken so that all parties involved are supported and there is opportunity for organisational learning. This legal imperative has made debriefing part of sector guidance thus this is echoed by other publications (RCN, 2014; DoH, 2014; NICE, 2015). Violence reduction models such as the 6 Core Strategies (Huckshorn, 2005), the checklist for organizational readiness to reduce restraint and seclusion (Colton, 2004) and the Irish strategy for reducing seclusion and restraint (Mental Health Commission, 2014) also advocate for it. CHC's own policy for promoting safer and therapeutic services follows suit. The practice is therefore an expectation and is now so enshrined in our practice that it

has become seen a task done as a matter of course following incidents. Despite this however, recent research has highlighted that service user debriefing is not routinely offered and approaches to the intervention are inconsistent, with a lack of clarity as to its primary function, what it consists of, when it should be delivered and who should deliver it (Bonner *et al.*, 2002; Needham & Sands, 2010; Ryan & Happell, 2009). It must be noted however that the MHA CoP says debrief "should" happen rather than "must" meaning that there are accepted justified exceptions. The misunderstanding of these 2 words has unfortunately caused some organisations to require that everyone undergoes debrief for fear of consequences such as unfavourable reports from CQC inspections and service commissioners. There is a need to change perceptions and systems to allow for improved clinical practice before organisations can profess to have discharged their responsibilities.

Interestingly, despite the strong drive for debrief, there is limited evidence on its effectiveness (Sutton *et al.*, 2014; Raphael & Wilson, 2014; Wessely and Deahl, 2003; Rose *et al.*, 2012). There are very few studies on its positive impact and most do not use control groups. Comparison of these studies is made more difficult by that different groups are studied using various measures and timescales across a diversity of unspecified interventions and techniques with little information on how the debriefs were conducted or the skill level of the people facilitating them (Raphael & Wilson, 2000). Most studies without control groups show that debrief is effective (Raphael *et al.* 1983, Stallard and Law, 1993, Chemtob *et al.* 1997, Mitchell and Bray, 1990 cited by Raphael & Wilson, 2000) while those that do use control groups show either no effect or worryingly, a negative impact. Hytten & Hassle (1989) found that fire fighters who were debriefed scored the same on the Impact of Events Scal e (IES) as those who had talked informally amongst themselves while a study by Griffiths & Watts (1992) showed that debriefed bus accident workers had higher IES scores than the control group who were not debriefed. Calier *et al.* (1994) found that police officers who were debriefed showed more PTSD symptoms while Bisson *et al.* (1997) also found that burns victims who had been debriefed were more anxious and depressed 13 months after that and had 3 times more the PTSD rate.

In summary, having reviewed relevant evidence what is now clear is that it is time to urgently change how we respond to trauma in order to reduce violence and aggression. The culture of compulsory and/ or single session psychological debriefing that aims to support victims and learn lessons all at the same time should cease. Although intuitively appealing and a response to perceived need, demonstrating its effectiveness has proved difficult. Individuals should not 'debriefed' but instead be offered immediate practical, social and emotional support; trauma focused therapy should be offered if the period of watchful waiting shows them to be symptomatic. At the very least those who are asked to take part in debriefing must warned that it could do harm as well as good and make an informed decision about engaging in it; any health care intervention always has the capacity to do harm as well as good. A post incident review from an organisational learning point a view is very important but very different to post incident support for those involved thus changes need to be made in order for these to viewed and treated these separately. Current systems are set to hit 2 birds with one stone and do not do a good job in either case. New systems need to be put in place to make the change, monitor and evaluate it and give feedback to all. Special attention needs to be given to the change in culture; changing an entrenched culture is the toughest of all organisational management tasks (Murray, 2010).

This presentation examines relevant literature relating to how organisations discharge their responsibility with regards to reducing violence and aggression using post incident debrief and the practice implications within general adult mental health services. It takes into account current drivers, practices and monitoring and evaluation.

Educational Goals

- Delegates are to understand the importance of debrief in Reducing Restrictive Practice

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Aggression and violence towards health care workers in a Psychiatric Department in Italy

Poster

Jacopo Vittoriano Bizzarri, Daria Piacentino, Sabine Moser & Andreas Conca (Italy)

Keywords: Aggression, violence, health care workers, psychiatric department

Abstract

Background: violence at work is one of the major concerns in health care activities. Although prevention programs have been conducted to deal with violence towards health care workers, in Italy activities of research and implementation of practical intervention programs are still scanty. The Department of Psychiatry of Bolzano-Bozeb (Italy) adopted a de-escalation model developed by the Institut für Professionelles Deeskalations-Management (ProDeMa®). This model includes interventions of evaluation, prevention, as well as theoretical and practical trainings aimed to prevent or reduce patients' aggressive behaviours towards health care workers.

Aims: the aim was to investigate whether the frequency of verbal and physical aggressions and injuries differed among health care professionals in different psychiatric settings, i.e., inpatient (INP) unit, outpatient (OUTP) unit, rehabilitation (REHAB) facility. Moreover, possible risk and protective factors for violence and aggression (e.g., gender, age, work experience, specific trainings, behavioral patterns) were analysed.

Methods: a retrospective questionnaire-based survey on workplace aggression was conducted at the Department of Psychiatry of Bolzano-Bozen. A sample of 211 health professionals, including psychiatrists, psychologists, nurses, social workers, and clerks, were interviewed by using the 11-item ProDeMa® questionnaire. Parametric statistics was used to compare variables.

Results: a total of 165 out of 211 surveyed workers (20.7% working at the INP, 37.2% at the OUTP, and 42.1% at the REHAB) completed the questionnaire (response rate=77.7%). The participants were mostly females (64.6%) with a mean age±standard deviation (SD)=44.9±7.7. The survey assessed frequencies and types of aggressions, and situations and behaviours that could produce or prevent the aggressions. The one-year total number of verbal aggressions (VAs) was 9766, with 35.2% (mean number±SD=13.3±27.8 per worker) at the INP, 26.1% (mean number±SD=6.2±30.6 per worker) at the OUTP, and 38.1% (mean number±SD=8±26.8 per worker) at the REHAB. The one-year total number of physical aggressions (PAs) was 1502, with 88.7% (mean number±SD=3.3±12.2 per worker) at the INP, 4.1% at the OUTP (mean number±SD=0.1±0.5 per worker) and 7.2% (mean number±SD=0.1±0.2 per worker) at the REHAB, respectively. Finally, the one-year total number of injuries (INs) was 200, with 80% (mean number±SD=0.5±1.8 per work er) at the INP, 14% (mean number±SD=0±0.5per worker) at the OUTP and 7% (mean number±SD=0±0.2 per worker) at the REHAB. Chi-squared test showed no significant differences in terms of sociodemographic features among INP, OUTP, and REHAB employees. ANOVA showed significant differences in terms of mean VAs, PAs, and INs, among the three workplaces (p-values=0.000), with post-hoc Tukey test showing higher frequency of physical aggressions and injuries at INP. Conclusions Based on our data, VAs are common at all our Department units, whereas PAs and INs are more frequent at INP. Our project of de-escalation management in psychiatric care is still in progress. After the survey, a theoretical/practical training for all psychiatric professionals

Educational Goals

1. Participants will have an understanding of the frequencies and types of aggressions and of the situations and behaviours that could produce or prevent the aggressions at work place during a year in a Psychiatric Department in Italy.
2. Participants will have a basic understanding of the theoretical and practical training for all psychiatric professionals that we are implementing in our Psychiatric Department to prevent or reduce aggressive behaviours of patients.

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Can alternative risk factors or indicators improve existing methods of violence risk assessment?

Workshop

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Keywords: self-perceived risk, self-reported risk, HDL, cholesterol, biological risk factors, bio-psychosocial

Introduction

Traditionally, the assessment of violence risk among psychiatric patients and risk assessment instruments, such as the HCR-20, VRAG and the V-RISK-10, has been based on psychosocial and criminological factors. Despite continuous development and improvement of these instruments the predictive values did not seem to improve over time, and it has been suggested a "glass-ceiling effect" of the instruments (Coid *et al.*, 2011). A possible contribution to this effect could be that important alternative risk factors outside the psychosocial / criminological field had not yet been identified, and that the possibility of such risk factors should be explored (Singh, Serper, Reinharth, & Fazel, 2011). Another aspect of the ceiling effect is that good risk assessment and management could prevent violence and turn a true positive into a false positive, and thereby reduce the predictive validity.

In this workshop at the Dublin conference two studies on alternative risk factors will be presented. Both studies were part of a larger prospective observational project on risk assessment in Oslo University Hospital. The design was an observational prospective inpatient- and post-discharge study in a naturalistic setting. Target population in the project was all acutely admitted patients in a psychiatric emergency hospital during one year (N=558). Baseline measures of (i) patients' risk statements and (ii) cholesterol levels at admission, were compared with recorded violence during hospital stay and after discharge. The research was approved by the Regional Committee for Medical and Health Research Ethics.

(i) Self-report Risk Scale (SRS).

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Patient's self-perceptions have rarely been emphasized as useful to violence risk assessments. Few studies have been conducted on this topic (J. O Roaldset & Bjørkly, 2010; Skeem, Manchak, Lidz, & Mulvey, 2013). One of these used a "Self-report Risk Scale" (SRS) (Roaldset, 2010). The SRS is a self-report scale were patients are asked to choose one of the six respond options to express their risk estimate; *no risk* (will definitely not happen), *low risk* (will hardly happen), *moderate risk* (limited to certain situations), *high risk* (in many situations), *don't know the risk, or will not answer about the risk*.

The main objective was to investigate whether patients own violence risk assessment can contribute to violence risk assessments in acute psychiatric settings (Lockertsen et al, submitted International Journal of Mental Health Nursing). The amount of patients reporting *no risk* was 63.1 %, while 16.8 % reported *low risk*. Very few patients reported increased risk of violence. One percent reported *moderate risk*, while only 0.4 % reported *high risk*, 8.6 % reported *don't know*, and 10.2 % of the patients refused to answer *(would not answer about the risk)*.

Univariate logistic regression was conducted for SRS as an ordinal variable; (0) *no risk*, (1) *low risk* (OR = 1,90, 95% CI= ,96-3,97, p=0,066), (2) *moderate- + high risk + don't know + won't answer* (OR = 5,48, 95% CI= 3,16-9,50, p=<0,001). Based on the results the SRS can be transformed into a dichotomous variable where *low risk* is either treated as reference, OR = 4,65, 95% CI = 2.79-7.74, p<0,001, or as a risk predictor, OR = 3,61, 95 % CI = 2,20-5,92, p<0,001.

The results indicate that SRS can be an additional factor to violence risk assessments in acute psychiatric settings, and it can easily be implemented for daily use in acute psychiatric units.

(ii) Cholesterol levels

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Low level of cholesterol might be a risk marker of violence, but prospective studies are scarce. In this one year research project from an acute psychiatric ward we investigated (i) low levels of total cholesterol (TC) and high density lipoprotein cholesterol (HDL) as potential risk markers of violence (Eriksen *et al.*, 2016), and (ii) HDL as a supplement to a psychosocial screening tool for violence risk as part of a study on a biopsychosocial model of violence risk assessments. There was also a focus on possible gender differences.

Total cholesterol (TC) and high-density lipoprotein cholesterol (HDL) were recorded at admission, Violence risk screening 10 (V-RISK-10) were recorded at admission and discharge. Violent behavior was recorded during hospital stay and three months post-discharge. In the first study, HDL was a significant risk marker of violence in the inpatient sample (n=362), OR = 0.52, 95% CI = 0.28-1.0, p = 0.049. For men (n=46), but not women (n = 53), HDL was also a significant risk marker of violence post-discharge, OR = 0.1, 95% CI = 0.010-0.95, p = 0.045. There was no significant association between total cholesterol and recorded violence.

Preliminary results from the second study show, in the inpatient setting, that HDL significantly increased the variance of recorded violence beyond the variance that could be explained by the V-RISK-10 (Violence risk checklist-10; a psychosocial risk assessment screen) for men (n=156), OR = 0.26, 95% CI = 0.078-0.89, p = 0.032, , but not for women (n=192). In the post-discharge setting (n = 101), HDL was not a significant part of the model. Low sample size and moderate effect size makes it possible for the non-significant contribution to the model of HDL among men could be a type II error. Gender difference in HDL as a risk marker of violence among men was significant, p = 0.030. In line with results from earlier projects (John O. Roaldset, Bakken, & Bjørkly, 2011; J. O. Roaldset, Hartvig, & Bjorkly, 2013), results from this project indicate that low HDL could be a potential risk marker of violence in acute psychiatry, and that low HDL might be a supplement to an existing screening tool for violence risk, for men but not for women.

Discussion

The impact of these two studies on risk assessment of violence, and aspects and importance of other possible untraditional risk factors, will be discussed in the workshop.

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Learning objectives

1. learn about the potential of patients own risk statements as additional risk marker for violence during hospitalization
2. learn about the potential of a biological factor as additional risk marker for violence during hospitalization

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Prediction and prevention of aggressive incidents during outpatient crisis contacts

Workshop

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Abstract

Tension and emotions can run high during emergency services of the Mental Health Care. During late night hours and under time pressure, decisions are often made which not all parties agree with. At the start of the 'Safety in healthcare' project in 2002, not much statistical data was available regarding the frequency, timing, and situations in which aggression occurred during emergency services provided by the Association of Mental Health Care. (GGZ). In 2002, the Oost-Brabant Mental Health Emergency Services therefore launched a study, in the framework of this project, of the number of threatening incidents during emergency contact and risk-increasing factors. All aggressive incidents during emergency services were initially registered according to the Staff Observation Aggression Scale-Revised (SOAS-R). The percentage of emergency contacts during which aggression was observed was 14% in 2002. Remarkably, the emergency contacts involving aggression occurred relatively often in the late morning or late evening / early night. During this initial inventory study, all registered incidents of aggression were also discussed every week in the team meetings. Structurally discussing the incidents together was found to be useful, as knowledge and experience regarding dealing with aggression was shared with all the staff members.

Aggression against emergency service workers by psychiatric patients has become a topic of increasing interest in recent years. Less attention has been given to the fact that the patient is relatively often also a victim of aggression from others. In our study a group of 74 patients diagnosed with DSM-IV-R schizophrenia were asked standardized questions about their most severe experience with aggression, in order to gain insight into the (possibly traumatic) aggressive incidents experienced by patients. The experience could involve either aggression from the patient towards others or aggression from others towards the patient. A large majority of the patients interviewed reported having experienced an aggressive incident during psychosis. That was true for 53 of the 74 patients studied (72%). Of these 53 patients, 19 incidents (36%) involved aggression from others towards the patient. In some of the psychotic patients, the aggressive incidents experienced could possibly lead to symptoms that could be diagnosed as Post Traumatic Stress Disorder (PTSD). When treating psychotic patients, more attention should be paid to the diagnostics and possible treatment of comorbid PTSD symptoms.

Due in part to the nature and severity of a number of the aggressive incidents it made sense to study whether the 'predictability' of potential aggression during emergency contact could be increased. We investigated whether we could predict, in regards to the often brief information provided by the referrer (usually the GP), aggressive behavior from the patient. A method for assessing the risks beforehand, based on the information received, could be of importance for the prevention of dangerous situations. To initially this study, from 2003 to 2005, emergency service workers completed a specially designed Emergency Services Risk Checklist (CRC) prior to all outreach contacts with patients in psychiatric emergencies over the course of two years. After the contact, any aggression observed in the patient was registered using the SOAS-R. Aggressive behavior in patients was registered in 51 of the 499 emergency contacts (10%) that were part of the study. The checklist's predictive validity for subsequent aggression seemed to be quite good. Three factors played a part in this: 1) the emergency service worker's clinical judgment on a visual analogue scale with respect to the risk of aggression during the emergency contact, 2) the emergency service worker's assessment

whether or not there are aggressive individuals in the vicinity of the patient involved, and 3) whether or not the emergency service patient had requested the help themselves. These three factors from the CRC could predict aggression towards others with accuracy of 74% and a specificity of 84%. The conclusion of the study was that the use of a tool such as the CRC by emergency services appears to be advisable, although a replication study of the findings would be desirable.

The replication study is described over the course of four years (from 1 January 2006 to 31 December 2009), emergency service workers completed the CRC prior to outreach contacts with patients in psychiatric emergencies. The result of this study replicated the earlier findings, indicating that the structured clinical risk assessment on the CRC's visual analogue scale, together with the answer to the question of whether there may be dangerous individuals in the vicinity of the patient, were useful 'predictors' of subsequent aggression. The use of the CRC, registration of aggressive incidents using the SOAS-R, and the weekly discussion of said incidents were therefore concluded to be effective tools to aid in identifying and analyzing risks and incidents in order to increase the safety of mental health workers. The number of emergency contacts in which aggression was reported has declined since the start of the project.

According to the studies the initial diagnosis of the patient's psychological state by emergency service workers correlated with the risk of aggression during the forthcoming emergency contact. Therefore, it was also important to research further whether the diagnoses made during emergency contacts corresponded with the diagnoses made later, following a comprehensive intake and diagnosis. An accurate diagnosis by emergency services will result in faster referral to the correct team, the start of the most appropriate treatment, and cooperation with or referral to another institution, such as substance abuse treatment centers. During emergency services, however, the diagnostic process takes place under time constraints, and it is important to research this first assessment. The differences between the assessments of patients' psychological state by emergency service workers during emergency contact and the diagnoses made later, following a regular and a comprehensive intake. This study involved 129 patients who were unknown to the GGZ, and who had never been in contact with the emergency services during 2009 – 2010. Using Cohen's kappa, the validity of each initial assessment of psychological state by emergency service workers was examined relative to the subsequent diagnosis. Generally speaking, the emergency service workers proved capable of assessing diagnostic categories above the level of chance. Cohen's kappa ranged from 0.31 (borderline personality disorders) to 0.81 (psychotic disorders). Relatively often borderline personality disorders prove to be overestimated by emergency service workers. Correct assessment of psychotic disorders by emergency service workers based on initial information may reduce the risk of aggression. After all, the earlier study shows a correlation between particularly these issues and an increased risk of aggression during outreach contact.

Until now, research into aggression within the GGZ has mostly focused on the characteristics of the aggressive patients. Aside from our interest in potential aggression from patients, we were equally interested in the personalities of the emergency service workers and any correlation between those characteristics and aggressive incidents. The fact that emergency service workers are relatively often occupationally involved in unpredictable and sometimes threatening situations is precisely why it is conceivable that the nature of their work requires specific personality traits. We therefore researched whether, and by which personality traits, emergency service workers are distinguished from highly educated people from the general population. We asked employees of the Oost-Brabant Mental Health Emergency Services Centre (Uden/Veghel and Helmond region) to fill in a NEO-PI-R, which we used to map out the most important personality traits. Of the 59 employees who were invited to participate, 44 people returned the questionnaire (76%). We found that, in comparison to other highly educated people from the general population, emergency service workers scored significantly lower in the 'Neuroticism' dimension, especially in the facets 'Vulnerability' and 'Self-Consciousness'. They scored higher on the facets 'Competence' and 'Self-Discipline', and lower on

‘Straightforwardness’ and ‘Order’. In comparison to community psychiatric nurses, psychiatrists scored higher on the facets ‘Assertiveness’ and ‘Openness to ideas’.

The lower scores in the ‘Neuroticism’ dimension and the facet ‘Vulnerability’ in particular, suggest that emergency service workers are relatively emotionally stable and keep their cool in difficult situations. Such characteristics can be of importance in dire situations where peace and calmness must be maintained. However, given the limited sample and the relatively large number of statistical tests, the findings of this exploratory study as described should be interpreted with restraint.

We then studied to what extent there was a correlation between an emergency service worker’s personality traits and the occurrence or reporting of aggression. It was a small sample, but a few indications did emerge. For this study, all emergency service workers (n = 21) in the Uden/Veghel region were asked to complete a NEO-PI-R. Prior to 576 outreach contacts by the emergency service workers, the CRC were also completed and, if the patient displayed aggressive behavior, a SOAS-R was filled in after the contact. Based on this information significant differences were found between employees. The differences involve both the estimation of possible aggression during the consultation and the frequency with which aggressive behavior was reported. Evidence suggests that a higher level of ‘Conscientiousness’ in an employee has a positive correlation to an increased chance of reporting aggression during consultations. ‘Agreeableness’ seems to have a negative correlation to the initially estimated risk of aggression by the patient during the consultation.

It is possible that people who score high on ‘Conscientiousness’, and who therefore work meticulously, orderly, and systematically and stick to the rules, are less able to respond flexibly to what is happening in the interaction with the patient. This causes irritation and further aggression in the patient sooner. On the other hand, it is conceivable that these employees have followed the instructions for reporting aggression more closely, leading to both an increased initial estimate of risk of aggression and an increased number of reports of actual aggression.

In summary, it appears that mental health workers are relatively often confronted with aggressive behavior by patients and that patients are partly also victims of aggressive behavior from others, sometimes with serious consequences. We further conclude that there is supporting evidence that the past years’ efforts in the concerned emergency service have led to an increase in employee safety. Simultaneously, alternative explanations for the discovered decline in number of reports of aggression, cannot be ruled out. A reduced willingness to report incidents as the project progressed cannot be ruled out, especially in the absence of a control condition. In any case, various items in the CRC seemed to have a significant correlation to aggression, as later documented by the emergency service worker after the emergency contact. The predictive validity of the checklist for subsequent outwardly directed aggression appeared to be reasonably good, due mostly to three items: 1) the emergency service worker’s clinical judgment, 2) assessment whether or not there are aggressive individuals in the vicinity of the patient involved, and 3) whether or not the request for help came from the patient. The use of the CRC by emergency services seems to be beneficial in estimating risks.

For this reason we created an aggression app for use on mobile phones. Mental health crisis workers use this application instead of the paper version of the CRC. In the presentation we would like to discuss our research with you and demonstrate yhe use of the aggression application in the field of emergency services of the Mental Health Care.

Educational Goals

1. The aggression application in the field of ambulant mental health care for risk assessment about aggression.
2. The most dangerous patient's features and other specific elements who predict aggression in the field of ambulant Mental Health Service.

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Further decrease in seclusion use after implementation of an Intensive Care Units (ICU)

Paper

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Keywords: Seclusion, Psychiatric intensive care unit (PICU)

Abstract

Background

This study was conducted in a CMHC that has been engaged in seclusion reduction programs for over a decade (1). A recent study showed a 62% decrease in the number of seclusion hours per 1000 admission hours between 2007 and 2013. We also observed a decrease of 44% in the number of days on which coercive measures occurred. However, the ward environment in the participating hospitals was built in 1985, impairing environmental alternatives such as one on one treatment or the use of special retreat rooms as part of best practice implementation.

Inspired by ideas of High and Intensive Care (2), Psychiatric Intensive Care Units and Safe Wards (3), and after visiting comparable initiatives in the Netherlands, Germany and Denmark, we built a Dutch PICU version facilitating inpatient and outpatient care in the same building. It provides outpatient crisis care as well as 2 closed, one half open and one open unit for 9 patients each. The central part of the building is a High Care Unit with 2 'Extra Secured Rooms (EBK)' and an Intensive Care Unit for 2 patients. In case of acute crises staff numbers can be increased. The building was opened in October 2015.

Aim

Coercion Reduction and safe de-escalation

Methods

Best practice in conjunction with a new building containing an Intensive Care Unit. Registration of coercive measures using the Argus rating scale, covering seclusion, restraint and enforced medication.

Results

Looking at the implementation time frame of the PICU, we saw a 43% reduction in the ratio of seclusion hours per admission hours, comparing 2016 to 2015 or 2014. This is in addition to reduction found earlier (Verlinde et al, 2017). Comparing the findings over the full time frame of 10 years, we observed a reduction of seclusion hours per admission hours of above 90%.

The number of days on which enforced medication was used decreased substantially by 44% after 2015, whereas we found in increase in the years before. After 2015, a 50% decrease of aggression incidents on staff was observed, whereas these varied largely in numbers before 2015.

Discussion and Conclusion

The provision of an Intensive care unit, best practice measures already implemented and a structured medication protocol reduced seclusion use to a level comparable to a number of other European countries. Enforced medication became less common during the time of observation, possibly due to the provision of enough space for the patients in crisis, although this needs further exploration.

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Educational Goals

- To understand which environmental factors in treatment and ward environment contribute to seclusion reduction
- To understand the interplay of treatment protocol, risk assessment and enough space in the prevention of seclusion and restraint

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A scoping review of incident reporting in mental health services: history, development and current challenges

Paper

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Keywords: Clinical incident reporting, risk assessment, mental health, patient safety

Introduction

The process of reporting 'incidents' has become a well-established practice across all areas of healthcare including mental health services (HSE, 2007; MHC, 2008; European Commission, 2014; NHS England, 2015a). At their most serious these incidents may include suicides and homicides; their relationship to mental health services continuing to attract negative media exposure (Panorama, 2017; Pym, 2016). The aftermath of such incidents, occurring within inpatient and community settings can have a serious impact on professionals, patients and their families (Bonner and Wellman, 2010; Bohan and Doyle. 2008).

Beyond the extremes of suicide and homicide are more frequently reported incidents, varying extensively in origin, nature, level of seriousness and factors/people involved (Anderson *et al.* 2013). This diversity is often compounded by contrasting systems of reporting and difficulties ascertaining when and what to report (Stavropoulou *et al.* 2015). These differences also extend to basic terminology, where the expression 'clinical incident' is used interchangeably with other commonly used terms such as 'adverse event,' 'untoward incident' or 'patient safety incident' (Rafter *et al.* 2016; Donaldson, 2000; O'Connor *et al.* 2010).

Pham *et al.* (2013) cite a number of other limitations including the failure of incident reporting systems (IRS) to measure and compare safety across different organisations, whilst producing too many reports and no tangible change. Macrae (2016) is critical of the use of incident reports to assess organisational performance and cites a lack of post incident feedback for those involved. The wider role of risk management, of which incident reporting is seen as an important element (NHS, 2015a), also receives criticism for ultimately impacting on patients in terms of restricting choice and independence (Heyman, 2004; Clancy *et al.* 2014). Comparatively, statutory bodies such as the Mental Health Commission in Ireland (MHC, 2008) argue that incident reporting leads to the identification and resolving of problems so that patients can receive a better and safer standard of care.

Background

Incident reporting has developed over a number of years in the context of risk and litigation management (Anderson *et al.* 2013) and efforts to ensure patient safety (Mitchell *et al.* 2015). Risk management strategies, serious incidents and their relationship with mental illness remain a pertinent topic for services, governments and the media, suggesting a strong impetus on protecting not only patients, but also staff and the public in general. Relevant examples include a long running national public inquiry in the UK relating to suicides and homicides by people with mental illness (National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, 2016) and a wealth of micro-level literature focusing on serious incidents such as violence and suicide within inpatient psychiatric units (Dack *et al.* 2013; Bowers *et al.* 2014; Papadopoulos *et al.* 2012).

Current review

This review aims to examine clinical incident reporting and its particular relationship with mental health services, using Arksey and O'Malley's scoping review framework (Arksey and O'Malley, 2005). It considers whether mental health services face unique safety/risk challenges compared with other areas of healthcare and whether social and political changes focusing on risk have had an impact. The review also examines whether incident reporting is effective in mental health services and whether it creates a learning environment as originally intended. With serious incidents of violence, harm and loss within communities and hospitals continuing to affect public confidence in mental health services, a major question exists over the efficacy of heavily invested incident reporting systems and risk management strategies.

Data sources

Search terms were generated from knowledge of current clinical practice. The search terms 'patient safety incidents,' 'clinical incidents,' 'adverse incidents,' 'serious untoward incidents,' and 'serious reportable events' were used via the following databases: Pubmed, EBSCO Host (including Cinahl, Medline, psychINFO and psychARTICLES), Science Direct, Wiley Online and the Cochrane Library. Further applicable evidence such as organisational/statutory documents and reports were collated via Google search and a number of relevant websites such as the HSE (Health Service Executive) in Ireland and The NHS (National Health Service) in the UK.

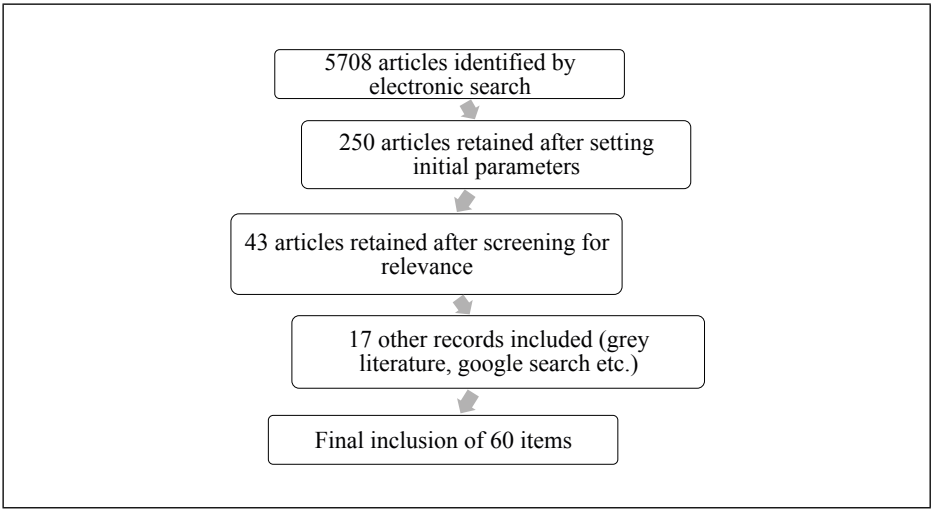
Inclusion and exclusion criteria are presented in Box 1. Published data was reviewed between 2006 and 2017, with literature preceding 2006 also included where particular significance was identified. The search process is summarised in Figure 1. A synthesis of the relevant literature revealed 6 main themes, (i) History of clinical incident reporting, (ii) Terminology, (iii) Risk and mental health, (iv) Contributory factors, (v) Staff perceptions and (vi) Patient involvement.

Box 1. Inclusion/Exclusion Criteria

Inclusion Criteria
Research studies pertaining to clinical incidents, the process of implementation/reporting and the views of professionals and service users.
Research studies related or at least part-related to mental health.
Grey Literature/ policy documents focusing on organisational or service-wide approaches to recording and processing clinical incidents.
Literature relevant to the background and history of incident reporting.

Exclusion Criteria
Research studies where the focus was clearly unrelated to mental health/psychiatry (e.g. medical devices)
Articles where full text was not available
Articles not available in English

Fig.1. Article Search



History of clinical incident reporting

The World Health Organisation estimate that adverse events occur at a rate of 8% to 12% during hospitalisations in Europe, suggesting that strategies to minimise adverse events such as incident reporting could reduce deaths continent-wide by 95,000 per year (WHO, 2017). In UK mental health services, a 31% increase in serious incidents over a 4 year period has been identified, with recent efforts to improve incident recording practices seen as a possible explanation for this rise (Pym, 2016).

Incident reporting in healthcare is clearly not a new phenomenon, illustrated by UK Department of Health guidance published over sixty years ago which shares similarities with the type of information frequently sought today. This recommended that "a brief report be prepared…as soon as possible after any occurrence of the kind in question, giving the name of any person injured, the names of all witnesses, details of the injuries and the full facts of the occurrence and of the action taken at the time" (NHS, 1955 cited in Donaldson, 2000: p51).

In the USA, medical malpractice insurance claims in the 1970's led to the development of formal incident reporting by the following decade (Singh and Ghatala, 2012) as a means of self-indemnification for staff. By the 1990's a Clinical Negligence Scheme was introduced in the UK which obliged NHS departments to develop incident reporting systems, conforming to risk management standards and therefore minimising insurance premiums (Dineen and Walsh, 1999).

Beyond the financial/litigative basis for reporting incidents, two important reports from the USA and UK saw improved incident reporting as a way of reducing patient harm as a result of clinical/organisational fault. The American Institute of Medicine report 'To Err is Human' (Kohn *et al.* 1999) was published after a perceived 'epidemic' of errors including, suicides; adverse drug events; burns; patient misidentification and falls. It recommended that a mandatory system of reporting should be introduced for occurrences of serious harm and death and a voluntary system identifying less significant events but aiming to address safety concerns before the critical stage was reached.

The UK report, 'An organisation with a memory' (Donaldson, 2000), referencing the US report and produced a year later, recommended the standardisation of incident reporting and the need to learn

and improve from systemic/organisational failures. The UK health service was and continues to be encouraged to mirror incident reporting practices already established in outside industries such as aviation; reported to have reduced fatalities by harbouring a learning culture and minimising individual blame (Hunt, 2016).

Although these reports contain some reference to mental health, they appear to be predominantly concerned with physical/medical care. Writers such as D'Lima *et al.* (2016) question the relevance of generic patient safety strategies to mental health and indeed there do seem to be clear differences in the type of reports submitted. A study comparing psychiatric and medical/surgical wards (Anderson *et al.* 2013) found that absconding; violence; smoking/risk of fire; medication errors, and self-harm/suicide were the top five reported areas in mental health services when compared with staffing levels; staff competency; medication errors; medical devices and IT systems on general wards.

Terminology

Efforts to determine the exact nature of clinical incidents is reflected in wide-ranging terms and definitions which serve to capture both actual and potential sources of harm. Whereas unanticipated physical injury or sudden death may be obvious examples of incidents necessitating completion of a report (Rafter *et al.* 2016), alternative definitions include a number of other more contentious scenarios such as psychological harm (Joint Commission, 2016) and near misses (O'Connor *et al.* 2010). The all-encompassing nature of many incident definitions extend to areas such as financial loss, reputation damage and decreased public confidence (Bowers *et al.* 2006; NHS England, 2015a). Some guidance also aims to isolate the most serious incidents of disability and death, imposing mandatory reporting requirements. Terms such as 'Sentinel Events' (Joint Commission, 2016) 'Never Events' (NHS England, 2015b) and 'Serious Reportable Events' (HSE, 2015) are used in this context, commonly presupposing a degree of preventability.

Risk and mental health

The history of incident reporting and the terminology used spans all areas of healthcare. However, the reporting of incidents in mental health services also stems from a historical focus on risk, which occurred well before any notion of 'patient safety' or 'never events.'

For example, the UK killing of Jonathan Zito by a known psychiatric patient took place in 1992, leading to a well-publicised government inquiry (Ritchie *et al.* 1994). Previous and successive violent and fatal incidents, widely reported and criticised in the media, led to increased perceptions of dangerousness amongst the general public (Hulatt, 2014). This, in turn, led to major changes in mental health care, including an overhaul of forensic services, an increased focus on severe and enduring mental illness and the development of assertive outreach and crisis resolution teams (Turner *et al.* 2015).

The occurrence of such incidents demonstrates the unique risk factors evident in mental health. Whereas patient safety tends to focus on reducing direct harm to patients in care, mental health services contend also with the potential of harm to members of the public by patients in their care. Furthermore, the risks posed to staff safety as a result of violence are well documented in the literature (Kelly *et al.* 2015; Renwick *et al.* 2016; Staggs, 2015).

Contributory factors

Macrae (2016) argues that incident reports do not require significant detail as they should act as a precursor for more in-depth examination. As such incident reports are often used as the basis for analysing potential causes or antecedents. Some writers have endeavoured to categorise these causes into specific groups (Box 3).

Box 3. Contributory factors relating to clinical incidents

Safewards model – six originating domains (Bowers, 2014)	**Factors affecting patient safety (Vincent, 2010)**
1. The staff team; 2. The physical environment; 3. Outside hospital; 4. The patient community; 5. Patient characteristics; 6. The regulatory framework.	1. Patient factors; 2. Task and technology factors; 3. Individual staff factors; 4. Team factors; 5. Work and environmental factors; 6. Staffing level/skill mix; 7. Organisational and management factors; 8. Institutional context factors.

Incidents themselves are also categorised in the research literature with some studies examining antecedents solely relating to violent/aggressive incidents (Panagioti *et al.* 2015; Papadopoulos, 2012) with others exploring self-harm/suicide risk (James *et al.* 2012; Najim *et al.* 2013; Bowers *et al.* 2011); each study considering multiple antecedents or focusing on one particular area such as patient characteristics (e.g. race, gender, diagnosis, illness acuity).

The impact of staff attitudes on reported incidents is examined (Louch *et al.* 2016; Totman *et al.* 2011; Morse *et al.* 2012) alongside organisational factors such as skill mix (Kirwan *et al.* 2012) inpatient ward environment (Lewin *et al.* 2012) and availability of therapeutic activity (Carr *et al.* 2008).

Staff perceptions

A number of studies have examined staff perceptions of incident reporting, raising a number of issues and criticisms. Mitchell *et al.* (2015) suggests that incident reports are rarely completed by medical staff whilst highlighting that systems are often underfunded or outdated. The unique risks evident in mental health are acknowledged by Anderson *et al.* (2013) who notes that mental health staff are often less involved in the reporting process, more sceptical and less likely to submit reports than colleagues in medical/surgical specialities.

The 'under-reporting' of incidents is another area of debate, frequently stemming from a perceived lack of management support or concern that patients will be negatively affected as a result (Gifford and Anderson, 2010). Gallagher (2010) makes the point that some staff may under-report for fear of implicating colleagues, whilst Hewitt and Chreim (2015) suggest that incidents may not be reported when they are easily resolved and no visible harm is caused.

Patient involvement

Involving patients in the incident reporting process is a theme highlighted in the examined literature, reflecting the current focus on recovery orientated care (Higgins *et al.* 2015; Roberts and Boardman, 2014; Slade, 2009). Bishop *et al.* (2015) and Giles *et al.* (2013) advocate for the involvement of patients in identifying safety issues whilst McCaughan and Kaufman (2013) suggest the better utilisation of patients' illness expertise in addition to their observation skills in clinical areas.

Discussion

The evidence suggests that incident reporting within mental health services has developed within a generic framework of patient safety, staff and organisational indemnity requirements and a background of highly publicised incidents involving mental health patients. Although addressing patient safety has become a major reason for the reporting of incidents across all specialities, it is evident that these types

of incident differ widely in relation to the clinical area concerned. Although factors such as falls and medication errors, for example, may relate to all departments, mental health clearly has its own unique risks to contend with including factors such as recurrent violence, suicide, self-harm and absconding.

Whilst incident reports may provide basic, factual accounts of events such as violence, the evidence suggests that many of these incidents go unreported, hence the true incidence of violence in clinical areas cannot be quantified by reports alone. Completed reports may support the establishing of facts which can be re-visited (e.g. in the case of local inquiries, root cause analysis and legal investigations) but they only provide a snapshot of the incident and not an exploration of the possible causes. Simultaneously the causes of serious incidents such as violence in mental health may relate to any number of internal and external factors, making the task of identifying solely 'organisational failures' a difficult process.

Despite this issue, the antecedents of incidents are clearly worthy of detailed exploration, but ideally staff and patients need to feel more informed, involved and valued in this process. As previously noted, staff often receive inadequate feedback after reporting incidents or fail to observe any positive change as a result. Conversely, when a specific incident is investigated further, staff may often feel that establishing blame is the objective rather than an exploration of possible causes or a team learning experience. This partly suggests a widespread misunderstanding of the original principles of incident reporting, where the procedure has become confused with other processes such as audit and internal investigation. Staff may also feel that patient and public safety receives too great an emphasis at the expense of staff safety, another area worthy of further investigation.

The purpose and value of incident reporting in mental health services needs to be considered and whether this process (particularly voluntary reporting) is leading to the identification and subsequent correction/improvement of specific issues. Utilised effectively they should form the basis of further research into cause, better involve staff and patients in the process and generate a culture of learning as opposed to blame. Reviewing incidents in clinical supervision or inter-professionally are examples of where this approach could be developed.

Opportunities for further research exist within political and cultural attitudes to mental health and risk, with the potential for incidents to be directly or indirectly influenced by changing trends. For example, concern about the risks posed to self and others by mental health patients in the community continues, with some writers questioning whether the continued development of community care is safe and sustainable (McCrae and Hendy, 2016). In contrast, more inpatient hospitalisation may increase the incidence of violence reports as a result of containment and conflict with other patients (Papadopoulos *et al.* 2012; Bowers *et al.* 2014). It is also worth exploring how incident reporting corresponds with the recovery movement in mental health, its focus on positive risk taking, active user involvement and espousal of shared risk responsibility (Higgins *et al.* 2015; 2016).

Conclusion

This paper presents evidence from a scoping review of incident reporting and its relationship to mental health services. The highlighted themes suggest that there is an ongoing lack of clarity about the purpose and effectiveness of incident reporting, particularly in fulfilling any tangible service improvements.

Given these findings, further research and debate would be beneficial in examining the ongoing use of incident reporting systems in mental health services. This is particularly timely, given the ever-changing political context relating to risk and mental health; with the opposing views of containment and public protection versus the concept of recovery, liberalism and personal responsibility.

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Study and ranking the impact of nurse's job stress on patients safety using Analytic Hierarchy Process (AHP)

Poster

Amir Sabet Mohammadi & Mohammad Godarzi Nik (Iran)

Keywords: Job stress, patient safety, AHP

Abstract

Considering staff's physical and mental health in relation to production and efficiency of an organization is one of the characteristics of a healthy organization. Health staff working in hospitals face high physical and psychological events that affect their stress and fatigue levels which consequently results in their potential adverse effects in patient care. This study was conducted to examine the effects of nurse's job stress on patient safety utilizing AHP (analytic hierarchy process). The study was carried out in three hospitals affiliated to Islamic Azad University-Tehran Medical Branch during August to December 2016. A questionnaire was prepared and its validity and reliability was shown. A population consisting of 90 nurses were randomly selected and responded to 53 questions. A group of Experts including three headmasters and hospital managers determined their criteria including cost, time and organizational regulations for preferred top choice based on AHP (Analytic Hierarchy Process) to implement in order to reduce job stress. The results demonstrated that participation in planning and decision-making were the most stressful factors followed by security and career prospects, welfare and staff support and justice.

Educational Goals

- One of the characteristics of a healthy organization is that staff's physical and mental health is treated as equally as productivity. Consider a society that although its organizations have reached the desired level of production, utilizing different ways and neglecting human dimensions of work place, but the staff of these organizations are nervous, sad, unhappy, aggressive, pessimistic and waiting for an opportunity to show their mental distress with low performance and spreading destructive rumors [2].

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Risk management by the Early Recognition Method in patients with Huntington's Disease

Paper

Frans Fluttert, Henk Slingerland, Els Verschuur, Lia van Gelder & Karen Lammertsen (Netherlands)

Keywords: Riskmanagement, Aggression, Huntington's Disease, Prevention and Care

Abstract

Huntington disease is an inherited fatal disease destroying brain cells. Symptoms vary from physically uncoordinated body movements, talking problems to mood and mental problems. During the first phase of the disease severe aggression often occurs (Roos, 2010).

Nurses were trained to identify and manage early warning signs of aggression by means of ERM . ERM in HD-patients was studied. Outcome was the number of aggressive incidents, nature of early warnings signs and team climate. The first preliminary results suggest ERM to contribute to a better understanding and management of aggression in HD-patients for patients, nurses and members of the social network.

Objective

Huntington's disease (HD), also known as Huntington's chorea, is an inherited disorder destroying brain cells. Symptoms usually begin between 30 and 50 years of age, but can start at any age. About 8% of cases start before the age of 20 years. The earliest symptoms are often subtle problems with mood or mental abilities, however severe aggressive episodes are likely to occur which burden the social network. As the disease advances, uncoordinated, jerky body movements become more apparent. Physical abilities gradually worsen until the patient is even unable to talk. Death typically occurs fifteen to twenty years from when the disease was first detected.

The most common behavioural problems in patients with Huntington's disease (HD) are addressed adequately by nurses aiming to avoid escalation or crisis situations. However, in the case of aggression or when escalation is imminent, a risk management strategy addressing the management of aggression is needed. Due to lack of a risk-management strategy concerning patient's aggression, nurses and family members of HD-patients often feel powerless and desperate in their need for support in the management of the patient's aggression.

The ERM is a risk-management strategy aiming to assist nurses in the management of patient's aggression in (forensic) mental health care (Fluttert *et al.* 2008, 2016). In applying ERM early warning signs of aggression are identified by means of the FESAI (Fluttert *et al.* 2011). Early warning signs and early interventions are described in an 'early detection plan'. Patient's behaviours are monitored in order to identify those early warning signs and apply early interventions in order to stabilize patient's behaviours. In ERM the collaboration and dialogue between patient and nurses is imminent.

Initially ERM was developed and tested in forensic mental health care. Results suggest ERM contributes to an improved aggression management and a decrease of the frequency and severity of patient's aggression (Fluttert *et al.* 2010). ERM was never applied in the care for HD-patients. In this pilot study ERM was adapted, applied and studied in the care for HD-patients. Nurses of a 'Skilled HD unit' in a long term care facility were trained in ERM in order to identify early warning signs of aggression in

HD patients. The early warning signs were recorded in an early detection plan and exchanged with HD patients in order to apply early interventions and avoid crises.

Aim of the study

To explore the feasibility of ERM Risk Management by identifying early warning signs of aggression and monitoring behaviours from stability to deterioration in HD patients. Experiences of nurses, patients and family members could explain how ERM could contribute to the management of aggression displayed by HD-patients.

Method

First the ERM strategy, described in the ERM-protocol, was assessed and adapted for application in HD-patient's purpose. Nurses of a HD-Skilled Nursing Facility were interviewed concerning possible modifications in the ERM-protocol. The ERM-protocol was modified according these interviews to a ERM-protocol-HD version.

Second, in a training program the nursing staff learned to apply the protocol and accordingly to identify early warning signs of aggression in HD-patients. In weekly evaluations early warning signs of aggression were explored and discussed between nurses and patients. When early warning signs arose, nurse and patient carried out early interventions in order to stabilize patient's behaviour. Early warning signs were rated on the FESAI .

Third, the effects of applying ERM was studied by comparing the number of incidents in the period before and after ERM is implemented. Outcome measures are: number and severity of incidents (rated on the SOAS-r), team climate (EssenCES) and HD-behaviour (BOSH). The experiences of nurses will be studied by qualitative research techniques such as interviews and the analyses of daily reports.

Results

ERM was succesfully introduced at two Skilled Nursing Facilities. All nurses followed the training program and they showed enthusiasm to apply the ERM protocol in clinical practice. The first experiences with the ERM-HD-protocol are positive. Nevertheless, due to patients' communication problems, not in all eligible cases could the early warning signs be discussed with the patients. This revealed new study opportunities to adjust ERM and the protocol in order to establish better communication with HD patients concerning their aggression.

Nurses reported an increased alertness for small behavioural changes towards aggression. Some patients show their active involvement in the way they adopt elements of ERM when discussing their behaviour with nurses and family. Family members reported experiencing a better understanding of HD-patient's aggressive behaviours.

Conclusion

The preliminary results suggest that ERM may contribute to effective behavioural aggression management for nurses working with HD patients living in a long term care facility. Additional it establishes an understandable risk-management framework between nurses and the family network. The recording of early warning signs in HD-patients provides new insights in those early warning signs which characterises the onset of aggression in HD-patients. This knowledge allows a modification of the FESAI in order to develop a FESAI-HD-version.

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Educational Goals

- After reading the paper the specific value of the ERM-risk management strategy for patient with Huntington's Disease could be articulated.
- At least two outcomes of the pilot study 'ERM in patient with Huntington's Disease' could be mentioned and explained.

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Violence prevention and containment in an acute mood disorder ward

Poster

Jani Turunen & Riitta Askola (Finland)

Keywords: evidence-based practices, patient-centered care, de-escalation

Abstract

Background

Helsinki University Hospital ward 7 is an acute 18-bed mood disorder ward with patient admission 24/7. Patients suffer from severe bipolar disorders and depressions with psychotic symptoms or suicidality.

Nursing personnel of ward 7 implemented the Safewards model, and Evidence-based Care Bundle 1 (prevention of violent behavior, and seclusion/restraint) & Care Bundle 2 (seclusion/restraint) for patients in psychiatric care. These models are structured ways of improving the processes of care and patient outcomes. The violence risk of patients admitted involuntarily to the ward is assessed using the Dynamic Appraisal of Situational Aggression (DASA).

Aims

The aims of this study were to examine the suitability of the implemented models (Safewards, Care Bundle 1 & Care Bundle 2) in an acute mood disorder ward and to evaluate the impact on containment and the rates of conflict. The aim is also to develop nursing strategies for preventing violent incidents.

Methods

Existing official reports i.e risk notifications of staff (HUS-Riskit), patient safety incidents (Haipro-reports) and the amounts of use of coercive methods (seclusion and mechanical restraint) were collected and evaluated. The time period of evaluation was between 2015-2016.

Results

According to the statistics the use of seclusion and restraint were significantly reduced during implementation processes of the Safewards model, and Care Bundle 1 & 2. The amount of use of seclusion was reduced from 80 days (2015) to 71.5 days (2016). The amount of use of mechanical restraint was reduced from 43.4 days (2015) to 20.6 (2016).

Official reports (HUS-Riskit and Haipro-reports) are being evaluated and preliminary results indicate that rates of violence, self-harm and other incidents threatening patients and personnel have decreased. Patients also felt being treated respectfully and being heard in decision-making considering their treatment

Conclusions

Implemented models (Safewards, Care Bundle 1 & Care Bundle 2) are effective and suitable for increasing the safety of the ward. Developing patient-centered care and focusing on staff´s de-escalation techniques and skills support the nurses to avoid using coercive methods. The fluent and logical

processes of communication and interaction between patients and personnel are important. Orientation to professional practice and ethics is crucial.
To conclude, workplace safety can be increased and the risk of violence can be decreased by means of coherent procedures and consistent guidelines.

