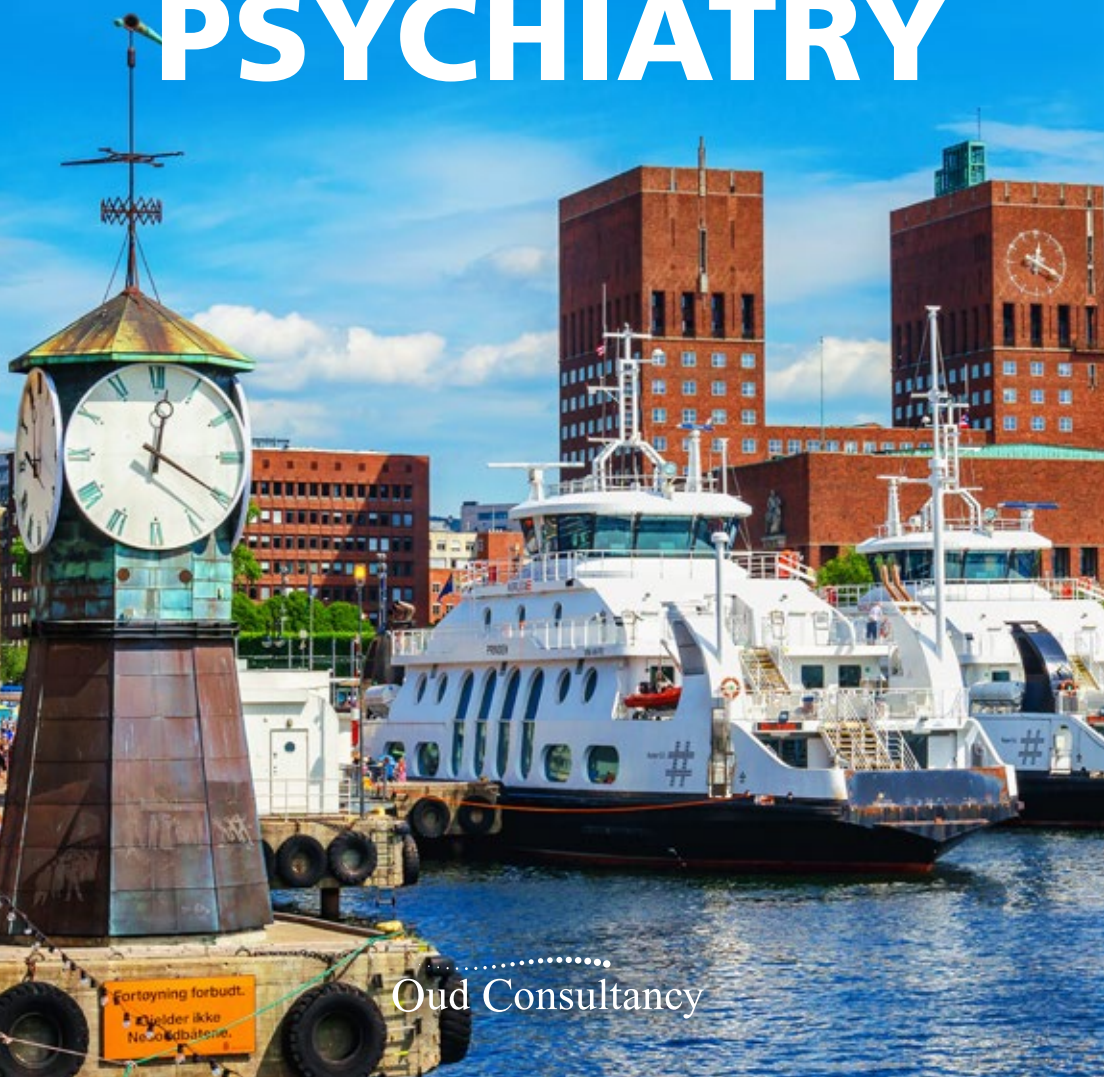


*Patrick Callaghan - Nico Oud - Henk Nijman
Tom Palmstierna - Joy Duxbury*

Proceedings of the 11th European Congress on

VIOLENCE IN CLINICAL PSYCHIATRY



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Violence in Clinical Psychiatry



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

Editors

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Oud Consultancy & Conference Management
Hakfort 621
1102 LA Amsterdam
The Netherlands
Telephone: +31 20 409 0368
Telefax: +31 20 409 0550

conference.management@freeler.nl
info@oudconsultancy.nl
www.oudconsultancy.nl

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Preface

Norway's capital and most populous city Oslo, hosts the 11th European Congress on Violence in Clinical Psychiatry. Once again, the Congress is co-organized by the European Violence in Psychiatry Research Group (EViPRG) and the European Network for Training in the Management of Aggression (ENTMA⁰⁸), and will be a World Psychiatric Association (WPA) co-sponsored meeting.

Since its inception 27 years ago, a central feature of the Congress has been its focus on presenting clinically relevant and practically useful interdisciplinary scientific and practical knowledge on preventing violence, reducing its incidence and impact, managing its consequences and understanding how and why it manifests itself. The Congress' purpose is to present the best available evidence that will be of use to anyone with a keen interest in the subject, be they clinicians, researchers, educators, policy makers, or mental health service users and their carers.

“Unravelling and understanding violence in clinical practice”, is this year's Congress theme. The range of evidence generated over many years, often by delegates at this conference, has aided our understanding of violence in clinical psychiatry. Nevertheless, much remains to be unravelled, and knowledge that we thought was well understood, the value of risk assessment, for example, is being re-examined. Having looked in detail at the keynote papers, workshops, symposia and posters, we are confident that this year's Congress will showcase intellectual, practical and humane solutions to the problems it uncovers.

This year's Congress sees the usual distinguished gathering of international experts from all corners of the globe. There are those researching violence and aggression, providing education, delivering, and managing, clinical care, as well as those living with the reality of violence in their day-to-day lives, experts by experience.

Our keynote papers have once again attracted leading lights from across the world. Professor Kevin Douglas from Canada draws together the current state of art of what we know about violence risk assessment and management, and where we should be heading next. In contrast, Professor Linda Groning from Norway, takes a more conceptual approach examining how the law conceptualizes mental disorder and its relationship to violent crime. Dr Wilma Boevink from the Netherlands, discusses the possibilities and pitfalls of a charter for collaboration between service users and professionals in tackling violence in clinical settings. Increasingly, we have seen an increase in the study of how physiological processes relate to violence. Measuring nurses skin conductance using biosensors and testing the impact on nurses' burnout and how this in turn impacts on episodes of patient violence is an interesting study that Peter de Loeff and colleagues from the Netherlands will present. We are pleased to welcome back to the Congress one

of the leading international researchers in the field of violence in clinical psychiatry: Professor Stål Bjørkly from Norway. This time out Prof Bjørkly turns his attention to reviewing just what the evidence tells us about the impact of risk management interventions, an often-under-represented area of investigation and an issue that lacks high quality studies of the effect of risk management interventions. Our penultimate keynote speaker, Professor Gerben Meynen, from the Netherlands examines one of the most debated concepts in international jurisdiction: legal insanity, revisiting the McNaughton law in particular. Our final keynote lecture, that Dr Pål Grøndahl from Norway will deliver, revisits a painful episode in Norway's recent history, the terrorist atrocities in July 2011. In what promises to be a moving presentation, Dr Grøndahl, focusses on what lessons can be learned from this dark episode.

We have expanded the sub-themes to truly capture a wider range of presentations. Of particular note this year are concurrent sessions examining violence in children and young people, those with dementia and work investigating the role of new technologies, including virtual reality.

We also have an interesting, and sometimes provocative array of posters, workshops and symposia. We welcome the number of interactive sessions that will involve collaborations between presenters and their audiences to resolve everyday clinical challenges. The many sessions seeking to develop more humane and safer ways of providing mental health care to reduce violence and aggression is notable. It is also evident that mental health service users continue to play a key role in co-designing interventions, and the structure, organisation and delivery of services. This is especially welcome.

Prof Dr Patrick Callaghan

Mr Nico Oud MNSc

Prof Dr Henk Nijman

Prof Dr Tom Palmstierna

Prof Dr Joy Duxbury

Welcome and historical background

The scientific committee welcomes all psychiatrists, practitioners, (psychiatric mental health) nurses, psychologists, health scientists, educators, trainers, researchers, managers, and policymakers engaged in the prevention, management, research into violence and aggression in mental health and intellectual disability settings here at the 11th European Congress on Violence in Clinical Psychiatry, in Oslo / Lillestrøm, Norway, 24 – 26 October 2019.

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 Tom Palmstierna as his scientific secretary. The Congress was held at the Swedish Medical Association, 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 (EVI PRG) founded in 1997. Following the success of this partnership all subsequent Congresses were co-organised with EVI PRG with the aim of bringing the latest science of violence and aggression to clinicians, researchers and managers.

London in the Summer of 2003 was the venue for the third Congress organized by Tom Palmstierna and Gerd Nyman, supported by the Addiction Center and Prof. Stefan Borg and involved 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 EVI PRG. Since 2011 the World Psychiatric Association (WPA) co-sponsored the meeting. Since 2015 the European Network for Training in the Management of Aggression (ENTMA⁰⁸) has been a collaborator in the organisation and delivery of the Congress.

In 2019 the congress will be held in Oslo / Lillestrøm - Norway. 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. Some congresses were attended by about 600 participants from 36 countries worldwide.

In line with previous congresses in Vienna (2005), Amsterdam (2007), Stockholm (2009), Prague (2011), Ghent (2013), Copenhagen (2015) and Dublin (2017). All contributions to the 11th European Congress on Violence in Clinical Psychiatry will be published in a “*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 11th European Congress on Violence in Clinical Psychiatry is co-organized by the European Violence in Psychiatry Research Group (EViPRG) and the European Network for Training in the Management of Aggression (ENTMA⁰⁸), and will be a World Psychiatric Association (WPA) co-sponsored meeting. The 11th European Congress on Violence will focus strongly on clinically relevant and practically useful interdisciplinary scientific and practical knowledge with regard to interventions aimed at treating and reducing violence and aggression. The overall congress theme: “*Unravelling and understanding violence in clinical practice*” reflects our commitment to partnership working between clinicians, researchers, educators, service users and carers.

Accreditation will be requested from the World Psychiatric Association (WPA) for the award of Continuing Medical Education (CME) Credits, and from the International Council of Nurses (ICN) for the award of International Continuing Nursing Education Credits (ICNECs).

The broad multi- and interdisciplinary scope of the European Congress on Violence in Clinical Psychiatry is expressed in the various subthemes that will be addressed in Oslo / Lillestrøm in 2019:

- Epidemiology and nature of inpatient violence against staff
- Epidemiology and nature of violence against patients / patients as victims
- PTSD & violence prevention and treatment
- Trauma informed care & practice
- Assessment of risk, prevention & protective factors
- Humane safe & caring approaches in and reduction of restrictive practices
- Neurobiological approaches and pharmacological therapies
- Psychological approaches & interventions
- Service users & family perspectives
- Race, gender, cross-cultural & ethnicity perspectives
- Ethical, human rights and legal perspectives
- Sexual offending violence
- Specific populations: forensics
- Specific populations: intellectually disabled / learning disabilities
- Specific populations: child & adolescent
- Specific populations: elderly / dementia
- Specific populations: community & ambulant care
- Training and education of (interdisciplinary) staff
- Application of new technology (media – social networks – information technology – e-learning – virtual environment)
- ENTMA⁰⁸ presentations / contributions
- Other related themes

The congress provides a wonderful opportunity to network and establish contacts with a diverse community of colleagues engaged in this important area of work. Apart from the geographical diversity of delegates, the Congress program reflects multiple perspectives including clinical/service, organizational, educational, research and regulatory. In order to maximize the potential contribution of networking opportunities the conference will include social activities:

- A complimentary welcome reception on Thursday the 24th of October 2019.
- A special social evening event / Conference Gala Dinner on Friday the 25th of October 2019. (Conference Gala Dinner is at additional cost).

Oslo has the distinction of being the largest city in Norway and the third largest city in Scandinavia region. The city has long historical heritage as it was founded by the King Harald Hardrade in 1048. The city is full of landmarks and attractions which can be explored by various modes including boat, local trains, bikes and taxis. The City Hall is the venue where the Nobel Peace Prize is awarded every year. If you want to experience the history of the town then head to Akershus Festning, a medieval castle and fortress, situated close the city center. The castle was built in 1299 and provides stunning viewpoints to the surrounding areas. Oslo is also well known for its museums such as Munch Museum and Nobel Peace Center.

Thon Hotel Arena is the conference hotel and is centrally located in Lillestrøm, right next door to the Norway Trade Fairs arena and a short walk to the train station. From the station, you can access both Oslo city centre and Gardermoen airport in just a little over ten minutes.

We cordially welcome you to Oslo / Lillestrøm – Norway in October 2019

Prof. Henk Nijman & Prof. Tom Palmstierna (Chairs of the Scientific Committee of the 11th European Congress on Violence in Clinical Psychiatry)

Prof. Joy Duxbury (EViPRG)

Dr. Brodie Paterson (ENTMA⁰⁸)

Mr. Nico Oud, MNSc, N.Adm, RN. (Congress Organiser)

Supporting Organizations

- European Violence in Psychiatry Research Group (EViPRG)
- ENTMA⁰⁸
- 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

- CONNECTING, Partnership for Consult & Training
- CONNECTING, Partnerschaft für Beratung & Training
- Karolinska Institute
- NAGS Deutschland e.V.
- BILD Restraint Reduction Network
- St. Olavs Hospital, Trondheim University Hospital
- The Psycho-Physical Consultants
- Oslo University Hospital
- Molde University College
- ForintForensisch Psychiatrisch Centrum Dr. S. van Mesdag
- University of Southern Denmark
- National Institute for the Prevention of Workplace Violence, Inc

The Scientific Committee

- Prof. Tom Palmstierna (Sweden) (chair)
- Prof. Henk Nijman (Netherlands) (chair)
- Dr. Roger Almvik (Norway)
- Dr. Hulya Bilgin (Turkey)
- Prof. Stål Bjørkly (Norway)
- Prof. Patrick Callaghan (UK)
- Dr. Mojca Dernovsek (Slovenia)
- Prof. Joy Duxbury (UK)
- Mr. Gunnar Eidhammer (Norway)
- Ass. Prof. Frans Fluttert (Netherlands)
- Prof. Sabine Hahn (Switzerland)
- Dr Alina Haines (UK)
- Dr. Mary E. Johnson (USA)
- Dr. Kevin McKenna (Ireland)
- Dr. Brodie Paterson (UK)
- Dr. Liselotte Pedersen (Denmark)
- Prof. Tilman Steinert (Germany)
- Mr. Bart Thomas (Belgium)
- Dr. Marie Trešlová (Czech Republic)
- Prof. Richard Whittington (UK)

The Organisation Committee

- Henk Nijman (Netherlands) (chair)
- Tom Palmstierna (Sweden) (chair)
- Joy Duxbury (UK)(chair on behalf of the EViPRG)
- Dr. Brodie Paterson (UK)(chair on behalf of ENTMA⁰⁸)
- Ass. Prof. Frans Fluttert (Netherlands)

- Patrick Callaghan (UK) (main editor of the proceedings)
- Nico Oud (Oud Consultancy – Congress Organiser)

The Local Committee

- Mr. Gunnar Eidhammer
- Ass. Prof. Frans Fluttert
- Marianne Løkken
- Lars Erik Selmer

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 endeavours 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 194 abstracts from 33 different countries worldwide, of which 16 (8%) were rejected, 15 (8%) were withdrawn mainly due to financial reasons or not getting funding in time, and 10 (5%) 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 163 presentations from 26 different countries worldwide were presented.

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Chapter 1 – Keynote speeches and special presentations

Violence risk assessment and management: What we know, and what we still need to focus on

Keynote 1

Prof. Kevin S. Douglas (Canada)

A great deal of progress has been made over the past three decades in the violence risk assessment and management field. The first third of this talk will recap what we know, and the latter two-thirds of this talk will focus on where the field should be heading in light of what we know.

What We Know

The field of violence risk assessment and management, in general, rests upon a solid evidence base. Across many hundreds of research studies, it is clear that risk assessments can be made with respectable reliability, and that judgments about risk made by professionals are indeed linked to future violence. That is, various contemporary methods of risk assessment possess respectable predictive validity. We also know that, with some exceptions, contemporary methods of violence risk assessment have shown trans-national and linguistic validity. That is, methods developed in one country or language, and then evaluated in another country or language, perform comparably. Further, although premised upon a smaller evidence base, we know that changes in dynamic risk factors – increases or decreases – tend to be linked to future increases or decreases in violence perpetration. Together, therefore, the evidence generally supports reliance on contemporary violence risk assessment methods to identify and monitor key risk factors, their changes over time, and hence the fluctuation of risk over time.

In principle, then, this body of evidence supports the application of risk-reducing interventions that are linked to a person's specific constellation of dynamic, or changeable, risk factors. However, it is this principle – linking violence risk assessment to risk-reducing intervention – that remains one of the most neglected areas of the field, and hence must still be focused upon moving ahead.

What We Still Need to Focus On

- (1) The field has reached asymptote in terms of knowing “*what predicts*” violence. There is a large, growing, and relatively consistent literature on predictive factors, and on risk assessment measures. There is also a relatively large literature on “*what works*” in terms of violence risk reduction and intervention. However, there is a much smaller literature on the crucial step of linking these two rich bodies of knowledge. This is particularly true in certain settings (health; workplace; forensic), but reasonably well accomplished in others (prison and corrections). As such, regardless of the setting, both clinical and research activities must move beyond the basic employment of risk assessment measures, or the mono-methodical application of interventions, and focus on finding the meaningful nexus between these two bodies of work. Such a focus has great potential to reduce violent behaviour most effectively and efficiently.
- (2) As described above, there are many hundreds of studies on violence risk assessment, and also many hundreds of studies on risk reduction. However, for the field to move forward, evaluative efforts need to shift to the reliable and valid implementation of these principles at the practical and systemic levels. That is, they must “*work*” for any given practitioner within a system, and they must work for the systems or agencies that adopt them. Knowing that a certain risk assessment measure predicts violence in a set of research studies is a very different thing than knowing that it is accepted by practitioners, that it helps people do their work, that it helps patients, and that it ultimately reduces violence within systems. This is a question that must rely on implementation science – that is, putting empirically supported practices into place in useful, useable ways. We know much less about this topic as it pertains to risk assessment and risk reduction than we do about risk assessment risk reduction themselves.
- (3) Violence risk assessment and management “*works,*” but does it “*work*” for everyone? This is a question of diversity, both in terms of settings, but also in terms of people. From a settings perspective, the question is a relatively pragmatic one relating to generalizability – does a method developed in Setting A (long-term forensic) work in Setting B (acute mental health)? There is slow but sure progress in this area.

The more challenging and problematic question is whether contemporary measures and methods used in risk assessment and management “*work*” or are “*fair*” for people of all backgrounds (ethnicity; nationality; gender). There have been clear and serious legal challenges to some contemporary methods of risk assessment in North America, Australia, and elsewhere, that such methods essentially are untested or under-tested for certain groups of people, and hence should not be used, or, that they are discriminatory, and hence also should not be used. Examples will be provided in the presentation.

It is crucial to ensure that measures and practices that can deprive people of liberty on the one hand, and that bear upon public safety, on the other, have been shown both to “work” for all persons to whom they are applied, but also that they do not, by their nature, contain legally objectionable risk factors, as some are accused of. Moving forward, therefore, there is a pressing need to incorporate diversity and fairness into the regular and routine development, evaluation, and employment of risk assessment and management measures and practices. Not only are courts requiring this around the world, but it is simply the right thing to do.

Correspondence

Kevin S. Douglas, LL.B., Ph.D.

Centre for Research and Education in Forensic Psychiatry, Haukeland University Hospital, Bergen

Simon Fraser University, Canada

Centre for Research and Education in Forensic Psychiatry, Oslo University Hospital
douglask@sfu.ca

Mental disorder and violent crime: Legal concepts, distinctions and problems

Keynote 2

Prof. Linda Gröning (Norway)

This lecture approaches mental disorder and violent crime from a legal, criminal law point of view. Its core topic is how the law conceptualizes mental disorder and how it relates to (violent) crime.

The lecture involves an explanation of the concepts of a crime, criminal accountability and punishment, and how these concepts in law are linked to concepts about mental disorder.

Furthermore, the lecture suggests a constitutional perspective to the criminal law, emphasizing the values of individual autonomy and equality, as the basic justification for rules concerning mental disorder and crime.

From that perspective, the discussion draws attention to certain problematic issues in current legal and forensic practices.

Correspondence

Linda.Groning@uib.no

Towards a charter for collaboration between users and professionals

Keynote 3

Dr. Wilma Boevink (Netherlands)

Wilma Boevink is a social scientist at Trimbos Institute, currently involved in the development of the Dutch User Research Center, a network of ‘*Scientist-Users*’ in close co-operation with Maastricht University. She is also a parttime ‘*strategic advisor recovery*’ at GGNet, a large mental health care organization. Because of her experiences as a patient in psychiatry she developed into an ‘*expert by experience*’. In a combination of roles, but also through many publications, lectures and consultancy she is an advocate for persons who suffer from severe and disruptive mental dis-tress and for those close to them. She is board member of the Union for Experiential Experts and of Psychosenet (www.psychosenet.nl). Together with Jim van Os, Philippe Delespaul and Michael Milo she is striving for ‘*The new mental health care*’. They published a book on this subject in 2016.

After having received the ‘*Parelprijs*’ from ZONMw and the Douglas Bennett Award for her work, she was honoured with an oeuvre award from Fonds Psychische Gezondheid. She received this prestigious price because of the remarkable way in which she – based on experiential knowledge and expertise – inspires persons with severe mental health distress to develop their strengths and talents for the sake of their recovery.

Planting a Tree - On Recovery, Empowerment and Experiential Expertise
<https://www.trimbos.nl/docs/e5b58bcc-d191-4b8a-9113-7b9cddb92624.pdf>
<https://www.youtube.com/watch?v=qq7eABQavB4>

Correspondence

Vereniging voor Ervaringsdeskundigen (VvEd)

www.vved.org

User Research Centre (URC)

www.urc-hee.org

Trimbos-instituut

Da Costakade 45

3521 VS Utrecht

The Netherlands

wboevink@trimbos.nl

Predicting aggression of patients and burnout symptoms in nursing staff with the use of biosensors

Keynote 4

Dr. Peter de Looff (Netherlands), Dr. Liza Cornet, Dr. Matthijs L. Noordzij, Dr. Mirjam Moerbeek, Prof. Dr. Robert Didden, Prof. Dr. Petri Embregts, Prof. Dr. Henk Nijman

Keywords: aggression, burnout, wearable technology, heart rate, galvanic skin response, forensic care

Our research focused on the associations between ambulatory physiological measurements with biosensors and both burnout symptoms in nursing staff and aggressive behaviour of patients with MID-BIF (mild intellectual disabilities to borderline intellectual functioning). This text is a modified version of chapter 8 of the dissertation by Peter de Looff which can be found here (1). The research presented at the conference was conducted from 2014 to 2018.

Pilot study

We started out with an exploratory pilot study that investigated the association between skin conductance levels (i.e. an autonomic nervous system marker) with different shifts and ward activities in forensic nursing staff (2). The aim of the study was to investigate whether specific working times were associated with higher levels of skin conductance, and to gain insight into whether certain ward activities appeared to be associated with higher levels of skin conductance. The study showed that the skin conductance level of 10 psychiatric nurses significantly differed between day, evening, and night shifts. The average skin conductance level turned out to be nearly twice as high during evening shifts when compared to the other shifts (3.2 μ S vs 1.8 μ S and 1.7 μ S). Although arousal levels vary as a consequence of diurnal variation in skin conductance (3,4), the differences found in the study were substantial. This is an indication that an increase (instead of the current decrease) of staffing numbers during the evening shifts on wards caring for patients with MID-BIF may be helpful for the ward staff to meet the demands during the evening shift. Note that during the evening healthcare professionals such as psychiatrists, psychologists, occupational therapists etc. are no longer available, leaving the direct ward staff with the entire patient case load on the ward, while having to perform several demanding (and potentially stressful) tasks. In discussing the results with the nurses, the temporal variations in skin conductance suggest that arousal-increasing tasks or moments may have been handing out (and arguing over) medication,

testing the alarm system, hand-over meetings for the next shift, discussing the day and preparing for meals.

However, it should be noted that the study design and the limited sample size do not allow for drawing any firm conclusions. In addition, we hypothesized that specifically neuroticism from the Big Five personality test (5,6) would be associated with higher skin conductance levels. Despite the small sample, neuroticism was indeed found to be positively associated with the skin conductance level. In line with this, Boucsein (7) noted in his standard textbook about electrodermal activity that Eysenck in 1967 already hypothesized that "individuals scoring high on the personality dimension emotional lability should exhibit a higher tonic level as well as hyper reactivity of the limbic system, especially under conditions of stress. In the early 1970s, a high correlation between this trait and EDA had been regarded as being one of the most established results in psychophysiological personality research (.....), which was, however, questioned later (...)." (7; pp. 396-397). A more recent Dutch study from Penterman et al. (8), however, reported that caregivers working at a psychiatric emergency response unit had lower neuroticism levels in comparison to the general population. Earlier, Bowers et al. (9) found a negative correlation between neuroticism and how secure staff members felt in working with forensic patients with severe personality disorders. Possibly, high neuroticism levels may make people less suitable for working with patients that have increased risks of becoming aggressive.

Systematic review

During this pilot study, new devices became available on the market which measured both skin conductance and heart rate (10). This opened up new opportunities for the inclusion of heart rate measures. This also led us to first investigate the association between both heart rate and skin conductance with job stress and burnout in a systematic review (11).

Several outcomes of the systematic review are worth noting. First, no studies on skin conductance could be included because there had not yet been any studies performed on the associations between skin conductance and burnout that met the inclusion criteria, and thus no indicator of pure sympathetic arousal was available (i.e. heart rate [variability] measures are either mixed or parasympathetic in nature). Second, in general higher heart rate consistently has been found to be associated with higher levels of job stress. The results on burnout were less conclusive and there were fewer studies that published results on the heart rate-burnout association. Third, lower levels of HRV are associated with higher levels of job stress. Again, fewer studies were reported on the HRV-burnout association, therefore the association between heart rate and burnout is less clear.

Burnout studies

We conducted two studies into the associations between physiological indicators and burnout symptoms in nursing staff. These studies included aggressive behaviour of inpatients as this has been associated with the increased risk of developing a burnout in previous studies (12,13). Both physical and other forms of aggression were also associated with higher levels of both emotional exhaustion (14,15) and depersonalisation (16).

Study 1

For the first, correlational study (17), 110 forensic nursing staff members completed questionnaires measuring experiences with aggressive behaviour, burnout, emotional intelligence, personality, and job stress during four waves of data collection across a 2-year period. The first study reported on the first wave of data collection. In addition, the staff members wore an Empatica E4 (10) to measure heart rate and skin conductance during a workday. The aim of the study was to explore the association of type and severity of aggressive behaviour as experienced by nursing staff and the level of burnout symptoms reported by staff members. Moreover, the moderating roles of personality characteristics and emotional intelligence were studied. Earlier research on personality indicated that there may be a positive association between burnout and neuroticism, and negative associations between burnout and extraversion, conscientiousness and agreeableness (6). Besides personality, recent research indicated that emotional intelligence and burnout dimensions were negatively associated (18–21).

The results of the study indicated that experiencing physical aggression was positively associated with staff's burnout symptoms (in terms of emotional exhaustion and depersonalization). Although the correlations are modest, the results suggested that being confronted with physical aggression during work increases the risk of burnout symptoms. In addition, it was found that stress management skills, a subscale of emotional intelligence, but not personality, moderated this relationship. Remarkably, the association between experiencing aggression and burnout symptoms was highest for staff reporting a higher number of stress management skills. Surprisingly, skin conductance was not associated with burnout symptoms in the correlational study. This outcome was neither in line with the hypothesized association nor in line with previous findings that (the amount of) non-specific skin conductance responses are a valid indicator of emotional strain (7; pp. 460-462) or chronic stress or fatigue (22) as reflected in burnout symptoms.

Study 2

Several authors (23–25) called for longitudinal studies that investigate the mediators and moderators that are associated with burnout symptoms. We therefore investigated

if individual changes in burnout symptoms were associated with job stress, patient aggression, personality, and emotional intelligence over time in the second study (26). In addition, it was investigated if these variables moderated the associations over time. Lastly, the usefulness of ambulatory measures was investigated further, and heart rate was included. For this study, we assessed burnout by summing the three subscales of burnout as there is no clear definition of clinical burnout (27,28). Moreover, with the summation of the three scales, no information is lost and we were able to assess the amount of burnout symptoms of staff members caring for forensic patients with MID-BIF. Job stress (16,29) and aggression (13) were hypothesized to be risk factors for developing burnout over time, while several personality characteristics (6), emotional intelligence (30) and social support (31) were identified as potential protective factors. Most remarkably, the results showed an increase in 1 burnout category over a two-year period. The multilevel models resulted in four main conclusions. First, the predictors of emotional intelligence, neuroticism, altruism, job stress, and patient aggression were associated with burnout over time; The standardized model indicated that emotional intelligence was the strongest predictor, followed by job stress, neuroticism, altruism, and finally aggressive behaviour. Second, the predictors did not moderate the association over time, which indicates that the association is similar at different levels of the included predictors. Third, as for skin conductance, it should be noted that only the amplitude of the skin conductance assessments was associated with burnout symptoms over time. Interestingly, this physiological effect was significant after controlling for the other *'psychological'* predictor variables. This finding suggests that changes in (the amplitude of) skin conductance is a possible indicator of increasing burnout symptoms, but more research is necessary to investigate this potential association. Several parameters of skin conductance ([i.e., skin conductance level, skin conductance peaks per minute, area under the curve of these peaks, amplitude of these peaks, width of these peaks, rise time of the peaks, and decay time of the peaks) were tested in association with developing burnout symptoms, it cannot be ruled out that an association of burnout symptoms with a lowered amplitude of the skin conductance peaks was found by chance. However, the power analysis indicated that a sufficient sample size was used. Fourth, social support did not moderate the development of burnout symptoms over time which indicates that the association is similar at different levels of the included predictors. Note that social support, which is a subscale of job stress in our study, was a predictor of burnout symptoms.

Aggression study

In our most recent study, the results of physiological assessments with the wearable devices in association with aggressive behaviour in patients are presented (32). Most of the research into the association between physiology and violent and aggressive behaviour was conducted in laboratory and experimental settings (33). The aim of the study was to investigate these associations in a naturalistic setting of (forensic) psychiatric treatment facilities for patients with MID-BIF. It was hypothesized

that aggressive behaviour was preceded by a significant rise in heart rate and skin conductance compared to baseline levels when the patient is not aggressive. In addition, the time period before the aggressive behaviour was assessed to investigate the changes in physiological parameters. Moreover, the influence of psychopathy was assessed as this was expected to result in lower levels of skin conductance preceding aggressive behaviour (33). The multilevel models indicated that rises in both skin conductance and heart rate are visible up to 20 minutes preceding aggressive behaviour controlling for within-subject variation. This indicates that these parameters might be promising for aiding the early detection of imminent aggressive behaviour. Unfortunately, it was not investigated what could have contributed to the rise in heart rate and skin conductance preceding aggressive behaviour which might be an interesting area of study. The participants who showed aggressive behaviour had slightly lower levels of skin conductance levels (SCL), non-specific skin conductance response per minute (PPM) and heart rate (HR) on average. In addition, there was a positive association between PPM, SCL, HR and number of aggressive incidents. These findings show that both skin conductance and heart rate rise significantly preceding aggressive behaviour, and might be used as predictors of imminent aggression. However, more research is necessary to investigate these associations further and to attempt to develop (personalized) models with an increased accuracy of the predictions. Nevertheless, the finding that several of the physiological measures showed significant (and consistent) changes over time before the first behavioural manifestations of aggression became visible to the staff members is a very promising and important result for the prevention of (the consequences of) inpatient aggression that warrants further study. Contrary to our expectations, no support was found for the hypothesis that psychopathy was a covariate in any of the fitted models (33–35). However, the mean PCL-R psychopathy score of the patients who participated in the study was ‘only’ 15.04 (SD = 7.59), whereas in Europe a cut-off score of 26 or higher, or even 30 or higher, is often used for diagnosing ‘*psychopathy*’ (36,37).

Future research

Several directions for future research aimed at the prevention of burnout symptoms of staff and aggression incidents of patients can be identified. Considering the high burnout, sick leaves and attrition rates among psychiatric nursing professionals (12,29), we feel that more research on the direct impact of working with aggression-prone forensic psychiatric patients on stress levels of nurses is warranted, and these studies should specifically focus on the impact it has on the autonomic nervous system as this is closely associated with cardiovascular disease, metabolic disease, and obesity (38), but also on measures of burnout and stress as became apparent in the current research. Moreover, aggressive patients have a higher risk for coercive treatment or seclusion (39) which also increases the risk of negative treatment outcomes (29,39). Therefore, efforts have to be made to detect changing levels of physiology associated with burnout symptoms in nurses or imminent aggressive behaviour of patients.

One of the most important directions for future research would be the need for longitudinal data on the associations between physiological predictors and both burnout symptoms in nursing staff (29) and aggressive behaviour in patients (13). In accordance, there is a need for larger sample sizes which provides more power to discover a true effect (40). Longitudinal data with larger sample sizes can be used to study specific causal relationships and distinguish between various mediators and moderators (41). For example, and this point was also made by Winstanley and Whittington (13), aggressive encounters could be causally related with an increase in burnout, most notably on the emotional exhaustion and depersonalisation scales. However, an alternative explanation might be that elevated burnout symptoms might lead to susceptibility of victimisation. Future research should focus on specific combinations of moderators or mediation effects in the development of burnout symptoms, which is especially relevant considering there is a growing literature on longitudinal mediation analysis (42,43) which makes it easier to estimate complex longitudinal growth models. Moreover, it might contribute to the development of theory on the development of burnout symptoms in nurses and aggressive behaviour in patients and their association with the predictive validity of physiological measures. Also, it will contribute to interventions that are targeted at reducing burnout symptoms and aggressive behaviour (29,44,45). In future studies, it may also be preferable to investigate (even) more aggression prone, high risk, patients as this might increase the number of physical aggressive incidents which presumably may have more detrimental and more arousing effects. However, it is worth noting that even with a relatively high number of verbal aggressive incidents compared to physical aggressive incidents, we found rising levels of physiological parameters towards aggressive behaviour. Future research should make an effort to include more physical aggression incidents, and potentially also more incidents concerning sexual aggression, auto aggression, and aggression against objects, as these were underrepresented as well.

Future research should also be used to increase the validity and reliability of the predictive models. Studies should be targeted at determining the specificity and sensitivity of these physiological markers in association with burnout and aggressive behaviour which was beyond the scope of the dissertation. The question is whether the differences in physiological markers are pronounced and specific enough to be clinically relevant and helpful to signal changing levels of burnout symptoms or signal imminent aggressive behaviour, and will allow for making (personalized) prediction algorithms that are useful to prevent (the negative consequences of) both burnout and aggressive behaviour in clinical practice. Two points are worth mentioning related to the distinctiveness of the physiological markers. First, a major point of concern is the fact that the wrist may not be the best location for detecting emotion-related data like stress, burnout, or aggression. It was suggested that the wrist is more closely related to thermoregulatory indices of the body (46) instead of emotion regulatory indices. Further research in this area is necessary. Second, it was pointed out that heart rate increases as a result of anger and anxiety, but also as a result of more positive emotions like happiness and joy (47). To strengthen the prediction, we might have to take multiple physiological

variables (heart rate, skin conductance, temperature, breathing) and parameters (peaks per minute, skin conductance level and heart rate variability parameters) in combination into account.

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Correspondence

peterdelooff@gmail.com

Evidence based violence risk management – What, how and why not ?

Keynote 5

Prof. Stål Bjørkly (Norway)

Oslo University Hospital and Molde University College.

Keywords: Evidence-based, risk management, violence, inpatient, mental health

Introduction

Definitions of Evidence based practice (EBP) in the health services have emphasized the use of current best evidence in making decisions about the care of individual service users. This practice means integrating individual clinical expertise with a critical appraisal of the best available external clinical evidence from systematic research (e.g Mears, 2007). Critics across scientific disciplines have asserted shortcomings such as; (i) how “*evidence*” should be defined and weighted against each other, (ii) how and when the patient’s and/or other contextual factors should enter the clinical decision-making process, (iii) the definition and role of the “*expert*”, and (iiii) what other variables should be considered when selecting an evidence-based practice. In spite of these objections EBP still have a strong position within the health services, including the mental health sectors. It is far from flawless, but probably the best approach to clinical practice and has given birth to a plethora of guidelines.

The ultimate aim of risk management of violence is to mitigate risk through prevention. Optimal management should be strategic and tactical by specifying what preventive steps that shall be taken and to provide resources and coordination. Management strategies are usually divided into monitoring, supervision, treatment and victim safety planning. This presentation will be limited to the treatment subgroup, and further limited to the milieu treatment context. Milieu treatment is defined here as a structured risk management strategy that is used in the ward. The strategy may be based on principles from dynamic psychotherapy, person-centred therapy, cognitive-behaviour therapy, nursing perspectives, etc.

Even if a steadily growing number of studies have been published examining a diversity of risk management strategies, little guidance exists on how good they are and what works for whom. Basic observation and recording of how often a strategy is used, the quality of it, and even the effect of it, are challenges inherent in the social context where it is implemented. Implementation and follow-up measurement of prevention and treatment strategies is easier in the intra-institutional than in the

extra-mural context. Hence, one may regard the hospital wards as laboratories or arenas for implementation research.

Aims

1. To conduct a small-scale literature search concerning EBP within the field of risk management strategies (**What?**)
2. To present and discuss some key challenges that must be solved to develop EBP in prevention of violence in mental health facilities (**How?**)
3. To discuss pros and cons for developing EBP in inpatient mental health care (**Why not?**)

What?

A preliminary literature search

I will start this presentation with findings from a preliminary literature review on the effect of risk management strategies in mental health facilities.

Inclusion criteria: Review or meta-analysis of Evidence-based practice milieu treatment methods for adult and adolescent persons with major mental illness. The intervention must be operationalised, observable and measurable, and with mitigating risk of violence as the specified outcome target.

Exclusion criteria: Seclusion, restraint and the use of prescribed medication.

Data bases: Preliminary literature searches were conducted in the following databases: PsycINFO, CINAHL, OvidMEDLINE® and Cochrane Database of Systematic Reviews.

Search terms: Review or meta-analysis and evidence-based practise and milieu treatment and risk management and violence or violent behaviour or aggression or aggressive behaviour and forensic or psychiatric patients.

Results: The searches resulted in six reviews for assessment. Only two articles met the inclusion criteria. One systematic review concluded that there were no relevant randomised controlled trials on the management of violence involving persons hospitalized with serious mental illness (Muralidharan & Fenton, 2006). Gaynes and colleagues (2017) found 17 studies of adult psychiatric patients in acute care settings. For prevention risk assessment reduced both aggression and use of seclusion and restraint and multimodal interventions reduced the use of seclusion and restraint. However, all studies had low strength of evidence (SOE) and only one study had low risk of bias. Two of the rejected reviews failed to pass because they did not research milieu treatment (Ross et al., 2013; Browne & Smith, 2018). The third and the fourth review covered a mixture of somatic

and mental health care without presenting separate analysis for mental health care (Baby, Gale, & Swain, 2018; Morphet, Griffiths, Beattie, Velasquez Reyes & Innes, 2018).

Conclusion: Within the limitations set by this preliminary review of the literature, there appears to be a void of systematic reviews of violence risk management strategies in milieu treatment contexts in mental health care. This does not prove that there are too few research studies on risk management of violence in milieu treatment. Neither is this evidence of lack of risk management strategies in clinical practice.

How?

So, how can we move ahead? *First*, we should conduct a more sophisticated review of the literature. *Second*, and dependent on the findings in that review, we must assess the results and conclude on whether there actually exists an evidence-based risk management strategy or not within this field of research. *Third*, if yes, we should inform the health authorities in our respective countries about this and instigate the development of evidence-based practice by teaching and updating guidelines for best practice. In my opinion, the research field is far away from answering yes to the third point.

A better approach would perhaps be to enter this nine-step ladder:

1. Get money and commitment (particularly in clinical settings)!
2. Organize, or use already established, research networks
3. Identify and single out the most promising risk management strategies
4. Decide what may work best for whom (diagnoses, treatment contexts, gender, etc.)
5. Develop and embed the research within a stable and predictable project organization
6. Conduct validation studies which meet the requirements for evidence-based practice
7. Gather and interpret the results
8. Start the work for a broad implementation
9. Evaluate and look for improvements

Why not?

At present, there appears to be no evidence-based practice in risk management of violence in mental health facilities. This does not mean that it is not feasible. But I am going to argue for and against the development and validation of EBP in the use of risk management strategies.

The pros are:

- Risk management strategies can reduce the use of overmedication, seclusion and restraint
- There are strategies that already have documented effect in single studies, such as the Early Recognition method (ERM, Flutters, van Meijel, Nijman, Bjørkly, & Grypdonck, 2010)

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- Most of these approaches are founded on active user involvement
 - It is less complicated to do this research within intra-mural contexts than by follow-up after discharge into society
 - This implies that testing of such strategies can be carried out in a secure environment
 - Clinicians who carry out the strategy will be more inspired and enthusiastic if it works
 - Implementation of EBP can generate a more positive status for mental health services, and in particular, the facilities that treat violent persons.
 - But first and foremost, successful implementation of a risk management strategy will generate hope and progress for the users and their relatives

The cons are:

- Many clinicians are worried about having more tasks in a busy and unpredictable workday
- Implementation of new management strategies in mental health facilities requires adherence and fidelity to the research protocol, and that is not always the case
- A substantial proportion of violent patients refuses to cooperate because of paranoid delusions
- There are cultures or sub-cultures within the milieu treatment staff who protect “the old routines” and do not want change and progress
- Researchers may ignore to inspire and motivate the staff by tight follow-up through the research period

Conclusion

I will round off by suggesting some key points to meet the research requirements before implementing EBP in risk management of violence:

First of all, a multicentre research project will provide the sample size needed for reliable validation of the actual risk management strategy. The multi-center approach is time-efficient, too. *Second*, elements from the risk principle and the growth principle should be integrated in the strategies if possible. This means to combine the risk principle, keeping measures of mitigating risk in accordance with the risk the actual person represents (Andrews, Bonta & Hoge, 1990) and the growth principle, focusing on personal development, hope, protective factors and resilience (e.g. de Vries Robbé, Vogel, & Stam, 2012). *Third*, treatment personalization with individualized approaches within one type of strategy must be prioritized. Fourth, the development and implementation of prevention strategies should include user involvement. *Finally*, a systematic and strict follow-up control in each research project is required to solve the adherence and fidelity issues.

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Correspondence

Stal.Bjorkly@himolde.no

Legal insanity and free will

Keynote 6

Prof. Gerben Meynen (Netherlands)

Keywords: Criminal responsibility; free will; neuroscience; legal insanity

1. Introduction

Sometimes, defendants who have committed serious crimes are considered legally insane. This means that they cannot be punished; they are excused. Still, depending on the jurisdiction, measures may be taken to protect society, for instance by involuntary admission to a forensic psychiatric facility. Legal insanity is one of the most debated elements of criminal law [1]. The debate concerns many aspects of the defence, for instance the reliability of psychiatric evaluation: some are doubtful that psychiatrists can reliably assess mental illness in the past, especially when defendants may be faking good or bad. Another concern is that deterrence may be undermined, because people may feel that the insanity defence provides a way to escape punishment. Yet, another central problem regarding the insanity defence is its theoretical justification. Why is it in the first place that mental disorders may excuse a defendant for his/her criminal behaviour? In other words, what is it these disorders do that justifies withholding blame and punishment, even if very serious crimes have been committed? This is the question we will be concerned with in this paper.

The outline of this contribution is as follows. First, I will consider a common justification for legal insanity which refers to a *lack of free will* as a result of a mental illness. Even though this explanation of the defence is often mentioned in the literature, we will encounter a complication concerning this argument: the existence of free will is controversial. This is the first problem regarding '*free will*' as an explanation for legal insanity. Next, I will propose to look at the most influential criterion for legal insanity in the Western world, the M'Naghten rule. As it turns out, according to this criterion, free will is not relevant to legal insanity. This implies a second problem for free will. In the fourth section, we look at the model penal code test for insanity, and some criticism regarding this criterion. This will yield a third problem for free will. In the end, we will have assembled three problems regarding free will as a justification of the insanity defence. Still, I conclude, that doesn't mean free will is irrelevant to legal insanity. Finally, I will propose another ethical framework, derived from Aristotle, to justify the insanity defence. See for a more elaborate discussion of topics discussed in this paper [1] (in particular Chapter 4) and [2].

2. Free will

A common view regarding the justification of the insanity defence is that free will is required for criminal responsibility, and that mental disorders may undermine free will. Therefore, mental disorders may render a defendant not responsible for his crime. This idea is succinctly expressed by Walter Reich: “*the law recognizes that insanity compromises free will, and classifies someone without free will as legally not responsible for his or her actions.*” [3] Vonasch et al. argue along the same lines: “*Free will is central to ideas of justice and responsibility: a person cannot be found guilty of a crime if the person lacked the ability to control his or her actions, which is the basis of the insanity defence*” [4], p. 57. These quotes illustrate the often-encountered explanation of legal insanity in which free will is central.

But there is an important problem with that view. Free will has been a topic of debate for centuries and the discussions are still ongoing [5, 6]. The main issue is whether something like free will is possible in our – allegedly – deterministic world, or universe. Philosophically, the problem is called the compatibility problem of free will and determinism. Supposedly, our universe is deterministic and everything that happens, happens because of cause-effect relationships, which are determined by the laws of nature. These unrelenting laws – unlike legal laws – cannot be circumvented. They rule whenever and wherever we act. Consequently, the argument goes, all our actions are determined, and this does not seem to leave any room for free will and free action. In recent years, on top of this physics-derived argument relying on the laws of nature, a neurobiological argument has gained prominence. Neuroscience, it is argued, shows that our actions are determined by brain activity, which would exclude the possibility of a role for a robust free will. The brain pulls the strings. Free will is an illusion. This line of reasoning has also received support from psychology [7].

Clearly, many counterarguments have been developed to show that there is still a robust free will possible in a deterministic world [6] or given the neuroscientific data [5]. (In this paper, I will not go into the variety of definitions of free will.) Two main strategies of dealing with the problem can be distinguished. First, to show that the determinism of physics and neuroscience are actually compatible with some form of free will. Philosophers argued, for instance using thought experiments, that freedom and responsibility do not require alternative possibilities [8, 9]. So, even if everything that happens is determined, there is some free will possible – sufficient for moral responsibility. The other strategy concerns downplaying the robustness or relevance of the neuroscientific data [10]. One can point to flaws or uncertainties regarding the neuroscientific and psychological experiments. And it is true, experiments tend to have shortcomings. Still, others emphasize that there is *converging* evidence [11] that concepts such as free will are incompatible with what science teaches us.

The debate continues and we can safely say that, at least to some extent, free will is a *controversial* concept. Now the question is: should we want to rely on such a contested concept regarding the insanity defence? The matter of legal insanity is grave – and already somewhat controversial in itself. Wouldn't it therefore not be preferable not to have to refer to a controversial concept in order to justify the defence? This is the first problem regarding (lack of) free will as a justification of legal insanity. We now move to the second problem.

3. The McNaughton rule

In the previous section, we started with some quotes underlining the relevance of free will for legal insanity. But is free will relevant? There are many ways to address this question. We will look at the most influential legal criterion for insanity in Anglo-American jurisdictions, the McNaughton Rule. The question we will address is: what is the role of free will in this criterion?

How should we look for free will in the *McNaughton rule*? Do we have to search for the exact words '*free will*', or could other terms also be indicative of '*free will*'? Free will, as it turns out, is intimately related to the notion of control. In their already mentioned paper, Vonasch et al. state about ordinary people's views of free will: "*A core aspect of belief in free will is the idea that one is capable of controlling one's own actions*" (p. 57) Apparently, there is a strong link between free will and control. This is not only the case for ordinary people, but also in philosophy. Tim O'Connor writes in the *Stanford Encyclopedia of Philosophy*: "*The term 'free will' has emerged over the past two millennia as the canonical designator for a significant kind of control over one's actions.*" And somewhat later: "*As should be clear from this short discussion of the history of the idea of free will, free will has traditionally been conceived of as a kind of power to control one's choices and actions.*" [12]

Now, it is beyond the scope of this paper to examine the exact relationship between free will and control. But let's assume that any reference to the ability to control one's behavior in the *McNaughton rule* is indicative of the potential relevance of free will for this influential insanity criterion. So, what we are looking for is either the term free will or control-related terms. *The McNaughton rule* reads:

"...at the time of the committing of the act, the party accused was laboring under such a defect of reason, from disease of mind, and not to know the nature and quality of the act he was doing; or if he did know it, that he did not know he was doing what was wrong."

McNaughton's Case, 10 Cl. & Fin. 200, 8 Eng. Rep. 718 (H.L. 1843)

What is central to this rule? The short answer is: knowledge. The rule specifies that, if a mental disorder resulted in the absence of a certain type of *knowledge*, the defendant

is legally insane. In a way this is unsurprising since knowledge – or lack thereof – is important to excuses in everyday life. We may apologize to another person, referring to our lack of knowledge: “*I am sorry I took your chair, I didn’t know you were working here today.*” (If I would have *known*, I would never have taken your chair.) Also in criminal law, nonculpable ignorance may well lead to a non-guilty verdict. If a person did not know something (in the absence of the obligation to know), this may constitute a valid excuse. The McNaughton rule contains exactly this moral and legal notion. And it is definitely relevant for defendants suffering from a mental disorder at the time of the crime, because these illnesses may affect a person’s knowledge. An example is a delusion. A person may as part of a delusion believe that someone is attacking him, and he may defend himself against the presumed attacker. If the attacker gets hurt, the case may go to trial and the defendant may explain that even though he knew what he was doing, he didn’t know that his actions were wrong. On the contrary, the defendant may explain that his act was justified, since it was self-defence. In other words, as a result of the delusion, he didn’t know that his violent behaviour was wrong. Therefore, he fulfils the criterion of the *McNaughton rule*. All of this turns on the defendant’s knowledge.

But knowledge is not free will. In fact, since Aristotle, two issues have been considered relevant to moral – and legal – exculpation: 1) ignorance and 2) a lack of control. [1] The first element is an *epistemic* component. The term is derived from philosophy and it refers to issues related to knowledge, broadly conceived (understanding, appreciation, etcetera). The second element has to do with behavioural control: even though a person may know that something is forbidden, he may not have the behavioural control to guide his conduct. This is also a common moral intuition. In everyday life, we may well excuse people for behaviour that was beyond their control. For instance, you step on a person’s foot, but since someone pushed you, you are excused. Note that the epistemic and the control component are *different* issues. Importantly, nowhere in the McNaughton ‘*rule*, we see any reference to the latter component: *free will isn’t mentioned and neither is control*. McNaughton is *merely* interested in epistemic matters. Apparently, for the most influential criterion for insanity in Anglo-American legal systems, free will is irrelevant. This is the second problem for referring to free will to justify legal insanity.

4. The Model Penal Code insanity criterion

Even though the *McNaughton rule* is considered the most influential insanity standard in the Western world, it is certainly not the only one. Whilst most of the states in the US have the McNaughton rule, a minority uses the Model Penal Code test for insanity [13]. It reads:

“a person is not responsible for criminal conduct if at the time of such conduct as a result of mental disease or defect he lacks substantial capacity either to appreciate the criminality (wrongfulness) of his conduct or to conform his conduct to the requirements of the law.”

This test has *two* elements. The first concerns the *appreciation* of the criminality or wrongfulness of the conduct, the second refers to the ability to *guide* one's conduct. The appreciation prong reflects the epistemic component, but the guidance element refers to behavioural control. Since control is conceptually related to free will, it seems fair to say that free will *could* be relevant to the Model Penal Code test for legal insanity. In fact, many insanity standards contain such a control prong (often alongside an epistemic component) [14]. Examples of countries with such a twofold insanity criterion are Italy [15] and China [16]. Consequently, free will may be relevant to many legal systems – just as far as a lack of control is included in the criterion for insanity.

Still, there is a third problem. People have been hesitant or reluctant to include a control element in the insanity standard. The problem is clearly expressed by Stephen Morse (1985, p. 817):

“There appears to be a prima facie case for a compulsion branch of the insanity defense, but is it persuasive and would the test be workable? If or to what degree a person's desire or impulse to act was controllable is not determinable: there is no scientific test to judge whether an impulse was irresistible or simply not resisted. At best, we may develop a phenomenological account of the defendant's subjective state of mind that will permit a common sense assessment of how much compulsion existed.”

Some scholars tend to be sceptical about the possibility of reliably assessing control issues in forensic psychiatric evaluations. According to Helm et al., including a control element in the insanity defence “*is more controversial*” [17]. Earlier (2016), I have tried to identify relevant differences between epistemic and control issues, that may, at least partially, explain the scepticism. I focused on the element of time. Let's compare a delusion – a classic example of a knowledge problem – to a “*control*” problem. The delusion tends to be there for a longer period (weeks, months, years) and it is relatively stable over time: if a person has a delusion on Monday morning and Monday evening, he probably also had that delusion during the Monday afternoon. Delusions in the standard case do not come and go. Typically, for impulse control problems, the situation is very different: depending on the situation a person may or may not experience a problem with control. A person may not have a problem to control his alcohol use in the morning at work, but in the evening, it may be extremely difficult to resist the urge to drink. Control problems tend to be more irregular and unpredictable. This may be an explanation why people feel that control problems are more difficult to determine. We may know that a person has a disorder that leads to problems of control, but were these problems also present at the time of the crime, and if so, what was their intensity?

In other words, in many legal systems, we find a control prong. The control prong can be considered conceptually related to free will. This means that free will *could* be relevant to these legal standards of insanity. However, as we have seen, there is an

immediate problem regarding this control prong: there is more scepticism about the reliability of control assessments compared to knowledge evaluations. So, as far as free will could be relevant to legal insanity, it has to do with the *more controversial* element of the insanity test: the control prong.

5. Discussion

In this paper, I have examined the relationship between legal insanity and free will. We started with the observation that a common justification for the insanity defence is that mental disorders may undermine free will. In our analysis, meanwhile, three problems were identified regarding free will as a justification for this defence:

First, *scepticism* about the existence of free will. Based on several lines of scientific research scholars from different backgrounds have expressed serious doubts that we actually have free will.

Second, the *irrelevance* of free will regarding the most influential standard for insanity in the Western world: the *McNaughton rule*. This standard for insanity is all about the defendant's *knowledge* at the time of crime. Consequently, free will cannot be the justification of *this* standard and all other standards that have a similar form, which means focusing entirely on the epistemic factor.

Third, as it turned out, many jurisdictions have a control prong in the insanity criterion (often alongside an epistemic component). The control prong is related to free will, and therefore, free will could, at least in principle, be relevant to the justification of this part of the insanity defence. Yet, we encountered a third problem: the control element is considered more *controversial* than the epistemic component; doubts have been expressed that it can be reliably assessed.

At the same time, indirectly, our analysis brought to the fore another possible justification of the insanity defence: it is the Aristotelian model for responsibility and excuse, which contains both a knowledge and a control element (see section 3). Throughout the ages, this model has been influential in both ethics and the law [18]. Given its two components, it can explain both the relevance of the epistemic – knowledge/appreciation – component and of the control component often reflected in insanity standards.

In sum, we have examined, using a specific approach, the helpfulness of free will as justification of legal insanity. We found serious limitations of this justification. Still, if we would have followed another approach, the results might have been different.

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Correspondence & Affiliations

Vrije Universiteit Amsterdam, Faculty of Humanities, Department of Philosophy & Utrecht University, Willem Pompe Institute for Criminal Law and Criminology & Utrecht Centre for Accountability and Liability Law (UCALL)
 Newtonlaan 201
 3584 BH Utrecht
 The Netherlands
 g.meynen@uu.nl

The terror of July 22th of 2011: What can we learn

Keynote 7

Dr. Pål Grøndahl (Norway)

The lecture will be divided in two main sections

Section one: Background

The first part section will give a brief overview of the terrorist attack, what happened and how many were killed and injured. This section will also present some of the first reactions when news of the attack became known. The second part will provide insights into the insanity regulations in Norwegian criminal law. The reason for this is to give an understanding of the central question of the litigation: was the terrorist insane or was he responsible for his actions. The third part will undergo forensic investigations by the terrorist. How was he examined, what methods were used, why did the court appoint two additional forensic psychiatric experts? In this section, the court's decision will also be reviewed.

Section two: What can we learn?

The first part of this section will elaborate the problems of insanity in certain high profile cases. Are some cases so special that we are reluctant to admit that a perpetrator was insane at the time of the act?

The second part will deal with penal law. After the trial against the terrorist the Norwegian parliament has adopted a new law regarding insanity. Was it necessary to implement a new law?

The final part of the section will deal with our possibility to predict terror. That is, can we predict the next terrorist, mass murderer or school shooter? What methods do we have, what does the research say about such predictions?

Correspondence

pagron50@gmail.com

The Restraint Reduction Network : Mandatory standards for training in using restraint, focusing on reduction, prevention, and safe management.

Special Workshop

Presenters: Sarah Leitch (UK) & Kevin McKenna (Ireland)

There will be a special workshop organized and carried out through a partnership of BILD, RRN & ENTMA about the draft RRN mandatory standards for training in using restraint, focusing on reduction, prevention, and safe management. Ethical training standards to protect human rights and minimise restrictive practices.

There has universal concern consistently expressed for many years regarding the structure and content of training in the prevention and management of aggression and/or violence provided to personnel across health, social care and education services.

Central to these concerns are the paucity of evidence underpinning the content, safety and effectiveness of such training, and the virtual absence of standards and quality assurance governing the provision of training.

In response to these concerns, a major improvement was undertaken in the UK, driven by government policy, which has resulted in the production by the *'Restraint Reduction Network'* of mandatory standards which are formally sanctioned by government and will govern the future provision of aggression prevention and management training. Specifically, from April 2020, it will be mandatory for any and all training provided within any UK NHS facility, or those receiving NHS funding, to adhere to these standards.

Within the UK this is by far the most ambitious initiative ever undertaken to standardise such training, and is unparalleled at this time within an international context.

The workshop will place particular emphasis of facilitating active participant engagement, in identifying existing good practice, and potential improvements in this complex subject area. Specifically, this highly interactive workshop, will:

- present the RRN standards, discuss their development, and some of the challenges involved in implementing a reform of training provision of this magnitude
- present the experiences of the first training providers to pilot implementation of the standards

- discuss the challenges involved in conducting a robust service specific training needs analysis, involving service users in training delivery, and implementing a programme of effective post incident recovery and learning

Participants will have the opportunity to:

- discuss these opportunities and challenges from their own national and service related perspectives, and explore the role of training in driving and/or supporting the required cultural change necessary to effectively implement restraint reduction approaches.
- have the opportunity to use a standardised self-assessment tool to objectively assess their current training provision, and a ‘training impact tool’ which might inform how changes in staff practices following training might be reliably measured.

Correspondence

mckennakj@eircom.net

s.leitch@bild.org.uk

Chapter 2 – Epidemiology and nature of inpatient violence against staff

Aggression on the psychiatric ward: prevalence and causes. A systematic review of the literature

Paper

*Irene Weltens (Netherlands), Maarten Bak, Patrick Domen, Therese van Amelsvoort, Marjan Drukker
Department of Psychiatry & Neuropsychology, Maastricht University, and Mondriaan Maastricht. Netherlands*

Keywords: aggression, violence, inpatient, psychiatric, ward, demographics, causes of aggression, staff factors, ward factors, patients factors, influence on aggression

Introduction

During the last 5 years, about 66% of staff (nurses, psychiatrists, doctors or other workers) in mental health hospitals in the Netherlands had to deal with some form of aggression.

Causes of aggression are described as multifactorial: environment-related, mental health care-system related, patient-related and clinician-related [1, 2]. These factors are extensively described in the literature, but what is missing is evidence to what degree these factors contribute to causing aggression on the ward.

The aim of this review was to compile an overview of the available knowledge on factors that contribute to the cause of aggression on the general psychiatric admission ward so that with this knowledge more insight is obtained en better preventative measures can be designed.

Method

This review was written in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines [3].

Studies were included when their main objective was to study the prevalence and causes of aggression on inpatient wards for adults of a psychiatric hospital admitted both voluntarily or involuntarily. When a study was conducted on a forensic ward, authors decided after reading, whether the results appeared to be applicable for regular psychiatry.

Results

Prevalence

The range in prevalence of aggression on psychiatric wards (both acute and non-acute) varies from 3-44% [4] with 17% of all patients admitted being involved in at least one incident during the admission (95% CI 14–20%).

The overall mean incidence of aggression was 32.4% in the psychiatric inpatient setting [5]. One study reports 130 incidents which were caused by 72 patients, of whom 33% accounted for 66% of the total incidents [6].

The annual risk of experiencing aggression among psychiatric nurses is 10% [7]. The first days of admission appear to have the highest prevalence rates [8]: 54-59% of the incidents took place in the first week of admission, 20% in the first 24 hours and 28% in the first 2 days of admission [9, 10].

Causes of aggression

Patient factors

Aggressive behaviour was positively associated with: younger age (SMD= -0.32 CI 95% -0.39-0.25 $z=9.30$ $p<0.001$), involuntarily admission (RR 2.17 CI 95% 2.01-2.34 $z= 20.37$, $p<0.001$), male gender (RR 1.10 CI 95% 1.03-1.17 $z=2.88$ $p<0.01$), being unmarried (RR 0.72 CI 95% -0.63-0.83 $z=4.70$ $p<0.001$), diagnosis of schizophrenia (or psychosis) (RR 1.16 CI 95% 1.10-1.22 $z=5.52$ $p<0.001$), more previous admissions (SMD 1.2 CI 95% 1.05-1.35 $z= 15.60$ $p<0.001$), longer admission, history of violence (RR 2.27 CI 95% 1.90-2.69 $z=9.24$ $p<0.001$), history of self-destructive behaviour (RR 1.24 CI 95% 1.03-1.50 $z=2.26$ $p<0.05$) and history of substance abuse (RR 2.09 CI 95% 1.46-3.00 $z=4.03$ $p<0.01$). No significant results were found for ethnicity, diagnosis of affective disorder or years of education [11].

Aggressive patients were more likely to report persecutory delusions ($c^2=9$, $df=1$, $p<0.01$) and a higher level of suspiciousness ($z=-2.34$, $p<0.05$). The following demographic factors were also significantly associated with aggression: a history of victimization (OR=6.1, 95% CI 4.0-9.1, $z=8.7$), recent homelessness (OR=2.3, 95% CI 1.5-3.5, $z=3.7$), a history of homelessness (OR=2.3, 95% CI 1.5-3.4, $z=4.0$), being male (OR 1.6, 95% CI 1.2-2.1, $z=3.6$). A criminal history was significantly associated with aggression, as shown by the following factors that were studied: history of

assault (OR=21.4, 95% CI 5.2-86.6 $p<0.001$), history of imprisonment (OR=4.5 95% CI 2.7-7.7 $p<0.001$), recent arrest (OR=4.3 95% CI 2.7-6.7 $p<0.001$) and history of violence (OR=3.1 95% CI 2.2-4.4 $p<0.001$). Clinical factors associated with higher risk for aggression were lack of insight (OR=2.7 95% CI 1.4-5.2, $z=2.9$), higher PANSS scores (OR= 1.5 95% CI 1.0-2.2, $z=2.2$), a history of polysubstance abuse (OR=10.3 95% CI 2.5-41.5 $z=3.3$), a diagnosis of co-morbid substance use disorder (OR=3.1 95% CI 1.9-5.0, $z=4.5$) and recent substance misuse (OR=2.9 95% CI 1.3-6.3, $z=2.6$) [12]. Of all aggressive incidents, 82% was preceded by a warning sign, mostly agitation [7], but also explosive or unpredictable anger, intimidation, restlessness, pacing and excessive movement, self-abuse, verbally demeaning or hostile behavior, uncooperative or demanding behaviour, impulsiveness and impatience [7].

Staff factors causing aggression

It was estimated that 6.25-88.2% of male nurses experience aggression and 14.3-89.7% of female nurses do, with odd ratios ranging from 0.78-2.50 [13]. In self-reported aggression, the odds ratio for aggression to female versus male staff was 1.21 (95% CI 1.05-1.40) [13]. Most incidents happen between patient and staff of the same gender ($\chi^2=157.42$ $p<0.0001$) [14]. The age of the nurse was a risk factor for aggression with OR=0.65, (95% CI 0.47-0.91) [15]. The younger the nurse, the greater the risk for aggression [16]. Student nurses and trainee nurses were more likely to experience aggression [16, 17].

The likelihood that incidents occurred was increased at times with more intense patient-staff interaction: during shift changes, breakfast and medication times [16]. This is also found in the review by Hamrin with 20% of all incidents [18] and Papadopoulos with 39-56.7% of the incidents being provoked by patient-staff interaction [19]. Incidents that preceded a conflict resulting in aggression were: limit setting (25%-64%) [10, 19, 20], discussion about cigarettes (21.1%) discussion about off-ward privileges (13.3%) [21], a patient being denied something (30%), conflict with other patients (23-31%), helping a patient with Activities of Daily Living (4%) and staff requiring the patient to take medication (13%) [19, 22].

When non-nursing staff (psychiatrist or psychologist) was absent from the ward, more aggression occurred (RR=1.16 CI 1.12-1.19, $p<0.001$) [23]. An increase in staff-patient ratio was thought to reduce the risk of aggression on the ward, but there is mixed evidence for this [24].

Evidence from narrative studies

The greater the fear for patients, the more rule enforcement was emphasised with strict limit setting and the greater the chance that aggression will occur [25]. The interaction with staff was also mentioned as cause of aggression, specifically a superior attitude, strict hierarchy, a lack of empathy, a lack of knowledge of the illness, demeaning procedures and enforcing rules in a strict way [26].

Nurses perceived less aggression when they were satisfied with the hospital and felt supported by management [27]. These nurses put less emphasis on rules, were more committed, and more focused on getting the job done [27].

Ward factors causing aggression

Bed occupancy rates and overcrowding led to aggression [5, 16, 18]: 53.1% of all incidents happened when one or more extra beds were occupied more than the standard ward maximum allowed [9]. In a study of 226 incidents weekly occupancy rates of beds were correlated with the number of incidents per patient ($r=0.21$, $p<0.05$) [28]. Aggressive incidents were associated with a substantial proportion of admitted patients under the age of 36 years (IRR=1.17 95% CI 1.01-1.37) and the number of male admissions during the week (IRR=1.12 CI 95% 1.05-1.21). Patient based surveys showed that a lack of privacy triggers aggressive behaviour [1, 16, 26].

Incidents of aggression happened most in public spaces or high traffic areas on the ward [18]. The patient's room was a frequent place of incidents (21.9%, 13%, 22%, 28.1%) [9, 21, 29, 30], as well as the nursing station with 25% [21].

Sensory rooms or comfort rooms reduced the risk of irritation leading to agitation or aggression [31].

Both excessive stimulation and boredom contributed to aggression [5]. A structured ward with structured daily activities seemed to have lesser aggression than a ward where patients felt bored [24]. A higher rate of assaults was associated with weekends where activities were scarce [16, 18].

Studies assessing the impact of a locked door were inconclusive [1]. Nevertheless, closed wards were seen as a precipitating factor for aggression [17]. The locked door of a ward led to an increased risk of violence of 11% [32]. According to staff and patients locked doors made the patient feel trapped, anxious, frustrated, unsafe, more aggressive, creating a prison-like environment, reinforcing stigma, increasing the feeling of punishment; visitors may feel less welcome and staff showed more authoritarianism [33-35].

Morning was associated with high rates of aggression in some studies, with 19-61% of all incidents taking place in the morning [9, 21, 30, 36-39]. More specifically, during the transition of nursing shifts (in this study from 13:00-15:00) most incidents happened with a prevalence of 99 incidents per hour compared to 62.3 incidents during the other hours of the day: $\chi^2=33.9$, $df=1$, $p<0.001$ [39]. However, other studies reported the highest number of incidents in the evening between 42-56.7% [40-42]. The most recent study on this subject showed no statistically significant differences in time of the day [43].

Discussion

The large differences in prevalence might in part be explained by the fact that studies are conducted with different methods of registering incidents and different patient samples [44].

Demographic patient factors, whilst extensively studied, might not be very useful clinically because they cannot be changed. They need to be taken into account in managing admitted psychiatric patients, but cannot be used when aiming for a reduction in aggression.

Not only is staff on psychiatric wards often involved in an aggressive incident as victims, they also contribute to the occurrence of aggression. The quality of the interaction between staff and patients appears to be more important than its quantity. Hence, the HIC model implemented in the Netherlands, was welcomed leading to more contact between nurses and patients: more autonomy for patients may lead to less aggression. Also, annual training for nurses and close contact when needed (one-on-one nursing) might lead to less aggression on the ward.

Environmental factors are mentioned by patients as important in inducing aggressive behaviour [45]. The literature is contradictory whether a more strict environment or more flexible environment with less rules leads to more aggression [46].

No explanation is given in the literature for the high rates of aggression in the early stages of admission. It might be due to the severity of the psychiatric disorder or intoxication at the moment of admission or to the fact that a patient is admitted without their consent and without understanding why. It might also be due to the patient having to wait for hours, being tired or hungry. That is why on the HIC, patients are admitted in a welcoming manner with drinks, food and basic toiletries.

Without fully understanding the development of aggression, interventions that focus on adequately coping with aggression and prevention of coercive strategies are difficult to generate but are very much welcomed.

Limitations

There is a lack of controlled prospective studies; 70% is based on retrospective designs. The retrospective research design hampers the possibility to study the nature or causes of the aggression [16] and leads to recollection bias. However, the retrospective design is informative on which factors might in retrospect have contributed to the development of aggression.

The heterogeneity of the papers is large because of differences and shortcomings in methodology and definitions of aggression. Local ecological differences are not comparable [4]: if described at all, the culture and structure of the wards are not clear, there is a mix of diagnoses, setting (acute admission wards, forensic wards, open admission wards), number of beds, patient-staff ratio, bed occupancy rates, duration of admission, ward structure, locked door and culture. Security levels differ between studies and are largely dependent on legislation in different countries and management of the hospital.

The studied outcome measures differ and there is no consensus on how data are collected [14].

Definition of aggression

The majority of the studies do not define aggression. Three states are distinguished: agitation, aggression and violence. They are however used interchangeably, with indistinct and unclear underlying concepts and demarcations.

We recognise an evolving process that starts with agitation, followed by aggression and ultimately violence with the latter differing from aggression by the severity and intentionality of the behaviour.

Despite these shortcomings the results do give a clear view of the magnitude of the problem of aggression on the inpatient ward and supports the model of the three main factors (patient, staff and ward) in contributing to a risk of aggression.

Future research requires a prospective design, with clear descriptions of patient factors, ward culture, structure, occupancy rates, locked door and staff indicators such as training, staff-patient ratio, ways of communicating with the patient and ways of interacting with the patient.

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Corresponding author

Irene Weltens, MD
c/o Mondriaan
Vijverdalseweg 1
6226NB Maastricht
The Netherlands
irene.weltens@maastrichtuniversity.nl

Predictors of (repeated) physical violence in a forensic psychiatric hospital

Paper

Nienke Verstegen, Vivienne de Vogel, Robert Didden & Henk Nijman (Netherlands)

Keywords: Inpatient violence, forensic psychiatry, physical violence, logistic regression

Abstract

Background

There is preliminary evidence demonstrating that the consequences of physical violence during treatment, in terms of burn-out symptoms and absence from work due to illness, are more severe compared to consequences of other forms of violence, such as verbal aggression or witnessing aggression against property. There is limited knowledge on characteristics of these patients that cause physical violence during treatment.

Aims

The present study aims to contribute to the limited body of evidence on predictors of (repeated) physical violence. It aims to increase insight in a patient group that exerts a large influence on ward safety.

Methods

All violent incidents that occurred in a forensic psychiatric hospital in the Netherlands between 2014-2017 (n=3603) are coded with the MOAS+. Violent incident data are coded by researchers based on hospital reports. Two binary logistic regression analyses were conducted on patient variables that best predict: i. physical violence towards others and ii. repeated physical violence towards others.

Results and conclusion

The results of this study are currently being analysed and will be presented during the conference.

2 Educational Goals

1. To increase insight in a patient group that exerts a large influence on ward safety.
2. To learn about predictors of physical violence during mandatory inpatient treatment

3. To learn about predictors of repeated physical violence during mandatory inpatient treatment

Correspondence

Email: nverstegen@dfzs.nl

Workplace aggression against student nurses. How prepared are they?

Paper

Wim Janssen & Chantal Emerenciana (Netherlands)

Keywords: Students, Aggression, Incidence, Severity, Preparation.

Introduction

Nurses working in health care settings are repeatedly confronted with aggression (Hanson et al, 2015). In health care the most common situation is when the perpetrator (i.e. patient, family member, visitor) has a legitimate health care relationship, but becomes violent while being cared for (Phillips, 2016). Aggression is defined as: Any verbal, non-verbal or physical behaviour that was threatening (to self, others or property), or physical behaviour that actually did harm (to self, others or property (Morrison, 1990) or as any behaviour intended to harm a target motivated to avoid that harm (Allen, et al. 2017). The majority of these incidents of workplace violence are verbal, some concern assault, domestic violence, stalking or sexual harassment (Phillips, 2016). It is an occupational hazard in hospital and non-hospital settings (Phillips, 2016).

Half to three quarter of all nurses experienced more than one incident of aggression at work a year (van Leeuwen & Harte, 2015, Hanson, et al. 2015, Phillips, 2016, Pourshaikhian, et al. 2016). In one third of these incidents nurses suffered injuries, associated with long-term pain. In approximately five percent of the violence incidents, nurses sustained serious physical injuries such as contusions, broken bones or dental damage (van Leeuwen & Harte, 2015). Notable is that nurses with less work experience were more often involved in aggressive incidents or injured than experienced colleagues (Zhang, et al 2017). Nurses experiencing aggression by patients or visitors may suffer many health problems, such as fear, anger, stress and being less able to function in work. In 4% of nurses, aggression leads to short-term absenteeism. About 1 in 6 nurses have problems with job satisfaction, while some considered changing jobs (van der Kemp, et al . 2004).

In line with their graduated colleagues, student nurses experience aggression during their traineeship. A study of Bachelor social work students showed 85% experienced aggression (Ensing & Janssen 2013). Another study showed little attention is paid in nursing education programs in dealing with aggression in workplace settings (Nau, et al. 2010, Pourshaikhian, et al. 2016). Nau et al, (2010) concluded trained nursing students were better able to prevent or deal with aggression effectively. A report of the Dutch Ministry of Welfare and Sports, (2012) acknowledged up-and-coming health personnel seem insufficiently trained in preventing and dealing with (expressions of) aggression.

The Ministry of Welfare and Sports (2012) pointed out educational institutes have their own role in preparing students in dealing with aggression. The Bachelor of Nursing study of The Hague University of Applied Science only pays attention to general communication skills, and does not specially include dealing with aggression. Full time nursing students have their hospital internships from the second year of the course. Part-time nursing students work in the health care settings during the whole course and are at school one day a week. Little is known of frequency and seriousness of aggression these students experience. It is also not known whether these students feel they are adequately trained in dealing with aggression. The main question of the current study is: To what extent were students from the HBO-V study program at The Hague University of Applied Science skilled in dealing with occurring aggression.

This study is important for future nurses, educational institutes and health care settings in which futures nurses will work. It is therefore important to know more about the frequency, impact, ways it occurs and risks of being confronted with aggression and in line with this, the degree of training to deal with aggression.

Goals of the study are:

- Mapping aggression or violent incidents that the students of the nursing college (HBO-V) have to deal with
- Gathering experiences of student subject to such incidents during internships or apprenticeships
- Empirically leading to a program for the students in learning to deal with aggression and violence in a safe way.

Methods

A cross sectional design using a questionnaire about the nature, the severity and the preparation of how to deal with aggression was distributed to a large group of students. Students in the propaedeutic phase of the course were excluded. The questionnaire allows an accurate description of the current context: how many times over the last twelve months were students confronted with aggression during their internship?

The questionnaire was along the following lines:

- Some background information of the respondent, year of the course, field of their internship;
- Frequency, expressions and severity of experienced aggression
- Level of skills in dealing with aggressions.
- Degree to which students are prepared by the study program for occurring aggression.

The Staff Observation Aggression Scale – revised (SOAS-r) (Nijman, et al. 1999) was included in this questionnaire to describe the nature and severity of one of the severest aggression incidents respondents experienced over the last twelve months. All students

received an email informing them of the goal and content of the study. Following the digital information, the main researcher invited students to complete the survey in the classroom. All students had the opportunity to participate anonymously. All data were entered in SPSS. Frequency, nature and severity of the aggression incidents were calculated and split over health care fields where the respondents underwent their internships. Next, the validated SOAS-r severity scores were calculated.

Results

Within a population of 560 students, 204 students completed the questionnaires. The respondents had their traineeships in all fields of the health care. Table 1 provides an overview of the fields in which the students had their traineeship and the number of incidents of aggression. In the same table the number of students per year of the course and number of aggressive incidents were presented. In total, the students reported 1018 aggressive incidents. Only 15 students (= 7%) experienced no aggression during their traineeships. More than half of students reported 1 to 5 incidents. Overall, the students reported an average of 4 aggressive incidents per student per traineeship.

Table 1. overview of students in the different courses and number of days in the practice.

Number of student in traineeship setting / number of in the year of the course	Full time course			Part time course		
	Number of students	Number of days traineeship a week	Number of aggression incidents	Number of students	Number of days working in de hospital a week.	Number of aggression incidents
Home Care	28		160	20		109
General hospital	22		121	44		255
Psychiatric hospital	15		71	18		81
Nursing home	16		92	16		83
Mental disabled patients	4		21	6		20
Second year	35	3 (20 weeks)	190	27	4	138
Third year	14	4 (20 weeks)	79	27	4	158
Fourth year	37	4 (40 weeks)	205	49	4	261

Table 1 shows that the students on weekly base did not work full time in the hospitals or home care setting, as they had school lessons one or more days per week. Full time students in their second and third year had 20 week internships. When we take this in account, it could be estimated that students experienced on average eight to nine aggressive incidents per year. This implies an average of one incident per five to six weeks per student. The severity of aggression was investigated using two scales. First, on a 10-point VAS scale the student filled in how serious was the aggressive incident experienced (see figure 1). Second, the students filled in a Soas-r on the same aggressive incident (see figure 2). The results were shown per work field in boxplots. Both scales

show that students experienced severe aggression and the aggressive incidents occurred in any field of health care. Measured with the Soas-r scale, the most severe aggressive incidents took place in psychiatric hospitals and in the institutes for patients with intellectual difficulties. Based on the VAS scale, the aggressive incidents occurred in general hospitals; students experienced serious incidents as much as permanent staff.