Educational Goals

- To describe how to reduce the risk of violence in an acute psychiatric mood disorder ward.
- To describe how to reduce coercive methods in the acute psychiatric mood disorder ward.

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Chapter 7 – Human safe & caring approaches in and reduction of restrictive practices

De-escalation of Violence in the Context of Intellectual Disability: Working with complexity

Paper

Andrew Lovell (UK)

Keywords: Complexity; workshop; intellectual disability; violence; de-escalation

Introduction & Background

There has been a growing consensus over recent years around reducing the reliance on physical interventions when responding to violent and aggressive behaviour, a critique, which, in relation to the care of individuals with an intellectual disability and a background of such behaviour, has led to considerable changes in approach. The development of less intrusive techniques, for example, sometimes employed alone and sometimes in conjunction with more enhanced interventions, acknowledges the need to understand the individual, his or her capacity for violence and the most effective ways to respond. Nevertheless, there remains a considerable reliance in services on varying types of physical interventions, along with the use chemical and other restraining apparatus, and coercive seclusion, as means of effectively responding to service user violence. There is a consequent need, therefore, particularly if services are serious about moving towards a system that is no longer reliant upon physical interventions, perhaps even ceasing to recommend their use, for a renewed emphasis on de-escalation, not as a skill for the few but as a pre-requisite for working with people with intellectual disabilities and a background of violent behaviour. This article describes the components of a 2-day workshop, which has been delivered to a whole staff population working with those with intellectual disabilities detained in secure accommodation, which is based on the notion of fully comprehending individual complexity as the basis for engagement with those with a propensity for violence.

De-escalation has been defined as "a complex process in which the patient is directed towards a calmer personal space" (Stevenson, 1991: 6), generally revolving around the use of verbal strategies, so that the patient's anger and agitation is diminished and he/she re-establishes a sense of calm and self-control (NICE, 2015). The complexity of this interaction, however, is sometimes not fully understood, referred to frequently as 'defusing' or 'talk-down', the full extent of skills involved is difficult to fully elaborate (CRAG, 1996). Despite ongoing interest in de-escalation, however, there is little evidence of particular approaches or general effectiveness (Richmond *et al.*, 2012; Robertson *et al.*, 2012). There has been some work toward understanding de-escalation in the context of the assault cycle (Kaplan & Wheeler, 1983), such as elaborated in the ACT (Assessment, Communication and Tactics) cyclical model (Dix & Page, 2008), but there is no real evidence that an incident of violence follows such a logical format, and interpretation in terms of the assault cycle phases is problematic (Spencer & Johnson, 2016).

Methods & Results

The 2-day workshop was delivered on seven occasions between October 2016 and April 2017, with participant groups ranging from eight to twenty-five in size, the optimum group size being sixteen. All but one of the workshops were held in a hotel close to the secure service site, so that participants were unburdened of association with their regular working environment and could use at least some of the time to reflect on their work and discuss situations in depth with colleagues. The composition of participants was about two-thirds health care assistants and one-third qualified intellectual disability nurses. There were also a small number of mental health nurses, occupational therapists and physical interventions trainers. Each workshop was formally evaluated at the end of the second day, information which was later sent to the Trust, and an overall evaluation, comprising an overview of all seven evaluations, was provided after completion of the programme. Some minor changes in workshop delivery were undertaken following the first workshop, which served as a pilot, particularly around breaking information into small packages and focusing on practical activities. The evaluations were overwhelmingly positive, which suggested participants had understood the primary messages, and gained a lot from the opportunity to participate.

The core of the workshops related to understanding de-escalation in terms of a model, which essentially pervaded the two days but was only presented as a theoretical model towards the end of the second day. The most practical approach to de-escalation constitutes the over-arching framework adopted in the workshop, the basis of which relates to the knowledge that we have; in essence, there being four dimensions to de-escalating an incident or potential incident:

- Knowing oneself
- Knowing the patient or service user
- Knowing the situation
- Knowing how to communicate

(Paterson, Leadbetter & McCornish, 1997).

Discussion

These four elements of knowledge provide a means of breaking down de-escalation, as a concept, into its constituent parts and demands that people need to comprehend each part both in relation to the others and by itself. Workshop participants, for example, complete an individual exercise, which requires that they reflect on their own relationship with anger, and their own mechanisms for negotiating such feelings. It is important that the workshop facilitator is familiar with the exercise and able to provide feedback to participants relating to their exercise scores. The exercise promotes discussion around the nature of anger, the individual's own anger, in particular, and suggests a number of ways in which we might respond to feelings of anger, displacement, catharsis and accumulation being the most usual. Knowledge of communication surrounds verbal, non-verbal and para-verbal dimensions, acknowledging yet also critically discussing Mehrabian's (1971) findings relating to the relative weight given to the different aspects of communication. Comprehensive understanding of communication, therefore, requires knowledge of the initial verbal strategies relating to the words and phrases that we select, in conjunction with the tone, pitch, quality, volume, rate and rhythm of speech, and the complex array of non-verbal behaviours, such as body posture, facial expression, eye contact, gestures, touch, proximity, body movements, silence and symbols (tattoos, hairstyle etc.).

Knowledge of the situation involves the first engagement with the proposed model. The spine of the model follows Davies & Frude's (1993) work on the process by which a particular situation may result in violence, wherein it is the way in which the circumstances of the situation are appraised that influences the extent to which an individual becomes angry, since such appraisal may be charitable or uncharitable; then for anger to be translated into violence requires the individual negotiating various inhibiting factors (psychological, cultural, moral) before determining his/her response. This approach

to understanding how violence might occur is one of process, regarding the degree of anger experienced and the way it is interpreted as underpinning the other elements of the model.

The final dimension of de-escalation constitutes the one attracting most attention, and explains the emphasis on complexity – knowledge of the patient or service user. The workshop's emphasis on interspersing activities with small packages of information enabled information to be delivered in segments, yet also accentuated that it was critical for participants to regard the information in relation to the other packages. These information packages, furthermore, were underpinned by data extracts from published studies undertaken by the author on different aspects of violence (Lovell & Bailey, 2017; Lovell *et al.*, 2014; Lovell & Skellern, 2013; Lovell, Skellern & Mason, 2011). The process by which a situation might flare up into violence, therefore, is influenced by the degree of complexity experienced by the individual. The intellectual disability itself constitutes the first complexity factor, influencing the way in which staff might respond to overt displays of aggression, for example, through recognition of the difficulties such individuals may have in processing and interpreting information conveyed to them. The important factor relates not to the certainty that staff may have about how much information has been properly understood, but in recognizing that there will be difficulties in this area and therefore working with the individual with this in mind. The second factor revolves around additional conditions that might interact with the intellectual disability, such Autism Spectrum Disorder (ASD), Borderline Personality Disorder (BPD), Attention Deficit Hyperactive Disorder (ADHD) or Attachment Disorder. In the case of ASD, for example, there are expectations of a degree of rigidity in the patterns of behaviour, which can indicate an inordinate amount of anxiety when there are breaks in routine or unexpected events. The interrelationship, therefore, between the intellectual disability and the ASD might influence how someone's stress levels can escalate out of control and be expressed on occasion by a propensity for violence. The relationship between intellectual disability and BPD is a particularly complicated one, since it is only in recent years (in the UK at least) that the two conditions have come to be understood as compatible. Previously, the diagnosis of BPD was rarely applied to this population, which suggests that some of the behaviours that we might now associate as arising from the condition were perceived as behavioural, with no clinical basis. It is always difficult to have certainty when working directly with such complexity, but some impulsive behaviour, feelings of intense anger, tendency towards self-injury, or difficulties in sustaining relationships might arise from the BPD, then be complicated further by manifestation alongside the intellectual disability. Conditions such as ADHD and attachment disorder similarly present many issues, not just in developing therapeutic relationships, since experience of abandonment (in the case of attachment disorder and BPD) can have a dramatic effect on relationship stability, but also in handling specific situations that have the potential to escalate out of control. Many individuals have multiple diagnoses, some historic and some continuing, and the challenge, especially in avoiding recourse to traditional physical intervention responses, relates to staff being able to comprehend how such diagnoses inter-relate in the context of intellectual disability, and impact on the behavioural choices made, whether an individual can successfully control his or her temper, understand the consequences of their actions, even begin to see things from the other's viewpoint.

Frequently underpinning this array of clinical conditions, which may be further complicated by issues of mental ill-health, there are additional issues arising from someone's background. Many people with intellectual disabilities experience neglect and abuse in childhood and early adulthood (Emerson, 2013), and this early history significantly affects the likelihood of their engaging in violent and/or offending behaviour. Furthermore, many of the issues not immediately associated with this group, such as difficulties around substance misuse, particularly dependence upon alcohol, have increased over recent years. They are much more likely to have spent time in prison, though diversion schemes have modified this to some degree, experienced extreme family dysfunction, such as other members of the immediate family having similar issues, including mental health problems, been subject to abusive relationships, even homelessness. Staff working with those who are potentially violent, whether with an intellectual disability or not, are generally influenced by a climate of risk

assessment, with a current emphasis on their validity and precision (e.g. Van Brunt, 2013; Cook, 2013; Haines *et al.*, 2013). An over-reliance on risk, however, has a potential consequence of de-skilling people in the development and maintenance of negotiation skills, reading situations, knowing when to be alarmed or when someone is genuinely distressed and unable to control their emotions – in sum, reduces their capacity for working effectively with complexity. This is the third strand to the model, the ways in which staff utilize knowledge of both the process by which violence occurs, and knowledge of complexity, to inform therapeutic engagement.

Conclusion

Many staff are highly skilled in working with people with an intellectual disability and a background of violence, employing such skills in their responses to difficult situations, preventing anger from escalating out of control and underpinning therapeutic relationship development. There is a need, though, for enhanced understanding of the impact of complexity with regard to the manifestation of violence. An increased knowledge of clinical conditions, particularly the ways in which they might interact with the intellectual disability, and some comprehension of other background and lifestyle issues, is likely to enhance the ways in which staff respond in circumstances of crisis. The role of a working model is to understand how situations escalate into violence, interpret in terms of individual complexity, and examine the implications in terms of therapeutic engagement in such circumstances.

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From thousands to zero restraints a year: Which organizational conditions and staff-requirements made it possible?

Paper

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Keywords: Restraint reduction, coercion, organizational preconditions, staff-requirements, intellectual disability, group home

Introduction and/or background

Which preconditions made it possible to go from thousands of restraints a year to zero in a group home in Norway?

This paper presents findings from an ongoing research project in Norway focusing on the quality of extensive care services, funded by The Research Council of Norway and led by Professor Jan Tøssebro. In the project researchers cooperate with different municipalities. Together with employees from these municipalities we are looking at political guidelines, self-determination, management, the role of the employee and other issues. From each municipality we have selected form one to four cases. Each case is a group home for people with intellectual disabilities. The service users in this group home consisted of people who had severe behavioral problems. During a few years the group home managed to end the use of restraint and physical intervention despite the fact that the number of employees was reduced. This paper focuses on the organizational preconditions and staff-requirements that formed the framework of the start-up, together with the principals for development of this group home. This means that we are not looking at the methods itself or the daily work in the group home. Our interest is the preconditions for the method that is developed and used.

Aims/main ideas

This paper states that it is possible to decrease challenging and violent behavior without restraint and with a minimum of staff-members. In this paper we also show the preconditions and premises for how it is possible to decrease the amount of challenging behavior.

Area of focus, research questions and methods

The area of focus and research questions are as following:

1. **Organizational/external preconditions: Why did the municipality build the group home? Which preconditions and demands were given from the administration of the municipality?**

Services for people with intellectual disabilities have gone through several changes and trends the last decades (Tøssebro 2016). When it comes to managing violence great changes has also taken place. Some even talk about a shift in paradigm (van Engelen 2010). Looking at preconditions and premises became a part of this.

2. **Internal preconditions: What were required from the personnel in the group home?**

Pointing at staff members role and their ability to communicate and prevent aggression from rising is more and more acknowledged (Paterson, Bennet and Bradley 2014; McDonell 2010). In this paper we look behind even this and consider what requires from the staff in order to follow a particular way of dealing with challenging behavior.

In this particular case we interviewed staff-members, management and advisers at the councilor's academic staff in the municipality. We also spent several days with the employees to observe the work.

In Norway services for people with intellectual disabilities most often are organized as a kind of group home where several persons live together. The service users have their own flat and usually a common area/living room. The group home also consists of a base for the staff.

A brief description of the professional method at the group home

This paper is mainly about the conditions of a method used at a group home. First we would like to give a brief description of the method they developed. Key elements in the method are self-determination, avoiding demands in critical situations and pulling out when the service users become aggressive. Another crucial idea was working 1:1. This means that instead of having between 2 and 4 employees keeping watch on every service user, there should be only one employee working close to, and being aware of, the person`s need. We will get back to that. The method also consists of three statements which are used to test whether they promote or inhibit the person.

1. Caregivers are often the main development inhibitor
As caregivers we often tend to think that they are indispensable for the people we work with. Instead of leaving them alone and letting them do things themselves, we do it for them for several reasons. This is not help, but interdiction. An important part of the job is to know when not to intervene. Furthermore we have to accept diversity. Many of those we are working with are unusual in many ways. We have to let them be that way. Instead of a regime of control, we want the person to naturally experience consequences of his or hers acts.

2. Focus on diagnoses, creates more symptoms
In the struggle to be predictable in our actions for those we work with, we often demand that everybody in the staff have to react and behave the same way. If you focus on diagnoses you will automatically seek for anything that confirms the diagnoses instead of treating him or her like an individual with its own needs and desires. What is needed according to our experience is flexible caregivers who do situation-based caregiving. By replacing the focus on diagnoses with an individual approach we want to reduce the symptoms instead of increasing them.

3. Focusing on risk, increases the risk
Focusing on the risks makes the personnel behave as if the service users are aggressive. This increases the emotional experience of needing physical intervention techniques, training and knowledge about how to control a person. The most obvious tools at hand will then be restraining and controlling. The service user recognizes this and responds by confirming the role he or she is given, that is as an aggressive person. By meeting the users with a relaxed attitude and accepting the lack of control, the caregivers make room for the persons' own way to solve his difficulties.

Telling stories about dangerous service users is also an inhibiting factor. This will affect the next caregiver and cause them to be alert and stressed. This does not create good relationships. Storytelling can make you good professional but it certainly also can make you a bad one. The group home try new ways of dealing with the person and avoid phrases like "we`ve tried that before…"

Main findings

Condition 1: A new law and ideological change
The first condition was a general condition that applied for everyone in Norway and not only for this particular municipality. 1. January 1998 an amending legislation came. The legislation became a game changer. Among others things the municipalities now had to register every use of restraint on people with intellectual disability. It became visible that the use of restraints were high, especially

related to a few people. It was evident that a change was needed. The amending legislation was a part of an ongoing ideological change focusing on rights and self-determination. Some might say the ideological change came because of the law. Others would see the law and the amending legislation as a broader ideological and professional change which has taken place in various fields the last twenty years. Important for this matter was the fact that the municipality interpreted the law in a strict way and saw an urgent need of change.

Condition 2: Economic issues
At the same time there was a discussion about the high economic costs of the group homes in the municipality. It was estimated that a new group home would reduce the costs by 1.790.000 USD. What actually caused the building of a new group home is therefore uncertain.
Economic issues were also a crucial condition for how they organized the work in the new group home. The new group home was run on a much lower budget then the earlier ones. They could therefore no longer afford to be two, three or for employees working with one service user. The management now had to look at others ways to work and it was decided that 1:1 should be standard; this meant that instead of working between two and four employees together, they would now be working alone with the service users. One employee worked with one service user.

Conditions 3: a safe professional community of personnel
Even though the total number of staff members was reduced, they were now gathered at one place. A safe professional community of personnel was created. This gave an important back-up system for those working alone with the service users. The employees were in other words not left by themselves to work with potentially aggressive people, as it might sound at first. Gathering the employees also led to further professional discussions and individual development of skills and performances. The professional community questioned each other's work, perspectives and solutions to tasks and challenges in daily work.

Conditions 4: strong leadership and involvement of all employees
There is no doubt that a strong leadership was necessary. The management had a very clear goal and purpose. At the same time all the employees were involved both in planning and establishing of the group home. This involvement continued after start-up. They took part in different discussions of how the professional work should be done. Engaging all staff members also meant that instead of waiting for external help they started to believe in their own skills and knowledge. Instead of waiting for external guidance and supervision they now developed their methods themselves.

Conditions 5: Committed and bold staff-members
Because of the dominant ideology staff members had to commit themselves. The premise was staff members who had the courage to do so. Working alone with aggressive people was the new standard. Working alone meant that staff members had to believe 100 % in the method and the ideology. They also had to be committed to the goal and the three statements. The premise of bold staff members was an important one. All together it took several years until all the aggressive behavior had stopped. The employees had to accept a certain degree of uncertainty and insecurity – and they had to feel comfortable with it.

Conditions 6: Unwilling staff members where relocated
As mentioned it could not be expected that all staff members agreed, but what if they didn`t? Normally in Norway during transitions of all kind in the public services, you still have to use the same group of staff as you had before. The transition will therefore be just as good and just as bad as the group of staff you have available. In this case, staff members could either voluntarily relocate to another job in the municipality or they would be relocated by the management. The controversial changes in the group home would not have been possible without this premise: those who believed in the method and ideology stayed and had to be committed. Unwilling staff members had to find another job.

Conclusion and/or Discussion

We conclude that it`s possible to manage challenging and violent behavior without restraint and with a minimum of staff-members. We also conclude that there were evident conditions and premises for the method.

There were several premises and conditions for the method at this group home. We have mentioned the most conspicuous ones. Especially we want to emphasize the importance of the economy. We state that a combination of economic conditions and ideological/professional conditions were the reasons why the municipality build the group home. Yet the most important of these factors are still uncertain. It seems certain that the group home would not have established without a reduction of costs. This implicates that the rise of a new way to work with aggression was not caused by ideological or professional reasons, but by economy. This was the most sensational finding in the study. On one hand the economic background is discouraging: we would like the new way to work at this group home to be a pure ideological and professional invention. One the other hand it`s great that minimizing challenging behavior could be a low cost enterprise. Often we see that managing such behavior is expensive and takes a lot of resources. New ways of thinking and treating people with intellectual disabilities were nevertheless developed. For a great part the reason why they managed to do so was a strong leadership who involved all staff members. It seems as if a strong leadership was most important at the beginning, before the new way of working had settled.

The requirements of those working in the group home were obvious. They had to be committed and bold, otherwise they would have to relocate – voluntary or involuntary. The relocation of unwilling or unfitting employees seems to be significant for the new group home and the method they developed. It was controversial back then to put employees alone in front of people with severe challenging behavior. Today this would be even more difficult because of the Norwegian Employment Protection Act. January 1. 2017 an amending legislation became operative. Among other things it instructs all work places to consider whether working alone is safe or not. Working alone in this group home did not mean they were left alone completely. Gathering many employees created a professional community. So, the premise for working alone was back-up systems and professional colleagues prepared to assist. It also meant that the employees had someone to discuss the work with. Through an open dialogue among the staff member the work and the method were further developed.

We want to emphasize that the conditions for those who planned, built and developed this group home were different compared to those who want to do the same today. The group home has shown that it`s possible to reduce challenging behavior without the use of restraint and with a minimum of staff members. Critic of approaches like this is that avoiding demands is not a solution, but a way of avoiding challenges. That`s another discussion. We have to remember the background for the people at this group home. They were by far the most aggressive and violent people with intellectual disabilities. The main task for the group home was to minimize the destructive behavior. Now when behavioral issues isn`t as dominant as before, the question is whether the service users have potentials for further development and whether the staff manage to facilitate such a development.

The group home with its management and staff members went into unknown waters, even though many around them claimed that what they were about to do, was impossible. The waters were surely unknown, but "the earth was not flat": It was possible to find new ways to reduce challenging behavior and the staff members survived the journey. Today the question does not seem to be whether you believe what they did is possible, but whether you accept some of the premises and preconditions.

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Reduction of coercive measures - results of a systematic review

Paper

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Keywords: Coercive measures, seclusion, mechanical restraint, systematic review

Background

Since 2015, a working group has been updating and upgrading the guideline on therapeutic interventions against aggressive behaviour of the German Association of Psychiatry, Psychotherapy and Psychosomatics using the methodology of evidence-based medicine and of consensus-based guideline development. Aggression and violence are disruptive for the therapeutic community. Coercive measures are often traumatizing to patients and staff. There are case reports on physical injuries and even death in physical or mechanical restraint [1]. People who experienced seclusion or restraint rated it humiliating and anti-therapeutic [2]. Due to the well-known reciprocal effects between aggressive behaviour and coercion a systematic review on evidence-based interventions to reduce coercive measures has been initiated.

Methods

We conducted a systematic review. The search was done in the databases MEDLINE and CINAHL. We used two distinct PICO search terms. This was necessary because MEDLINE and CINAHL do not understand the same keywords and operators, e.g. the Thesaurus Medical Subject Headings (MeSH) may only be used in MEDLINE. A hand search was done, too. We included articles describing interventions to reduce, prevent or eliminate seclusion and restraint in adult persons with mental illness in different settings. We excluded data on children, settings not eligible for the German health care system (especially psychiatric emergency rooms and community treatment orders). There was no restriction of language.

We made a narrative synthesis including a divisive cluster analysis to identify different clusters of intervention (such as staff training or environmental enhancement). If interventions were not explained in detail, we contacted the authors of the articles via email. We could not realize a quantitative synthesis (meta-analysis) because data heterogeneity was assumed to be quite high.
This systematic review has been registered with Prospero on 25/08/2016 (# 42016035541).

Results

Our search yielded 2915 hits. 2578 records remained after duplicates have been removed. After Title-Abstract-Screening 336 full text articles were assessed for eligibility. 260 of records were excluded. 87 articles describing 79 studies were included in the review.
There were 8 clusters of interventions identified:

- environmental enhancement (including architectural changes and sensory modulation),
- staff training (including training programs, internal and external supervision) focusing on communication and de-escalation , less restrictive interventions or new culture and policies,
- organizational changes just like improved staffing , integrated treatment models , open door policy, strengthening of the therapeutic community, stricter documentation and review of seclusion and restraint episodes and downsizing of units and wards ,

- Psychotherapy (including individual treatment plans, psycho-education, family interventions and cognitive behavioural approaches),
- Structured and individual risk assessment with consecutive early interventions,
- Debriefings (cognitive behavioural and trauma-therapeutic approaches),
- Advanced directives,
- and legislative and institutional changes

Approaches from different fields such as quality improvement initiatives, trauma-informed and recovery-based care as well as political and organizational changes could be identified. Most of the programmes which helped health care suppliers to reduce their seclusion and restraint rates were complex in their nature including different components and/or were acting on different levels of mental health organizations (individual patient or staff, their relationships, ward atmosphere, hospital, family or even the society).

Discussion

Most of the studies were effective in reducing seclusion and restraint episodes or at least the duration of seclusion and restraint. Risk of bias must be expected to be high due to selective reporting. Constraining inclusion criteria of this review to controlled trials or even to RCTs would have minimized bias but would have provided too little information.

Quality of the studies was mostly low. There were just 12 controlled trials of which 3 were randomized. Many studies used pre-post-designs and were set up retrospectively after a clinical program to reduce coercion was established successfully. The studies investigating complex interventions with multiple components did not use a cross-over or multiple baseline design but in one study [3]. So in most cases it was not possible to distinguish which components were effective. Even if the single components were implemented step by step there was a notable risk of carry-over effects. But it was obvious that these complex programs were particularly effective in studies and useful in clinical routine to influence culture and daily practice. Therefore these programs will be recommended in the German clinical practice guideline.

It is interesting that studies that include a retrospective and prospective baseline show a huge Hawthorne effect [4]. In addition, many changes seemed to occur due to changes in the attitudes of leaders and staff. So working on the reduction on stigma of mental illness and education about the adverse effects of seclusion and restraint will play a central role in the process of reducing coercion.
Many studies were excluded from this review because their primary outcome was a better treatment of psychiatric disorders, especially treatment refractory psychosis, dementia and delirium. But in many cases interventions to improve the treatment of people with mental illness also helped to reduce seclusion and restraint. New insights in the optimal treatment of mental disorders may lead to a further reduction in the use of coercive interventions in the future.

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Aggression management in an adolescent forensic unit: change over time

Workshop

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Keywords: inpatient care, aggression management, adolescent forensic psychiatry, coercion, patient self-determination

Abstract

The adolescent forensic unit EVA in Tampere University Hospital (Finland) is a national service for adolescent psychiatric patients with formal forensic status as well as non-court ordered adolescent patients with severe mental disorders complicated with persistent and severe violent and noncompliant behaviours. In this symposium we describe how our approaches to aggression management have evolved over the almost 15 years of operation. The educational aims of this symposium are to offer ideas for service development for units working with challenging adolescents, and to promote ethical evaluations of justice in treatment of (younger) patients whose own behaviours may threaten the rights of others.

Legislation concerning involuntary treatment and coercion in psychiatric care has not changed during the described unit's time in operation, but emphasis on patients' self-determination and individual needs have increased. Supervisory authorities now demand some practices that were previously understood be not allowed, and question other practices previously seen as necessary for safety. Scientific research increasingly emphasizes rewarding positive behavior instead of focusing on predictable consequences of negative behavior.

Early in the unit's history we focused a lot on being clear about ward rules, and understood justice as predictable and similar interventions – consequences - with all patients in similar situations or for similar behaviour. Current understanding emphasizes interventions according to individual needs. In understanding individual needs, structured assessments such as behaviour analysis, START and SAVRY are systematically used.

The most important steps in the unit's comprehensive aggression management program are supporting self-control and de-escalating emerging loss of behavioural control. These are approached within the fraemworks of Safewards and Management of Actual and Potential Aggression (Mapa). In addition to group interventions in which most of the adolescents participate, namely Aggression Replacement Training (ART) and training emotion regulation skills according to principles of dialectic behavioural therapy, offering structured activities for most of the active daytime is essential for maintaining positive treatment milieu, as the adolescents admitted to the unit mainly have remarkable deficiencies in social skills and in self-regulation skills. In order to enhance positive peer contacts, essential for adolescent development, we offer a lot of group activities.

An important challenge which particularly leaders and managers need to focus is ensuring that the staff does not feel that changed views of the supervisory authorities and changes in treatment philosophy question our previous work. With increasing scientific knowledge and societal changes, adolescent forensic psychiatry also needs to evolve.

Educational Goals

- To offer ideas for service development for units working with challenging adolescents
- To promote ethical evaluations of justice in treatment of (younger) patients whose own behaviour may threaten the rights of others.

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Sensory profile – a personal individually designed tool to reduce the risk of violence and coercion

Workshop

Tina Sognstrup Pedersen, Else Poulsen, Majbritt Kildedal & Agnethe Clemmensen (Denmark)

Keywords: Partnership between staff and patient, individual approach, reducing violence and coercion, focus group interview with patients, coping strategies, sensory profile, psychoeducation.

Introduction/Background

It is a clinical option in Denmark, as in other countries, to force a medical treatment and/or to limit a patient's freedom when a severe psychiatric disorder results in harm. Forced treatment cannot represent a standard, when an acute situation in the unit develops. Preventing and reducing coercion is a high priority in Denmark, as well as worldwide.
In Regional Psychiatry, West Denmark, the Sensory Profile (SP) is used as part of an effort, to reduce coercion and violence. Sensory profile has shown, that an individually adapted approach to patients is preventive, in terms of coercion and conflict.
All mental disorders are deeply connected to a feeling of too much insecurity, giving a risk that the person will react violently either towards others or to themselves. Sensory profile makes it possible to increase the sense of security, by creating an understanding of one's individual Sensory Profile.

Methods/results

The project, Sensory Profile, has a direct link to the Danish National Agenda, about reducing coercion in psychiatry. And we have set out to investigate this issue in cooperation with the patients:
Can Sensory Profile contribute to reduce the use of coercion and the risk of violence, and furthermore increase the sense of security?

The Sensory Profile is designed to promote self-evaluation of behavioural responses to everyday sensory experiences. It provides a standard method for professionals and individuals to measure and to profile the effect of sensory processing on functional performance.
There are 2 principal purposes for the SP:
The first is to provide information, vital to understanding the sensory processing of an individual. Many people do not understand why they engage in certain behaviours and/or why they prefer certain environments and experiences. The completion of SP results in an increased awareness and understanding of an individual's sensory processing preferences. And not only for that individual, but also for the professional who administers the measure, team members, family members and others, who are close to the individual.
The second principal purpose is to enable more informed intervention planning, which takes into consideration the individual´s preferences. And it is appropriate for people with physical and/or psychiatric disabilities, as well as for individuals without an identified disability.

From a sensory integrative perspective, learning occurs when a person receives accurate sensory information, processes it, and uses it to organize behaviours. When people receive inaccurate or unreliable sensory input, their ability to process the information and create responses is disrupted. Difficulties in sensory processing can take many forms and must be inferred from observations of people´s behaviour and performance. Poor sensory processing can take the form of over-responsivity (e.g. becoming agitated, when someone brushes against him/her (tactile defensiveness) or lack of

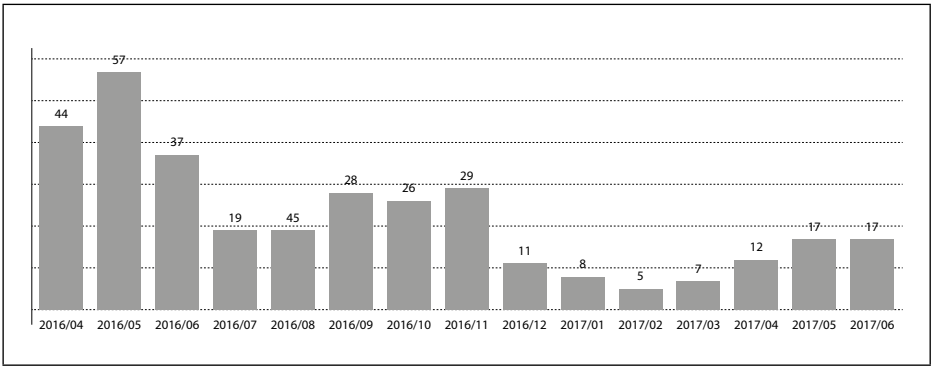
responsivity (e.g. must be tapped on the shoulder several times to gain his/her attention). Individuals, families and service providers have reported that low sensory responsivity can affect performance.

Sensory profiling allows us to identify patients' individual sensory difficulties, and any challenges concerning the senses, for example sound sensitivity, touch problems, etc.
So, when a patient is angry, frustrated and close to losing control - it could be a sign of overstimulation /understimulation or poor sensory processing. Identifying patients' sensory profile means, that staff can take individual considerations to the patient's sensory profile during the day, and thereby prevent frustration and violence.

Follow-up in the project is done by analysing data from the Regional Coercion Registration Database (a ward in our department is compared with a ward in another department, differing by not having implemented the SP) and focus-group interviews.

Although the preliminary result are not significant because of small datasets, the trend is clear: the number and length of belt fixations in the ward with sensory profiling is declining both in intern comparison and in comparison with the other ward.

The total numbers of belt fixations since april 2016 in Regional Psychiatry West, DK.



It is important, that the patients can transfer the good results from the use of the SP in the psychiatric ward to their home environment.
To investigate this, a focus-group interview was planned. We succeeded in getting four previously admitted patients to participate.

Conclusion/discussion

The focus-group interview resulted in very positive statements. It confirmed that patients experience greater understanding from the staff following the development of a sensory profile. Patients emphasized the importance of being able to use the results of the profile at home after their discharge, which indicates, that SP also can be used to prevent further admissions, because it is very easy to transfer to your home environment.
The interviews confirmed that SP is very meaningful and helps to create a greater understanding of one's sensory processing difficulties, and what individual considerations one must take. Furthermore, it confirmed that SP creates an understanding between one's sensory sensitivity and behaviour.

It is also important to mention some other actions, that has been implemented in the unit, to reduce the use of coercion and violence.
We have implemented the method, Safewards. The goal with Safewards is to make the units calmer, safer and more secure and thereby reduce the use of coercion and violence. It focuses on communication and the relationship between staff and patient. So far, we have great experiences with it.
In addition to this, the staff is taught methods to de-escalate a situation - also in order to prevent coercion and violence.

Acknowledgments

Wendy & Co.
www.wendyco.com (provider/sponsor of Fingerrollers)
www.tangletoys.com (provider/sponsor of tangles)
www.procare.dk (provider/sponsor of tactile massageballs)

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Implementing a rapid response system, the Psychiatric Behaviours of Concern Call (Psy-Boc) for managing the deteriorating patient in the psychiatric setting, Melbourne Australia

Paper

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Keywords: early intervention, prevention, seclusion reduction

Abstract

The medical emergency team (MET) is a rapid response system that has become a routine way to identify & manage the early signs of the physically deteriorating patient. The MET team is used widely in general health settings in Australasia, North America and the UK.

This study applies the MET rapid response principle of early intervention to manage clinical deterioration in the inpatient psychiatric setting, by initiating psychiatric behaviors of concern call (Psy-Boc). The aim of this initiative was to address a local rising seclusion rate, lack of systematic early intervention of clinical deterioration, and ad-hoc involvement of senior staff.

The general principle with rapid response systems is matching the right people, with the right skills and knowledge, with the right patients at the right time. The (Psy-Boc) early intervention initiative involves a psychiatric rapid response team consisting of Nurse Managers, allied health representative, Operations Manager, and Nurse in Charge rostered to respond to early signs of behavioral health deterioration within business hours.

An after hour's roster includes psychiatric registrar on call and senior psychiatric triage clinicians. Behavioral deterioration criteria were established in the same way vital signs measurement and criteria triggers a MET response. Staff concern was also a criterion used for (Psy-Boc) and is an important MET criterion.

A comparative analysis was undertaken in the 6 months prior to implementation and post using 3 measures, seclusion rate, incident rate and security staff calls. A significant reduction in seclusion episodes per 1000 bed days by 39%, and incident rate per 1000 bed days 32% was achieved. Security involvement reduced slightly by 20%.

Educational Goals

- Delegates will appraise and evaluate the merits of early intervention and prevention approaches in psychiatric inpatient settings
- Delegates will describe and recognize early intervention and prevention criteria to initiate escalation of clinical deterioration in mental health inpatient settings.

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Intervention Team reduces use of mechanical restraints

Paper

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Keywords: psychiatric emergency response team, collegial sparring, de-escalation, mechanical restraint, second opinion

Background

The Danish government has set a goal of reducing the use of mechanical restraints (MR), that is, fixation with a belt, by 50% by the year 2020. Since 2015, Mental Health Centre Ballerup (MHC Ballerup) in the Capital Region of Denmark has been involved in a national project on MR reduction that runs through 2017. The goal is a maximum of 10 MRs in 2017 vs. 329 in 2013.

The intervention team (IVT) was developed in 2015 and implemented in February 2016 as one of several interventions at MHC Ballerup aimed at reducing the use of MR. Evaluation of earlier incidents involving MR had shown that staff could benefit from here-and-now-second-opinions in escalated situations to avoid using MR. Furthermore, there was a need to offer service users a new relation when communication with staff had collapsed, and the situation was deadlocked.

To tailor an intervention that could meet the specific needs and fit into the organisational context at MHC Ballerup, an interdisciplinary working group of nurses, nursing heads of units, psychiatrists, and service users was established. The working group defined the intervention in terms of concept, instructions, flow chart, and what qualifications were needed for IVT staff.

The purpose of this paper is to introduce the IVT, present and discuss gains and challenges, and hopefully inspire others to use similar means to reduce the use of coercive measures.

Methods and context

This section describes what the IVT is and how it operates; it also outlines the sources of information used for this paper.

What is the IVT?
The IVT was implemented on February 1, 2016, and had operated for 17 months when this paper was written. The IVT consists of two staff from the intensive psychiatric care ward with the most experience reducing MR. The IVT can be called on when another ward needs assistance in de-escalating and preventing MR or other means of coercion. The intervention team can be called on in situations

- when service users previously exposed to coercion are hospitalised,
- when a situation or a service user's condition is at risk of escalating,
- and in acutely escalated situations.

In the situations listed above, the IVT can offer professional sparring to the staff or can take over contact with service users.

Before calling on the IVT, staff at the ward should estimate the risk level via BVC (Brøset Violence Checklist), assess if cooperation is possible, apply de-escalating communication and activities, and PRN medication (i.e., 'when necessary') should be offered. The service user should also be offered

another staff relation. When IVT is called, the situation is briefly described, and staff roles on the ward are allocated (staff with the patient, with IVT, and in the ward environment).

When the IVT is on the ward, the nurse in charge briefs the staff using an IVT scheme. Secondly, a plan of alternatives to MR is prepared and performed. When the plan is performed, the BVC level is assessed again, and the plan is adjusted. Throughout the process, timeout can be used and a psychiatrist can be involved. When cooperation between service user and staff is obtained, a follow-up plan is prepared. The plan is discussed with the service user and a cooperation agreement is prepared or revised.
After the IVT intervention, involved staff evaluate the intervention using the IVT scheme.

Interventions can last from minutes to hours, and the team can be called on several times to the same situation in different phases. The ward hosting the IVT has been upgraded with three extra staff to cover IVT tasks during day and evening shifts.

Sources of information
For this paper, the following sources of information have been used:

- **IVT schemes** with brief evaluations of all interventions. The schemes are filled out by IVT staff immediately after every intervention.
- **A questionnaire survey** performed in October 2016 targeted staff from the wards using the IVT and the ward hosting the IVT.
- **An interview survey** performed in March-June 2017. Three service users and 10 staff members (from the wards mainly calling on the IVT, IVT staff, and young psychiatrists) were interviewed. All interviews were semi-structured.
- **Observations** by the recovery mentor, who is also the first author of this paper, in an intensive care unit
- **Data on the use of coercion** from the project on MR reduction at MHC Ballerup

Results

Results will be grouped into three areas: Data on the use of the IVT, staff and service user experiences with the IVT, and data on the use of coercion before and after the implementation of the IVT.

The use of the IVT
Data from IVT evaluation schemes on the use of the IVT indicate that intervention is, on average, called on four times a week. However, there is great variation over time, and the database is not complete. The real number might, therefore, be higher. Furthermore, it is not always clear if the task is a regular IVT task. The format of IVT schemes was changed ultimo 2016. Therefore, only the data from 2017 are used. A thorough examination of schemes from 2017 shows that 63 of the 93 calls were indisputable IVT tasks, while 30 were disputable. One source of information on the outcome of the IVT interventions compares before and after BVC values. A comparison of BVC values from the interventions in 2017 shows that service users' BVC is, on average, down by 1.6 from an average 'before' value of 3.5. It is unknown how BVC would have changed without IVT interventions.

The most frequent 'action' taken by the IVT is 'taking over contact with the service user'. In the 93 interventions in 2017, the IVT took over contact with the service user in 47 cases or 51%. Another frequent action was 'motivating for taking medicine' which is registered in 31% of all cases in 2017. Different kinds of activities, change of contact person, and sensory integration were used as interventions in 12%, 6%, and 5% of the cases respectively. Furthermore, all interventions involve cooperation with staff on the ward and elaboration of plans, but we do not have data from the IVT schemes indicating the quality of cooperation and plans.

In a small number of cases, IVT interventions involved coercion, but none of them were MR. Pharmacological restraint, that is, forced emergency medication administered orally or as an intramuscular injection, used to sedate the patient (Wynn, 2002), and manual restraint, that is, immobilising the patient with physical force (Janssen *et al.*, 2011), was used in 16 or 2%. of the interventions.

Staff and service user experiences

A questionnaire distributed among staff from the three wards primarily using the IVT, staff from the 'IVT ward', and young psychiatrists was answered by 54 staff members. Among those, 63% had experienced to 'some degree' or 'a large extent' that the IVT had 'prevented coercion or escalated situations'. There were significant differences between the wards calling the IVT. The emergency department, where staff has limited experience with critical situations, had more positive experiences with the IVT compared to the intensive care units. The open question on IVT qualities shows that the IVT function is valued because it provides 'extra staff in acute situations', 'they are good at talking to the service user', they are 'fresh eyes on the situation', 'IVT often has a relation to the service user in advance and knows what works', and 'they keep calm and are good at de-escalating'. Suggestions for improvement primarily concern cooperation between IVT and the ward and a lack of clarity of IVT tasks.

The interview survey confirmed the main conclusions of the questionnaire survey and added important extra knowledge. The key points are summed up below.

Interviews made it clear that 'extra staff' is appreciated for bringing new energy into locked situations: *'They can take over the situation when the rest of us are all done—you can say when we hit rock bottom'*, as a staff member put it. Also, new faces in a critical situation send a clear signal to service users: *'Then service users think "OK, now it is serious"'*. Service users confirm this signal value of new staff showing up: *'In that moment I knew that people were here because of me and that is in fact what counts. That people are there for you.'*

Courage and experience are mentioned as key IVT qualifications: *'In situations where we would have thought, "OK, now I take two steps backwards, they might step forward and have an ordinary, relaxed conversation"'*. The service users who are potentially the most aggressive are admitted to the 'IVT ward' giving staff there more experience: *'They are in this environment where externalising behaviour is always an option… They just approach these things differently because it is their everyday.'*

Having a relation with the service user in advance is mentioned as *'extremely important'* in critical situations. *'For example, we had a situation last week when an IVT person came over and said: "I know this service user really, really well; I will go to this service user on my own, because I can find a way to sort things out, so he will take his medicine. And so, he did"'*. Also, since most service users with complex issues and potentially externalising behaviour were previously admitted to the 'IVT ward', the IVT can sometimes take advantage of an existing alliance. A service user who had had negative experiences on the 'IVT ward' explained that existing relations can also be problematic, if relations to IVT staff are negative in advance.

Cooperation between the IVT and the other wards is a key element of the IVT function, but it is also described as the most difficult part. One of the reasons is that there are divergent interpretations of the role of the IVT—to what extent shall the IVT take control and involve staff on the ward? At the two intensive care wards, staff would prefer to be more involved: *'Sometimes, you have a feeling of being overruled'*, says a staff member from the calling ward. At the emergency department, which has the least experience with critical situations, they have no problem letting others take control. At intensive care units, however, some staff members see the IVT as competitors and find it difficult to share and give away control: *'At our ward, we think we are just as good as the IVT'*. Interviews

made it clear that the ability to deal competently with acute situations is a profound part of staff's professional identity at intensive care units. Calling the IVT in critical situations can, therefore, be interpreted as a sign of incompetency. Especially in the early implementing phase, professional pride and 'competition' between wards created obstacles to the IVT function.

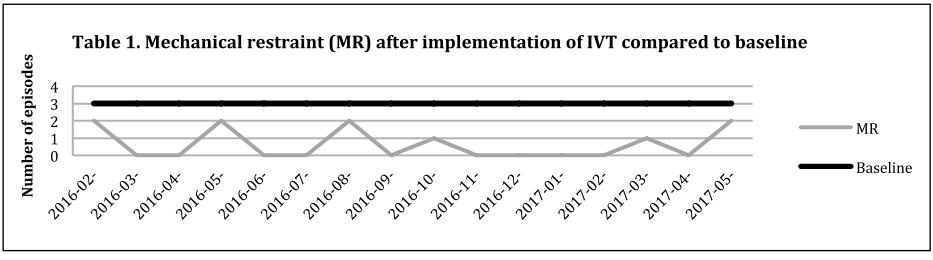
The IVT staff also experiences difficulty cooperating, but from their point of view, the reason is that staff from the calling ward withdraws from the situation. An IVT staff member says: *'Sometimes, we experience that staff withdraws: "Well, now you have come, and you are just so skilled, so you can better take over"'*. Another reason the 'here-and-now-second-opinion' can be challenging for the IVT is that they are sometimes called on after the situation already has escalated too much. An IVT staff member says: *'Staff calling IVT must feel seen, heard, met, and involved, but the opportunities to involve them are so much better if you have 15-20 minutes for knowledge sharing and making a good plan together, because if I am called to a patient who has a BVC score of six [maximum] and is already destroying the interior, I take over the situation … In such situations I don't involve staff on the ward very much.'*

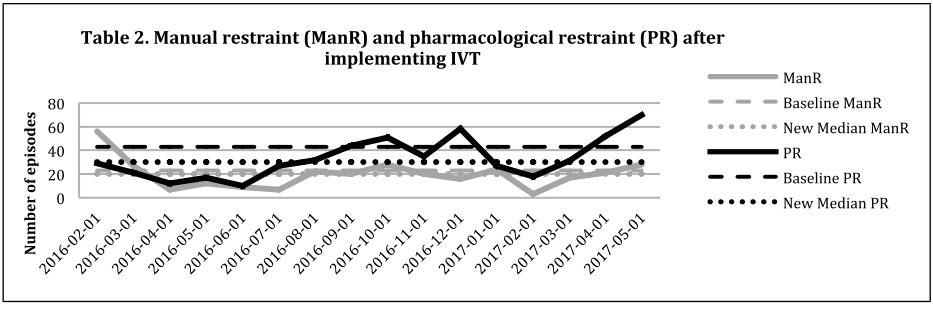
When staff are asked about suggestions for improvement, they mention the need for a more common understanding of the IVT task and roles. They are also aware of the cultural differences and suggest initiatives that could create a common ground in the centre—perhaps a rotation principle enabling staff to work with colleagues from other wards.

Data on the use of coercion

As the charts below on the use of coercion at the centre show, the use of MR has dropped significantly. Table 1 shows the number of MRs from the time when IVT intervention was implemented and the following 16 months. The red line is the median of the previous 16 months and serves as our baseline.

As Tables 2 and 3 show, the drop in use of MR was achieved without any statistically significant changes in the number of manual restraints or pharmacological restraints. In fact, the medians for manual and pharmacological restraint are lower after implementing the IVT compared to baseline.





The implementation of the IVT coincides with a reduction in the use of MR, but we cannot demonstrate an unambiguous link between the two, since other interventions took place simultaneously. However, this evaluation substantiates that IVT is a major contributor to the results.

Discussion

On the drawing board, the IVT had two main functions: a here-and-now-second-opinion and the possibility of exchanging staff contact. Experience has shown that sparring with colleagues from another ward can be challenging because of time pressure (late calls), differences in culture between wards, and so forth. Taking over contact with the service user is considered by many staff members to be the (main) IVT task, and this function is apparently less complicated. When conflicts are deadlocked, both staff and service users appreciate the possibility of changing relations. The IVT might not do something else, but in some situations, it matters that others take the same actions. Also, if a good relation to the IVT staff already exists, it can be a major asset.

The timeouts that an intervention adds to critical situations are a structural aspect of the IVT intervention that is easily overlooked. A young psychiatrist said that she easily gets stressed out in critical situations, and she believes that structured timeouts in the IVT intervention help her make better decisions. Sometimes, nothing more than a timeout is what it takes for a critical situation to 'resolve itself'.

On an organisational level, the signal value of establishing a team with the specific aim to reduce the use of coercion should not be underestimated. The IVT, so to speak, embodies a key priority at the centre. In Pennsylvania, a deputy secretary announced that seclusion and restraint represent 'treatment failure', and this was considered a key factor in their significant reduction in the use of MR in the late 1990s (Smith *et al.*, 2005; Smith *et al.*, 2015). They established psychiatric emergency response teams (PERTs) with some similarity to IVTs that also became organisational representations of a change in attitude and culture towards a recovery model.

Conclusions

The IVT has contributed to a significant reduction in the use of MR at MHC Ballerup. Through the IVT, one ward specialising in de-escalation has benefitted other wards at the centre in acute escalated situations. The intervention gives staff a timeout and the IVT adds new energy in critical situations. Exchanging staff contact has been of particular value. Collegial sparring is considered an important element in the intervention, but cooperation between staff from different wards in acute situations has been the most challenging part of the implementation process.

Acknowledgements

We would like to thank the staff and service users at MHC Ballerup who willingly participated in questionnaire and interview surveys.

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Systematic "second opinion" of unwanted incident in a closed ward: analysis, reflection and decision-making

Workshop

Annick Urfer Parnas, Karen Jurlander, Eva Pacini & Katarina Nenadovic-Olsen (Denmark)

Abstract

It is well-known that an incident on a psychiatric ward can be the result of "something" that began several hours before, involving different factors, which are often difficult to identify. Such incidents may tend to repeat themselves unless we can get a better grip and understanding of their emergence. With the term "incident", we are talking about an unpredicted and harmful episode of confrontation, quarrel or violence. Inspired by the use of "reviews" to reduce mechanical restraint or other forms of coercion (1;2;3;4), we developed a simple survey that we named "second opinion".

Our aim was to analyze and prevent the major episodes that are leading to violent behavior. The other purpose was also to identify minor events, whose impact on daily life can be overlooked.
It is known that one of the major factor tied to unquiet or violent episodes is the presence of psychotic symptoms (5). Thus, the analysis of minor incidents (about 100 episodes since 2015) by a qualitative method (6) in our ward reveals the role of different factors playing a role in the development of an episode: The patient is described unquiet several hours before the incident, the role of stressful factors as a long visit of the family, a telephone call, refusal of a discharge, conflicts with the staff or other patients at the dining room…. Some of these themes, well known, have already been reported in an article of Bonner *et al.* I 2008 (7).