Figure 1. Severity of the aggression incidents measured by Visual Analogue Scale

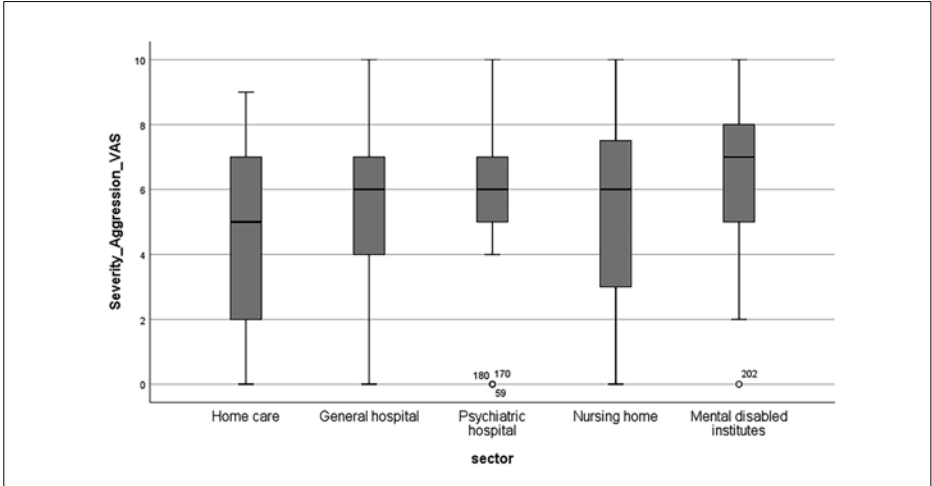
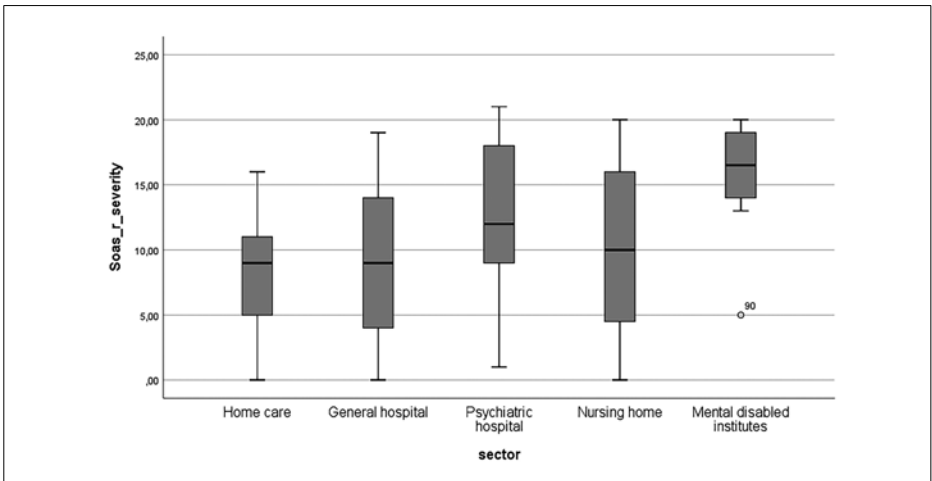


Figure 2. Severity of the aggression incidents measured by Soas-r



Concerning the extent to which students feel competent in dealing with aggression, opinions differ between full-time students and part-time students (see figure 3). The majority of the full-time students considered themselves not competent enough in

dealing with aggression. The part-time student had a more positive image about themselves. They consider themselves fairly competent to deal with aggression.

Figure 3 Opinion about the degree of competence in dealing with aggression.

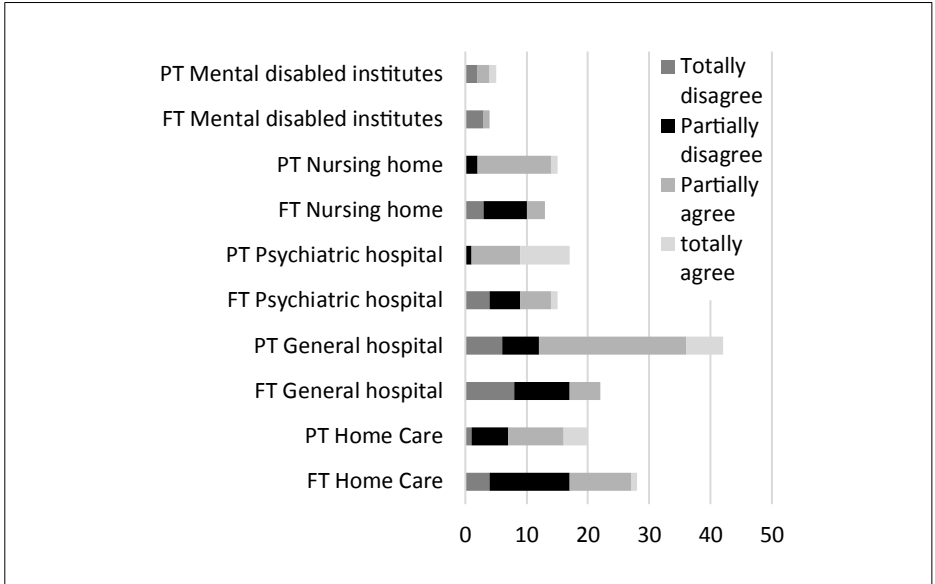


Figure 4. Knowledge in dealing with aggression received from.

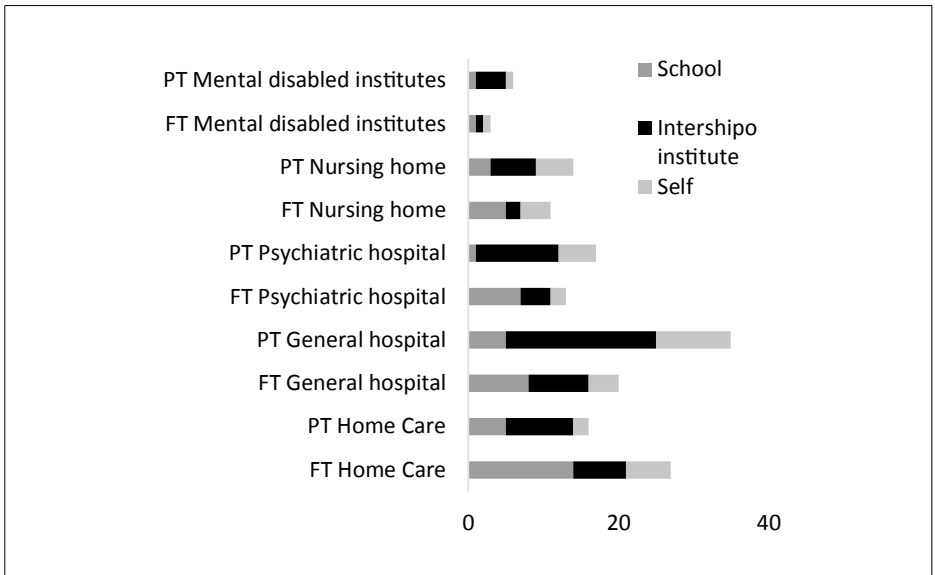


Figure 4 shows that full time students gained knowledge mainly at school, but they find the content very limited. The part-time students received their knowledge in dealing with aggression predominantly from the settings they work in.

Conclusion / discussion

Students regularly experienced aggression from patients and their relatives during their traineeship. They are poorly prepared to deal with aggression. The contribution of the study program on The Hague University of applied science on this subject is limited. The differences in the opinions between full time nursing students and their part-time colleagues can be explained as part-time student have an employee – employer relationship in the institutes they work at. These students are often allowed to have priority over courses in dealing with aggression. Full time students have fewer these facilities during their training. Therefore, the educational institutes must take responsibility to prepare full-time students in dealing with possible aggression. This is in line with earlier statements of the Ministry of VWS (2012).

Recommendations

The Hague University of applied sciences must to develop training in dealing with work-related aggression. Such a training program must be provided for all course years. These training programs need to be tailored to the needs of both students as well as the health care institutions.

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Correspondence

Wim Janssen Senior lecturer and Senior researcher.
The Hague University of Applied Science
Faculty of Health, Feeding and Sports.
School of Nursing Studies.
Johanna Westerdijkplein 75
2521 EN Den Haag.
w.a.janssen@hhs.nl

Demographics that correlate to high rates of aggression, absconding, deliberate self & sexual harm

Paper

Gamze Sonmez (Australia)

Keywords: behaviours of concern, aggression, absconding, harm.

Introduction

A current gap exists within Alfred Psychiatry that investigates, specifically, the unique individuals who present to the inpatient unit who are most likely to display a behaviour of concern. Anecdotal evidence suggests an increase in methamphetamine use associated with an increase in aggression; however, this has not been established through independent research within the local service.

Previous research exploring the prevalence and impact of these behaviours of concern (BOC) has in most cases explored each in isolation. However, this prevents analysis of whether differences exist in who engages in each BOC and their management and outcome.

This paper unravels the results of a retrospective audit to measure the nature, response and outcomes from an adult inpatient (58 beds) psychiatry audit examining the behaviours of concern including aggression, absconding, deliberate self-harm, and sexual harm. It will examine how patients engaging in different BOCs differed, characteristics and risk indicators for all BOCs during the 12-month study period, characteristics for patients with a BOC documented and management and outcomes for all BOCs during the 12-month study period.

Method

Clinical incident data was collected from the health service incident reporting system over a 12-month period (1 August 2016 to July 2017).

Results

Across the 12-month study period, 981 patients were in an episode of inpatient care and 179 (18.2%) had a documented episode involving one of the four specified BOCs.

There were 433 total BOC episodes with 357 involving verbal/physical aggression, 66 absconding, 35 deliberate self-harm and 21 sexual harm.

Patients involved in a BOC episode were more likely to be male, had more than double the hospital length of stay and were more likely to have a schizoaffective or borderline personality disorder as a primary diagnosis. Many used or abused illicit substances, were homeless, single and unemployed. 60% of deliberate self-harm and 70% of sexual harm episodes occurred outside of normal business hours (17:00-07:59). The presence of cluster B personality traits (e.g. antisocial personality disorder) was higher in patients engaging in physical aggression and sexual harm. Patients with diagnoses that suggested impaired cognitive reasoning (e.g. autism spectrum disorder or intellectual disability) were more frequently represented among people engaging in or attempting deliberate self-harm. Medication and verbal de-escalation were used during the majority of episodes although in approximately one-quarter of episodes' sensory modulation was used. Deliberate self-harm was more likely to result in injury to patients whereas deliberate self-harm and aggression were more likely to result in injury to staff.

Conclusions

In conclusion, BOC occur frequently and produce adverse patient and staff outcomes. Homelessness, current substance abuse, schizoaffective disorder and borderline personality disorder or antisocial personality disorder traits were common in patients engaging in BOC.

2 Educational Goals

1. An understanding of the demographic of patients who are more likely to exhibit violence on an acute adult inpatient unit.
2. Interventions and the associated outcomes for managing behaviours of concern.

Correspondence

Email: g.sonmez@alfred.org.au

The prevalence and consequences of workplace aggression on employees in elderly care settings

Paper

Ellen Delvaux, Emma Boonen, Lode Godderis

Keywords: Workplace aggression, Psychological well-being at work, Prevalence, Elderly care

Introduction

Aggression in the workplace is a hazard that may impair employees' psychosocial well-being. Several studies have shown that employees are often confronted with workplace aggression. For instance, results from the European Working Conditions Survey show that, on average, about 14% of European employees have encountered aggression or another form of intimidation in the year before completing the survey (1).

In addition, it has been shown that employees in health care settings are more exposed to workplace aggression. In the same European Working Conditions Survey, it was found that employees from health and social work were especially vulnerable to workplace aggression: the prevalence in these groups goes up to 23%. A meta-analysis across more than 150.000 nurses showed that 36.4% have encountered physical aggression and up to 66.9% have encountered non-physical aggression in their career (2). Few studies have focused on aggression in elderly care settings. The studies that have done so report high prevalence of aggression: In a Swedish study, it was reported that 40% of the staff caring for the elderly was confronted with workplace aggression (3).

Workplace aggression has detrimental effects on employees' psychosocial well-being at work. In an extensive systematic review on the consequences of workplace aggression, it was reported that workplace aggression had physical, psychological, emotional, social and financial consequences, both within and outside the workplace (4). In one study testing the link between workplace aggression and burnout, the experience of both physical and psychological aggression was related to emotional exhaustion; the experience of psychological aggression was related to reduced personal accomplishment (5).

Although we have some first insights into the prevalence and consequences of workplace aggression in elderly care settings, this study was set up to investigate (a) the prevalence of workplace aggression in elderly care settings in Flanders, and (b) the consequences of workplace aggression on several dimensions of psychosocial well-being of employees in elderly care settings, including emotional exhaustion and detachment, absenteeism and job satisfaction.

Methods

Participants: Questionnaires were administered to employees of 17 different elderly care settings in Flanders, Belgium. In total, 1389 of the 2528 employees who received an invitation completed the questionnaire. Of the participants, 88.6% was female. This reflects the working population in this type of work. The mean age of the participants was 42 years ($SD = 11.86$).

Measures

Workplace aggression was measured with 3 items (e.g., You were threatened with physical violence (6)). This scale has good reliability ($\alpha = 0.86$). Job satisfaction was measured with one item (How satisfied are you with your work, all things considered? [7]).

Work engagement was measured with 6 items (e.g., At my work, I feel I am bursting with energy (8,9)). This scale has good reliability ($\alpha = 0.92$).

Intention to stay was measured with two items (e.g., I want to stay with this organisation as long as possible (10)). This scale had good reliability (Spearman-Brown $r = 0.76$).

Absenteeism due to psychosocial factors at work was measured with one item (If you were absent, was at least part of your absence caused by your job? Self-administered item).

Stress was measured with two items from the COPSOQ-II questionnaire (e.g., How often have you been stressed? (11)). This scale had good reliability (Spearman-Brown $r = 0.74$).

The two most central sub-dimensions of burnout were measured with the Dutch version of the Maslach Burnout Inventory (UBOS): emotional exhaustion and detachment. Emotional exhaustion was measured with 5 items (e.g., I feel mentally exhausted because of my work), detachment was measured with 4 items (e.g., I doubt the usefulness of my job (12)). The reliabilities of both scales were good ($\alpha = 0.91$ en $\alpha = 0.83$ respectively).

Results

Prevalence of workplace aggression in elderly care settings

In the six months prior to completing the questionnaire, 20.8% of the employees in elderly care settings encountered workplace aggression. Of this percentage, 0.9% encountered workplace aggression on a daily basis, 2.2% on a weekly basis, 1.8% on a monthly basis, and 15.5% from time to time.

We also made a distinction between aggression by colleagues or supervisors (= internal aggression) or aggression by third parties, such as elderly patients, family or other visitors (= external aggression). 46.8% of the employees experienced external aggression, 29.8% internal aggression, 11.3% experienced both (12.1% left this question open).

Employees were confronted most frequently with insults or threatening gestures (18.5%), followed by physical aggression (12.7%), and finally threats of physical

aggression (10.8%). There were no significant differences in prevalence according to gender ($\chi^2(1) = 2.70, p > 0.05$) or age ($\chi^2(1) = 0.77, p > 0.05$). Differences in prevalence occurred between function types ($\chi^2(5) = 42.30, p < 0.001$) with the highest prevalence for nurses (30.4%) and the lowest prevalence for logistics employees (10.0%).

Consequences of workplace aggression in elderly care settings

In order to test for the consequences of workplace aggression, we performed hierarchical regressions. In the first step, we entered the control variables age, gender and function type as predictors of several work outcomes. In the second step, we entered workplace aggression as predictor. Table 1 shows the results for the different regression models. Controlling for age, gender and function type, we found that workplace aggression was negatively related to job satisfaction, work engagement and intention to stay, and positively related to absenteeism due to psychosocial factors, stress, emotional exhaustion and detachment, as we expected.

Table 1. Results of the hierarchical regression analyses for the relationship between workplace aggression and work outcomes

	Job satisfaction	Work engagement	Intention to stay	Absenteeism due to psychosocial factors	Stress	Emotional exhaustion	Detachment
Predicting variables	Beta (standardized regression coefficient for the total regression equation with all predicting variables)						
Step 1							
Age	0.06	0.11***	0.10***	0.01	-0.04	-0.05	-0.02
Gender (0 = female)	-0.01	-0.04	-0.03	0.04	0.07*	0.06*	-0.00
Nurse vs. health care professional	-0.00	-0.08*	-0.02	-0.01	0.02	0.00	0.01
Paramedic vs. health care professional	0.08**	0.05	0.07*	-0.04	-0.11**	-0.15***	-0.03
Logistics employee vs. health care professional	0.04	-0.00	0.07*	-0.02	-0.12**	-0.10**	-0.07*
Administrative employee vs. health care professional	0.10**	0.05	0.06	-0.11**	0.00	-0.12***	-0.08*
Step 2							
Workplace aggression	-0.09**	-0.09**	-0.10**	0.12***	0.14***	0.13***	0.12***

* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

Discussion

A substantial number of employees in elderly care settings are confronted with workplace aggression. In our study, 1 out of 5 employees were confronted with workplace aggression six months prior to filling out the questionnaire. No differences in prevalence occurred for age and gender, only for function type: nurses experienced the highest levels of workplace aggression, employees in supporting functions such as

logistics experienced the lowest levels of workplace aggression. This may be because the latter have less (physical) contact with the residents.

Moreover, encountering workplace aggression has adverse effects on employees' well-being at work. We found that workplace aggression impacted several indicators of both wellness and ill-health at work: the higher the levels of workplace aggression, the lower the levels of job satisfaction, work engagement and intention to stay; the higher the levels of workplace aggression, the higher the levels of absenteeism due to psychosocial factors, stress, emotional exhaustion and detachment.

Given the high prevalence of workplace aggression and its negative consequences, elderly care settings may benefit from a policy towards workplace aggression that includes both preventive and curative measures. Preventive measures may entail training on workplace aggression and adaptations to safety procedures. Curative measures may involve a good working aftercare system both at the individual and the team level to strengthen employees' resilience, such that the negative consequences of workplace aggression are alleviated.

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Correspondence

ellen.delvaux@idewe.be

Leave End Associated Violence Evaluation (LEAVE): staff returning from annual leave don't experience more violence

Paper

Stuart Thomson, Helena Austin & Keith Reid (UK)

Keywords: violence, annual leave, holiday, violence, human resource, data

Background

NTW is one of England's largest mental health and disability trusts, with more than 6,000 staff, population approximately 1.4 million, 60 sites, over 2,200 square miles and national services e.g. combinations of forensic and developmental services which are more liable to restrictive practice. Our size, clinical need and external links give us a duty to innovate. We have a successful restraint reduction strategy with an innovation portfolio (1).

As part of this we are learning to integrate information from our real time electronic incident reporting system with other data such as human resource data.

We are aware of a widely held belief that temporary staff use is associated with violence. This is not easily amenable to research but is supported by a small evidence base. A PUBMED literature search on the 10th of September 2018 (locum OR temporary OR bank OR agency) AND (staff OR nurse OR team) AND (violen* OR aggress* OR assault OR inciden*) identified three relevant papers of 424 in the last five years, Bowers 2013 (2), Munoz 2012 (3) and Jafree 2017 (4), suggesting correlations between violence intensity and temporary staff. Confounding factors and reverse causation make analysis of this relationship complex. We wished to explore this as part of our trust's systemic restraint reduction programme.

We considered one putative confounding factor of relational event blindness: "*not seeing first-hand what happened recently*". We imagined this may affect both substantive staff returning from leave and agency staff. We developed a methodology to isolate this. In turn we established this service evaluation to calculate odds of violence against substantive staff on their first day returning to the ward, following annual leave. A more distant aim was to develop competence in integration of differing sorts of data.

Method

Staff annual leave data from the four adult Medium and Low Secure (MSU and LSU) wards in Newcastle upon Tyne was gathered between June 1st and August 31st 2017. Periods of between 7 and 21 consecutive days away from a staff member's usual ward of work were included. This could comprise of annual leave, rostered days off and leave to attend training. Periods of sick leave were excluded as this could confound the results.

The date of the First Day Back to work (FDB) was used as the period of exposure for analysis. Data for violence and aggression towards staff was sourced from daily electronic incident reports which took place during the evaluation period. These are an integral part of the restraint reduction program in the trust and the trust has evidence that they are completed with good reporting (5,6). Service Evaluation ethical permission (SER-17-041) was obtained prior to gathering any data. All staff information was anonymised using payroll number. Ward managers gave annual leave data anonymised by payroll number to KR who was also at that time in a medical managerial grade that allowed access to sickness and violence data.

We reviewed each violent incident during the time period, and whether a staff member on their first day back from leave had been involved. A priori we planned a contingency-table-based approach using Fishers exact or similar analyses of frequency, sub-analyses of hourly rates using shift patterns if necessary, and Kaplan–Meier survival curves, but the results did not require analysis being so clear.

Results

Table 1. Contingency table summarising incidence of VA on FDB

First Day Back (FDB)	Violence/aggression (VA)		Total
	Yes	No	
Yes	0	81	81
No	43	5761	5804
Total	43	5842	6285

Over the 5761 dates analysed there were a total of 90 incidents of Violence and Aggression (VA), an incident type which includes threats and verbal aggression. 53 occurred on the MSU admissions ward, 15 on the LSU, 2 on the MSU rehabilitation ward, and 20 on the MSU personality disorder ward. Not one incident of violence occurred against substantive nursing staff on their first day back from leave of the type that we assessed.

All dates of VA and FDB can be set in a 2x2 contingency table as above to show the calculation:

There was also no correlation found between VA and FDB ($P=1.0$). This was consistent with the base rates of violence and leave. We discontinued our secondary, shift-based analysis and more elaborate analyses due to diminishing returns.

The zero figure was entirely consistent with chance and base rates. For clarity, here is the calculation. When looking at how common assaults are in the population we studied we used the equation:

- A- FDB and VA
- B- FDB and no VA
- C- No FDB and VA
- D- No FDB and no VA

X = odds of any given day featuring violence or aggression.

$$X = (A+C/A+B+C+D)$$

$$X = (0+43)/(0+43+81+5761)$$

$$X = 0.007306712$$

Z = the number of assaults you'd expected as "A" if we apply rate X to $(A+B)$ which represents the number of FDB

$$Z = (0.007307) X (0+81)$$

$$Z = 0.591867; \text{ less than one, as found in the data}$$

Discussion

Candidly, though this was not research, if we had had an expectation, it may have been that there would be an increased risk of violent incidents on the first day back. This would have been important for our service to know about. If this had been the case then the factors driving the increase in violence may have been similar to those in temporary staff. We invite replication of our data. Perhaps we are good at handover, and/or have a relatively static population, and other services may have a correlation between leave and staff being subject to violence.

Conclusion

Substantive regular staff members working at our site do not appear to be at an increased odds of violence on their first day back from leave. This would suggest that the factors driving correlations between temporary staff and violent incidents may not be mediated by processes common to substantive staff having leave.

The ambient rate of violence and the number of staff on their first day back would be expected to be zero (less than 1) due to chance if there were no effect. This was the case.

Future directions

An important aspect of this work is that it sits within a developing innovation portfolio. We feel more confident in integrating human resource data with violence figures.

We have received legal and data protection advice and applied for ethical permission to do a larger scale service evaluation of rates of violence against employment status. Employment statuses are agency (externally employed) staff, bank (internal locum nurses) and substantive staff. The evaluation is designed to be well controlled with regard to sensitive protected characteristics such as self-identified first language. It is called PERCEIVE - Patterning Employment status, Race, Clinical experience & English in Violence against Employees. We have the full support of our equality and diversity department. We would strongly welcome any discussion of ethical or methodological aspects to this proposed evaluation from the floor.

Learning Objectives

1. To develop strategies to analyse organisational/contextual variables and their possible relationship with violence and aggression
2. Learn how to influence trusts to provide relevant data required for research and service evaluation purposes
3. Invite participants to develop their own plans for investigating putative non-patient risk factors, and comment on the ethics or methodology of our next step

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Correspondence

keith.reid@ntw.nhs.uk

Measuring Both Sides of Aggression: Aggressive Event & Worker Exposure Characteristics in Inpatient Psychiatry

Paper

Joanne Iennaco (USA)

Keywords: Aggressive event, aggression exposure, inpatient psychiatry, measurement methods

Abstract

Background

Aggression is a common problem in inpatient psychiatric settings. Obtaining accurate measures of aggression can be difficult, particularly when considering that two rates are of interest, the rate of patient aggressive behavior as well as the rate of healthcare worker exposure to aggression. Very few measurement methods are able to carefully characterize both rates.

Methods

A longitudinal study was undertaken to measure aggressive events in a group of four acute inpatient psychiatric units in the United States. During a 4 week study period, incident and injury reports, the Staff Observation of Aggression Scale-Revised (SOAS-R), the Patient Conflict Containment Shift Report (PCC-SR), and Aggression Exposure Counters were used to measure aggressive events ranging from mild verbal events to severe verbal and physical events.

Results

Over the time period, the number of events measured ranged from 6 using Incident and Injury reports to 197 events using handheld Aggression Exposure Counters. Recorded characteristics of events varied by measurement method used. While most measures included categories to describe aspects of an event, Aggression Exposure Counters provided more specific information including brief descriptions of the events. Only Aggression Exposure Counters provided worker specific aggression exposure information and brief event descriptions to offer more information on the characteristics of events. Comparison of events across measures can provide information to better understand and gauge event severity.

Discussion

Different measures offer different perspectives on the nature and trajectory of aggressive events in clinical settings. Development of methods that provide more realistic counts of events may lead to better characterization of patient aggressive events and worker exposure and lead to more specific strategies to reduce aggressive behavior in clinical settings. In addition, having specific rates of worker exposure offers a more direct estimate of the impact and consequence of aggression exposure on workers.

2 Educational Goals

At the completion of this presentation participants will be able to:

1. Discuss the value of measures that characterize the trajectory of aggressive events and worker aggression exposure.
2. Evaluate the ability of aggression measures to provide descriptive characteristics and severity information related to aggressive events and exposure.

Correspondence

Email: joanne.iennaco@yale.edu

Sleep at night and association to aggressive behaviour; Patients in a Psychiatric Intensive Care Unit

Paper

Knut Langsrud, Håvard Kallestad, Arne Vaaler, Roger Almvik, Tom Palmstierna & Gunnar Morken (Norway)

Keywords: Sleep, Aggression, Violence, Psychiatry, Inpatients, Risk assessment

Abstract

Evaluations of associations between sleep at night and aggressive behaviour in Psychiatric Intensive Care Units (PICU) are lacking. The aims of this study were to explore if sleep duration or night-to-night variations in sleep duration correlated with aggressive behaviour and aggressive incidents the next day and through the whole admission. Fifty consecutive patients admitted to a PICU were included (521 nights) and the nurses registered the time patients were sleeping, aggressive behaviour with The Brøset Violence Checklist (BVC) and aggressive incidents with The Staff Observation Aggression Scale-Revised (SOAS-R). At admission, short sleep duration the first night correlated with aggressive behaviour the next day and admissions with violent incidents had a median of 4.0 h difference in sleep from night one to another compared to 2.1 h for the rest of the admissions. During the stay, large absolute difference in sleep duration between two nights correlated with aggressive behaviour the next day and short sleep duration was associated with violent incidents. Short sleep duration and night-to-night variations in sleep duration are both associated with increased risk for aggression in PICUs. This observation might help to predict and prevent aggressive incidents.

2 Educational Goals

Better understand:

1. The association between sleep and aggression among patients in a Psychiatric Intensive Care Units (PICU).
2. How the findings might improve prediction of aggression.
3. The limitations of a study from a naturalistic setting.

Correspondence

Email: knut.langsrud@ntnu.no

Establishing a uniform measure of aggression and violence in emergency departments throughout New Hampshire USA

Paper

Lisa Mistler (USA)

Keywords: emergency departments, violence, measurement

Abstract

Background

Workplace violence in healthcare remains a serious problem, despite decades of efforts designed to address it. The field is plagued by inconsistencies in definitions, particularly the definition of violence, and in wide variation in methodological approaches to measurement. Currently used measures are not accurate, as workplace violence is under-reported.

Aims

To establish the use of consistent definitions and uniform measures of aggression and violence among emergency departments (EDs) in New Hampshire (NH) hospitals.

Methods

Initially, we presented the concept to the New Hampshire Hospital Association (NHHA), a group of administrators from each of the 26 community hospitals in NH. They established a uniform definition of violence. Hospitals were then recruited by invitation through the NHHA. Our team had an initial meeting with each hospital's leadership, presenting the aims of the project and describing what participating entailed. For each hospital, it was essential to identify an information technology "*point person*," who is now assisting in implementation of a variation of the Modified Overt Aggression Scale (MOAS) in each hospitals' electronic record. The MOAS was modified to allow staff to collect data contemporaneously with violent events, so they would be completing a MOAS for each patient at the end of each shift. We developed and will be providing a 1 hour inter-rater reliability training for those completing this modified MOAS. Once staff have completed the training, they will collect daily, per shift data on episodes of violence in the ED and send it to a centralized, anonymized database.

Conclusions

This project is still in progress as it has taken considerable time and energy to gain momentum with EDs. Many hospitals were cautious about participating because this is simply a measure and not an intervention. Essential in the process was our explaining that since there are no uniform measures yet, we have to start somewhere, and we hope to be able to either use this instrument or continue to develop an instrument that fits easily into the workflow, that provides staff and hospital administrators with some meaningful data, and that can provide insight into interventions and prevention approaches that work and that do not. The goal is for facilities to share this important information with each other to reduce variation in approaches and ultimately to reduce the insidious sequelae of workplace violence in EDs in NH.

2 Educational Goals

1. Describe barriers to and facilitators of implementing consistent approaches to measurement of aggression and violence in Emergency Departments.
2. Identify reasons for under-reporting of workplace violence in Emergency Departments.

Correspondence

Email: lisa.a.mistler@dartmouth.edu

Exploring the time trend of first aggressive episodes in pediatric psychiatric inpatient units

Paper

Ping-I Lin & Drew Barzman (Sweden)

Abstract

Objectives: To assess the temporal trend of changes in aggressive tendencies in the pediatric psychiatric inpatient unit and to identify the predictors for recurrent aggressive episodes.

Design: Longitudinal study

Setting: The medical records with a focus on aggressive behaviors were extracted from inpatient units at the Division of Child and Adolescent Psychiatry at Cincinnati Children's Hospital Medical Center in the U.S.A.

Participants: A total of approximately 5,610 adolescents were enrolled in this study. Main outcome measures: The hazard rate and hazard ratio corresponding to the event (i.e., first recurrent aggressive episode).

Results: Our data suggest that there might be two peaks (i.e., 7th and 17th days) of incidences of recurrent aggressive behaviors within the 30-day hospitalization period. The the highest aggression levels (defined by Overt Aggression Score > 2) occurred before the the 10th day of hospitalization and were more likely to be male. The time line of recurrent aggressive behaviors might depend on sex, age, and prior history psychiatric hospitalization.

Conclusion: Our data suggest the two peaks of incidence rates for first recurrent highly aggressive behaviors occur during the first ten days of hospitalization. Prevention and intervention strategies should take the predictors for this time trend into consideration.

Introduction

Inpatient aggression on pediatric mental health units continues to be a challenge jeopardizing both patient care and staff safety, but limited research exists on practical, proven strategies for predicting and preventing aggressive behavior (Baeza et al. 2013; Bernsten et al. 2011; Malas et al. 2017). In a survey conducted at pediatric hospitals and consultation-liaison services, 84.2% of respondents reported encountering agitation and behavioral escalation seen as precursors to explicitly aggressive behavior at least once

per month and as frequently as every week (Malas et al. 2017). However, more than 50% of respondents reported insufficient support due to lack of training to deal with aggressive behaviors (Malas et al. 2017). Therefore, a better understanding of the nature of aggressive behaviors in clinical settings is urgently needed. Effective prevention or intervention strategies for recurrent aggressive behaviors rely on the risk assessment – which includes the identification of at-risk individuals and the timing of interventions.

We need to clarify the relationship among multiple risk factors and the outcome in order to identify at-risk individuals. Several previous studies have attempted to identify demographics of patients who are at a higher risk of aggression in the inpatient unit and on re-hospitalization. According to Baeza et al., aggressive patients are typically 15.2 ± 1.6 years old, African American, have had previous psychiatric treatment and higher levels of aggression, impulsivity, oppositionality and/or common diagnoses of disruptive behavior diagnoses, bipolar disorder and pervasive developmental disorders (Baeza et al., 2011). Tossone et al. states that patients at risk of rehospitalization are typically Caucasian, 13-years-old, have medicaid insurance, come from a single-parent or divorced household, have a history of victimization, parents with mental health issues, suicidal behavior, learning problems and/or problems with peers (Tossone et al., 2014). Most of these previous studies have reported risk factors of aggressive behaviors. The studies also demonstrate a lack of standardized, objective measures of risk of aggression and a plan to maintain the safety of patients and staff.

Little is known about the predictors for time lines of recurrent aggressive behaviors. The time trends may vary by many different factors related to individual characteristics as well as interventions. The time trends may also vary by the clinical severity. We need to properly predict the time trend of recurrent aggressive behaviors at clinical settings in order to administer appropriate treatments or preventions. Additionally, we need to properly perform the risk assessment with regards to the time-dependent clinical course in order to provide appropriate advice on the length of the treatment. This assessment is particularly imperial for patients with severe aggressive behaviors on inpatient settings, since ideally the termination of inpatient treatments should only occur when no is no imminent high risk of recurrence. There have also been studies that have shown that different types of programs and interventions can be used to lower the frequency/amount of auto-aggression and aggression towards others and objects (Noelck et al., 2019). Similarly, these studies lack objectivity in that they are based on clinical judgement and, moreover, fail to integrate a predictive scale to determine the risk and/or severity of these aggressive acts.

We have developed The Brief Rating of Aggression in Children and Adolescents (BRACHA) (Barzman et al., 2011) – which is an objective and standardized clinical rating scale that can predict inpatient aggression and aid in psychiatric treatment. This instrument will provide a foundation for us to explore how we could predict the timeline of recurrent aggressive behaviors. In the current study, we have combined the BRACHA

score and various demographic and clinical features to examine how different factors might influence the time trend of recurrent aggressive behaviors at psychiatric inpatient units.

Methods

Setting

We have conducted a prospective study to collect the data on recurrent aggressive behaviors for adolescents who were hospitalized at the psychiatric inpatient units of Cincinnati Children's Hospital Medical Center in Ohio, U.S.A. We have extracted the medical records of 5,610 adolescent patients who were hospitalized at the inpatient units of Division of Child and Adolescent Psychiatry. A majority of these patients were hospitalized because of problems of behavioral or emotional dysregulation.

Participants

We prospectively collected data on aggressive behaviors at psychiatric inpatient units at Cincinnati Children's Hospital Medical Center from May 1, 2010 to April 30, 2015. Behavioral assessments of child and adolescent patients (mean age: 13.24, SD: 3.45, range: 2.1-20.6) were completed throughout the whole period of hospitalization. The sample was slightly male predominant (boys: 53.57%).

Data

Outcome measures

Aggressive behaviors were assessed using the overt aggression scale (OAS) during the hospitalization period. "*The first aggression day*" was defined as the first day when the OAS score was found to be greater than or equal to 1. The "*first high aggression day*" was defined as the first day when the OAS score was found to be greater than or equal to 2. We derived a time to event variable using data on length of stay (in days) and information on the time (in days) to first aggressive event per individual[CB1], which was used to measure the incidence rate per day from admission as well calculate hazard ratios using survival analysis.

Predictors

We have selected several individual characteristics, such as the patient's age, sex, race, health insurance status and living arrangement, as predictors for the time trend of first recurrent aggressive behaviors. Our data also included information on exhibited behaviors at the prior to admission or during clinical evaluation at the time of admission. The information recorded was[CB2]: prior history of psychiatric hospitalization, trouble accepting adult authority, physically aggressive towards others, if the patient showed signs of impulsivity or agitation during the evaluation, if they were intrusive towards others during the evaluation, if they have committed violent acts or attempted to commit violent acts (?), showed violent ideation while calm, is threatening towards others or property, has destroyed property, has been aggressive towards themselves

or others during the last 24 hours (before admission), showed a pattern of verbal or physical aggression, was aggressive or showed signs [CB3] of antisocial behaviors prior to the age of 10, lacks remorse, shame or guilt, if they have a history of suspension or expulsion from school. The data also includes a composite aggression score (BRACHA) developed by Barzman et al. (2011) calculated from these variables. Disregarding the composite score, the dataset consists of 19 potential predictors of aggression.

Statistical methods

To examine the factors associated with the time trend of recurrent aggressive behaviors, we have used survival analysis methods to estimate incidence rates and hazard ratios (HR). Given the large set of predictors at our disposal ($k=19$), we decided that it would be appropriate to perform a variable selection analysis before deciding on which variables to include in the final models. Following the recommendations in Walter & Tiemeier (2009), we first applied a Least Absolute Shrinkage and Selection Operator (LASSO) model to the data. The main benefit of the LASSO model is that it penalizes and shrinks the coefficients of unstable variables, correcting the extremes of the distribution. It also effectively excludes unstable predictors. Hence, we are (often) left with a smaller, but more reliable, set of predictors to use in the final analysis. Specifically, we used the Coxnet model implemented in the `glmnet` package for R to perform this analysis, selecting the optimal regularization parameter using leave-one-out cross validation. The drawback with this method is that there is no consensus regarding how to obtain p-values and confidence intervals for the coefficients produced by LASSO models (ref). After obtaining the set of variables that were retained (i.e. not shrunk to zero) in the Coxnet model, we therefore returned to the conventional Cox regression model to run the final analysis and obtain confidence intervals for HR. This analysis was performed using the R package “*Surv.*” Sensitivity analyses included checks for violations of the proportional hazards assumption by including time*covariate interaction terms, as well as running censored Poisson regression as an alternative model.

Results

Descriptive data

The average length of stay was 6.84 days (SD: 4.10, range: 1-64), amounting to 39,359 person-days of follow-up time in total. The characteristics of the study participants are detailed in Table 1.

Outcome data

Out of the 5,610 patients included in the sample, 1,761 (31.4%) had at least one aggressive episode during their length of stay. For these individuals, the average time to first aggressive episode was 3.35 days (SD: 2.58, range: 1-25). Accounting for the fact that we only define individuals as ‘*at-risk*’ up until their first aggressive event, we observed a total of 28,184 person-days at risk. This corresponds to an incidence rate of 6.25 (95% CI: 5.96 - 6.55) per 100 person-days.

Main results

1. Unadjusted univariate analysis

We have plotted the hazard for different subgroups classified by different demographic or clinical features, for those features that were statistically significant associated with the hazard (p -value < 0.05). Overall, most hazard curves could be approximately fit using an asymmetrical sigmoid function. Fig 1 contains the eight panels that represent eight different comparisons of hazard curves. The results indicate that the two subgroups classified by each demographical/clinical feature have shown different patterns when the outcome was defined differently. When the outcome was defined as the “*first aggression*,” the high-risk group had always a greater incidence rate than the low risk group throughout the 30-day period. Additionally, the incidence rates of both high-risk and low-risk groups decreased monotonously during the whole period of hospitalization. However, when the outcome was defined as “*first high aggression*,” the high-risk group did not always exhibit a greater incidence rate than the lower group. Furthermore, the incidence rates of wither high-risk or low-risk group decreased in the first 7-12 days but could increase abruptly around 17th – 20th days.

2. Variable selection analysis

Fitting a regular cox regression model using the covariates that were included in the cross-validated LASSO survival model yields the following results.

2.1. First aggression as an outcome

Older age seems to be a protective factor (HR 0.90 per one year increase in age, 95% CI: 0.89-0.92), but we might examine non-linearity in this relationship. **Being male** is a clear risk factor (HR 1.49, 95% CI: 1.34-1.66), as well as belonging to the Black or African American demographic as opposed to being White/Caucasian or other (HR 1.18, 95% CI: 1.06-1.31). **Living with at least one biological parent** shows a tendency towards a decrease in the risk of aggression (HR 0.92, 95% CI: 0.83-1.02), but the results are non-significant for this factor.

Prior history of psychiatric hospitalization indicates an average risk increase of roughly 50 percent (HR: 1.49, 95% CI: 1.35-1.65). Being physically aggressive towards others (when is this measured? Is this directly related to the outcome variable?) indicates an increased risk as well (HR: 1.78, 95% CI: 1.45-2.17). Showing signs of impulsivity/agitation (HR: 1.76, 95% CI: 1.54-2.00) and/or being intrusive towards others (HR: 1.40, 95% CI: 1.20-1.63) during evaluation are also statistically significant predictors of aggression. Patients with **a history of suspension or expulsion from school** are more likely to have recurrent aggressive behaviors than those without such histories (HR: 1.40, 95% CI: 1.25-1.56). Having been aggressive to self or others during the last 24 hours prior to admission is also a significant indicator for aggression (HR: 1.34, 95% CI: 1.17-1.53).

Interestingly, it seems that threatening others or property was associated with a decreased risk of aggression (HR: 0.74, 95% CI: 0.63-0.87) [note: perhaps because verbal threats this is another way to vent instead of actually being aggressive? Or obvious confounding problem?]. Another odd result is that having violent ideations while calm also seem to have a tendency ($p = 0.06$) towards being a protective factor (HR: 0.83, 95% CI: 0.68-1.01).

The time to aggressive episode decreased linearly with higher BRACHA scores according to a linear regression model (regression coefficient = -0.032, $p = 0.026$). The results suggest that there is a one day difference between an average individual with the highest possible score compared to an average individual with the lowest score (-1.00, 95% CI: -1.87, -0.12). This suggests not only that individuals with higher scores are at higher risk of aggression, but that these events tend to happen sooner as well.

2.2. First high aggression as an outcome

We have re-run the survival analysis using the Cox proportional model to re-evaluate the effects of the same set of covariates on the hazard ratio. The results show that fewer covariates exerted statistically significant effects on the hazard ratio compared to the analysis results at the section 2.1. The covariates include gender with a marginally significant effect (HR: 1.17, 95% CI: 1.00-1.39), the BRACHA score (HR: 1.03, 95% CI: 1.00-1.06), and the history of suspension or expulsion from school. (HR: 0.81, 95% CI: 0.68-0.96).

Discussion

Our data suggest that the time line (expressed as time-dependent incidence rate) of recurrent aggressive behaviors might vary by the clinical severity. When the first recurrent episode of aggression (the OAS score > 0) was considered to be the target event, the incidence rate reached the peak approximately within the first week during the hospitalization, and then followed the reverse sigmoid curve to decline until the end of the hospitalization. The time trend was similar regardless of the subgroups classified by various risk factors, such as gender or the BRACHA score. However, when the first recurrent episode of high aggression (the OAS score 2) was considered to be the target event, the time trend of incidence rate appeared to have two peaks: 7th day and 17th-20th day. In addition, the relationship between the incidence rate and some risk factors might not remain monotonous throughout the 30-day period. For example, the incidence rate in boys appeared to be greater than girls within the first 10 days, but the incidence rate in girls began to exceed the incidence rate of boys after the 12th day. Furthermore, prior history of psychiatric hospitalization was associated with a greater incidence rate when the target event was defined as any level of aggression, but became inversely associated with a lower incidence rate when the target event was defined as high aggression. Note that the higher BRACHA score seemed to predict a greater incidence rate throughout the 30-day hospitalization regardless of the clinical severity of the target event, although.

The differences between the two sets of survival analyses might be attributable to several reasons. First, the second set of survival analysis (i.e., high aggression regarded as the event) had fewer events than the first set of survival analysis (i.e., aggression regarded as the event), and hence some risk factors became non-significant due to the lower statistical power in the former set of analysis. Second, the second set of analysis focused on the aggression with higher levels of clinical severity, compared to the first set of survival analysis, which might lead to a selection bias towards more severe cases that responded relatively more poorly to initial treatments. For example, patients with no prior history of psychiatric hospitalization might be treated with regimen without prior evidence for efficacy, and hence such patients might hence more likely exhibit more severe symptoms that often respond more slowly to treatments compared to less severe symptoms. Therefore, one of the major limitations of the current study is the lack of adjustment for variable treatments between individuals. Third, the patients with a longer period of hospitalization might tend to have aggression with a more severe clinical severity level – which may explain why we observed a second peak of incidence rate in the second set of survival analysis when we focused on high aggression.

In conclusion, the time trend of the first recurrent episode of aggression might indicate when the prevention or intervention should be prioritized to de-escalate the related symptoms. Caution needs to be exercised to assess the risk since different choices of target event might correspond to different time trends. More research is warranted to validate the patterns of time-dependent risks based on different levels of clinical severity, so the clinical management guidelines can take these individualized factors into consideration.

Funding

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Figures and legends

Fig. 1 Panels A and B show the comparison between boys and girls when the target event was aggression and high aggression, respectively; Panels C and D show the comparison between groups of “*lack of remorse/guilt*” and “*with remorse/guilt*,” when the target event was aggression and high aggression, respectively; Panels E and F show the comparison between the groups with prior psychiatric hospitalization and no prior psychiatric hospitalization, when the target event was aggression and high aggression, respectively. Panels G and H show the comparison between the groups with higher BRACHA scores and lower BRACHA scores (cutoff: 6), when the target event was aggression and high aggression, respectively.

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Correspondence

pingi.lin@gmail.com

drew.barzman@cchmc.org

Workplace violence against healthcare workers in different levels of hospitals in China

Paper

Yusheng Tian, Jiansong Zhou & Yamin Li (China)

Keywords: workplace violence, healthcare workers, China

Abstract

Background

Workplace violence (WPV) is a serious issue for healthcare workers, and leads to many negative consequences. However, little information is available on the correlates of different types of WPV for healthcare workers in China. The study aimed to explore the demographic and occupational correlates of different types of WPV among healthcare workers in China.

Methods

The study is a cross-sectional design. The convenience sample was from 149 cities across 23 provinces. A Chinese version of the workplace violence scale was used to measure the WPV. Other potential influencing demographic and occupational factors were collected using a structured questionnaire. Descriptive analyses and binary logistic regression were performed on the collected data.

Results

1. A total of 3684 valid questionnaires were obtained (74.6% nurses and 25.4% physicians). Respondents were aged from 18-72, with nearly 50% aged below 30, and the mean age was 31.6 ± 7.7 .
2. The incidence of workplace violence among healthcare workers was 56.4% (2079/3684), and the highest was emotional abuse (48.6%), followed threat (27.0%), verbal sexual abuse (16.2%), physical abuse (15.9%), and sexual abuse (8.1%).
3. Healthcare workers in mental health departments are most vulnerable to all five types of violence, followed by emergency department and the pediatric department.
4. A binary logistic regression revealed that being male, shift work, lower level of education, higher professional title, longer working hours per week and working in secondary hospitals have greater odds of experiencing workplace violence.

Conclusion

Healthcare workers in secondary hospitals in China are at a significant higher risk of workplace violence compared to those in primary and tertiary hospital. Interventions aimed at workplace violence reduction should be taken by health authorities to create a zero-violence practicing environment.

2 Educational Goals

1. The audience will know the prevalence of different types of workplace violence against healthcare workers in China.
2. The audience will know the condition of different types of violence against healthcare workers in different levels of hospitals.

Correspondence

Email: 2274129589@qq.com

Determination and characterization of violent episodes in a psychiatric unit in India: Insights and perspectives

Poster

Virtu Chongtham, Nitasha Sharma & Bir Singh Chavan (India)

Keywords: violence, inpatient psychiatric unit, restraint

Abstract

Background

The Mental Health Care Act of India, 2017 has for the first time focused on violence management interventions especially restraint and seclusion in psychiatric settings and recommended important guidelines in this aspect. This has created a strong need to review violence in inpatient settings, its associated clinical and social correlates keeping a preventive model in context.

Aim

In view of the newly enacted Mental Health Care Act of India, 2017, this study was undertaken to identify the prevailing characteristics of violence in inpatient settings and its management practices.

Specific Objective

To explore the socio-demographic and clinical profile of patients exhibiting violent behaviour in inpatient psychiatric units; To characterize violent episodes and management practices adopted; To serve as a basis for planning future initiatives for prevention and minimization of violence in Indian inpatient psychiatric settings in alignment with the Mental Health Care Act of India, 2017.

Methods

A retrospective chart review undertaken for all patients who were admitted during two years of study and exhibited violent behaviour during the hospital stay. Socio-demographic and clinical characteristics of patients along with descriptive details of violent episodes as well as intervention strategies employed were extracted. Additionally,

the data on the risk profile of patients who exhibited violent behaviour more than 3 times during a single hospitalization was also obtained.

Results

A total of 188 violent episodes were recorded during the two-year study period involving 95 patients over 21,397 patient days. The violent episode density was 8.78 per 1000 patient days. The majority of patients exhibiting violence were single males in their early thirties and the most common psychiatric diagnosis was BPAD. For nearly half of the violent episodes (45.2%), the antecedent leading to violence by patient was refusing patients' request for going outside the ward/parole/discharge; physical violence being the most common type including both threatening behaviour without direct contact as well as direct contact. 7.4% episodes of violent behaviour could be managed through use of verbal de-escalation only while in remaining 92.6%, restrictive interventions were required even after verbal de-escalation was tried in some cases. The most common form of restraint used was chemical (53.2%). The outcome of majority of the episodes (83%) showed no major injury to persons requiring medical intervention while damage to property had the next highest score.

Conclusions

In conclusion, factors associated with violence are in concurrence with previous existing literature. Important factors such age, gender, marital status, diagnosis and type of admissions were identified. The findings of the study can be taken as an initial exploration which highlights the strong need for realigning our existing services towards evidence based violence prevention, minimization and management practices.

2 Educational Goals

1. The presentation of this work will enable participants to foresee the practical changes required in Mental health care in India, regarding violence in inpatient psychiatric setting that are triggered by the introduction of Mental Health Care Act of India, 2017.
2. This work will provide an insight into the prevalence and management of violence in inpatient setting in a resource limited situation of a developing country like India.

Correspondence

Email: virtu05gmch@gmail.com

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

“The dark side of care”- Inadequate care, abuse and neglect in Norwegian mental health care

Paper

Tonje Lossius Husum, Per Nortvedt, Reidar Pedersen & Olaf Aasland (Norway)

Keywords: mental health care, ethics, inadequate care, abuse, neglect.

Abstract

Introduction

Parallel to increased attention on issues related to users' rights, experiences and participation in mental health care (MHC) services, users' experience of inadequate care, abuse and neglect have got attracted lots of attention. The behaviours described stretch from being treated with disrespect, through verbal scolding to physical violence. The purpose of this study was to investigate if and to which extent users and staff have experienced/performed, witnessed or heard about inadequate care, abuse and neglect toward users by staff in MHC. Since these issues are scarcely investigated, the study was explorative in nature.

Method

Data was gathered through an anonymised web-based questionnaire to users and staff. Staff was recruited through the professional's organizations and users was recruited through Norwegian user organizations. The study was part of a comprehensive multi-centre study investigating different ethical aspects in relation to care and use of coercion in mental health services. Altogether, 1160 staff and 320 users answered the questionnaire about their experiences with different kinds of inadequate care, abuse & neglect toward users having mental health care.

Results

Users experienced a wide variety of inadequate care, abuse and neglect during mental health care: As much as 67 percent had experienced disrespect; 63 percent had experienced condescending behaviour and 59 percent had experiences of rejection. Staff verified the high amount of inadequate care, abuse and neglect during care: Altogether 21 percent of staff said they had treated patients with disrespect; 16 percent said they had used condescending behaviour, and 46 percent said they had rejected patients.

Discussion

This study shows that some users' experience inadequate care, abuse and disrespect during care. Staff verified the findings by stating they have used, observed and witnessed inadequate care, abuse and disrespect of users. The paper discusses alternative explanations and risk factors for inadequate care, abuse and neglect; like staff burn out, high work load, staff insensitivity, lack of empathy and lack of good role models/ leadership.

Conclusion

A disturbingly high number of users and staff report users being treated with inadequate care, abuse and neglect while having mental health care. Users in mental health institutions are vulnerable and at risk of inadequate care, abuse and neglect because of the imbalance in power between staff and patients in the institutional setting. It is therefore of considerable scientific value and important for this group of vulnerable users that this issue be further examined. User's experiences of inadequate care, abuse and neglect should be taken seriously, and efforts should be made to prevent this practice.

Founding

The project received funding from the Norwegian Health Directorate and Extrastiftelsen (NGO founding).

2 Educational Goals

1. Increased awareness (cognitive & emotional) of user perspectives in MHC care.
2. Increased awareness and knowledge (cognitive & emotional) of potential harm, inadequate care, abuse and neglect towards users in MHC.

Correspondence

Email: t.l.husum@medisin.uio.no

Chapter 4 – Trauma informed care & practice

Implementing a trauma informed care approach in psychiatric wards – a pilot project in psychiatry South Denmark

Paper

Gitte Nørreskov Vase, Anne Katrine Gjerløv, Mathilda Randris Andersen, Lene Høeg & Anne L Eisenhardt (Denmark)

Keywords: Trauma informed care approach, mental health, pilot project, implementing process, clinical experience, “top down process”

Abstract

Trauma informed care is implemented in many hospitals across the US. In Denmark, the awareness of a trauma informed care approach is huge. In south Denmark, there is a continued focus on reducing coercion and conflict, which led to introducing the trauma informed care approach (TIC).

Knowledge regarding TIC is undefined, and there are no options in learning from peers in Denmark. South Denmark is introducing TIC as a pilot project in 12 psychiatric units. The project is created as a “*top-down*” implementation, insisting on participation from ward management, consultant doctors and key workers.

The aim is to try implementing TIC and learn if the method used is valuable and useable in clinical practice.

The method used is “*lay the path while we are walking*”, via the PDSA process, questioning the staff in the wards during the project period. The project creates the conditions for optimal transfer of learning by studying literature together, giving presentations which relate to TIC and encourage practical exercises on the pilot wards. The process is ongoing, and this presentation will present a view of the process, results and experience from the clinical wards in Aabenraa.

This a method of introducing TIC, against a background of a lack of experience and we are interested to investigate its success. By slowly introducing the theory, the aim is that it will change the culture and reduce conflicts and coercion.

From the results, we expect to see a difference in staff actions and a reflection of TIC in their interventions. Also, staff will gain new knowledge on how to prevent coercion. At the very least, the project will help us gain knowledge on best practice in implementing TIC; at present this knowledge is lacking.

2 Educational Goals

The participants will:

1. gain knowledge on the process implementing trauma informed care approach
2. learn concrete examples of interventions made in clinical practice

Correspondence

Email: giva@rsyd.dk

Implementation of the German Guideline on Prevention of Coercion and Therapy of Aggressive Behaviour: Pilot Study and Consecutive multi-centre RCT

Paper

Tilman Steinert (Germany)

Keywords: Coercion, violent behaviour, Guideline, implementation

Abstract

Background

In July 2018, the evidence-based German Guideline on Prevention of Coercion and Therapy of Aggressive Behaviour was published after a formal consensus process with 23 medical and other societies, patients' and relatives' organizations. In December 2018, the German Association for Psychiatry, Psychotherapy, Psychosomatics (DGPPN) approved a recommendation for the implementation of this guideline on psychiatric wards, in hospitals, and in regions. The recommendation for wards encompasses 12 single aspects. We developed a study design for implementation and evaluation and started a pilot study.

Methods

The 12 recommendations are: 1. Introduce routine recording of coercive interventions and aggressive incidents with the possibility of obtaining results on the ward level; 2. introduce detailed internal guidelines for the use of coercive interventions; 3. introduce a monthly team conference where recent data on aggressive incidents and coercive interventions are discussed; 4. introduce a training schedule in de-escalation management for all staff members with patient contact, at least once within two years; 5. ensure 1:1 supervision during seclusion and mechanical restraint; 6. ensure debriefing after coercive interventions; 7. engage peer workers on the ward; 8. establish an action plan for environmental design of the ward once per year; 9. implement the Broset Violence Checklist and ensure that actions occur according to risk assessments; 10. recommend a joint crisis plan to all patients after a coercive intervention; 11. ensure guideline-adapted pharmacotherapy, e.g. by a special monthly visit; 12. introduce Safewards or another evidence-based complex intervention. Special trainers for the implementation (mostly researchers in the field) agreed on the implementation procedure and will participate among selected psychiatric wards in Germany, in a pilot study. Teams of

psychiatric wards are supposed to have realized some but certainly not all of these recommendations. Hence teams are encouraged to select some points according to their preferences and to work on their implementation, supported by the trainers. The degree of successful implementation will jointly be assessed before and after one year on a scale developed for this purpose. Primary outcomes will be the numbers of coercive interventions and aggressive incidents per bed per month.

Results and Future

The pilot study began in April, 2019. First results will be reported. We applied for funding for an RCT with 52 participating wards. The study design may be adjusted according to results of the pilot study.

2 Educational Goals

1. learn key contents of the German guideline on Prevention of Coercion and Therapy of Aggressive Behaviour
2. learn about problems and strategies of implementation of complex interventions

Correspondence

Email: tilman.steinert@zfp-zentrum.de

Reducing incidents of violence in clinical settings through Collaborative Care Planning and Comfort Kits

Workshop

Monica McAlduff, Jane Sun & Janice Fyfe (Canada)

Keywords: Patient Aggression, Care Planning, Trauma Informed Practice, Family Inclusion

Introduction

Aggression and violence towards providers, patients and family members in psychiatry are a serious concern. Patients who are in acute psychiatric distress have a higher chance of aggression or violence aimed at themselves or others (1). Acute inpatient settings often do a good job of using the environment and medications to promote patient recovery and safety. However, as incidents of aggression and violence can often be triggered by staff-patient interaction (2) there is an increasingly need to promote safety through multiple methods, including psychosocial & Trauma Informed Practices (TIP), for providers, patients & families in a health care system constrained by financial and time resources.

Vancouver General Hospital (VGH) Inpatient Psychiatry piloted client groups for Collaborative Care Planning & Comfort Kits throughout 2017 and 2018 on the short stay Psychiatric Assessment Unit (PAU). Groups were led by Dr. Jane Sun and included having clients fill out their own Comfort Plan, reviewing a starter Comfort Kit, and creating their own unique Comfort Kit ideas. In addition to the pilot work, Monica McAlduff, Janice Fyfe & Dr. Jane Sun worked with the Patient Safety Movement to create an Actionable Patient Safety Solution centred on Collaborative Care Planning and Comfort Kits that is available for free download. With the help of funding from the VGH & UBC Hospital foundation the Collaborative Care Planning & Comfort Kit initiative was expanded in 2019 to include all areas of the portfolio with the aim that all clients who receive care at our sites will have access to collaboratively creating a Comfort Plan with their clinician and a starter comfort kit.

Collaborative Care Planning & Comfort Kit Method

Collaborative care planning uses a TIP approach through combining the efforts of providers, patients, and their family caregivers in working together to set and achieve health goals, and involves greater patient involvement in the planning, delivery, and

evaluation of care. This self-recognition may translate to preventing patients from reaching a point of crisis where they are at a higher chance of aggression or violence. Participants in this workshop will complete the collaborative care planning process for building a comfort kit with a client. Collaborative care planning begins with a conversation between client and carer about emotions that a client may experience during periods of feeling well, feeling a bit anxious, feeling “down” or feeling intense negative emotions (crisis). For each emotional period, client and carer complete a “*comfort plan*” collaboratively addressing: what the client notices, what others notice, what the client can do and how others can help. Clients are encouraged to contribute as many ideas as possible and to do the physical writing of the plan, if they are able, to gain a sense that the comfort plan is their own. When addressing “*what other’s notice*” ideas from community care providers, family, friends etc. are encouraged depending on the clients consent.

Once the Comfort Plan has been created by the client, carers can introduce the Comfort Kit as a way to strengthen the comfort plan. In order to assist clients in building a range of self-regulation resources a starter comfort kit is introduced. The items are reviewed one by one with the client and the client is given autonomy to determine which items are helpful to them and which are not. In our work the hospital provides only a starter comfort kit to help clients understand the concept of collaborative care planning and comfort kits. Clients are encouraged to build a personalized kit throughout the rest of their stay which they will take with them upon discharge. Carer and client can brainstorm items that are unique to the client reducing their level of emotion. Because funding in institutions is often limited, family and friends can be contacted to help bring items for the comfort kit that will also meet the regulations of the unit. The inclusion of family and friends in collaborative care planning & comfort kits can also ease the feeling of helplessness among family and friends and provides another layer of collaboration during admission and support after discharge.

After creating a comfort kit and identifying unique items, clients are encouraged to hang the Comfort Plan on their wall where it is able to act as a reminder of what to try when an emotional challenge arises. Although the Comfort Plan is created between a client and one clinician a copy of the Comfort Plan must be made available in the clients’ chart so that other clinicians can use this as a resource when the clients is agitated. Understanding how a client would like to be help may deescalate situations in timely manner than using stock de-escalation skills (2).

Conclusion

Collaborative care planning is applicable to inpatient & outpatient settings and is a low-cost (starter kit: CAD\$3) tool to help patients and their family caregivers recognize when they are reaching levels of acute psychiatric distress. The inclusion of a patient’s family and/or support persons (friends, religious leaders, private mental health clinician,

etc.) in a patient's care planning is vital to providing complete care for the patient in a trauma informed way. We have identified the involvement of family and other supports as a key factor in promoting optimal patient outcomes.

The Two-Step Comfort Toolkit is used in collaborative care planning with TIP values to systematically build a patient's awareness and support the patient's skills development in an effective and efficient way. Implementation of the tool can lead to better treatment for the patient through provider, patient & family understanding; reducing the incidents of aggression & violence and focusing on maintaining wellness rather than responding to problems as they arise.

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Correspondence

Janice.Fyfe@vch.ca

Enhancing CAMH's Safety Program with Safewards: Creating Safer Spaces for Work and Recovery

Paper

Stephanie Carter, Emily Johnstone & Stephen Canning (Canada)

(Authors: Aileen Spratt, Emily Johnstone, Julia Duzdevic, Stephanie Carter, Stephen Canning)

Keywords: Safewards, Safety, Training, Implementation, CAMH, Canada

Introduction and Background

The Centre for Addiction and Mental Health (CAMH) in Toronto, Ontario 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 fully affiliated with the University of Toronto, and is a Pan American Health Organization/World Health Organization Collaborating Centre.

Safe & Well CAMH is an organization-wide priority designed to ensure staff and patients are physically and psychologically safe and healthy. TIDES (Trauma Informed De-Escalation Education for Safety and Self-Protection), Safe & Well CAMH's key initiative, is a mandatory, hands-on staff training program encompassing the latest research evidence including Safewards.

Safewards is an open-source, evidence-based, patient-centered model of care proven to reduce conflict and containment in mental health care settings (Bowers et al., 2015). In 2016, CAMH selected three forensic inpatient units with relatively high levels of violence as pilot sites to evaluate the impact of Safewards over one year. This resulted in a downward trend of conflict severity (as measured using organizational data and the Modified Overt Aggression Scale) (Yudofsky, Silver, Jackson, Endicott & Williams, 1986). Additionally, focus group findings indicated improved perceptions of safety, enhanced relationships from both staff and patient perspectives.

The conclusion of the pilot presented an opportunity to embed Safewards within CAMH's mandatory safety program (Prevention and Management of Aggressive Behavior) undergoing revision at the time. With leadership endorsement, TIDES launched in 2018 utilizing a big bang approach with initial focus on inpatient staff and physicians working directly with patients.

TIDES Program Overview

TIDES aims to:

1. Enhance skills and build confidence through team-based learning
2. Drive fundamental day-to-day processes proven to keep everyone safe
3. Bring learning to the point-of-care

Program Delivery:

TIDES utilizes a variety of learning modalities including didactic, interactive group activities focused on practice enhancements, case-based learning, and simulation.

TIDES is delivered in an ongoing two-year cycle with one year comprised of three (non-consecutive) days of in-class training and the next year consisting of simulation-based learning activities. Training is delivered to intact teams (i.e. those that respond to codes together) spanning the following topics:

Day 1: Foundations of prevention –develops knowledge and introduces strategies setting a common foundation for staff to prevent escalated situations and increase everyone’s safety. Staff learn about Safewards interventions (practice enhancements) and identify ways to use them in practice.

Day 2: Team response, crisis/code white response, self-protection – focuses on continuing collaboration and relationships with patients, families (i.e. any person or group of people a person identifies as belonging to his/her/their family or significant circle of support) and staff to help manage rapidly changing situations.

Day 3: Trauma-aware physical interventions and restraints - focuses on the use of trauma-aware interventions and restraints in rapidly changing situations that become emergencies.

In-class training uses a unique co-facilitation model consisting of: an Education Specialist, a Point of Care Facilitator (POCF) (a peer clinical who has received additional specialized training) and a Service User Educator (an educator who has lived-experience as a client/patient or family member in the mental health care system).

While physicians are encouraged to train with their intact teams, additional offerings are available to accommodate their varied schedules. Day 1 is also available via e-learned narrated by a physician champion, and Day 2 is also offered during evenings and weekends, co-facilitated by a physician champion. Day 2 training received accreditation from the University of Toronto Faculty of Medicine Continuing Professional Development program providing a valuable incentive to attend.

Beyond the classroom, staff engage in monthly, customized on-unit learning facilitated by POCFs in areas of interest or need, to maintain and enhance confidence, knowledge and skills.

TIDES Development:

Developed collaboratively by an inter-professional committee with diverse representation from key stakeholder groups including: clinical staff, clients/patients and family, unions and leadership, TIDES will undergo iterative quality improvements annually to reflect program evaluation results and the latest research evidence.

Safewards within TIDES:

CAMH's Safewards pilot resulted in numerous learnings along three primary themes: required culture change, challenge integrating into practice and resistance to elements of the Safewards model, all of which culminated in a challenge with buy-in. These learnings informed the refined approach undertaken with TIDES to implement the Safewards interventions.

The Safewards interventions were renamed TIDES practice enhancements and incorporated in *Day 1: Foundations of prevention* as core concepts of prevention. Further, each practice enhancement was renamed to better reflect CAMH's culture and become more action oriented.

Table 1. Revised Safewards intervention naming

Safewards Intervention	TIDES Practice Enhancement
Clear Mutual Expectations	Setting Clear Mutual Expectations
Soft Words	Communicating Collaboratively
Talk Down	De-escalating
Positive Words	Identifying Strengths
Bad News Mitigation	Mitigating Bad News
Know Each Other	Knowing Each Other / This is ME
Mutual Help Meeting	Shared Support Meeting
Calm Down Methods	Providing Comfort Items
Reassurance	Reassuring
Discharge Messages	Displaying Transition Messages

In addition to these language changes, Knowing Each Other was expanded upon through the creation of "*This Is ME*", a new landing page in each patient's electronic health record (EHR) emphasizing who our patients are beyond their diagnoses. Here, patients have the opportunity to share hobbies, interests, and other details about themselves to provide caregivers with a more holistic view of who they are. "*This is ME*" encourages mutual familiarity and helps staff and patients form stronger therapeutic relationships, faster.

To increase applicability and buy-in, elements of standardization and opportunities for customization were developed for each practice enhancement. Unit leadership (Manager, Advanced Practice Clinical Lead (APCL), Nurse Educator) then received specialized training delivered over a series of lunch-and-learns to increase awareness of TIDES and prepare to lead their teams through practice enhancement co-design and implementation. Once 80% of staff completed Day 1: Foundations of prevention, implementation was initiated with support from the Enterprise Project Management Office (EPMO). A TIDES Toolkit consisting of a detailed checklist to guide conversations and document decisions, as well as other supporting materials (e.g. poster templates, comfort items, decals for displaying transition messages, etc.) was provided to each team.

At the time of this report, direct-service inpatient staff have completed Day 1 and Day 2 training and are currently completing Day 3. All have been incorporating practice enhancements for approximately 6 months.

Methods

Moving beyond the pilot to inpatient-wide implementation allowed the organization to leverage the EHR by embedding practice enhancements into clinical documentation to further drive integration into daily clinical practice. This also provides a lens into the degree to which various practice enhancements are happening and identify opportunities for improvement and/or celebrate uptake.

The measurement plan for TIDES utilizes a variety of quantitative and qualitative evaluation and monitoring tools.

Assessments undertaken at various milestones to review achieved results against hypothesized results include:

- *The Combined Assessment of Psychiatric Environments – Revised (CAPE-R)* (Delaney, 2013) – this valid and reliable instrument was used to assess perceptions of care from the patients’ perspective and of the practice environment from the staffs’ perspective. Evaluation was scheduled for baseline (immediately prior to practice enhancement implementation) and again at 3 months, and 6 months post-practice enhancement implementation. Surveys are paper-based and participation was voluntary.
- *Pre and post in-class training evaluations* – these evaluations measure knowledge, skills and confidence gained as well as perceptions of the training delivery. Evaluations are paper-based and completed within each in-class session to increase response rates.
- *Outcomes tracking* – key safety and wellness outcomes reported in the organization’s Key Priorities Dashboard such as reduced rates of: restraint use,

code whites, unauthorized leaves of absence (ULOA) and leaves against medical advice (AMA) and workplace violence incidents are being evaluated at various points in time aligned with the TIDES program delivery.

The various monitoring components center on fidelity assessment and consist of:

- *Team Check-in Tool* - this tool was developed by the EPMO to help APCLs facilitate weekly team reflection on the progress of practice enhancement adoption. It provides criteria for each practice enhancement as well as discussion prompts. Teams assigned themselves a score based on criteria indicating the degree to which each practice enhancement has been implemented on a scale from 0 (not at all) to 3 (always) over the course of four months.
- *TIDES Report*—this report provides units with a monthly view of EHR documentation rates related to the seven practice enhancements embedded in clinical documentation (*Knowing Each Other, Displaying Transition Messages, and Communicating Collaboratively* are not included). This provides teams with an opportunity to reconcile perceptions of practice enhancement adoption against clinical documentation.
- *CAMH Fidelity Checklist* – this checklist contains 1-4 questions per practice enhancement and was adapted from the Safewards Organizational Fidelity Checklist (Bowers et al., 2015) to assess practice enhancement sustainability and fidelity 6 months post-implementation. Half of the units completed the checklist independently, while half did so with a member of the EPMO during a site visit. This provided the EPMO a final opportunity to reflect on design decisions, ensure fidelity was upheld and support teams to optimize where necessary.

Ultimately, the *Team Check-in Tool*, *TIDES Report*, and *CAMH Fidelity Checklist*, serve as proxy measures for practice enhancement adoption, building on the Safewards Organizational Fidelity Checklist that received criticism during the pilot for providing a superficial view of adherence to the model.

Efforts were made to ensure the measurement plan was not just ticks against a ‘to-do’ list. If Team Check-in Tool data reflected strong practice enhancement adoption but organizational data and/or clinical documentation showed otherwise, team discussions around improving practice enhancement adoption and other TIDES concepts would occur.

Early Findings

CAPE-R:

The staff version contains 20 questions and 5 dimensions. At baseline, 22 of 24 units responded, declining to 13 of 24 units at three months.

Table 2. Staff CAPE-R Results

	Definition	Baseline	3 Month	6 Month
Dimensions	Staff's sense of...	n=22	n= 24	
Effectiveness	Skills to effectively work with patients and have meaningful impact	2.2	2.2	
Resources	Whether there is adequate staffing on the unit to be safe and effective	2.0	2.0	
Teamwork	The interdisciplinary team's ability to trust and work collaboratively	2.4	2.4	
Team Voice	Whether staff have a voice in the interdisciplinary team	2.1	2.1	
Autonomy	The ability to protect themselves from injury, and access comfort items	2.2	2.1	

Rating Scale: 0=never, 1=sometimes, 2=very often, 3=always

The patient version of the CAPE-R contains 17 questions and 2 dimensions. At baseline, 17 of 24 units responded, declining to 11 of 24 units at three months.

Table 3. Patient CAPE-R Results

	Definition	Baseline	3 Month	6 Month
Dimensions	Patient's sense of...	n=22	n=24	
Staff Competence	Staff abilities, the therapeutic relationship, and inclusion in care planning	2.3	2.3	
CAMH Specific	Expectations on the unit, needs being met, and ability to direct care	2.2	2.1	

Rating Scale: 0=never, 1=sometimes, 2=very often, 3=always

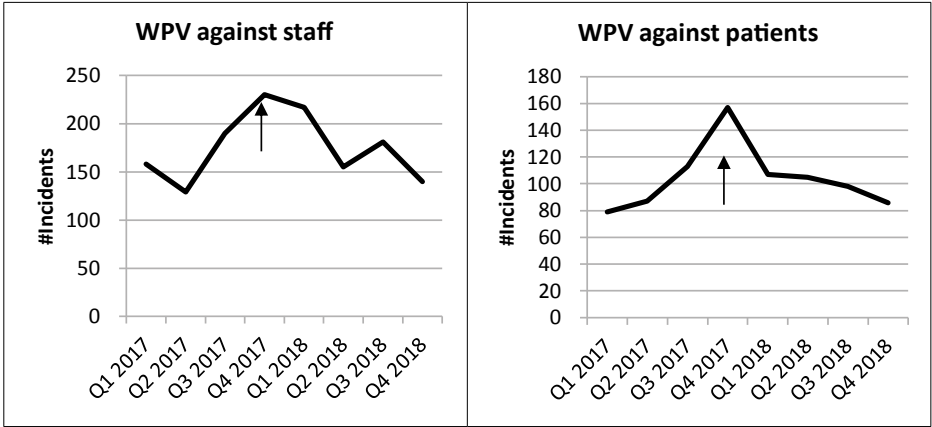
Results for both staff and patient CAPE-R indicate no significant change from baseline to 3 months across each dimension. The average response for each dimension is 'very often' indicating positive perceptions of care (patients) and the practice environment (staff). At the time of this report, six-month survey administration is underway.

Outcomes Tracking:

Early findings indicate that the volume of workplace violence incidents against patients and staff have been decreasing in alignment with the implementation of the TIDES practice enhancements as indicated by arrows in the tables below. While these statistically significant trends indicate improvements in recent quarters, the contribution of this initiative to the outcomes observed requires more in-depth investigation.

Table 4.
Workplace violence against staff

Table 5.
Workplace violence against patients



Team Check-in Tool:

Average scores began low and improved overtime as expected. The practice enhancement lagging the longest was Knowing Each Other. Feedback from the pilot and TIDES revealed that many staff were uncomfortable displaying profiles containing basic information about themselves for patients to see. As a result, this became the only optional practice enhancement.

Mitigating Bad News, Providing Reassurance and Holding Shared Support Meetings scored the highest on average. This is likely the result of these activities occurring commonly on the units prior to implementation.

Practice Enhancements	Week														
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Holding Shared Support Meetings	2.3	2.2	2.5	2.6	2.7	2.7	2.9	2.8	2.8	2.8	2.9	2.7	2.7	2.7	2.4
Setting Mutual Expectations	1.9	1.9	2.1	2.2	2.3	2.4	2.6	2.4	2.7	2.7	2.8	2.6	2.7	2.7	2.6
Providing Comfort Items	1.7	1.8	1.8	1.8	2.2	2.1	2.1	2.2	2.2	2.2	2.3	2.1	2.4	2.5	2.2
Displaying Transition Messages	0.9	1.6	1.7	1.9	2.0	2.0	2.0	2.2	2.0	2.1	2.1	1.9	2.0	2.1	2.0
Knowing Each Other	1.6	1.6	1.6	1.7	1.7	1.9	1.8	1.9	2.1	2.2	2.1	2.3	2.4	2.4	2.2
De-escalating	1.5	2.2	2.2	2.3	2.3	2.2	2.4	2.4	2.6	2.8	2.7	2.5	2.4	2.4	2.4
Reassuring	2.0	2.2	2.4	2.5	2.5	2.6	2.5	2.6	2.6	2.8	2.6	2.5	2.6	2.6	2.5
Mitigating Bad News	2.1	2.5	2.6	2.7	2.8	2.6	2.7	2.7	2.7	2.8	2.7	2.6	2.6	2.7	2.4
Communicating Collaboratively	1.7	2.0	2.2	2.3	2.3	2.4	2.6	2.4	2.5	2.4	2.5	2.3	2.2	2.4	2.2
Identifying Strengths	1.3	1.8	1.8	1.9	2.1	2.2	2.1	2.2	2.2	2.3	2.4	2.3	2.4	2.2	2.1
Units reporting (/24)	22	22	22	21	21	21	20	20	19	18	17	16	15	15	14

Rating Scale: 0=not at all, 1=sometimes, 2=most of the time, 3=always

TIDES Report:

It is challenging to ascertain the level of practice enhancement adherence relying on EHR documentation alone as many practice enhancements do not have a denominator. For example, it is difficult to determine how often Mitigating Bad News should have occurred in a given period. Most units expressed that the TIDES Report under represented the actual practice enhancement activity on the unit.

CAMH Fidelity Checklist:

Results indicated a high degree of fidelity and sustainability across all units with the lowest level of fidelity assigned to Knowing Each Other, the only optional practice enhancement.

Next Steps

Outpatient teams will commence TIDES training in 2020. CAMH's Nursing Practice Advisory Council completed a review to determine the applicability of practice enhancements in this setting and found that only minor modifications would be required as many were already in place to varying degrees. Implementation of the practice enhancements in the outpatient setting is being explored as a potential research opportunity.

Work is underway to expand and customize the TIDES program to reflect the needs of non-clinical administrative and corporate staff, patients and their families.

Upon completion of the full TIDES program, a fulsome evaluation will be conducted to inform any necessary revisions. This approach will continue annually as an iterative, continuous improvement cycle ensuring relevance and effectiveness to keep everyone at CAMH safe and well.

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Correspondence Details:

Julia Duzdevic
Patient Safety Specialist
100 Stokes St. Toronto
M6J 1H4

Chapter 5 – Assessment of risk, prevention & protective factors

Violent Behavior and aggression in Schizophrenia: prevalence and risk factors. A multicentric study from three Latin-America countries

Paper

Alejandra Caqueo-Urizar, Guillaume Fond, Alfonso Urzúa, Laurent Boyer & David Williams (Chile)

Keywords: Violent Behavior, Aggression, Schizophrenia.

Abstract

Objective

The aim of the present study was (i) to assess the prevalence of Violent Behavior in Schizophrenia (VBS) in a sample of community-dwelling outpatients in three middle-income countries of Latin America and (ii) to determine the clinical and socio-demographical risk factors associated with VBS and aggression levels.

Methods

The study included 253 stabilized outpatients with schizophrenia and their principal caregivers from 3 public ambulatory psychiatric care centers in Bolivia (N=83), Chile (N=85), and Peru (N=85). VBS was defined according to the Overt Aggression Scale (OAS) score and the aggression levels were measured by the aggression subscore of the Agitated Behavior Scale of Corrigan. We collected socio-demographic information and clinical data. Multiple linear and logistic regressions were performed to determine which variables were associated with VBS and aggression levels.

Results

The prevalence of VBS differed statistically between the three countries.

Conclusion

These results may guide future health policies to specifically provide social support and rehabilitation care to VBS patients in middle-income countries, including psychoeducation and a more integrated work between the treating medical team and the social workers.

2 Educational Goals

1. The presentation will fill the gap regarding the indicators of aggression and violence of patients with Schizophrenia in developing countries where a lack of research is observed.
2. The study allows participants to identify psychosocial factors related to the level of aggression and violence presented by patients with Schizophrenia in Latin American countries.

Correspondence

Email: acaqueo@uta.cl

TAPIR Timeline Analysis of Patient Incident Relationships - Using patient to patient correlation as a short term dynamic risk factor - - Non-independence of patient self-harm

Workshop

John Moore & Keith Reid (UK)

Keywords: Self-harm, statistical, risk, dyadic, social network, python

Introduction

Self-harm is common in children and adolescents with mental health difficulties (1). Prevalence has increased over decades (2). It has been suggested that *'modelling'* may trigger incidents in some settings or precipitate self-harm in those who have not previously self-harmed (3). They may be maintained by a learning-reinforcement, or serve to regulate dysphoria (1). The default reporting style in our trust is of frequencies of incident by patient over time, aggregated through ward then service lines. We hoped for an interpersonal addition. We counted incidents between pairs and applied Fisher's exact test. We did this for events occurring in the same time period, then a staggered, *'directed'* version, where we counted when a patient had an event one period after another specific patient. We used the resulting probability scores to draw lines between pairs. This makes a social network graph.