The workshop begins with a presentation of the instrument, which has been developed and used at the Psychiatric Center of Glostrup (University of Copenhagen) the last 2 years. The séance of "second opinion" lasts 15 minutes, includes different members of the staff, residents, leaders of the ward, recovery mentor, and psychologist. The meeting starts with the description of the entire situation from its beginning to the end. Subsequently, an analysis of different factors is performed, following a relational model: the patient and its world, the patient and the staff, the patient and the outside world and the patient and the other patients. A conclusion concerning the most appropriate response is achieved through discussion and the care-management is adapted. In a second time, the patient is invited to another meeting to share with some members of the staff his/her experience of the incident.

A film with English sub-title will illustrate a prototypal review.

The participants of the workshop are invited to present their own cases with the view of getting a "second opinion".

We conclude that a systematic use of this approach reduces the frequency of coercive measures and inspires the staff to reflect upon and discuss problematic cases and situations; those improves the quality of care.

Finally, this approach may also be useful for general improvement of collaboration between team-members and different treatment-units by using it in situations where different wards are involved.

Educational goals consist of

1. To know and try by themselves a simple and systematic method to analyze conflictual or violent episodes
2. To stimulate self-reflection and appreciation of the patient's point of view.

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"Copenhagen's second opinion" of unwanted incident in a closed ward: qualitative study of 100 reviews

Paper

Annick Urfer Parnas, Karen Jurlander, Eva Pacini & Katarina Nenadovic (Denmark)

Background

It is well-known that an incident on a psychiatric ward can be the result of "something" actually beginning several hours before, involving different factors that are often difficult to identify. Such incidents may tend to repeat themselves unless we get a better grip and understanding of their emergence. By the term "incident", we are talking about an unpredicted and harmful episode of confrontation, quarrel or violence. There is general acceptance in literature that the origin of these incidents is multifactorial. Inspired by the method of "review", a retrospective examination of the incident, we decided in 2015 to introduce in our closed ward a systematic review of each incident that we called "second opinion". The meeting of a "second opinion" lasts 15 minutes and includes different members of the staff, residents, leaders of the ward, a recovery mentor and a psychologist. The meeting begins with a description of the entire situation from its beginning to its end.

Subsequently, an analysis of different factors is performed, which is following a relational model: The patient and their world, the patient and the staff, the patient and the outside world and the patient and the other patients. A conclusion concerning the most appropriate response is achieved through discussion, and the care-management is adapted.

Aim

The aim of this study was a qualitative analysis of the themes reported in "second opinion" and an identification of eventual patterns.

Method

The sample comprised about 100 "second opinions" concerning different incidents: self-injuries, physical violence against the staff or other patients, verbal aggression, conflict situations... Each "second opinion" follows the same schema of questions (semi-structured form). At the end, a written rapport is delivered, a combination of narration and data as: time and day of the incident, psychopathology, earlier history of violence and/or use of mechanical contention…. Data analysis of the narrative part adhered to the principles of thematic analysis and was carried out in a joint effort between the authors. All the authors have long experience in psychiatry and include different members of the staff.

Results

We identified six themes:

1. **Changes in patient's behavior and reactions by the staff in the period before the incident:** "The patient has been observed several hours "irritable and restless", "the patient was declining throughout the week before the incident", "short repetitive talks helped the patient until today" "the patient did not come down after a walk…

2. **Indicators for a risk of coercive measures:**
   "The patient threatened to set fire to himself", "the patient threatened to kill the nurse with a knife", "the patient tried to kill herself with her trousers around her neck"

3. **Clashes ensuing from disagreement/conflicts concerning the rules of the ward or :**
   "A nurse refused the patient a cup of coffee, because it was dinner time", "the patient wished to be discharged, but the psychiatrist refused/rejected it", "the patient wanted to buy a cigarette, but the kiosk was closed (the staff is not allowed to give the patients their own cigarettes)", "he didn't have any more cigarettes"…

4. **Stress factors before the incident:**
   "The patient got a telephone call from his father, who informed him that his economic situation was catastrophic", "the patient was angry, wanted to speak to the doctor alone, the doctor refused the patient's request, and the patient then destroyed the closet in his room"

5. **Psychopathology:**
   "the patient became more and more paranoid and hurt herself in the face", "the patient suddenly became tense and began to shout very loudly", "patient experienced that all the persons around him were talking about him".

6. **Conclusion and act of "second opinion":**
   "There is a need to help the patient to get more sleep", "the staff has to be taught about catatonia", "It is necessary to talk with the patient and her family about the duration of the family's visits", "it should be written more clearly in the crisis plan that the patient is helped by the "sense-room" when he is anxious.

Conclusion

From a clinical point of view, we conclude that a systematic use of "second opinion" reduces the number of coercive measures. Moreover, it inspires the staff to reflect about the facts and to see their own role in the interaction. It gives a better comprehension of the patient's way of understanding stressful situations and elaborating on them in a therapeutic setting. This learning could facilitate the process of recovery and improve the quality of care. Finally, this approach may also be useful for a general improvement of collaboration between team-members and different treatment-units by using it in situations where different wards are involved. From the perspective of research, the analysis by themes may reveal more subtle details of interactions and patterns. By comparing these results and identifying common topics between different wards, it could contribute to disentangling the complexity of factors that are leading to the use of coercive methods and to a better comprehension of the process itself.

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De-escalation: more than an intervention!

Paper

Minco Ruiter (Netherlands)

Keywords: de-escalation, 1op1 support, de-escalation supporters, relational based care, de-escalation culture and vision

Abstract

At "Inforsa", Arkin, a specialised Psychiatric very Intensive Care and Forensic care clinic, we have realised for a couple of years now, that 'de-escalation' is the key word in diminishing both violation and coercion. We have specialised 'forces', like a de-escalation supporters team and a 1on1 supporters team. They are doing successful work to support both workers and clients in finding de-escalating solutions when serious conflicts even with potential violence occur, or when clients and workers does not seem to be able to find a constructive way of cooperation with each other, with conflicts as a way out.

In this presentation we will present the key ingredients of their success from previous research. It will show their results and their activities, both in a practical way, as in a more existential way.

But despite their successes, there are also failures, which are as important to share. It seems to be difficult to get it properly organised for instance. And second, where they function and cooperate very well in some part of our clinic, they seem to be neglected or even rejected in other parts.

In this presentation we will analyse the cause of these successes and failures, we have experienced. We will show that cultural aspects, including a specific well shared vision are crucial.

The key word remains de-escalation, which is however far more than an intervention, a technical action, or a way to solve crisis. De-escalation does not work, when we still speak about aggressive behaviour which need to be controlled. And this seems to be quite hard to change!

De-escalation works best in a relational care based organisation. In this presentation we will show some fundamental aspects of this way of thinking, so we can reveal the ultimate conditions of building a proper de-escalating culture, where the de-escalating interventions succeed best.

Educational Goals

Attending this presentation one will have:

- detailed knowledge about two practical de-escalating interventions: 1op1 supporter and de-escalation supporter.
- Insight in the fundamental aspects of a de-escalation culture and vision which are necessary to make these interventions successful

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Active Recovery Triad: A new perspective in long-term mental health care

Paper

Lieke Zomer, Yolande Voskes, Lisette van der Meer, Guy Widdershoven, Sylvia Gerritsen & Jaap van Weeghel (Netherlands)

Keywords: Active Recovery Triad (ART), long-term mental health care, serious mental illness (SMI), stagnated recovery process, model fidelity, psychiatric crisis, reduction coercive measures, triad, validation and implementation.

Abstract

Background

Among current transitions in the Dutch mental health care, less focus was on one group of people with serious mental illness: namely people whose recovery process in long-term mental health care has stagnated. One of the latest initiatives is the ART (Active Recovery Triad) model, focusing on this neglected group of people.

Aim

The aim of this research is to validate the ART monitor and to gain insight in the implementation process of ART.

Methods

Similar to recent innovative models as High and Intensive Care (HIC), Forensic High and Intensive Care (FHIC), and Flexible Assertive Community Treatment (FACT), the ART model includes an instrument that enables us to assess professional, organizational, and architectural characteristics of ART: the ART monitor. For this research, a variety of research methods will be used. This includes audits in 15 participating ART teams in the Netherlands on the basis of the ART monitor and a qualitative approach to gain in depth insight in the implementation process of ART. Limiting and facilitating factors with regard to the implementation process will be examined.

Results

ART involves focus on independent living and community participation for people with severe mental illness. Central in this model is collaboration in the triad; the client, relatives, and the professional. In this presentation, the focus is on the ART model, as well as the mixed-methods research design on the validation and implementation of the ART monitor. The ART monitor is developed in order to examine the quality and model fidelity of the care provided by an ART team.

Conclusion

The ART model provides a guiding framework for developing recovery oriented mental health care, which will hopefully lead to an improvement of the quality of the long-term mental health care in the Netherlands.

Educational Goals

- To describe the concept of Active Recovery Triad (ART) in long-term mental health care
- To describe the implementation process of the ART-model by using the ART-monitor
- Insight in the analysis of the validity and fidelity of the ART-monitor by using a mixed-method research approach
- To contribute to the improvement of the quality of care in long term mental health care

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The word is mightier than locked doors: Enhancing the Safewards nursing model with consumer perspectives

Paper

Indigo Daya (Australia)

Keywords: Safewards, nursing, consumers, language, training, education

Abstract

Everyone wants to reduce violence in mental health units: consumers, staff, managers and funders. Currently there is a common culture of coercion, compulsion and restrictive interventions towards patients and occupational violence towards staff. The concept of 'model of care' is not the reality for many people. How can we utilise lived experience in changing these cultures of violence and restrictive practice?

The Safewards Model is an evidence-based nursing model to reduce conflict and increase safety for patients and staff in acute units (Hamilton et al, 2016). In Victoria, Safewards is being implemented state-wide.

As part of Victoria's Safewards implementation, a consumer advisor has been employed for the first time.

The inclusion of consumer perspective in developing and delivering implementation has resulted in a range of welcomed adaptions to the model and training. Consumer perspectives have highlighted that shifting words can shift culture and ultimately improve safety. Consumer perspectives have highlighted opportunities to bring Safewards up to date with contemporary consumer perspectives, recovery research, and concepts of care rather than control.

This presentation will examine practical examples of how consumer perspectives can contribute to improvements in clinical practice, and how language use can mirror and influence the culture and violence.

Educational Goals

- Participants will be able to explain the relevance of language use and meaning in the prevention of violence.
- Participants will be able to explain the benefits of consumer participation in the development and implementation of clinical practice models

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Music for relaxation, distraction and sleep in intensive care psychiatry

Paper

Helle Nystrup Lund, Lars Rye Bertelsen & Lars Ole Bonde (Denmark)

Keywords: Music, intervention, music therapist, relaxation, distraction, sleep, reduction, coercion, sound, equipment, empowerment, research, The Music Star app, log files, clinical, ethical.

Abstract

This presentation offers an introduction to a new music intervention with specially designed music equipment in a psychiatric hospital setting. This is followed by an evaluation of the early research results.

A number of pilot studies in Aalborg University Hospital - psychiatry have shown how special playlists and sound equipment can be used by patients and administered by caregivers. Results from the pilot projects have shown that music is used for three purposes: relaxation, distraction and as sleep support. Some technical challenges with the existing equipment have been reported. The results points towards that specialists, i.e. music therapists are needed in the process of implementing music intervention in clinical practise (Hannibal, Lund & Bonde 2013 and Lund, Bertelsen & Bonde 2016). Based on a national initiative to reduce the use of coercion in psychiatric care in Denmark in 2014-16, new robust and secure sound equipment has been installed in intensive care units at Aalborg University Hospital - psychiatry.

This new music equipment includes a special developed application for iPad: "The Music Star" app, which is a user interface to select supportive music from specially designed playlists developed by music therapists. The app has a built-in log function that records all details about the music played, e.g. time of day, duration of the music selections volume. Thus, the log files from "The Music Star" app can for the first time reveal patient preferences and listening behaviors in an objective way. We argue that self-selected music may lead to decrease of arousal, anxiety and pain and/or improved relaxation/ sleep. The empowerment of the patient by facilitating individual choice of music is a key point, also from an ethical point of view.

A discussion of findings including clinical and ethical perspectives on music interventions in hospital settings conclude the presentation.

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Educational Goals

- name general clinical implications when applying music intervention in intensive care in psychiatric hospital settings
- identify key issues related to selecting appropriate music for the patient population

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Rapid tranquillisation - Getting it right: the continuous struggle of an acute psychiatric unit

Paper

Anna Björkdahl (Sweden)

Keywords: Rapid tranquillisation, acute inpatient psychiatry, work flow, implementation, teamwork.

Abstract

Background

Rapid tranquillisation (RT) is an option and last resort when a patient shows imminent risk of violent behaviour that requires urgent pharmacological action and when oral medication is not appropriate or has been proven ineffective (NICE guidelines, NG10, 2015).

After a long period of increasing problems with aggression and severe violence on a Swedish psychiatric intensive care unit (PICU), the clinical department management decided to allocate resources for an improvement project. The unit was under great strain with high rates of coercive interventions, staff and patient injuries and a flood of reported violence- related complaints by patients and staff. There was a shortage of qualified nursing staff which had to be covered by temporary bank nurses and mandatory overtime. At the same time the ward manager was about to go on long term maternity leave and there had not been a qualified psychiatrist or trainee psychiatric doctor in post for many months. Due to the difficulties of the PICU, other psychiatric wards at the hospital were now forced to admit severely acute patients rather in need of psychiatric intensive care, leading to rapidly increased rates of violence and coercion on these wards as well.

A root cause analysis suggested that the routine for RT was unclear. The analysis found causal factors to be related to differences between physician and nursing staff assessments of patients' need for RT, and differences of opinions among physicians and between physicians and nursing staff in regards to medication of choice, doses and oral versus intramuscular administration. Furthermore, there was no established routine for the monitoring of vital variables after a RT was given to a patient.

Aim

The objective of this clinical development project was to reduce the levels of violence and coercive interventions at the PICU by the development of a new routine workflow for RT: assessment, medication, monitoring and follow up.

Methods

To fully understand the dynamics behind the dysfunctional situation, individual interviews were held with key staff members from different professions. A workflow for the updated RT process was developed based on significant findings from the interviews, clinical data and recent international recommendations for RT. Initially, series of small scale tests of the new RT workflow were conducted under controlled conditions, i.e. only daytime Monday to Friday, controlled by the ward's senior psychiatrist who had just been recruited. Secondly, meetings were held with the nursing staff as well as the large hospital group of physicians and psychiatrists who would be in charge of RT decisions on the PICU as doctors on call out of hours. The new RT workflow was discussed and questions and

ideas were taken into consideration. Finally, in February 2017 the workflow was clinically released on a 24/7 basis.

Results

Preliminary results look promising, however this project will be continuously evaluated during 2017. The routine RT workflow and the results will be presented and discussed at the seminar. Ethically complicated issues in this project will be specifically addressed.

Educational Goals

- Identify three ethically complicated issues related to RT routines.
- Name five variables that should be systematically monitored after RT in order to secure patient safety.

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Forensic High and Intensive Care: A new model for forensic psychiatric patients in crisis

Paper

Sylvia Gerritsen, Petra de Leede, Yolande Voskes, Laura van Melle & Guy Widdershoven (Netherlands)

Keywords: Forensic psychiatric care, crisis, acute stepped care, reduction coercive measures, High and Intensive care, contact

Abstract

Background

Current transitions within the Dutch mental health care aim to further reduce coercive measures and the number of beds in inpatient facilities, and are being supported by models as HIC (High and Intensive Care), FACT (Flexible Assertive Community Treatment) and ART (Active Recovery Triad). Within the forensic psychiatry there is a need for a model as well, intended for patients in crisis as at these moments the patient's condition deteriorates and the risk of recidivism increases which often results in a frequent use of coercive measures.

Aim

To develop a model for acute stepped care for forensic psychiatric patients in crisis, with a central focus on humane care and were safety is provided by contact.

Methods

The Forensic High and Intensive Care (FHIC) model is developed by the mental health sector itself, inspired by High and Intensive Care (HIC) model for non-forensic psychiatric inpatient care. Eighty experts from both the forensic and regular mental health care have been invited to several meeting in order to discuss the FHIC model. To support the implementation of the FHIC-model, a model fidelity scale (the FHIC monitor) was developed.

Results

As a result of the expert meetings, the FHIC model was developed and formulated. An admission to a FHIC ward is intended for forensic psychiatric patients in crisis. The basis for FHIC is the theory of an open living and working climate at the ward, based on growth, contact, support and the prevention of repression. Coercive measures are prevented as much as possible, by means of a deescalating and consistent interpersonal treatment. Within the FHIC ward, stepped care can be provided by one-to-one care, as needed in an Intensive Care unit. Central is the cooperation between patients, family and care providers of the FHIC. The care provider of the referring setting remains in a prominent and supporting role during an admission at the FHIC ward, stimulating a continuous care process.

Conclusion

The FHIC model is developed for the forensic field to prevent further disruption and/or criminal recidivism and to create safety by contact. Further research will be performed on ten forensic psychiatric wards which start with the implementation of FHIC to validate the FHIC-monitor and evaluate its effects. The outcomes of this research will contribute to the evaluation of the FHIC model.

Educational Goals

- To describe the Forensic High and Intensive Care (FHIC) - model and its development
- To improve the quality of care in the forensic field and reduce the use of coercive measures, and thereby contribute to the prevention of disruption/ criminal recidivism

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High and Intensive Care: evaluating the implementation of a new model for acute inpatient care

Paper

Laura van Melle, Yolande Voskes, Sylvia Gerritsen, Lieke Zomer, Niels Mulder & Guy Widdershoven (Netherlands)

Keywords: High and Intensive Care, acute psychiatric care, quality of care, reduction of coercion

Abstract

Background

To achieve a further reduction of seclusion and improve quality of mental health care High and Intensive Care (HIC) was developed in 2013. HIC provides for new standards for acute admission wards for patients in severe mental crisis for whom outpatient treatment is no longer sufficient and admission in a closed setting is necessary. The HIC-model focusses on restoring and maintaining contact, crisis prevention and stepped care. HIC requires close collaboration with relatives and with the ambulatory teams. At the moment, the HIC model is being implemented in mental health care institutions throughout the Netherlands. In previous research on HIC the HIC-monitor, a model fidelity scale was validated, paving the road for further research on the implementation of the HIC-model throughout the Netherlands.

Aim

This follow-up study aims at describing the developments within the implementation of the HIC model.

Method

This study is being conducted over a period of 18 months within 45 inpatient adult psychiatric care units of 24 mental health care institutions throughout the Netherlands. Audits are performed by trained auditors from the collaborating mental health care institutions using the HIC-monitor to assess the implementation of the HIC-model. New audit results will be compared to data of audits performed during 2014 and 2015.

Results

The results of this new study on the implementation of the HIC model in the Netherlands will be presented. We expect to see further improvements in the implementation of the HIC model in comparison to two years ago. But will we be able to distinguish national trends in the implementation process? What parts of the HIC- model prove to be difficult to implement?

Conclusion

This presentation will show the results of the current study on the implementation of HIC in comparison to the results of previous audits held two years prior to this study. This research is part of a larger study on the effects on the reduction of coercion and improvement of quality of care at HIC wards. First results concerning the effects of HIC are positive, showing that wards that score high on the HIC-monitor, use less coercion than units that score low on the HIC-monitor.

Educational Goals

- To describe developments within the High and Intensive Care (HIC) model and gain insight into the implementation of HIC by using the HIC – monitor
- To improve the quality of care on acute admission wards and reduce coercion, in particular seclusion

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Service User involvement has to be at the heart of Reducing Restrictive Practice

Paper

Nick Horne & Wayne Saville (UK)

Keywords: Reducing, Restrictive, Practice, Strategy, Service User, involvement, Co-Production, culture, Leadership, Knowledge, Understanding, Morale, Positive, Expert, Experience, Improve, Service.

Abstract

The abstract and presentation aims to communicate a strong theme of co-production in Reducing Restrictive Practice (RRP). The abstract has been co-produced and will be delivered by an Expert by Experience and RRP lead.

The presentation will demonstrate and support current evidence based practice on the need to have strong leadership, co-production and involve service users at all levels of implementation to support recovery focused working to start changing cultures and reducing restrictive interventions.

Cygnet Health Care aims to develop a plan to change how risk behaviour is managed and to develop a culture to promote recovery and reduce the need for restrictive interventions. The organisation provides a range of specialist inpatient mental health services across England that are complimentary to NHS provision. It launched the implementation of the RRP Strategy in April 2016. The organisation used the Restraint Reduction Network self-assessment tool to benchmark against best practice standards and to support action planning and review.

Joint Leadership, the Expert by Experience role and service user involvement have been key to identifying and supporting the development of best practice to share wider across the group and externally. Evidence-based results illustrate reductions in the identified performance measures in some services (Manual Restraint, Prone Restraint, Seclusion and Rapid Tranquilisation) and identify services where there needs to be more focused work.

Experts by Experience and service users have had a key role in strategic decision making that currently includes membership in RRP project board meetings, membership of RRP delivery boards, RRP awareness work, staff training and support, and co working to support the implementation of the Safewards model. One of the key objectives is for service users to be empowered to decide on their involvement, and how they would like to be involved to support changing the relationship between staff and service users, to one of risk sharing.

The presentation will provide:

- Insight into the value of RRP leads and experts by experience working alongside each other.
- An overview of the implementation plan with a focus on the service user perspective.
- Examples of how to overcome barriers to support effective co-production to support a recovery focused and risk sharing culture.
- Brief outcomes demonstrating reductions in restrictive interventions and progress in meeting the standards set within the Restraint Reduction Network tool.
- Information on how the successful introduction of RRP has resulted in a safer, calmer environment and led to an improvement in staff morale.

Educational Goals

- To increase knowledge and understanding of the importance of co-production and co-delivery, to support service user involvement and to increase staffs awareness of the service user perspective in reducing restrictive practice.
- To increase awareness of the" Restraint Reduction Network Reducing Restrictive Practice checklist" to inform the organisation's improvement/development plans.

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Music in seclusion rooms – what impact on nurse-patient interactions and on caregivers' well-being at work?

Paper

Angelika Güsewell, Emilie Bovet, Cédric Bornand, Alexia Stantzos & Gilles Bangerter (Switzerland)

Keywords: isolation room, acute psychiatric wards, music, nurse-patient interaction, well-being at work

Abstract

This research is closely linked to the ongoing questioning on, and debate about intensive care in acute psychiatric wards. Presented as a care measure, the placement of patients in seclusion rooms (designated locked rooms that provide a low-stimulus space for patients experiencing high levels of arousal, in order to allow them regaining control) is highly controversial in Switzerland: low sensory stimulation (i.e. hypo-stimulation) may involve risks, the therapeutic function of the measure is poorly perceived by patients, and finally, such interventions can make it difficult to establish a caring nurse-patient relationship based on contact and communication.

In this context, the care team of a Swiss psychiatric center suggested the installation of a music listening device in the seclusion rooms: on the one hand, to allow patients to listen music on their own and thus to recover a certain impact on their environment; on the other hand, to foster interactions and communication between patients and caregivers about an object that is not be related to illness. An interdisciplinary research team comprised of psychiatric nurses, engineers, musicians, psychologists, and anthropologists has worked for three years to develop such a device. The first challenge this team had to address was respecting the very strict safety regulations of the hospital that is conceiving the device as an integral part of the room (i.e. incorporated in the walls). The second challenge concerned the selection of a limited number of music pieces covering the broadest possible range of affective states.

The two seclusion rooms of the psychiatric facility will be equipped with the device from April 2017. From this moment on, it will be possible to document its use and above all its impact. The present contribution will focus on the nurse-patient verbal and social interactions (model by Rask & Blunt, 2007): Do these interactions change following the implementation of the music listening device? Is there any impact on the caregivers' well-being at work?

To answer these questions, quantitative and qualitative data on the subjective experience of the care team and on the interactions that develop around music will be collected for a period of six months. It is planned to use a series of standardized questionnaires (Moral Sensitivity Questionnaire, MSQ, Lützén, 1993 ; Work Environment Questionnaire, WEQ, Severinsson & Kamaker, 1999 ; Professional Quality of Life Questionnaire, ProQoL, Stamm, 2010 ; Verbal and social interactions questionnaire VSI, Rask & Brunt 2007) and to conduct semi-structured interviews with voluntary members of the intensive care team.

Educational Goals

On attending this presentation, participants will

a. develop an understanding of the impact music can have on the social and verbal interactions in the nurse-patient relationship in acute psychiatric wards
b. be aware of the impact such changes may have on caregivers' well-being at work

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Evaluating the implementation of Safewards in Victoria, Australia: Impact on seclusion rates and key learning's about successful implementation

Paper

Justine Fletcher & Bridget Hamilton (Australia)

Keywords: Acute inpatient psychiatry, seclusion reduction, process evaluation, mental health, mental health nurses, SafeWards

Abstract

Restrictive practices are used in response to conflict and aggression in psychiatric inpatient settings. Reducing such practices is the focus internationally of policy and legislative change, many initiatives and a growing body of research. Safewards is a model and set of 10 interventions designed to reduce conflict and containment in inpatient services. In light of National and Victorian policy directions to reduce the use of seclusion and restraint, Safewards was trialled in Victoria and evaluated independently.

Two key aims of the evaluation were to, one assess the impact of implementing Safewards on seclusion in Victorian inpatient mental health services. Two, understand factors associated with successful implementation.

To measure the impact of Safewards on seclusion rates we used a before and after design, with a comparison group matched for service type. Eighteen wards, from seven health services, opted into a 12-week trial to implement Safewards and 1-year follow-up. The comparison group was all other wards (n=50) with seclusion facilities in the jurisdiction, matched to service type. Mandatorily reported seclusion event data for all 68 wards over a 15-month period was analysed using negative binomial regression. Adherence to Safewards was measured via fidelity checklists at four time points, twice during the trial, post-trial and at one-year follow-up.

To evaluate factors associated with successful implementation Safewards Lead's in each Health Service kept a diary about the implementation of the Safewards model and 10 interventions. We took a thematic approach to analyse the diaries.

In trial wards seclusion rates were reduced by 36% by the 12-month follow-up period, whereas there was no reduction in rates of seclusion for comparison wards. Fidelity results indicated implementation of Safewards continued to gain momentum after the trial phase to follow-up.

The evaluation findings support the implementation of Safewards in inpatient settings and highlight that it is effective in reducing the use of seclusion. The implementation diaries highlighted a range of barriers and enablers. For example engagement of staff at several levels of the organisation was facilitative of Safewards being implemented successfully. In addition, findings suggest that Safewards may be appropriate for practice change in Victorian inpatient mental health services more broadly than adult acute wards.

Educational Goals

- To demonstrate to the relationship between 1. Safewards intervention fidelity and reduction in rates of seclusion in acute adult and adolescent inpatient units

- To explain the facilitators and barriers to implementing Safewards in Victorian adolescent, adult, aged wards and secure extended care units.

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The Psychopathic Institution: Cold Nurses, Hot Risk and Violence in Mental Health Services

Paper

Richard Whittington (UK)

Keywords: violence, organisational theory, burnout, risk

Abstract

An emphasis on the risks presented by some people at times of mental distress has tended to overshadow discussion of the risks faced by people at this time as well. Experiences in both the community and in-patient mental health services themselves can add significantly to the psychological burden at times of crisis.

This paper will examine some of the ways in which institutions which are designed to provide mental health care can develop cultures which are emotionally cold and anti-therapeutic where violence becomes more, rather than less, likely. It will draw on relevant theories of organisational behaviour and burnout in the context of recent institutional care failures to explore the idea of 'hot risk' as a common factor in violent incidents. It will also consider current research on potential interventions at the organisational and interpersonal levels which may prevent such cultures developing.

Educational Goals

- To increase awareness of organisational and interpersonal factors in violent behaviour within in-patient settings
- To evaluate evidence for the effectiveness of some interventions designed to address these factors

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The comfort room as experienced by adolescents and nurses in a psychiatric hospital: qualitative study

Paper

Karel Desmet & Eddy Deproost (Belgium)

Keywords: comfort room, sensory room, inpatient adolescents, mental health nurse, safety, control, responsibility, commitment

Abstract

Background

Comfort rooms, also known as sensory rooms, have gained increasing attention in mental healthcare as a means to reduce seclusion rates. As part of a larger project to reduce restraint and seclusion on a youth psychiatric ward, a comfort room was co-designed with the inpatient adolescents with mental health problems in order to support their self-preservation and self-management.

Objective

The aim of the study was to understand how mental health inpatient adolescents and mental health nurses (MHN) experience the use of the comfort room (CR).

Method

A qualitative research study was set up between a psychiatric hospital and a university centre. Data collection and analyses took place in two well-defined time cycles in order to collect perceptions and experiences both at the start of the implementation and after two years of experience with the CR. Thirteen adolescents and six MHN were selected through purposive sampling. Semi-structuered interviews were conducted using an (evolving) interview guide comprising open questions. The data analysis proceeded iteratively using the constant comparative method. Rigor was achieved by several rounds of researcher triangulation, audio-recording and transcribing the interviews, audit trail, and peer debriefing.

Results

All participants described the CR as a place of safety, control, responsibility and commitment with different conceptual interpretations between adolescents and MHN. The adolescents perceived the CR as a sanctuary in difficult times during the prevention and aftercare of a crisis. Because of the meaning and function of the CR, it is very precious for them. They have great respect for materials, peers and themselves when being in the CR. Participants describe the need for transparant rules for the use of the CR. They also want clarity on the contact with the MHN in order to use the CR successfully. To ensure feelings of security, participants pointed to the importance of MHN being available, willing to listen, and engaging in normalizing interactions. Positive experiences of peers provide an effect of lowering thresholds to use the CR. The perceived thresholds are enhanced by previous negative experiences with the CR and disclosure of the own vulnerability.

The MHN described the CR as a new element bringing new professional responsibilities. Operationalizing the CR requires the integration of a new vision of care and (operational) policies

representing the principles of : safety, feasibility, equality and clarity. The MHN indicated that there is a need for space to discover, to experience and to test the use of the CR (trial and error). In addition, MHN reported that this space is enhanced by learning in ‘real time’, commitment to be heard by superiors, and by receiving a framework of guidelines, values and principles.

Conclusion

The CR is perceived as important because its enhances the therapeutic relation between patients and MHN in difficult times of a crisis. As the CR provides a less intrusive way for de-escalation, its implementation by a process where communication and involvement of all stakeholders is essential, can reduce the traditional use of coercion and seclusion.

Educational Goals

- The power of infrastructural infrastructional support for enhancing the self-control and self-management power of the adolescent, the MHN and the therapeutic relation.
- To successfully implement a CR in mental health care, the importantce of to elaborate and use an collaborativeviely, tailored and well- organized implementation plan.

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Restrictive practice in relation to self-harm: necessary or unnecessary?

Paper

Bart Debyser, Eddy Deproost, Karel Desmet & Sofie Verhaeghe (Belgium):

Keywords: qualitative research, self-harm, self-injurious behaviour, restraint and control, nursing, safety

Abstract

Background

Despite the use of restrictive measures in mental healthcare to keep patients and staff safe, they are a highly controversial issue, this practice is still ongoing in inpatient mental healthcare. A possible explanation is that mental healthcare providers and psychiatric patients have different understanding of what is perceived as restrictive.

Objective

Within the framework of the nurse patient relationship in relation to measures that were taken to reduce or limit self-injurious behaviour, this study was designed to explore: 1) What measures were perceived as restrictive and (2) Why these measures were perceived as restrictive?

Method

A qualitative research study in cooperation with the University Centre for Nursing and Midwifery of Ghent was conducted. Data were collected from 10 patients and 6 nurses. The participants were selected using purposive sampling. Data were analysed using the constant comparative method influenced by a grounded theory approach. Rigour was achieved through audit trail, peer debriefing, data-saturation and research triangulation.

Results

Beside measures that 're experienced' as restrictive due to the already restrictive nature of the measure, the participants described a variety of atypical restrictive measures, like being instructed to take care of themselves for their self-inflicted wounds. With regard to their own recovery, all participants described conflicting perceptions and an ambivalent position towards the appropriateness of the mentioned measures.

This ambivalence was not only related to the measures that are taken to prevent self-injury, but also in relation to their urge to self-harm and the way how they dealt with it and how help was offered by nurses. Analysis of the data gathered from the patients showed how the use of restrictive measures increased their perceived ambivalence towards their own self harm-related behaviour. Analysis of the data from the nurses showed how exposure to self-injurious behaviour evoked strong and overwhelming feelings, resulting in protective responses which enhanced the use of restrictive measures.

Conclusion

Instead of focussing on the use of restrictive practice, patients who self-harm want nurses to be sensitive with respect to their ambivalent feelings and thoughts. By exploring and normalising this ambivalence, nurses can help patients to maintain themselves.

Educational Goals

Participants will:

- Have an understanding of how restrictive measures are experienced by hospitalised self-harming patients and their primary nurses
- Realise how interpersonal attitudes and skills of health care providers contribute to help self-harming patients to maintain themselves in disturbing conditions or circumstances

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Does patient-staff relationship change after implementation of Safewards?

Poster

Julia Standfield Birck, Jesper Bak & Steen Madsen (Denmark)

Keywords: Mental Health, Qualitative, Safewards, Forensic psychiatry, Prevention, Coercion, SafeWards.

Abstract

Introduction

The Safewards model will be implemented on a forensic psychiatry ward over a period of 1 year, with 2 interventions per month.

Background

Psychiatric wards manage patients whose actions may threaten safety (conflict). Staff act to avert or minimize harm (containment). The Safewards model enabled the identification of ten interventions to reduce the frequency of both.

Simple interventions aiming to improve staff relationships with patients can reduce the frequency of conflict and containment.

Ojectives

To explore the patient-staff relationship change after implementation of Safewards.

Methods

There will be qualitative semi-structured interviews with 6-8 patients before start-up.

Only patients with at least 6 months of hospitalization will be eligible for these interviews. These initial interviews will inquire into the patients' current experiences under current conditions. Additionally, 6-8 staff members, who all have at least 6 months of employment on the ward, will be interviewed before and after the implementation. The same interview-guide will be used on both groups.

It will be possible to follow-up after the implementation of Safewards, because the patient population on that ward has at least 2 years of hospitalization. You can thereby enquire of the same group of patients, how they experience the relationship to the staff after the implementation. Follow-up interviews with the staff members will be conducted, in order to see the changes in the relationship from another perspective. This perspective will be compared to the patients' perspective. When analyzing the 2 perspectives, it will be with a focus on changes in behavior in both the patient group and staff members after the implementation.

Results

Preliminary results from the first interviews are expected to be ready for presentation in October 2017.

Conclusions

Conclusions cannot be drawn before the study ends in September 2018.

Discussion

Discussion cannot be made before the study ends in September 2018.

Educational Goals

- It will be possible for the participants to obtain knowledge and insight in the approach used in this to study, as the study and implementation commences on the 1st of September 2017.
- Preliminary results from the first interviews are expected to be ready for presentation in October 2017.

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Organisational strategies to reduce the use of restrictive practices in services for people with intellectual disabilities and /or autism - current experiences of putting policy into practice

Poster

Sarah Leitch & Roy Deveau (UK)

Keywords: organisational strategies, restraint reduction, intellectual disabilities, autism, policy, individual restraint reduction plans.

Abstract

Revised UK government policy regarding the use of restrictive interventions 'Positive and Proactive Care: reducing the need for restrictive interventions (Dept. of Health, 2014) and professional guidance on best practice (Allen, 2011; BILD) 2014) has promoted the reduction of restrictive practices (RP) as a major aim for organisations and professionals providing services for people with ID and behaviour that may be described as challenging. Other groups that may experience RP are people with mental health problems and children living away from their families. This provides significant pressure on organisations and practitioners to meet this policy/best practice guidance which are subject to monitoring by service commissioners, professionals and CQC inspectors. Policy and best practice guidance is specific upon a number of practices that organisations need to provide to reduce RP, e.g. strategic and practice leadership, data use to inform practice and a variety of other service practices e.g. provide post incident review or de-briefing for staff.

This poster describes the results of a follow-up to a study conducted in 2015, that examines experiences of organisations in implementing new policy and best professional practice guidance in reducing the use of RP. This has lead to the authors developing practice tools for those who wish to implement individual restraint reduction plans through the use of specific strategies, data collection and practice leadership.

Educational Goals

- After reading the poster delegates will be aware of the experiences of some organisations who are attempting to reduce restrictive practice and the successes and barriers to this.
- They will be able to reflect on whether this is similar to their own experiences
- Delegates will also be able to describe how an individual restraint reduction planning tool can be used in practice .

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The "Sigmaringen model" to reduce seclusion and restraint in psychiatry

Poster

Alex Gogolkiewicz, Frank-Thomas Bopp & Tilman Steinert (Germany)

Keywords: coercive measures, coercion, restraint, seclusion, intervention, dangerous behaviour, violence, involuntary treatment, staff development, standards, leadership, preventative measurements, team spirit, debriefing

Abstract

During the past years, a number of activities both in research and clinical practice to reduce coercive measures in psychiatry can be noted. Numerous interventions have been described in the literature and were tested in psychiatric hospitals. Nevertheless, it has been shown that the sole unsystematic propagation of these solitary successful interventions undoubtedly does not show through in the clinical practices and the measureable effects still remain low. Based on this background the idea of creating a practically relevant manual came up to combine already successful concepts in reducing seclusion and restraint in psychiatry. A multimodal intervention program was developed that has been evaluated in the Clinic of Psychiatry, Psychotherapy and Psychosomatic Medicine at the SRH Hospital at Sigmaringen from August 2016.

The "Sigmaringen model" connects the scaffolding of "six core strategies" (USA) with the "safewards model" (UK) as well as the German Association of Psychiatry and Psychotherapy (DGPPN) guidelines regarding measurements concerning aggressive behavior. These concepts were adapted to the conditions of a psychiatric clinic at a general hospital in Germany. The primary goal is to reduce the frequency and duration of mechanical restraint and seclusion. Interventions at the levels of clinical administration and organization, continuous analysis of data, talent management of the staff in terms of a central team spirit, the implementation and continuous policing of preventative measurements as well as structured debriefing techniques at various levels were implemented.

During the first period from September 2016 to March 2017, a significant reduction in cases of coercive measures were observed. Altogether, 392 cases were treated at the acute psychiatric ward of which only 13% compared to the previous 20.5% of the cases had undergone restraint or seclusion. An analysis of the intervention will be conducted after a period of 12 month in which the frequency and duration of restraint and seclusion before and after the intervention will be evaluated. In addition, an analysis about aggressive assaults will be conducted.

Educational Goals

The educational goal is to demonstrate the readers of our poster / the audience that major changes regarding the usage of restraint and seclusion in a psychiatric hospital can be archived by changing the attitude about violent behavior and its management by creating standards. Concerning this matter, readers will be able to analyse how are were able to reduce coercive measures by one third within only a period of seven month.

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A seclusion free policy by 2020: feasible or an unrealistic pursuit?

Poster

Iris Dijkhuizen (Netherlands)

Keywords: Reducing seclusions, seclusion policy

Abstract

Background

Recently, the Dolhuys manifest 'Dutch mental healthcare seclusion free!' was established. Twelve institutions have signed this, including The Parnassia Group. By 2020 The Parnassia Group wants to have a seclusion free policy.

Aim

Assess the opinion of employees Palier, part of The Parnassia Group, regarding the feasibility of a seclusion free policy.

Method

A cross-sectional survey was used used and between the 28th March and 12th May a questionnaire was given to nursing and care staff, therapists (psychologists, psychiatrists and doctors) and management staff working within Palier. This questionnaire consisted of 24 questions using a 5 point likes scale. A total of 65 respondents have completed the questionnaire. The data was processed in IBM SPSS Statistics 23.

Results

Most of the employees in Palier do not find it feasible to have a seclusion free policy. On the other hand, a majority indicates that they find it realistic to reduce the frequency and duration of seclusions. Correlation analysis has shown positive correlations between the variable 'reducing seclusions' and the variables'familiair with the manifest' ($p=0.012$) and 'obstruction treatment'($p=0.016$). A negative correlation was found between the variable 'reducing seclusions' and the variable 'sufficient use of individual crisis plan'($p=0.001$).

Conclusion

There is a discrepancy between the Dolhuys manifest message and the healthcare providers of the investigated divisions. It is important that good communication takes place with the staff at mental healthcare divistions and investing in the search for alternatives of seclusion must be taken place.

Educational Goals

- Participants will be more aware of the discrepancy between the Dolhuys manifest message and the healthcare providers of the investigated divisions.
- Participants will know more about potentially influential factors why employees find it feasible or not to stop seclusions.

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How interventions in acute psychiatric in-patient unit can abate the risk of violence. What works and what does not. A meta-analysis and meta-regression

Poster

Michael Bo Pedersen & Antonio Drago (Denmark)

Keywords: Meta-analysis; Meta-regression; acute intervention; seclusion; restraint

Abstract

Introduction:

Strategies to reduce violence in psychiatric acute in-patient units have been the focus of intense research in the last decades. Interventions may shift from education of the professionals, education of patients and implementation of de-escalation interventions. A meta-analysis was conducted in 2000 (1) to assess the efficacy of such interventions, but no conclusive result was retrieved. A meta-regression is missing, to the best of our knowledge, to identify the mediators of effectiveness of such interventions.

Objective

A meta-analysis and a meta-regression were conducted to test the efficacy of interventions to reduce violence in psychiatry and to identify the specific interventions' aspects, that may influence the final outcome.

Methods

The following key-words were used in combination to interrogate Pubmed, Embase and Google Scholar: "seclusion", "restraint", "de-escalation" "psych*", "violence", "acute in-patient unit", "schiz*", "bipol*", "personality disorder" and "intervention". Only English-written clinical trials published after 1999 were selected for the analysis. Bibliographies were manually searched for the identification of relevant published reports. Variables chosen for the meta-regression were: "quality of the study","diagnosis","kind of intervention","intervention has focus on the patient","intervention has focus on the operators", "intervention promotes the patient's independence in de-escalating strategies", "duration of the trial", "% males", "study is focused on adult" and "outcome of choice".

Results

17 published clinical trials were selected for the analysis. Analysis was restricted to dichotomous outcomes due to the lower quality of other reports. 13 articles were then analyzed. Under the random effect model a significant efficacy of interventions aimed at reducing violence in acute in-patient psychiatric unit could be inferred (Log Risk Ratio = -0.30) but the amount of heterogeneity (Q(df = 12) = 2 19.8877, p-val < .0001) prevented any conclusive consideration. Heterogeneity was significantly reduced but it was still present (QE(df = 8) = 26.1606, p-val = 0.0010) while performing the meta-regression. Quality of the study was the single main significant variable to influence the meta-regression's result (estimate = 0.2; p=0.0032).

Conclusion

Evidence in literature provides suggestive but not conclusive meta-analytic support for the effectiveness of any interventions to reduce violence in psychiatric acute in-patient units. It was not possible to extrapolate the single characteristics of any interventions, able to modulate the final outcome. Studies of higher quality are required to gain conclusive evidence in this field.

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Educational Goals

1. This study summarizes the current evidence about interventions aimed at reduction of the use of seclusion and restraint in acute in-patient through a meta-analytic and meta-regressive analysis.
2. The analysis of result can help in understanding what is really working for reducing seclusion and restraint, offering the opportunity to re-shape interventions in in-patient units and to create research protocols able to surpass the current limits of the published evidence in this field of research.

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Mental Health and Criminal Justice System Collaborative Approach to Violence Reduction in Baltimore, MD, USA

Poster

Vedrana Hodzic, Christopher Wilk, Christopher Miller, Ashley Hernandez, Marissa Flaherty & Eric Weintraub (USA)

Keywords: Law enforcement, violence reduction, substance abuse, mental health court

Abstract

The city of Baltimore, Maryland consistently ranks highly in U.S. violent crime statistics. Several multidisciplinary initiatives have been developed within the medical community, the city, and the state to reduce violence. These programs require coordination between mental health providers, law enforcement, and the courts to identify those in need of treatment and to facilitate care. We analyze the relationship between these initiatives and outline the efforts to identify and curb violent behaviors in at-risk individuals, serving as a multidisciplinary violence prevention model for urban areas with high rates of concomitant substance use, mental illness, and crime.

The Law Enforcement Assisted Diversion Program (LEAD) is a pre-booking diversion program designed to divert individuals engaging in minor drug offenses and prostitution from prosecution and incarceration, guiding them instead to mental health and supportive services. Nationally, LEAD has shown statistically significant reductions in arrests (58%) compared to control samples. Baltimore City implemented the LEAD program in February 2017 striving for similar results. LEAD follows the Recovery Model promoted by the Substance Abuse and Mental Health Services Administration (SAMHSA), emphasizing interdisciplinary approaches to co-occurring disorders.

In Baltimore City, the courts have similar diversion programs. Mental Health Court is specifically designed to reduce incarceration for individuals with a serious mental illness or trauma-related disorder, while maintaining public safety. Similarly, Drug Court has this objective for individuals with serious substance use disorders. Both diversionary courts consult with forensic psychiatry subspecialists through the Baltimore City Circuit Court Medical Services Division. These subspecialists provide expertise in diagnosis and treatment, competency to stand trial evaluations, insanity evaluations, and risk assessment evaluations, particularly in presentence phases. The Mental Health Court also consults with the Forensic Alternative Services Team (FAST) to provide pre-trial screening, and to develop post-trial mental health treatment referrals.

Local providers, including those within the University of Maryland Medical System, often provide services in a variety of practice settings for those individuals with legal entanglements. With the patient's consent, the treatment providers can provide important feedback to the courts in cases where treatment is a condition of probation. Such feedback can be used to tailor individual conditions of probation in an effort to reduce violence risk.

Educational Goals

1. Explain the interplay between mental health providers, law enforcement, and the court system in reducing recidivism and diverting individuals with mental illness or substance use into treatment
2. Utilize the interdisciplinary approach as a model for violence prevention in other urban areas with high rates of mental illness, substance use, and crime.

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Clinical implementation of a novel treatment protocol (High and Intensive Care model) significantly reduces restrictive measures such as segregation without increase in aggression or violence

Poster

Astrid Dirks, Niels Bouwhuis & Sandra Vos (Netherlands)

Keywords: HIC (High and intensive care), treatment model, reduction, segregation, aggression, violence

Abstract

Segregation is an extreme measure which brings significant risk of adverse physical or mental health effects for patients concerned. Since 2002, psychiatric units have attempted to limit both frequency and duration of patient segregation. . After the study of "best practices" (Voskes *et al.*), a novel field model was constructed; the High & Intensive Care (HIC) model. [5] Aim of this model is to reduce use of segregation, shorten total length of stay on the clinical psychiatric ward and improve patient satisfaction, and had the reduction and prevention of aggression as one of its central themes.

The model was first published in "High & Intensive Care workbook" (Van Mierlo *et al.*, 2013). Our department has been closely involved in the development and implementation of the HIC model and monitor. This model is now being implemented throughout the country, and our HIC psychiatric ward in Tilburg, the Netherlands, was one of the first to open. Our clinical department is a closed ward that provides care for people with severe and acute psychiatric problems, frequently on an involuntary basis.

In this poster presentation, the principles and implementation of the HIC model will be discussed, and especially its strategy to prevent aggression. We will discuss our practical solutions, our pitfalls and successes. Furthermore, we will showcase some of our results; a spectacular reduction in use of restrictive measures such as segregation, significant shortening of length of stay and great improvement of patient satisfaction. This has not resulted in an increase in aggression or violence on our clinical ward.

At the time of this abstract submission some of our data was still being analysed. We will present the latest result in our poster presentation and discuss our new findings.

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Educational Goals

- participants will be able to formulate the principles and clinical implementation of the HIC model in the Netherlands, a model aimed at reduction of restrictive measures.
- participants will be able to use new strategies to prevent aggression on a closed clinical psychiatric ward.

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Chapter 8 – Neurobiological approaches and pharmacological therapies

Pharmacological interventions for recurring agitation and aggression in different diagnosis groups – results of a systematic review

Paper

Sophie Hirsch & Tilman Steinert (Germany)

Keywords: Psychotic disorders, personality disorders, dementia, intellectual disability, psychotropic drugs, aggression

Background

Since 2015, a working group has been updating and upgrading the guideline on therapeutic interventions against aggressive behaviour of the German Association of Psychiatry, Psychotherapy and Psychosomatics using the methodology of evidence-based medicine *and* of consensus-based guideline development. As a part of this guideline, a systematic review on pharmacological interventions against recurring agitation and aggression in different diagnosis groups has been performed.

Methods

We conducted a selective literature review searching MEDLINE. In addition, we asked the clinical experts of the guideline development group about relevant articles. We included articles describing pharmacological interventions for rapid tranquilisation in adults with severe mental illness presenting with agitation or aggressive behaviour. We also included articles describing pharmacological approaches on recurrent aggressive behaviour in different mental disorders (psychosis, personality disorders, dementia, intellectual disability and autism, delirium, traumatic brain injury). Articles in German and English were included; articles in other languages were excluded from the review. We included only drugs used in the German healthcare system because this review was part of a German clinical practice guideline.

For the review, we used a technique which is typically recommended for working groups developing guidelines with limited resources. Firstly, we screened the literature for pre-existing systematic reviews and meta-analyses. In a second step, we screened for articles which were too recent or too specific to be found in a review. We performed a narrative synthesis.