Methods

Ward safety incidents including self-harm are subject to regular scrutiny. Our R&D department advised that data open to us in our day-to-day clinical work required no further ethical clearance. We read authorities in dyadic data analysis, and KR coded in python. We intend to release open source code with library citation if this paper provides peer review of the clinical concept. The subject ward was for young people. Anonymised times of all incidents of self-harm for a 6 month period from a ward were copy pasted into Excel. Analysts divide the period that any two active patients were together into *'epochs'*, i.e. periods of the same length. Code only constructs a binary outcome as to whether the event occurred or not in each epoch. One, Two, Three or any events are all coded as "1" for "Yes" for each patient.

Table 1, A non-directed epoch strip

	epoch 1	epoch 2	epoch 3	epoch 4	epoch 5	epoch 6	epoch 7	epoch 8	epoch 9
A in pair	↓	↓	↓	↓	↓	↓	↓	↓	↓
B in pair	↑	↑	↑	↑	↑	↑	↑	↑	↑
	1,0	0,0	0,1	1,0	0,0	1,1	0,0	0,1	0,0

Dyadic data is established in developmental specialties and concerns pairs, perhaps a spousal pair. Two authorities are Card et al 2008 (4) and Kenny et al 2006 (5). A key concept is ‘*distinguishability*’, whether one in the pair is clearly different from the other. We did not treat our pairs as distinguishable. Cillessen and Borch demonstrate in Card et al that parametric data can be used to model adolescent social networks. Our underlying data are categorical. Kenny et al recommend a two-way table of association between pairs as we have done here. In Table 1, a series of epochs is assigned a pair of values meaning that both, one or neither people had an event in each epoch. The length of an epoch is arbitrary. There are constraints. Incident times are recorded in 5 minute blocks. The largest epoch would be an eighth of the total length. Fisher’s exact requires a minimum of eight epochs for $p \leq 0.05$. Comparison of simultaneous epochs we call ‘*non-directed*’.

Directed dyadic analysis method

Analysts may consider ‘*directed*’ analyses. That code only reads whether one patient is likely to have an event in the epoch after a specified first patient had an event. The first patient is called an ‘*actor*’ and the second is a ‘*partner*’, terms from dyadic analysis. Table 2.1 and 2.2 are directed epoch strips of notional patients A and B. In each strip, patients have identical incidences of events, but the order is reversed. The values of certain epochs are highlighted for clarity.

Table 2.1

	epoch 1	epoch 2	epoch 3	epoch 4	epoch 5	epoch 6	epoch 7	epoch 8	epoch 9
actor A			↘				↘		ignore box
partner B	ignore box			↖				↖	
		neither	neither	A then B	B	neither	A	A	neither

Table 2.2 - B then A

	epoch 1	epoch 2	epoch 3	epoch 4	epoch 5	epoch 6	epoch 7	epoch 8	epoch 9
actor B			↘		↘			↘	ignore box
partner A	ignore box			↖		↖			↖
				neither		B then A			B

A directed epoch strip A then B

The contingency table that would arise from Table 2.1 is Table 3.

Table 3 - Contingency table derived from a notional directed epoch strip Table 2.1

	Patient B did self-harm next epoch (i, 1)	Patient B did not self-harm next epoch (i, 0)
Patient A did self-harm (1, j)	1	2
Patient A did not self-harm (0, j)	1	4

Results

The most complex networks appear around an epoch of 1500-2500 minutes. The directional graphs have more significant patterns than the non-directional graphs, in general.

Figure 2 - An example directed social network graph of the probabilities of actor-partner self-harm patterns, from an epoch length of 1850 minutes, which is ~1.25 days

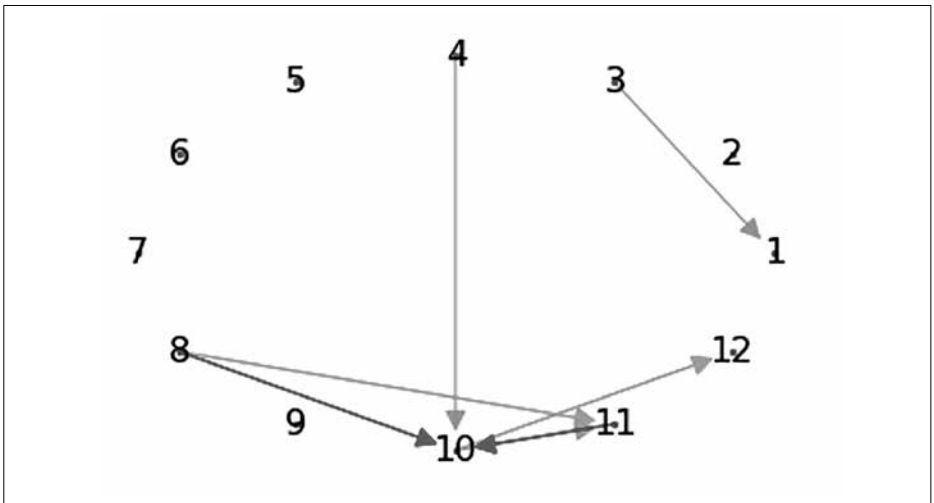


Figure 2 is a graphical representation of self-harm when the epoch is set to 1850 mins, which is about a day and 6 hours. Each number represents one of 12 patients. The lines between them are significant p values ≤ 0.05 or ‘less than or equal to 1 in 20’ which we annotate as 1:20. Our code makes 1:20 blue, 1:100 green, and 1:1000 red.

The pair 8, 10 have the following timeline if the admission is split into epochs of 1850 minutes. It can be seen that 8 then 10 becomes more frequent over time: [neither, neither, neither, 8, neither, neither, neither, neither, neither, neither, neither, neither,

neither, 8, neither, neither, neither, 8->10, 8, 8, 8->10, 8->10, 10, neither, 8, 8->10, 8->10, 8->10, 10, neither, neither, neither, neither, neither, neither, neither, 8->10, 8, 8, 8->10, 10, 8->10, 8->10, 8->10, 10, 10, 8->10, 8->10, 8->10]. Fisher's exact odds ratio = 9.6 and p value = 0.00088. It can be seen that 10->8 does not appear as significant in the graph, so p for "10->8" at this epoch is more than 1:20. The directional analysis does not consider non-directed, '*simultaneous*' events in the same epoch.

Regarding all 132 possible lines:

- "4->10", "3->1", and "10->11" are 1:20, where for example in "4->10", patient 10 is counted as having events in the epoch after patient 4.
- "8->11" and "10->12" are less than 1:100
- "8->10" and "11->10" are less likely than 1:1000

We would only by chance expect a 13% chance of any 1:1000 lines and we see two. The odds ratios are largely in the order of 5-15 meaning that when the first person in a significantly unlikely pair has an event the second is at 5-15 times more risk in the next day or so.

Discussion

We suggest that the graph presented does not support an assumption of independent patterns of self-harm. The formulation of possible causes for non-independence can be performed by the teams who have access to this analysis. We hope formulation can be co-produced with the patients involved. These results are independent of any judgment or blame.

In order to identify relationships, there has to be a high enough frequency of occurrences of the incident. Also, it is possible to have highly significant patterns with a high odds ratio but small absolute numbers making the tool of limited utility for that pair. Visual inspection of the various data forms together is helpful. The data relies to on staff completing timely and accurate forms for each separate episode of self-harm which may be challenging. It is our understanding that reporting cultures in our trust are good and tend towards high reporting rates compared to levels of harm (4). We also have 'Talk1st', a cohort-based formative learning and quality improvement system where wards meet quarterly to share data and good practice. Data are incorporated into routine meetings. 'Seni's Law' (7) will require adequate reporting of incidents in all mental health providers; all we have added is basic statistical tests. National data are available on reporting rates and ours are rated by a national body as being at low risk of under-reporting (8). It is conceivable that certain patients may only be reported after more severe behaviour, which could create a bias. However, we think that this is mitigated by clear definitions of self-harm, or could itself be a subject of formulation.

We warn against moral ascriptions based on TAPIR. We do feel consideration of interpersonal patterns moves discourse away from individual ascriptions which we feel can tend to be moral. TAPIR cannot support simple statements that the actor '*causes*' the event in the partner, nor that the partner '*copies*' the actor.

Kenny et al suggest four interacting sources of non-independence. We will use an allegory of affluence in friendship pairs. Firstly, compositional effects are that the pair are together because of the similarity. People may become friends due to coming from similarly affluent backgrounds. TAPIR non-independence is an epoch specific directional tendency in a partner, to have self harm events, in relation to a specific actor patient, presumably met for the first time at admission. So strictly it cannot have existed prior to admission and so should not be compositional. However some general tendency, to form non-independent dyadic patterns of self-harm in previous settings, may have influenced admission to the ward.

A second source is a partner effect, whereby the action of an '*actor*' in a pair directly or indirectly influences a '*partner*'. Rich actor friends might make their partner friends affluent. This and the third source, mutual influence, are what staff suggested before analysis.

A third is mutual influence. Friends may make each other affluent mutually, perhaps starting an enterprise as an aspect of their relationship. We think this may be relevant in our ward given the theory of '*modelling*'. Pairs of patients may mutually influence each other in a way that reinforces TAPIR non-independence, a very speculative example might be that the non-independence is linked mutual concepts of shared identity, support or attachment.

The fourth source is '*common fate*' whereby both in the pair are exposed to similar relevant environmental factors. Friend pairs may experience similar economic circumstances which drive affluence in both. A general mood, milieu, or staff or peer culture that support TAPIR non-independence could be relevant - again we are wary of value statements. But general environment does not explain the centrality of certain patients well, nor explain directionality. One environmental possibility, somewhat elaborate, is that each in a pair is sensitive to an intermittent cue for self harm but sensitive with differing latencies. An example is one patient being stressed by the start of the week on a Monday and the other on a Tuesday. This is not supported by the timeline e.g. in 10->8 or generally, but may be helpful in other formulations. We suspect all four sources of non-independence interact and can be formulated.

Conclusion

Some patients appear to present with self-harm in a non-independent way when assessed using our methodology. The intention of this work is to articulate our idea, develop a

methodology for detecting a pattern, subject it to peer review, and foster understanding of the complexity and importance of an open mind.

Declaration of Interest

None

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Dr Tomás Sherwen, University of York, advised KR on early drafts of code and provided inspiration and moral support.

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Correspondence

john.moore2@ntw.nhs.uk

craig.newby@ntw.nhs.uk

keith.reid@ntw.nhs.uk

Measuring the violence prevention climate: the VPC-14

Poster

Nutmeg Hallett (UK)

Keywords: Violence prevention, ward atmosphere, ward climate, staff and patient views, scale development

Abstract

Background

The activities undertaken at a ward level by patients, staff and organisations that prevent violence can be described as the violence prevention climate. Whilst there are numerous scales to measure ward climate, the violence prevention climate is less well explored.

Aims: To describe a new measure of the violence prevention climate, the VPC-14. To explore differences between and within staff and patient groups in perceptions of the VPC as measured by the VPC-14.

Methods

Scale items were developed from a literature review, patient focus groups and staff interviews. Items were subject to expert review and pilot testing. Subsequently all patients and staff within mental health care pathways in one trust, and who fulfilled the inclusion criteria, were invited to participate in a study to determine the factor structure of the tool, and to assess its acceptability, cogency, and internal consistency. The factor structure of the scale was tested using principle components analysis (PCA) and Rasch modelling using PCA of the residuals (PCAr). Patient and staff variables were collected to explore differences between and within groups. T-tests were conducted to compare patient and staff scores. Regression analyses were run to assess the relationship between VPC scores and within group variables.

Results

Development strategy yielded a 40-item scale. Response rates were 66% (n=95) and 93% (n=326) for patients and staff respectively. PCA of the items yielded a 16-item, two-factor structure: patient actions and staff actions. PCAr corroborated that each factor was unidimensional. Two items were removed as they returned high inter-item correlations. There were significant differences between the perceptions of patients and staff, with staff having a more positive view of the actions that staff take to create a

positive VPC and patients viewing the actions of the patient group more positively. There were less marked differences within groups.

Conclusions

The VPC-14 is quick and easy to administer for patients and staff, and demonstrates good internal validity. In line with other research on the ward environment, patients and staff perceive the VPC differently. The small amount of variance in both patient and staff perceptions of the VPC accounted for by individual variables suggests that the VPC is a valid construct; i.e. that despite individual differences, groups of patient and staff have similar perceptions of the VPC. The VPC-14 has the potential to evaluate violence prevention initiatives and can be used to measure trends over time.

2 Educational Goals

1. To better understand the violence prevention climate
2. To identify how the VPC-14 can be utilised

Correspondence

Email: n.hallett@mmu.ac.uk

Short-term risk assessment in acute psychiatry: a step towards an extended model

Paper

Øyvind Lockertsen, Sverre Varvin, Ann Faerden, Bjørn Magne Sundsbø Eriksen, John Olav Roaldset, Nicholas G Procter & Solveig Karin Bø Vatnar (Norway)

Keywords: acute psychiatry, aggression, repeated measurements, risk assessment, violence

Abstract

Background

Most structured violence risk assessment instruments achieve a moderate accuracy, suggesting a 'glass ceiling' effect. Inpatients' fluctuating mental states and behaviour patterns reinforce the need for a short-term risk prediction instrument to predict potential imminent violence. Previous studies on risk assessment of imminent violence in acute psychiatry have been limited in at least three aspects: the examination of only one instrument at a time, use of professionals' observations without including patients' self-perceptions of risk, and use of statistical and methodological analysis, which do not adjust for repeated measurements. Thus, there is a need to investigate whether different and extended approaches may improve predictions.

Aim

The aim was to investigate whether an extended short-term risk assessment model combining (i) short-term risk assessment with the Brøset Violence Checklist (BVC), (ii) patients' own prediction of violence with the Self-report Risk Scale (SRS) and (iii) single items from Violence Risk Screening 10 (V-RISK 10) would provide improved short-term predictive accuracy of violence compared to the BVC alone.

Methods

The design was a naturalistic prospective inpatient study. All patients admitted to a psychiatric emergency hospital in Norway during one year were included (N = 508). Stepwise multivariate generalised linear mixed model (GLMM) analyses were conducted. The extended model consisted of three steps: (i) BVC recorded at every nursing shift. (ii) BVC and SRS recorded at admission. (iii) The final extended model in which BVC, SRS and two items from V-RISK 10 were included.

Results and conclusions

When adjusting for repeated measurements, the results indicated that an extended model for short-term risk assessment, consisting of the BVC, SRS and one of the two single items from the V-RISK-10 was valid and that the extended model explained more variance of imminent violence, compared with the BVC alone. All components of the final extended model remained significantly associated with imminent violence when controlling for gender. Similar to global trends towards person-centred care, clinicians move closer to entering into the patients' conceptualisation of their risk for violence by including the SRS.

More studies are recommended to investigate whether such an extended model including patients' own prediction of violence provides a clinically better violence risk prediction than short-term risk assessments with the BVC alone.

2 Educational Goals

1. Increase knowledge about combining different approaches in short-term risk prediction.
2. Discuss the potential of an extended model for short-term risk prediction in acute psychiatry.

Correspondence

Email: oylock@oslomet.no

Root Cause Analysis: plenty roots = plenty ideas – a mindful view with the NOW-Model

Workshop

Gernot Walter, Johannes Nau & Nico Oud (Germany)

Background and Context

Root cause analysis is one of the main interventions suggested in many papers discussing complex interventions as a means for violence prevention (for example: 6 Core Strategies by Huckshorn 2006).

Also, the concept of zero-tolerance may support the creation of a good-bad dichotomy with an upper-lower-difference (Ilkiw-Lavalle et al. 2003; Middleby-Clements et al. 2007). In fact, aggressive behavior is a challenge which needs answers or – better – prevention (Mental Welfare Commission for Scotland 2017; National Institute for Health and Care Excellence (NICE) 2015). Therefore, we think, the emphasis should be on identifying influencing factors. That means 100%-mindfulness regarding all the contributing factors, which will help a client (and staff) to stay calm despite a distressing situation e. g. in an emergency department, psychiatry, nursing home etc.

Typically, in the health care context situations often are defined by the here and now which should therefore be the focus. For such situations a model is necessary which enables us to communicate easily what takes place in the cause of such an aggressive incident (“*here and now*”) without neglecting temporal or situational aspects of the situation.

Therefore, and for didactical reasons the NOW-Model (Box 1) was developed to emphasize the actual present situation of client or staff (“*here and now*”). One focus here is on the resources for all involved persons and circumstances in order to enable them to integrate respectful interactionist and situational approaches which considers not only flaws but abilities of clients, staff and the environment for maintaining or promoting a sense of security and equilibrium.

Methodology

After face validity was attested by research fellows, a grid was derived and the applicability of the model in multiple settings was tested by asking experts in the field to complete the grid (Box 2).

Results

Finally, we received completed grids from

- Accident and emergency department
- Community nursing
- Drug and alcohol dependency treatment and detox
- Forensic care
- General hospitals
- Gerontology and dementia care
- Ambulance paramedics
- Nursing students
- Nursing homes
- Pediatric care
- Psychiatric inpatient care
- -Children and adolescent psychiatric inpatient care
- Homes for people with learning disability

(Walter et al., 2012)

Users of the grid reported that it was easy to complete the part which asks for factors which promote aggression. And they reported that it was more difficult to complete the resources (inhibiting factors) section. But the latter was perceived as the most enriching part of the exercise. Interestingly, many adaptations towards strengthening the sense of security and equilibrium which were derived from the grid were rather easy and cheap to implement.

The grid has been used since in different forms in education and practice using case studies or as a means for a case review regarding clients with recurring episodes of aggressive behavior. Here the same processes took place, after a difficult start exploring the preventive factors, new ideas for intervention were developed and – if it was a team exercise – a new approach seemed to have been kindled (“*Let’s try this out!*”).

Overall, users of the grid reported a wider perspective which opened new ways of thinking and intervening.

Implications for practice, research, education & training, organization/management, policy and guidance

The zero-tolerance approach to violence could easily be reduced to zero tolerance regarding perpetrators. Subsequently, this could prevent people looking for further (root) causes beside the person behaving aggressively. Instead: 100%-mindfulness should be used to identify internal, interactive and environmental conditions which may enable us to keep in balance or to regain balance. The model highlights interaction, behaviors and organizational processes, their interferences and correlations. It helps for primary, secondary and tertiary prevention.

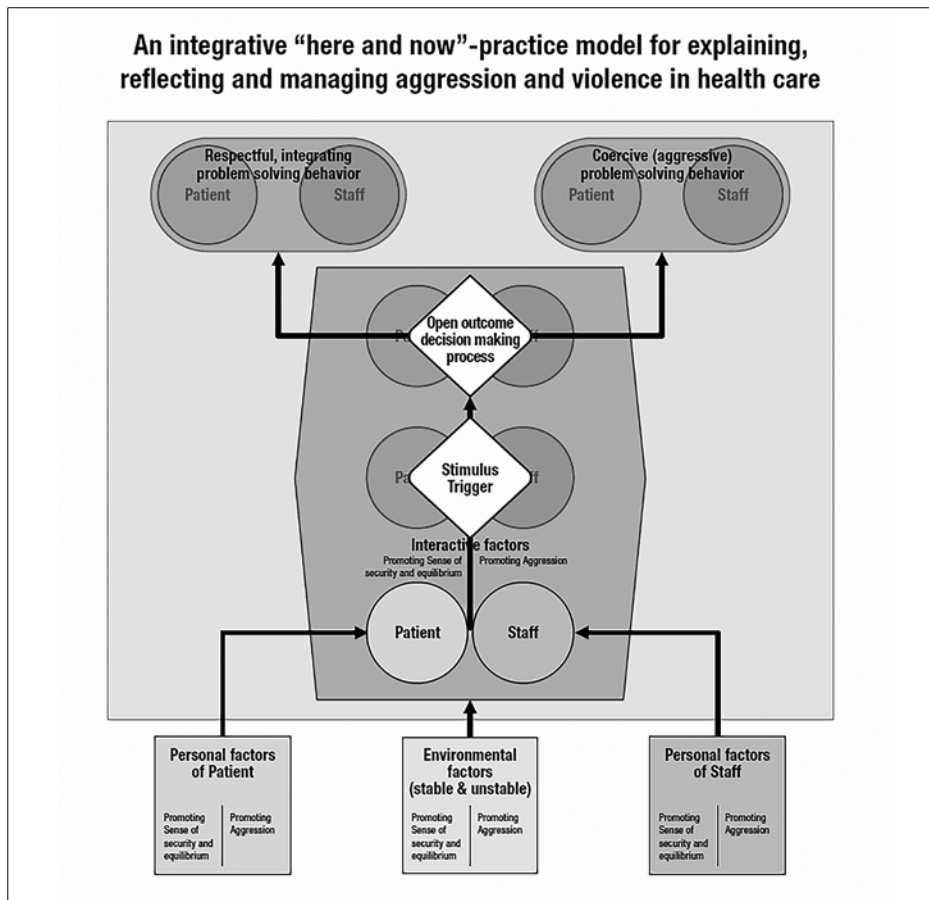
The NOW-Model is a valuable instrument for identifying crucial factors and achieving these aims.

The model is suitable for analyzing aggressive episodes, team-supervision, counselling, clients, relatives, and is convenient as a checklist for self-supervision. It may be used by colleagues and other people who have experienced violence.













Educational goals:

1. To better understand an integrated, respectful interactionist and situational approach which considers not only flaws but the abilities of clients, staff and environment for maintaining or promoting a sense of security and equilibrium.
2. To discuss how aggressive episodes within a team could have more emphasis on elements which promote sense of security and equilibrium

Box 1



Box 2 - Check-Grid to determine influencing factors:

	Promoting Sense of security and equilibrium	Promoting aggression
Personal factors of patient	 ...	 ...
Personal factors of staff	 ...	 ...
Contributing factors within other persons	 ...	 ...
Environmental factors (stable and variable)	 ...	 ...
Interactive factors	 ...	 ...
Examples of Triggers	 ...	
CONNECT! (new) ideas how to come in contact again	 ...	

Literature

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Correspondence

post@gernotwalter.de

Root Cause Analysis: plenty roots = plenty ideas – a mindful view with the NOW-Model

Poster

Nico Oud, Johannes Nau & Gernot Walter (Netherlands)

Keywords: multifactorial approach, contributing factors, preventing factors

Abstract

Background

Root cause analysis is one of the main interventions suggested in many papers discussing complex interventions. Aggressive behavior is a challenge which needs complex answers. These answers should consider not only aspects which may contribute to aggression but also aspects which prevent involved persons becoming aggressive respectively support their capability to stay calm and communicate in an appropriate manner. Thus, the emphasis should be on identifying influencing factors. For that reason, the NOW-Model was developed.

Methodology

After face validity was attested by research fellows, a grid was derived and the applicability of the model in multiple settings was tested by asking experts of the field to complete the grid.

Results

Completed grids from more than a dozen settings (including e.g. Psychiatric inpatient care, Forensic care, Gerontology and dementia care and many more) (Walter et al., 2012) applicability was accredited.

Users consistently reported that identifying aggression promoting factors was easier than identifying the resources (inhibiting factors), although the latter was more inspiring for practice. Interestingly, many adaptations towards strengthening the sense of security and equilibrium deriving from the grid were rather easy and cheap to implement.

Implications for practice, research, education & training, organisation/management, policy and guidance

Using mindfulness to identify internal, interactive and environmental conditions may enable balance or to regain balance. The model highlights interaction, behaviors and organizational processes, their interferences and correlations. The NOW-Model is a valuable instrument for identifying crucial factors usable in primary, secondary and tertiary prevention. The model is suitable for analyzing aggressive episodes, team-supervision, counselling, clients, relatives and is convenient as a checklist for self-supervision. It may be used by colleagues and other people who have experienced violence.

2 Educational Goals

1. To better understand an integrated, respectful interactionist and situational approach which considers not only flaws but the abilities of clients, staff and environment for maintaining or promoting a sense of security and equilibrium.
2. To discuss how aggressive episodes within a team could have more emphasis on elements which promote sense of security and equilibrium

Correspondence

Email: nico.oud@freeler.nl

An ethnomethodological exploration of police officers' use of a cognitive aid when encountering mental disorder

Workshop

Ivan McGlen (UK)

Keywords: Situation awareness, cognitive aid, police, mental disorder, ethnomethodology, Public Psychiatric Emergency Assessment Tool-Revised, mental health assessment.

Abstract

Background

Up to 40% of police encounters are associated with someone experiencing a mental disorder. Operational difficulties due to situational complexity, and the police officer's ignorance regarding the features of mental disorder, often translate into flawed situation awareness.

Aim

This study investigated a police officer's situation awareness, when encountering a potentially mentally disordered person. This underpinned the development of a cognitive aid to support them during such encounters.

Method

Building upon the work of Wright et al. (2008) with Lancashire Constabulary (UK), an ethnomethodological design was employed, viewed through the theoretical lenses of symbolic interactionism and Endsley's (1988) situation awareness framework. Completed in two stages, stage one utilised narrative synthesis, and individual semi-structured interviews with eight police officers. Data was thematically analysed to identify emerging themes which underpinned the cognitive aid's development. Stage two employed a pre-post-test design, utilising video vignettes, note-taking exercises, and focus group interviews with seventeen police officers. The cognitive aid was used operationally prior to conducting semi-structured interviews with ten police officers.

Results

Emergent themes identified that pre-encounter factors shaped police officers' situation awareness. These pre-encounter factors embodied both their expected and perceived policing role, including role-specific rules shaping their response to a mentally disordered person. The pre-encounter factors governed their assessment of danger, often resulting in pre-set behaviours to control a situation. The use of force as a first response, appeared common. Police officers demonstrated improved situation awareness, recognising and responding to a greater range of features of mental disorder when they used the cognitive aid. The use of force now appeared more judicious. It was to control, contain and prevent injury (to self or others), rather than as a default response.

Contribution of new knowledge

This was the first study to explore a police officer's situation awareness, when encountering a potentially mentally disordered person. It identified features police officers specifically associated with mental disorder. The findings highlighted the effect of pre-encounter factors and their influence upon their perception of danger. Significantly, the cognitive aid caused a paradigm shift from one defined by an assumption of criminality, to one defined by the interpersonal in which police officers recognised and better responded to a person's mental health and well-being.

2 Educational Goals

1. To better understand the methods, rules, actions and behaviours shaping the situation awareness police officers used to identify and respond to a potentially mentally disordered person.
2. To better understand the extent to which a police officer's identification and response to a potentially mentally disordered person, was shaped by the cognitive aid.

Correspondence

Email: imecglen@uclan.ac.uk

National data on coercive measures – Dutch and Flemish experiences within European General Data Protection Regulations

Workshop

Peter Cosemans, Eric Noorthoorn, Paul Doedens & Bart Thomas (Belgium)

Keywords: Coercion, National, Standard, Experience, Privacy, European regulations

Abstract

Background

Obtaining a grasp of figures on coercive measures in Mental Health Care is important in violence prevention. From 2006 onward, a nationwide register was established in the Netherlands, accompanied by hospital based and nationwide studies. For this purpose, the Argus rating scale was developed, covering seclusion and (chemical) restraint.

Aims

An important issue in using coercion findings is the difference in the interest of the health organisations, who use the findings as a means to learn from one another, where the National Health Inspectorate uses these for accountability. Between 2007 and 2014 this conflict of interest was resolved by organizing a central address for data processing and providing general nationwide data to the National Health Inspectorate. However, privacy issues related to data protocols unfit for EGDRP regulations impaired the gathering of data after 2016. Recently, due to developments concerning high and intensive care the need was identified to re-design definitions. In several rounds of expert meetings, definitions were updated to current care provisions. A data protocol allowing validated data control was developed at hospital level, within EGDRP regulations.

Recently, the Flemish Inspectorate published a report on the use of coercive measures in children's wards in general and child psychiatric hospitals in particular. This report showed that registration of coercive measures, by the lack of a conceptual framework, was not valid, reliable nor complete. Therefore, the Flemish Government funded a register in collaboration with mental health youth care organisations, adapting the Dutch model. This register was established in several phases. In 2019 the first pilot was implemented in child psychiatry, youth and adolescent care. General psychiatry for elderly and adults will begin in 2020.

Methods

By coincidence, both countries are developing a register aimed at gathering the same data in a valid and consistent way at the same time, in collaboration with the institutes. A mixed methods design was used, first by qualitative analysis of nurses' opinions at ward level, followed by expert opinion and quantitative data acquisition.

Results

In the workshop we present the outcome of the definition process, illustrated by figures. We focus on issues met in taking care of developing same definitions in different settings and which standards were used in calculating findings. These are presented in an interactive way, seeking shared experience with the audience.

Conclusion

Once consistent, nationwide data can be counted and compared. Implementation requires input of experts, policy makers as well as ward nurses.

2 Educational Goals

1. To learn how to assess coercion in a valid and consistent way, covering all measures, thus allowing analysis of alternatives
2. To learn how to use feedback of findings in developing ward or hospital policy against the background of the European General Data Protection Regulation

Correspondence

Email: PC@vivosocialprofit.org (Peter Cosemans)

EuroSTART: Variations in strengths and risk factors assessments among forensic patients in four European countries

Paper

Richard Whittington, Charlotte Pollak, Alice Keski-Valkama, Andrew Brown, Jesper Bak & Jacob Hvidhjelm (Norway)

Keywords: START; risk assessment; structured professional judgement; international comparison

Abstract

The Short-Term Assessment of Risk and Treatability (START) instrument (Webster et al., 2004) has been widely adopted by mental health services in North America and Europe to support effective management of violence and other risks. The EuroSTART consortium is an international collaboration convened to create a combined dataset of START assessments with adequate power to examine key questions empirically about dynamic risk fluctuations and item clustering. The aim of this presentation is to provide an overview of the project and an initial profile of the assessments. There are currently 2945 assessments conducted 2011-2018 in four secure forensic mental health services in Denmark, Finland, Sweden and the UK (n=696 patients). The frequency of assessments per patient varied widely across sites. Missing data analysis indicated that certain features of the START are prioritised by staff with some emphasis on social skills and relationship strengths. Mental state, external triggers and emotional state were the most strongly endorsed strengths. Mean Strength, Risk and item ratings varied significantly between sites in different countries as did the internal consistency of the Strengths and Risks scales. The clustering of items is currently being examined and the dynamic relationship of assessment scores to violent and other outcomes will be explored in the future.

2 Educational Goals

To examine variations across different European countries in terms of

1. how risk assessments are conducted in forensic services and
2. the strengths and risks profile of those receiving the service

Correspondence

Email: richard.whittington@ntnu.no

Outpatient coercion in psychiatry: evidence and feasibility. An narrative review of community treatment orders, psychiatric advance directives and joint crisis plans as ways to contain danger

Paper

Eric Noorthoorn, Stephan Gamsa, Henk Nijman, Peter Lepping, Martine Fledderus, Hein de Haan & Giel Hutschemaekers (Netherlands)

Keywords: Law, outpatient coercion, Community treatment orders, Evidence in coercion

Abstract

Introduction

Over the last decades many countries implemented outpatient compulsory treatment orders (CTOs) as alternatives to inpatient compulsory treatment. Dutch law will be adjusted by 2020, allowing outpatient coercion. Compulsory treatment may be seen as a continuum, starting with persuasion, followed by constraints, coercion, containment, and finally seclusion and mechanical or chemical restraint. In this review we therefore included studies on CTO, psychiatric advance directives and joint crisis plans. Against the background of the implementation of the new Dutch legislation, we were interested in which approach is associated with fewer admission days. This review provides an overview of all levels of evidence as opposed to a systematic review, which only aims at the highest level, a randomized clinical trial.

Methods

With the keywords “community” and “treatment” and “orders” or “psychiatric” and “advance” and “directives” or “joint” and “crisis plans” we identified 438 articles, and included 360 in this review. Studies were excluded when published before 1990, or when their focus was on medical rather than psychiatric care. Articles were included if they covered opinion on feasibility, legal context, and presented qualitative or quantitative (empirical) data.

Results

Findings show limited evidence on the level of randomized clinical trials. However, several authors discuss the feasibility of randomized trials in compulsory treatment and

advocate observational studies to be more valid. This debate remains difficult as patient selection processes remains a challenge with healthy patient selection hard to prove in patients refusing treatment.

In a number of countries, community treatment orders and outpatient compulsion have been common practice over decades. Observational studies show an effect on treatment compliance and an indirect effect on the reduction of re-admission rates. For clinical practice, preliminary analysis of the vast body of literature shows that an approach including not only community treatment orders, but combining these with persuasive measures as joint crisis plans or psychiatric advance directives do have an effect on treatment compliance and reduced readmission rates. In the presentation, we provide a full overview of the various levels of evidence, drawn both from qualitative and quantitative studies.

Conclusion

Even though at the level of RCT's the effect on readmission rates remains inconclusive, we suggest a discussion on the clinical validity of CTO's in the European context. This should include the constraints current legislation provides and information about how outpatient compulsory treatment is designed in daily practice, learning from Commonwealth countries.

2 Educational Goals

To better understand:

1. The influence of legislation on choice of coercive measures but also on readmission rates
2. The evidence in coercion and containment

Correspondence

Email: e.noorthoorn@ggnet.nl

Pathways of seclusion reduction programs to sustainability: ten years follow up

Paper

Eric Noorthoorn, Patricia Mann-Poll, Annet Smit & Giel Hutschemaekers (Netherlands)

Keywords: Coercion, Sustainability, Long- term follow up

Abstract

Introduction

In the past decade, several seclusion reduction programs (SRP) were developed, implemented and evaluated in the Netherlands. The Dutch government invested €35 million between 2007 and 2012 to reduce seclusion by 10% a year.

Aims

Little is known about the sustainability of these programs. In this study we compare three programs on their reduction of seclusion use over a ten year period.

Methods

We monitored the seclusion rates using the Argus coercive measures scale and described three complementary Dutch seclusion reduction programs over a period of ten years. For comparison purposes, we identified 3 time frames: start-up between 2008 and 2010, consolidation between 2011 and 2013 and follow up between 2014 and 2017. The outcome was the number and duration of seclusions. Interviews with project leaders were held to understand findings in the context of policy planning beforehand.

Results

The first hospital showed a clear decline in the first, some increase in the second and a clear relapse of +61% ($R^2=0.75$, $p<0.001$) in the third time frame. The second hospital showed in general a near to flat line. A slightly decreasing line was observed over all time frames (- 17%, $R^2=0.28$, $p<0.25$). The third Hospital showed a continuous decrease of 28% across each of the time frames (- 52%, $R^2=0.67$, $p<0.01$). Interviews revealed clear differences in approach during and after the project period. In the first hospital, a reduction policy was implemented only in the project period. In the second hospital, policy was changed over the various time frames, first bottom up, later top down. The third hospital showed a consistent top down as well as bottom up approach organized

along a number of lines (Verlinde et al, 2016). Such findings, both increase, flat line and decrease, were also observed in nationwide data comparing trends of figures gathered in 21 institutes between the years 2014 and 2017.

The presentation first presents the organisational differences between the hospitals, then describes the findings against the national background.

Conclusion

One of the institutes showed a decline in their use of seclusion across all time frames, one institute showed an almost flat line in their seclusion use despite their project, where one institute showed a clear increase. The nationwide data, however, imply some generalization of these findings and stress continuous awareness and monitoring of the seclusion use remains necessary at an organizational as well as professional level and should be a shared agenda.

2 Educational Goals

1. To better understand organisational factors associated to sustainability of seclusion reduction programs
2. To better understand the relevance of consistent top down and bottom up policy development

Correspondence

Email: e.noorthoorn@ggnet.nl

Assessing and preventing violence with the Brøset Violence Checklist[®] in an adult psychiatric ward

Poster

Jane Portier, Serge Boulguy, Marie Chieze, Julia Reverdin, Adriano Zanella & Othman Sentissi (Switzerland)

Keywords: Psychiatry, coercion, seclusion, violence, Brøset Violence Checklist[®]

Abstract

Background

In our adult psychiatric admission ward, the multidisciplinary team is regularly confronted with violence. Therefore, managing violence is a priority to improve the quality of psychiatric care. Global reflections on this subject, including risk assessment (primary assessment), management (secondary assessment), and “*post-violence*” (tertiary assessment) are being considered.

Aims

Confronted with the challenges of human rights and legal aspects, a project to improve our practices is underway. The aim of the study was to better assess and prevent violence in the ward whilst ensuring the safety of patients and caregivers and reducing coercive measures.

Methods

A violence risk assessment scale, the Brøset Violence Checklist[®] (BVC[®]) was introduced at the end of 2018. It is carried out by the healthcare team to assess risk on the day of admission and three days after, for all patients regardless of any past history. In addition, the scale is completed daily by nursing and medical staff for all secluded patients, for the duration of the seclusion, as well as three days after leaving the seclusion room.

Results

1. The first results, from January to May 2019, show that the number of seclusions is similar to the period from January to May 2018, the averages over five months over the two years are not significantly different.
2. On the other hand, a significant decrease in the duration of seclusion between these two periods is noted.

Conclusions

We assume that these results are a consequence of the use of the Brøset Violence Checklist[®] which supports multidisciplinary discussions on coercive measures, including limitations and indications. Further analyses are however needed to support the effective correlation of its use and the decrease of seclusion durations. This project offers the opportunity to develop and implement clinical interventions and guidelines depending on BVC[®] severity scores. In our institution, this study constitutes a pilot project with the aim of extending it to the entire Psychiatry Department of Geneva University Hospital.

2 Educational Goals

To better assess and prevent violence

Correspondence

Email: jane.portier@hcuge.ch

Prediction and prevention of aggressive incidents during outpatient crisis contacts in the ambulant mental health care

Workshop

Berry Penterman (Netherlands)

Keywords: aggressive behaviour, crisis service, risk assessment

Abstract

Tension and emotions can run high during emergency services in Mental Health Care. During late night hours and under time pressure, decisions are often made with which all parties do not agree. 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 of the number of threatening incidents during emergency contact and risk-increasing factors. Aggressive incidents during psychiatric emergency service contacts were registered the Staff Observation Aggression Scale-Revised (SOAS-R). The percentage of emergency contacts during which aggression was observed was 14% in 2002. During this initial inventory all registered incidents of aggression were also discussed every week in team meetings.

Following this first study, we investigated whether we could predict, with 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. For this, emergency service workers completed a specially designed Checklist called the Checklist of Risks Crisis team (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 again 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 of 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 help themselves. These three factors from the CRC predicted aggression towards others with an 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 advisable. 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 workshop, we would like to demonstrate the use of the aggression application in the field of emergency services of Mental Health Care, and we want to present some data that were collected using this aggression app. The focus of the workshop will be on completing the CRC on the basis of audio recordings of phone contacts with the general practitioner who is calling in for assistance (and assessment) of the psychiatric emergency service.

2 Educational Goals

1. To learn how to use the aggression app in the field of the ambulant mental health care (psychiatric emergency service);
2. To make assessments in relation to the information the general practitioner can provide.

Correspondence

Email: e.penterman@home.nl

Deceit, Deception, Distortion, and Dissimulation- Looking beyond the Obvious

Paper

Dr. Julian Gojer MBBS DPM MRCPsych FRCPsych FRCPC JD, Dr. Monik Kalia PhD (C. Psych), Ms. Iva Giljanovic BSc, Mr. Sanjeevan Athavan BSc, Ms. Caroline Kerjikian BA, Ms. Jane Koh BA, Ms. Julie Magritte (Canada)

Keywords: malingering, mental illness, forensics, clinical assessments

Malingering, Factitious Disorders, lying, and feigning wellness are not uncommon problems seen in a forensic setting. The problems that clinicians face when interviewing clients begin can include lying about specific aspects in the history, distortion of facts, omissions of details, exaggerations, minimizations, embellishments, concocting of symptoms, faking signs and false reporting of diagnoses.

No branch of medicine is subject to such deceit as psychiatry given the subjective nature of disorders and the reliance on history taking. Mentally ill individuals also can and do malingering for various reasons and clinicians in a forensic setting can become skeptical about a genuine defense in the setting of malingering.

The assessment of a forensic case where there is a concern that an illness is being presented or denied is dependent on the time and effort invested and is no small task.

While the starting point is a clinical examination, a thorough review of collateral documents, review of prior clinical records, interview of clinicians, family members and relevant individuals who know the accused cannot be understated. The presence of an obvious gain, be it financial or otherwise, avoidance of an obligation or a legal situation and simply attention seeking behaviors all should factor into the equation.

The clinical assessment takes into consideration known signs and symptoms of various illnesses. Complicating situations involve assessing individuals from different social, cultural and racial origins and attempting to explain their presentations in terms of standard classificatory systems like the DSM 5 and the ICD11. In forensic settings, unusual presentations are seen and associated with a variety of offenses and many non forensic clinicians do not get exposed to such individuals and can become dismissive of the presentation, labeling it as malingering.

In recent years psychologists have become involved in the detection of deception, malingering and associated deceit in clinical presentations. Screening tests, and statistically based complex malingering tests have been designed.

The psychological assessment of malingering is also not very different from other diagnostic assessments. However, reliably diagnosing malingered presentation in an individual is a complex process as compared to other assessments. Use of multiple sources is crucial to arrive at a meaningful opinion regarding malingering. This includes comprehensive review of background information, multiple clinical interviews, collateral information and psychological testing.

Psychological testing is only one component but it has increasingly proven successful in the detection of malingering. The convergent evidence is collected through use of highly reliable psychological measures which are extensively validated in the forensic samples. It is also important that the tests chosen in a particular assessment of malingering should be appropriate and sensitive to the context or condition evaluated.

The most widely used psychological test for assessing malingering is the Minnesota Multiphasic Personality Inventory-2 (MMPI-2). It has one of the most extensive empirically validated data set. Other personality inventories which are helpful to assess the fake bad response style are MMPI-2-RF, PAI, and MCMI-IV. These personality tests not only pick up attempts to fake bad but also identify defensiveness.

There are also screening measures of malingering which are used to decide if comprehensive psychological testing is required to assess malingering. The examples of these screening measures are SIMS and M-FAST.

The Structured Interview of Reported Symptoms, SIRS-1 and SIRS-2 use a structured interview format to assess feigning of psychiatric disorder. While the SIRS-2 has come to be regarded as psychometric benchmark for the assessment of feigning, some authors still recommend using the SIRS-1. As the psychological testing cannot infer the evaluatee's motivation, feigning is the term used to describe the results of testing rather than malingering. The psychological tests with excellent specificity and sensitivity cannot replace a careful and comprehensive forensic examination. Standalone, the psychological test results can only help the assessor to know the extent of feigning but the final clinical opinion about malingering is based on consideration of all the data at hand.

The presence of malingering is not an all or none phenomena. Individuals presenting signs of malingering are not a homogeneous group. Malingering can range from endorsing exaggerations in psychiatric symptoms to a complete fabrication of symptoms which are otherwise not present. Malingering and mental illness are not mutually exclusive conditions. It is possible that genuine mentally ill individuals may also exaggerate or malingering symptoms for the similar gains that non-mentally ill individuals do. It is pertinent that alternative explanations of feigning are examined before providing opinion regarding malingering. A clinical opinion regarding malingering can have far reaching consequences due to the inherent high-stakes nature of the forensic cases.

It must be kept in mind that sometimes inconsistencies or a set response style on psychological measures can be due to several reasons rather than equating it to just malingering. Therefore, it is extremely important that any assessor providing a diagnosis of malingering must carefully examine the various clinical domains.

In light of the above, we discuss several difficult cases encountered in our forensic practice.

Case 1

PR is a middle-aged man who was charged with 2nd degree murder of a woman who he was having a sexual relationship with. At some point in the relationship, he began to believe that people were following him, trying to harm him and that he was going to be killed. He shared this information with the victim who, in a caring way, and who also had an interest in black magic and spells, believed him and believed that someone was doing black magic on him. She gave him sage and some special stones to ward off the evil. PR began to believe that she was connected to the persons who were trying to kill him. In that setting he killed her.

He was assessed initially for a mental health defence of Not Criminally Responsible On Account of Mental Disorder and the assessing psychiatrist for the defense noted that there were some inconsistencies in his psychological test results for malingering but opined that he had such a defence. The prosecution psychiatrist assessed him and noted that the accused reported bizarre experiences that suggested malingering and offered such an opinion. The defence abandoned the defence and pled the client guilty to second degree murder. A third set of experts were asked to assess him for sentencing and the issue of a mental illness being present was again raised. The accused admitted to fabricating psychotic symptoms to get away from detention, believing that he was going to be killed. Other psychotic symptoms were still present and following the assessment, the guilty plea was struck and the accused took the stand in his defense. The repeat assessment acknowledged malingering at different phases of the assessment but again concluded that an NCRMD defense was available. At the trial however, and with inconsistencies on the part of the accused in his tendencies, the judge did not accept the accused's account and felt that the defense psychiatrist was biased and found him guilty again. The judge however accepted that a mental disorder was present but the test for NCRMD was not made out. Though the result was a guilty conviction, the assessing process was very difficult and the lesson learned was about keeping one's mind open to the presence of mental illness in the face of malingering.

Two other cases currently before the courts involve homicides too. In both cases drugs and alcohol were involved and the accused individuals claimed amnesia. This poses a problem given the convenient nature of the symptom and the likelihood of amnesia being a real possibility in the setting of intense drug abuse capable of triggering a

psychosis, altered awareness and the concomitant use of alcohol that has the potential, alone or in combination of other drugs to cause blackouts or in severe intoxication, a failure to register any memory of the offending. In both cases, additional unlikely symptoms reported suggested malingering and NCRMD defenses were not supported. This however, does not assist when less offenses like manslaughter are also a viable option. However, deceit, lying and malingering also affect the credibility of the client that can impact on the trial and affect how other defenses that are potentially available, are also lost on the individual.

A fourth case, a young male below the age of 20 years had a problem with pathological lying from his early teens. He made a confession to a teacher of being involved with a group of males who as a group committed a homicide and being at the scene. He was hoping to evoke sympathy from the teacher. However, in the absence of any witnesses, the jury accepted his confession and convicted him of manslaughter. This was after he was assessed as having a history of pathological lying.

Our last case was another middle-aged man who had a long history of antisocial behaviors and was appropriately diagnosed with an antisocial personality disorder. He also had a history of drug abuse and developed a drug induced psychosis that persisted with time continuing as an ongoing schizophrenic illness. He developed delusional ideas about his ex wife and repeatedly harassed her with messages accusing her of sexually abusing his child. He was charged with criminal harassment and while an NCRMD opinion was offered by the defense, the prosecution acknowledged a psychotic illness being present but the diagnosis of antisocial personality disorder seemed to weigh the balance against an NCRMD finding.

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Correspondence

Email: juliangojer@themanasaclinic.com

Aggression as a function of Intermittent Explosive Disorder, Alcohol Use Disorder and childhood abuse

Poster

Michael McCloskey & Alexander Puhalla (USA)

Keywords: Aggression, Childhood Abuse, Alcohol Use Disorder, Intermittent Explosive Disorder, Intoxicated

Abstract

Intermittent Explosive Disorder (IED) is the only psychiatric diagnosis where affective aggression is the cardinal symptom, with some evidence that a history of childhood abuse (CA) and alcohol use disorder (AUD) uniquely predict to a diagnosis of IED. Moreover, both a history of CA and AUD are associated with increased general aggression and aggression while intoxicated, respectively. Yet, no study to date has examined the separate and combined effects of a history of childhood abuse and AUD on predicting to a diagnosis of IED, nor their effects on sober and intoxicated aggression among those with and without IED. The following study aimed to fill these gaps. Participants consisted of 493 individuals (68% female; Age M = 26.65) who completed a diagnostic interview to determine history of CA, assign IED (n = 265) and psychiatric control (PC; n = 228) status, and determine lifetime frequency of sober and intoxicated aggression. Results found that a history of CA, but not AUD, was uniquely predictive of IED status. Additionally, the main effects of IED and AUD on intoxicated aggression were limited by an interaction, such that only among individuals with IED did those with AUD report increasingly greater amounts of intoxicated aggression as the severity of the AUD increased. Overall, these results suggest that a history of CA may increase the chances of developing IED by increasing emotion dysregulation characteristics in childhood, while also demonstrating that AUD severity primarily increases intoxicated aggression among those who are already aggressive while sober.

2 Educational Goals

1. To learn the relationship between alcohol use disorders, childhood abuse and IED
2. to learn the extent to which IED status, childhood abuse history and alcohol use severity predict aggression.

Correspondence

Email: mikemccloskey@temple.edu

Combining an aggression and violence risk assessment with a structured tiered care pathway

Paper

Amir Niazi, Eugene Meehan & Kevin McKenna (Ireland)

Keywords: Risk assessment, structured care pathway, interventions tiered according to level of assessed risk

Abstract

Introduction

Aggression and violence is a universally acknowledged challenge within healthcare settings generally, and in psychiatric services in particular. While aggression and violence can, and do, occur in all psychiatric care settings, it is well acknowledged that the problem poses a particular challenge within acute inpatient settings.

Acknowledgement of the indisputable physical and psychological risks associated with managing this problem imposes professional, statutory, clinical and moral imperatives upon service providers to proactively assess inherent hazards and put in place all and every reasonably practicable measure to mitigate associated risks.

Intervention

In this context one Irish regional acute inpatient psychiatric service developed and implemented a structured aggression and violence risk assessment pathway entitled AVRAP. This pathway combined the Broset Violence Checklist [BVC], with a tiered pathway of medical, environmental and interactional interventions to support patients, based on their assessed risk. Essentially the AVRAP involves the use of the BVC in the first instance, with interventions implemented on a tiered basis based on the assessment of low, moderate or high risk as identified on the BVC.

Implementation of the AVRAP was paralleled with a multi-method study which investigated its effectiveness. The quantitative strand of the study involved an interrupted time series design which investigated the frequency and severity of occurrences of aggression and violence toward personnel, and/or between service recipients, and the frequency of the use of coercive interventions before and after the implementation of the AVRAP. The qualitative strand involved a focus group study which explored the experience of the front line multidisciplinary personnel involved in their implementation and use of the protocol in practice.

Outcomes

This paper will present compelling quantitative evidence of the effectiveness of the protocol in reducing the frequency and severity of occurrences of aggression and violence and the use of coercive measures, and important insights from the implementation and utilisation experience of the multidisciplinary clinicians involved.

Conclusion

This study expands on previous studies in three ways, firstly by combining the use of validated risk assessment instruments with a structured care pathway which is tiered according to the level of identified risk, secondly by including occurrences of aggression and violence between patients, and finally by the addition of a qualitative account of the implementation and utilisation experience of the multidisciplinary clinicians involved.

2 Educational Goals

Participants will have the opportunity to:

1. Understand the expansion of risk assessment to include with a structured care pathway which is tiered to support patients according to their level of assessed risk.
2. Understand the AVRAP pathway which is available free of charge in the public domain

Correspondence

Email: mckennakj@eircom.net

Student Nurses' Aggression and Violence Experiences during Mental Health and Psychiatric Nursing Clinical Practices

Paper

Hulya Bilgin, Emre Çiydem, Kubra Arslanturk & Sevil Yilmaz (Turkey)

Keywords: Aggression, violence, mental health and psychiatric nursing, student nurses

Abstract

Background

Aggression and violence is the main concern for student nurses during their clinical practices in mental health and psychiatric nursing course. To examine their experiences would provide an insight on what happens during aggressive and violent events in acute mental health wards.

Aims

To explore students nurses' aggression and violence experiences in clinical placements in the context of mental health and psychiatric nursing course.

Methods

A qualitative study focusing specifically on mental health nursing students' aggression and violence experiences was conducted using interviews with students. Descriptive content analysis will be used and common themes will be extracted in the data analysis. Results: We will present the results from the interviews. Aggression and violence will be analyzed from patients to others and others to patients.

Conclusion

Causes of aggression and violence in mental health settings and dealing with these events are multifaced issues. Objective assessments should allow us to recognize its complex and dynamic structure by each stakeholder in the clinical environment.

2 Educational Goals

1. From student nurses' perspectives, to be aware of aggressive and violent events in acute mental health settings.
2. To learning about the responsibilities in generating safety and security places for everyone.

Correspondence

Email: hcbilgin@hotmail.com

Comparing settings: a survey of nurse managers exploring organizational safety culture against aggression in psychiatric and general hospitals

Paper

Birgit Heckemann, Sabine Hahn, Joy Duxbury, Sanaz Riahi, Bridget Hamilton & Joanne DeSanto Iennaco (Switzerland)

Keywords: organizational safety culture, nurse managers, leadership, survey, quantitative research, patient and visitor aggression

Abstract

Introduction

Certain aspects of patient and visitor aggression such as the causes, assessment of risk and prevalence, as well as interactional factors have been researched widely over the past two decades. However, organizational safety culture, an important factor in the prevention and management of patient and visitor aggression has received comparatively little attention. In a positive organizational safety culture against aggression, employees perceive organizational safety policies and procedures as aligned with everyday clinical practice.

Aims

This study investigated and compared the perception of organizational safety culture among psychiatric and general hospital nurse managers.

Methods

The present data were collected within an international research project - PERoPA (Perception of Patient and Visitor Aggression). PERoPA examines patient and visitor aggression in healthcare from the nurse managers' perspective with a cross-sectional, open access web-based survey in German and English-speaking countries. The data collection in the German-speaking countries (Germany, Austria and Switzerland) took place between November 2016 and February 2017. The data were analyzed descriptively. Organizational safety culture against aggression was measured by the following factors: (a) Shared organizational attitude; (b) Official definition; (c) Guidelines and policies for the prevention and management of patient and visitor aggression; (d) Resources; (e) Official incident reporting system; (f) Environment.

Results

Six hundred and forty-six nurse managers consented to take part in the survey, 446 responses were included in this analysis. The results indicate that general hospital managers perceived organizational safety culture against patient and visitor aggression to be less positive than managers in the psychiatric setting. Fewer managers in general hospitals (37%) perceived the shared attitude towards addressing aggression to be mostly positive, compared with managers in psychiatry (65%). Overall, 22% of general hospitals had an official definition of patient and visitor aggression, compared to 50% of psychiatric hospitals. Resources such as financial resources, post incident support and intervention teams were significantly more widely available in psychiatric settings, whereas security personnel was significantly more widely available in general hospitals. Staff training was often available in general hospitals (71%) and psychiatric settings (68%). Official reporting systems were significantly less widely implemented in general hospitals (45%) compared to psychiatric hospitals (88%), and environmental factors, for example adequate lighting and safe entrances, were considered in the majority of general hospitals (84%) and psychiatric settings (92%).

Conclusion

The findings underscore the differences in organizational safety culture against aggression between the general hospital and the psychiatric setting. General hospitals could learn from approaches in psychiatry to improve the management of aggression, but more research is needed to deepen our understanding of organizational safety cultures.

2 Educational Goals

1. The participants will be able name at least three factors related to organizational safety culture.
2. The participants will be able to critically discuss this study's findings in the context of current research literature.

Correspondence

Email: birgit.heckemann@bfh.ch

Risk assessment instrument: Construct validity of the Mechanical Restraint - Confounders, Risk, Alliance Score (MR-CRAS)

Poster

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

Keywords: Forensic psychiatry, forensic mental health, physical restraint, mechanical restraint, risk assessment

Abstract

Background

A new short-term risk assessment instrument, the MR-CRAS checklist, has been developed in close collaboration with forensic mental health (FMH) nurses, psychiatrists' etc. with the purpose of supporting decisions on releasing the patient with the aim of reducing the duration of MR as much as safely possible. Clinical validation of MR-CRAS showed evidence of the checklist being comprehensible, relevant, comprehensive, and easy to use for assessing the patient's readiness to be released from MR. The next step was therefore construct validation.

Aim

The specific objective was to construct validate whether scores in the three MR-CRAS subscales; confounder, risk and parameters of alliance, were an adequate reflection of its content domains and determine the final domains of MR-CRAS, and to evaluate the use of MR-CRAS and determine the need for revisions of the checklist and its user manual.

Methods

A multi-site field study testing including a pragmatic mixed methods approach was used to evaluate the psychometric adequacy of the three subscales and experiences of use among nurses, nurse assistants and social and healthcare assistants in 13 Danish closed forensic mental health inpatient units. During an MR episode, 18 subscale items were observed, assessed and scored every hour, by the clinician who had observed the patient during that hour. Completed checklists from each MR episode were collected from March 2016 to February 2017.

Results

Descriptive statistics, Mokken analysis of scalability and Spearman correlation analysis were performed on MR-CRAS data and content analysis were performed on feedback data.

MR-CRAS was completed in 143 episodes of MR, representing 88 patients, with a mean duration of 63.25 hours. Most patients were younger men, diagnosed within the schizophrenia spectrum.

MR-CRAS, and especially the parameters of alliance, were perceived as usable for assessment of the patient's readiness to be released from MR.

The psychometric analyses showed that the three subscales were unidimensional.

Conclusions

The study shows evidence of the construct validity of MR-CRAS among clinicians at closed FMH inpatient units. MR-CRAS contributes with a common language and structured, systematic, and transparent observations and assessments on an hour by hour basis during MR.

2 Educational Goals

Educational goals:

1. To realize that MR duration can be prolonged among FMH inpatients.
2. To become better acquainted with the MR-CRAS checklist aiming at reducing the duration of MR.

Correspondence

Lea Deichmann nielsen

Email: ldni@ucsyd.dk

Conflict Tolerance: - Forensic mental health staff perception of inpatient conflicts with staff

Poster

Frederik Gildberg, John Baker & Frans Fluttert (Denmark)

Keywords: Conflict management, Violence and Aggression, Staff perspective, Forensic

Abstract

Background

The Danish government requires a 50% reduction in coercion by 2020 (Health, 2014). Existing research indicates that staff interactions play a central role in patient-staff conflicts (Duxbury & Whittington, 2005; Papadopoulos et al., 2012; Price & Baker, 2012). A call for further research regarding clinical decision-making and the use of restraint by forensic mental health staff has recently been proposed (i.e. Laiho, Hottinen, Lindberg, & Sailas, 2016).

Aim

The aim of this study was to investigate forensic mental health nurses' and nursing assistants' perceptions of conflicts with forensic mental health inpatients.

Method

Data was collected through 24 semi-structured, in-depth interviews with forensic mental health staff using an interview guide informed by the above aim. Interviews were transcribed and analysed using empirically testing thematic analysis [ETTA] (Gildberg F.A., 2015). Informed consent from staff was obtained and the Regional Research Ethics Committee and Danish data protection agency approved the project.

Results

Findings suggest a dynamic model interlinking the themes '*personal staff tolerance to conflict*' and the use of '*conflict strategies*' to '*patient factors*', '*collegial factors*' and staffs perceived feelings of '*safe or unsafeness*' through staff's '*assessment, staff-patient relationship and observation*'.

Conclusion

This study offers an empirical model of staffs' clinical management of conflict situations in a forensic mental health inpatient setting and by showcasing how staffs' conflict-tolerance and strategies may change depending on the individual staff member, their perception of colleagues, and the observation, assessment and relationship with patients.

2 Educational Goals

1. Increased knowledge about the dynamics and management of aggression and violence in mental health services.
2. Enable greater differentiation between patient factors, collegial factors, perceived safe or unsafeness in a complex interplay with forensic staff's tolerance to conflict and use of conflict management strategies.

Correspondence

Email: fgildberg@health.sdu.dk

Factors influencing decisions of mental health professionals to release service users from seclusion

Poster

Haley Jackson (UK)

Keywords: Seclusion, Adult Mental Health inpatient, Aggression Management, Decision-making, Nurse - Patient interaction, Multiprofessional Practice, Qualitative Approaches

Abstract

Aim

This poster presents the results of a qualitative study that explored factors which influence the decision making of mental health professionals when terminating episodes of seclusion.

Methods

Semi-structured face-to-face interviews with twenty-one professionals were undertaken between May 2017 and January 2018. The professionals included medical, nursing, psychology, occupational therapy and social work staff working on one of four inpatient units in one mental health service in the north of England. Data was recorded and transcribed verbatim. Framework analysis was used to systematically manage, analyse and identify themes, whilst maintain links to the primary data and provide a transparent audit trail.

Results

Six themes were identified in which professionals looked for service users to demonstrate a balance between co-operation and compliance before they would agree release. Decisions were subjective, being influenced by the experience and composition of the review team, the availability of resources plus the emotional tone and physical environment of the ward. Release could be delayed by policy and protocol.

Conclusion

Professionals should have greater awareness of factors that hinder or facilitate decisions to release service from seclusion and an understanding of how service user views and involvement in decisions regarding seclusion should be explored.

2 Educational Goals

1. To understand factors that affect the decision making of staff releasing service users from seclusion
2. To be able to identify factors that could be used to facilitate service users' earlier release from seclusion

Correspondence

Ms. Haley Jackson

Email: hchj@leeds.ac.uk

Implementation and use of advanced statements and calm down methods in Psychiatry

Poster

Gitte Laugesen, Camilla Petersen & Lene Lauge Berring (Denmark)

Keywords: Primary prevention, violence prevention, coercion prevention, advanced statements, calm down methods

Abstract

Background

Since 2016, Psychiatry South Oringe Denmark reduced the use of coercive measures from 372 incidents in 2016 to 185 incidents in 2018. We have implemented several reduction approaches guided by the six- core strategy [©], such as Safewards, a Relations and De-escalation learning program and an intervention team. Our aim is to prevent the use of coercive measures at our hospital.

Managing high arousal in psychiatric hospitals can be a challenge for both patients and staff. The evidence shows that it can cause self-harming behavior, violence and threats towards staff and result in staff making use of coercive measures. Research concluded that one of several factors in avoiding violence and threats is to focus on primary prevention such as advanced statements, where the patient is involved in identifying his/her coping strategies and triggers.

In Denmark, advanced statements (AS) are a legal requirement, which should be completed within 24 hours (if possible) after hospitalisation.

The ASs are used to prevent coercion by reducing and alleviating high arousal when hospitalized and as a health-promoting tool when patients are at home to avoid violent or self-destructive behavior. Unfortunately, this has not been used consistently for many reasons, primarily due to lack of knowledge.

Aim

This pilot-study aimed to establish the consistent use of AS and ensure that 100 % of hospitalized patients have a completed AS by 2020.

Method

All staff and patients were introduced to AS in January 2019.

The introduction consisted of how AS is used to clarify the patient experience of challenges, triggers and their worries when they are in a crisis / high arousal and how patients can be best helped such as how staff:

- address the health care needs to become the apprentice in the patient's life, They must ask the questions in a nonjudgmental manner, this will allow the patient to teach staff about their story.
- can include a description of the patient's previous experiences and own coping strategies.
- can introduce calming methods, which are available in the ward.
- can include a description of how the staff should interact with the patients in the situation.

Finally, Staff must ask whether the patient previously has been subjected to coercion and if so his/her experience with this. We focus on the fact that we will do everything possible to avoid coercion, so our attention focuses on what else we are able to offer. Everything needs to be documented so all staff are able to use the patients' personal strategies helping him/her to regain self-control.

Results

Staff and patients reported that the AS gave them a sense of coherence, as it is meaningful, manageable and comprehensive. The patients got the guidance they needed when they were highly arousal. They were able to regain self-control without self-harming or being subjected to coercion.

Conclusion

The implementation is difficult. Staff needs to be reminded about the AS, however AS gives both patients and staff new strategies to avoid violent- and self-harming behavior and most importantly, without using coercion.

2 Educational Goals

- The participants will gain knowledge about advanced statements
- The participants will discuss the calming methods, which are accessible and designed to help patients to gain self-control
- The participants will reflect upon how it will decrease coercion when implementing advanced statements and calming methods in psychiatric hospitals

Correspondence

Mrs. Gitte Laugesen
Email: glau@regionsjaelland.dk

A biopsychosocial approach to violence risk assessment in acute psychiatry

Poster & Paper

Bjørn Magne S. Eriksen (Norway)

Keywords: risk assessment, acute psychiatry, biomarkers, HDL, self-report, V-RISK-10, gender

Abstract

Current violence risk assessment methods in psychiatry seem to have reached an upper limit of accuracy (1). Alternative and supplemental approaches might, therefore, be necessary.

The main aim in this PhD project from acute psychiatry was to investigate predictive accuracy of a biopsychosocial approach (BPS model) to violence risk assessments during hospital stay, and the first three months after discharge. The model included the Violence risk screening - 10 (V-RISK-10), a Self-Report Risk Scale (SRS) and two potential biological markers of violence: total cholesterol (TC) and high density lipoprotein cholesterol (HDL). Sub-aims were to explore the predictive accuracy of each element of the model, and gender differences.

The final sample consisted of 528 patients, after 30 withdrew, during one year in a prospective, naturalistic design. Baseline measures were V-RISK-10 and SRS recorded after admission and before discharge, and TC/HDL recorded after admission. The outcome of interest was violence recorded during hospital stay and after discharge. Effect sizes were based on ROC-AUC and logistic regression analyses.

Results from the project are presented in three papers (2-4). The model showed good predictive validity, across genders, but improvements in predictive accuracy compared to V-RISK-10 were only marginal and non-significant (e.g., AUCs 0.80 vs. 0.79 during hospital stay and 0.74 vs. 0.73 after discharge). V-RISK-10 showed good properties as a screening tool (AUC = 0.8), but potential gender differences in some single items. SRS contributed significantly to the BPS model after discharge, and also seemed to increase its specificity. HDL was a significant risk marker of violence for men, especially after discharge (OR = 0.1), and contributed significantly to the BPS model for men during hospital stay.

Findings indicated that a biopsychosocial approach might be suited in violence risk assessments in acute psychiatry, and that some gender differences in single factors

and markers of violence risk may exist. As overall changes in predictive accuracy of the model compared to V-RISK-10 were only marginal, and statistical power in some analyses were low, further research on similar approaches and larger sample sizes is needed.

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2 Educational Goals

1. Understand some limitations of existing methods of violence risk assessments.
2. Learn about some potential alternative and supplemental approaches to violence risk assessments, and the potential impact of gender on risk factors of violence.

Correspondence

Mr. Bjørn Magne S. Eriksen
Email: bjormse@yahoo.no

Suicide Risk Screening and Assessment in a Pediatric Healthcare Setting to Reduce the Incidence of Childhood Self-directed Violence

Paper & Poster

Reginald E. Bannerman, Clarissa Chan Salcedo, Brenda McNeely, Finza Latif, Colby Tyson, Sandra Woody, Theresa Wavra, Ram Oula & Adelaide Robb (USA)

Keywords: Self-directed violence, suicide prevention, suicide screening and assessment, suicide risk level, Columbia Suicide Severity Rating Scale (C-SSRS), suicide risk factors and protective factors

Abstract

Children's National Medical Center made it a priority over the last five years to address violence and most recently suicide prevention through screening and assessing patients for self-directed violence, specifically suicide risk. Suicide is the second leading cause of death for ages 10-24 and is a serious public health problem across all ages which led the Joint Commission to revise its National Patient Safety Goal (NPSG) for preventing suicide and improving at-risk patient care.

Our aims to reduce suicide risk are to (1) improve quality and safety for those being treated for behavioral health conditions and those identified as high risk for suicide, (2) use of a validated screening tool for all patients presenting with behavioral health concerns, and (3) use of a standardized suicide assessment process for patients identified as at risk, documentation of the level of risk and the plan to mitigate the risk.

In 2018, Psychiatry and Behavioral Sciences along with a group of stakeholders began work to integrate suicide risk screening and assessment into its workflow and Electronic Health Record (EHR). Screening starts at six years for the psychiatric population and 10 for universal screening. The Columbia Suicide Severity Rating Scale (C-SSRS) was selected. It is evidence-based and allows for screening, assessment and stratification of risk level. Phase I implemented in May 2019 and was limited to patients with psychiatric complaints in inpatient psychiatry and the emergency department (ED). Policy and procedures, education, and guidelines for 1:1 attendants were developed. Informatics built two C-SSRS screeners into the EHR to determine level of risk (N/A, low, moderate, high), and automated safety orders. Screening is done on entry and Social Work assesses risk factors and protective factors to determine if the patient is discharged to home or admitted to inpatient units. Patients discharged home receive a

safety plan and education regarding lethal means including guns. Patients admitted are given a daily re-screen and any change in risk level guides safety interventions.

Ten weeks post go-live 354 ED patients screened positive for suicide risk. Of those, 29% were ages 6-11 and 71% 12-17. The risk levels found were 26% low, 32% moderate and 42% high. A total of 146 were transferred to inpatient. These results are significant and indicate that suicide risk screening in healthcare settings can reach large numbers of at-risk individuals who would not otherwise be identified, and provides for early intervention to prevent childhood death by suicide.

2 Educational Goals

1. Explain how a pediatric healthcare center addressed the Joint Commission revision to its National Patient Safety Goal (NPSG) for preventing suicide and improving at-risk patient care.
2. Describe how a validated screening tool is used to screen for suicide and a standardized process is used to assess patients identified as at risk, document the level of risk and the plan to mitigate the risk.

Correspondence

Email: RBannerm@childrensnational.org

The clinical utility of evidence based risk evaluation combined with de-escalation interventions in emergency psychiatry

Workshop

Roland van de Sande (Netherlands)

Keywords: risk management acute psychiatric wards

Abstract

Early recognition of alarming signs associated with the risk of severe escalations are crucial for caring for patients that have to rely on emergency psychiatric services. Over the past few years robust scientific evaluations reveal several evidence based approaches in this area. Time has arrived to link dynamic and frequent risk evaluation with tailored psychosocial de-escalation interventions to enhance stabilization and recovery. This workshop will address to the clinical utility of frequent short term risk evaluations (Crisis Monitor approach) and a tailored set of research informed de-escalation Safewards interventions. Pairing these interventions in a dynamic and personalized way will be demonstrated in five typical crisis scenario's. The implications for training, implementation, sustainability and future research will be discussed with the participants. The learning objectives of this workshop will be focused on mastering the basic principles of the two research based approaches in five realistic crisis scenarios.

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Learning objectives:

1. To enhance the tailored utilization of evidence based interventions in hectic clinical environments
2. To reflect on relevant implementation challenges, sharing lessons learned in training and clinical leadership trajectories.

Correspondence

roland.vandesande@hu.nl

Chapter 6 – Humane safe & caring approaches in and reduction of restrictive practices

Decreasing Duration of Mechanical Restraint by Increasing Frequency of Registered Nurse Assessments and Surveillance

Paper

Diane Allen (USA)

Keywords: Restraint, mechanical restraint, physical restraint

Abstract

Summary

This presentation describes a quality improvement project that decreased duration of mechanical restraint episodes by increasing the required frequency of registered nurse assessment and surveillance during restraint episodes. Evidence will be provided to support the feasibility and value of continuous nurse presence at the bedside during psychiatric emergencies requiring mechanical restraint.

Background

Application of mechanical restraints is an emergency measure that poses significant physical and psychological risks for individuals who are restrained and requires intensive care by a registered nurse. However, according to U.S. conditions of participation for Medicare and Medicaid, assessment by a registered nurse is required only once per hour and surveillance of restrained individuals is often delegated to unlicensed personnel.

Available Knowledge

This project builds on research done in Spain that demonstrated a regulatory change requiring more frequent registered nurse assessments led to decreased duration of

mechanical restraint episodes in an acute psychiatric hospital (Guzman-Parra et al., 2015).

Method

In a three-part quality improvement process that spanned over four years in an acute inpatient psychiatric hospital, the practice standard for frequency of required registered nurse assessments for mechanically restrained individuals was incrementally increased from once every hour to every thirty minutes and then to continuous 1:1 registered nurse presence.

Duration of physical restraint episodes was measured before and after the changes to the nursing department standard for mechanical restraint. Registered nurse hours per patient day were also measured.

Results

Comparison of mean duration of restraint episodes over the course of the three-part quality improvement project revealed a statistically significant ($p < .01$), 30% overall decrease in the duration of restraint episodes. There was essentially no change (-.01%) in registered nurse hours per patient day.

Implications

This project demonstrates the feasibility and value of continuous nurse presence during emergencies that require the use of mechanical restraint. Psychiatric intensive care by a registered nurse provides increased patient safety during mechanical restraint episodes and expedites an end to the emergency situations.

2 Educational Goals

Upon completion of this presentation, participants will be able to:

1. Recognize improved outcomes from a practice change that increased frequency of registered nurse assessment and surveillance during mechanical restraint episodes.
2. Propose similar practice change in other work settings to improve patient safety and expedite an end to emergencies that require mechanical restraint.

Correspondence

Ms. Diane Allen

Email: allenfamily518@gmail.com

A trauma-informed approach to de-escalation: working with patients to create safe environments

Workshop

Lene Lauge Berring, Nutmeg Hallett & Owen Price (Denmark)

Keywords: De-escalation, trauma informed care, safe environment

Abstract

Background

Coping with and understanding violent and threatening behaviour in mental health care settings is a challenging, but integral part of a caregiver's job. If not managed well, such situations can result in staff and patient injuries, and they can lead to the use of harmful restrictive practices and coercive measures. Moreover, facing violence is a traumatic experience for all parties and can cause secondary traumatic stress in staff.

This workshop is based on the presenters' research about trauma informed de-escalation approaches undertaken in the UK and Denmark in collaboration between service-users, staff and researchers.

The research is related to 1) how patients and staff members understand violent and threatening situations and how they ascribe meaning to the stream of actions in successful de-escalation situations, 2) literature searches, 3) surveys and 4) de-escalation training. Trauma-informed de-escalation is founded in the public health perspective and involves patients in creating a safe physical and emotional environment. Taking this approach changes focus from reacting to violence, to focusing on changing the social, behavioral, and environmental factors that cause violence.

A trauma-informed approach can foster shared problem solving and offers a turning point in violence management: instead of blaming the patient, members of staff will help the patient to gain control by understanding what brought the patient to this specific situation. Trauma-informed de-escalation, approaches every patient with the assumption that at some point in their lives they may have experienced trauma. Based on that knowledge they ask sensitive questions and motivate patients to advocate for themselves, by explaining to staff about their concerns. This lifts de-escalation to a professional level and avoids confrontations and power struggles.

The aim of the workshop is to discuss and reflect upon how de-escalation practices can be trauma-informed and how a personalised de-escalation approach can reduce violence and the use of coercive measures.

The workshop contains

1. An introduction to the trauma informed de-escalation approach and the underlying research including presentation of a de-escalation training program
2. A discussion about what constitutes trauma informed de-escalation approaches
- 2a. Participants will be divided into groups. Each group will discuss the trauma informed de-escalation approach and transferability to their own clinical setting.

2 Educational Goals

1. To reflect on de-escalation as a trauma informed approach and gain knowledge about essential de-escalation skills
2. Through interactive discussions gain knowledge about the evidence behind de-escalation

Correspondence

Ms. Lene Lauge Berring
Email: lelb@regionsjaelland.dk

Treatment results of voluntary, involuntary and involuntary coercion admissions in an acute urban psychiatric clinic in the Netherlands

Poster

Udo Nabitz, Hans Nusselder, Jack Dekker & Jaap Peen (Netherlands)

Keywords: Acute psychiatric clinic, voluntary and involuntary admission, treatment effect, HoNOS

Abstract

Background

During the last ten years we have seen a constant increase of patients with severe psychiatric disorders with involuntary admissions with and without coercion in our psychiatric clinic in Amsterdam. In addition policy makers and funders have increased the pressure to shorten the duration of an admission and introduced the program '*manage coercion*' (Dwang Bedwingen). Consequently we adapted our clinical work to three treatment paths, with a maximum duration of three months, enhanced our personalized treatment pathways approach, increased the diversity of our therapy modules, emphasized milieu therapeutic aspects and engaged family members. With this clinical policy we expected to be effective in the treatment of voluntary and involuntary patients diagnosed with schizophrenic, psychotic and bipolar disorders.

Aim of the study

Provide insight into the result of the three treatment paths. What is the treatment effect of voluntarily, involuntarily or involuntarily and coerced patients? What are the prominent aspects of treatment effects?

Methods

In 2012, the HoNOS (Health or Nation Outcome Scale) was introduced in the clinic as part of the regular outcome monitoring (ROM). The 12 scales plus the 3 addendum scales are the national standard for the measurement of psychiatric problems in patients with severe mental disorders. A medium Effect Size (ES = 0.5) was used as a measure for the change of the problem (Beurs et al 2016). A distinction is made between worsened (< -0.5 ES), stable (> -0.5 and $< +0.5$) and improved ($> +0.5$ ES) presentations.

Results

The five-year research cohort (2013 to 2017) included 1407 patients: 492 patients were voluntarily admitted, 511 involuntarily admitted (BOPZ admissions, IBS and RM) without coercion and 404 were involuntarily admitted with coercive treatment (separation and coerced medication). The admission to the clinic took 2 to 3 months. There are differences in the pre-scores of the HoNOS between the groups. On all 12 HoNOS scales except '*depressive disorders*' and '*self-injury*', the scores of the voluntary patients are less severe.

After the admission the average total score of the HoNOS improved by 9.1 points (pre-score 17.8 and post-score 8.7). The Effect Size is 1.2 or Delta T = 12. A striking result is that no statistically significant difference in the treatment result could be found between the three groups (Effect Size voluntary admissions = 1.3, involuntary admissions = 1.2, involuntary admission with coercion = 1.2). 74% of patients improve, 16% are stable, 10% worsens.

Conclusions

Patients who follow the personalized treatment pathways in a metropolitan clinic for acute psychiatry in Amsterdam improve after a short treatment: 74% improve, 16% is stable and 10% worsen. Treatment outcomes for voluntary and involuntary hospitalized patients do not differ.

2 Educational Goals

1. Learn about the use of the HoNOS as a clinical instrument.
2. Understand the approach of measuring treatment effect.
3. Deliver benchmark statistics for acute psychiatric services for an urban setting.
4. Discuss approaches to voluntary and involuntary treatment.

Correspondence

Email: Udo.Nabitz@Arkin.nl

NTW successful Restraint Reduction: total case series from large hospital trust

Workshop

Keith Reid, Paul Sams, Craig Newby, Kelly Hudspith, Rod Bowles, Gail Kay & Ron Weddle (UK)

Keywords: Restraint, reduction, strategy, violence, challenging, self-harm, humane

Abstract

Background

NTW is one of England's largest mental health and disability trusts, with more than 6,000 staff, population approximately 1.4 million, 60 sites, over 2,200 square miles and national services liable to restrictive practice. For four years we implemented a "Positive and Safe" strategy, with large reductions in disturbed behaviour and restraint 2015-16 vs 2018-19.

Aims

To reduce violence, self-harm and restraint strategically in a large heterogeneous trust.

Methods

The strategy comprises: staff training/education; clinical support/supervision; post incident support/review; recruitment/retention; therapeutic environments; criminal justice/police liaison; organisational boundaries/clear documentation; joint policy development; interagency working/information sharing; MDT working/collaborative risk management; robust organisational reporting/monitoring arrangements; service user/carer involvement.

All incidents (e.g. falls, data breaches, restraints) are reported to "Safeguard", a safety management program. Staff on wards see their own summary data plotted by time and can easily drill down to individual patients or restraints. Groups of ward teams meet quarterly to "Talk 1st". There they learn, review incident data, plan SafeWards, Star Wards and other public-health-model concepts. The Positive and Safe team publicly committed to measure nine reported features of behaviour and restraint. Each day, dashboards forecast total end-of-year counts for April-April projections. In March 2019, for this conference submission, we present actual previous annual data and the forecasts of 2018-19 figures.