Results

Studies on the treatment of acute agitation and aggression investigate by and large typical and atypical antipsychotics and benzodiazepines. Aripiprazole, olanzapine, ziprasidone i.m. and asenapine s.l. were

effective in controlling agitation. The best evidence for an anti-aggressive effect, which may go beyond the antipsychotic and sedating effect, is available for clozapine in the treatment of psychotic disorders. Recurring agitation and aggression in personality disorders has traditionally been treated by non-pharmacological approaches only while pharmacological interventions were thought to be ineffective. But different substance groups such as antipsychotics, antidepressants and mood stabilizers have impact on the symptom complexes of psychotic, impulsive and interpersonal aggression due to sedating/calming effects but possibly also due to specific anti-aggressive effects which might be explained by disruptions in serotonergic, dopaminergic and other transmitter systems in many mental disorders.

For cluster B personality disorders, aripiprazole, mood stabilizers and omega-3-fatty acids show positive results in controlling recurrent impulsive behaviour. There are also other agents showing positive effects in studies, but due to their unfavourable side-effect profile they are not recommended in this indication, e.g. olanzapine might worsen weight gain in co-morbid eating disorders (bulimia, binge eating), benzodiazepines may decrease inhibition and increase self-injurious behaviour.

For elder people and people with dementia, there were black box warnings from the FDA and "Rote-Hand-Briefe" in Germany due to cases of thrombosis and cerebro-vascular events. Nevertheless, rispieridone, melperone and dipiperone are still approved drugs for the treatment of agitation and psychosis in dementia. Risperidone was effective in several studies. Evidence for treating agitation and aggression in people with other mental disorders is limited. In intellectual disabilities, most of the evidence comes from trials on children and adolescents.

Discussion

There is a huge amount of publications about rapid tranquilization and also a growing body of literature dealing with recurrent aggressive behaviour in individuals with severe mental illness or mentally disabled persons. Most of the drugs show an effect in at least some of the patients in at least some of the trials, but open questions remain.

First of all, quantitative studies cannot brush aside ethical concerns. Prescribing drugs to calm a patient with the primary intention to protect others (care givers, family members) is not compatible with German law but violates professional ethics of medical doctors. On the other hand, it might be the only opportunity for a patient to stay in their familiar surroundings.

Secondly, there are some methodical flaws that should be discussed. Many of the studies lack of external validity. Usually, patients with current alcohol or drug abuse are excluded from clinical trials. People with mental disorders presenting with severe agitation and aggressive behaviour are mostly not able to give informed consent. Therefore, they are also excluded from the studies. Because of that, some of the knowledge about the treatment of aggression in psychiatric settings is generated in developing countries or emerging nations [1], which lowers external validity and raises ethical questions, e.g. if we may use evidence that was generated under conditions we would not support or even allow in our countries.

In addition, some recommendations on medication in our guideline as well as in other guidelines are based on few small studies [2]. Especially, if a drug is not approved for a specific medical indication, this encourages off-lable use without having any data on safety (e.g. small trials on hormones or cannabinoids in dementia).

Acknowledgements

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on coercion, aggression and violence was supported by the German Association of Psychiatry, Psychotherapy and Psychosomatics (DGPPN).

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Does the use of antipsychotics increase when coercion decreases in a general psychiatric ward?

Poster

Mikkel Højlund, Lene Høgh, Povl Munk-Jørgensen & Eslebeth Stenager (Denmark)

Keywords: Coersion, restraint, antipsychotics, benzodiazepines, intervention

Abstract

Background

Antipsychotic medication is known to contribute to cardio-vascular disease and reduced life expectancy in patients with severe mental disorders. Our hypothesis is that reduction of coercion might lead to unwanted increase in doses of psychotropic medication.

Aims

To evaluate type and doses of psychotropic prescriptions during intervention to reduce coercion in a general psychiatric ward.

Methods

Cohort study of patients in risk of agitation and coercion admitted to a general psychiatric ward during first half of 2013 (baseline) and of 2016 (intervention). Eligible patients were diagnosed as having organic mental disorders, substance abuse, psychotic disorders, mania, bipolar affective disorder or personality disorders (ICD-10: F0x, F1x, F2x, F30-31, F60). Primary outcome is exposure to antipsychotic medication measured and summarized in WHO defined daily doses. Cohorts are compared by Wilcoxon Rank sum test.

Results

In total 304 admissions with relevant diagnoses were screened for eligibility (174 from 2013 and 134 from 2016). Hereof 192 were included in the further analyses (89 respectively 103 admissions). Exclusions were due to insufficient prescription history (12 resp. 11), or one-day admissions for electroshock treatment (73 resp. 20). Among the included patients psychotic disorders (F2x) was the most common primary diagnosis (57 resp. 46%), followed by personality disorders (15 resp. 20%), bipolar affective disorder (11 resp. 16%), substance abuse (17 resp. 16%) og organic mental disorders (0 resp. 3%).

Number of coercive measures during the intervention period were: 2 episodes of mechanical restraint (Difference from baseline -80%), and 3 episodes of forcibly given medication (-50%).

During the intervention period (2016) mean total dose of antipsychotics across all diagnoses was 1.51DDD (Interquartile range (IQR) 0.68-2.72).

Comparison between cohorts 2013 and 2016 did not reveal any significant difference in mean total dose of antipsychotics (Diff -0.23 DDD, p=0.44).

Quetiapine was the most frequently used antipsychotic drug in fixed dosing (38%), followed by olanzapine (22%), risperidone (18%) and clozapine (15%). In flexible dosing the most frequently used antipsychotic drug was also quetiapine (50%) followed by olanzapine (27%) and chlorprothixene (17%).

Conclusions

Reduction in coercive measures at the Department of Psychiatry in Aabenraa has not lead to an increase in antipsychotic medication. The majority of prescribed drugs and doses were within recommendations.

Educational Goals

- Insight into antipsychotic treatment of general psychiatric patients in risk of coercive measures.
- Insight into an intervention tailored to reduce the use of coercive measures.

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The Pharmacological Management of Violence in Psychiatric Inpatients

Paper

Laura Dardashti, Jennifer O'Day, Michael Cummings, Jonathan Meyer, George Proctor, Eric Schwartz, Katherine Warburton & Stephen Stahl (USA)

Keywords: psychopharmacology, violence, impulsive, psychotic, inpatient, treatment, forensic

Abstract

A vexing issue for clinicians working in psychiatric inpatient and forensic settings is the management of persistent violence. While the diagnostic mix in such environments weighs heavily towards schizophrenia spectrum disorders, intellectual disability, and cognitive disorders, classification of the nature of the aggressive events in conjunction with the patient's psychiatric diagnosis is a critical step before embarking on any pharmacological course of action. A current working model for violence parses such acts into one of 3 primary forms: psychotic, impulsive or predatory/planned. Among the 3 forms of aggression, impulsive violence is the most prevalent, comprising 45% of all acts, while psychotically motivated violence is the least common at 15%. The California Department of State Hospitals (DSH), the world's largest forensic inpatient system (approximately 6000 beds), has developed comprehensive guidelines that use the categorization of violent acts to gu ide clinicians in their choices of rational therapeutic medication strategies. These guidelines were developed from a collection of prescribing recommendations, clinical trial results, and years of clinical experience in treating patients who are persistently violent in the DSH system. Many of the recommendations employ off-label prescribing practices; thus, sound clinical judgment based on individual patient needs and on restrictions within each institution must be considered when applying these guidelines to clinical practice.

Educational Goals

1. To be able to classify the three different types of violence.
2. To better understand the proper psychopharmacologic treatments for each specific type of violence and apply this understanding to patient care.

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Chapter 9 – Psychological approaches & interventions

Implementation of advanced practice psychiatric nursing resources for behaviourally disturbed patients on medical/surgical units in an academic acute care hospital

Paper

Regina Sawh (Canada)

Keywords: early intervention, Clinical Nurse Specialist, clinical consultation, staff safety, Quality of Care

Abstract

In 2014, University Health Network (UHN), saw an increasing numbers of violent incidents. Models of early intervention developed internationally over the last few years, highlight early identification of at-risk patients and intervention before behaviors escalate to violence is best practice and most safe for patients and staff. With increased attention to staff safety at UHN, it was clear there was no mechanism to provide applied case based teaching to the nursing staff on the medical and surgical units. Through consultation with senior hospital administrations and frontline Nursing staff, a Clinical Nurse Specialist (CNS) role was developed and added to the Medical Psychiatry Service. As a member of the Medical Psychiatry Service, the CNS provides leadership and clinical expertise in the management of inpatients with complex medical and behavioral disturbances. This role includes emergency response in the context of a violent episode, early case identification and intervention, clinical consultation with the medical/surgical teams and mental health education.

Results for fiscal year 2015 showed a 70% reduction in the use of physical restraints, a 75% reduction in the use of constant care sitters and a 40% reduction in the number of emergency codes for violence incidents within the Medical/ surgical inpatient units with no subsequent increases in patient or staff injury. Overall the implementation of the CNS role proved to be an efficient and cost effective strategy in enhancing staff safety and increasing of the staff safety of mental health patients admitted to medical/surgical inpatient settings.

Educational Goals

1. Outline key Strategies in the successful management of the behaviorally disturbed patients in general medical / surgical inpatient settings
2. Generalize and adapt similar role/strategies within a variety of health care settings

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Prevelance of Criminal Risk in a forensic mental health sample

Paper

Susan Velasquez, Katherine Warburton, Darci Delgado, Ben Rose, Andrea Bauchowitz & Angelea Bolanos (USA)

Keywords: Criminogenic risk factors, forensic mental health, prevalence of criminal risk factors in forensic facility

Abstract

Methods

Data were collected from adult psychiatric inpatients from a psychiatric unit within a larger private hospital (N = 142) and forensic inpatients from the California Department of State Hospitals who classified as Not Guilty by Reason of Insanity (NGRI) (N = 107).

Participants in both samples were administered a battery of assessments. They are: a demographic form (where participants reported history of criminal justice involvement and previous mental health treatment), the Self-Appraisal Questionnaire (SAQ; Loza, 1996; an assessment of criminal risk), the Measure of Criminal Attitudes and Associates (MCAA; Mills & Kroner, 1999; an assessment of criminal attitudes and level of involvement with criminal associates), the Brief Symptom Inventory (BSI; Derogatis & Melisaratos, 1983; an assessment of psychiatric functioning), and the Multidimensional Scale of Perceived Social Support (MSPSS; Zimet, Dahlem, Zimet, & Farley, 1988; an assessment of perceived social support).

Multivariate Analysis of Covariance (age, race, and gender were entered as covariates in all analyses) was used to examine mean scores between psychiatric inpatients who were and were not CJ involved and NGRI . Overall, results indicated that CJ involved PMI and NGRI inpatients reported having significantly more criminal associates and spent more time with these associates than non-CJ involved PMI. CJ involved PMI also produced higher scores on measures of criminal attitudes; however, there were no significant differences between the NGRI and non-CJ involved PMI individuals. Additionally, there were significant differences on criminal risk between the three groups such that CJ involved PMI produced the highest criminal risk scores, followed by NGRI and non-CJ involved PMI. NGRI inpatients reported significantly higher levels of perceived social support; however, there were no significant differences between CJ involved PMI and non-CJ involved PMI. NGRI inpatients also produced the lo west scores on psychiatric symptomatology; however, there were no significant differences between CJ involved PMI and non-CJ involved PMI except for scores on the subscale assessing Paranoid Ideation.

Educational Goals

Learning Objectives

- Individuals will gain a better understanding of criminogenic risk among PMI with varying levels of criminal justice involvement.
- Individuals will gain a better understanding of the unique treatment needs of NGRI inpatients and how to tailor interventions to meet the needs of this population.

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Suicidal risk in young people in school education of Madeira Island, Portugal

Paper

Helena Gonçalves Jardim, Rita Silva, José Peixoto Caldas, Geraldo Bezerra Silva Junior, Zélla Santos & Raimunda Silva (Portugal)

Keywords: suicidal risk, suicide, young people, school education, adolescents, suicidal risk scale of Stork

Introduction

Violence and environmental changes cause adolescents feelings of anger, apathy and insecurity, and are linked to suicide risk, leading to urgent calls for mental health promotion in young people. Studying suicide in adolescents requires an understanding of the feelings that cause young people despair and is linked to their vulnerability. Worldwide, suicide is the one of the three leading causes of death in young people aged 15-44 and the second leading cause of death in those aged 15-29 years (Patton *et al.*, 2009). In Portugal, the more youth unemployment there is the more young people live in poverty, the m ore they live in poverty the increased likelihood of death by intentional violence (OPSS,2013).

Globalization postmodern individualism provides a lifestyle that is detrimental to the stability and development of good relations between people and disrupts family links. At the same time, partner violence is on the increase causing emotional, physical and sexual problems as well as substance abuse. The passage from childhood to adolescence leads to the loss of security in order to be autonomous and occupy a place in the adult world. This is one of the reasons why adolescents tare prone to suicide risk (WHO,2014). Consequently, it is crucial to understand how young people become suicidal and the factors that influence this. Anxiety, depression, substance use, weak family support, friendship issues and stories of abuse may lead to suicidal ideation in adolescents. However, some studies show that certain risk factors are developed because of the impact of economic crises on the family, financial and social environment which the teenager inhabits. Suicide attempts and self-harmful behaviours are the main public health concerns among teens (Tuisku, V. *et al.*, 2014).

A of 1401 youths (Lereya ST, Copeland, Zammit S, Wolke D (2015), revealed that children involved in bullying behaviours either as perpetrators or as victims in primary schools or secondary schools are at higher risk of mental health problems by the end of adolescence, regardless, irrespective of their state of victimisation. Therefore, health professionals and teachers should consider victimization as a risk factor for the emergence of mental health problems. Depression is one of the most common psychiatric disorders in adolescence in the 21st century (Levisky, 2007) and interferes significantly in life, social relations and overall well-being, and can lead to the risk of suicide ideation (Nabais, 2014).

According to data from the National Statistics Institute of Portugal (2015), suicide ranks higher in death caused than traffic accidents, and is among the five leading causes of death in those aged15-19 years, and the second highest in those aged 1§5-29 years (WHO, 2013). Evidence shows that factors such as hopelessness, interpersonal skills, social isolation, depression and unemployment, taken together increase and trigger the suicide.

Methodology

The aim of this study was to evaluate the suicidal risk of students aged 12-18 years of the islands of Madeira and Porto Santo, Portugal.

The Data collection instruments are Characterization survey (in particular: sex; age; health; grade level; school failure; consumption of alcohol and drugs; socializing with colleagues and sports) and The Suicidal Risk Scale (Stork): This scale measures suicidal risk within a range of behaviours, allows, also, a suicidal, depressive personality profile, and assesses two strands of depression: feeling and action. The authors also measured from the Stork scale: loss of subject (6 items); anguish (17 items); guilt (8 items); Ideal of himself (15 items); family situation (11 items); relationship with his mother (9 items); relationship with the father (4 items); aggression (4 items); addiction (1 item) and psychosomatics (1 item). The scale was validated for the Portuguese population (Eufrásio et el., 1986) and was reduced reduced from 175 items to 76, without compromising validity. This scale assumes the existence of a relationship between the suicidal act and a depressive type personality or depressive personality profile. In this sense, the higher the score of the subject on the scale, the greater the likelihood that person has a depressive personality (or depression) and, consequently, the greater their suicidal risk. The scale provides five levels of risk based upon the person's score: 0-63 Normal risk; 64-79 Intermediate or Doubtful risk; 80-97 Weak Risk; 98-107 Important Risk Important; above 107 extremely important. Suicidal risk

A representative sample composed young people in school education from 12-18 Years (N = 1557, standard error = 1.2%). Inclusion criteria: young people attending normal school, students from the 7th grade, 12 to 18 years inclusive, without psychiatric complaints or ingestion of psychoactive substances. Exclusion criteria: students who had psychiatric treatment, aged below 12 and over 18 years, that did not meet the socio-demographics or the questionnaire cut-off score used in the study.
The authors guaranteed confidentiality and anonymity of the results and informed consent (Regional Secretariat of Education, Directors of Schools Councils and carers). All data were collected at the beginning of the school year 2014-2015.

The Type of study was descriptive and analytical. Statistical treatment: Data analyses were Descriptive, Correlational and Inferential statistics calculated with the help of SPSS version 22.

Conclusions and Discussion

The average distribution by ages is 15.20, with a standard deviation of 1.7 (Table 1), with the majority (55.2%) female.

Table 1: Descriptive statistics of the age of the adolescents

	N.	Minimum	Maximun	Average	Standard Deviation
Age	1557	12	18	15.20	1.78

Analysing the suicidal risk (Table 2), shows that notes that adolescents (67.7%) expressed a "normal" risk; . 10.1% had a reveal weak risk, 4.0% showed important suicidal risk and in 2.7% suicidal risk was extremely important. Observed scores ranged from 2 and 146 points, average of 51.49 and standard deviation equal to 27.29. In addition, half of the young people obtained scores equal or smaller to 48.00. The frequency distribution was significantly from a normal distribution.

Table 2: Characteristics of the sample in terms of suicidal risk

Rank of suicidal risk	n	%
"Normal" State	1054	67.7
Intermediate state or doubtful	241	15.5
Weak risk	158	10.1
Suicidal risk important	62	4.0
Suicidal risk is extremely important	42	2.7
$x = 51.49$; $Md = 48.00$; $s = 27.29$; $x_{min} = 2.00$; $x_{máx} = 146.00$; $p = 0.000$		

There was a significant association (p = 0.000) between depression and suicidal risk, which concurs with most cited literature, which stresses that young people who have suicidal ideation suffer from depression (Table 3). Similarly, Botega, Barros, Oliveira, Dalgalarrondo and Marin-Leon (2005) referred to a study designed in Sao Paulo that showed suicidal ideation is strongly related to mental disorders.

Table 3 - Correlation between suicidal risk and depression

Variable	Depression		
	n	r	p
Suicidal Risk	1557	+0.67	0.000

The results obtained in this study also showed that there was a significant difference between suicidal risk age (p = 0.000), gender (p = 0.000) and education (p = 0.004), being more evident in older teens (15 to 18 years), females and among these with higher schooling levels and those whose parents didn't work. State of health, drug use, alcohol and lack of socialising with colleagues significantly influenced the emergence of suicidal risk (p = 0.000).

The ecological disaster that we have seen and consequent deterioration of the socio-economic conditions of the population have increased the occurrence of suicide in young people.

Awareness and information of the population constitute, from a public health perspective, a key pillar in suicide prevention, through multi-sectoral cooperation programmes (multicultural and multidisciplinary).

The media play a fundamental role in developing training strategies focusing on mental health promotion. The results showed that the main risk factors for adolescent's suicide are the presence of stressful events, substance abuse, family problems, relational issues, geographical issues and depression.

The mental disorders of young people require that educational institutions, as well as the family, is instrumental in in protecting the health and welfare of young people. Schools must be privileged spaces where the troubles and anguish of young people can be minimized and the increase of knowledge is a tool for growth, development and ownership of healthy lifestyle behaviours, discussion of healthy themes and consolidation of appropriate conduct at school and in the family.

Suicide is an increasingly important social phenomenon which should be eliminated in all societies around the world. More and more men and women opt for voluntary death in adulthood, as a way of coping with unresolved difficulties in childhood and adolescence.

In this way, it becomes essential to strengthen support networks of adolescents, involving mainly the family, colleagues and the school, promoting more satisfactory relations and greater well-being, with a view to better personal relationships and the assumption of universal values. We must rethink the true meaning that life has for each of us and our community, never neglecting the socio-cultural and spiritual values, respecting integration and social cohesion in a globalized world.

The severity of mental disorders so early in life requires a psychosocial intervention with effective and concerted strategies to reduce future harmful repercussions, particularly in the psychological suffering, deviant behaviours, violence/aggression, abuse of alcohol and other psychoactive substances in young people

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Attitudes towards aggression, perception of aggression in groups of somatic, psychiatric and students nurses-comparative analysis

Paper

Jakub Lickiewicz (Poland)

Keywords: aggression, nurses, perception of aggression

Abstract

Aggression by patients and visitors (PVV) in health care sector is a well- known international problem. There is a link between patient aggression and high level of stress and burnout in health care workers group (Jackson, Clare, Mannix, 2002). The research's shows, that nurses attitudes about reasons of patient aggression may influence their management of aggressive patients (Whittington, Higgins, 2002). However, most of the studies concentrate on psychiatric nurses, saying only a little about other nurses specialisations.

Aim

This study aimed to investigate the differences in attitudes and perception of aggression in three groups- psychiatric, somatic nurses and students of nursery.

Methods

The study population consisted 482 participants- 200 somatic nurses, 180 psychiatric nurses and 102 student nurses. To measure attitudes and perception of aggression Attitudes towards Aggression Scale (ATAS) (Janses et al, 2005) and Perception of Aggression Scale (POAS) (Palmstierna, 2006) were utilised.

To obtain knowledge about other factors which might affect perception of aggression of psychiatric nurses, Social Competence Questionnare (KKS) (Matczak, 2000). were used.

Approval for the study was granted by proper Ethics Committee.

Results

The results shows differences between the study groups in attitudes towards aggression and perception of aggression. Age, experience and nurse workplace affects to those factors. It seems, that student nurses have more stereotypical view of PVV. However, social competences of psychiatric nurses did not affect to their perception of aggression.

Conclusions

Perception and attitudes towards aggression are important factors in management of PVV. The study indicates, that frequency of contact with aggression and past experience with violence might be key component in future nurse reaction to PVV. There is a need of deeper analysis of this issue due to its practical application, including changes in nurses study curriculum.

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Educational Goals

The participants will...

- be able to have an understanding of factors influenced on nurses management of PVV
- be able to identify factors and strategies that need to be adopted to solve the PVV problem

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Presentation of the Conducted Electrical Weapon De-Escalates Violence in the Healthcare Setting

Poster

Jeffrey Ho, Michael Coplen & Brian Driver (USA)

Keywords: Conducted Electrical Weapon, Behavior De-Escalation, Psychological Deterrence, Healthcare

Abstract

Background

Violent behavior control within healthcare institutions is challenging because special rules apply. Conducted Electrical Weapons (CEWs) have been successfully used in healthcare as part of a comprehensive behavioral control policy. Outside of healthcare, there are reports that the mere presentation and display of the CEW to the agitated person often de-escalates violent situations and CEW probe deployment is not needed. This phenomenon has not been formally studied or described in the healthcare setting.

Aim

To determine if presentation/display of a CEW can de-escalate violent behavior when harm to another is imminent in a healthcare setting.

Methods

Security department records over 9 years were reviewed for a single Level 1 Trauma Center healthcare campus housing a 100-bed secure mental health facility, an acute psychiatric evaluation facility, a secure emergency services area for agitated subjects, and a busy emergency department with >103,000 visits annually. Data reviewed included the total number of calls for service, number of events where a CEW was displayed to a violent person but did not require probe deployment, number of times the CEW required probe deployment for behavior control, and the circumstances for each CEW use. Descriptive statistics were applied including a binomial test for significance.

Results

There were 752,138 calls for service over the 9-year period and 182 events where a CEW was presented/displayed to a violent person. Of these, 36 resulted in CEW probe deployment (19.8%) and 146 (80.2%) did not because the person de-escalated their behavior upon presentation and display of the CEW (p

Conclusions

CEW use within this healthcare setting was done only when there was no other option to stop the immediate threat of harm to a person that was present. The visible presentation and display of a CEW appears to have a statistically significant effect on de-escalating violent behavior of persons within a healthcare facility overall.

Educational Goals

Upon reviewing this work, the audience will:
- Learn how the presence of a CEW can change behavior.
- Understand how a CEW can be part of a comprehensive behavior control plan in a healthcare setting.

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Preventing Relapse in Psychiatric Ambulant Care by means of the Early Recognition Method

Poster

Kirsten Kjær Johansen & Frans Fluttert (Norway)

Keywords: Staff-training, treatment approach, early warning signs, relapse, prevention

Abstract

Background

Patients suffering from severe mental illness experience psychotic relapse resulting in incidents such as escalating psychosis and re-hospitalization. This intervention study trained nurses in ambulant Mental Health Care to identify and manage individual warning signs of imminent crisis, by means of Early Recognition Method (1). Initially ERM was used and studied in forensic MHC (2). The approach presented by ERM has not previously been implemented in outpatient care.

Research Question

Does implementing ERM in ambulant psychiatric care reduce the number of incidents /readmissions among patients suffering from Schizophrenia or Bipolar Disorder?

Aim

We aim to adapt ERM to ambulant MHC, preventing or reversing imminent crisis among ambulant psychiatric patients, reducing the necessity for coercive measures as risk management in ambulant MHC.

Objectives

Patients with SMI as Schizophrenia or Bipolar Disorder are aware of their warning signs for impending crisis at an overall level. ERM is a Risk Management Strategy aiming to assist nurses and patients in MHC to identify personalized Early Warning Signs of impending crisis (3). In this process staff patient collaboration is essential for patient's engagement. Management of each EWS is described in an Early Detection Plan (1). Presence of EWS in patient behavior triggers the described actions.

Design

A longitudinal study with a naturalistic mixed design.

The ERM staff training strategy is adapted to meet the professional needs of nurses in ambulant MHC, and match ambulant treatment. After each ERM training, a focus group interview with the nursing-team is conducted, to acquire knowledge about the nurse's experience of the ERM-training and its applicability resulting in an "ERM-ambulant care version". In this study six ambulant MHC centers will implement the ERM treatment approach.

Sample

Nurses: ACT teams/ ambulant care centers; Adult patients with Schizophrenia or Bipolar disorder. Data-collection: Interviews and patient records.

Expected Results

A reduction of relapse and rehospitalization of patients with schizophrenia and Bipolar disorder in ambulant MHC is expected. The outcome will contain comparison of incidents experienced by the patients before and after implementation of ERM. It is expected that implementation of ERM in MHC will benefit both patients and nurses: patients gain improved insight and control and experience less relapses and nurses acquire a tailored risk management tool to systematize their treatment approach. Further knowledge regarding the nearness-distance of nurses to patients and ranking of EWS related to diagnosis is expected.

Educational Goals

- Name an intervention with a systematic and collaborative treatment approach to patients in mental health care.
- At an overall level explain the concept Early Warning Signs

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Mindfulness-based intervention reduces aggression: A systematic review

Poster

Akihiro Shiina (Japan)

Keywords: mindfulness, violence, aggression, psychotherapy, Mindful-based meditation, Dialectical Behavioral Therapy, Acceptance and Commitment Therapy, Mode Deactivation Therapy, meta-analysis, systematic review

Abstract

Background: Mindfulness is rather a newly developed concept adopted in psychotherapies. In mindfulness technique, clients are encouraged to focus on their current live emotions as it flows. Being aware of the vivid movement of the emotion and accepting them are considered to be helpful in not being overwhelmed by destructive emotions.

Recently, several studies suggest the possibility that psychotherapies including mindfulness-related technique will reduce clients' aggression and violent behaviors. However, its actual effect has not been clarified.

Aim

To examine the effect of mindfulness-based approach on reducing aggression and violent behaviors.

Material and Method

We conducted a comprehensive literature search with PubMed, Science Direct, PsychInfo, and Web of Science electronic databases. We attempted a meta-analysis of identified studies which were conducted with an appropriate way of research.

Result

We examined a total of 2,405 articles published until August 2015, of which 49 were randomized controlled trials, including mindful-based meditation, dialectical behavioral therapy, acceptance and commitment therapy, and mode deactivation therapy, and 6 were meta-analytic reviews. We conducted a meta-analysis following the PRISMA statement. Statistical analysis revealed that mindfulness-based approach was effective in reducing aggression and violent behaviors of clients.

Conclusion

Mindfulness-based approach can potentially reduce clients' aggression and violent behaviors. This results can be adopted in several clinical settings.

Educational Goals

- To learn the effect of mindfulness-based approach on modifying aggression and violent behaviors.
- To learn how the meta-analytic review about the effect of mindfulness on aggression and violent behaviors was conducted.

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Emotion Regulation and Awareness in Intermittent Explosive Disorder

Paper

Michael McCloskey, Jonathan Prichard & Martha Fahlgren (USA)

Keywords: Intermittent Explosive Disorder, Aggression, Emotion Regulation, Empathy, Alexithymia

Abstract

Intermittent Explosive Disorder (IED) is a disabling psychiatric condition characterized by recurrent, problematic, impulsive aggressive outbursts. IED is associated with difficulties controlling angry emotions. However, less is known about to what extent individuals with IED have an accurate awareness of their and/or others emotions. Individuals with IED were compared to psychiatric and healthy comparison groups on measures of emotion regulation, empathy and alexithymia.

Aim

Intermittent Explosive Disorder (IED) is a disabling psychiatric condition characterized by recurrent, problematic, impulsive aggressive outbursts. Once thought to be rare, recent studies have shown IED to have a lifetime prevalence of 4-6 %. IED is also associated with severe psychological distress. Anger dyscontrol and tendency to interpret others' behaviors as malicious in intent (i.e., a hostile attribution bias) are common in IED, suggesting both emotion regulation problems and poor awareness of both self and other's emotion. However, no studies have examined alexithymia or empathy in IED. Our aim was to assess emotion regulation and emotional awareness among individuals with IED relative to non-aggressive individuals with and without other forms of psychopathology

Methods

375 participants either (1) meeting DSM-V criteria for IED, n =125, (2) meeting for a non-aggressive psychiatric disorder, n = 125, or (3) healthy volunteers who do not meet for any lifetime psychiatric disorder, n =125. All participants completed the structured diagnostic interview for the DSM: SCID), as well as self-report measures of emotion regulation (Difficulties in Emotion Regulation Scale: DERS), empathy (Basic Empathy Scale: BES), and Alexithymia (Toronto Alexithymia Scale: TAS-20]).

Results

Three one-way (diagnostic group) multivariate analyses of variance (MANOVAs) were conducted to assess the three diagnostic groups on the DERS, BES and TAS-20, followed (when significant) by univariate analyses and tukey HSD post-hoc tests. There was a significant multivariate effect of group on the DERS and TAS-20 (ps $< .01$). For the DERS IED participants showed greater emotion dysregulation on multiple DERS scales relative to psychiatric and healthy control group (all $p < .05$). For the TAS-20, follow-up analyses showed that the IED and psychiatric control groups reported greater difficulty identifying and describing their emotions relative to healthy control ($p < .05$) but did not differ from each other. There was not multivariate group effect for the BES ($p > .10$)

Discussion

These results support previous research showing severe emotion regulation deficits in IED. However those with IED do not appear to have difficulty identifying others emotions and their ability to

understand and express their own emotion is comparable to others with non-aggressive psychiatric conditions. Thus, aggression in IED may not be the result of a lack of emotional understanding, but rather an inability to control their emotions.

Educational Goals

- Learn the relationship between IED and emotion regulation
- Learn the relationship between IED and emotional awareness

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Chapter 10 – Service users & family perspectives

Forensic psychiatric patients' perceptions of situations connected with the use of mechanical restraints

Paper

Ellen Boldrup Tingleff, Lise Hounsgaard, Stephen Bradley & Frederik Alkier Gildberg (Denmark)

Keywords: Forensic psychiatry, mechanical restraint, patient perceptions, qualitative research

Abstract

Introduction

In Denmark, the objective is to reduce coercion in psychiatric settings by 50% by 2020 and to improve clinical practice. Despite this, the use and duration of mechanical restraints (MR) is particularly prevalent among forensic psychiatric patients. Research suggests that the involvement of patients' experiences and perceptions can contribute to the reduction of coercion, and the area of patients' perceptions of coercion has also been scrutinized by an array of researchers. However, research explicitly examining patients' perceptions of coercive measures as a process, which includes situations before, during and after exposure to coercion is sparse. Furthermore, the existing research within the area is generally challenged by inconsistencies in the use of concepts and definitions of the different types of coercive measures under investigation. Finally, the area is only sparsely examined within a forensic setting.

Aim

To generate knowledge about the meaning forensic psychiatric patients ascribe to perceptions of situations before, during and after MR episodes and to develop knowledge about what, from the patients perceptive, can reduce use and duration of MR.

Method

Semi-structured interviews with forensic inpatients and outpatients have been conducted. The recruitment continues until data saturation is achieved.

Results

Preliminary results will be presented at the conference.

Educational Goals

- On completing this presentation, participants will be able to identify forensic psychiatric patients' perceptions of situations associated with the use of mechanical restraint
- On completing this presentation, participants will be able to identify factors, that from patients' perspectives, may reduce use of mechanical restraint

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The lived experience of mental health inpatients with an autistic spectrum condition- A Phenomenological Study

Paper

Paul Maloret (UK)

Keywords: Autistic spectrum conditions, anxiety, self-harming and aggressive behaviours.

Abstract

A person living with Autism and Sensory Processing Disorder find importance within their structure of their day to day life, which helps to manage the sensory world and the affects it has on them. When they experience admission to acute mental health inpatient services, often their structure is significantly disrupted to the extent that it causes heightened anxiety and distress. During 2015/16, semi structured qualitative interviews were conducted with mental health patients with ASC and SPD in the East of England.

Qualitative analysis using Interpretive Phenomenological Analysis techniques to identify emergent themes were used, the purpose of this paper is to explain the methodology and emerging themes using direct quotations from the data, which highlight the lived experience of the participants. One of the most talked about themes emerging is that of Sensory Processing Disorder and its contribution to the inpatient experience. The anxiety caused by the physical environment is one that appears to be largely overlooked by the mental health practitioners and a greater understanding awareness is crucial to the care provided. Despite growing acknowledgement that admission to mental health facilities should be a last resort, reported figures in the UK on admissions continue to rise.

Educational Goals

- to improve participants understanding of the impact that a psychiatric inpatient experience can have on the mental well-being of a person with an autistic spectrum condition.
- to understand this specific drivers of anxiety and consequential self harming and aggressive behaviours, for people with autistic spectrum conditions in mental health inpatient units in the UK.

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Gender differences in consumers own prediction of violence using a self-report risk scale (SRS)

Paper

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Keywords: risk assessment, violence, mental disorders, self-report, inpatients

Abstract

Background

Meta-analyses have concluded an upper limit seems reached for the precision of existing violence prediction instruments. A recent review article also pointed to the importance of combining knowledge from different disciplines regarding violence risk assessments. Consumers' self-perception has rarely been emphasized as useful to violence risk assessments, and only few studies are conducted. The SRS is a self-report scale were consumers are asked to choose one of six available respond options to best explain their own self-assessment of risk; no risk, low risk, moderate risk, high risk, don't know the risk, or will not answer about the risk. There are emerging studies describing gender differences in violence within mental health settings and the results are contradictory. When gender has been investigated within acute mental health settings, results tend to be inconclusive.

Aim

The aim was to investigate SRS as a possible additional risk marker for violence during hospitalization, and possible gender differences in the SRS.

Method

The design was a naturalistic prospective inpatient study. All acutely admitted consumers in a psychiatric emergency hospital in Norway during one year were included in the study (N=512).

Results and Conclusion

The results show that nearly 80 % of the consumers reported "no risk" and "low risk", and only a handful consumers reported "moderate – and high risk" (1.4%). The violence rates among consumers who reported "no – and low risk" were about 10 % and 15 %, while almost 40 % of the remaining consumers were recorded with violence. The results also display gender differences in the logistic regression regarding which variables are associated with violence. The OR for SRS for women were higher compared to men both in the univariate and the multivariate analysis.

The results indicate that SRS can be an additional risk factor for violence in acute mental health settings, either transformed into a dichotomous variable, or transformed into a three steps ordinal variable. The results also target SRS to be a more significant risk factor for women compared to men.

Educational Goals

- To increase knowledge about gender differences in consumers own violence risk assessments with SRS
- Discuss the potential of SRS as a possible additional risk factor for violence during hospitalization

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Resonant relationships and service user influence on matching prevent mechanical restraint

Paper

Esben Sandvik Tønder & Eva Ørsted Sery (Denmark)

Keywords: resonance, matching, recovery, user participation, working alliance, mechanical restraint

Background

Relational competences and communication skills are key factors in staff efforts to prevent the use of mechanical restraint (MR) and other kinds of coercion in mental health service (MHS). It seems to be a common presumption that staff members with the right communicative and relational qualifications can relate to any service user and apply relevant strategies to calm uneasy service users in conflict situations. Nonetheless, this paper will argue that we miss a crucial factor if the approach to relational professionalism gets too instrumental.

In everyday life, no one questions that the quality of our relationships differs. From early childhood and throughout our lives, we experience differences in resonance, personal 'chemistry', and this factor influences how we choose or avoid relationships. The question is what difference it makes if this everyday phenomenon is not taken into account when relations are professional in MHS?

The concept of resonance originates from physics and music, but, as this paper will argue, it can advantageously be applied to partnerships in a recovery-oriented MHS. The hypothesis is that focusing on resonant relationships, that is, positive 'chemistry' in relationships between service users and staff, and service-user influence on the process of matching can contribute to reducing mechanical restraint (MR).

Mental Health Centre Ballerup (MHC Ballerup) is part of a Danish national project aiming on reducing MR. In 2014, The Danish government set the political target of reducing the use of mechanical restraints (MR) by 50% by the year 2020. MHC Ballerup has been successful in reducing MR, and focusing on resonance has been one the means.

Methods and context

Methodologically, this study is inspired by phronetic research with its focus on praxis, values, and with case-descriptions as a central element (Flyvbjerg, 2001). Context is seen as essential because praxis can be understood only in the specific and variable settings in which it takes place.

In the following, resonance will be placed within the paradigms of recovery and shared decision making. We will then describe what role service-user involvement has played at MHC Ballerup, the context for the case, and the way data has been collected.

Resonance, recovery, and shared decision making
Efforts to prevent use of coercion in MHS are closely interconnected with the recovery paradigm, where service users are more actively engaged in the process of cooperation with professionals. Shared decision making (SDM), the central model for cooperation within the recovery paradigm, has metaphorically been described as a tango (Charles, 1997)—where (at least) two persons are engaged in an equal partnership. On the dance floor as well as in recovery-oriented MHS, a good partnership is characterised by mutual respect and understanding—resonance and not coercion.

Qualitative studies on SDM have addressed the importance of service-user-staff relations (Matthias, Salyers & Frankl, 2013; Eliacin, Salyers, Kukla & Matthias, 2015), and lack of influence on cooperation partners has been identified as one of the main barriers to SDM (Joseph-Williams, Elwyn & Edwards, 2014).

A central principle in SDM is that service users should be able to influence all important treatment decisions. If recovery and SDM should be taken seriously, it could be argued that service users should have influence on the matching of staff and service users. The hypothesis here is that user-influence on matching might have the potential of creating more resonant relationships and thereby reducing coercion in MHS.

The service user perspective and co-production

At MHC Ballerup, service-user involvement and co-production have been cornerstones in the centre's development of new strategies to reduce MR. The new focus on resonance and matching is a direct consequence of user involvement. Service users have pointed out that conflicts that arise in dissonant service-user-staff relations in many cases can be avoided if relationships are more resonant. Clinical staff and service users have collaboratively found ways to incorporate attention on resonance in clinical practice.

From first-hand experiences of MHS hospitalisation, including experiences of MR, the first author of this paper is familiar with the importance of good relationships in critical situations. Bad experiences of cooperation in a state of despair and confusion with randomly chosen staff has been a strong motivation to consider the importance of the quality of partnerships and the process of matching service users and staff.

Context: Intensive care unit implementing 'cooperation agreement'

The intensive care unit at MHC Ballerup, where the study was carried out, has 16 inpatients. Staff at this ward use a so-called 'cooperation agreement', with questions on service users' coping strategies, treatment preferences, and early warning signs. A new question on service user preferences among staff—that is, staff with whom service users collaborate particularly well—has been added to the agreement to address the question of resonance. The rationale behind the cooperation agreement is to increase service-user involvement and build on earlier experiences and preferences to prevent MR and other kinds of coercion. If service users have identified staff members with whom they have good relations, the staff can try to meet preferences to de-escalate situations.

Resonance has also been considered in the development of a so-called intervention team. In short, the intervention team consists of two staff who can be called on when a ward needs assistance to de-escalate and prevent MR. Before calling the team, the service user should be offered another staff relation (and thereby taking the question of resonance seriously), and when the intervention team arrives they can take over direct contact and offer new relations. The intervention team is the topic of a separate paper, 'Intervention Team reduces use of mechanical restraints', and will therefore not be discussed further here.

Data collection

The study includes participatory observation for three days, four staff interviews, and four service-user interviews. Interviews were semi-structured and fully transcribed. The interview guides focus on resonance, matching of service users and staff, and the 'cooperation agreement' as a tool to engage service users more actively in their process of recovery and thereby prevent the use of coercion.

The first author, with lived experiences of MHS hospitalisation and coercion, initiated and carried out the qualitative study with the personal experiences as a backdrop. User experience is the 'lens' through which clinical practice is seen and analysed. During the study, lived experiences were 'used' actively to build trust and confidence in the interviewees.

Results

Resonance makes a difference
According to both service users and staff, resonant relationships are of major importance for many different reasons. For service-users, good relations equal more confidence, more openness, willingness to cooperate, fewer experiences of provocation and dominance from the staff, and less aggression and violence. An interviewed service user was serving a treatment sentence that, according to him, could have been avoided. If he had been met by staff with whom relations were resonant and not dissonant, the situation would have had a less dramatic outcome. In general, service users expressed that the need for resonant relationships increases with service users' mental suffering.

Staff acknowledges that resonance varies from one relation to another, and they find it easier to use their professional skills in relations with mutual understanding. A staff member puts it this way:

> *When I think back upon service users I have worked with, it [resonance] means everything. Well, when I have managed to de-escalate situations with service users in really acute situations, it has been more about the concept of resonance and less about my skills or whether I could meet the service user's wish or not.*

For staff, the concept of resonance is challenging a deeply rooted professional self-image according to which they should be able to help every service user when applying the right methods. Difficulties building good working alliances have consequently been experienced as professional failures. Therefore, differences in resonance can be experienced as a taboo as the following quote demonstrates:

> *It is a bit difficult for me to say it out loud, but there are some service users that I am more enthusiastic about. And it is really strange, because it is not a special category […], there is something human about it.*

Interviews revealed that a professional self-image that is incompatible with or denies the existence of 'human chemistry' in professional relations can result in difficulties applying professional skills. Dissonant relations can block communication, whereby professional, relational skills are incapacitated, and coercive measures can seem the only way out of a conflict situation. Staff's communication skills are extremely important in conflict situations, but no matter how well a staff member communicates, it might not be enough if a relationship is predominantly dissonant. Also, when differences in resonance and dissonance are not articulated, difficulties building working alliances become embarrassing professional 'failures'.

Having become more aware of resonance, staff has started articulating differences in resonance more openly, and changing service-user-staff relations in conflict situations has become a conscious de-escalation strategy.

The cooperation agreement and influence on matching
In general, staff sees the 'cooperation agreement' as a useful tool to match expectations and they acknowledge it as an invitation to user-participation: *'If I were the service user, I would prefer to be asked what do you already know, how can staff help you, and what do you think, instead of meeting staff who think they are experts in my field.'*

Both staff and service users assess the new question on service user preferences among staff positively. Service users find it difficult to express preferences on professional partners spontaneously, and therefore, they welcome the new question: *'I definitely think it can be an advantage […] if it is a kind of formalised thing you go through, so it is not personal, but a more structural thing that you just do.'* Thus, it is important that service-user influence on matching is formalised. If staff should not mistake requests from service users as personal criticism, it must be given a professional/organisational frame.

Staff has good experiences using information from the cooperation agreement on service-user preferences among staff in critical situations and thereby preventing use of coercion. It is still not possible for service users to choose their contact persons, but it might be the next step. A staff-member puts it this way: *'We have not come that far yet […], but I think this is the direction we will go in the years to come.'*

Significant reduction in mechanical restraints

Focus on resonance, the 'cooperation agreement', and a range of other initiatives have reduced the number of MRs at MHC Ballerup from 329 incidents in 2013 to 13 in 2016. Even though addressing the question of resonance in service-user-staff relationships is only one of many actions to reduce the number of MRs, it plays a pivotal role in the centre's overall change towards a more recovery-oriented culture where service users are regarded equal partners who can influence matching. The experience is that the more engaging and recovery-oriented a culture is, the more capable it is of preventing use of coercion.

Discussion

In acute inpatient wards, service users are, in many cases, involuntarily hospitalised. As a starting point their motivation to cooperate is therefore limited, and the question 'who would you prefer to cooperate with', might seem irrelevant. From a user perspective, it is evident that 'the whole system' can be seen as enemies in moments of despair during an involuntary hospitalisation. Nonetheless, it can make a huge difference what vibrations you sense when a staff-member is approaching, and an invitation to influence matching might have a positive influence on the willingness to cooperate.

During staff interviews, the concept of resonance was often discussed in contrast to a professionalism associated with setting limits for service users. The question is if it makes sense to contrast professionalism and resonance? If resonance and dissonance are inescapable underlying factors, the phenomenon will always interfere in the (professional) interaction— (professionally) addressed or not. Consequently, the ability to pay attention to and discuss resonance (also with service users) can be seen as important professional skills. The ability to 'tune in' and be aware of the 'partner' can be understood as a skill of relational professionalism as well as the ability to judge if the degree of dissonance makes it more opportune to let another staff member take over.

Lived experiences and a qualitative study in acute inpatient settings have indicated that focusing on resonant relations in MHS makes a positive difference in staff-service user relationships and contributes to the reduction of coercion. At the same time, it should be stressed that context matters. The specific context must be considered when new solutions with regards to resonance and matching should be found in outpatient settings, in residential mental health treatment environments, or elsewhere where conditions for interaction between service users and staff are different. Nonetheless, our presumption is that focus on resonance and user influence on matching is important in all MHS settings.

In accordance with the findings of this study, it would make perfect sense to add a focus on resonance to existing training programs in communication and de-escalation techniques in MHS. Having good communication skills is not enough. A systematic approach to user involvement in the process of matching in acute and subacute critical situations is needed to support the staff in de-escalating critical situations. Bringing attention to whether a colleague has better chances getting through to a certain service user in a certain context and not being afraid of asking the service user about staff preferences are important steps in the preventing of mechanical restraint.

Conclusions

The study indicates that there is a great potential in focusing on resonance in service-user-staff relations. Inviting service users to influence who they cooperate with can be an effective step toward a more recovery-oriented MHS with less use of MR and other means of coercion.

Making resonance a professional point of attention, and thereby challenging the taboo around differences in resonance in service-user-staff relations, can be considered part of relational professionalism. Incorporating a conscious attention on resonance in the professionalism of MHS staff apparently makes it easier for staff to apply the full potential of their professionalism to reduce the use of coercion.

Raising attention on resonance as an essential component in relational professionalism and making it a legitimate topic of sparring among staff can be a good starting point. However, from a service-user and recovery perspective, the essential challenge is to find ways to invite service users to influence the process of matching. Service users become more equal partners in the MHS 'tango for two', at eye level with staff, when they participate in deciding with whom to make decisions. When the service user and staff become partners instead of opponents, the chances of avoiding the use of coercion are improved.

Acknowledgements

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Improvement with self-administered inhaled loxapine in agitated patients outside the hospital setting: preliminary results of a phase IV open-label trial

Poster

Anca Craciun Boldeanu, Ana Gonzáles-Pinto, Jordi Domingo-Ribas, Ramón Palmer & Thais Baleeiro Teixeira (Spain)

Keywords: agitation, schizophrenia, bipolar disorder self-administered, patients 'satisfaction, caregiver, human approach

Abstract

Background

Patients with agitation can escalate from a mild to severe stage when coercive and involuntary measures are taken. Staccato® loxapine for inhalation (ADASUVE®) provides a non-invasive treatment option with a rapid onset of anti-agitation effects. ADASUVE® interrupts the escalation of the symptoms at the beginning and could avoid coercive management and/or involuntary patients 'hospitalization.

Objective

To assess the safety profile, time to improvement, patient satisfaction and concordance between the patient/caregiver and physician, in terms of scoring of agitation severity (CGI-S) and the decision to self-administer ADASUVE® for the treatment of agitation episodes in out-of-hospital settings.

Methods

A phase IV, open-label, multicentre, clinical trial is being conducted on adult patients with schizophrenia or bipolar disorder. The primary endpoint is the incidence of serious and respiratory adverse events related to use of ADASUVE® outside the hospital setting. The patients must have received a specific training session for adequate out-of-hospital self-administration of ADASUVE®. All patients are being followed up for 6 months, during which period it is expected one episode of agitation to occur. Patients are using a diary card to register the CGI-I information after their agitation episode. Adverse events and CGI-I scores for the first 10 patients that have completed the study are reported. All the results were analysed using descriptive statistics.

Results

A total of 10 first patients were assessed (50.0 % male), 50.0 % were diagnosed with schizophrenia and others, bipolar disorder. The mean (SD) age of patients was 33.1 (9.4) years and the mean time since diagnosis 8.5 (7.5) years. None adverse event was reported. After 10 minutes, the CGI-I score was rated as "improved" for all patients; 60.0 % of patients scored "very much improved", 10.0 % scored "much improved" and 30.0 % "minimally improved". The improvement was maintained up to two hours post ADASUVE® inhalation. The patients' satisfaction after self-administration is assessed, with a ranking between "very satisfied" until "dissatisfied"; all patients assessed "very" and "satisfied" with the treatment. All self-administrations of ADASUVE® by the patients/caregiver were evaluated in the follow up visit and were in accordance with the physicians' instructions.

Conclusion

These preliminary results showed a good safety profile of ADASUVE® and a control of the episode of agitation in the first 10 patients out-side the hospital. Therefore, ADASUVE® may represent a new therapeutic option providing a rapid control of agitate episodes avoiding coercive measures and/or involuntary hospitalization.

Educational Goals

Cognitive Domain:
- Gain understanding of agitation in the psychiatric patients and associated symptoms out-side the hospital
- Recognize the importance of symptom management for psychiatric patients out-side the hospital
- Learn specific strategies for training the patients in identify and manage their agitation
- Analyse the preliminary results of the ongoing trail with inhaled loxapine out-side the hospital

Affective Domain:
- Be aware of patients and caregivers' perspective in the identification and management of their agitation episodes out-side the hospital
- Gain insights regarding therapeutic rapport out-side the hospital and alliance between physicians and patients
- Notice differences between clinical judgment of agitation and patients/caregivers' perspectives

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Chapter 11 – Race, gender, cross-cultural & ethnicity perspectives

Migrants at high risk for treatment in secure mental hospitals. Where do they come from?

Paper

Thomas Ross, Klaus Hoffmann, Jan Querengaesser & Jan Bulla (Germany)

Keywords: migration, schizophrenia, mental hospital order, forensic psychiatry and psychotherapy

Abstract

Aim

In the literature, there is strong evidence for a substantial correlation between migration, social disadvantage, and the prevalence of schizophrenia. We aimed to investigate the relationship between countries of origin, the risk of becoming a forensic patient, and the proportion of schizophrenia spectrum disorders.

Method

Data from comprehensive evaluation tool of forensic inpatients in the German federal state of Baden-Württemberg (FoDoBa; n=524) were compared with German population statistics and correlated with the Human Development (HDI) and Multidimensional Poverty Indices (MPI).

Results

For residents with an immigration history, the risk ratio to receive a mental hospital order is 1.3 compared with non-migrants. There is a highly significant association between the HDI of the country of origin and the risk ratio for detention in a forensic psychiatric hospital. The proportion of schizophrenia diagnoses also correlated significantly with the HDI. In contrast, the MPI did not correlate with schizophrenia diagnoses.

Discussion

Two lines of explanations are discussed: First, high prevalence of schizophrenia in migrants originating from low human development countries in general, and second, a specific bias in court rulings with regard to involuntary forensic treatment orders for these migrant groups.

Educational Goals

1. to understand that some migrant groups are at high risk for schizophrenia
2. to understand the relationship between countries of origin, the risk of becoming a forensic patient, and the proportion of schizophrenia spectrum disorders.

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Chapter 12 – Ethical, human rights and legal perspectives

Subjective experience of coercion related to medication: Study in a forensic psychiatric population with an adapted version of the Admission Experience Survey

Paper

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Keywords: Forensic Psychiatry, Coercive Treatment, schizophrenia, subjective experience

Background

Coercion imposed on mentally ill patients can occur in various forms. Two major types should be distinguished: Freedom-restrictive measures (involuntary detention, locked wards, seclusion, mechanical or physical restraint) and treatment by use of coercion. The latter mostly refers to drug treatment, but can also comprise in some cases electroconvulsive therapy or coerced withdrawal from alcohol or drugs. While freedom-restrictive measures are used only or at least primarily for reasons of safety of the patient himself or others, coercive medication can be used similarly to mechanical measures in the sense of "chemical restraint" for reasons of safety or (and sometimes overlapping) as a necessary treatment of the underlying condition itself. In Germany, a term such as "chemical restraint" is used very reluctantly by professionals. Psychiatrists emphasize that treatment in the pure interest of third persons would not be allowed to physicians and that no drugs are licensed for such purposes. Since two decisions of the Constitutional Court in 2011, legal frameworks for coercive medications have been revised and pose a high threshold for coercive treatment. Except for cases of acute emergency, administering medication by coercion requires a separate court's decision based on an expert review by a psychiatrist not involved into treatment of the respective patient. The expert should assessed the patient's capacity to consent to treatment, possible dangers and side effects of the treatment, their relation to the expected effects on the patient's health and the necessity of the proposed treatment to prevent danger for the patient's health. Danger to others is mostly not considered as a relevant condition for the approval of involuntary treatment because it is judged to be manageable by safety measures. These legal requirements are roughly the same for forensic and non-forensic psychiatry, with the threshold in practice being seemingly even somewhat higher for forensic patients due to their supposed special vulnerability.

Under these legal conditions, 0.5 % of all non-forensic patients in German psychiatric hospitals received coercive medication, out of these two thirds in cases of acute emergency (Flammer & Steinert 2015). Involuntary medication after a judge's decision concerned nearly exclusively patients with schizophrenic disorders (ICD-10 F2). However, it is well-known that beyond explicit coercive medication either given intramuscularly in case of an emergency or based on a court decision, there exist many forms of informal coercion or pressure to take medication, e.g. threats with seclusion in case of refusal or negative impact on prospectives of relaxation of regulations. With respect to forensic

psychiatry, to our knowledge no data is available on the frequency of use of coercive medication neither from Germany nor from other countries and as well on the subjective experience of informal aspects of coercion. The purpose of this study was to develop an appropriate instrument for the assessment of the experience of coercion related to medication and to investigate the population of two forensic psychiatric hospitals with psychotic disorders. Further, predictors of experienced coercion should be determined.

Methods

We adapted the Mc Arthur Admission Experience Survey for medication instead of admission (adapted Admission Experience Survey, aAES). Further, we used the Drug Attitude Inventory (DAI-10), the Fragebogen zur Krankheitseinsicht (questionnaire on insight into illness) (FKE-10), the Coercion Experience Scale (CES), the Positive and Negative Syndrome Scale (PANSS), and two visual analogue scales for the extent of experienced coercion by medication and by detention in forensic psychiatry. Patients with psychotic disorders in the two forensic psychiatric hospitals Weissenau and Bad Schussenried in Germany should be included. Exclusion criteria were lack of informed consent, lack of sufficient skills in German language, and intellectual disability. Predictors of experienced coercion by medication should be determined in a multivariate model.

Results

56 patients could be included (response rate 50 %). Only a small proportion of patients had been subjected to formal involuntary medication. The subjective extent of coercion was relatively low on average, but with a high inter-individual variance. Results will be presented in detail in a journal article. Conclusion: The study yielded evidence that the aAES is a valid instrument to assess experienced coercion related to drug treatment. We aim to gain a bigger sample for the further development of the instrument also in non-forensic populations.

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Effects of open-door policies in acute psychiatry on (perceived) coercion, serious incidents and absconding – a qualitative empirical interview study

Paper

Jakov Gather, Johannes Bernard, Janice Kalagi, Marco Knoll, Ina Otte, Georg Juckel & Jochen Vollmann (Germany)

Keywords: open-door policy, legal commitment, coercion, serious incidents, empirical ethics

Abstract

Recent court rulings in Germany raised the judicial threshold for coercion in psychiatry which has prompted changes in the law at federal and federal state level. An "open psychiatry" aims to reduce (perceived) coercion by treating patients in open rather than closed wards. Open-door policies in acute psychiatry are controversial, and the concern is often expressed that open-door policies will lead to absconding and that absconding increases the risk of harm to self or others. On the other hand, closed doors may result in higher tension on the ward and consequently more aggressive incidents within the clinic. This qualitative empirical interview study explores how service users, nurses and doctors experience and view open-door policies and their effects when it comes to patient well-being and the security of patients, employees and society.

Educational Goals

1. After attending the presentation, listeners will be able to distinguish characteristics of open and closed acute psychiatric wards.
2. Furthermore, listeners will be able to analyse ethical challenges concerning legal commitment of patients posing a danger to themselves or others.

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Effects of open-door policies in acute psychiatry on (perceived) coercion, serious incidents and absconding – a prospective cohort study

Paper

Simone Efkemann, Janice Kalagi, Jakov Gather, Bianca Überberg, Hans-Jörg Assion, Swantje Küster, Peter Nyhuis, Thomas Aubel, Ronald Bottlender & Georg Juckel (Germany)

Keywords: open-door policy, legal commitment, coercion, serious incidents, empirical ethics

Abstract

Recent court rulings in Germany raised the judicial threshold for coercion in psychiatry which has prompted changes in the law at federal and federal state level. An "open psychiatry" aims to reduce (perceived) coercion by treating patients in open rather than closed wards. Open-door policies in acute psychiatry are controversial, and the concern is often pressed that open-door policies will lead to absconding and that absconding increases the risk of harm to self or others. On the other hand, closed doors may result in higher tension on the ward and consequently more aggressive incidents within the clinic. The prospective cohort study investigates whether the treatment of legally admitted patients in open rather than closed wards reduces (perceived) coercion, and examines the effects of open-door policies on absconding rates and the frequency of harm to self or others in and outside of the clinic.

Educational Goals

After attending the presentation, listeners will be able to distinguish characteristics of open and closed acute psychiatric wards. Furthermore, listeners will be able to indicate numbers of serious incidents and absconding from open and from closed acute psychiatric wards.

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Come join our Moral Case Deliberation Workshop and experience an ethical dilemma!

Workshop

Marieke Visser & Sylvia Grauwelman-Schouten (Netherlands)

Keywords: Moral questions, quality health care, standards and values, dilemmas, reduction of coercive measures, autonomy and well-being.

Abstract

A moral case deliberation (MCD) session entails a professional self-examination of your values based on a specific example. During your daily routine with clients you will come across small moral predicaments as well as weightier issues. Moral deliberation can help to gain insight into questions such as: What is good care and what is the right thing to do in this situation? How can we accurately detect any particular tensions? What values are important from different perspectives? And which value stands out for me or for us as a team in this instance?

By taking time to consider these questions, MCD sessions can contribute to the process of reflection on how to bring about proper healthcare. During an MCD session, those who are directly involved are themselves the moral experts.

An MCD leads, among other things, to more mutual understanding, to more leeway when dealing with difficult situations and dilemmas, as well as to your own empowerment and that of your team. Participants feel supported and acknowledged concerning their own moral or ethical intuition and as a result they will be encouraged to investigate them further.

MCD makes you aware of freedom of choice and different viewpoints, strengthens your professional skills and enhances mutual cooperation. By taking time to reflect on your own underlying values, those of the participants and the clients, the process of decision-making and thus the quality of care as a whole will improve.

Within Arkin, the largest mental health organization in Amsterdam and its surrounding areas), MCDs take place on a regular basis. The MCDs are organised by the Arkin Ethics Expertise Centre under the supervision of a group of specially trained facilitators. They are implemented for example to reduce dilemmas that occur during compulsory treatment or involuntary seclusion, or, failing this, to be applied judiciously. Or in the event of an imminent therapeutic impasse (which would slow down or put a halt to the treatment).

Educational Goals

- Learn how to obtain insight into your own moral considerations. Moral considerations which are bound to affect your actions and views. Learn to become aware of your own values and standards, those of the client and his or her partner, family members and others who are closely involved.

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Psychiatric risk assessment, involuntary treatment, and discrimination of persons with mental disorder

Paper

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Keywords: dangerousness, psychiatric risk assessment, involuntary treatment, discrimination

Abstract

Mental health laws in many jurisdictions employ dangerousness to self or others as a necessary condition for involuntary treatment. We will refer to these laws as Risk Laws. Whether a person presents a danger to herself or others is commonly established by means of psychiatric risk assessment. Actuarial instruments for risk assessment have been shown to be more reliable than clinical judgment. Such instruments rely on statistical data showing that the prevalence of harm to self or others is higher among persons with certain properties: If a person exhibits risk factors for harm to self or others, she is categorized as "high-risk"; if she does not exhibit such risk factors, she is categorized as "low-risk." Under Risk Laws, persons categorized as "high-risk" are more likely to receive treatment against their will, while persons categorized as "low-risk" are excluded from such treatment.

Several authors have demonstrated that given the low prevalence of seriously harmful acts among the general population of persons with mental disorder, even the best possible actuarial tool for psychiatric risk assessment will yield many false positives; that is, many persons will be labeled as "high-risk" although they will never commit any seriously harmful act (Mossman 2006; 2009; Large *et al.* 2008; Ryan *et al.* 2010; Szmukler and Rose 2013). In this presentation, we investigate whether Risk Laws are discriminatory.

We assume that a law is discriminatory if it imposes a relative disadvantage on persons based on their membership in a salient social group (Altman 2015) and that a discriminatory law is morally objectionable insofar as the relative disadvantage that the law imposes on persons is disproportionate with respect to the benefits that the law yields.

Two arguments may be launched in defense of the thesis that Risk Laws are discriminatory: It may be argued that (1) given the low base rates of violence among the general population of persons with mental disorder, it is unlikely that the benefit accruing from the prevention of harm compensates for the relative disadvantage that Risk Laws impose on persons categorized as "high-risk." And it may be argued that (2) by making dangerousness a necessary condition for involuntary treatment, Risk Laws impose a relative disadvantage on incompetent persons categorized as "low-risk" inasmuch as many of them will be deprived of the treatment they would have preferred had they been competent. In this presentation, we will evaluate these arguments.

Educational Goals

- Attendants will understand why statistical approaches to psychiatric risk assessment will necessarily yield many false positives.
- Attendants will be able to identify the burdens that are imposed on persons with mental disorder due to being categorized as 'high-risk' or 'dangerous to self or others.'

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Patients` views on their own involuntary hospitalisation on the treatment criterion - a qualitative study

Paper

Sara Kaern Linstow & Annick Urfer-Parnas (Denmark)

Keywords: Involuntary hospitalisation, treatment criterion, autonomy, ethics, patients´ perspectives.

Abstract

Aim

The aim of this study was to investigate if patients who had been involuntarily admitted under the treatment criterion felt their condition had improved and that their admission had been justified. We wanted to examine whether patients consider an involuntary hospitalisation as an act of care and if they want to be taken care of. Under what conditions, if any at all, do patients consider involuntary admission under the treatment criterion as justified?

Finally: What is more important; their free will or being taken care of during a psychotic episode. What would they prefer if a similar situation occurred and would they consider someone else in a similar situation as themselves to be in need of help?

Background

The use of coercion in psychiatry has been discussed for many years among medical professionals, lawyers and in the public debate in general (1)(2). The arguments are presented in the continuum ranging from individual freedom and respect of a patient's free will to paternalism and the intention to take care of members of society whose condition makes them unable to ask for help.

Some essential thoughts on care are formulated by the Danish philosopher K. E. Løgstrup in "The Ethical Demand". He argues that it is impossible to have an interpersonal relation without influencing each other's lives. The result could for instance be to make decisions on behalf of the other person, as an act of care, because it is considered to be in the best interest of this person (3).

On the other hand fundamental thoughts on liberty rights for the individual to make free decisions over one's own life is described by J. S. Mill in "On Liberty". He argues that every person has the right to think freely and to live their life exactly as they wish, as long as it doesn't harm anybody or deprive other individuals from this freedom (4).

According to Danish law it is possible to involuntarily admit psychotic persons under the treatment criterion if it is indefensible not to admit the person for the purpose of treatment because the possibility of improvement otherwise will be significantly deteriorated. Involuntary hospitalisation under the treatment criterion is considered an act of care towards a psychotic person with the aim of improving or avoid deterioration of their condition (5). When involuntary admission is considered, the patient's point of view should be weighed as part of the decisionmaking process, coercion should always be the last resort and it is important to make solutions that interfere least with the patient's freedom (5)(6)(7).

However, the results of involuntary hospitalisation and treatment are inconclusive (8)(9). Some studies show that patients' conditions improve (10)(11)(12) and that patients consider the hospitalisation as

useful and justified (13)(14), others that they do not (15)(16). Most studies show a mixed picture (17)(18)(19)(20)(21)(22). The studies are difficult to compare due to different designs, and because the results of involuntary hospitalisation and treatment are measured in different ways, such as questionnaires, structured interviews, semi-structured interviews, intensity of psychotic symptoms and global functioning. In some cases it is the patient's points of view and in others it is the clinician's opinion that is assessed (8).
The question of whether psychotic involuntary admitted patients are able to make free choices are also discussed, and it is stated that there is no crucial clinical data showing that suffering from serious psychiatric disease, compared to not suffering from serious psychiatric disease, is related to lesser insight and competence in decision-making regarding one's own treatment (2). Furthermore, studies are missing on whether these patients' condition deteriorates if they are not treated, and if such a deterioration occurs, would it then be considered worse than the disagreeableness of involuntary admission and treatment (2)(18). Some studies show that insight is correlated to higher satisfaction with involuntary admission (23). Other studies investigate insight and noncompliance in schizophrenic patients in relation to self-disorders. They argue that self-disorders are present constantly and propose to discuss the psychotic experiences as meaningful to the patients in order to enhance compliance and insight (24)(25).

More studies indicate that patients experience more coercion if they feel a lack of influence, if they feel that the staff don't see them as an individual or if they find the procedures surrounding the admission unfair. On the contrary patients experience less coercion and more satisfaction and improvement if they have influence on decisions regarding their treatment (11)(14)(21)(26)(27)(28)(29).

Methods

10 patients who were involuntarily admitted under the treatment criterion and able to give informed consent were interviewed twice just before discharge.
The first interview was a semi-structured, in-depth interview exploring the patients' opinions on the following themes:

- Did the patients consider involuntary admission as an act of care of society, if they wanted to be taken care of, and under what conditions, if any at all, did they consider involuntary admissions under the treatment criterion as justified?
- Did the patients feel that their condition had improved during the stay in hospital?
- Which kind of help from society would they like to receive, if any at all?

The patient files were studied between the interviews in order to ask the patients in detail about the conditions that had led to their involuntary admission, and relate their answers to their opinions from the first interview.

All the interviews were recorded on dictaphone and subsequently transcribed verbatim and thematically analysed (30).

All interviews were conducted by the same interviewer. The patients were offered the transcription of their own interviews.

9 of the patients accomplished both interviews, 1 patient accomplished only the first interview.
5 women and 5 men between the age of 20-64 were interviewed. 4 of them had never been admitted to a psychiatric hospital before, 6 of them had previously been involuntarily admitted to a psychiatric hospital.

Results

Data analysis adhered to the principles of thematic analysis (30) and was carried out in a joint effort between the authors. Through the thematic analysis of the interviews several themes were identified. The main themes concerning our aim were the following:

1. Justification of involuntary admission under the treatment criterion in general.
2. Society's role in taking care of psychotic persons who don´t ask for help.
3. Justification of the interviewed persons own involuntary admission.
4. Improvement during stay in hospital.
5. Wishes for their own psychiatric treatment and other kinds of help.

1. & 2.:
All the participants agree that involuntary hospitalisation is justified if a psychotic person is dangerous. When it comes to involuntary admission under the treatment criterion, there are different opinions. Free will and the right to live the life that they wish were very important to most of the patients. They point out that it is always possible to refuse treatment of a somatic disease, and that they don´t think that society should interfere with the way people live their lives.
Concerning care, many agree that society should take care of psychotic persons. However, a majority of of the participants do not perceive what is actually happening during their admission as an act of care - for instance being taken to hospital by police, being placed involuntarily in hospital, and receiving medication against their will. Generally they appreciate that society offers help to people who feel mentally unwell but they would categorise it more as an act of care if there was a possibility to choose among different treatment options or possibly refuse altogether.

On the other hand, a few of the participants see involuntary admission with the purpose of treatment as justified if a psychotic person refuses voluntary hospitalisation. They argue that the doctors have knowledge of what the patients need and that the admission helps the patients to keep on living a normal life.

Some participants state that they don´t think psychosis alone justifies involuntary admission. They give examples of conditions that might justify it, such as the risk of harming oneself, not being able to provide food for oneself, suffering from dementia, or if ones way of acting in public may be humiliating to oneself.

3., 4. & 5.:
One of the participants was satisfied with the involuntary admission and would want to be readmitted if doctors find it necessary. Many of the other patients do not understand why they were admitted. Some do not agree with the way they have been described in their medical record, some agree with the description, but do not think that such behavior justifies involuntary admission. Interestingly, some of those patients agreed that their behaviour could have seemed odd and that they would have offered help to someone else, should they have been acting as they did.

Only two participants thought they were psychotic at the time of admission and during hospitalisation. Many patients found it unclear what the staff meant by psychosis, and they do not agree that they have had a psychotic episode. Some describe themselves prior to admission as ”stressed” or ”angry”, and others that they were perfectly well all the time.

Most of the participants feel that they have improved during stay in hospital, although few attribute this improvement to treatment, medication and contact to fellow patients and staff. Most patients thought that they could have improved equally by relaxing at home or by being taken care of by family and friends, and they disagree that the medication has a role in their betterment. Those who thought they had been well all the time either found the question of improvement irrelevant or felt that they had deteriorated during hospitalisation.

Some of the participants would like to receive psychiatric care in the future. They mention conversations with doctors, psychologists or nurses in outpatient clinic or in hospital as helpful. Many also wanted help from social workers. In general they would like this treatment presented to them as an option and not as an obligation. Some of the patients never want to have anything to do with the psychiatric system again because they found the involuntary admission to have violated their free will.

Discussion

When some of the participants think that involuntary hospitalisation under the treatment criterion interferes too much with the personal freedom of a non-dangerous individual, when they do not see the admission and treatment as part of their improvement and furthermore do not consider it an act of care it is questionable whether involuntary hospitalisation under the treatment criterion can be justified. When some of the participants think the treatment criterion is good or necessary, it would have consequences for them if it is removed from the Danish Mental Health Act.

As previously mentioned, studies are missing on whether patients' condition deteriorate if they are not treated, and if such a deterioration occurs, if it is worse than the disagreeableness of involuntary admission and treatment. At the same time there is no crucial clinical data showing that patients with serious psychiatric illness are less able to make competent choices regarding their own treatment.

This indicates that we cannot be sure if the consequences of not treating psychotic persons are worse than involuntary admission and treatment. It is important to let patients consider the consequences of refusing admission and treatment, and consider whether these consequences would be worse than the discomfort of being admitted and treated involuntarily.
We propose a future study that attempts to comply with these patients´ wishes, even if they should refuse treatment; for instance an agreement between patient, psychiatrist and a close relative made through in depth discussion of possible future scenarios.

Limitations

This is a small study with 10 participants and it is not possible to make general conclusions regarding attitudes of patients admitted involuntarily under the treatment criterion.
Some patients refused to take part in the study and their reasons are not investigated further. The attitudes of this group of patients could maybe differ significantly from the ones who participated.
It is important to bear in mind that the issues raised in this study are complex and it is supposed that many different factors - such as social conditions, the public debate, the gravity of the patient's illness, conditions on the wards, the patients' earlier experiences with psychiatry and others – influence the interviewees points of view.

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Obstacles in seeking a legal reaction on violent incidents in psychiatry

Paper

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Keywords: Legal reaction, reporting to police, criminal law

Background

Compared to other professionals, caretakers in psychiatry encounter a lot of aggressive incidents that can have severe and far reaching consequences (Richter & Berger, 2006; Foster, Bowers & Nijman, 2007; Anderson & Wets, 2011; Van Leeuwen & Harte, 2015; Van Zwieten et al, 2015; Evers, Jettinghoff & Van Essen. 2015). In society, reporting violent incidents to the police is an acceptable reaction. However, mental health professionals who are victimized by an assault caused by a patient appear to be reluctant to seek a legal reaction, even if the incident resulted in severe injuries. This is also the case if there seems to be no relation between the patient's disorder and his aggressiveness.

In general, a criminal procedure starts with the victim who reports the delinquent act to the police (Wittebrood, 2006). Not reporting serious violence, that takes place within a psychiatric hospital, to the police might result in legal inequality and dangerous situations for mental health care workers, other patients and, ultimately, for society. In this study we examined the literature on the needs of mental health care workers after being victimized. We investigated what victims, who decide to report an incident to the police, hope to achieve. Subsequently, the obstacles and dilemma's victims encounter when they consider reporting an aggressive incident to the police were investigated and described.

Literature

Examination of the literature reveals that victims of violence on the psychiatric ward are in need of support, recognition from colleagues, employers and, when seeking legal support, recognition from the police and the public prosecutor (Ten Boom& Kuijpers, 2012; Wikman, 2014). Additionally, they are in need of information and legal advice (Goudriaan, Nieuwbeerta & Wittebrood, 2005). The main reasons for victims to report an incident to the police are mostly rational (Harte, Van Leeuwen & Theuws, 2013). They aim to set a limit to the perpetrators behaviour, to build a file on a patient who is repeatedly violent, and to protect other colleagues and other patients. It appears that victimized care workers do not aim retaliation, especially if the perpetrator did not act on purpose (Darley & Pittman, 2033; Sitka & Houston, 2001).

When mental health care workers consider to report an incident to the police, there appears to be severe obstacles and dilemma's (Dinwiddie & Briska, 2004; Van Leeuwen & Harte, 2011; Wilson e.a. 2012; Clark e.a. 2012; Knoth & Ruback, 2016): 1) the patient's possible diminished criminal responsibility, 2) the fear to break the professional confidentially, 3) the fear of retaliation by the patient or the patient's network, 4) the fear to disturb the therapeutic relationship, 5) the idea that reporting violence caused by a psychiatric patient is not a legitimate response. Moreover, 6) victims who do report the incident to the police are informed poorly by their case.

Method

Empirical data were collected on the obstacles victims face when seeking a legal reaction on violent incidents in psychiatry. First, national as well as local policy documents and covenants between the

police and mental health care institutions, with regard to violence in psychiatry were gathered and scrutinized to find out to what extent the before mentioned obstacles and dilemmas are addressed. Second, an inventory questionnaire was sent to lawyers working in intramural psychiatry and filled-in and returned by 23 of them. Third, a total of 34 in-depth interviews were conducted with stakeholders and experts. Participants were 13 mental health care workers who had been victimized by violence caused by a patient and who had reported this to the police, 10 persons working as a manager in a mental health care institute, 6 police officers, 3 public prosecutors, 1 barrister and 1 judge.

Preliminairy results

We gathered and aggregated all respondents experiences with regard to the barriers and dilemma's that had emerged from the literature:

1) diminished criminal responsibility
How victims perceive the violence they encounter largely depends on whether or not the patient intended to hurt them. In general, if the violence derives from the patient's psychopathology, victims argue that a judicial reaction does not make any sense as the patient cannot be held responsible for his behaviour. But, if the patient forms a serious threat to his environment as a consequence of a severe psychiatric disorder, a court's decision might be necessary to have the patient transferred to a high security hospital. To prosecute a case, assessment of the patient's criminal responsibility is needed. Therefore, the public prosecutor often demands information on the psychiatric condition of the assailant, whereas the employee is not able and not allowed to provide such information.

2) fear to break the professional confidentially
In the Netherlands, the regulations on professional confidentially are complicated, difficult to apply in real-life situations and very strict. Policy documents and covenants provide contradictory instructions on which information is allowed to be communicated to the police and the public prosecutor. As the legal consequences can be far-reaching, mental health care workers who consider reporting a violent incident to the police are afraid to break the rules of professional confidentiality. As a consequence, they choose to refrain from providing any information. In practice, police officers and public prosecutors, not acquainted with the strict regulations, can react annoyed when confronted with the victim's reluctance to provide any information on the perpetrator.

3) fear of retaliation
Victims regularly decide not to report an incident to the police as they fear retaliation by the patient or the patient's network. There are some procedures to conceal the victims identity. However, anonymity cannot be guaranteed when the case is brought to court. Moreover, the perpetrator most often knows who has been victimized. Some employers choose to report the violence that has been committed against their employees. However, according to some police officers and the public prosecutors a victim's own testimony is necessary to make a case.

4) fear to disturb the therapeutic relationship
As treatment in clinical psychiatry is often involuntary, care needs to be continued, even after a violent incidence. In practice it appears to be very difficult to have a patient who has been violent transferred to another institute. As a consequence, the victimized and sometimes traumatized mental health care worker is forced to continue providing care to the perpetrator. Being afraid to disturb the therapeutic relationship, caretakers sometimes decide not to take any legal steps.

5) reporting violence in psychiatry is not a legitimate response
Almost all interviewed respondents consider violence in psychiatry to a certain extent as an occupational hazard. It is, however, unclear in which cases a judicial reaction might be a legitimate response. Was the incident serious enough? Was it the patients intention to hurt the care taker? Was the victim, to a certain extent, self to blame? In most psychiatric institutions consensus on in which cases a legal reaction is

suitable, or even necessary, is lacking. Victims are regularly advised by colleagues and managers not to seek legal action by stating that violence is part of their job.

6) victims are informed poorly by their case
For most victims it is important to be informed about their case and the decisions made by the public prosecutor. The stakeholders have acknowledged that informing the victims is relevant as covenants and policy documents include agreements on this topic. In practice, however, victims seldom receive any information on, for example, the fact that the case was dismissed by the public prosecutor.

Conclusion

Violence against mental health care workers is a substantial and serious problem. To a certain extent, violence caused by patients is part of the job. Even with strong preventive measures, it won't be possible to prevent all aggressive incidents. It is, however, of great importance to support mental health care workers who encounter violence by patients and inform them on the possibility to report a violent incident to the police.
Our results show that in psychiatry there is a lack of consensus on in which cases reporting violence to the police is an appropriate response to inpatient violence. There also appears to be a lack of clarity about in which cases the professional confidentially might be broken, and if so, which information can and cannot be shared with the police and public prosecutor.

The police and public prosecutor should acknowledge the amount and severity of violence that mental health care workers encounter while doing their work. They should also realize that victims who seek legal measures mainly have rational motives; they do not aim any retaliation but want to prevent future violence. Moreover, police officers and public prosecutors should be aware of the limitations health care workers have to deal with when reporting a violent act, as a consequence of their professional confidentially, and their possible fear for retaliation by the patient or the patients network.

Violence in psychiatry is a complex and substantial problem. In the majority of the cases, prosecution is certainly not a suitable reaction. However, in some cases a judicial reaction might be necessary, for example to continue the treatment of a serious aggressive psychiatric patient in a high security hospital. A judicial reaction starts with the victim who reports an incident to the police. It is the responsibility of all stakeholders to jointly tackle the barriers and complications victims face when they consider to report the violent acts to the police.

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Limiting the freedom of action of psychiatric patients causing psychological violence to staff

Poster

Søren Birkeland & Frederik Gildberg (Denmark)

Keywords: Psychiatry, Violence, Coercion, Law

Abstract

Background and context

Psychiatric staff are often subject to aggressive behavior. Sometimes violence is physical but as often, it is psychological. Thus, it has been found that threats and verbal abuse are experienced by most nurses during a one-year period. Victims subsequently are required to cope with the negative consequences like anxiety, sick leave. A number of studies have been directed towards effective measures to predict and prevent aggression as well as risk management yet much less research has dealt with the judicial aftermaths of violence in terms of criminal prosecution. Likewise, the legal aspects of managing psychological violence has received only scant attention. In this respect, the question could be raised as to which remedies staff members can immediately apply when subject to harsh bullying or sexual intimidation while agreeing with law. It is common in most countries that coercive measures can be used in cases of physical violence though in this study the question in focus is to what extent measures aiming at limiting the freedom of action of psychiatric patients causing psychological violence to staff can be legally used.

Methods and settings

Danish legislation, case law, case descriptions and comparison with Sweden and Norway.

Results

When looking from the perspective of Danish legislation it appears that applying coercive measures to psychiatric patients owing to harassment of staff members lacks a legal basis though coercion (e.g. belt-fixation) can in some situations be applied if other patients are subject to psychological violence. By way of comparison, Norwegian respectively Swedish law in principle legalize coercion to limit the freedom of action of psychiatric patients following harassment of staff members. Danish case descriptions suggest that 'quasi-coercive' measures sometimes may take place in terms of, e.g., threats concerning patient privilege limitation, commanding a patient to go to the patient's ward, and/or 'crowding' of staff members.

Discussion and Conclusion

While physical assaults specifically harassment of other patients may justify coercive measure use, opportunities to limit the freedom of action of psychiatric patients harassing psychiatry staff members seem lacking in Denmark. In some instances, alternative non-legally based measures are possibly applied. This situation may pose a legal problem but also may cause difficulties in some situations where, e.g., staff is severely distressed or patient care is obstructed. Further research is merited concerning the legal framework surrounding violence episodes and possible need for extra remedies to control psychological aggression in the psychiatric hospital ward.

Educational Goals

- Even though psychological violence towards staff is a common occurrence in the psychiatric ward, there is limited research available about how to handle these episodes and what are the legal implications.
- The study in Danish settings suggests that, seemingly a little different from neighboring Nordic countries, opportunities to forcely curb patients harassing psychiatric staff members is lacking, a fact that can sometimes be problematic legally as well as practically.

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Chapter 13 – Sexual offending violence

Reducing Risk of Recidivism by Fostering Resiliency: An Examination of the Impact a Restorative Treatment Program Has on Juvenile Sex Offender Outcomes

Paper

Doyle Pruitt (USA)

Keywords: Juvenile sex offender, recidivism, family, program evaluation

Abstract

The manifestation of sexual aggression in juveniles is a unique composition of diverse individual, structural and environmental factors. Contemporary treatment approaches for juvenile sex offenders (JSO) that are restorative in nature attempt to address these various factors by focusing on the person as a whole, not just the subsection of sexual deviancy, as well as with their family unit and the systems they are embedded within. As such, a thorough examination of the impact restorative treatment approaches have across multiple outcomes, including recidivism rates, academic functioning, family relationships, and psychological functioning is necessary.

This presentation begins by describing the multi-disciplinary, specialized treatment program then reports the findings from the program evaluation that examined the impact this restorative residential treatment approach had on male JSO 10-21 years of age (n=81). Findings showed an improvement in psychological and academic functioning, increased resiliency, and high rates of family involvement with treatment, all of which led to a discharge to a lower level of care. While data obtained pertaining to recidivism were limited, results indicate rates consistent with the nationally established norm. The results of this study are consistent with the existing empirical evidence and provides further support for the need of treatment programs to utilize a holistic approach to the treatment of JSO.

Educational Goals

- Attendees will articulate the components of a restorative therapeutic residential treatment program aimed at reducing risk of recidivism in juvenile sexual offenders.
- Attendees will critically assess the study findings on the effectiveness of a restorative therapeutic residential treatment program and generalize the information to application in practice and research.

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Dangerous Sex Offenders: Recidivism Rates and Risk Characteristics

Paper

Michael Rowlands, Gavan Palk & Ross Young (Australia)

Keywords: Sex offenders, sex offending, dangerousness, recidivism.

Introduction

The focus of this paper is the population of sex offenders classified as 'dangerous' by the Queensland Supreme Court (Australia). The current study aims to consider whether this construct, as defined in Queensland legislation (Dangerous Prisoners (Sexual Offenders) Act 2003), is valid. There may be certain individuals that legitimately are dangerous sex offenders, in which case the judicial process for classifying and managing them is justified. However, there is scant research on dangerous offenders (recidivism and factors that make them more at risk of sexual violence), worldwide (and particularly in Australia). The current study is the first to examine reoffending of a sample of Queensland dangerous sex offenders.

The decision of classifying an offender as 'dangerous' is based on an actuarial model of justice, where level of risk equates to level of threat to the community (McSherry, 2014; Petrunik, Murphy, & Fedoroff, 2008; Scott & Resnick, 2006). Hence, dangerousness is equivalent to risk of further serious sexual harm. The modern approach to determining individuals as dangerous displays a shift from a diagnostic (medical) model to an actuarial justice model. Judicial decision making classifies offenders as a low, moderate or high level of risk. Someone at a high risk is more likely to engage in criminal activity.

This risk framework also reflects the view that some persons are more of a risk to the public, and that the government is obligated to contain this risk (McSherry, 2014); hence, dangerous offenders are considered unacceptable to be released. In this framework, legislation that allows for individuals to be detained or placed under strict conditions could be argued as justifiable if the community is protected.

However, are these offenders actually dangerous? A review of the literature found a dearth of articles on recidivism rates, and limited information on rates of Australian samples. This is problematic, as such research could validate the use of legislation. Given that there is limited research on reoffending of dangerous offenders, it is difficult to evaluate the ethics of detention versus community safety (and possible violations of core legal tenets). Although, it is likely that due to legislation only being relevant to a limited population, sample sizes should be low, and studies will therefore lack statistical power.

If offenders released under supervision are a more dangerous cohort it is expected that they should recidivate (sexual, nonsexual violence, contraventions, and general offences) at a high rate. Survival analyses of each of low-moderate (including low), moderate, moderate-high and high-risk categories will explore whether their risk level is valid. It is expected that the high-risk group will have (i) a higher proportion of recidivists (all types of offences), and (ii) will reoffend sooner compared to lower risk groups, for the four offending categories.

Methodology

The current research project is observational. No offenders were randomised into experimental groups, and no control group was established; due to important differences in how DPSOA offenders are managed in the community, it was not considered necessary to compare the sample to (legislatively) non-dangerous sex offenders.

The independent variable is risk category (low-moderate, moderate, moderate-high, and high). The dependent variables are: time until re-arrest (Ra) (based on the date release from custody on a DPSOA supervision order until the date of rearrest for a new offence or contravention of the order) and type of reoffending (sexual, violent, contravention, and general (which includes the previous three categories)). Kaplan-Meier (Mantel-Cox) analyses were used to explore whether overall and by risk level, the DPSOA offenders are dangerous (sexually and non-sexual violently reoffending).

Participants

The current study samples from a population of (male) offenders (n=104). The participants were all classified as dangerous sex offenders under the Dangerous Prisoners (Sexual Offenders) Act 2003.

Table 1. Demographics of DPSOA Offender Sample

	DPSOA Offenders (n=104)	
Characteristic	n	%
Male	104	100
Non-Indigenous	71	68.3
Indigenous	33	31.7
Index offence		
Rape (of adult)	44	42.3
Sexual Assault	3	2.88
Intrafamilial child sex offending	6	5.77
Extrafamilial child sex offending	51	49.0
Child Pornography	1	0.96
Prior offending		
General (non-sexual)	22	21.2
Sexual	16	15.4
Diverse (sexual & non-sexual)	50	48.1
None	11	10.6
Age of onset of offending		
Juvenile	45	43.3
Adult	41	39.4
Victimology		
Prepubescent	39	37.5
Pubescent	13	12.5
Adult	44	42.3
Mixed (adult & prepubescent/pubescent)	6	5.77
Female	71	68.3
Male	20	19.2
Female & Male	11	10.6
Multiple victims	51	49.0
Overall Risk Level		
Low-Moderate	13	12.5
Moderate	14	13.5
Moderate-High	46	44.2
High	31	29.8

Results

The demographics of the 104 offenders included in the survival sample is displayed on Table 1. The average age of the offenders, at the time of release was 43.5 years (SD = 11.1), and 50.7 years (SD = 10.8) the year of data collection (2016).

Table 4.8. Recidivism counts

	DPSOA Offenders (n=104)	
Category	n	%
Recidivism – Ra (first arrest or court appearance)[1]	44	42.3
Recidivism – total arrests and court appearances	52	N/A
First New Offence	14	26.9[2]
General (non-sexual & non-violent)	2	14.3
Sexual	4	28.6
Violent – nonsexual	7	50.0
Substance	1	7.14
First New Contravention	38	86.4[2]
Technical Violation	16	42.1
Substance	16	42.1
Sexual	4	10.5
Violence – nonsexual	2	5.26
Recidivism by risk category		
Low-Moderate	5	38.5[3]
Moderate	3	21.4[3]
Moderate-High	15	32.6[3]
High	21	67.7[3]
Proximal Events (Ra)		
Ecological	13	29.52[4]
Stressors/Mood/Psychiatric	20	45.5[4]
Technical/Violation	6	13.6[4]
Substance Misuse	25	56.8[4]

1. Note that the total number of reoffences and contraventions is greater than the Ra statistic, due to it being a count of first arrest and court appearance.
2. Proportion of total recidivism events, not sample.
3. The percentage reflects the proportion of the risk category that have recidivated, not the proportion out of the total sample.
4. Proportion of first recidivism count.

Table 2 lists the reoffending counts by category. The majority have an index offence of rape (42.3%) or extrafamilial child sex offending (49.0%). Most of the sample (48.1%) had diverse (sexual and nonsexual) offending criminal backgrounds. The victims were predominantly female (68.3%), with approximately equal prepubescent (37.5%) and adult victims (42.3%). Last, most (44.2%) of the sample were classified as a moderate-high risk in court, with high-risk offenders being second most common (29.8%). Both low-moderate (12.5%) and moderate (13.5%) were fewer in count, which is not surprising given the determination of dangerousness is for there to be a high risk of serious sexual harm.

Regarding reoffending, 42.3% of the sample had recidivated (new conviction or contravention) within the six-year follow-up period. 26.9% of these were a reconviction for a new offence (n=14), of which the majority (50.0%) were violent (non-sexual) followed by sexual (28.6%), general offences (14.3%)

and substance related (7.14%). However, most recidivism events (73.1%) were for a contravention (n=38), of which technical violations and substance misuse were the most common (42.1%), followed by sexual-related contraventions (10.5%), and violence (non-sexual) (5.26%).

Most reoffending occurred within the high-risk group, as 67.7% had reoffended with a general offence within the six-year follow-up period, and 16.1% with a sexual offence. The moderate-high group were the second most common, with 32.6% reoffending generally, and 4.35% sexually. The low-moderate group (including low risk offenders) was next common, with 38.5% reoffending generally (and 0.0% sexually), and the fewest proportion within the moderate risk group (general: 21.4%; sexual: 7.12%).

Figure 1. Survival Curves (All Contraventions) - by overall Risk Category

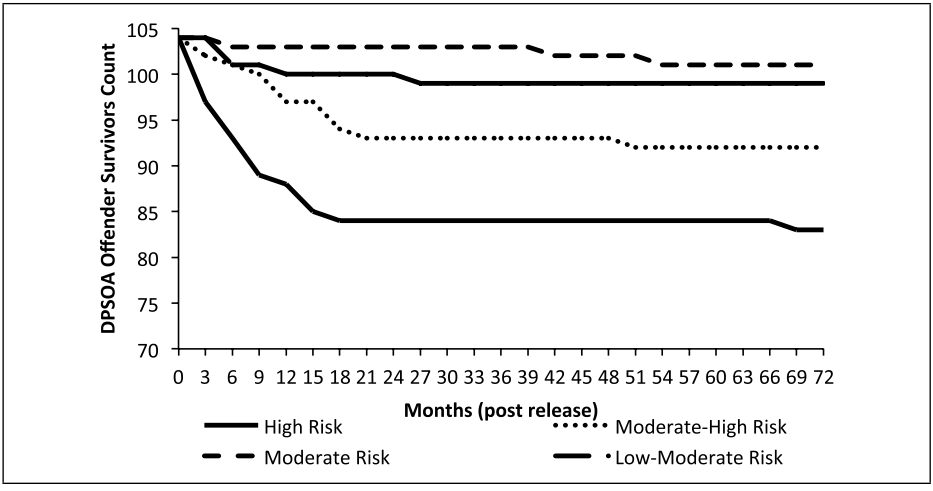
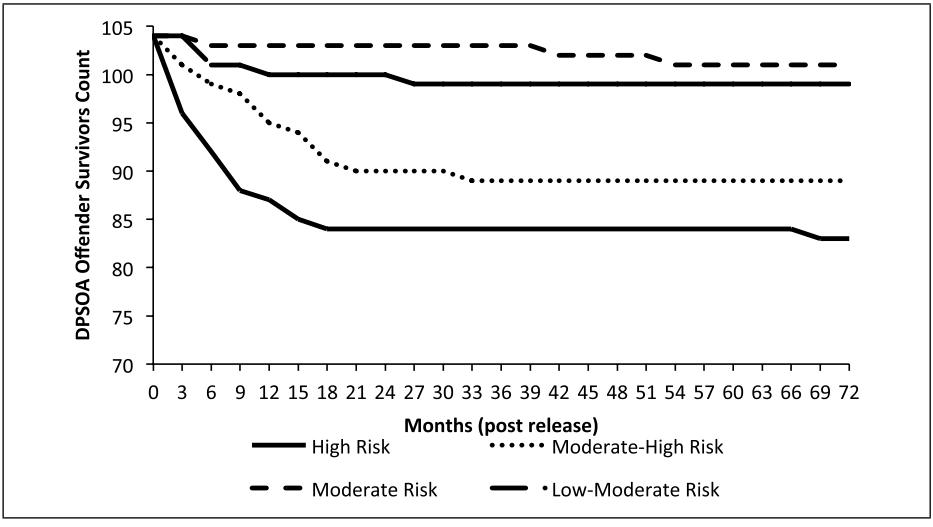


Figure 2. Survival Curves - by overall Risk Category (all reoffences/contraventions)



Kaplan-Meier (Log Rank (Mantel-Cox)) tests for differences between risk curves were non-significant for sexual ($\chi 2$ (3, N= 104) = 4.94, p = 0.18) and nonsexual violent recidivism ($\chi 2$ (3, N= 104) = 5.41, p = 0.14). Although this may have been due to the low count of recidivism events (sexual: 8; violence: 9). Significant differences were found between the risk curves for contraventions ($\chi 2$ (3, N= 104) = 20.67, p < .0001), and general reoffending ($\chi 2$ (3, N= 104) = 16.54, p < .001). As expected, the high-risk and moderate-high risk group displayed more reoffending and reoffended sooner than the lower-risk categories; high risk offenders reoffended the most for contraventions and general offending.

For contraventions, Cox Regression analyses, found that offenders with diverse criminal careers were nearly half (0.48) as likely to contravene an order compared to those with only sexual or general careers (HR = 0.48, 95%, CI = [0.24, 0.96], p < .05). Offenders with male and female victims were one-tenth as likely to contravene as individuals with female victims (HR = 0.10, 95%, CI = [0.01, 0.79], p < .05). For general reoffending, the analyses identified that offenders that started offending as juveniles were 3.58 times more likely to reoffend than those who began their criminal careers as adults (HR = 3.58, 95%, CI = [1.40, 9.19], p < 0.05). Offenders with both male and female victims were almost 10 times more likely reoffend (HR = 9.74, 95%, CI = [2.73, 34.78], p < 0.001). Psychopaths were (unexpectedly) significantly less likely to reoffend (HR = 0.32, 95%, CI = [0.12, 0.86], p < 0.05). Last, those that misused substances were 11 times more likely (HR = 11.22, 95%, CI = [4.97, 25.36], p < 0.001), and offenders with proximal (ecological) changes were also 11 times more at risk (HR = 11.30, 95%, CI = [3.80, 33.58], p < 0.001).

Discussion

The hypotheses were partially correct. It cannot be said that the highest risk group is more dangerous than other categories, as they did not commit more sexual or nonsexual violent reoffending. However, the high-risk DPSOA offender group had more contraventions than those in the lower-risk groups, and they recidivated sooner (see Figures 1). The next highest category was the moderate-high group. Compared to lower risk groups, fewer offenders had survived at the end of the survival period (although, more than 50% had not contravened by the 72-month point). 39.4% of DPSOA offenders had contravened their order within the six-year follow-up period. This is evidently less than half of the sample. After 18-months, the cumulative proportion of those contravening nearly flattens out, which suggests that they remain an issue for a long period (if at a lower rate).

For general offending (Figure 2), at the end of the period more high-risk offenders had reoffended (67.7%) than those in the lower-risk groups. They also had reoffended sooner. The next highest category was the moderate-high group (32.6%). Offenders considered a high risk or moderate-high risk appear to be more antisocial than dangerous, as compared to the lower-risk categories; their curves are steeper and fewer offenders had survived at the six-year mark. Overall, 42.3% of the sample had reoffended with a new (general) offence or contravention of order within six years. When measuring all types of offences, the rate is equivalent to the research: in their meta-analysis, Hanson and Morton-Bourgon (2005) reported a general recidivism rate of 36.2%. Analysis of risk factors identified that offenders with early onset of criminality, diverse criminal careers, were misusing substances on release, and resisted their orders through proximal changes, were more likely to reoffend in general.

It can therefore be argued that these high-risk DPSOA offenders represent a risk, but they are not dangerous in terms of sexual or nonsexual violence. The rates of sexual and nonsexual violence are equivalent to what has been reported in the literature (Hanson & Morton-Bourgon, 2005; Heil *et al.*, 2009; Rettenberger, Boer, & Eher, 2002). The rate of general reoffending 'masks' the seriousness of offending, as the curves also include less serious recidivism events such as contraventions and nonsexual/nonviolent offences (i.e. substance and property-related); however, as noted earlier, the highest risk group were no different in sexual and nonsexual violent recidivism than the other risk categories. The high-risk offenders are evidently costly to society from a utility perspective;

rearrests, court appearances, reincarceration and release all cost time and money. But the impact of serious harm appears to be low.

The study has some limitations. First, the low count of sexual and nonsexual violent recidivism meant that it was difficult to conduct a robust test of the survival curves. This may have been resolved with a longer survival period, but this would have been not possible with the current scope of the research. Second, the number of new offences and contraventions is, at best, conservative; it is expected that some criminal activity was simply not reported (Maltz, 2001). Last, the current study did not measure non-dangerous sex offenders or general offenders. This may have provided information with comparing reoffending rates, and whether the DPSOA offenders as a whole are more dangerous. However, given that the supervision conditions (and offender profiles) are not equivalent to a control sample, it would be difficult to compare the findings. Perhaps in the absence of strict conditions, therapeutic and intervention supports, the latter may reoffend at higher rate and sooner. This would provide a useful analysis of the utility of DPSOA conditions, which the current research cannot provide.

In conclusion, it is important to note that while psychiatrists and judges are seemingly accurate in identifying risk, the means of managing it by the Supreme Court and Queensland Corrective Services is problematic. Higher risk offenders should be provided more strict supervision conditions and clinical support to reduce and contain risk. Supervision does not appear to effective; the process should be reflected in a non-significant difference between the risk curves. Although, as the non-significant Mantel-Cox results for the sexual and nonsexual violent recidivism curves suggests, sexual and violence risk is likely being appropriately identified and managed through clinical and systemic means.