Three patient features were: Self-Harm (SH), Violence/Aggression (VA) and assaults to staff (AS).

Six staff behaviours were: Oral Rapid Tranquilisation (ORT), Mechanical Restraint (MRE), Restraint (RS), Injected Rapid Tranquilisation (IRT), Seclusion (SEC) and Prone Restraint (PRS).

Results

This is not a sample but a report of every incident that occurred during four years. Incidents typically have more than one feature. There were marked reductions. Final figures will be reported.

2015-16:

Patient features: 3415 SH, 12563 VA, 3715 AS

Staff features: 2946 ORT, 371 MRE, 8782 RS, 1360 IRT, 2006 SEC, 3198 PRS

2018-19 feature reductions:

Patient: SH -2%; VA -8.2%; AS -27.9%,

Staff: ORT - 7.7%, MRE -29.4%, RS -32.5%, IRT -41.25%, SEC -42.5%, PRS -44%.

Conclusions

We thank patients, carers and staff. There were large reductions in violence, behaviour that challenges and self-harm. There were greatest reductions in features of staff restraint behaviour. Less restraint did not mean more violence and self-harm. We infer that more primary and secondary interventions are deployed, in keeping with Talk 1st. Experience shows that broad based approaches, engaging all people involved with prevention, data and decisions are crucial. Learning models at patient and ward level deliver change effectively.

2 Educational Goals:

1. Discuss the technical and human factors in successful violence reduction with reference to the public health model of restraint reduction, strategy, reporting and innovations
2. Leave with a plan on how to achieve culture change and violence reduction in your own clinical setting

Correspondence

Email: Keith.Reid@ntw.nhs.uk

NTW's "Positive Practice Process" (PPP) flowchart poster guides restraint prevention, planning, co-production and learning

Workshop

Keith Reid, Daniel Rippon, Paul Sams, Gail Kay & Ron Weddle (UK)

Keywords: positive, practice, process, restraint-reduction, debrief, learning, coproduction

Abstract

Background

Northumberland, Tyne and Wear NHS Foundation Trust (NTW) summarised legal and clinical literature, and consulted with carers, staff and patients, to create "Positive Practice Process" (PPP), a wipe-clean flowchart poster. PPP emphasises the preventative Public Health Model, organisational learning, clear boundaries, and co-production of primary/secondary/tertiary interventions as part of NTW's successful Restraint Reduction program 'Positive and Safe'.

Aims

- To produce a form of poster supporting multidisciplinary risk formulation, coproduction and debrief
- To support safety, welfare and rights of service users, staff and others
- To provide content which is accurate, usable and congruent to our caring values

Methods

NTW's communications department, our NTW Innovations arms-length company, and an observing body NEQOS, all collaborated to produce PPP with the core P&S team which includes safety managers, clinical and patient expertise. P&S is subject to rigorous evaluation and has been an organisational priority. P&S has reduced restraints: for example trustwide seclusion, injected rapid tranquilisation and prone restraint each appear reduced by over 40% over four years.

Part of this PPP has been informed by evidence and conveniently brings together the recommendations from key publications and our organisational strategy. It aims to support the safety, welfare and human rights of service users, staff and others. The

content succinctly clarifies legislative requirements such as the Mental Health Act Code of Practice 2015, and the Human Rights Act 1998. Prior to drafting the poster GK, DR and KR performed focus groups regarding staff, patient, service user, and lay responses to restraint vignettes, published elsewhere.

Results

PPP begins with standard good care and covers any escalation through to tertiary interventions, allowing consideration of resource, quality and performance issues. PPP provides a tool to support consistent standards of safe and therapeutic practice across all services. It is wipe-clean so it can be photographed with comments and saved as a viewable document in notes. It is large so it can hold content and not be lost in wards. PPP allows for table top discussions, inclusion of patients, and flattening of hierarchy in formulary discussions. It has been presented to all inpatient wards in training sessions, with a positive response, and presented at NTW's nursing conference. PPP is supported and complemented by a revised debrief policy allowing for brief post-incident support and by more detailed After Action Review. Traction is gaining, through senior formulating staff championing its use. In time PPP could be nested in interactive devices.

2 Educational Goals:

1. Understand the principles and application of PPP our Positive Practice Process poster
2. '*Walk through*' a fictional case using PPP to inform possible ways to reduce restrictive practice and risk events

Correspondence

Email: Keith.Reid@ntw.nhs.uk

Understanding Key Components of Interventions to Reduce Restrictive Practices: Findings from the COMPARE Evidence Synthesis

Paper

Krysia Canvin, Kathryn Berzins & John Baker (UK)

Keywords: restrictive practices, evidence synthesis, interventions, adults, Behaviour Change Taxonomy

Abstract

Background

Numerous interventions to reduce the use of restrictive practices have been developed over the past two decades. Evidence of their effectiveness is limited, however, by the absence of a standardised description of their procedures that would enable systematic comparison and evaluation.

Aims

This study aimed to: provide an overview of the vast landscape of interventions designed to reduce restrictive practices; to highlight the key components or '*active ingredients*' of these interventions with a view to understanding which ones may be the most effective; and, to offer directions for future research.

Methods

We conducted an evidence synthesis of published and unpublished interventions. Our inclusion criteria were: English-language interventions aimed at adults (>18) in inpatient settings from 1999-to date. Our exclusion criteria were: interventions aimed exclusively at adults with dementia or learning disability, and children and adolescents. We conducted comprehensive searches of databases and an "*environmental scan*" of grey literature. Two of the authors (KC and KB) screened citations for relevance and then extracted data following WIDER recommendations for reporting behaviour change interventions including intervention aims, target, setting, and outcome measures. KC and KB then coded the procedures specified by these interventions using the Behaviour Change Technique taxonomy.

Results

We identified 216 interventions. Most of these aimed to reduce seclusion and/or restraint, while very few were concerned with the use of either PRN or forced medication. Others specified the reduction of violence or promotion of safety. Although many interventions had been subject to some sort of evaluation, just nine of these were randomised controlled trials. Overall, the reporting of methods, sample size, and results was inconsistent, partial and ambiguous. From our analysis of the intervention components we found that the most common Behaviour Change Techniques were '*instructions on how to perform behaviour*', '*action planning*' and '*restructuring the social environment*' (e.g. through improving communication, reviewing rules, increasing access to staff.)

Conclusions

Service providers urgently require high-quality evidence regarding which interventions are most effective for reducing restrictive practices. The lack of systematic and comprehensive reporting and randomised controlled trials precludes meaningful comparison. Further weaknesses in the current evidence-base include underuse of patient-centred (and patient-reported) outcome measures, and, lack of assessment of antecedents and triggers for staff use of restrictive practices.

2 Educational Goals

At the end of this session, delegates will be able to:

1. Differentiate between the different components of interventions to reduce restrictive practices; and,
2. Evaluate the potential of an intervention and/or its individual components based on the evidence presented.

Correspondence

Email: k.canvin@leeds.ac.uk

The influence of staff attitudes towards coercion on decisions to apply coercive measures

Paper

Simone Agnes Efkemann, Jakov Gather & Georg Juckel (Germany)

Keywords: coercion, SACS, mental health professionals, attitudes, decision-making

Abstract:

Background

Despite legal regulations, mental health professionals have discretionary power over the use of coercive measures. Up to now, little is known about the decision-making process in this regard, but several individual factors such as personal experiences, personality traits and attitudes might influence the decisions of mental health professionals in specific situations.

Aims

The aim was to validate a German version of the “*Staff Attitudes towards Coercion Scale*” (SACS; Husum, Finset & Ruud, 2008) and confirm its psychometric properties. In a further step, the scale will be used to analyze the influence of staff attitudes towards the use of coercion on the decisions that are being made in this regard. Furthermore, the relationship between staff attitudes on the use of coercion and other individual factors such as personality traits will be examined.

Methods

The validation was conducted in three psychiatric hospitals by asking mental health professionals to fill out a translated version of the SACS. The subsequent study will take place in three additional psychiatric hospitals. Decisions of mental health professionals on the use of coercion will be obtained by means of case vignettes describing patients which might require involuntary admission to a psychiatric hospital and coercive measures. Apart from the SACS, further personality traits such as the Big Five, perception of aggression and need for cognitive closure should be assessed.

Results

Principal component analysis on preliminary data of the validation ($n = 78$) could not confirm the factor structure of the original SACS consisting of the three independent

subscales “*coercion as offending*”, “*coercion as care and security*” and “*coercion as treatment*”. Instead, the analysis revealed a 2-factor model. The first factor consisted of the same items as the initial subscale “*coercion as offending*”, whereas the second factor combined the remaining items of the other two subscales. Both scales reached high reliability with Cronbach’s $\alpha = 0.801$ for the first and $\alpha = 0.817$ for the second factor.

Conclusion

The results indicate that the German version of the SACS can be used to adequately assess mental health professionals’ attitudes towards the use of coercion, though there was a more distinct demarcation between positive and negative attitudes. For subsequent studies, it is hypothesized that mental health professionals differing in their attitudes also differ in the likeliness of deciding to apply coercive measures. This would contribute to a better understanding of decision-making processes that could lead to the reduction of coercion.

2 Educational Goals

After attending this talk, participants are able to

1. understand the general role of attitudes and personality traits on the decision-making process and subsequent behavior and
2. assess the relationships between different kinds of attitudes and personality traits and their relevance in the reduction of coercion

Correspondence

Email: simone.efkemann@rub.de

Nursing care quality and chemical restraints: an evaluation tool

Paper

Catherine Hupé, Caroline Larue & Damien Contandriopoulos (Canada)

Keywords: Quality of care, chemical restraints, nursing, behavioural symptoms, violence

Abstract:

The use of chemical restraints is a common practice that can help promote safety and effectiveness in nursing psychiatric services as long as appropriate quality standards are followed (Peisah, Chan, McKay, Kurrle and Reutens, 2011). However, when overprescribed, antipsychotics, benzodiazepines and other substances with sedative properties used to control behavioural symptoms can lead to a deterioration of the patients' physical and mental health. Such practices can also undermine the patient caregiver relationship, cause adverse events like falls and even death (Brophy, Roper, Hamilton, Tellez and McSherry, 2016; Foebel et al., 2016; Heckman et al., 2016; Hsu, Rego, Esmaily-Fard, Lee and Rego, 2015; Maust, Kim, Seyfried et al., 2015; Pakpoor and Agius, 2014; Yaoming, Song and Dongfeng, 2016).

In order to limit those risks, regulations and guidelines about the use of chemical restraints have been put in place by many governments and health organizations across the globe. For example, according to the Act Respecting Health Services and Social Services (118.1), every health-care centre in the province of Quebec, Canada, must annually evaluate clinical teams in relation to their compliance with quality standards regarding the use of chemical restraints (Québec, 2016). However, at present, no consensual definition of chemical restraint, no validated quality indicators or measurement tools are available to operationalize this evaluation requirement.

This presentation describes the ongoing approach used to develop, validate and test a measurement tool to assess the quality of care in the use of chemical restraints. The first step was a realist review (Pawson, 2005) of the available practice standards to develop quality indicators. The content validation of the resulting quality indicators will then be performed through a Delphi technique. The measurement tool will next be tested empirically. A snowball sample of experts in nursing (validation phase) followed by a convenience sample of clinical nurses will be formed. Data analysis will be based on quantitative and qualitative methods, including Cronbach alpha and Kappa K as well as narrative content analysis.

The use of this evaluation tool will promote the integration of care standards to the nursing practice, in addition to fostering a patient-centred and safe approach to care (Baker, 2012, Cunha et al., 2016; Peisah and Skladizen, 2014; Reus et al., 2016). In the long term, a reduction in the use of chemical restraints is expected.

2 Educational Goals

At the conclusion of this presentation, the participants :

1. will be able to articulate an operational definition of the term chemical restraint
2. will be able to describe three innovative methods used to develop, validate and test a quality of care measurement tool regarding the use of chemical restraints in psychiatric facilities

Correspondence

Email: catherinehupe@gmail.com

Expanding treatment possibilities – development of the Academic High Intensive Care model

Paper

Paul Doedens (Netherlands)

Keywords: Intensive psychiatric care, university hospital, academic high intensive care model

Abstract

The High Intensive Care (HIC-) model is currently the leading organisational model in Dutch intensive psychiatric care. Key elements of the HIC-model are a healing environment, a recovery-orientated alliance with patients and intensive collaboration with family and outpatient treatment teams.

The implementation of the HIC-model in several mental health facilities has shown to result in a decrease in patients' violence and staffs' use of coercive measures. In the last few years, the mental health community developed adjustments to the HIC-model for the forensic mental health care (FHIC) and child and adolescent mental health care (HIC-J).

Adjustment for use in acute psychiatric departments of university medical centres (UMC's), which provide tertiary, highly specialised care, was both needed and challenging. From 2018 onwards, the Amsterdam UMC collaborated with the other UMC's in the Netherlands to develop an adjustment of the HIC-model specifically for acute psychiatric UMC-facilities: the Academic High Intensive Care model.

We held several consensus meetings to work on the foundations of the new organisational model. Key elements were advanced diagnostics, therapy resistant patients, obstructed treatment alliances and combining intensive psychiatric and physical care. The initiative also resulted in a mission statement of Academic High Intensive Care. Performing high quality scientific research and developing postgraduate education in acute psychiatry were stipulated as part of the foundations of the Academic High Intensive Care model.

The model has now been developed further in collaboration with the mental health partners in the regions of the UMCs, to assure that we expand the treatment possibilities in the mental health care field, instead of building a new type of facility in name only. Optimal collaboration between the university hospitals and with the mental health facilities is the major challenge for the future.

Together, we aim to improve patient safety, reduce violence and the use of coercive measures further and to provide new perspectives for patients with treatment resistant conditions.

2 Educational Goals

1. To inform on the adjustment of the High Intensive Care model for psychiatric departments of UMC's
2. To discuss the value of tertiary care to reduce violence and use of coercive measures in mental health care

Correspondence

Email: p.doedens@amc.uva.nl

The Restraint Reduction Network: Mandatory standards for training in using restraint, focusing on reduction, prevention, and safe management

Special Workshop

Sarah Leitch & Kevin McKenna (UK)

Keywords: Restraint Reduction; Human Rights; training

Abstract:

There has universal concern consistently expressed for many years regarding the structure and content of training in the prevention and management of aggression and/or violence provided to personnel across health, social care and education services.

Central to these concerns are the paucity of evidence underpinning the content, safety and effectiveness of such training, and the virtual absence of standards and quality assurance governing the provision of training.

In response to these concerns, a major improvement was undertaken in the UK, driven by government policy, which has resulted in the production by the '*Restraint Reduction Network*' of mandatory standards which are formally sanctioned by government and will govern the future provision of aggression prevention and management training. Specifically, from April 2020, it will be mandatory for any and all training provided within any UK NHS facility, or those receiving NHS funding, to adhere to these standards.

Within the UK this is by far the most ambitious initiative ever undertaken to standardise such training, and is unparalleled at this time within an international context.

The workshop will place particular emphasis of facilitating active participant engagement, in identifying existing good practice, and potential improvements in this complex subject area. Specifically, this highly interactive workshop, will:

- present the RRN standards, discuss their development, and some of the challenges involved in implementing a reform of training provision of this magnitude
- present the experiences of the first training providers to pilot implementation of the standards
- discuss the challenges involved in conducting a robust service specific training needs analysis, involving service users in training delivery, and implementing a programme of effective post incident recovery and learning.

Participants will have the opportunity to:

- discuss these opportunities and challenges from their own national and service related perspectives, and explore the role of training in driving and/or supporting the required cultural change necessary to effectively implement restraint reduction approaches.
- have the opportunity to use a standardised self-assessment tool to objectively assess their current training provision, and a 196training impact tool which might inform how changes in staff practices following training might be reliably measured.

2 Educational Goal

The aim of this workshop is to present a robust framework of standards governing the provision of training in prevention and management of aggression developed, and for participants to have an opportunity to consider the challenges and opportunities inherent in their implementation.

Learning Objectives

Through participation in this workshop, participants will have had the opportunity to:

1. Understand a robust framework of standards governing the provision of training in prevention and management of aggression
2. Explore and utilise instruments associated with these standards to consider their current practice and potential future enhancements.

Correspondence

Email: s.leitch@bild.org.uk

Music in seclusion rooms – impact of a music listening device on patients’ subjective experience

Paper

Angelika Güsewell, Gilles Bangerter, Alexia Stantzos, Emilie Bovet, Cédric Bornand & Matthieu Thomas (Switzerland)

Keywords: Music, seclusion rooms, patients’ subjective experience, caring-relation

Abstract

Our project 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 regain 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, it allows patients to listen to music on their own and recover from the negative impact of the environment. On the other hand, music fosters interactions and communication between patients and caregivers about an issue that is not related to illness.

An interdisciplinary research team comprised of psychiatric nurses, engineers, musicians, psychologists, and anthropologists developed a music-listening device. The first challenge this team had to address was respecting the very strict safety regulations of the hospital by 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.

Within the scope of a pilot study, interviews were conducted with the nurses in charge of patients placed into a seclusion room equipped with this newly developed device. It appeared that the music player was user friendly, encouraged patients to make choices and decisions, and helped them to regain control over themselves and their behavior; finally, it elicited various patient-nurse interactions, thus contributing to the establishment of a caring relationship (Güsewell et al., 2018).

Five seclusion rooms in four different psychiatric facilities in Switzerland and France have been equipped with the device to date. A new research project was launched in 2018 to document its use and to investigate its impact on the subjective experience of both patients and caregivers, on the daily routine of the ward, and on patient-nurse interactions. Quantitative data are being collected using standardized questionnaires: Barcelona Music Reward Questionnaire (BMRQ; Saliba et al., 2016), Survey of Nurses' Attitudes to Seclusion (SNAS; Heyman, 1987), Verbal and Social Interaction Nursing Students questionnaire (VSI-NS; Rask et al., 2018). Furthermore, interviews were conducted with both patients and nurses to explore some of the issues in more depth.

Our contribution will first present comparative data on the subjective experience of patients placed in seclusion rooms with and without the music listening device.

2 Educational Goals

On attending this presentation, participants will

1. develop an understanding of the impact a music listening device in seclusion rooms can have on patients' subjective experience
2. be aware of the possibilities to capture this experience using standardized questionnaires

Correspondence

Email: angelika.gusewell@hemu-cl.ch

Perceived quality of care on wards for High and Intensive Care in the Netherlands

Paper

Laura van Melle, Yolande Voskes, Sylvia Gerritsen, Lieke Zomer, Yolande Nijssen, Niels Mulder & Guy Widdershoven (Netherlands)

Keywords: High and intensive care, Quality of care, coercion, recovery

Abstract

Introduction

In the Netherlands over recent years, the High and Intensive Care (HIC) model has been developed to improve the quality of care of acute psychiatric admission wards. The HIC model represents a new approach to care and focusses on contact, crisis prevention and stepped care. The HIC model combines the medical model with a recovery-based approach. Currently, the majority of Dutch mental healthcare institutions have started implementing the model. This research aims to investigate the quality of care perceived by patients and to determine the relationship between the implementation of HIC and the perceived quality of care at wards for High and Intensive Care.

Methods

This study was conducted over a period of 18 months within 41 inpatient adult psychiatric care wards in 25 mental health care institutions in the Netherlands. In all wards, a process of implementing HIC took place. Implementation of HIC was assessed by auditors using the HIC monitor, a validated model fidelity scale. Perceived quality of care was measured using the KWAZOP. A total of 495 interviews were conducted with patients at 18 HIC wards. A multilevel analysis was conducted to establish the relationship between HIC monitor scores and KWAZOP scores.

Results

Patients indicated greatest satisfaction with “*freedom and privacy*” and rated care related to “*coercive measures*” as low. The subscale “*recovery oriented care*” scored second lowest. The low rating of the coercive measure scale seems for a large part to be influenced by the rating of the item “*evaluation of coercive measures*”, meaning that on many wards patients experienced little opportunity to evaluate coercive measures afterwards. Patients who experienced coercion gave a significantly lower rating of the quality of care than patients who did not experience coercion. No significant relationship

was found between the scores on the KWAZOP and the level of implementation of the HIC model.

Conclusions

Our results show that coercive admission or coercive interventions during admission have a huge effect on the perceived quality of care. This indicates that the HIC approach, which focuses on prevention of coercion, does not foster quality of care as perceived by patients should coercion not be prevented. Also, recovery-oriented care, which is a core aim of the HIC approach, scored relatively low. We recommend paying more attention to evaluation in case coercion does take place in the context of HIC and to focus on recovery-oriented care in implementing the HIC model.

2 Educational Goals

1. To gain knowledge and understanding of the high and intensive care model and its implementation in the Netherlands
2. To gain insight in the perceived quality of care on wards for high and intensive care and the relationship between the implementation of HIC and quality of care

Correspondence

Email: a.vanmelle@vumc.nl

Validation of the Active Recovery Triad (ART) monitor; a model fidelity scale for long term mental health care

Paper

Lieke Zomer, Yolande Voskes, Lisette van der Meer, Jaap van Weeghel & Guy Widdershoven (Netherlands)

Keywords: Active Recovery Triad (ART), long-term mental health care, serious mental illness (SMI), recovery, model fidelity, validity.

Abstract

Introduction

The 'Active Recovery Triad' (ART) model is an integral care approach aimed at recovery for people with Serious Mental Illness (SMI) in long-term mental health care. For a long time, this neglected group were the 'permanent residents' of long-term facilities in the Netherlands. ART combines an active role for professionals, service users and family (A), a focus on recovery (R), and cooperation between the service user, family and professional in the triad (T). The aim of the ART model is to provide a new perspective for this group of service users: a perspective of hope and empowerment. ART is currently being implemented in teams of 18 mental health care organizations in the Netherlands, in a variety of settings; from (closed) clinical wards to residential care facilities.

Methods

The ART model is operationalized in a model fidelity scale; 'the ART monitor', in order to assess the quality and model fidelity of the care provided by an ART team. The aim of current research is to validate this instrument. This large national study includes a mixed methods design. 18 audits were performed within teams of mental health care organizations, on the basis of the ART monitor. In addition, the scores from the audits were evaluated with the ART teams by means of a focus group approach. The data retrieved from these audits and focus groups were used to assess the content validity, construct validity, and inter-rater reliability of the ART monitor.

Results

In this presentation, the ART model will be explained and the results of the validation process will be presented, addressing the following questions: How do teams score on

the ART monitor in terms of the different key characteristics of the ART model? What patterns do we recognize in the data? What do teams find difficult? And what aspects are already well implemented within teams?

Conclusions

The ART model provides a guiding framework aimed at recovery for people with SMI. The ART monitor contributes to the implementation process of ART within teams. Using this model fidelity scale during audits provides teams with practical insights in their current situation: what is already going well and what could be improved. We expect that implementation of the ART model will lead to an improvement in the quality of care in long term psychiatry and opportunities for recovery for service users.

2 Educational Goals

1. Gain understanding of the Active Recovery Triad model in a Dutch context.
2. Gain insight in the results of the validation process of the ART model fidelity scale.

Correspondence

Email: l.zomer@vumc.nl

How do service users evaluate treatment pressures in comparison to formal coercion? Preliminary results of a qualitative empirical study

Paper

Jakov Gather, Sarah Potthoff, Anna Werning, Georg Juckel, Jochen Vollmann & Matthe Scholten (Germany)

Keywords: treatment pressures, informal coercion, qualitative empirical research, ethics

Abstract

Background

During involuntary commitments, psychiatric service users often experience treatment pressures, such as persuasion, interpersonal leverage or threats. From a conceptual point of view, treatment pressures are usually regarded as the milder means in comparison to formal coercive interventions, such as locked ward doors, mechanical restraint or seclusion. However, there is little empirical data on how service users evaluate treatment pressures when compared with formal coercive measures.

Aims

The aim of the study is to gain insight into psychiatric service users' evaluation of various forms of treatment pressures when compared with formal coercion.

Methods

Qualitative interviews were conducted with service users who have experienced coercive interventions in psychiatric hospitals. The study is based on the Q-methodology. In a first step, Q-cards will be developed based on interviews with service users. These Q-cards will be sorted by service users in a second step. The empirical results will be the input of an empirically informed ethical analysis.

Results

Preliminary results of the qualitative empirical study will be presented. It is hypothesized that service users will not rank all forms of treatment pressures as the milder means in comparison to formal coercion. The various kinds of treatment pressures and coercive interventions will be assessed ethically in light of the findings.

Conclusions

Empirical data on the experiences and attitudes of psychiatric service users are relevant for the ethical evaluation of treatment pressures and coercive interventions in clinical psychiatry.

2 Educational Goals

After attending this talk, participants will be better able to:

1. reflect on treatment pressures and coercive interventions in the light of psychiatric service users' experiences and attitudes, and
2. ethically assess various forms of treatment pressures and formal coercive interventions on the basis of empirical data.

Correspondence

Email: jakov.gather@rub.de

MAVAS-R Factor Loading: Medical Staff Responses on Adult and Pediatric Inpatient Hospital Units

Paper

Della Derscheid, Sabine Hahn & Joy Duxbury (USA)

Keywords: MAVAS-R, medical inpatient units, workplace violence, inpatient aggression, inpatient violence, adult, pediatric, hospital setting

Abstract

Background

Management of violent patients on medical units is an important clinical issue for multidisciplinary teams. Staff attitudes and beliefs influence their choice of management approaches to deal with these complex situations.

The purpose of this study was to test validity of the Management of Aggression and Violence Attitude Scale-Revised (MAVAS-R) among staff in medical healthcare settings.

Methods

Two samples of multidisciplinary staff (N=380) including Registered Nurses, Patient Care Assistants, Physicians, Social Workers and Security from either adult or pediatric inpatient medical units within a large Midwestern academic hospital were surveyed. Participants completed the MAVAS-R identifying their own attitudes and strategies regarding management of patient violence. The 1-5 Likert scale items create four subscales that reflect perceived contributions to patient violence: Internal (biomedical), External (environmental), Situational/interactional (patient-healthcare worker interaction), and Management (methods to manage violence).

Factor analysis with orthogonal rotation was used to test MAVAS-R validity after three items related to seclusion were removed. Factors with eigenvalues of 1.0 or greater were retained and 24 tool items were assigned to factors, with a loading threshold of 0.4 Cronbach's coefficient alphas, to measure how closely the questions in each factor were related. Results: For all 24 MAVAS-R questions, complete respondent data from staff on adult units (n=293) resulted in 18 items loading on two factors. Cronbach's alpha ranges were .81-.75 with Eigenvalues of 3.8 and 2.3. The two themes surrounded communication/interaction and causes/prevention measures. Respondent data from staff on pediatric units (n=88) resulted in 21 total items loading on five factors. Cronbach's

alpha ranges were .43-.72 with Eigenvalues of 1.2 – 4.2. The five themes surrounded management, patient internal factors, interaction with others, use of external controls, and causes of patient violence.

Implications

Study results may have been impacted by application of the MAVAS-R in medical settings through: a) removal of the three non-pertinent seclusion related MAVAS-R items thus decreasing the total number of available items for factor loading, and b) differences in tool sensitivity to staff attitudes and beliefs about management of violent patients in a medical context. Variation in staff attitudes and beliefs between adult versus pediatric medical units may relate to developmental differences in patients' presenting problems, patient violence severity, or medical staff perception of violence based on patient age. Attitude is a difficult construct to measure and medical staff respondents' understanding of MAVAS-R questions may have varied. Additionally, the smaller sample of pediatric staff respondents resulted in less statistical power than that of the adult staff sample.

Next research steps may include focus groups of staff in different medical healthcare settings to ascertain whether MAVAS-R questions and constructs are similarly understood; or, if potential bias is reflected in measurement between different healthcare settings.

2 Educational Goals

Participants will:

1. recognize the four key MAVAS-R themes from the original tool reliability testing.
2. describe the MAVAS-R theme differences between adult versus pediatric healthcare staff on medical units from this study.

Correspondence

Email: derscheid.della@mayo.edu

Perspectives of Consumers and Staff one year after the implementation of Safewards in inpatient mental health wards in Victoria Australia

Paper

Bridget Hamilton & Justine Fletcher (Australia)

Keywords: Safewards, service users, consumers, staff, acute inpatient mental health

Abstract

Background

Safewards is designed to reduce conflict and containment, through the implementation of 10 interventions that serve to improve the relationship between staff and consumers of inpatient mental health wards. It is recognised that mental health inpatient units are complex and challenging environments from both the perspective of consumers and staff. There has been a policy shift in Australia and internationally to reduce the use of restrictive interventions and promote the delivery of recovery-oriented care, in an effort to improve the experiences of consumers. Safewards was trialled in Victoria and evaluated independently.

Aim

To describe the impact of Safewards from the perspectives of consumers and staff in inpatient mental health services.

Methods

A post-intervention survey was conducted with 72 consumers on 10 inpatient mental health wards and 103 staff from 14 inpatient mental health wards, 9-12 months after the introduction of Safewards. Consumers and staff represent four service settings: adolescent, adult and aged acute, and secure extended care units. Fidelity scores at the time of the surveys indicated that on average wards were implementing 9 of the 10 Safewards interventions.

Results

Quantitative data showed that both staff and consumers felt more positive about being part of the ward, safer and felt more connected to each other. Both staff and

consumers believed there to be a reduction in verbal and physical aggression since the introduction of Safewards, although consumers held a more conservative view of this. Qualitatively consumers described increased respect, hope, sense of community, and safety, and reduced feelings of isolation. Staff described a shift in culture, resulting in better relationships with consumers and other staff, as well as renewed focus on patient-centered, recovery-oriented care.

Conclusions

Consumers and staff highlighted numerous improvements of importance since the introduction of Safewards. Staff in particular believed Safewards contributed to a reduction in conflict events and is an acceptable practice change intervention. Both consumers and staff appreciated an equalising of their relationships. These findings suggest that Safewards is a valuable practice change initiative for Victorian inpatient wards with the potential to reduce conflict and help promote recovery-oriented care.

2 Educational Goals

1. Participants of this presentation will gain an understanding of the impact of Safewards on consumer and staff relationships
2. Participants of this presentation will understand the links between Safewards and recovery-oriented-practice

Correspondence

Dr. Bridget Hamilton
Email: bh@unimelb.edu.au

Understanding variation in implementation of Safewards in 18 inpatient mental health wards in Victoria Australia using the Consolidated Framework for Implementation Research

Paper

Justine Fletcher & Bridget Hamilton (Australia)

Keywords: Safewards, implementation science, inpatient mental health, consolidated framework for implementation research

Abstract

Background

Safewards is designed to reduce conflict and containment, through the implementation of 10 interventions that serve to improve the relationship between staff and consumers of inpatient mental health wards. The implementation in Victoria demonstrated high fidelity 9-12 months after the introduction of Safewards. The outcomes of implementation in the UK RCT and Victorian evaluation have both shown reductions in containment events. Implementation in other countries has reportedly been mixed, fidelity has been variable and staff have reportedly been skeptical about the introduction of the model. Implementation of new innovations in health care is often challenging and numerous potentially useful and worthwhile innovations are not incorporated into routine care. The Consolidated Framework for Implementation Research offers a meta-theoretical framework from which to consider implementation.

Aims

To discover and contrast the barriers and facilitators influencing the implementation of Safewards across 18 inpatient mental health wards using the Consolidated Framework for Implementation research.

Methods

Data for this study was drawn from 7 implementation diaries completed by Safewards leads representing the 7 involved Health Services, The Readiness Checklist completed prior to the implementation of Safewards, and the Fidelity Checklists completed for each ward at the end of the 12-week trial phase. The Codebook for the Consolidated

Framework for Implementation Research is being used to analyse quantitative and qualitative data from each of the 18 wards involved.

Results

Preliminary analysis reveals that at least 20 constructs across the 5 domains are relevant to the implementation of Safewards. Key differences between high, medium and low implementers emerged from; the Inner Setting domain specifically the constructs of leadership engagement and access to knowledge and information; knowledge and beliefs about the intervention from the Characteristics of Individuals domain; and from the Process domain regarding the constructs of planning, key stakeholders, innovation participants, and reflecting and evaluating.

Conclusions

The Consolidated Framework for Implementation Research has enabled us to utilise our qualitative and quantitative data to understand the barriers and enablers that are at play for wards who achieved variable levels of implementation fidelity within and across health services. It is possible these findings could be useful to inpatient mental health services more broadly when they are considering how to implement Safewards.

2 Educational Goals

1. Participants of this presentation will gain an understanding of how to apply the Consolidated Framework for Implementation Research to evaluation data post hoc
2. Participants of this presentation will learn the key barriers and facilitators to implementing Safewards successfully

Correspondence

Email: justine.fletcher@unimelb.edu.au

Reflection on best practice in physical intervention

Workshop

Pål-Erik Ruud (Norway)

Keywords: Best practice, physical intervention

Abstract

Reflection on best practice in physical intervention is a presentation of dilemmas related to best practice. Dilemmas that will be presented involve ethics, validity of research, quality of competence, and a presentation of dilemmas related to choice of techniques and training.

Reflection on best practice in physical intervention is based on training experience within a number of professions since 1992, involving more than 150 000 participants. Dilemmas presented are a result of numerous training needs analysis, literature, research, and a cross reference between different professions.

The main purpose of this workshop is to share experience and knowledge that will contribute to raised awareness when evaluating clinical practice in search of best practice in physical intervention.

2 Educational Goals

1. Better understanding of how to evaluate best practice in physical intervention
2. Raised awareness of challenges related to the development of best practice in physical intervention

Correspondence

Mr. Pål-Erik Ruud

Email: ruud@verge.no

Using the humanities to enhance our understanding of aggression and/or violence within mental health practice

Workshop

Kevin McKenna, Ian Needham & Lois Moylan (Ireland)

Keywords: Humanities, Aggression and violence, mental health settings, movies

Abstract

Aggression and/or violence pose a particular challenge within psychiatric care settings, with compelling evidence that management of the problem is associated with a range of very significant negative impacts including inherent risks of physical and psychological trauma for both service recipient and provider, and the potential to diminish therapeutic working relationships.

Enlightened thinking and recent evidence now acknowledge the contextual and interactional aetiologies of aggression and/or violence within mental health contexts, and that such occurrences are not always a function of pathology alone. There is also a dawning recognition that occurrences are multi-dimensional, with causal factors that are often not fully appreciated, misunderstood and attributed quite differently by those involved.

Occurrences of aggression and/or violence are unsatisfactory for all concerned. Apart from the serious and indisputable physical risks, significant psychological distress has also been associated with involvement in, or witnessing such occurrences with service users having reported feelings of anger, abandonment, depression, despondency and re-enactment of previous traumas, and personnel having reported feelings of intense fear, stress, ambivalence, guilt and disappointment that situations were not resolved in a more benign fashion.

Understandably personnel may find it difficult to fully appreciate the complex dynamics at play when they find themselves in the precarious position of having to balance compassionate respect for service user autonomy with the imperative to manage imminent risk. Similarly insights amenable through effective debriefing and/or clinical supervision are not always fully exploited, as a function of time and task demands of busy clinical services, and/or reliance on recall of what are potentially emotionally laden and sometimes very fearful experiences.

One alternative approach to facilitate reflective explorations which can enhance clinical effectiveness is through the use of the humanities which can reveal the struggles of all concerned. The use of appropriate works from the humanities can facilitate the clinician to explore such issues as dynamics, attribution, identification and transference free from the immediate duty-bound imperative to preserve the safety of those involved, and/or the potential of recall bias from their own experience.

This highly interactive workshop will draw upon the humanities by utilising a selection of extracts from popular movies to facilitate discussion and interactive exploration regarding occurrences of aggression and/or violence from the perspectives of all involved. The potential subject related and personal learning from these exploratory and reflective discussions is an easily accessible and transferable skill which can assist participants confronting future occurrences within their practice setting.

2 Educational Goals

This highly interactive workshop will provide participant with the opportunity to:

1. Draw upon the humanities to facilitate reflective explorations of the often hidden dynamics which influence aggression and/or violence from the perspectives of all involved.
2. Explore humanities as a source of potential subject related and personal learning which is easily transferable to practice settings.

Correspondence

Dr. Kevin McKenna

Email mckennakj@eircom.net

Development and testing of the intervention “Guided Clinical Decision-making for Mechanical Restraints Use” (GCDMR)

Poster

Jonas Harder Kerring, Lea Deichmann Nielsen, Søren Fryd Birkeland, Søren Bie Bogh & Frederik Alkier Gildberg (Denmark)

Keywords: MR, Coercion, Forensic psychiatry, Restraint, External review, Staff

Abstract

Introduction

There is an ongoing request from politicians etc. to reduce the use of Mechanical restraint (MR), not least in the forensic psychiatric setting. Evidence-based measures to achieve this goal are scant but previous research findings suggest that systematic evaluation provided by a team or committee of external staff could be a solution.

Aims

Based on existing research literature, the aim of this Ph.D.-project is to develop an expert team structure “*Guided Clinical Decision-making for Mechanical Restraints Use (GCDMR)*” to support clinical staff in decision-making about MR. The project includes testing the effect of GCDMR on MR utilization and investigating staff interactions with the intervention.

Methods

In the first part of the project, a systematic review will be conducted that provides the basis on which GCDMR is developed. The review will include both quantitative and qualitative studies. The exact type of review will depend on the types of studies available. The objective of the first part of the project will be to uncover and understand factors that could contribute to the effectiveness of GCDMR or be detrimental to its effect, so that its contents can be defined in detail. In the second part, GCDMR is implemented in three forensic psychiatric departments and statistical analyses are conducted to examine changes in MR duration and frequency. The exact composition of the team structure will be subject to the findings of part one. Depending on input from participating facilities, teams are employed every time a patient has been restrained for more than 12 hours or every 8 hours when staff rotate. The last part of the project consists of a qualitative

study, including thematic analysis of transcriptions of intervention conversations with staff, to explore staff interactions with the intervention. Politicians are pushing for a reduction in the use of MR, this factor should be controlled for. By spacing out initiation of each psychiatric department during part two, an interrupted time series analysis design should allow us to control for any nation-wide trend beginning around the time of the start of the study, which is expected to run from 2020-2022.

Results

Data analysis will be conducted using segmented multi-level regression analysis. The study includes different staff compositions on a ward level and different overall psychiatric cultures depending on the region of the facility. The regressions will account for both ward, facility and region as separate variables.

Conclusion

Results are pending and expected in 2022.

2 Educational Goals

1. Increased knowledge about interventions to introduce team-based review and their potential to reduce the use of coercion and specifically MR in forensic psychiatry
2. Increased awareness of the importance of external review procedures for staff employing coercion and MR.

Correspondence

Email: jonaskerring@gmail.com

Developing targeted MR-CRAS intervention to reduce the duration of mechanical restraint among forensic psychiatric inpatients

Poster

Charlotte Fagan (Denmark)

Keywords: MR-CRAS, developing interventions, reduce the duration of mechanical restraint, forensic psychiatric inpatients

Abstract

Background

The duration of mechanical restraint (MR) is high among forensic psychiatric inpatients in Denmark. A new short-term risk assessment instrument, the Mechanical Restraint – Confounder, Risk, Alliance Score (MR-CRAS) checklist has been developed to support staffs' decision to release the patient from MR, but the checklist does not indicate reflections of conflict management and potential care interventions to improve MR-CRAS scores of the patient, contributing to a decrease in the duration of MR.

Aim

With a strong emphasis on user involvement, this project aims at 1) developing management interventions targeted to confounders, risk behavior and parameters of alliance inherent in the MR-CRAS checklist that are based on existing evidence and perceived usefulness from the perspective of both patients and staff to promote release from MR, and 2) evaluating patients and staffs' perceived impact during MR of a combined use of MR-CRAS with such targeted interventions.

Methods

This PhD project will be conducted within a Danish Psychiatric Department among forensic psychiatric patients and staff through a participatory action research approach that combines user orientation with a collaborative change process inspired by the experience-based co-design.