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Chapter 14 – Specific populations: forensics

An unusual chapter. Relational care in a forensic psychiatric hospital

Paper

Petra Schaftenaar (Netherlands)

Keywords: Forensic care, wards, relational care, patients- and workers perspective, ethnographic study.

Abstract

Background

In this presentation the results of an ethnographic participant observation study of relational care (based on ethics of care and the Dutch Theory of Presence) in a Dutch hospital for forensic psychiatry will be presented. We will give attention to the underlying principles and theory and we will present the main findings of the way relational care is given on forensic wards. Also the implication for treatment programs will be discussed.

Aim

As part of a broader study on relational care and recidivism an ethnographic study was designed and conducted in order to describe and explore the way relational care was given at a forensic psychiatric hospital in The Netherlands. Relational care is based on principles of Ethics of Care (Tronto, 1993) and the Dutch Theory of Presence (Baart, 2001).

Methods

A participant observation was conducted on two wards of the hospital. In total, 240 hours of observation have been done, over two periods of time (2015 and 2016). The material was analyzed inductively, based on thematic analyses. The goal of the study was to give insight in the way care was given and takes place in this practice. Results were discussed in focus groups with participants, to validate the findings.

Results

This study yielded three main findings on relational care on forensic wards. First of all, living on a ward in these circumstances, is very unusual. Not only for patients, but for workers. The way workers act, will be illustrated. Secondly, to live this unusual life together on a ward is very difficult. How do patients get through? We developed some new understanding on this topic. Third, relational care suggests a certain way of working, by which the negative and systemic forces on patients are minimalized and compensated by staff.

Conclusion

With the insights we developed, we maybe add something new on caring staff-patient relationships in forensic psychiatric care. Workers are trying to compensate the pressure forensic care (by its claims, rules and regulations) has on patients. Caring, supportive relationships, with elements of honesty and a personal touch, are as important in forensic care as they are everywhere.

Educational Goals

- After attending this presentation participants will be able to understand the impact and the complexity of admission on a forensic ward.
- After attending this presentation, participants will learn more about effective staff-patient relationships.

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Do female forensic patients evoke stronger feelings in staff members? An exploration of gender differences

Paper

Vivienne de Vogel (Netherlands)

Keywords: gender, Feeling Word Checklist, staff

Abstract

It has been suggested that female forensic psychiatric patients evoke different or stronger feelings in their treatment staff compared to male forensic patients. More specifically, it has been stated that it can be more difficult and emotionally draining to work with women as they are seen as more manipulative and demanding than men (Lewis, 2006). However, there is not much empirical research to support this suggestion.

In the present paper results will be discussed from a pilot study into 146 staff members working in a gender-mixed Dutch forensic psychiatric hospital. They all completed the Feeling Word Checklist for their most complex female and male patients. Overall, it was found that staff members felt more helpful, accepting, strong, relaxed, affectionate, sympathetic, and receptive towards their most complex female forensic patients and more anxious, threatened and overwhelmed by their most complex male forensic patients. Differences were found between more experienced and less experienced staff members as well as between female and male staff members.

Staff members working over five years in the hospital experienced much less differences in feelings towards female and male patients. Less experienced staff had significantly more positive feelings towards female patients and more negative feelings towards male patients. Female staff members usually felt more strong and in control with female patients and more overwhelmed by male patients. Male staff members felt more angry with male patients and more receptive towards female patients. Compared to female staff members, male staff members felt more cautious with female patients. It was concluded that there are substantial differences in feelings towards female and male forensic patients that could possibly impact treatment and that more training and supervision with respect to working in gender-mixed settings would be valuable.

Educational Goals

1. Understand the interaction between patients and staff members
2. Understand more about gender differences in forensic psychiatry

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Characteristics and Offences of Women with Borderline Personality Disorder in Forensic Psychiatry: A Multicenter Study

Paper

Julie Karsten, Vivienne de Vogel & Marike Lancel (Netherlands)

Keywords: Forensic psychiatry, women, borderline personality disorder, characteristics, offence

Abstract

Background

Although female forensic psychiatric patients diagnosed with Borderline Personality Disorder (BPD) are generally considered taxing in clinical practice, little is known about their specific characteristics or offences.

Aim

To compare characteristics of female forensic psychiatric patients diagnosed with BPD and the characteristics of their crimes, incidents, and risk factors for recidivism with those of female forensic psychiatric patients diagnosed otherwise.

Methods

The female population in forensic psychiatry is small, compared to the male population. Therefore, a multicentre study was conducted including the majority of forensic psychiatric clinics in the Netherlands admitting women. A total of 156 female forensic psychiatric patients diagnosed with BPD were compared to 113 diagnosed otherwise. Information on demographic and psychiatric characteristics, victimization, index offences and incidents during treatment were gathered from patient files. Risk factors for recidivism were assessed using the Psychopathy Checklist-Revised (PCL-R) and historical scale of the Historical Clinical Risk Management-20 (HCR-20), including items from the new Female Additional Manual (FAM).

Results

Compared to non-BPD women, BPD women were more likely to have been abused as children and to have a history of outpatient treatment. While less likely to be convicted for (attempted) homicide, a higher percentage of BPD women was convicted for arson. Co-morbid substance abuse was more frequent in the BPD group and aggressive incidents directed towards others and themselves were more violent in nature. The PCL-R and the Historical scale of the HCR-20/FAM indicated several risk factors especially important for BPD women, such as poor behavioural control, impulsivity, and irresponsibility.

Conclusions

The results support the clinical impression that women diagnosed with BPD are a subgroup within the female forensic psychiatric population, with specific focus points for treatment and management.

Educational Goals

- Gain knowledge on women in forensic psychiatric clinics.
- Enhancing awareness on the characteristics of female forensic psychiatric patients diagnosed with BPD and the characteristics of their crimes, incidents, and risk factors for recidivism.

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Poor sleep and its relation to impulsivity and aggression in forensic psychiatric patients

Paper

Maaike Van Veen, Jeanine Kamphuis, Julie Karsten & Marike Lancel (Netherlands)

Keywords: Insomnia, sleep, impulsivity, aggression, forensic psychiatry

Abstract

Background :

Studies consistently demonstrate a relationship between poor sleep and impulsive and aggressive behaviour. These findings are clinically relevant for psychiatric populations, for whom co-morbid insomnia might negatively affect behavioural and emotional inhibition.

Aim

To investigate the prevalence of insomnia in forensic psychiatric populations and its association with impulsivity and aggression.

Methods

Self-report questionnaires were used to measure sleep quality, sleep disorders and levels of impulsivity and aggression in two samples of forensic psychiatric inpatients. In the first sample additional data were collected on the number and nature of aggressive incidents and on clinician-rated levels of hostility and impulsivity.

Results

In the first group of 110 forensic psychiatric inpatients, almost 30% had one or more chronic sleep disorders, predominantly insomnia. A larger number (49.1%) reported poor sleep quality. The most common causes of sleep problems were suboptimal sleep hygiene, stress or ruminating, negative sleep conditioning and side effects of psychotropic medication. Worse sleep quality and higher insomnia scores were significantly associated with higher self-reported impulsivity and aggression, clinician-rated hostility and involvement in aggressive incidents within the facility. The second study involved a cross-sectional sample of forensic psychiatric inpatients with antisocial or borderline personality disorder or traits thereof. In this group of 112 participants comparable results were found, with more than half of the participants (53.6%) reporting poor sleep quality and 22.3% appearing to suffer from severe chronic insomnia. Both poor sleep quality and chronic insomnia were significantly correlated with self-reported impulsivity.

Conclusions

Chronic poor sleep is highly prevalent in forensic psychiatric populations and is related to impulsivity and aggression. Targeted treatment of sleep disturbances in this population might not only ameliorate sleep, but also reduce impulsive and aggressive behaviour. This possible contribution to risk reduction in forensic psychiatry is a promising direction for future research.

Educational Goals

Gain knowledge on the prevalence and impact of sleep disturbances in clinical forensic psychiatry
Enhancing awareness on the specific implications of such sleep disturbances in people prone to impulsive and/or aggressive behaviour

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Using Technology to Enhance the Therapeutic Impact of Seclusion

Paper

Lucy McCarthy, Gareth Garrett, Gillian Bennett, Dee Vujkovic, Patrick Sims & Nicholas Taylor (UK)

Keywords: seclusion, communication, technology, engagement, recovery

Background

Seclusion is a 'last resort' measure and provides severely disturbed or violent patients with nursing care in a low-stimulus environment. Seclusion is used to maintain the safety of others and some forensic patients may be nursed in seclusion for prolonged periods of time. Seclusion suites should allow medical staff to communicate with patients even when the door is locked, however it can be a challenge to engage patients in therapeutic activities in such a sterile environment.

Our presentation will report on the impact of installing an innovative door-sized, touch-screen media tablet device (the Communication Wall or 'Cowall') in the seclusion suite of an English NHS Medium Secure Hospital. The presentation will report on the efficacy of Cowall to offer severely agitated patients alternative ways to settle, engage and interact within a secure and safe environment.

We will describe the steps taken by a multi-disciplinary steering group to oversee the commissioning and implementation of Cowall and will report on how policy and procedure developments have evolved with the commissioning of the device. Our presentation will also describe how multi-media applications and content can be personalised for individual patients and we will report on an evaluation of the use of the Cowall

Abstract

The setting
Arnold Lodge is a medium secure forensic psychiatric hospital located in Leicester in the East Midlands of the UK. The hospital has undergone significant development since it opened in 1983, and now has 102 beds for patients within three separate cares streams; Male Mental Illness service (one acute admission ward and two rehabilitation wards), Personality Disorder Service (one admission/slower stream ward and one treatment ward) and Women's service (one standard ward and one enhanced medium secure ward).

The original hospital building has been extended by the addition of new-build wards; and redevelopment of the original building has also been undertaken. The installation of Cowall was originally suggested as an innovative addition to the refurbishment of the male mental illness rehab wards and a business case presented and generously supported by the Nottinghamshire Healthcare NHS Foundation Trust.

Introducing the communication wall 'Cowall'
The Cowall is a door-sized, tablet device, fitted flush into the wall of a patient's bedroom. Just like a smart phone, Cowall is a touch screen device that uses icons to help users navigate between multiple applications ('apps'). The Cowall provides patients with opportunities to control aspects of their environment. There are applications that control environmental stimuli (e.g. colour and brightness of room lighting) and communication-focused apps such as telephone and videophone. There are also apps that provide patients with relaxing activities. Cowall can seamlessly transform into an artist's sketchpad, jigsaw puzzle or an MP3 player, radio or television. The Cowall can make telephone calls

to the nursing station and other pre-agreed numbers. It also has the capability to make video-calls and allow patients to stay connected with their family and friends. The device can also be used to share important documents with the patient, including their personalised care plans and legal documents.

Staff appreciate that Cowall is safe, secure and adaptable. It has an 'indestructible' screen that has been designed to be fitted flush into the wall so that it is safe for use even by patients who are extremely agitated or distressed. Multi-Disciplinary staff teams can develop personalised Cowall profiles that are appropriate for the needs of the patients. The personalisation of Cowall profiles means that the apps available meet the clinical and social/emotional needs and capabilities of patients at any particular time; importantly the profiles can be easily updated as the presentation of the patient changes.

Management of Cowall

The Arnold Lodge Cowall is managed by a steering group which meets regularly. The steering group is made up of consultant psychiatrists and medics from the male mental illness service ward mangers and senior nurses, occupational therapists, a consultant clinical psychologist, a research fellow and IT technicians. The multi-disciplinary nature of the steering group means that development of the Cowall can be extremely responsive to feedback from patients and staff. A local procedure for the use of the Cowall has been published and a Cowall care plan is opened for all patients who use the device.

Initial feedback on Cowall

Patients and staff are regularly consulted about the use of Cowall and it has now been used therapeutically with six patients. Initial feedback has been very positive;
'Cowall is easy and fun to use'
'It will give patients another way to communicate with staff'
'Cowall will help patients manage their feelings'
'Cowall will help patients communicate with their friends & family'
'It may help patients move out of seclusion or long-term segregation more quickly'

An exciting aspect of Cowall is that patient feedback can be used to quickly adapt and improve its use. One example of this is the way in which videos have been produced by therapy service staff to demonstrate yoga & mindfulness breathing exercises for patients. Videos have also been produced to demonstrate safe entry and exit procedures to patients who may find verbal instructions difficult to follow.

Opportunities and Challenges

The installation of the Cowall provides our service with opportunities to maximise the benefits to patients that using such a device can bring. However there are also challenges to overcome. We have encountered issues around IT and cyber security that have meant that making changes to the software can be slow.

Clinically, there are issues around using technology safely with a forensic population. We also need to strike a balance between making the Cowall room therapeutic and interactive, whilst at the same time encouraging patients to move back to being nursed with their peers.

Conclusion and/or Discussion

We believe that the use of Cowall aligns strongly with three major priority areas in mental health care; the increased use of technology[1], the reducing restrictive practice agenda[2]
and the drive to increase service user and carer involvement[3]. We feel the opportunities that Cowall offers patients will enhance the therapeutic influence of seclusion and ultimately improve patient engagement.

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ADHD and delinquency: Cross the line for collaborative care!

Workshop

Marijn du Prie, Kirstin Heerdink, Rosalind van der Lem & Stefan Bogaerts (Netherlands)

Keywords: ADHD, violent behaviour, multimodular treatment program, synergy, collaborative care.

Abstract

Developmental disorders are associated with an elevated risk of aggressive and criminal behaviour. This can be explained by the Risk Need Responsivity model assuming that the presence of psychopathological symptoms and risk factors, and the absence of protective factors, can increase the likelihood of delinquent behavior and future recidivism (Andrews & Bonta, 2006). Attention Deficit Hyperactivity Disorder (ADHD) is a psychiatric disorder in which impulsivity, a lack of concentration and diminished planning skills are the core symptoms. Twenty-five percent of the incarcerated adult population suffers from ADHD (Young *et al.* Psychological Medicine, 2014). However, ADHD remains very often ignored and undetected in criminal populations.

ADHD is associated with high rates of substance abuse, impulsivity, marital problems, (intimate partner) violence, problems in raising children, and lower performance on school and labour. Treatment may have a positive effect on reducing symptomatology and criminal behavior. Thus, crime rates seem to be reduced dramatically when ADHD patients are treated pharmacologically. However, forensic ADHD patients are very difficult to treat in regular non-forensic treatment settings for several reasons. No show, drop-out and intermittent treatments are very common in these forensic population and are difficult to handle in regular psychiatric settings. Therefore, a specific (multimodal) approach for aggressive behaviour in forensic ADHD patients is needed.

In this workshop, we present our new treatment program, which was recently awarded with a 'Topggz' certificate for forensic outpatient treatment of ADHD patients. This certificate ensures high specialized (innovative) treatment, which is theory- and data-driven. This quality label is only awarded to complex target groups suffering from complex disorders, which requires complex treatment based on scientific research. This certificate is granted for a period of five years and is renewable after positive evaluation.

In this workshop, participants will learn more about the complexity of the treatment of forensic outpatients suffering from ADHD. We have developed our program based on the principal that the creation of a whole is greater than the simple sum of its parts. We constantly try to find synergy. By taking the audience on an exciting journey, we will introduce our ADHD multi-modular treatment program by showing how psychiatrists, psychologists, rehabilitation experts, addiction experts, general practitioners and researchers achieve synergy by working together. We will also emphasize the need to involve significant social contexts, such as spouses, parents, school and work in the treatment.

In this ground-breaking workshop, we will explain the audience about the latest scientific findings on ADHD and violent behaviour. Finally, the audience will actively be involved in an experiment. In a provocative and stimulating setting, participants will be invited to participate in a lively debate about ADHD and to learn to look beyond the borders of their own discipline. Working together is the only possible way to cross the line for collaborative care!

Educational Goals

- Update your current knowledge of the treatment of ADHD patients in outpatient forensic psychiatry with the latest scientific insights.
- Discuss the opportunities and limitations of forensic outpatient treatment of ADHD patients
- Evaluate the current state of collaborative care with other caregivers.

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Empowering community mental health teams by providing forensic consultation

Paper

Diana Polhuis, Ben Lijten & Rene Mooij (Netherlands)

Keywords: Empowering, CMHT, forensic, consultation

Abstract

In western countries community mental health teams are increasing (Burns, Fioritti, Holloway, Malm, & Rossler, 2001; Catty *et al.*, 2002; Firn & Brenton, 2015; Killaspy *et al.*, 2006; Vugt, 2015). In the Netherlands for example we see an increase of intensive home treatment teams and flexible assertive community treatment teams. At the same time we are facing a reduction of mental health beds. The duration of admissions has decreased over the last decades as well as the total admissions.

This development is in a sense a good one, because people with mental health problems are more able to recover at home and encounter fewer stigmas. But now we are starting to face other problems. In the Netherlands we also see a reduction in mandatory forensic psychiatric inpatient treatment and a reduction in incarcerations. National financial cuts lead to cuts in the police force, cuts in sheltered housing, cuts in supported employment and cuts in day care. Social benefits decreased and rents increased. All together society experiences an increase in people with visible behavioral problems, many times due to social problems and in 50 percent of the cases due to mental health problems (Planije & Hoof, 2016).

This all leads to extra workload and extra complex cases for the community mental health teams. To prevent every patient with behavioral problems needs forensic treatment, we think it is necessary to empower the community mental health teams by providing forensic consultation. Working in a forensic assertive community team we developed a systemic way for forensic consultation in order to empower our colleagues is several community mental health teams. The consultation is based on the principles of the Risk-Need-Responsivity model (Andrews & Bonta, 2010; Prins, Skeem, Mauro, & Link, 2015). During the presentation we will illustrate the systemic consultation that consists of the following steps:

1. Analysis of the case;
2. Risk assessment;
3. Advice: either risk management advice or reflection on difficult behavior;
4. Contacting the forensic key partners (forensic outpatient programs; parole board; police; community safety platform; etc.).

In one year we visited 12 community mental health teams every two weeks. They provided treatment for 2400 patients. In 128 cases we provided consultation. Only 10 patients finally were admitted to our forensic assertive treatment team. By empowering the CMH teams they are more able to handle difficult situations, and to make a distinction between difficult behavior and criminal behavior. They also know how to handle the cases better or when referring to a special forensic program is necessary. The teams felt empowered and extra forensic stigma for the patients was prevented.

Educational Goals

- The participants are able to discuss what knowledge and skills are necessary to empower CMH teams in order to treat difficult behavior.

- The participants are able to describe how to make a difference between difficult behavior and criminal behavior and when CMH teams should refer the patient to a specialized forensic program.

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Women with Mental Illness that commit Filicide: A case series

Paper

Ugasvaree Subramaney (South Africa)

Keywords: Filicide, schizophrenia, mania, neuropsychiatry, HIV, forensic

Introduction and/or background

Homicide may be regarded as the most extreme form of violence. Filicide is the tragic crime of murdering one's own child, with neonaticide and infanticide referring to subgroups thereof. There is an established association between mental illness and homicide.(14, 17); and regarding filicide, research has found a two-fold increase in relative risk of child homicide in relation to parental mental illness. (12 with offending parents having had prior use of psychiatric services. Suicide is often an associated act and these extended homicide-suicides, which fall into the category of Pathological filicide, have a strong association with severely ill mothers.(21) In developing countries, there is a limited research on filicide and the risk factors associated with it. In an unpublished study done at Sterkfontein Hospital, Johannesburg, South Africa , 42% of referred cases of child homicide to the forensic unit for observation were found to have a history of psychiatric illness.(16) Mentally ill women who committed filicide were found to frequently be diagnosed with psychosis, depression or suicidality prior to the offence.(20)

The main paper / article

The author describes a case series of women that were referred for forensic psychiatric observation in terms of the criminal procedures act (CPA) sections 77, 78 and 79 to ascertain fitness to stand trial and criminal responsibility. Prosecuting authority's reports, forensic psychiatric reports as well as clinical records were examined. The site of the study was a forensic psychiatric hospital in Johannesburg South Africa, where courts refer individuals charged with offences for forensic observation to ascertain fitness to stand trial and criminal responsibility. For those that are found not fit and/or not responsible by virtue of mental illness, provision is made for admission to the hospital as a state patient in terms of section 42 of the mental health care act (MHCA).

Results

Case 1
LN
The woman was a 23 year old female who had stabbed her 2 month old infant in a random fashion, and presented with amnesia for the entire event. She woke up in hospital, having severely injured her left forearm, and with random cuts on her neck. She had a history of petit mal seizures as a child and during the observation period, 2 grand mal seizures were noted. There was also a history of substance (cocaine) use at the time of the offence. A diagnosis of Epilepsy, substance use disorder and borderline personality traits was made. She was found to be fit to stand trial, but not criminally responsible and treated as a state patient. She made good recovery on lamotrigine 150 mg and citalopram 20m mg daily, together with individual and group therapy. She also attended a substance abuse rehabilitation programme and is currently out on LOA (Leave of absence).

Case 2
NM
NM was referred for forensic psychiatric observation for a charge of murder of her infant. She had flung the baby boy against the wall, bashing his head repeatedly, before falling asleep with him, to keep him warm when he went ice cold. She could not give a cohesive account of why she acted in this manner, and her memory for the event, was patchy. She was found to be HIV positive, with a low CD4 count. Diagnosis most likely Delirium and a psychotic disorder due to HIV. She was found not fit to stand trial, and not criminally responsible. She was commenced on antiretrovirals (ARVs) and antipsychotic treatment, and is also currently on LOA.

Case 3
GH
GH is a known schizophrenic with a history of violence – her initial presentation to psychiatry at age 19 was following an assault on her grandmother. She was also notoriously noncompliant with poor insight. She was 2 weeks post partum, having refused a termination of pregnancy. She developed bizarre delusions around the baby's chances of survival due to her "poor eating" and having eaten potatoes at a barbacue causing the baby to be floppy. She smothered him with a pilllow at the height of psychosis. She proved treatment resistant, with prominent negative and cognitive symptoms of schizophrenia. After a protracted period, she made some response to Paliperidone palmitate and is currently also on LOA, with very close monitoring

Case 4
MK
This is an index presentation of psychosis ? schizophrenia. MK is a registered nurse who killed her baby related to religious delusions of needing to sacrifice him. She responded very quickly to olanzepine 5 mg daily. A full organic workup including EEG, CT Scan(brain) and neuropsychological testing was done. The latter was in keeping with schizophrenia in the residual phase, with a prominence of negative symptoms clinically. Full rehabiliation included occupational therapy (OT), Individual therapy and family interventions. Marital strife appeared to be an issue, with a very strong influence of her mother, who is quite religious. She is currently on LOA, returning regularly to the ward for follow up.

Case 5
MM
MM is a known patient with Bipolar disorder. When referred for forensic psychiatric observation, she had a mixed presentation. Despite compliance on her medication, she had not received medication on time at the local clinic due to miscommunication. She stabbed her baby to death, thinking he was a monster, that there was a snake on his belly. During the observation period and subsequent admission as a state patient she shifted to being very depressed, psychotic with suicidal ideation related to remorse and guilt. She was found not fit and not responsible for the offence. She did very well on a mood stabiliser (Lithium) and an antipsychotic (Risperidone) together with intensive psychotherapy. Post traumatic stress disorder was also diagnosed as a comorbid condition, and a course of cognitive behavioral therapy (CBT) was administered; to which she responded well. She is on Leave of abscence and application will soon be made to the courts for conditional discharge.

Conclusion and/or Discussion

The 5 cases illustrate the importance of screening for mental illness in the antenatal and postnatal period. The highest risk of filicide was during the first year of life. In each case psychotic, mood and cognitive symptoms predominated. The findings of this study correlated with studies conducted in developed countries, which suggest that filicide follows similar pattern throughout the world. Health care professionals who have contact with at-risk individuals should screen for and thoroughly assess filicide, similar to suicide.

Acknowledgments

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Piloting the Safewards Model in a Forensic Mental Health Inpatient setting in Toronto, Canada

Paper

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Keywords: Safewards, Conflict, Containment, CAMH, Forensic, Canada

Introduction and background

The Centre for Addiction and Mental Health (CAMH) is Canada's largest mental health and addiction teaching hospital as well as one of the world's leading research centres in its field. CAMH is located in Toronto, Canada. It combines clinical care, research, education, policy development and health promotion to help transform the lives of people affected by mental health and addiction issues. CAMH is fully affiliated with the University of Toronto, and is a Pan American Health Organization/World Health Organization Collaborating Centre.

The safety of clients and staff has long been a concern for hospitals (Gadon, *et al.*, 2006; Bowers *et al.*, 1999). At CAMH, the highest strategic priority is the "Safe and Well" initiative, two of its key aims being the elimination of avoidable client death and physical injury to staff and clients. To that end, CAMH is piloting Safewards on three Forensic inpatient units with a view to organization-wide adoption.

Safewards is an evidence-based, open source, model developed by Len Bowers in the United Kingdom which evolved from significant research seeking to explain varying degrees of conflict and containment, and the domains that interact to produce this variation, on psychiatric inpatient units (Bowers, 2014). In a randomized controlled trial involving 31 inpatient units, Bowers *et al.* (2015) found support for the model, and identified 10 clinical interventions that reduced conflict events by 15% and containment incidents by 26.4%.

In the Safewards model, "conflict" is defined as all client behaviours that threaten the safety of the client and/or others including aggression, self-harm, suicide, absconding, substance/alcohol use and medication refusal (Bowers, 2014). "Containment" is defined as all the formal interventions staff can deploy to prevent conflict or mitigate its impact, such as seclusion, mechanical restraint and special observation (Bowers, 2014). The model suggests conflict arises from specific factors that create "flashpoints" which then trigger conflict situations and consequent efforts at containment. In a reciprocal fashion containment strategies can result in further conflict (rather than reducing conflict). Through intervening in the development of a flashpoint by reducing or eliminating the factors that create conflict and containment, it is suggested staff can impact the rates of conflict and containment.

The ten interventions used in the Safewards study include the development of mutually agreed and publicized standards of behaviour by and for clients and staff ('clear mutual expectations'), short advisory statements ('soft words') to be used for respectful and judicious limit setting, training in de-escalation techniques ('talk down'), discussing positive characteristics about clients during handover report ('positive words'), being aware of occasions or events that might generate angry or violent reactions ('bad news mitigation'), providing shared, superficial/innocuous personal information about staff to the clients ('know each other'), facilitating opportunities for a regular client mutual support meetings ('mutual help meeting'), offering sensory modulation tools ('calm down box'), supporting

clients following potentially frightening incidents ('reassurance'), and a display of positive messages about the unit from discharged or transitioning clients ('discharge messages') to imbue hope to those who are arriving (Bowers *et al.*, 2015).

The empirical evidence for the implementation of Safewards in a forensic mental health setting has been tested using a non-randomized control design. The results noted poor adherence to the interventions, and the authors were unable to draw meaningful conclusions as to the efficacy of the effects of the of the Safewards interventions (Price *et al.*, 2016).
Forensic programs in Ontario are implementing Safewards to different degrees. A "Safewards Community of Practice" has formed which engages stakeholders from across Ontario and supports implementation and sustainability among the Forensic mental health care sites.

Method

CAMH selected three forensic units, with relatively high levels of reported violence, as pilot sites to assess the impact of the Safewards model over a twelve-month period. The project is being carried out as a quality improvement initiative with the support of the hospital's Project Management Office.
A front line Registered Nurse was appointed to the role of Safewards Implementation Coordinator. The Coordinator has acted as an organizational champion for the Safewards model, including developing and adapting education materials from Safewards as well as the delivery of comprehensive introductory training and facilitating weekly staff education sessions, "Safewards councils", on the pilot units. The Coordinator has also spent considerable time getting to know the unit communities through various clinical conversations and unit meetings. Unit leadership (Managers and Advanced Practice Clinical Leaders) has championed the model and assisted in the delivery of training and weekly councils and participated in regular meetings, guiding project approach and resolving ongoing challenges.

The implementation sought to enhance the client-centered approach of the Safewards model in three ways. First, members of CAMH's Empowerment Council ("EC", a CAMH funded nonprofit corporation made up of current or former mental health and addiction clients) were part of the project's steering committee. The EC's mandate focuses on systemic advocacy, education and outreach for CAMH clients. Second, through the EC a Peer Research Assistant was engaged in centering the epistemological importance of lived experience in Safewards implementation and project evaluation. This was complimented by subsequent work regarding CAMH's Client Bill of Rights, creating a platform for staff reflection and appreciation of its alignment to Safewards. Third, a CAMH Peer Facilitator held "client councils", a counterpart to the staff councils, on each of the pilot units with the aim of enhancing awareness and understanding of the model through discussion of the interventions and providing an opportunity to speak freely about experiences and views on safety and client care.

Training took the form of a two-day session prior to implementation aimed at unit "leaders" who were to spread knowledge of Safewards interventions to their teams. Weekly Safewards councils provided ongoing opportunities for education on the model and its interventions. Through these councils, the model and its interventions were introduced to all team members over a ten-week period.
The approach to evaluation consisted of a mixed method design, including quantitative and qualitative components.

Evaluation

Evaluation points for implementation were set at baseline, and at the three, nine and twelve-month marks.

The primary desired outcome for the pilot is the reduction of total conflict and containment incidences on the pilot units. Conflict incidents are measured through a review of reports from CAMH's incident reporting system, "SCORE", and coding of these reports using the Modified Overt Aggression Scale

(MOAS), based upon the original Overt Aggression Scale (Yudofsky, Silver, Jackson, Endicott & Williams, 1986) to categorize the severity of any violence reported. Containment incidents are measured through health record data on the use of mechanical restraint, seclusion, chemical restraint and continuous observation. The total number of incidents and the average amount of time that the containment strategy was in use, along with the total number of unique clients subject to containment interventions, were measured.
It was hypothesized that a reduction of conflict and containment would lead to staff feeling less fatigued or burned-out as demonstrated through improved scores on the Maslach Burnout Inventory (MBI) (Maslach & Jackson, 1981). The MBI is the most widely used measure of job burnout (Maslach & Leiter, 2016).

CAMH is also seeking to determine whether the implementation positively impacts the clients' and staff's perception of the social and therapeutic climate of the units as demonstrated by improved scores on the Essen Climate Evaluation Schema (EssenCES) (Schalast, Redies, Collins, Stacey & Howells, 2008). Client surveys were administered by peer supports where possible.
Qualitative data on the model and implementation was gathered through staff focus groups lead by a CAMH Education employee not affiliated with project implementation and client interviews and client councils by the project's Peer Facilitator. A Peer Research Assistant also produced a report focusing on the implementation of Safewards from the client's perspective.
Fidelity was monitored using an adapted version of the Organization Fidelity Checklist developed by Bowers *et al.* (2015).

Results

At the three and nine-month evaluation points, preliminary data did not demonstrate a clear trend towards a reduction in total conflict or containment as compared to the twelve months preceding implementation. The MBI and EssenCES results at the three and nine-month mark also showed no significant changes.

Staff focus groups revealed four themes relating to project purpose, disconnects, relationship building, and "us versus them" culture.

With respect to project purpose, the staff reported understanding the rationale of Safewards model but deemed interventions already a part of daily practice and therefore saw no additional value. At the same time, staff were unclear regarding the purpose of each intervention, assuming all ten apply all the time, and were not always aware of the steps and critical thinking involved in the interventions.

On team building, staff reported notable improvement in their communication with each other and an improvement in the overall milieu. The "us versus them" culture theme emerged from staff expressing concern about Safewards being a top-down initiative, and perceiving the pilot as a negative commentary on the quality of existing practice. Staff also noted the superficiality of the fidelity checks and some staff disagreed with the standardized approach to the interventions.
Weekly client councils led by a Peer Facilitator have provided significant feedback regarding general milieu and care in the pilot units. Preliminary findings indicate clients have trouble grasping the concept of Safewards. There is also concern on the part of some clients that speaking openly about safety or care issues could have consequences that will negatively affect their discharge.
Preliminary findings from the Peer Research Assistant include that the implementation offers an opportunity for the discussion of how CAMH can work to improve and standardize client-centered and recovery-oriented care. This is achieved by creating space to have difficult and necessary discussions on the complexities of what violence and safety mean for clients and staff and helping to establish what is needed for positive institutional change. Findings also noted that the implementation has provided an opportunity to strategize on how to be accountable to the client experience by identifying gaps in

service provision insofar as working with policies in place to support clients such as The Bill of Client Rights and Safety and Comfort Planning.

Discussion and Conclusion

Key challenges experienced by the implementation to date center around staff buy-in to the model and difficulty measuring staff adherence to the interventions in a meaningful way.

Staff buy-in: In addition to staff focus group results, the implementation team observed that clinicians are skeptical of Safewards' ability to impact rates of conflict and containment.
The implementation team experienced significant opposition from several clinicians whose perception was that certain interventions were unsafe. Some clinicians reacted strongly to the calm down box intervention where every item was perceived as a potential weapon; therefore items were not given, or at times, taken back from clients. Participation rates for 'know each other' was very low with staff unwilling to share innocuous information with clients who are perceived as having a history of harming others. Staff from a pilot unit filed a grievance with the union regarding language used and stated approach of the "Control Yourself" element of the 'talk down' de-escalation poster.

Measuring fidelity: Given the significant relational focus of the model, it has been challenging to meaningfully assess whether staff are adhering to the interventions of the model beyond anecdotal perceptions by unit leadership and the implementation team. The implementation team echoes the sentiment of the staff that the fidelity check from the Safewards Organizational Fidelity Check did not provide a substantial enough indication of whether staff was adhering to the interventions. To this end, the team has begun audits of unit rounds and reviews to determine whether interventions are being used. Meaningful results have yet to be compiled.

Dynamic implementation: In response to these challenges, increased training was delivered to staff. Due to staffing shortages and scheduling issues, less than 50% of participating staff have received focused class room based training. However, substantially all staff has had the opportunity to participate in the weekly council meetings where continuous updates to the approach has been the norm to attempt to better engage and educate staff.

Conclusion

Greater acceptance and use of the interventions is required to determine whether outcomes can be replicated in Forensic inpatient units. The recovery-oriented philosophy that underlies Safewards represents a change in practice in Forensic services at CAMH. Consistent with the literature of implementation in Forensic services it has been difficult to get staff to accept and adhere to model and more extensive training would be needed to properly assess the effect of the model (Price *et al.*, 2016).

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Cost-effectiveness of a Specialised Medium Secure Personality Disorder Service

Poster

Ravi Lingam, Rachel Woodward & Foteini Papouli (UK)

Keywords: Cost-effectiveness, Medium Secure, Forensic Unit, Personality Disorder.

Abstract

Background

The Oswin unit located in the North East of England is commissioned primarily for offenders screened on the Offender Personality Disorder (OPD) pathway based on measures of Personality Disorder being linked to moderate to high risks to other persons.

The Oswin Unit was re-designed in early 2014 meeting commissioning specifications to meet objectives based on access, measuring quality and reducing. The primary objective of this pathway is to ensure Personality Disorder Offenders have access to "community-to-community", joint-up care and monitoring of risks. The Oswin unit implemented a re-designed service offering individuals formulation based assessments and risk management embedded in the OPD pathway. The overall objective of this project is to evaluate the effectiveness and risk amelioration of this hospital-based service.

Aim

As part of a broader service development and evaluation project, the cost-effectiveness of the current model of the unit was compared to that of the unit prior to the redesign of the service.

Method

Collection of data on number of admission and length of stay and calculation of expenses per capita. Retrospective analysis of costs of care.

Results

Analysis of comparative figures post-implementation of this new model of care found 41% more episodes of care. Cost-analysis indicated a saving of £200,000.

Conclusion

The new Oswin Model meets commissioning objectives in offering access to hospital-based care and focused treatments for prisoners 'stuck' in prison pathways. This finding led to further investigation using thematic measures of quality of care to evaluate the effectiveness of this service and risk amelioration.

Educational Goals

- On completing this subject, audience will have acquired knowledge of a new model of services for a specific forensic population.

- On completing this subject, audience will be able to consider the financial implications when setting a new service.

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Violence and threats against forensic mental health staff– Staff perception of workplace violence and threats

Poster

Gitte Munksgaard, Frederik Alkier Gildberg, Joy Duxbury & Lise Hounsgaard (Denmark)

Keywords: workplace violence, violence, threats, aggression, forensic, staff perception,

Abstract

Background

According to a recent national survey, ordered by the Danish Nurses Organization (DSR) in 2015, three out of five (59%) Danish nurses, employed in the area of psychiatry, had been subject to one or more types of violence during work hours, over a period of 12 months.

Aims

The aims of this study, is to generate knowledge on, how forensic mental health staff perceive everyday workplace related patient-staff violence and threats, and subsequently to explore how staff perceive the impact thereof on themselves as health care professionals and on daily inpatient care provided in clinical forensic practice.

Method

This study employs an overarching exploratory qualitative research approach rooted in symbolic interactionism (SI). An empirical testing design is adopted to drive the research methods (Blumer 1986; Gildberg and Hounsgaard 2010).

The methods comprise a literature review, in-depth semi-structured individual interviews and focus group interviews. Results from a literature review will feed into parts of both single and the focus group interviews. The interviews will be analysed and results tested by conducting additional interviews, in an ongoing circular process, in order to empirically falsify, validate or refine results with new perspectives on the subject, as part of the testing design.

Inclusion of literature in review

The literature review will be based on a systematic keyword combination search in the following databases: CINAHL, PsycINFO and MEDLINE. Papers will be included if peer reviewed, written in English, Danish, Norwegian or Swedish, with stated aims, methods, results and a conclusion in accordance with the IMRAD criteria (Sollaci & Pereira, 2004).

Inclusion of staff for in-depth interviews and focus group interviews

This study uses purposive sampling (Polit & Beck, 2008) and ongoing volunteer recruitment of forensic mental health staff members with a high degree of first-hand experience on the subject. Recruitment will be ongoing until data saturation in analysis can be established (Morse, Barrett, Mayan, Olson, & Spiers, 2002).

Results - Analysis

Data will be analysed in relation to aims and research questions, using a thematic analysis based on the methodological approach described by Herbert Blumer, stressing the need for careful and disciplined examination of data in regard to relations between categories of data, theory, and the testing of findings against the original data (Gildberg 2012, Blumer, 1986).
Results will be published in peer reviewed journals internationally and the PhD thesis.

Educational Goals

- Understanding of a specific qualitative research design, rooted in symbolic interactionism.
- Understanding of the extend of patient-staff violence and threats in a Danish as well as an international forensic psychiatric setting.

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"Only a matter of time before I´d relapsed into crime" Personal recovery in forensic psychiatry

Paper

Charlotte Pollak, Tom Palmstierna & Per Ekstrand (Sweden)

Keywords: Forensic psychiatry, high security, personal recovery, care, content analysis, inpatient, patients own view, interviews

Abstract

In forensic psychiatric inpatient treatment, the focus on safety and security at the same time as psychiatric rehabilitation is a core issue. Methods for assessing and managing patients at high risk for reoffending have been developed over the last decades. However, no studies address these patients' own view on what matters in reducing their risk for serious reoffending.

The aim of this study is to explore forensic psychiatric high risk patients' own views on what they think they need in order reduce their risk of serious reoffending. A qualitative analytic approach was used and data was collected from semi-structured interviews.

Four separate themes, Time, Trust, Hope and Toolbox, were identified. These themes are found to be fit into recovery processes found in studies on personal recovery from severe mental illness in general psychiatry. Within all these themes, a continuum from full participation over to non-participation in care and treatment is found.

Time is found to be of special importance when patients reflect upon how their risk for reoffending could be reduced.

The content of the found themes may help understand forensic psychiatric patients' recovery process. Such an understanding including appreciating the importance of time, could potentially increase compliance and thereby facilitate rehabilitation and possibly also reduce the risk for reoffending. Future research should focus on if there is a connection between serious reoffending and the patients' own views and trajectory in a recovery process.

Educational Goals

- Profounder understanding of patients own view in forensic psychiatric care
- Increase awareness of patients need to recover in forensic psychiatric care

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Violent Phenomenology, Patient/Staff Disclosure and Collaboration: Game Theory Analysis

Poster

Evelyn Rogerson, Keith Reid, Sandeep Reehl & James Brotherson (UK)

Keywords: Game theory, modal, strategy, collaboration, rational, dominance, positive, tell, forensic, violence, risk, formulation, future

Abstract

This study introduces game theory analytic approaches to clinical data, modelling disclosure of violent ideas using estimates by patients and staff of decisional clinical interactions.

It was hypothesised that there would be sufficient agreement between expressed preferences to allow coherent interaction; these solutions would conform to the model of a non-zero sum game in which collaboration could improve outcomes where dominant rational solutions differ from the optimum.

12 patients and 12 staff, in a male secure forensic mental health unit, volunteered to complete a questionnaire in which they would estimate the utility of outcome for themselves and their counterpart in different clinical interactions. The primary outcome modelling the typical interaction was the modal game.

The most tightly dispersed patient modal estimates were hide vs carefree ('very bad', n=8) and admit/tell vs positive ('very good', n=7). Themost tightly dispersed staff modal estimates were hide vs carefree('very bad', n=__) and admit vs careful ('good', n=8).The most dominant rational staff and patient modal strategies were positive and tell, respectively, without collaboration. Collaboration would have improved the outcome relative to a non-collaborative approach in 8% of individual games. Using Cohen's Kappa, patients were able to estimate staff preferences with moderate agreement (K=0.5263). Staff were able to estimate patient preferences with fair agreement (K=0.2373). Overall the two groups achieved fair agreement (K=0.3127)

Patient disclosure of violent ideas in a secure psychiatric unit conforms to the model of a non-zero sum game in which collaboration between patients and staff can improve outcomes for a minority but most players would rationally choose choices that lead to good or very good outcomes for the player and their counterpart. It can be rational and self-interested for patients to be open with regards to violent phenomena and for staff adopt a positive approach to care. Patients more accurately anticipate staff's preferences than vice versa. The application of a game theoretical perspective may provide insight into relational phenomena such as gate fever and provide a basis for the development of a mean of formulation which goes beyond the individual.

Educational Goals

- Understand the role of game theory in clinical interactions in a forensic setting
- Be aware of the possible future applications of game theory in forensic psychiatry

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Chapter 15 – Specific populations: intellectually disabled / learning disabilities

Schema Therapy in offenders with intellectual disabilities

Paper

Rose Schmitz & Marije Keulen-de Vos (Netherlands)

Keywords: schema therapy, intellectual disability, emotional states, forensic

Abstract

An intellectual disability (ID) is a generalized disorder that involves impairments of mental abilities that impact intellectual functioning and adaptive behavior, such as reasoning, learning and problem-solving skill. Approximately 1-2% of the general population has an intellectual disability, whereas prevalence rates among forensic psychiatric patients is typically up to 50%. Many people with IDs show highly-challenging or aggressive behavior. Although the true extent of aggressive behavior in ID populations is unclear, some studies report prevalence rates ranging from 11 to 60%, which would suggest that the prevalence rates are up to three to five times higher than in non-disabled individuals. Higher rates of aggressive behavior are found in institutionalized and secure settings. Many forensic treatments, such as cognitive-behavioral therapy, psycho-education and psychomotor therapy, originate from general psychiatric health care and have been adapted for forensic populations. Evidence on their effectiveness is, however, limited.

Recently, Schema Therapy (ST) has been introduced to the forensic field. The pillars of ST are early maladaptive schemas, dysfunctional coping styles, and schema modes or fluctuating emotional states that temporarily dominate a person's thinking, feeling and behavior. ST has been primarily developed for people with personality disorders (PD) and adapted for forensic patients with a high risk of recidivism and a history of aggressive behavior. Recent research shows preliminary evidence for ST in PD offenders. Patients with an ID are excluded from regular ST because their conceptual and intellectual deficits affect understanding the schema therapy concept. However, many individuals with intellectual disabilities do show highly challenging or aggressive behavior and are at high risk of re-offending. Also many ID offenders also have a co-morbid PD.

It was in this spirit that Keulen-de Vos and colleagues (2016) initiated the adaptation of Schema Therapy for ID offenders (ST-ID). Differences between standard forensic ST and ST-ID are the addition of schema modes that reflect typical emotional states for ID patients (e.g. regressive child), a strong focus on psychoeducation and visual techniques (i.e., through arts therapy) instead of cognitive demands, and a systems approach.

This paper presents the practical implications of ST-ID's theoretical and therapeutic framework on units for ID offenders.

Educational Goals

- Understanding ST-ID's multidisciplinary approach to treatment of aggressive behavior in ID offenders
- Review the key concepts of ST-ID for therapists and psychiatric nurses

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Heroes and Helpers: Schema Therapy for offenders with intellectual disabilities

Workshop and Paper

Marije Keulen-de Vos & Rose Schmitz (Netherlands)

Keywords: Schema therapy, intellectual disability, emotional states, forensic, responsivity

Introduction

A promising treatment for offenders with personality disorders is Schema Therapy (ST; Young, Klosko & Weishaar, 2003). Schema Therapy is an integrative therapy that combines elements from different therapeutic approaches. For example, certain techniques and theoretical concepts are derived from cognitive behavioural traditions, whereas other techniques and concepts are psychoanalytically oriented or originate from attachment theories, Gestalt or experiential therapies. The ST theoretical model is based on the following core concepts: early maladaptive schemas, maladaptive coping responses, and schema modes (Rafaeli, Bernstein, & Young, 2011; Young *et al.*, 2003). Early maladaptive schemas are self-defeating cognitive themes about the self and others. They are deeply entrenched patterns or traits, central to one's sense of self. A schema is not just a belief, but part of one's identity, part of one's self-awareness. They originate from adverse childhood experiences and early temperament; they guide people's perceptions and behavior and evolve over the course of a lifetime. Over time, they become more resistant to change and give rise to negative automatic thoughts and subjective distress. For example, early maladaptive schemas such as abandonment, social isolation, defectiveness, and mistrust/abuse can evoke emotions such as fear, sadness and anger (Bernstein, Arntz, & de Vos, 2007; Jovev & Jackson, 2004).

Young and colleagues (2003) hypothesized that one can cope with the activation of such schemas in three ways: overcompensating or acting as if the opposite of the schema is true; acting as if the schema is true; and avoiding persons or situations that trigger a particular schema. These coping styles are usually dysfunctional in the long run and bear similarities to the biological responses of fight–flight–freeze. The combination of early maladaptive schemas and maladaptive coping proved useful for working with most PD patients, but seemed inadequate for patients with more aggressive PDs and psychopathologies. These patients often have so many early maladaptive schemas that discussing them all in therapy was unmanageable. Moreover, patients with severe PDs, such as borderline and narcissistic, often switch or flip rapidly from one extreme emotional state to another, making it difficult for therapists to keep track of them. Young and colleagues (2003) introduced the concept of schema modes to help therapists monitor and work with these fluctuating states. Schema modes are responses to developmental experiences of unmet needs that continue to impact on the individual in later life. These developmental needs are in the domains of attachment, autonomy and having the experience of parenting where limits were set in a reasonable manner. The need to be protected from abuse, to be soothed or to be able to soothe oneself in the context of experiences involving extremely painful physical or emotional feelings.

The unmet need evidenced by abusive/cruel self-directed criticism or demands is evidenced in the way the individual has internalized their abusive manner of relating. Schema modes can be distinguished in several domains, referring to their origin. Child modes involve extremely painful physical and emotional feelings. When experiencing child modes, individuals act, feel, and think the same way they did when they were a child (Young *et al.*, 2003). Avoidant coping modes involve attempts to protect oneself from painful physical and emotional feelings by avoiding aversive stimuli and situations. Parent modes refer to experiences of abusive parenting where limits were set. The continuation of the abusive aspect

of the relationship with these caregivers is evidenced in the way the individual has internalized their abusive manner of relating either by self-directed criticism or demands on oneself. Over-compensatory modes are extreme overreactions to painful physical and emotional feelings (Rafaeli *et al.*, 2011; Young *et al.*, 2003). Modes can fluctuate from time to time. Healthy individuals are able to understand and regulate these fluctuations so they are milder and less frequent, whereas individuals who suffer from psychopathology are less cognizant of when one mode changes into another. According to ST, distinctive schema mode configurations or combinations of modes are believed to be markers of specific personality pathology.

In the early 2000's, ST was introduced to and adapted for forensic patients with personality pathology. Bernstein and colleagues (2007) expanded the schema mode model by adding five modes that are prevalent in forensic patients but seldom seen in general psychiatric settings: Angry Protector (refers to covert anger), Conning and Manipulative (refers to manipulative behavior and interpersonal stance), Predator (refers to cold and calculated aggression), and two Overcontroller modes (Keulen-de Vos, Bernstein, & Arntz, 2014). Moreover, they conceptualized these forensic modes as psychological risk factors for crime and violence. When these modes are triggered, they increase the probability of aggressive, impulsive, or other antisocial behavior. According to ST-theory, criminal and violent behaviour can be explained in terms of sequences of schema modes (Keulen-de Vos *et al.*, 2016). Events preceding the criminal/violent act often trigger painful emotions stemming from childhood situations in which they felt abandoned, lonely, hurt, etc. When these child modes are triggered, one of the aforementioned coping styles is used to deal with such painful emotions. Thus, forensic ST focuses on ameliorating the psychological risk factors that, when triggered, can lead to criminal or violent recidivism. ST integrates techniques from various approaches, such as cognitive, behavioral, psychodynamic and emotion-focused therapies. The initial phase of therapy is focused on assessment, education and building a therapeutic relationship between patient and therapist.

Main paper

Standard (forensic) Schema Therapy is excluded in case of serious neuropsychological impairments, and deficits in memory and reading function. For the same reason, offenders with an intellectual disability are also excluded from regular forensic ST. Intellectual disability (ID) is a generalized disorder that involves impairments of mental abilities that impact intellectual functioning and adaptive behavior, such as reasoning, learning and problem-solving skills. There is no specific age requirement, but the onset of symptoms is typically in early childhood. According to the DSM-5, ID equals an IQ score of 70 of below (APA, 2013). Approximately 1-2% of the general population has an intellectual disability, whereas prevalence rates among forensic psychiatric patients typically vary between 3-50% (e.g., Deb, Thomas, & Bright, 2001a; Holland, 2004). Many people with IDs show high-challenging or aggressive behavior (Deb *et al.*, 2001b; Myrbakk & von Tetzchner, 2008), although the true extent of aggressive behavior in ID populations is unclear. Some studies report prevalence rates ranging from 11 to 60%, which would suggest that the prevalence rates are up to three to five times higher than in nondisabled individuals (Hogue *et al.*, 2006; Janssen, Schuengel, & Stolk, 2002; McClintock, Hall, & Oliver, 2003; Rojahn, Zaja, Turygin, Moore, & van Dingen, 2012; Taylor, Novaco, Gillmer, Robertson, & Thorne, 2005). Higher rates of aggressive behavior are found in institutionalized and secure settings. This is not surprising because aggressive behavior is often the reason why they are institutionalized or admitted to a forensic psychiatric hospital in the first place (Benson & Brooks, 2008; Bhaumik *et al.*, 2009; Embregts, Didden, Schreuder, Huitink, & van Nieuwenhuijzen, 2009). Many forensic treatments for ID offenders, such as cognitive-behavioral therapy, psycho-education and psychomotor therapy, originate from general psychiatric health care and have been adapted for forensic populations. Evidence on their effectiveness is, however, limited. Regular ST is not suitable because ST requires metacognitive skills, or the ability to reflect on one's thinking, feeling and behaviour (Efklides, 2011). This ability is often impaired in patients with learning or intellectual disabilities (Nader-Grosbois, 2014). Moreover, the conceptual and intellectual impairments make it difficult for ID patients to understand regular ST. Also, people with intellectual disabilities who show aggressive

behavior are often diagnosed with a co-morbid psychiatric disorder or personality disorder, prevalence rates typically vary between 20 and 64% (Dias, Ware, Kinner, & Lennox, 2013).

It was in this spirit that Keulen-de Vos, Frijters and colleagues (2016) initiated the adaptation of Schema Therapy for ID offenders (ST-ID). Important theories, aspects or principles in the development of ST-ID were regular Schema Therapy for adults and children/adolescents (Loose, Graaf, & Zarbock, 2015); the risk-needs-responsivity [RNR] or what works model (Andrews & Bonta, 2010); existing Dutch treatment guidelines for patients with intellectual disabilities (De Wit, Moonen en Douma, 2011); readiness for treatment (Breckon, Smith, & Daiches, 2013); and taking into account the patients' social emotional development (Dõsen, 2007) and other characteristics of patients with intellectual disabilities. This has resulted in a specifically adapted ST program for ID offenders. Differences between standard forensic ST and ST-ID are the addition of schema modes that reflect typical emotional states for ID patients (e.g. regressive child), a strong focus on psychoeducation and visual techniques (i.e., through arts therapy) instead of cognitive demands, and a system approach (Keulen-de Vos *et al.*, 2016). The program is titled 'Heroes and Helpers' and refers to the program's purpose, namely to enhance healthy schema modes. The program consists of a theoretical manual, a treatment and session protocol, a set of 36 mode images for ID offenders, a workbook for patients and one for the patient's social network. The therapy consists of three phases: 1) intake and assessment; 2) psycho-education and recognition; and 3) recognition and change. Treatment takes place in a group.

Conclusion

Paper presentation
In this presentation, ST-ID's conceptual model and underlying theoretical principles will be explained briefly. Next, we'll discuss the practical implications of its theoretical and therapeutic framework for ID wards. We will focus on the content of the staff training; the effectiveness of training provision from a clinical and organizational perspective; the similarities and challenges when working with Schema Therapy for both PD and intellectually disabled offenders; and requirements regarding the ward's therapeutic climate. Finally, we'll present the outlines and results of a study on the therapeutic living environment on the hospital wards.

The presentation's educational goals are:
1. Understanding ST-ID's multidisciplinary approach to treatment of aggressive behavior in ID offenders
2. Review the key concepts of ST-ID for therapists and psychiatric nurses

Workshop
In this workshop, ST-ID's conceptual model and underlying theoretical principles will be explained briefly. Based on vignettes, images and case examples, we'll illustrate the core concepts of therapy. For example, how do you recognize behavior, cognitions and emotions that resemble the hero, the marionette, or the regressive child? And how do you recognize your own emotional states? The emphasis of the workshop is on introducing, experiencing and practicing schema therapy for offenders with intellectual disabilities.

The workshop's educational goals are:
1. Understanding ST-ID's multidisciplinary approach to treatment of aggressive behavior in ID offenders
2. Familiarize participants with the concept of schema modes in ID patients
3. Learn to recognize schema modes in ID patients

Acknowledgements

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A supportive relationship towards people with an intellectual disability and challenging behaviour

Paper

Tess Tournier, Lex Hendriks, Andrew Jahoda, Richard Hastings & Petri Embregts (Netherlands)

Keywords: intellectual disability, challenging behaviour, complex intervention, support, good practice, evidence based method

Abstract

Background

Supporting people with an intellectual disability (ID) and challenging behaviour (CB) can be challenging in itself. Therefore, support staff need clear guidance, based on scientific evidence, to provide high-quality care. However, there aren't many evidence based treatments to support people with ID and CB. Consequently, there is an urgent need for rapid evidence generation of mental health interventions. This study represents how evidence can systematically be generated in order to underpin a good practice intervention. The intervention, called Triple-C, is widely used in the Netherlands to support people with ID and CB, and is based on the fulfilment of their human needs in order to improve quality of life. To meet these human needs, Triple-C includes working on an unconditional supportive relationship, providing meaningful activities and taking a different perspective at CB.

Aim

The aim of this study was to define Triple-C and its possible effects by delineating the intervention's components and how they inter-relate. This study focuses on defining the first component of Triple-C, the relationship between a support worker and a client.

Method

First, we conducted a content analysis of official documents about the intervention. Resulting themes were subsequently made concrete by interviewing the founders of Triple-C. Next, we presented the results to clinical experts and integrated their feedback. Finally, to represent the collected data in a systematic way, a logic model was developed. A logic model is a visual way to present an understanding of the relationships among the resources of the intervention, the activities, and the results to achieve.

Results

As a result of this logic model, the supportive relationship is defined. The different phases of building a relationship between the client and his/her support worker have been specified as well as the corresponding competencies of the support worker. Equally important, we found out that this definition includes more elements than the official documents stated. By being unconditionally supportive, so keep providing humane support during stressful events, the support worker becomes more reliable and feelings of trust towards the support worker arise.

Conclusion

Scientific evidence is needed to provide high-quality mental health interventions for people with ID and CB. This study represents the results of the first steps of a sequential series in evaluating an intervention

called Triple-C. This process is clarified with respect to the relationship between a support worker and a client.

Educational Goals

- People will understand what an unconditional supportive relationship between a support worker and a client is.
- People will understand the value of the unconditional supportive relationship between a support worker and a client.

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Characteristics of self-injurious behaviour in people with intellectual disabilities: using the Self-Harm Scale

Paper

Kim van den Bogaard, Henk Nijman & Petri Embregts (Netherlands)

Keywords: intellectual disability, self-injurious behaviour, Self-Harm Scale, psychopathology, structured clinical assessment

Abstract

Background

Self-injurious behaviour (SIB) is one of the most detrimental behaviours for both the person showing the behaviour and for his/her environment. SIB puts the individual physically, psychologically, and socially at risk and has great impact on families and professionals, such as experiencing feelings of anger and inadequacy. There is increasing knowledge of causes and functions of SIB in people with intellectual disabilities (ID) and the recognition for research to guide evidence-based interventions. Nevertheless, structured clinical assessments of SIB, including when and where it occurs, are scarce.

Aim

The aim of the present study is to increase our knowledge about the situational determinants, triggers, and consequences of SIB, based on SIB incidents that are documented directly by observation in their natural context, using an instrument specifically designed to observe SIB.

Method

Staff completed a Self-Harm Scale (SHS) form every time they witnessed SIB (behaviour in which a person harms (or attempts to harm) oneself deliberately and physically) in clients with mild to borderline ID and co-occurring psychopathology on three wards. Descriptive statistics were conducted to explore the nature of the SIB incidents and the characteristics of the people involved.

Results

In a 41-week period of observation, 104 SIB incidents of 8 clients (24%) were reported. Clients who showed SIB were significantly more often female, more often diagnosed with a personality disorder and their communicative abilities were significantly better compared to the clients who did not show SIB. Incidents of SIB most often took place in the evening and cutting was the most common method. Support staff was not always able to label the triggers of SIB and in case support staff was able to specify a SIB trigger, stress inducing interactions (30%) and psychological state (33%) were mentioned. When intervening, support staff used manual restraints most often. In 38% of the incidents, SIB resulted in such severe injuries medical assistance was required.

Conclusion

SIB is a serious problem in people with mild to borderline ID. Both interpersonal (e.g., interactions) and intrapersonal triggers (e.g, mental state) are reasons for clients to show SIB. It is important to consider both functions, as they can differ between and within clients. Getting to know more about the

behaviour, but also the relation with support staff in the triggers and reactions to SIB can be useful to set interventions for clients who display SIB.

Educational Goals

1. People will understand the added value of incident-based recording
2. People will understand the role support staff can play related to SIB incidents of people with ID.

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Evaluating staff training on interactions between staff and people with intellectual disability and challenging behaviour

Paper

Petri Embregts, Linda Zijlmans, Linda Gerits & Anna Bosman (Netherlands)

Keywords: staff training, observation, interaction, intellectual disability, challenging behaviour, self-determination theory

Abstract

Background

Over the past decades, the role of support staff in caring for people with intellectual disability (ID) received increased attention and their importance in supporting people with ID has been acknowledged. As people with ID are at risk for developing challenging behaviour (CB), support staff working with these individuals are often confronted with behaviours like aggression or self-injury. Interventions focussing on knowledge, skills, and attitudes of support staff play a crucial role in improving their behaviour related to the challenging behaviour of the client and enhancing the interactions between support staff and people with ID and CB.

Aim

The aim of this study was to evaluate staff training on the interaction between support staff and people with ID and CB, by exploring the extent to which support regarding the three basic psychological needs as postulated by Self-Determination Theory (SDT) (i.e., the needs for autonomy, relatedness, and competence) improved as a result of the training.

Method

Thirty-seven support staff participated in the study, together with 37 clients. A pretest-posttest control group design was used; 19 support staff participated in the experimental group (i.e., they followed a training program focused on emotional intelligence (EI) and interactional patterns between support staff and people with ID) and 18 support staff participated in the control group (i.e., they followed the training program at a later stage). Video recordings of interactions between support staff and clients were analyzed with an observational system based on SDT.

Results

The results showed that the experimental group had higher scores on the post-test compared to the pre-test, indicating that support staff were able to support the fulfilment of the needs for autonomy, relatedness, and competence more adequately after the training program then before. Conversely, support staff in the control group showed lower scores on the post-test compared to the pre-test.

Conclusion

The results of the current study show that a training program focussing on emotional intelligence (EI) and interactional patterns positively affected the support provided by staff with regard to clients' needs for autonomy, relatedness, and competence. This is an important and valuable outcome, as most

EI-studies focussed on insights and understanding of oneself, whereas this study focused on staff behaviour towards clients with ID and CB during daily interactions. In future interventions this focus might be helpful, as it can enhance the well-being of clients with ID.

Educational Goals

1. People will understand the role support staff can play related to the fulfillment of needs for autonomy, relatedness and competence in people with ID.
2. People will understand that training support staff in emotional intelligence and interactional patterns will enhance the ability of support staff to create a supportive environment.

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Chapter 16 – Specific populations: child & adolescent

Workplace Violent Events in the Pediatric Inpatient Medical Setting

Paper

Della Derscheid (USA)

Keywords: pediatric, inpatient setting, medical setting, medical problems, parent, aggression, Haddon Matrix Model, resilience, MAVAS, Brief Resilience Scale, environment contributors

Abstract

Problem Healthcare settings experience five to twelve times' greater non-fatal violence than other settings. Reported aggression among children is in relation to medical problems. Parents of hospitalized children experience high levels of stress. Factors related to aggression in the inpatient medical setting are poorly understood.

Purpose

The purpose of this study was to better understand variables related to workplace violent events (WVEs) between healthcare employees and hospitalized pediatric patients or family members. The Haddon Matrix Model was the conceptual framework.

Procedures

A comparative, descriptive design was conducted in a pediatric hospital with a sample of behaviorally disruptive inpatients that required the Behavioral Emergency Response Team (BERT). Multidisciplinary healthcare employees (i.e. nurses, assistants, physicians and social workers) completed the Management of Aggression and Violence Attitude Scale-R (MAVAS-R), Brief Resilience Scale (BRS), Environment Contributor Checklist (ECC), and the Safety Climate Scale (SCS).

Analyses

Descriptive analyses of patient and family BERT WVE variables and comparisons of healthcare employee survey responses, between those involved and not involved in WVEs, were conducted using Wilcoxon rank sum, chi-square, or Fisher exact tests.

Results

First time pediatric BERT calls (n=16) were for a parent (n=1), patients (n=15) and were aggressive (75%), assaultive (50%), were 13-17 years old (75%) and female (63%). Common physical problems were developmental delay (25%), endocrine disorder (25%), and seizures (56%). Employee respondents (n=89) were female (94%), 35 years of age or younger (68%), and had 0-5 years of experience (61%)

in their role: nurse (69%), assistant (9%), social worker (8%), and physician (14%). Seventy-five percent (n=76) of employees reported WVEs with patients (84%), mothers (40%), and fathers (31%) and were nurses (p=0.0048) working on general care units (p=0.0192). They identified environmental contributors of noise (p=0.0107), high activity (p=0.0114), and crowding (p=0.0208). One MAVAS-R difference among employees involved in WVEs was the belief that patient aggression could be handled more effectively.

Educational Goals

Participants will identify

- Two demographic and two environmental factors associated with WVEs in the pediatric inpatient medical setting.
- The agent and the host for pediatric WVEs according to the Haddon Matrix Model

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Chapter 17 – Specific populations: elderly / dementia

Networks of Professionals 'without violence' for the elderly suffering from psychic disorders in Europe

Poster

Laurence Fond-Harmant, Isabelle Tournier, Jocelyn Deloyer, Gabriela Kelemen, Margarita Moraitou, Emmanouil Tzanakis, Simon Vasseur bacle, Cecile Hanon & Mihaela Gavriela (Luxembourg)

Keywords: Networks of Professionals, Elderly, professional practices, mental health, elderly suffering from psychic disorders, Europe.

Abstract

Our project is concerned with a neglected group: the elderly suffering from psychological disorders (anguish, anxiety, self-depreciation, depression, bereavement, overmedication, Diogenes syndrome, tendency to suicide, etc.).

Studies show that this population often suffers from institutional or private abuse.
Which network of professionals should mobilize to work effectively with this hetergeneous group? What differentiated professional practices should be exercised?

The medical! and social support is long-term and involves interventions from doctors, specialists, nurses, physiotherapists, occupational therapists, social workers, educators, psychologists, whose training is not specialized in gerontology and Mental Health. These professionals are not trained to work in a network of professionals who are sensitive to mental health and old age. Although work organization and care networks are becoming more and more topical! and studied, paradoxically, methods, modeled tools, guides to good practice are not yet available In a network of professionals, dedicated to the elderly suffering from psychic disorders.

But how can we improve professional practices for this highly heterogeneous, fragile public, for whom care is chronic? The aim of this project is to improve professional networking practices at European level. It draws on the expertise of researchers from universities and medical and social professionals in 5 European countries: Luxembourg, Belgium, Greece, Romania & France.

We will present the method and the results of an analysis of professional practices in this network for this population: 500 professionals of the European Psychiatric Association and 20 hearings of international experts were investigated.

From the results, we will discuss the proposal of a guide of recommendations on the conditions and parameters favorable to the efficiency of a network of care and follow-up 'without violence' of elderly people suffering from psychic disorders.

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Chapter 18 – Specific populations: refugees & displaced people

Acculturative Aggression: Myth or Reality? An Analysis of Levels of Aggression and Predictors of Aggressive Behaviour in Young Male Asylum Seekers in the Netherlands

Poster

Abigail Pickard & Elizabeth Wiese (UK)

Keywords: Aggression, asylum seekers, violence, frustration, anger

Abstract

Background

The mental health of asylum seekers has become of paramount importance with the recent increase of migration to European countries. Some maladaptive coping behaviours experienced among asylum seekers are strongly associated with anger, aggressive behaviour and violence (Hoge, Castro, Messer, McGurk, Cotting, & Koffman, 2004). This research focuses on current levels of anger and aggression of male asylum seekers at an asylum seeker centre in the Netherlands (AZC), and possible predictors for aggressive behaviour.

Method

A literature review was conducted regarding the specific population of interest. Qualitative and quantitative research was also conducted through five individual interviews and the distribution and analysis of the Buss Perry Aggression Questionnaire (1992). The interviews were transcribed and coded, before being compared with the existing literature.

Discussion and Conclusion

Levels of physical aggression were respectively low among the specific population of asylum seekers, although levels of hostility and frustration appeared somewhat high. The main causes for frustration and aggression at the AZC Middelburg appeared to be the uncertainty of the asylum status decision and the inability to plan for the future. Daily hassles, such as living in an enclosed environment, did somewhat appear to contribute to higher levels of aggression particularly among adolescents and young adults.

Consequently, this research would recommend that changes in the procedure of applying for asylum and the environment of an asylum seekers centre, could reduce levels of frustration and aggression among young male asylum seekers.

Educational Goals

- On reading this research, individuals will be able to identify the two main forms of aggression and violent behaviour in young male asylum seekers.
- Readers will also be able to identify the four main factors that increase the risk of violence or aggression in young male asylum seekers.

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Chapter 19 – Training and education of (interdisciplinary) staff

What you don't know CAN hurt you

Workshop

Lisa Mistler, Alexander De Nesnera, Diane Allen, Frank Harris & Matthew Friedman (USA)

Keywords: aggression, violence, psychiatric inpatient units, interdisciplinary, culture change

Abstract

Aggression and violence on inpatient psychiatric units has tremendous personal cost, in terms of staff and patient injuries, trauma to witnesses, days lost from work, staff and patient demoralization. While many hospitals have implemented various programs to address aggression and violence, we still have little understanding of the actual prevalence and underlying reasons. There is currently no common language that the psychiatric community uses to define, describe and measure aggression and violence. This greatly impedes our ability to figure out which environmental, administrative and interpersonal strategies to put into place and how to assess their effectiveness.

In this workshop we describe a unique collaborative training program that has changed the culture at a secure psychiatric hospital in the US and reduced assaults on staff by 60% and injuries by 65% over 5 years. The program, called SECURE (Safer Environments via Unified Response to Emergencies) training for Staying Safe, was developed between 2006 and 2009 by the Assistant Director of Nursing, Diane Allen MN, RN-BC, and State Police Lieutenant Frank Harris at New Hampshire Hospital (NHH). The SECURE model teaches clinical staff to attempt to help agitated or aggressive patients meet their immediate needs, while responding in an empathetic, professional manner to requests and demands.

Staff is taught to get help and have a plan before physically intervening with anyone. An essential part of the model is a unique coalition between NHH police and nurses that has resulted in development of a safe, clear, orderly process for transfer of authority from nurse to police during violent, clinically unmanageable emergencies. NHH policy and procedure guide clinical staff and law enforcement officers who respond to calls for help. There is clear communication and collaboration between professionals, with mutual understanding of roles and authority. We continue to develop the model and address the significant knowledge gaps identified earlier in the abstract by using various research methods, including ecological momentary assessment of inpatient aggression and violence using smartphone technology as well as mHealth interventions to address aggression. Results from 2 projects will be presented.

In this workshop, we will present the model from the perspectives of interdisciplinary staff, starting with hospital administration, continuing with the role of nursing, the role of the police and finally the role of research. After each speaker, we will engage the audience in active discussion of the principles underlying the model, especially the controversial topic of collaboration with police in a hospital.

Educational Goals

At the conclusion of the session, the participants should be able to:
1. Provide 3 examples of current gaps in knowledge regarding aggression and violence on psychiatric inpatient units
2. Describe 2 strategies for implementing culture change around safety in a hospital
3. Identify 2 reasons for transferring authority from nurses to police in emergency situations
4. List 2 advantages of having an Administrative Review Committee for risk management at a psychiatric hospital

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Psychosocial care through organisational peer support – evaluation of a training programme in the healthcare and welfare services sector

Paper

Claudia Vaupel, Mereike Adler, Dana Wendeler & Albert Nienhaus (Germany)

Keywords: Healthcare sector, workplace violence, organisational peer support system, psychosocial care, critical incident stress, evaluation

Introduction

Violence perpetrated by clients against carers is a matter of serious concern in the healthcare sector. Statutory accident insurance institutions in Germany (UV) receive approximately 16,000 reports per year of occupational injuries resulting from violence that have led to extended incapacity to work [1]. Since not all cases are reported, the actual number of violent incidents can be assumed to be considerably higher [2, 3, 4, 5].

In a survey comprising 1,973 employees of the German healthcare and welfare sector 56% of respondents reported to have experienced physical violence and 78% verbal aggression [7]. Other studies report similarly high rates [2, 8, 9, 10, 11, 12].

As a rule, alarming and physical injuries suffered by victims of assault receive due attention [6]. However, psychological consequences of assaults are given less attention. Two-thirds of all people working in healthcare report feeling stressed by such incidents, and around one in three workers feel seriously stressed by the violence experienced [7]. These incidents not only impact negatively on the health of the employees concerned [13, 14, 15] but also affect the quality of relations with clients [4, 6] and the organisational culture [15, 16]. In the context of current demographic trends, companies ought to attach importance to job satisfaction and to their ability to retain skilled workers [17, 18, 19].

Given the high risk of accidents at work resulting from violent incidents, systematic aggression management procedures should be implemented. In addition to implementing specific interventions at each stage of escalation, including developing possible action strategies for teams and individual employees [20, S. 114], it is important to have an appropriate aftercare strategy when violent incidents take place [5, 21]. In Germany, there is an obligation to train employees in first aid after physical injuries. However, provision for appropriate support after psychological injuries is often inadequate. Occupational support provisions for preventing such incidents and providing aftercare for victims of violence reduce the risk of incidents and of perceived stress [14, 22]. It is possible to counteract negative effects on an individual's stress levels if employers provide peer support within the organisation [7].

In-house peer support for employees is a form of aftercare arranged by employers as a fast response to an incident. It involves colleagues providing psychosocial peer support. The aim of this form of care is not to fulfil a therapeutic function [23], but to offer social and practical support after stressful incidents. The existing relationship of trust gives it an advantage over externally organised crisis intervention [20, S. 442, 24].

While acute psychosocial support systems exist in other sectors such as transport companies, to our knowledge most companies of the health and welfare sector are lacking this system. Therefore,

an organisational peer support approach was developed and tested. Employees from two different facilities for people with disabilities and an acute psychiatric hospital attended a two-day training programme to qualify them as frontline peer support providers.

The training programme was evaluated with a view to answering the following questions:
1. How frequently are staff the targets of aggression? Are there differences in the type of acts of aggression at the three institutions?
2. After training, to what extent do participants feel qualified to provide support to colleagues who have suffered violence?
3. Have there been changes within the context of the organisation due to the training? What factors/difficulties inhibit successful implementation of an in-house support and emergency management strategy?

Methods

The approach adopted was quantitative and qualitative. Quantitative surveys were conducted in the organisations at three points in time: before the training programme (T1), directly after (T2), and two years after completion of training (T3). On the third occasion we also conducted a semi-structured group interview.

Measures and strategy

The questionnaire employed comprised 22 questions (T1). Socio-demographic data (e.g. professional status) was collected. To record violent incidents we used a questionnaire based on SOAS-R (Staff Observation Aggression Scale-Revised) [25]. To operationalise the success of the training programme, we examined the extent to which the providers of frontline peer support felt that the training had qualified and empowered them to deal with colleagues affected by critical incidents [6, 26]. The second survey included questions on the degree of implementation of in-house peer support and any difficulties that had arisen.

In the third survey (T3), ten more detailed questions were asked in a semi-structured group interview. The oral material obtained in the interviews was transcribed and evaluated according to Mayring [27]. Quantitative data was analysed using SPSS Statistics 21.

Study participants

Training programme participants were recruited by the three organisations, so this was a self-selected sample. Fifty employees were trained, of whom 80% were from facilities for people with disabilities and 20% from the psychiatric hospital. The majority of the trainees were care professionals (63%). The remaining employees were from heterogeneous training backgrounds and worked in a variety of functions: employee representatives, school and workshop workers, human resources and health and safety officers, psychology and pastoral care staff. The dropout rate at the time of the third survey was 31% in the facilities for people with disabilities. There was no dropout at the psychiatric hospital.

Results

Frequency and severity of violence

Both the psychiatric hospital and the facilities for people with disabilities experienced different forms of workplace violence within a one-year period (see Table 1). The most frequently cited incident was verbal abuse (psychiatry 90%/disabled facility 87.5%). Suicide (psychiatry 80%/disabled facility 8%) and sexual harassment (psychiatry 60%/disabled facility 18%) were more frequent in psychiatry. An incidence of sexual assault/rape occurred in the psychiatric hospital.

Result of qualification through training
In assessing how confident the training participants felt in supporting affected colleagues, we found differences over time by type of violent incident and occupational field (see Table 1).

Table1 Confidence in supporting colleagues after the following events

Incident/adverse event	Before training (T1)		Directly after training (T2)		2 years after training (T3)	
	%		%		%	
	Psychiatric Hospital	Disabled facilities	Psychiatric Hospital	Disabled facilities	Psychiatric Hospital	Disabled facilities
Verbal abuse	100	83	100	97	92	82
Threats	90	78	100	97	92	75
Violence not requiring medical treatment	80	45	100	95	92	75
Violence requiring medical treatment	60	33	100	87	92	61
Auto-aggression	70	40	89	80	92	64
Sexual harassment	50	28	100	77	83	54
Sexual assault/rape	30	10	67	56	67	36
Suicide	70	15	100	59	92	29

Note: N = 50 at T1. Multiple answers permitted.

Directly after training (T2) there was an increase in know-how and the associated feeling of competence. This increase levelled off within a two-year period. However, a before and after comparison (T1 and T3) showed greater confidence in offering support after all forms of incidents after the training.

Respondents assessed themselves as confident in providing support after frequently occurring events such as verbal abuse, at all time points. They were least confident in their ability to support employees who had suffered sexual assaults, for which we found the lowest values, both before and two years after training.

Significant differences ($p < .01$) between psychiatry and the facilities for people with disabilities were observed as regards confidence in dealing with employees who had experienced an attempted suicide or suicide. While the majority of respondents from the psychiatric hospital felt confident in dealing with such events, respondents from the facilities for people with disabilities tended to assess their confidence as middling.

Implementing an organisational peer support system
Prior to the training and the introduction of the peer system, none of the facilities had established a systematic aftercare procedure for dealing with violent incidents or other stressful events.

In each institution, different support offers were used: Employees of the psychiatric hospital reported that all incidents were discussed in teams. Ninety per cent mentioned colleagues interceding to contain the situation (unsystematic), 90% referral to internal aid structures such as occupational health services, and 80% the involvement of external bodies such as crisis services or statutory accident insurance providers. Every participant was familiar with in-house support services (100%).

In the facilities for people with disabilities, 75% of respondents mentioned talking with colleagues, 50% mentioned referral to internal support facilities, and 28% to external support facilities. Four per cent of employees reported they were unaware of any support offers in their institution.

Changes since implementation of the peer support system
As indicators of successful implementation of peer support, we took the number of participants who had been called on to provide peer support during the two-year period and the total number of assignments. Ninety-one per cent of employees in the psychiatric hospital had been called on one or more times. In contrast, only 45% respectively 50% of those in the facilities for people with disabilities had been called on. A total of 91 assignments were performed, of which 42% were in the psychiatric hospital and 58% in the facilities for people with disabilities.

Difficulties in implementing the peer support system
In psychiatry, 56% and in facilities for the disabled, 15% of respondents stated organisational difficulties in connection with assignments. (see Table 2).

Table 2 Organisational difficulties in implementing a peer support system by occupational field:

Psychiatric hospital	Disabled facilities
• Delay in involving peer support provider • Technical difficulties (e.g., emergency mobile did not work) • Insufficient promotion of the topic by individual managers • Lack of communication about the peer support product • Person affected refused help (due to attitudes and self-image)	• Availability problems (decentralised structures in the disabled facilities / accessibility and absences of colleague providing support) • Working alone (or night shift) • Minimal staffing – shortage of personnel • Lack of information and communication about the peer support product • Insufficient promotion of the subject by management • Lack of an agreed concept of violence • Person affected refused help (anxiety about losing job, fear of stigmatisation, self-image)

Note: N = 10 in psychiatric wards, N = 30 in disabled facilities

Discussion

Our key findings indicated that qualitatively and quantitatively all forms of aggressive incidents had occurred in the organisations [2]. The implications are twofold: 1) Employers need to take preventive action to prepare for very serious events and to provide appropriate precautionary and aftercare concepts. 2) Training of organisational psychosocial peer support should cover the entire spectrum of incidents. The high number of peer support assignments in the fields of psychiatry and disability services likewise highlights the need for peer support.

There were major differences in actual implementation of the peer support concept within and more pronounced between the psychiatry and disability services.

The a priori higher level of professional training in the psychiatric hospital was positively associated with people's confidence in their ability to support those affected. In a before and after comparison, the feeling of competence grew across all events, an effect that had previously been found after aggression management training [26, 28]. Although confidence in the ability to provide appropriate support increased in both occupational fields, the baseline level was higher for psychiatric employees.

There were differences between the two occupational fields in terms of the type and severity of events. Because of this, only one third of disabled facility workers who had received training felt confident to provide assistance after serious events. Acute intervention after traumatic events demands an especially high degree of self-assurance from helpers. If the helper feels unsure, it

could be inauspicious for the victim of a potentially traumatising event, who needs to regain lost confidence in order to stabilise [32]. We recommend that external, professional help be called in directly when very serious events occur so as to reduce the psychological strain on peer support providers to the minimum level possible.

As regards implementation of the peer support system, participants from the psychiatric hospital mentioned more difficulties than respondents from the disabled facilities. Despite all difficulties, nearly all participants in the psychiatric hospital reported having been called on to provide peer support. Unlike in the disabled facilities, moreover, a systematic peer support system was implemented in the psychiatric hospital. The different percentages may be due to the fact that in the disabled facilities fewer than half of respondents had actually been called on to provide peer support and only those who had been called upon answered the question about difficulties.

Presumably, as a result of a greater degree of professional training in psychiatry, there was a different self-concept of discussing critical incidents within the team. Possibly, as a result of regular supervision sessions and case conferences, psychiatric workers are more accustomed to verbalising incidents. For employees in the disabled facilities, there was clearly some reluctance to accept help. The attitude of those affected in terms of admitting their need of help, fear of losing their job [3] and stigmatisation led to their failure to take advantage of the peer support instrument.

Furthermore, successful implementation depends on the structural nature of institutions. The disabled facilities surveyed provided services throughout the region with numerous smaller decentralised institutions (e.g. shared housing). The local structures were kilometres apart, so there was a problem with the availability of personnel. This applied in particular to night shifts. These difficulties must be taken into account in future.

Finally, support from managers and supervisors plays a crucial and beneficial role [8, 10, 26, 29]. If employers were to emphasise the importance of offers of this kind, in the long-term employees might be less reluctant to take advantage of aftercare structures. If employees are repeatedly reminded of the importance of early help and support, it might help to remove the taboo. Fundamentally, by the way they design working conditions managers can have a direct and indirect impact on the health of their employees [30] and are therefore important actors in workplace aggression management.

Conclusion

The success of aftercare measures is not only based on the competence of the persons trained, but above all on organisational conditions. It is important to take into account the lack of time or resources and to deliberate on how to arrange comprehensive provision with decentralised structures. It is often much harder to change such processes than to train peer helpers. Full commitment by managers and regular workplace meetings of core teams who continuously drive forward improvements to aftercare structures are both beneficial to success. Finally, aftercare concepts should be embedded in a general organisational aggression management concept [13]. Employers are recommended to create an early support offer [4] on both welfare and ethical grounds, regardless of the efficacy argument [31].

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Using the Rock & Water method in the treatment of forensic psychiatric patients and in educating staff

Workshop

Erik Timmerman & Ernst Janzen (Netherlands)
Van der Hoeven Kliniek, Utrecht, The Netherlands

Facilitators

Erik Timmerman is sports teacher, staff trainer and coordinator of the Sports department in the Van der Hoevenkliniek. As advanced Rock & Water trainer he provides individual workshops and group workshop for patients, as well as for staff members. He is owner of EighT – Opleidingen, Trainingen & Coaching in which he also predominantly works with the Rock & Water method.
Ernst Janzen is sports teacher and Rock&Water trainer in the Van der Hoevenkliniek.
He provides individual workshops and group workshop for patients, as well as for staff members.

Introduction

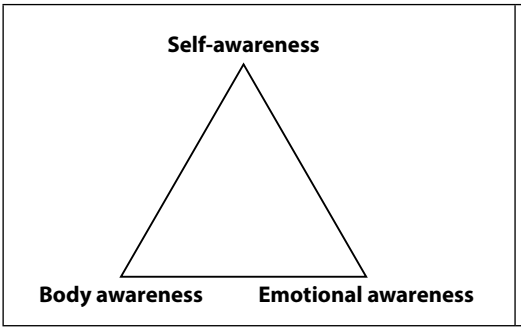
This workshop will be provided by Erik Timmerman and Ernst Janzen, both sport teachers and staff trainers at the Van der Hoeven Kliniek, a forensic psychiatric hospital in Utrecht the Netherlands. The Rock & Water method has been implemented within this hospital in 2008. Several workshops are provided for both patients and staff members. The workshops for patients focus on aggression regulation, learning how to set boundaries, and how to improve social skills. The workshops for staff members are provided within a professional education program that aims to learn how to intervene and de-escalate situations, conflict management and self-defence. For both patients and staff members, the focus is on becoming aware of their own behaviour and the impact of their behaviour on others in daily life.

The Rock & Water method
The Rock & Water method provides participants with skills for physical-social teaching with a focus on body awareness, emotional awareness and self-awareness. The concepts 'rock' and 'water' are being used as a metaphor to explicit different forms of communication.

By experiencing practice-focused physical exercises, it is easier to transfer these skills to situations in daily work or life. By creating moments of choice, the participants can learn to consciously make decisions and regain control over their behaviour in complicated situations, for instance, when it is needed to set boundaries without getting in an escalating conflict. Participants will learn to become aware of

personal possibilities, qualities and responsibilities. The workshop focuses on social competence and inner strength. In daily life, individuals will have to be able to function as a rock (strong, immovable and with self-confidence) and as water (remaining in contact, flexible and connecting). The basics of the program include grounding and centering exercises, standing strong and rock and water attitude in physical and verbal communication. The power of this method is that by practicing and experiencing the different physical exercises, one can learn to regain control in their daily life at work, school or society.

Golden triangle:



Applicability in daily clinical forensic psychiatric practice:
Since 2008, the Rock & Water program is being used with the Sports department. Just like the other sport activities, the program is part of the treatment program of the patient. When the method was implemented, it was immediately successful. All patients easily recognized the terms Rock and Water and the active part was appealing to them. These lessons are provided for individual patients or to small groups of maximum 6 patients.

For the TBS (disposal to be treated on behalf of the state implying mandatory treatment) patients with severe and complex psychopathology, we offer individualized programs in close collaboration with their psychotherapists or their supervisors. For patients with other judicial titles who are usually admitted for shorter-term , we provide series of 10 lessons supervised by a sports teacher together with a therapist. The workshop has multiple aims. Generally, the workshops focus on reduction of tension and emotion regulation, learning how to set boundaries and improving social skills.

Applicability in daily practice educating staff:
When we introduced the Rock & Water method for the patients to the sports department, all sport teachers were very enthusiastic. Various staff members recognized that this method could also be valuable for staff members. We started providing workshops upon request of treatment teams and later, the method became the basic course in the existing trainings Physical intervention, self-defence and de-escalation techniques and conflict management.

The central focus is the body, emotions, own actions and creating own choices in the treatment of patients. The aim is improve skills in acting more effectively and professional towards patients. Furthermore, the method turned out to be helpful in looking back and evaluating situations.

Workshop

During this practically focused workshop, we aim to explain the Rock & Water method and the way it is integrated within the treatment of our patients and in a professional educational program for staff. First, we will provide some basic physical exercises. Subsequently we will demonstrate practice oriented exercises and analyse them from the Rock & Water method. Furthermore, video material will be showed from the workshops provided at the Van der Hoeven Kliniek. We hope to show our own first results of research.

Educational goals

- To explain and experience the Rock & Water method and how it can be used within forensic psychiatric treatment
- To explain and experience how the Rock & Water method can be valuable in the professional education of staff in a forensic psychiatric hospital
- Show our first research results

Research & results

- The Rock & Water method started as a method for high school children. After the implementation the method was extended to several target groups and adjusted for these different groups. A number of studies have been conducted. Overall, it has been shown that:
- The Rock & Water program contributes to the development of positive social skills, more effective strategies in coping with bullying behaviour, as well as more self-control and confidence, improved skills for introspection, decrease in social problems.
- Use of the Rock & Water program results in reduced harmful behaviour.
- The Rock & Water program results in improvement of relationships between participants and relation with sociotherapists, improved group climate better coping strategies in case of bullying.
- The Rock & Water program is a well-substantiated program aiming for improving behavioral problems, bullying and sexuality.
- The Rock & Water program improves self-regulation and general self-efficacy.

Within our hospital, it has not yet been possible to examine the multidisciplinary approach for the specific target group. After the implementation in 2008, the use of the method has expanded enormously. For the TBS patients the method is oftentimes mentioned as one of the indicated treatment activities and there is constructive deliberation between the trainers and psychotherapists in improving treatment of patients. For the patients with other juridical titles, the Rock & Water program is standardly adopted in the treatment plan. Both patients and staff members are very enthusiastic about the method. Patients indicate that “not just talking” works well for them and that they like to be able to put things in their own perspective.
In 2016 we started a Rock Water research in our hospital, we hope to present the first results in Dublin.

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TAP training (tranquility, authenticity & possibilities) Increasing possibilities for efficient acting in crisis situations

Workshop

Erik Timmerman, Pim Suijdendorp & Ernst Janzen (Netherlands)
Van der Hoeven Kliniek, Utrecht, The Netherlands

Introduction

Erik Timmerman is sports teacher, staff trainer and coordinator of the Sports department in the Van der Hoevenkliniek. He is owner of EighT – Opleidingen, Trainingen & Coaching.
Ernst Janzen is sports teacher and staff trainer in the Van der Hoevenkliniek.
They both provide individual workshops and group workshops for patients, as well as for staff members. For the TAP training they work together with a team coach / supervisor.

The Van der Hoeven Kliniek is a forensic psychiatric hospital in Utrecht the Netherlands.
The hospital is treating TBS (disposal to be treated on behalf of the state implying mandatory treatment) patients and patients with other judicial titles who are usually admitted for shorter-term.

TAP - training

Since 2015, the TAP training is being used monthly to train sociotherapists and nurses to learn from experience and to increase possibilities to act adequately in stressful situations.

TAP means tranquillity, authenticity & possibilities. These are very important values at the Van der Hoeven Kliniek. Those values are even more important in a (crisis) situation with tension and stress.

Recent case examples of conflicts or other difficult situations with patients are proposed by the participants. This is a fundamental part of the training.

We make the staff more aware of the three values and how they can be used in a better way towards our patients. We invite the staff to evaluate their own skills and the way to cope with tension, stress or threats towards your staff team.

The skills we discuss, experience and train should be directly applicable on the wards.

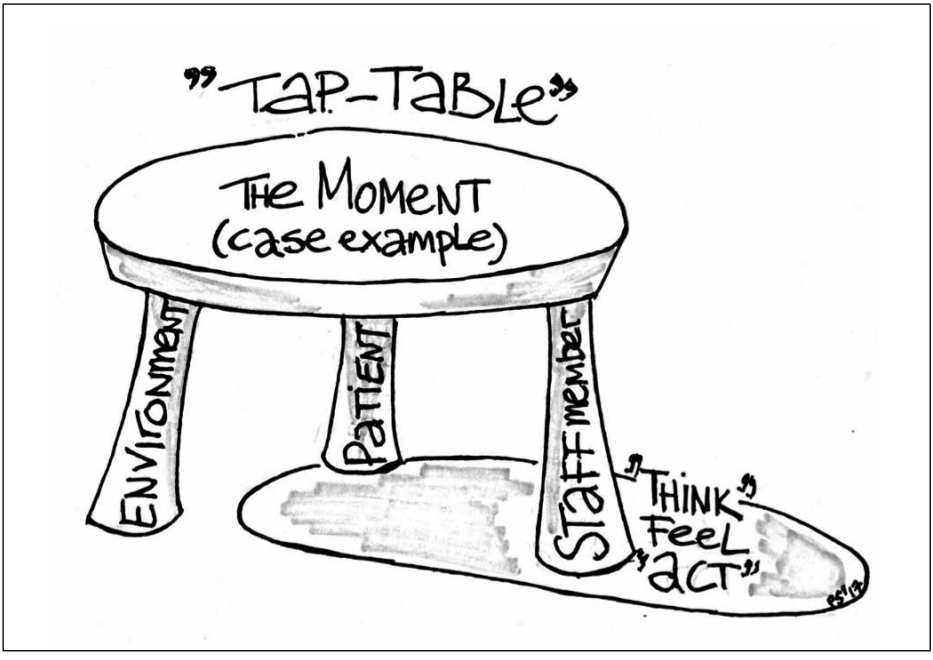
This is about being aware of your own behaviour and the impact on others, creating moments of choice, setting boundaries without getting in an escalating conflict, use the space around yourself and distance towards patients.

Besides the skills the training is also about insight. Insight in the way you act.
The way you act in stressful situations, when tension is building up or involving threats.
It is important to know yourself and your colleagues in these kind of situations. This knowledge will help being confident, determine your position and the co-operation with your colleagues.

The goal we try to achieve with the TAP training is creating a moment of tranquillity for yourself, in most cases it will also create tranquillity for the patient.
We achieve this by acting in your own way and own workstyle, it has to be authentic.
With the knowledge that there are always multiple solutions and possibilities in stressful situations.

The basics of the program

Workplace: concrete description of 'the moment'
1. Environment: 'facts' like location, day, time, other people involved
2. Patient: history, treatment relationship, issues, general impression
3. Staff member: think – feel – act, motivation of choices made, mood



Workshop

During this practically focused workshop, we aim to explain and experience the TAP training and the way it is used in a professional educational program for staff in the Van der Hoevenkliniek.
First, we will start some basic physical exercises, followed by a recent case example suggested by participants of a conflict or other difficult situation with a patient.

The participants learn to reflect on their own and others experiences on the wards.

Educational goals

- To explain and experience how the TAP training (tranquillity, authenticity & possibilities) can be valuable in the professional education of staff in a forensic psychiatric hospital

Research & results

- Staff members are very enthusiastic about TAP training.
- Besides this training there is no time on the ward to discuss and analyse stressful situation or learn from each other.
- Staff members experience an effective moment of reflection, sharing skills and possibilities.
- It is a structured way to analyse difficult situations and learn from it.

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Poor sleep is a risk factor for impulsive and aggressive behaviour. How to tackle it?

Workshop

Marike Lancel & Maaike van Veen (Netherlands)

Keywords: Poor sleep, Insomnia, Treatment of insomnia, Aggression

Abstract

A growing number of studies show that poor sleep negatively affects mental health. Disturbed sleep exacerbates symptomatology of psychiatric illnesses, such as mood, anxiety and substance use disorders, and delays their remission. In line with these observations in general psychiatry, poor sleep and, more prominently, chronic insomnia are associated with higher levels of impulsivity and aggression and more aggressive behaviour in forensic psychiatric patients. Thus, paying attention to sleep complaints of (forensic) psychiatric patients, and when severe and/or persisting diagnosing and treating sleep disorders, may be an effective and relatively easy intervention to further reduce violence and other problematic behaviour within the clinic as well as the risk of recidivism.

Chronic insomnia is the most prevalent sleep disorder in the general population (4-10%) and is even more common in general psychiatric and forensic psychiatric populations (>20%). In the first part of this workshop we will present the diagnostic criteria of chronic insomnia, discuss the most important factors that contribute to the development and maintenance of insomnia in (forensic) psychiatric patients and present psychotherapeutic (cognitive behavioral therapy for insomnia) as well as pharmacotherapeutic interventions. In the second part, people in the audience will get ample opportunity to apply their knowledge of chronic insomnia and the treatment options to several illustrative forensic case histories.

Educational Goals

- Getting insight into the consequences of chronic insomnia concerning both mental health and impulsive/aggressive behaviour in psychiatric populations
- Gaining knowledge on various treatment options for comorbid insomnia

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Can a simple board game change how we react towards potentially violent patients?

Poster

Ulla Hartvig, Gitte Vase & Susanne Foldager (Denmark)

Keywords: Safewards, simulation, game, de-escalation, prevention, conflict, dialogue; violence

Abstract

Background

The Mental Health Service in Southern Denmark has developed a board game for employees to make them think of alternatives to drugs and use of force when confronted with potentially violent patients.

The game is based on a series of fictitious patients. The idea is for the participants to prevent and de-escalate conflicts by using different interventions.

The board is designed from the English concept of Safewards. "Flashpoint" refers to situations that potentially can be the starting point of a conflict. Interventions and domains from Safewards are incorporated in the game.

Workplace environment is also a theme in the game with focus on a non-conflictual environment. Flashpoint is one of the tools we offer to the wards to focus on de-escalation in order to reduce the use of force and raise job satisfaction.

The board in the game represents a ward and the participants play together as a group to treat the patients and to avoid conflicts with the patients.

The ward has a number of patients. Participants will assess how best to prevent or de-escalate potential conflicts from information given on each patient. There are limited options of interventions which makes it difficult to prevent all conflicts and there may also occur 'human errors', which are all classic errors occurring in everyday life, e.g. sickness within the staff.

On the other hand, participants are helped by their "superpowers", which are examples of abilities that often exist within the staff, for example "the colleague who always seems to be able to calm down the patients"

Aim

We wanted a game that simulates the everyday life in a psychiatric ward and at the same time we wanted to create a safe space which would give the participants the possibility to reflect and try new interventions, while benefitting from the knowledge and experience of each other.

To minimize conflicts involving patients and to rethink behavioral patterns. We wanted to find a common language within the staff and share knowledge. To do that, people need to meet. And a board game is ideal for that purpose.

Method

Development of a board game to create space for a structured dialogue about alternative courses of actions in relation to potentially violent patients. In creating a dialogue and analyzing actions, insights occur. The participants then relate the generation of learning to the actual clinical care.

Results and Conclusions

Flashpoint is one of the tools we offer to the wards as part of the overall focus on less use of force. Overall we experience an increased interest in the offers we have on training the use of alternative courses of action, e.g. training in sensory stimulation and cognitive methods.

The purpose of using the game as a frame for a structured dialogue is working. The playful way of dealing with a serious topic makes the dialogue easier and makes it easy for all participants to contribute to the dialogue. We found that it is more important to support the dialogue than finishing the game as it is through the dialogue that learning occurs.

The greatest resource of the game is in the knowledge the participants have, which comes into play in the dialogue between the participants.

The game is a different and impactful way of working with cultural changes. The method is less time consuming than simulation training, whilst still maintaining a highly experiential learning situation.

Flashpoint has been well received in different settings:

- Seminars for Work Environment representatives
- 9 wards played at local seminars
- Ethical Committee including representatives from patient organizations and relatives
- Student nurses
- Staff educating in communicative de-escalation

Educational Goals

The poster will demonstrate how to use simulation and gamification to create cultural changes on violence in a psychiatric Ward
The poster will indicate how to create neutral, but impactfull dialogue between patients, staff, students and relatives about prevention and de-escalation of conflicts.

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Introducing Safewards into a forensic mental health unit

Paper

Tessa Maguire, Jo Ryan, Rachael Fullam & Brian McKenna (Australia)

Keywords: Safewards, forensic mental health, conflict, containment

Introduction

Safewards is a model that is designed to reduce conflict (events such as aggression, self-harm, suicide etc.) and containment (methods staff may use to prevent conflict from occurring or to try and minimise harm, such as seclusion and restraint). The model also has associated interventions which have been designed to decrease conflict and containment (Bowers, 2014). The model was developed in the UK by Professor Len Bowers, and since a randomised controlled trial was conducted in the UK, Safewards has been introduced in a variety of settings across the world including adolescent wards, aged care and secure care settings. Events that threaten staff and consumer safety are also of concern for forensic services.

To date there has been one evaluation of Safewards in a forensic setting that reported some difficulties with staff engagement with the Safewards model (Price, Burbery, Leonard & Doyle, 2016). This presentation will discuss the introduction of the Safewards model along with a staged introduction of the ten interventions onto a medium to long term male forensic mental health unit in Victoria Australia. Consumer input was considered a necessary element of the introduction and implementation. How consumers were engaged in this process will be explored, along with the evaluation of the implementation process.

Methods

A steering committee was established to guide the implementation and evaluation of Safewards. Membership of the steering committee was multidisciplinary and included a consumer consultant. A working party at the ward level was also established and membership included a practice development nurse, allied health staff, unit manager and two consumer representatives from the ward where Safewards was being introduced. Staff and consumers were provided with training on Safewards and the associated interventions during 2016. The Safewards fidelity check was used to evaluate the rate at which the interventions were being introduced, and included questions to staff and consumers about their experience of Safewards. Descriptive statistics were used to analyse the adherence to the interventions and content analysis was used to analyse the data relating to the staff and consumers experience of the introduction and implementation of Safewards, and to explore some of the perceived advantages and limitations.

Findings

During the implementation period, most staff and consumers received some form of training and/or education on Safewards. Involvement from the local working party and steering committee directed a change to the order of the introduction of interventions where it was considered that one of the interventions would be better suited in the initial implementation phase to enhance consumer experience and involvement. Changing the order of this intervention to earlier rather than later in the study proved to be successful in engaging the consumers on the ward and disseminating information about Safewards. The fidelity checks were conducted four times during 2016 indicated there was a high

level of adherence to the interventions, with the last fidelity check reaching 94% for all 10 interventions. Input from the Consumer Consultant and consumers was essential in steering the implementation as well as encouraging participation and collaboration with staff and consumers alike. Overall the introduction of Safewards was viewed positively by staff and consumers on the ward. The role and value of the consumer leads was also valued by staff and consumers.

Conclusion

Safewards can be introduced into a forensic setting with a high fidelity achieved during the implementation period. The input of consumers in the introduction and the implementation of Safewards may assist in the adherence, collaboration and success of Safewards at a local level.

Educational goals

Participants wil

- Identify some of the advantages of introducing the Safewards into the forensic setting
- Learn about the value and importance of having consumer input into the introduction and implementation of Safewards at a local and organisational level.

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Reducing restrictive practice: A key role of PMVA training/trainer

Paper

Abu Idris (UK)

Keywords: PMVA training, Prevention, Reducing Restrictive Practice

Abstract

Despite all publications and recommendations, reports still suggest a wide use of reactive measures to prevent and manage violence and aggression in inpatient settings (NHS Benchmarking Network ¨C DoH 2016, Nursing times, 2016). Instead of focusing on causes and prevention of restraint, the emphasis has been on the banning of specific restraint methods such as prone restraint and pain compliance techniques by private, public and sometimes regulatory bodies. Even de-escalation training as suggested by many (Cowin et al, 2003; NIHME, 2004), is not a solution to this complex problem. De-escalation is a reactive measure, it is used when behavior is escalating and even then, its success depends on how well it is implemented (Duxbury & Whittington, 2005). Identification and prevention of triggers, flashpoints and other contributory factors that leads to the use of restraint should be the main focus if any significant reduction is to be achieved.

Findings from research conclude that external and situational factors (enforcing rules or boundaries, needs not met, etc.) can exacerbate internal factors (mental or physical illnesses, hunger, etc.), thus triggering behaviors that require containment (Nijman et al, 1999 & Bowers, 2014). This suggest that removing practices that can increase stress and frustration amongst service users and staff will reduce the need for using containment such as restraint and seclusion. There are also other findings that conclude that PMVA and or similar training teaches staff to expect and react to violence and aggression (NMC, 2004; Horton, 2001), rather than identify and prevent behavioral disturbance. This is suggesting that there is a lack of clarity in the principles of PMVA training that needs to be addressed.

This presentation will emphasize on the importance of primary prevention within the Prevention and Management of Violence and Aggression (PMVA) syllabus. It describes how the role of PMVA training/trainer can contribute positively in reducing the use of restrictive practice. PMVA has for some time now been described or seen by many as a reactive tool, yet it should stretch far beyond the teaching of physical techniques. It is important for instructors, organisations and other stakeholders to recognise prevention as one of the most vital part of the roles and responsibilities of any PMVA trainer/training. A PMVA trainer/training should give staff knowledge, skill and/or ability necessary to effectively prevent and/or manage violence and aggression with a lot more effort/emphasis on prevention.

The presentation will also look at how competency as suggested by Paterson (2000) and HSE (2006) can affect an instructor in carrying out their role effectively. The presentation will share how effective use of PMVA training and trainers contributed in achieving a reduction on the use of restrictive practice in one mental health unit.

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Educational Goals

- Delegates to understand the role of PMVA training and trainer in Reducing Restrictive Practice

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Childhood Sexual Abuse Among Psychiatric Inpatients

Paper

Alexander Shestiperov, Ronit Kigli, Hilik Levkovitz & . Orli Grinstein-Cohen (Israel)

Keywords: Abuse, Childhood Sexual Abuse, Mental Health, Inpatients

Abstract

Background

As the awareness for sexual abuse has increased in the past few years, many of recent studies have shown the negative influence of childhood sexual abuse on the health of the victims. However, only a few of them have discussed the mental morbidity. Yet, in Israel, the connection between the abuse and mental health has never been studied.

Aims

To evaluate the prevalence of abused inpatients in a psychiatric hospital; Compare the sociodemographic background between abused/not abused inpatients; Characterize the type of the abuse; Check the distribution of mental disorders among abused inpatients.

Method

A cross-sectional pilot study which is based on convenience sampling of 47 inpatients in Psychiatric Center in Israel. Every inpatient who was recommended by the case manager/treating psychiatrist, and met the inclusion criteria, was admitted to Structured Trauma Interview for evaluation of childhood sexual abuse. The diagnoses of each participant for mental health disorders was drawn from the patient file. After almost five months of data gathering, the data has been divided into two groups; a group that underwent childhood sexual abuse, and the others.

Results

Using SPSS 19, Chi-square tests, T-tests, Mann- Whitney and Fisher's exact tests, showed no significant difference between the two groups of the study for their sociodemographic characteristics (age, gender, education, number of children, marital status, employment); 34% of the inpatients had been sexually abused in childhood; The abuse was characterized by touching the victim (42.3%) and rape/sexual intercourse (30.7%). In majority of the cases, the way that the victim was forced/pressured to take a part in it was: threats (30.4%), use of force (26.08%) and getting anything in return (26.08%). The duration of the abuse was 3.38 years in average (SD-3.99; Median-2; IQR=3) and characterized by non-consistent abuse (56.25%). In majority of the cases (63.63%), the perpetrator was familiar to the victim; The abused group had much more diagnoses of Unipolar Depressive Disorders, Borderline Personality, Alcohol/Drug Abuse, PTSD and committing suicide than the other group (25% vs. 9.6%; 50% vs. 19.35%; 37.5% vs. 29.03%; 18.75%; 68.75% vs. 43.38%).

Conclusions

Childhood sexual abuse is characterized by brutal and long term abuse. In our study, one-third of the inpatients who were sexually abused in childhood were diagnosed with a spectrum of psychiatric

disorders. Due to these findings, there is a need to develop a screening tool in all psychiatric facilities in order to establish a long term therapeutic interference.

Educational Goals

- The participants will know the specific mental disorders that have been mentioned in the context of childhood sexual abuse among inpatients.
- The participants will be aware of the importance of screening for childhood sexual abuse among inpatient at mental health facilities.

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Evaluation of physical conflict management techniques; a step towards a national standard in mental Health care in Norway

Workshop

Thomas Haugen Nag, Torill Storhaug Fotland, Thor Egil Holtskog, Kjell Kjaervik & Jakub Lickiewicz (Norway)

Keywords: Staff training, physical techniques, standardization

Abstract

Background

A workshop was conducted 23-24.march 2017 in which instructors from 5 different staff training programs in Norway attended.

Aims

To achieve the most appropriate repertoire of physical techniques when dealing With aggression and violence in a mental Health setting.

Methods

All techniques were shared and tested between the different staff training programs. They were then evaluated by the 16 attendees based on the following 7 parameters; effectiveness, easy to learn, easy to use, potential for pain inducing, offensive for the patient, and injury potential for both the patient and staff.

Results

The data was used to screen out which techniques were perceived as the most appropriate by the different staff training instructors. Then a consensus discussion were facilitated with the result of a common repertoire of physical techniques between the 5 different staff training programs.

Conclusions

A standardization of physical techniques in a mental Health setting would have implications both clinically and organizationally, but first and foremost; it would contribute as a quality assurance that both the patient safety and the staff safety are maintained in the most optimal way.

The conclusion from the workshop is that there was a great willingness to adapt and improve each other's techniques to the common good for the patient.

Educational Goals

- The participants will get to know a methodology of how to evaluate physical techniques in a mental Health context
- The partipants will get an introduction to the different techniques that was adopted between the five different staff training programs in Norway

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Changing attitudes: the effect of a training course on a forensic psychiatric units staffs attitudes

Paper

Neringa Aasdal & Tine Wøbbe (Denmark)

Keywords: Aggression management, attitudes, staff training

Abstract

Background

Preventive measures, de-escalation techniques and traditional methods such as restraint, seclusion and medication are used on a daily basis when preventing and managing patient aggression and violence in a forensic psychiatric ward. However, staff´s choice of method and behaviour in critical situations are influenced by staff´s attitudes towards aggression and violence (Foster *et al.* 2007; Duxbury, 2002). Three broad theoretical approached are used in the literature to describe staff´s attitudes towards aggression and violence.

The internal attitude model views patients as the cause of aggression and violence and justifies medical treatment, restraint or seclusion of aggressive patients.
The external model focuses on environmental factors, such as the ward atmosphere and staff, and requires various interventions in the management of patients' aggression.
The situational/interactional attitude model incorporates internal and external factors and refers to the contex t of the aggressive behaviour. The interaction between staff and patient is central in this model (Duxbury, 2002; Duxbury & Whittington, 2005).

Aim

Research has shown a limited effect from training programs on change of attitudes in staff members, nevertheless a revision of training quality is generally recommended from this (Hahn *et al.* 2006; Abderhalden *et al.* 2006). Comprehensive and targeted staff training in aggression management can potentially target attitudes and result in lasting improvements in understanding the ´external` and ´situational/interactional` factors in patient aggression. The aim of this study is to examine the effect of 4 weeks of multidimensional and targeted training in aggression management on staff´s attitude change.

Method

The current study examines the effect of 4 weeks training on attitude change of 24 staff members at a newly established forensic psychiatric unit. The design of the study was a pre-/post-test method using a Danish version of the Management of Aggression and Violence Attitude scale (MAVAS) (Duxbury, 2002). The MAVAS is a highly validated and reliable scale (Duxbury, 2002) incorporating 13 statements about causes of violence and 14 statements related to approaches to aggression management. The MAVAS scale was administered before and after 4 weeks training program, and again 6 (April 2017) and 12 months later (September 2017). The staff also completed a questionnaire with demographic data (including experience and the amount of previous training), and questions about their own personal experience of patient aggression and violence.

The aggression management training was a part of 4 weeks introduction package for the staff of a newly established forensic psychiatric word and consisted fr om 50 hours effective training including topics of legislation, psychopathology, risk assessments, prevention, de-escalation, communication and containment measures. Data analysis Data analysis will be carried out a question- by-question basis and the descriptive comparisons of pre-/post-training will be made.

Results are currently being processed.

Educational Goals

The participants will be able:
- To name the theory of attitudes.
- To describe staff´s attitudes on aggression and violence management.

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Dealing with child abuse: listening to professionnal's voices and learning ways of handling the impact of child abuse on professional's life

Paper

Christos Panagiotopolos & Eleni Papaspyrou (Cyprus)

Keywords: Child abuse, interdisciplinary approach, emotional burdening, mental health professionals

Abstract

Nowadays, the phenomenon of child abuse is considered to be one of the most serious and intertemporal social problems. In the international literature there are a lot of references related to the impact of abuse not only on the child's personality but also on the transition to adulthood. However what we are exploring in this case study is how mental health professionals, who are occupied with child abuse, feel and experience the abuse. As a consequence professionals that work with child abuse have to face their own challenges. It is very important for them to recognize their feelings so as to offer their services and their support to people who are in need. If the professional, through his own system of values, experiences and feelings recognizes his limits, he/she will have the chance to help the abused child until the end. This qualitative case study aims to show the feelings of professionals related to child abuse and how they manage them in their personal and professional life.

This case study showed that the most important elements in maintaining professional balance are a) the personal work of every professional b) clinical supervision and c) joint work which aims at defusing emotional tension.

Educational Goals

- Emotional handling of the child abuse effect on professionals' life
- Learning the importance of working together and sharing feeling and emotions caused by daily work with child abuse

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Empathy levels among undergraduate nursing students: a preliminary study in Italy

Poster

Paola Ferri, Sergio Rovesti, Nunzio Panzera, Carmela Giudice & Rosaria Di Lorenzo (Italy)

Keywords: longitudinal study, empathy, undergraduate nursing students

Abstract

Background and Aim

An empathetic approach is fundamental to the development of the therapeutic relationship between nurse and patient. According to some researchers, nursing students show a decline in their empathy levels as their studies progress. The purpose of this study is to assess the level of self-reported emotional empathy in undergraduate nursing students over a 3-year period at a single tertiary institution in Italy.

Method

In order to assess the development of empathy among the 142 students whose first year of enrolment in the programme was academic year 2015/16, three subsequent surveys were scheduled: one at the beginning of their course of study (T0), one at its mid-point (T1), and one at its conclusion (T2). This study presents the results from the first two of these surveys (T0 and T1). The Balanced Emotional Empathy Scale (BEES) was administered and data were statistically analysed.

Results

118 nursing students participated in the first test and 99 in the second. The BEES global mean score for the longitudinal group (n=99) fell slightly (t=1.202, p=0.232; t-test for paired data) from T0 (Mean=37.1 SD 19.5) to T1 (Mean=33.5 SD22.6). The findings of both surveys demonstrate that female students reported a statistically significant higher mean BEES empathy score compared with male students.

Conclusions

Our preliminary data suggest a slight decline in empathy scores among nursing students between the beginning and the mid-point of their undergraduate education, which is in keeping with previous studies. Completion of the longitudinal study is essential if we are to ascertain the actual nature of the trend in empathetic tendency. The gender difference is consistent with the findings of other studies, although in our study it is even more pronounced, showing higher levels of empathy in female students and lower levels in male students.

Educational Goals

- To know the development of empathy among nursing students.
- To analyze the factors related to empathy levels.

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Preliminary results: Forensic mental health staff perception of everyday patient-staff conflicts

Poster

Frederik Alkier Gilberg (Denmark)

Keywords: Conflict management, forensic, staff perspective, violence and aggression

Abstract

Background

In Denmark, sick leave due to work-related aggression and violence costs society approximately 86 million Euro annually (Bom, 2015). Recent systematic literature reviews highlight the following: mental health nurses appear to have three times higher odds of physical assault than nurses outside the area of mental health (Edward *et al.* 2016), social climate affects levels of aggression, and staff-patient relationships and staff attitudes seem to play a central role (Robinson *et al.* 2016); there is a call for research on how staff experience 'last resort' with regard to the use of restraint (Rihai *et al.* 2016).

Aim/Objective

In order to understand how, in some cases, staff arrive at the use of restraint, this study aimed to investigate staff's perceptions of the reasons for and characteristics of everyday conflicts between staff and forensic mental health inpatients, with a view to understanding the circumstances involved when staff decide on use of restraint.

Method

Twenty-four semi-structured, in-depth interviews with forensic mental health staff were conducted using an interview guide informed by the above aim. Participants had on average 6.88 years of clinical experience, the gender ratio was 9 male and 15 female staff and the interviews averaged 42.37 minutes. Written, informed consent from all participants was obtained, ethical approval was granted by the Regional Research Ethics Committee, and all data were rendered anonymous. Interview data were subsequently transcribed verbatim and analysed using thematic analysis.

Results

Preliminary results point towards three main themes: 'Personal attributes', e.g., tolerance, values, staffs perception of patients, fears and insecurities, 'Collegial attributes', e.g., uniformity, communication, safety behaviour, and 'Staff-patient interactional conflict management traits', e.g., assessment, observation, interactional conflict strategies.

Conclusion

These three themes suggest that the style of patient aggression management should be understood as the result of a complex interplay between staff's perceptions of their own 'personal attributes' and the 'collegial attributes' that give tone to the staff group's collective display of 'staff-patient interactional conflict management traits' in staff-patient conflict resolution. This could perhaps partly explain why, in some cases, forensic mental health staff use restraint and in some cases not.

Educational Goals

- Know about the impact of work-related aggression and violence in mental health care services.
- Distinguish between attributes in the complex interplay between forensic staff's 'personal attributes', 'collegial attributes' and 'staff-patient interactional conflict management traits'.

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Utilising the Positive and Safe Violence Reduction Programme & Communication Awareness and Skills to Reduce Restrictive Practices within Nottinghamshire Healthcare NHS Foundation Trust

Workshop

Mark Phillips, Jackie Ewington, Hayley Tutill & Elaine Rea (UK)

Keywords: violence, training, communication, aggression, structure, implementation, strategic, trust, overview, speech and language, visual, video, film,

Abstract

Utilising the Positive and Safe Violence Reduction Programme & Communication Awareness and Skills to Reduce Restrictive Practices within Nottinghamshire Healthcare NHS Foundation Trust

Nottinghamshire Healthcare NHS Foundation Trust provides services across the county for people with mental health needs, some relating to drug or alcohol dependency, mental and physical health services for people with intellectual disabilities and community physical healthcare. The Trust also provides secure mental health services, including low, medium and high secure services. The trust employs 8,800 staff including mental health nurses, psychiatrists, social workers, healthcare support workers, allied health professionals, psychologists, community nurses and physical healthcare nurses.

A Trust-wide initiative began in February 2016, following involvement in the co-production of a new High-Secure Violence Reduction Training Manual. The aim is to develop a consistent approach to all services within Nottinghamshire Healthcare Foundation Trust. Key changes have included a top-down review of current practice, an increased focus on staff – service user interactions, and a renewed commitment that all violence reduction training throughout the Trust will encompass the philosophy of least restrictive practice, reduction of techniques and a single core use of terminology and data collection.

The Trust has committed to developing and implementing a single organisational training curriculum for all staff that will reflect the clinical needs of each service, this presentation aims to give a strategic overview two years into the initiative, where we are now and where we are going forward.

The techniques taught within the Violence Reduction Training programmes have been reviewed, with an increased focus on strategies that do not include the use of physical interventions. The reduction in techniques has allowed us to identified core skills which are transferrable across the different services within the Trust. This has led to a reduction in the number and variety of physical intervention techniques that are taught.

Training that Highlights the Importance of Communication Awareness and Skills to Reduce Restrictive Practices.

The development of the Positive and Safe Violence Reduction Training programme has also included an innovative and unique collaboration between Rampton Hospital Speech and Language Therapy Team and the Violence Reduction Teams within Nottinghamshire Healthcare NHS Foundation Trust.

The aim of this collaboration has been to enrich communication skills and increase staff awareness of the importance of staff-patient interactions by developing a model for embedding communication and de-escalation skills training within all aspects of violence reduction training.

It is anticipated that this new approach to Violence Reduction Training across teams within Nottinghamshire Healthcare Forensic Services will have a significant impact on the culture of the services delivered across the Trust. The focus on least restrictive approaches to preventing and managing incidents of violence and aggression, and the emphasis on responding to service users needs.

Educational Goals

- The conference presentation will enable the audience to accurately understand area's specific to the implementation of a single training syllabus relating to physical intervention Training.
- The leaner will also gain an understanding to the Importance of Communication Awareness and Skills to Reduce Restrictive Practices.
- The leaner will achieve this though a variety of presentation tools, including power point presentation and videos and will conclude with question and answers session.

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Medical Simulation in Forensic Psychiatry

Poster

Thor Egil Holtskog, Kjell Kjaervik, Toril Garborg & Bjarne Dahl (Norway)

Keywords: Medical Simulation, Patient Safety, Personnel Safety, In house training, Team Building

Abstract

Also in psychiatric Health Care the need of patient safety has to be focused on. Training with colleagues instead of patients can be done in several ways. Pinpoint your challenges, train, debrief and training each other better!

South-East Regional Health Authority Norway (HSØ RHF) consists of seven hospital areas (HA) providing secondary healthcare in Norway; HSØ has a apx. 2, 8 mill. inhabitants.

Method

Knowledge is developed in scenario-simulations in all counties in HSØ. Technical and non-technical skills. Places and meeting points vary. Weekly, monthly, yearly. T-T-T education, CRM and debrief theory is central . Continuation and implementation has to be leadership anchored.

Establishing Medical Simulation in Psychiatric Health Care network in the HSØ region. Learning from each other different models for different challenges. And offering supervision possibilities.

Findings

The simulation principles gives better team- and individual preparation against violence. Registering feedback all the time tell us that staff find the training meaningful and useful. In these team training novices and experts train each other better and faster than before.

Several hospitals and units seems to work better together. The method makes it easier to share knowledge in our region. When staff feel safe enough they keep working with difficult challenges, and the common knowledge gets a chance to develop.

Feedback from participants show that they find this type of interactive training realistic and knowledge-enhancing.

Implications for practice

Routine based training, once a week, once a month or less. Staff from different units get to know each other. Cultures beat subcultures! Safe teams get higher tolerance for patients in unstable conditions. Training on the real challenges gives better working conditions if it can be done in safe environments.

Results

Since 2013, 182 participants have been educated as «Facilitators in medical Simulation» from Mental Health Care. These Facilitators are followed by Oslo University Hospital (SimOslo) and the simulation center at Innlandet Hospital trust, after the education, for easier implementation in their local workplaces.

At the Regional Department for Forensic and Security Psychiatry, Oslo University Hospital this method has been used since 2013. Weekly approximately 20 staff members train and debrief for 1 hour. Totally approximately 150 personnel is training in this system. The nurse students also have a separate program in collaboration with the university. Traditionally education is also arranged every Thursday. Approximately 20 participants attend this and 40 personnel get 1 hour every week.

Educational Goals

- Securing knowledge and clinical judgement developing culture
- Securing patient safety. Train With colleagues, not patients.

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Influence of psychiatric nurses' attitudes of aggression management on their impacts after dealing with aggression

Poster

Shing-Chia Chen, Hung-Yu Lin & Wen-I Liu (Taiwan)

Keywords: psychiatric nurse, attitude, patient aggression, aggression management

Abstract

Background

Aggression management is an important issue in psychiatric care. Psychiatric nurse's attitudes toward the causes and management of psychiatric patients' aggression are attributed to their impacts after dealing with patient aggression. This research aims to understand the influence.

Methods

A cross-sectional retrospective self-reported survey was designed. Sampling strategy was to recruit psychiatric nurses (N=246) who care for adult psychiatric patients on three community psychiatric centers of the Department of Health and qualified psychiatric hospitals in Taiwan. After the approvable process of the relevant research ethics committees and to get informed consent from participants, the Chinese version of modified Duxbury's 27-itemed Management of Aggression and Violence Attitude Scale (MAVAS), including three explanatory factors (internal, external, and situational/ interactional) and one factor toward aggression management strategies; and, the Chinese version of Needham's 10-itemed Impact of Patient Aggression on Carers Scale (IMPACS), including impairment of relationship, adverse moral emotions and adverse feelings to external sources; were administered by website.

Results

Findings showed that more positive attitudes had lower impacts ($r= -.169$, $p<.01$).

Conclusions

Psychiatric nurses' explanatory factors of psychiatric patients' aggression and their attitudes toward the aggression management strategies had positive influence on reducing their impacts after dealing with patient aggression. This could be applied in aggression management training and education of staffs.

Educational Goals

- To perform the construct validity of the sub-factors toward aggression management strategies in the Management of Aggression and Violence Attitude Scale and the Impact of Patient Aggression on Carers Scale
- To distinguish between psychiatric nurses' explanatory factors and their attitudes toward the aggression management strategies, and those influence on their impacts after dealing with patient aggression.

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Preparing Student Nurses to Manage Aggression: A Comparison of Approaches

Poster

Yvonne Murray, Lynn Clarke & Pat Bradley (UK)

Keywords: Student, Nurses, Midwives, Preparation, Training, University, HEI.

Abstract

Approaches to preparing student nurses and midwives vary across Higher Education Institutions in Scotland.

The differences and similarities in the training and preparation of students from two Scottish Universities are presented, along with the outcomes from the workshop of the same theme which took place at the ENTMA symposium in May 2017.

The findings from the comparison exercise and workshop form the beginning of a delphi study, the outcomes of which could inform the development of future training standards for students. This work would complement ongoing work in the development of International training standards for Management of Aggression Trainers across Europe.

Educational Goals

- Participants will participate in a debate of the perceived training needs of health care students.
- Participants will identify core elements of training used in the preparation of students nurses and midwives prior to their clinical placements.

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Responding to Violent Behavioral Emergencies: Educating Interdisciplinary Staff

Poster

Marissa Flaherty, Vedrana Hodzic, Christopher Miller, Christopher Wilk, Ashley Hernandez & Eric Weintraub (USA)

Keywords: Behavioral emergencies, staff training, educational model

Abstract

Background

Violent behavioral emergencies are a common occurrence on inpatient psychiatric units, leading to workplace hazards for staff members. The key to safely controlling such situations is the seamless coordination between interdisciplinary staff, which includes attending physicians, resident physicians, nurses, occupational therapy and social workers. Multiple education models exist for training staff to deal with disruptive and aggressive behaviors. Two commonly used programs are based on the Crisis Prevention Institute (CPI) model and the Mandt System and are used in the University of Maryland/ Sheppard Pratt Residency Program.

Aims/Methods

We aim to review and examine the strengths and weaknesses of the CPI and Mandt education models for behavioral emergencies provided for interdisciplinary staff. For each model, parameters including de-escalation techniques, physical intervention training, training of each type interdisciplinary staff member, and the extent that the role of each provider is emphasized in the team approach, will be assessed and presented. A literature review compares the efficacy of each model in recent larger population studies as well.

Results

Benefits of CPI include nonviolent crisis intervention techniques based on prevention, effective communication, and understanding levels of crisis acuity, with the principle that physical restraints should only be used as a last resort. Mandt training also stresses teamwork and communication for conflict resolution, but additionally teaches advanced techniques for safe assisting, separating, and restraint use. The strengths of the two models presented are incorporated into a novel model for educational training of interdisciplinary staff in behavioral emergencies. The goals of the proposed educational training model focus on safety and efficacy of the interventions, as demonstrated in the literature by minimization of injuries and the use of seclusion and restraints.

Conclusions

Behavioral emergencies, particularly violent ones, can be a vulnerable time for interdisciplinary staff, as well as patients, in psychiatric hospital settings to sustain injuries. Not only is it important for interdisciplinary staff to receive education and training in managing these situations, but it may be that the type of training model used can make a difference in safety outcomes, particularly staff injuries, as well as the confidence of staff in handling these situations. Combining preventative strategies with practical training may provide the best safety outcomes.

Educational Goals

- Understand the role of violence in behavioral dysregulation and emergencies.
- Review the education models and training that exist for interdisciplinary staff for behavioral emergencies.
- Learn how to optimally educate and train interdisciplinary staff to safely respond to and control behavioral emergencies.

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Collaboration Between Mental Health and Law Enforcement Professionals in Behavioral Emergencies in Baltimore, Maryland, USA

Poster

Vedrana Hodzic, Christopher Wilk, Christopher Miller, Ashley Hernandez, Marissa Flaherty & Eric Weintraub (USA)

Keywords: Behavioral emergencies, police training, behavioral de-escalation, psychiatric emergency services, seclusion and restraint

Abstract

Baltimore, Maryland has exceeded national averages for violent crimes rates for many years. In response, multiple public health and safety initiatives have been developed at the city and health system levels to coordinate between the Health Department, Police Department, and mental health providers in an effort to reduce violence. The Baltimore City Police Department implemented Behavioral Emergency Services Team (BEST) training with the goal of redirecting law enforcement efforts toward crisis intervention and de-escalation of behavioral health crises, to ultimately minimize arrests and reducing the risk of injury to both the public and the officers.

The program was useful, but was not mandated for all officers. In 2017, Maryland Senate Bill 594 outlined the creation of behavioral health units in the Baltimore City and County Police Departments, to be composed of specially trained officers who are better equipped to respond to emergency calls involving individuals suspected of having a mental health and/or substance use disorder. The goal of the legislation, which will be enacted into law on October 1, 2017, is to prevent and reduce unnecessary use of force and loss of life, and to divert such individuals away from the criminal justice system and instead into treatment.

As the largest public health system in the State of Maryland, the University of Maryland Medical System (UMMS) maintains a collaborative relationship with law enforcement, hospital security, and the Psychiatric Emergency Services (PES). Much like the BEST trained police officers in Baltimore City, UMMS hospital security has developed a specific Behavioral Emergency Response Team (BERT) skilled in de-escalating conflict to work with patients and families with disruptive or threatening behaviors to minimize violent events throughout the hospital.

PES, which is staffed with physicians, social workers, nurses, and peer recovery coaches, not only allows for rapid involvement from the psychiatric team in behavioral emergencies, but also plays a pivotal role in diverting individuals with mental health and/or substance use disorders toward an appropriate type and level of treatment. The PES staff utilizes a recovery model developed by the Substance Abuse and Mental Health Services Administration (SAMHSA) to provide immediate trauma-informed care. This collaboration in PES and the use of nationally recognized models has significantly decreased seclusion and restraint use at our facility.

We analyze the effects of these multidisciplinary efforts to decrease violent behaviors, both in and outside the medical setting, in order to provide a model for violence prevention in behavioral emergencies.

Educational Goals

Explain the role of mental health training for law enforcement professionals to de-escalate aggressive behaviors and reduce violence during behavioral emergencies
Demonstrate the impact of collaborative care in behavioral emergencies to minimize violent events and the use of seclusion and restraint

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A psychiatric Nurse Develops A Training Program For General Internal Medicine Staff To Reduce Violence

Poster

Antonia Purdy & Aideen Carroll (Canada)

Keywords: Training Program. Large urban Hospital

Abstract

This poster will outline a training program a psychiatric nurse in Toronto, Ontario, Canada, developed and implemented in 2017, for all clinical staff in General Medicine at a large urban teaching hospital, to reduce violence experienced by staff working within that program.

Violence in the workplace is considered to have become a global problem, crossing borders, work settings and occupational groups (WHO 2002). Workplace violence is considered in nursing to be "an incident of aggression that is physical, sexual, verbal, emotional or psychological that occurs when nurses are abused, threatened or assaulted in circumstances related to their work" (RNAO 2009).

The incidence of workplace violence is high in Ontario with 54% of Ontario Nurses Association members reporting that they have experienced physical violence or abuse in the workplace (ONA 2014). Evidence also suggests that in Ontario, the health sector has the highest rate of lost time injuries due to violence in the workplace, compared to any other sector in the province (RNAO 2009). Certain clinical areas tend to have a greater incidence of overall violence, including verbal assaults, emotional abuse, sexual harassment and physical assaults. These areas are the Emergency Room and Psychiatry (Wang 2005). However, there appears to be less research conducted in other clinical areas where complex comorbid medical issues may cause patients to become confused and combative such as in transplant and general medical and surgical units. Incident reports published by the Occupational Health Department at a large urban teaching hospital in Toronto indicated that the verbal and physical abuse experienced by staff from both patients and families in these clinical areas is increasing.

A psychiatric nurse with over 20 years of experience developed an educational training program on Situational Awareness for staff working in General Internal Medicine. The one-hour program content was divided into 3 core areas: Knowledge of the patient, Knowledge of self and knowledge of the environment. A short 15-minute video and pocket cards were developed to reinforce the educational content.

The goal of the program was to provide relevant education to staff to keep them aware and thus safer at the point of care, while developing a short transferable educational program.

One hundred per cent of all staff working within the program took part and the post evaluations indicated a 99% increase on knowledge post training.

Educational Goals

- To Develop a short relevant transferable training program.
- Define and implement Situational Awareness to keep staff safe at the point of care.

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Development of education in violence risk management at Regional Department for Forensic and Security Psychiatry in Oslo

Poster

Toril Garborg, Thor Egil Holtskog, Kjell Kjaervik & Geir Fossheim (Norway)

Keywords: Violent risk management, Education, Motivational Factor, Participant involvement, Learning by doing, Simulation training, Action research

Abstract

The Regional Department for Forensic and Security Psychiatry (RSA) in Oslo, receives patients with severe mental illness and serious abuse of violence, for psychiatric assessment and treatment. It is important to meet these patients with common attitudes to treatment and care in a safe environment. Teaching and interaction training in violence risk management is an important factor in ensuring this.

Despite the high degree of violence, there has been a lack of motivation among the staff to attend the training, which often consisted of unstructured role-play in which the participants were given different roles.

It was desirable to further develop the teaching methods through a structured action research project, so that the personnel should experience a more relevant and meaningful education and training.

The issue has been:

In what way can the education and interaction training program at RSA be developed so that role-play feels less intimidating to the participants and that they experience a relevant and meaningful education in relation to their clinical work with the patients?

Participant involvement has been the focus throughout the project. The principles “Learning by doing” (Dewey, 2007), “Learning is to discover” (Grendstad, 2004) and active participation in a practice community (Wenger, 1998). Hans-Georg Gadamer (2004) and his written words about hermeneutic has also been an important factor.

The participants wrote a log after each training session they attended, and the logs were used as data in the project. The participant’s thoughts, feelings and experiences in relation to actions that were tried out, were documented through the logs, and the training was adjusted in proportion to the participant’s wishes and needs. The data was analyzed using grounded theory, inspired by Bruce McKenzie and Kathy Charmaz. The SØT-model (Hartviksen & Kversøy, 2008) has been used in further development of teaching. The participants were asked about the individual’s situation now (S), the situation they wanted (Ø) and their suggestions for feasible measures (T) to achieve the wanted situation.

Role-play and simulation of situations have been the main content of the training and education at RSA for thirty years, and feedback has shown that many of the personnel feared the role-play. Oslo University Hospital (OUS) has a simulation center, SIM-Oslo. This works as a training unit in which simulations of both medical and psychiatric scenarios is trained with emphasis on pedagogical methods. The model was adapted to RSA`s use, and scenario-simulation training with structured debriefing and summary, replaced the previous role-play.

It was concluded after the project, that a structured plan for participant involvement in further development of the education, has proved to be a motivational factor for the participants, and that they experienced the scenario-simulation training as more realistic than role-play.

Educational Goals

- Participant involvement in development can be used as a motivational factor for the participants
- The SØT- model is a useful tool when you want to improve something in your practice

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De-escalation from theory to practice

Workshop

Kenneth Juel & Michael Aaldering (Denmark)

Abstract

A workshop "how to de-escalate". Presenting how The Psycho-Physical Consultants in Denmark are training "how to de-escalate" and taking the subject from theory to practice. Volunteers from the audience get involved in the practical exercises after a short presentation of theory behind de-escalate techniques.

Purpose

Guide the patient to a calmer mentally and physical state of mind and creating a safe environment, that helps the patient to regain control.

Method

De-escalation by The Psycho-Physical Method is a complex, interactive process, where the patient is supported in calming down, with a focus on safety, cooperation and roles by the staff when de-escalating the patient.

The staff is introduced to the technics to be used when to de-escalate a patient. Working with switching focus, time, intimate sphere, recognition and understanding, derivative, timeout and exit strategies.

The first practical exercise "meeting the patient", illustrates the necessity to focus on staff location, the patient's location, intimate sphere, comfort zone, safety and strategies.

The second practical exercise is a "team exercise", that will train the staff in the roles and techniques of de-escalation. The staff will be trained to work in a "safe zone" and how to work together and take care of each other's safety, while they have different roles and are using the de-escalations techniques to calm down the patient.

When succeeding in de-escalating the staff is also creating a safe environment for both the patient, fellow patients and the staff itself. Making it possible creating a safe environment for both patients and staff, means necessity on training and implement in preventing conflicts, risk assessment, roles in staff and cooperation, de-escalate, when to use time out or exit-strategies and knowing what to do, when preventing and de-escalation is no longer possible, but use of force or restraint is necessary.

Training "how to de-escalate" based on The Psycho-Physical Method, combine over thirty years of theoretical and practical experience in conflict management, violence prevention and gentle use of force and restraints, with evidence-based elements from Safewards, with over twenty years of research in reducing the risk of use of force and restraints.

Educational goals

- Staff is getting knowledge on de-escalation techniques and strategies when de-escalating.
- Staff is getting knowledge and knowhow on roles and cooperation when de-escalating.
- Staff is getting knowledge and knowhow on when to de-escalate or when to retreat.

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Chapter 20 – ENTMA presentations / contributions

Prevalence of manual restraint and characteristics of the team that restrained patients in Iceland

Poster

Jón Snorrason, Jón Friðrik Sigurðsson & Hjalti Einarsson (Iceland)

Keywords: Manual restraint, response team.

Abstract

Aim

The management of violence has been part of psychiatric practice for many years. Much has been done to prevent it and respond to it in a professional way. While it is uncertain whether it can be completely prevented, it is necessary to continue investigating it and seek ways to respond to it in the best possible way. The aim of this study was to find out how often a response team on the psychiatric hospital in Reykjavík was called for help, how often it had to restrain patients, the age and gender of the patients, on what days patients were most often restrained and the time of the day, the diagnoses of patients who were restrained, on what days after admission patients were restrained, the most common types of violence patients used, on what units patients were mostly restrained, what had happened before they were restrained and for how long time the patients were restrained. Also some characteristics of the team were studies e.g. the gender combination, the physical strength and physical height of the team members, the confidence of the team members, injuries of patients and team members, professionalism of the team and how the team were able not to use restraint.

Method

This is a longitudinal study that examined data from 21.10.2014 to 20.10.2015 in the Landspitali - University Hospital in Iceland. Every time that the response team was called for help information was sought about the patients it had to restrain and a questionnaire was sent to all four team members for each incidence.

Result

The response team was called 148 times in one year. The team had to restrain 56 patients, 85 times. The mean ages of the restrained male and female patients were 37 and 30 years, respectively. Patients were most often restrained on Wednesdays, between 12 and 24 hundred hours, during the first 48 hours after admission. Most restraint patients had substance abuse problems. Physical violence against staff was the most common anticipator for physical restraint. Most restraint took place in the psychiatric intensive care unit. A questionnaire was sent to 592 members of the team. The response rate was 32%. The majority of response team members were males. Those who had little or no self-confidence restrained the patients more often than those who had high self-confidence; self-confidence did not depend on the

gender of team members. Only four members said that patients got injured and three team members were injured during restraint. 61% and 32% of team members said that the professionalism of the team had been high and medium, respectively. Most members thought the restraint had lasted less than 10 minutes. Finally, the team members said the reasons why it did not have to restrain patients were professionalism (self-regulation, calming approach, assertiveness, good arrangement, courtesy, patient allowed to ventilate), experience, and skilfulness.

Conclusion

Violence and management of violence is a complex issue. The data about the response team can be helpful in terms of opinions regarding team composition as f. exp. gender of team members, physical strength and height of team members.

Educational Goals

- The research can give ideas about how a response team should be built up and how a response team can manage violence without manual restraint.

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Chapter 21 – Other related themes

Psychiatric Nurses' Experiences with Anger Compared to Nurses in General Wards

Poster

Naoko Shibuya & Risa Takahashi (Japan)

Keywords: Psychiatric Nurses, Experience of Anger, Questionaire, Path Diagram, Structural Equation Model

Abstract

Introduction

This study's objective was to explore certain questions: nurses' anger in various hospital wards, when did nurses feel anger in patient settings, what differences were there in the expression of nurses anger? and what paths that anger followed.

Aims

To investigate differences in the experience of anger between psychiatric nurses and general nurses; differences between the two groups in their strength of anger; investigate what influences the strength of anger for two nursing groups; create a causal model showing how a psychiatric nurse first experiences angers and its consequences.

Methods

Participants were 295 nurses working in 9 psychiatric hospitals in Japan. The authors assessed by questionnaire nurses' experience of anger, a description of nurses' anger toward their patients at work (surgery, internal medicine), nurses' anger toward their patients at work (psychiatry). Ethical considerations: This study was approved by the Chubu University Ethical Review Committee.

Results and Discussion

Characteristics of the psychiatric nurses:(1) Age:41.14years (SD=11.26), (2)Experience as nurse: 16.69years(SD=10.31), (3) Years of psychiatric experience:11.50years (SD=8.78).
The strength of each nurse's anger was analyzed for general wards and psychiatric wards. The analysis employed a t-test. Results showed a significant difference between nurses in general wards (N=181) and psychiatric nurses (N=259. The average value for nurses in general wards was 5.93 (SD=2.33) and for psychiatric nurses,5.44 (SD=2.33).

Results of multiple regression analysis. In general wards, anger was only strongly aroused when there was "loss of personal pride. In contrast, in psychiatry, anger was aroused when five of the injury items were felt; for instance, when there was a loss of personal pride or when there were behaviors that "violated expectations (e.g. a patient with borderline personality disorder insulted

someone in the same room).These results demonstrate that factors influencing strength of anger in general and psychiatric wards clearly differ. After nurses experience anger, what happens until they actually express it? The following process (causal model) was hypothesized: Experience with anger: ‘anger is caused’. response to anger (behavior they felt like doing; response to anger (behavior they actually did).

The investigation was conducted by generating a structural equation (path diagram), conducting a path analysis using SEM, and using the model’s goodness of fit index. Consequently, the following values were obtained: *f*Ô2(CMIN)=1196.6, GFI=0.77,AGFI=0.72,and RMSEA=0.087.The generally stated standard was not exceeded, but because the RMSEA was below 0.1. This clarifies the process until an actual behavior is executed and, at the same time, it demonstrates factors that influence the process.

Educational Goals

- Understand the promotion of nurses’ mental health by consideration and integration of the findings from nurses and the people with mental disorders.

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Restraints practices among psychiatric nurses in state mental health care setting, Karnataka, India

Poster

Raveesh B Nanjegowda, Sreevani Renetala & Ragavendra Nayak (India)

Keywords: restraints, psychiatry nurses, mental health care

Abstract

Background

Using physical restraints is a highly preferred practice in psychiatric wards. The main reason to use physical restraints in psychiatric wards is to prevent injury to patient and others and reduce violent behavior among mentally ill patients. Very few studies have been conducted in India about the use of restraints in psychiatric wards. This research study was conducted to determine the use of physical restraints and ongoing practices among nurses working at psychiatric wards.

Methods

This was a descriptive-cross sectional study done involving 50 psychiatric nurses. Nurses who agreed to participate in the study completed structured self-report questionnaire prepared by the investigators.

Results

The mean number of patients cared by each nurse per month was 52.88 and mean number of patients restrained by nurses per month was 7.74. Twenty percent of nurses reported that they use alternatives before employing restraint practices. Ninety percent of nurses reported using rolls of gauze as a restraint material. Ninety four percent of the nurses reported that they used four point restraints. A good number of nurses (68%) reported that the restraint procedure is limited to less than 2 hours. Only 4% of nurses reported receipt of written orders for use of restraints. Only twelve percent of the nurses reported that they received special education or training about restraint practices. There was a significant association between ages of the nurses with number of patients cared.

Conclusion

For a better nursing care it is very important to develop a restraint practice protocol and educate nurses to provide awareness about this highly used practice in mental health care setting.

Educational Goals

- There is lack of scientific studies in India about the use of restraints in psychiatric wards.
- Assessment of existing restraint practices is necessary before developing an educational program or indigenous guidelines to provide quality care in psychiatric hospitals.

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Reduction of patient assaults on the inpatient psychiatric units of an inner city hospital as a Quality Improvement Project using the PDSA Cycle

Poster

Lizica Troneci & AnnMarie McDonald (USA)

Keywords: assault, violence, psychiatric unit, quality improvement, PDSA cycle

Abstract

Background

St. Barnabas Health System (SBH) is a community based hospital, providing services to a diverse and psychosocially challenged patient population in the Bronx, New York. Reduction of patient assaults on the inpatient psychiatric units is a major challenge as multiple risk factors have been shown to be implicated and strategies to help prevent and manage aggression need to be studied and tailored to the patient population. Quality improvement of various processes within an inpatient psychiatric unit is a dynamic yet challenging task. One common approach is the plan-do-study-act (PDSA) cycle which allows for rapidly testing a change - by planning it, trying it, observing the results, and acting on what is learned.

Methods

This study used the PDSA cycle model to analyze the patient assaults on to the two inpatient psychiatric units. The data were collected from incident reports filed over the course of one year (January 2016 through December 2016). "Assault" was defined as an attempt or apparent attempt to inflict injury upon another by using unlawful force, along with the ability to injure that person.

Results

After 3 PDSA cycles promoting the use of several interventions:

- Flagged patients on the daily inpatient unit census to reflect "Alerts" (e.g. V=violent)
- Initiated a weekly 30 minute outdoor group (3 patients, 1 security, 1 nursing) for the patients with the longest LOS(except unstable and potential for elopement)
- Initiated x1-2/week "Movie night" on each unit
- Enforced implementation of PMCS(Preventing and Managing Crisis Situations) strategies

Both inpatient psychiatric units showed substantial overall reduction in patient assaults.

Conclusions

Structured PDSA cycle is an essential tool for attempting process improvement to advance quality in health care. The present study suggests that such a process with well-defined goals, process measures, and regularly scheduled meetings of the quality improvement team led to a significant reduction in assaults.

Educational Goals

- To utilize the PDSA cycle model of improvement on inpatient psychiatric units
- To identify and implement interventions which can reduce assaultive incidents

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Psychometrics of the Staff Observation Aggression Scale – Revised version (SOAS-R) in chronic psychiatric patients

Poster

Nienke de Bles, Elise van Wijk, Manoek Brobbel, Nathaly Rius-Ottenheim, Bert van Hemert & Erik Giltay (Netherlands)

Keywords: SOAS-R, psychometrics, aggression, psychiatric patients

Abstract

Introduction:

Aggressive behaviour frequently occurs in psychiatric inpatient wards. The revised version of the Staff Observation Aggression Scale (SOAS-R) is one of the observer-rated scales to measure the nature, number and the severity of aggressive incidents.

Aims

This study aimed to investigate the psychometric properties of the SOAS-R, as previous psychometric studies are scarce. A better understanding of the psychometric properties of the SOAS-R would contribute to the accurate assessment of the severity of aggressive incidents.

Methods

This study was conducted at several institutions for long-term psychiatric inpatient care. Four enacted aggressive incidents scored by multiple nurses working at the participating institutions were used to calculate the inter-rater reliability (IRR). The validity and reliability of the severity scoring system of the SOAS-R is assessed by a Multidimensional Item Response Theory (MIRT) analysis on the many dichotomous component items and the Visual Analogue Scale (VAS) of the SOAS-R forms of the training sessions, and the intervention phase, as part of a pragmatic randomized intervention trial.

Results

The internal consistency and IRR were adequate (ordinal á = 0.75; intraclass correlation coefficient = 0.62). Scale items showed differential psychometric characteristics in our analyses. The VAS demonstrated an excellent interval scale relationship. The test information curve indicated that the SOAS-R was most accurate and informative for aggressive incidents with a severity above the mean.

Conclusions

The SOAS-R was show to be a reliable scale to score aggressive incidents at the higher end of the severity range, but lacked discriminative power at the lower end. Our methodology may help to propose some changes in the scoring system of the SOAS-R.

Educational Goals

- The SOAS-R is a reliable scale with adequate agreement among rating nurses.
- The SOAS-R has less discriminative power to differentiate between milder aggressive incidents (e.g., involving shouting and cursing), but excellent discriminative power in the range of higher severity (e.g., involving punching and kicking).

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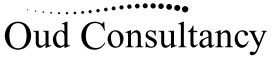
Announcement

The 11th European Congress on Violence in Clinical Psychiatry will be held in Oslo – Norway from the 24nd till the 26th of October 2019.

Congress Venue & Hotel will be the Thon Hotel Arena, Nesgata 1, 2004 Lillestrøm, Oslo, Norway

Please reserve these dates in your diary.

Supporting Organisations



Patrick Callaghan - Nico Oud - Henk Nijman
Tom Palmstierna - Joy Duxbury

"Creating collaborative care: a multi-partnership approach"

Ceud Mile Failte to Dublin, Ireland's fair, friendly and hospitable capital. A city of great music, fun festivals and historic locations, and, in 2017, the host of the 10th European Congress on Violence in Clinical Psychiatry.

Scholars the world over gather to debate contemporary issues in the prevention, treatment and management of violence in mental health and beyond. This year the Congress theme, 'Creating collaborative care: a multi-partnership approach' showcases our commitment to working in partnership with people using services and their advocates, health and social care agencies, policy makers, as well as the independent and voluntary sectors around the globe. This year's Congress also recognises the need to consider the effect of violence on displaced populations, those in conflict, and marginalised communities, and the implications these have for the prevalence of mental distress.

This year we celebrate 25 years since the inaugural Congress in Stockholm in 1992. In that time, we have witnessed huge strides in the advancement of our knowledge and understanding of violence in clinical psychiatry. Indeed, we have reported much of these advances at our various congresses. Throughout this time, we have remained true to our vision to gather the best evidence and use it to transform care.

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