Phase 1 serves to systematically review existing research literature to develop an evidence base of interventions, which on the groundwork of science have shown a positive result in reducing the duration of MR.

Phase 2 serves to gather experiences by qualitative in-depth interviews with clinicians and patients about their experiences with interventions that promote the patients' release from MR and analyzing data from the interviews through qualitative content analysis. The findings from the interviews and from the systematic literature review are presented to staff through focus-group interviews focusing on feedback regarding which interventions or elements in interventions they find useful for promoting the patients' release from MR.

Phase 3 presents an iterative process that serves to a) conceptualize concrete interventions based on the findings from phase 1 and 2, b) implementation of the interventions during MR and c) evaluating experiences with the use of these interventions during MR among patients, through in-depth interviews, and among staff through focus-group interviews, with a view to possible adaptation needs, re-implementation, and re-evaluation efforts. The project is expected to start in the first half of 2020

2 Educational Goals

1. To gain knowledge of future research with the aim of reducing the duration of MR.
2. To gain knowledge of future research with a strong emphasis on user involvement.

Correspondence

Mrs. Charlotte Fagan
Email cfag@ucsyd.dk

20-year documentary analysis of trends in the use of coercive measures in Finnish psychiatric hospitals

Poster

Tella Lantta, Maritta Välimäki, Min Yang, Tero Vahlberg, Virve Pekurinen, Minna Anttila & Sharon-Lise Normand (Finland)

Keywords: coercive measures, psychiatric inpatient care, trends, register analysis

Abstract

Background

Internationally, intentions in reducing restrictive practices have been promising. In Finland, despite a strong emphasis to decrease restrictive practices in psychiatric hospitals, it is still questionable if trends in using coercive measures have really changed over time.

Aims

Rates of coercive measures in the inpatient population across Finland were examined to identify changing trends as well as variations in such trends by gender and region.

Methods

Documentary analysis was conducted by extracting patient data from the national database (The Finnish National Care Register for Health Care). Adult patients admitted to psychiatric units who had faced coercive measures during their hospital stay were included. Units offering only forensic psychiatric or psychogeriatric care were excluded. The sample consisted of 226,948 inpatients (505,169 treatment periods, years 1995-2014). Measures included patient and psychiatric unit-level variables: gender of the patient, coercive measure used (seclusion, limb restraints, forced injection and/or physical restraints), admission time and region.

Results

Multilevel logistical models (a polynomial model of quadratic form) were used to examine trends in prevalence of any coercive measures and four specified coercive measures over time, and to investigate variation in trends among regions. The overall

prevalence of coercive measures was 9.8%, with a small decrease during 2011–2014. The overall prevalence of seclusion, limb restraints, forced injection and physical restraints on inpatients were 6.9%, 3.8%, 2.6% and 0.8%, respectively. Only the use of limb restraints showed a downward trend over time. Overall prevalence of any coercive measure, as well as prevalence of seclusion and limb restraints were significantly lower for female patients (8.35%, 5.63%, 2.74%) compared to males (11.23%, 8.02%, 4.74%). However, a higher prevalence of forced injection were found for females (2.71% vs. 2.41%), but there was no gender difference in physical restraints. Regional differences existed: the highest prevalence was in Eastern Finland (95% CI, 11.3%–11.7%), and the lowest was in the Åland region (95% CI, 4.7%–6.5%).

Conclusions

Although a strong emphasis to reduce the use of restrictive practices in Finland may have had positive affects by decreasing the use of coercive measures, clear, lasting changes in patient coercive measures have not yet been achieved. Based on our results, there is a need for the future development of clinical guidelines and interventions for preventing and more effectively managing challenging situations. Education related to the use of coercive measures should be critically assessed to ensure that the staff are competent to implement humane and safe caring approaches.

This abstract is based on an article in *BMC Psychiatry*, in press.

2 Educational Goals

1. Participants will learn what is situation in Finland with reducing use of coercive measures in 20-year timeline.
2. Participants will have a basic understanding of how policy and legislative changes may have an impact on use of coercive measures clinical practices at the national level.

Correspondence

Dr. Tella Lantta
Email: tejela@utu.fi

The Safe Technique of Physical Restraint in an Ambulance

Poster

Jaroslav Pekara & David Peran (Czech Republic)

Keywords: Safety. Restraint. Ambulance. Consequences. De-escalation. Supported prone position.

Abstract

Background

Manual restraint is one of a range of '*restrictive interventions*' available for the emergency short-term management of violent and aggressive individuals who are likely to cause significant or life-threatening harm to themselves or others. Interventions with violent patients, in the Prague Emergency Medical Services, is often carried out in cooperation with the police. Sometimes the crews of Prague Emergency Medical Services must provide the de-escalation of a violent patient alone without the presence of the police. The police are trained in physical de-escalation techniques. According to scientific literature, the training in physical de-escalation techniques for staff in the health care sector is insufficient.

Methods

The authors conducted a review of Proceedings of European Congress on Violence in Clinical Psychiatry in the years 2011–2017 and participated in workshops of the European Violence in Psychiatry Research Group. The main aim was to find the safe technique of physical restraint in an ambulance. Those results will help to create a standard for these purposes within Prague Emergency Medical Services.

Results

The most commonly applied position for physical de-escalation is the prone position. Research revealed a classification of possible injuries that can occur during physical limitation:

1. Direct injury – actual physical damage as a result of external pressure from restraint devices. (lacerations, contusions, limb bruising or strangulation, nerve damage).
2. Indirect injury – secondary complications (use of restraints was linked to prolonged hospitalization, increased mortality, a lower chance of being discharged home, and increased risk of nosocomial infection). Causes of death include excited delirium,

drug abuse, compromised cervical circulation and/or air entry, psychological stress, psychiatric disorders, psychotropic medications (CNS suppression and arrhythmia), anticholinergic medications (leading to tachycardia, hyper-pyrexia) and aspiration causing asphyxia.

Metabolic acidosis (low pH due to acid–base balance disruption) has been postulated as a cause of sudden death due to induced cardiac failure after a prolonged and/or extremely physically demanding restraint. The reduction of saturation was noticed only in obese people (BMI over 25). The Unsupported Prone Position (USPP) also led to more frequent reports of anxiety and discomfort. The Supported Prone Position, which has a lesser physiological and psychological impact compared to the USPP, should be considered the position of choice to reduce physiological and psychological risks for the person held.

Conclusion

Prone restraint should be the last resort, employed only after efforts to use supine restraint have failed. As a result of our review, taking into account the risks of injuring the the patients, the following rule should apply: Whenever possible, avoid actively using immobilization in the prone position. We must always use the maximum effort to manually restrain a violent patient on their back with their face upwards.

2 Educational Goals

1. To describe the physiological and psychological consequences of physical de-escalation on a patient in an ambulance.
2. To describe safe techniques of physical restraint in an ambulance and create a standard for these in Prague Emergency Medical Services.

Correspondence

Email: jaroslav.pekara@zzshmp.cz

Safewards – Improving the Relations and Collaboration leads to a Safe and Caring Environment

Poster

Dorte Graulund Olsen & Sabina Renee Beldring (Denmark)

Keywords: Safewards, Action research, Patient involvement, Safe settings, Coercion, Violence

Abstract

Background

In 2012, the Ministry of Health and the Danish Regions made an agreement to reduce the use of mechanical restraint by 50 % in 2020. The task has proven to be difficult and requires extensive cultural changes and a targeted and sustained effort. Safewards is an evidence-based conflict management model (Bowers et al., 2015) that has proven to reduce violence and coercion in psychiatric units. The model and process through the implementation allows innovative ideas to create a safe and caring approach.

Aim

The aim was to create a health-promoting environment that supports a respectful approach based on equality and trust. The users and staff members were joined to implement Safewards' ten interventions to prevent coercion and create a calm and safe environment. The aim was to make the implementation of Safewards last by making the innovative and creative approach a part of everyday practice.

Methods

Through an action research project in two psychiatric care units in Denmark with 22 inpatients, all staff members, service users and other collaborators were involved as co-researchers in the four phases. In the preparation phase, the staff was prepared through information about the aim and Safewards. The units created and decided on their values. The staff was divided into ten intervention groups and decided the implementation strategies and which data to collect. Every group needed to involve the service users in the process. Through staff meetings and coffee meetings, service users, staff and partners were informed about the project during the information phase. In the intervention phase, the interventions started every third week and the phase lasted 6

months. The process was evaluated at all times in all phases, and the implementation strategies were adjusted by the groups' experiences.

Results

- 75 % reduction of mechanical restraint (for the included units and 50 % for the entire hospital)
- Reduction of work related injuries
- Better work environment
- Positive feedback from service users and staff members
- Culture change – A better collaboration between service users and staff members
- Development of new calm down methods – Wellness bowl and SAFE-app
- Improved cooperation with collaborators across sectors
- Breaking down the walls – Open office

Conclusion

Safewards' ten interventions can increase the collaboration and focus on relationships, which might be the reason for the reduction in mechanical restraint. When staff members and service users work together in the circular processes of action research, they can learn and develop along the way, to ensure that the implementation can result in lasting change.

Implications for practice

- Secured funding from Trygfonden for a new project
- Implementation of Safewards throughout the entire hospital (7 more units), hoping to unite the service users, staff members and other collaborators
- Keep focus on Safewards – make the culture change last
- New action research circles
- Increased focus on patient- and next of kin involvement
- Giving a higher quality of care and making units safe
- Setting a good example and spreading knowledge on how to reduce coercion

2 Educational Goals

1. To be inspired by how Safewards can be implemented in everyday practice
2. How to change the culture, not for the service users, but with the service users

Correspondence

Miss Dorte Graulund Olsen
Email: dgol@regionsjaelland.dk

Restraint minimisation in mental health care: legitimate or illegitimate force? An ethnographic study

Workshop & Poster

Mick McKeown, Gill Thomson, Amy Scholes, Fiona Jones, Soo Downe, Owen Price, John Baker, Paul Greenwood, Richard Whittington, Joy Duxbury (UK)

Keywords: Physical restraint, coercion, legitimacy, inpatient services

Abstract

Coercive practices, such as physical restraint, are used globally to respond to violent, aggressive and other behaviours displayed by mental health service users. A number of approaches have been designed to aid staff working within services to minimise the use of restraint and other restrictive practices. One such approach, the '*REsTRAIN Yourself*' (RYS) initiative, has been evaluated in the UK. Rapid ethnography was used to explore aspects of organisational culture and staff behaviour exhibited by teams of staff working within 14 acute admission mental health wards in the North West region of the English NHS. Findings comprise four core themes of space and place; legitimation; meaningful activity; and, therapeutic engagement that represents characteristics of daily life on the wards before and after implementation of the RYS intervention. Tensions between staff commitments to therapeutic relations and constraining factors were revealed in demarcations of ward space and limitations on availability of meaningful activities. The physical, relational and discursive means by which ward spaces are segregated prompts attention to the observed materialities of routine care. Legitimation was identified as a crucial discursive practice in the context of staff reliance upon coercion. Trauma informed care represents a potentially alternative legitimacy.

There is international interest amongst staff, service users, policy-makers and other commentators in minimising restrictive practices within mental healthcare. This poster reports on a rapid ethnography that was situated within a larger evaluation of the ReSTRAIN Yourself (RYS) initiative within acute mental health inpatient wards. The ethnographic account provides a contextual overview of the range of environments in included mental health wards; focused attention to specific cultural aspects that could theoretically have been influenced by the RYS approach; and general description of changes occurring on the wards over the time of the study. Our discussion explores issues of the legitimacy of restrictive practices in psychiatric services through a sociological lens.

2 Educational Goals

Viewers of this poster will:

1. Develop an understanding of the Restrain Yourself intervention for minimising use of physical restraint by inpatient ward teams.
2. Appreciate the strengths and weaknesses of rapid ethnography as a research methodology in the context of mental health care.
3. Critically engage with notions of legitimacy in the use of physical restraint and other restrictive practices.

Correspondence

Email: mmckeown@uclan.ac.uk

Chapter 7 – Neurobiological approaches and pharmacological therapies

The pharmacological management of agitated and aggressive behaviour: a systematic review and meta-analysis

Paper

Maarten Bak, Irene Weltens, Chris Bervoets, Jurgen de Fruyt, Marjan Drukker & Geert Dom (Netherlands)

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Names of authors

Maarten Bak (a,b,*), Irene Weltens (a,b), Chris Bervoets (c), Jürgen De Fruyt (d), Jerzy Samochowiec (e), Andrea Fiorillo (f), Gaia Sampogna (g), Przemyslaw Bienkowski (h), W. Ulrich Preuss (i), Blazej Misiak (j), Dorota Frydecka (k), Agnieszka Samochowiec (l), Emma Bak (m), Marjan Drukker (a), Geert Dom (n)

- a. Department of Psychiatry & Neuropsychology, Maastricht University, the Netherlands
- b. Mondriaan Maastricht, the Netherlands
- c. Department of Psychiatry, University Psychiatric Centre KULeuven, Louvain, Belgium
- d. Department of Psychiatry, General Hospital Sint Jan Brugge-Oostende AV, Brugge, Belgium
- e. Department of Psychiatry Pomeranian Medical University in Szczecin, Poland
- f. Department of Psychiatry, University of Naples SUN, Naples, Italy
- g. WHO Collaborating Centre for Research and Training in Mental Health, University of Naples SUN, Naples, Italy
- h. Department of Psychiatry, Medical University of Warsaw, Poland

- i. Vitos-Klinik Herborn Psychiatry und Psychotherapy, Martin-Luther-University Halle-Wittenberg, Germany
- j. Department of Genetics, Wroclaw Medical University, Wroclaw, Poland
- k. Department of Psychiatry, Wroclaw Medical University, Wroclaw, Poland
- l. Institute of Psychology, Dept of Clinical Psychology, Szczecin University, Poland
- m. Medical Student, Maastricht University, Maastricht, the Netherlands
- n. Antwerp University (UA), Collaborative Psychiatric Research Institute (CAPRI), Edegem, Belgium

Introduction

During hospital admission, either in a psychiatric hospital, emergency department (ED) or at a general hospital ward, agitated behaviour (AB) is a challenging problem. Even more challenging is the management of AB in psychiatric outpatients as met by assertive outreach teams, community care or 24u/7 psychiatric crisis services. In this paper, we understand agitation as a continuum ranging from severe excitement to agitation to aggression to violence, without clear demarcations between these states. At some point AB may become that unmanageable that the behaviour becomes risky or dangerous for the patient, others or staff members. When non-pharmacological interventions fail to produce calm, a psychiatrist or other doctor considers a pharmacological intervention often called rapid tranquillisation. Hereafter we use the term agitated behaviour (AB) for all behaviour necessitating an acute psychopharmacological intervention.

AB is associated with serious problems and challenges warranting rapid intervention. It represents a real danger for the individual involved. Indeed, AB can be very stressful and may become life-threatening due to physical exhaustion. AB may also threaten the safety of other people involved whether it is family or medical staff. Finally, AB complicates the assessment and evaluation of the underlying somatic and psychiatric problems or disease.

The primary goal of any intervention towards AB is to ensure safety, facilitate assessment of underlying problems and prevent further escalation, through achieving calmness and collaboration (1, 2). Both psychosocial and pharmacological interventions need to be considered (3). The aim of acute pharmacological interventions is to achieve calmness and cooperativeness within a maximum of 2 hours (4, 5).

The objective of the current paper is to provide an overview and meta-analysis on the use of pharmacological interventions in the management of AB. The primary outcome is change in AB at 120 minutes (2 hours) and each drug is analysed separately. A systematic review and meta-analysis measuring the level of change on scales assessing AB was conducted. Second, a systematic review of the number and severity of adverse effects of the various medications to evaluate safety aspects of the medications used

for rapid tranquilisation was conducted. Finally, recommendations for clinical use and future research projects are proposed.

Main paper

Methods

Inclusion criteria and study evaluation

We identified randomised controlled trials with subjects randomised into intervention groups classified per medication to treat acute agitation.

The inclusion criteria were:

1. Agitation
2. Psychiatric disorder or intoxication
3. Rapid tranquilisation or pharmacological intervention
4. Setting: ED in general hospital, ward in mental hospital or mixed context.
5. Randomised control trial, controlled clinical trial, clinical trial or Phase IV clinical trial with adequate control group.
6. Raw follow-up data of period of 2 hours.
7. End date December 31st 2017

Exclusion criteria

Patients with a delirium were excluded from the study, as these patients have a clear organic origin and good protocols exist. Papers on children or adolescents under 18 years of age were searched separately with the same search string but age limit < 18 years. Data needed to be presented with raw outcome variables of the scale used per timeframe. Only studies including data within 2 hours are included. When studies presented only effect sizes or p-values, authors were contacted to receive raw data.

Studies only presenting data of more than 2 hours and, studies that only reported effect sizes, only indicating statistically significant difference by mentioning p-values or effect sizes without raw data, were excluded.

Outcome scales

The primary outcome was change on standardized rating scales; PANNS-EC (Positive and Negative Symptom Scale – Excitement Components, also called the PEC) (13), ACES (Agitation-Calmness Evaluation Scale; a scale developed by Eli-Lilly pharmaceuticals) and the OASS (Overt Agitation Severity Scale) (14), mean minutes of reaching calmness and repeated medication within two hours. The various RCT's that study rapid tranquillisation used a variety of scales and outcome measures to assess the effect of the intervention.

PANSS-EC: A clinical scale assessing agitation level in patients. PANSS-EC is a subscore of 5 items derived from the PANSS (13) that are associated with agitation: poor impulse control, tension, hostility, uncooperativeness and excitement. The PANSS-EC is a widely accepted scale for assessing agitation (15). Reliability and validity have been demonstrated showing a strong correlation with the CGI and ACES in agitated patients (16). The PANSS-EC and CGI are linearly correlated with an average increase of 3.4 point ($p < 0.001$) and linearly inversely correlated with ACES of 5.5 points ($P < 0.001$). Cronbach's alpha was 0.86 (16).

ACES: The ACES consists of a single item rating overall agitation and sedation. It has a 9-point Likert scale: 1 – marked agitation, 2 – moderate agitation, 3 – mild agitation, 4 – normal behaviour, 5 – mild calmness, 6 – moderate calmness, 7 – marked calmness, 8 – deep sleep, 9 – unarousable. This scale has convergent validity and reliability compared with PANSS-EC (16-18). Spearman correlation with PANNS-EC is 0.73 – 0.8. The Cronbach's alpha varied from 0.86 (at admission) till 0.9 (at discharge) (16)

OASS: The OASS contains 47 observable characteristics of agitation, which are sub-categorised into 12 behaviourally related units. Each subcategory is scored with likert-scale of 0 - no symptoms, 1- indicating mild symptoms to 4 - indicating very severe symptoms. The OASS exclusively rates observable manifestations of agitation. Interrater reliability is 0.97 (at 15 minutes) and 0.91 after 1 hour, whereas validity 0.81 compared with PAS (Pittsburg Agitation Scale (19)) suggesting reasonable reliability and validity(20).

Study Quality assessment

Quality assessment was based upon the MOOSE checklist, which summarises recommendations of an expert panel for reporting meta-analyses and systematic reviews of observational studies (21). Methodological issues evaluated with the checklist were; the presence of a clearly focused study question, an appropriate study type, adequate recruitment of patients and controls, an unbiased measurement of outcomes, the identification of statistical control of important confounding factors, the completeness of follow-up and the precision of estimates.

All papers were reviewed by independent researchers (MB and EB), studying the papers closely on methodology and outcome measure based on the MOOSE checklist criteria. In case of doubt papers were discussed with IW and consensus reached. Additionally, JdF checked the completeness of the search.

Outcomes

In the systematic review part of this manuscript the descriptive data per drug and publication are on the following variables are noted: dosage number of patients,

diagnosis, administration route, raw data of the psychometric scales (for the consecutive time intervals at follow-up), recall of a doctor within 2 hours and the percentage of the adverse effects after 2 hours. The main outcome of the meta-analysis is the change on PANSS-EC, CGI and ACES at 2 hours follow-up.

Statistical analyses

All analyses were performed using Stata (22). To examine the outcomes per antipsychotic for each scale (PANSS-EC, ACES and CGI, all at 120 minutes), the Stata command `metan` (23) generated forest plots including pooled estimates (absolute changes) with their corresponding 95% confidence interval (95% CI).

Computation of summary effects was carried out under the random-effects model, in which Tau was estimated using the DerSimonian-Laird method. Heterogeneity analyses were carried out using the chi-square, I-square, and Tau-square statistics. Tau-square estimates the total amount of variability (heterogeneity) among the effect sizes, but does not differentiate between sources. Heterogeneity may be due to random or systematic differences between the estimated effect sizes. I-square estimates the proportion of the total variability in the effect size estimates that is due to heterogeneity among the true effects.

Results

In total of seventeen drugs or combinations of drugs RCTs were included. These RCTs comprise 8829 participants.

Not all RCT's, discussed in the systematic overview, could be used for meta-analysis. Only studies that provided PANSS-EC, ACES or CGI including standard deviations at baseline and at follow-up could be included. Twelve studies were eligible for the meta-analysis based on the PANNS-EC. The changes after 2 hours' follow-up are presented in figure 2. Risperidone shows the most robust change of >14 points on the PANSS-EC after two hours. Followed by olanzapine, aripiprazole and haloperidol plus lorazepam. All these drugs resulted in a decrease on the PANNS of > 8 points two hours after the drug intervention. Risperidone plus lorazepam, lorazepam, risperidone plus clonazepam and haloperidol resulted in a modest decrease of agitation of 6-8 point decrease on the PANSS-EC. Levopromazine, ziprasidone and placebo hardly showed any clinical relevant decrease of agitation.

Seven drugs were eligible for the meta-analysis assessing ACES after 2 hours. Haloperidol plus lorazepam showed the strongest change as measured with the ACES, followed by lorazepam, olanzapine, aripiprazole, haloperidol, levopromazine and placebo. Given that the strongest reduction of ACES less than 2.5 points on a scale of 0 – 5, this seems a rather moderate effect in reaching calmness.

In the meta-analysis using data of the CGI only 4 drugs were available for meta-analysis. The largest changes were related with olanzapine, followed by haloperidol, aripiprazole and ziprasidone. The level of change does not differ strongly between olanzapine, haloperidol and aripiprazole.

Percentage of patients reaching calmness

- With lorazepam 63-88% of participants were calm at 120 min. About 78% reached calmness within 15 – 20 minutes.
- With midazolam only 1 study reports that 95% reached calmness after 120 minutes (33), whereas 55 – 89% reached calmness in 15 – 20 minutes.
- Haloperidol shows that after 120 minutes 60 – 89% reached calmness (36, 43, 46). In the short time (15-20 min) the percentage of patients reaching calmness was between 55% - 92% (43).
- The combination of haloperidol plus promethazine has a strong effect of 89 – 97% of the patients reached calmness in 2 hours. In the short term 67 – 91% reached calmness within 15-20 minutes.
- Studies with droperidol only report short term outcome data. About 53 – 92% reached calmness with 15-20 minutes and one study report 96% of the patients has reached calmness after 60 minutes (31).
- Only one study reported data on the combination of droperidol plus midazolam through IV administration, where 89% reached calmness with 15-20 minutes and 98% after 60% minutes (54).
- Aripiprazole results in calmness in 60 – 84% of the patients after 120 minutes.
- Olanzapine results in 73 – 91% of the patients being calm after 2 hours. One study reports that 66% of the patients reached calmness after 15-20 minutes by IV administration.
- Ziprasidone 29 – 90% of the patients reached calmness after 2 hours.
- For loxapine reaching calmness varied from 66 – 74% within 2 hours.
- Placebo results in 28 – 44% patients being calm after 2 hours.

Conclusion

Agitated or aggressive episodes impede the diagnostic and treatment process. A pharmacological intervention such as rapid tranquillization aims to reach calmness and restore contact within two hours. Haloperidol plus promethazine or olanzapine might be the first drugs of choice and are very well suited for use in hospital or outpatient interventions. This advice is in line with other guidelines (75). At an ED the context asks for a more rapid onset of calmness and medical safety equipment is at hand allowing midazolam, droperidol or droperidol plus midazolam IV or IM to be used, medications that help achieve calmness very fast but must be used with medical attention to hand. In the case of diagnostic insecurity or the probability of suspected contra-indications, lorazepam is a safe alternative. These recommendations are restricted to adult

populations only, as there are no studies on juveniles and adolescents or older people. Future research and publications would benefit from a comprehensive and uniform assessment procedure and presentation of data.

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Correspondence

Maarten Bak.

Email: m.bak@maastrichtuniversity.nl

Current understanding of the neurobiology of agitation – practical implications

Paper

Christopher Miller, Vedrana Hodzic & Eric Weintraub (USA)

Keywords: aggression management, neurobiology, psychopharmacology, emergency psychiatry

Introduction

Managing agitation is a challenge that many practitioners face regularly. Our evolving understanding of the etiological factors of aggressive acts has better informed our ability to intervene through pharmacologic and behavioral strategies. There have been exciting advances in the neurosciences over the past few decades, allowing for some degree of correlation between what is seen clinically and purported neuroendocrine alterations leading to aggressive behaviors. While our pharmacologic tools have not necessarily progressed at the same pace, there is greater appreciation of how particular interventions work on a neurobiological level. Newer agents have been developed to assist with treatment of agitation in emergency settings (e.g., inhaled loxapine and parenteral formulations of ketamine), expanding the arsenal of available agents when more traditional ones do not prove effective.

Methods

A review of psychiatric literature was performed, primarily through PubMed, investigating current understanding of the neurobiology of agitation/aggression, as well as the evidence-base for particular interventions.

Results

Neuroscientific underpinnings of agitation

There are well-established pathways which can lead to increased autonomic response and the potential for violence. The amygdala, a component of the limbic system, is sensitive to signs of threat and reciprocally innervates areas involved in salience-driven responses (e.g., locus coeruleus [LC], bed nucleus of the stria terminalis [BNST], anterior insula, periaqueductal grey [PAG], and hypothalamus) (1, 2). These connections function to regulate stress hormone release and enable appropriate actions. Efficient coupling of higher cortical areas (e.g., medial prefrontal cortex [mPFC], orbitofrontal cortex [OFC] and anterior cingulate cortex [ACC]) with limbic regions can aid in top-down control of responses (3). Such coupling allows for risk-reward considerations and calibration of behaviors to social

cues to be taken into account prior to engaging in action. This balance permits responses that are not excessively driven by immediate salience and affective tone. However, psychopathology and substance-induced perceptual distortions may lead to magnification of environmental stimuli significance and overestimation of threat, heightening the potential for aggression. It is in such instances that there is an excessive bottom-up activation, with insufficient control from higher cortical regions. Some psychiatric disorders are notable for hypoactivity in cortical areas, leading to a default of affectively-driven behavioral reactions, with little recourse for deploying more adaptive strategies; this occurs, for instance, in borderline and antisocial personality disorders (4, 5). Aggressive responses when faced with frustration may become something of a conditioned response, as sensitization of circuitry driving maladaptive behaviors leads to a kindling effect.

From a neurotransmitter and neuroendocrine viewpoint, overestimation of environmental threat may lead to over-activation of the hypothalamus-pituitary-adrenal (HPA) axis and to excessive release of catecholamines (e.g., norepinephrine and dopamine). Aggressive states are also marked by diminished levels of serotonin and gamma-amino-butyric acid (GABA), both of which are involved in the top-down control of limbic activation; indeed, these two neurotransmitter systems develop in tandem early in life, informing one's ability to modulate dysphoric reactions. This is a conceptually important point, as the fear activation pathway and the circuitry involved with aggressive responses show considerable overlap (6). In many instances (particularly in reactive agitation), the individual experiencing a behavioral emergency may sense the environment is unsafe and deploy strategies deemed necessary to ensure survival. This has been an essential concept of the recovery model of mental illness (7), which seeks to incorporate a holistic and developmental understanding of how a particular person is presenting in the here-and-now, with a strong emphasis on the potential effects of past traumatic events on current symptoms. This has helped guide practitioners towards a more supportive and less punitive template for providing care, as we empower patients to help regain control over their behaviors and maximize a sense of safety in the treatment environment.

When individuals are in an autonomically aroused state, the excess in norepinephrine release will bias activation in more posterior and inferior areas of the cortex. The PFC has reciprocal connections with the LC, modulating norepinephrine release (8). Optimal levels of norepinephrine are important for appropriate PFC activity, allowing for access to working memory and executive functioning. At lower levels of stress, the α_2 receptors (most abundant subtype in the PFC) are engaged preferentially (9, 10), allowing for access to higher cortical functioning, including control of limbic activity. As one's stress level rises and more norepinephrine is released, the more posterior and inferior receptors (α_1 and β) will become engaged, and an individual's ability to think and consider different behavioral options may be negatively impacted. Importantly, interventions aimed at decreasing autonomic arousal and the consequent behavioral overtones can include adrenergic drugs such as propranolol (a non-receptor-specific beta-blocker); the latter has been shown to be effective in conditions such as intermittent

explosive disorder and aggressive behaviors associated with traumatic brain injuries, with agitation disproportionate to the inciting stimulus (11, 12).

Management of agitation – pharmacological options

Published in 2012, the American Association of Emergency Psychiatry put forth evidence-based guidelines for treatment of agitation - Project BETA (Best Practices in the Evaluation and Treatment of Agitation) (13). The reader is referred to the source for protocols on pharmacological and non-pharmacological interventions.

In emergency settings, there may be limited knowledge about patients' backgrounds. For instance, there is increased ease of access to and dissemination of novel substances of abuse, many of which elude traditional drug screening (14, 15). As such, practitioners may see how patients are manifesting, yet do not have the tools at their disposal to make a more precise diagnosis. First-line treatment for unspecified agitation is benzodiazepines (13), many of which have considerable advantages in terms of route of administration and predictability of onset. (Lorazepam has the additional benefit of not undergoing stage I hepatic oxidation, making it an attractive option when liver function may be relevant but cannot be gauged.) Acting as GABA-A receptor agonists, benzodiazepines can aid with top-down cortical-limbic inhibitory input. Inhibitory coupling of areas of the PFC onto subcortical areas is facilitated by GABAergic interneurons (16), the functionality of which may be compromised in agitated states. In states of dysphoria, this circuitry may be entirely bypassed in favor of a more direct activation of the central amygdala, leading to instrumental and less flexible behavioral and affective responses. Benzodiazepines are also the treatment of choice in clinical scenarios in which there is a relative deficiency of GABAergic tone, leading to autonomic and behavioral symptoms (e.g., withdrawal from alcohol or from chronic benzodiazepine use). In cases where known GABA-A agonists (e.g., alcohol) may be leading to behavioral activation, providers should refrain from using benzodiazepines, as exposure to additional GABA-A agonism may result in further disinhibition and worsening of agitation (17). As such, the treatment of choice for agitation due to alcohol intoxication is haloperidol (13).

Acute management of aggression in the context of psychotic states focuses on attempting to decrease stimulation and providing medications which could be sedating and anxiolytic. As such, Project Beta recommends atypical antipsychotics as first-line (e.g., risperidone or olanzapine), with or without a benzodiazepine. Second-line treatment would consist of a typical agent (e.g., haloperidol) in combination with a benzodiazepine (13). The preference for atypical antipsychotics may derive from their more widespread receptor profile and less propensity for extrapyramidal symptoms (EPS). High-potency typical antipsychotics usually warrant a concurrent anticholinergic agent to prevent EPS (18). In addition to generally showing higher antagonistic affinity for histamine-1 receptors (H1) (19), resulting in sedation, atypical antipsychotics antagonize 5-HT_{2A}, decreasing glutamatergic tone and increasing release of dopamine in the nigrostriatal pathway, helping prevent EPS. These mechanisms are important and may factor into immediate

behavioral control more than the D2-blocking properties, which require longer-term use for full clinical effect. Project BETA guidelines for agitation in psychosis also apply for manic states in individuals with Bipolar I Disorder. As drugs such as lithium and antiepileptics may take weeks to achieve steady-state, more immediate behavioral control with antipsychotics may be necessary. One caveat - despite being approved by the U.S. Food and Drug Administration (FDA) for control of mania, as well as being a third-line agent for manic agitation (13), ziprasidone may lead to enhanced adrenergic output and serotonergic neurotransmission, potentially worsening symptoms (20).

A number of medical conditions can lead to delirium, oftentimes associated with agitation. Delirium is, in effect, a hyperdopaminergic and anticholinergic state. While recent evidence has questioned whether antipsychotics improve outcomes (21), typical antipsychotics are still utilized, ideally with low anticholinergic properties (e.g., haloperidol) (13). Importantly, giving anticholinergics or benzodiazepines may worsen confusion. Given the pathology-driven anticholinergic tone in the brain, EPS risk is low, even with high doses of antipsychotics.

Finally, a brief note on emerging treatments for agitation. Inhaled loxapine (a mid-potency typical antipsychotic), was FDA-approved in 2012 for agitation in schizophrenia and bipolar disorder. While effective for agitation (22), this medication requires patient cooperativeness, which is not always feasible. Ketamine, a non-competitive N-methyl-D-aspartate (NMDA) receptor antagonist, has gained considerable interest recently. Ketamine has complex and different mechanisms of action according to the dose (23). Trials assessing antisuicidal/antidepressant properties employed doses of 0.5mg/kg (24), while agitation doses (intramuscular or intravenous) range from 2-4mg/kg. Ketamine does not cause respiratory depression, making it an attractive option in acute care settings. Dissociative effects may become more pronounced as higher doses are utilized. It is an additional option for severe agitation of unclear etiology. One study showed that agitation control was not always optimal when ketamine was the first drug utilized (dosage varied from 40mg-400mg) (25); however, when used in cases refractory to benzodiazepines and/or antipsychotics, ketamine had remarkable efficacy, with no cases requiring additional drug control in the following three hours.

Conclusions

Aggression can present for manifold reasons. While interventions still lean on the evidence-base found in Project BETA, development of novel strategies has included parenteral ketamine use. In addition, non-pharmacological interventions have gained significant traction, in particular as the recovery model has been increasingly promoted to assist patients in feeling a greater sense of control and partnership in the management of their care, even when they engage in violent acts in clinical settings.

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Correspondence:

Christopher Miller

Email: chmiller@som.umaryland.edu

Impulsive-antisocial violent offenders differ from impulsive-antisocial non-offending individuals in neural connectivity during reward expectation

Paper

Robbert-Jan Verkes, Dirk Geurt, Erik Bulten & Roshan Cools (Netherlands)

Keywords: violent offenders, antisocial-impulsive personality traits, psychopathy, neuroimaging, reward expectation, neuronal connectivity

Abstract

Background

Antisocial-impulsive personality traits increase the risk of violent and aggressive behaviour. Recent studies in healthy individuals show that aberrant neural mechanisms involved in reward expectation might be critical to understanding impulsive-antisocial behaviour.

Aims

To improve our understanding of the neurobiological mechanisms underlying violent offending as part of an enduring pattern of antisocial-impulsive behaviour we tested the hypothesis of aberrant neurobiological mechanisms of reward expectation in psychiatric incarcerated male offenders.

Methods

We conducted a cross-sectional study comparing three different groups. The first group consisted of male inpatients of a high-secure forensic psychiatric hospital with a history of violent offending and meeting the criteria for psychopathy according to the Psychopathy Checklist-Revised. We focused on impulsive-antisocial traits, because these traits best predict future violence. We compared this group (n=14) to two groups of non-offending male individuals: one with high levels of impulsive-antisocial traits (n=10) and another with low levels of these traits (n=10). Functional magnetic resonance imaging (fMRI) was used to quantify neural responses during a task involving reward expectancy.

Results

First, analysis of data from all 34 participants replicated prior studies using the same task and revealed significantly greater BOLD signal in the ventral striatum during reward than no-reward cues ($xyz = [12\ 14\ -6]$, $T=3.49$, $p=0.007$). Next, we established that the reward-related BOLD signal in the ventral striatum was higher in the two groups with high impulsive/antisocial traits than in the group with low impulsive/antisocial traits (whole-brain corrected for multiple comparisons: $T=5.31$, $p=0.049$, small volume correction for ventral striatum: $T=3.30$, $p=0.011$). Next, we tested the hypothesis that the difference between the non-offending impulsive/antisocial group and psychopathic offending group did not lie in ventral striatal signaling per se, but rather in the degree to which this reward-related neural signal interacts with the prefrontal cortex. This task-dependent, functional connectivity analysis revealed a difference between the psychopathic offenders and the non-offending impulsive/antisocial group in the connectivity between the ventral striatum and dorsomedial prefrontal cortex.

Conclusions

The data suggest that not reward expectation per se, but the way in which reward expectations are communicated to frontal areas might be pivotal to understand the disposition to violent offending in impulsive/antisocial people. This suggests that violence in impulsive/antisocial individuals is accompanied by abnormal contribution of reward signalling to regions regulating the cognitive control of behaviour. These findings may be helpful to improve interventions to decrease the risk of future violent aggressive behaviour.

2 Educational Goals

To improve the understanding of the neurobiological mechanisms underlying violent behaviour in psychiatric antisocial-impulsive offenders

To better understand the role of reward expectation in violent behaviour

Correspondence

Email: robbert-jan.verkes@radboudumc.nl

Chapter 8 – Psychological approaches & interventions

The Unforeseen - proaction and reaction to inpatient violence. A grounded theory study

Paper

Snorrason Jón & Gudrun Ulfhildur Grimsdottir (Iceland)

Keywords: The unforeseen, aggression, grounded theory.

Abstract

Aim

The aim of the study was to find out what triggers inpatient aggressive behaviour and what nursing staff members do to prevent it.

Method

The study is qualitative and based on grounded theory. Interviews were undertaken with 9 nursing staff members, 3 males and 6 females, who work in psychiatric wards in Landspítali University Hospital in Reykjavik.

Results

The main concern of the participants was the unforeseen. The participants were concerned if and when patients would show aggressive behaviour and that someone would get hurt. Participants mentioned that to prevent the unforeseen personnel should be well-balanced, take the strain on the wards, learn de-escalation techniques, avert escalating behaviour, work well together and control the environment.

Conclusion

Although aggressive behaviour will never be abolished completely in psychiatric wards staff members can use different methods to minimize it.

2 Educational Goals:

The study shows that aggression and preventive measures against it in psychiatric departments are complex considerations. A high level of stress can be followed by working in a psychiatric unit, and if staff are not in good physical and psychological shape, this can trigger aggressive behavior by patients.

Correspondence

Email: jonsnorr@landspitali.is

A case study including risk management by use of Early Recognition Method (ERM) and education of staff

Paper

Magne Ultvedt, Audun Sundby, May Hege Kristoffersen & Johnny Waerp (Norway)

Keywords: Structured risk management, early warning signs, staff education, observation-plan, violence

Introduction

According to Fluttert et al., (2010), Staff working in forensic settings runs a risk of being confronted with inpatient violence. Such violence can substantially undermine staff members' feelings of safety and has a significant impact on nurses and patients. Important factors in the management and prevention of inpatient violence are assumed in the way staff and patients interact with each other, as well as the capacity of both staff and patients to recognise early signs of aggression. The early recognition method aims at improving collaboration between staff and patients to prevent aggression in forensic psychiatric care (Fluttert et al., 2008).

We will focus on violence and use of the Early Recognition Method (ERM); specifically use of observation-plan and its impact on the staff and patient in this case.

Background

A female patient in her early thirties from northern Africa had elevated risk of violence during psychotic episodes with severe incidents of violent behaviour. The patient used hair pulling, punches and kicks. Environmental management and crisis-plans were used to manage the violence. There were no apparent patterns in her behaviour. Due to this, we looked at ERM as method for management of this patient.

In this case, the patient had severe limitations impinging her ability to collaborate with and reflect on, her warning signs. Her skills in the Norwegian language was severely limited. The patient did not cooperate on an established ERM protocol. Therefore, the staff followed an ERM-observation plan with recommended interventions based on changes in her early warning signs.

Based on her earlier history and our experience with the patient we developed an ERM-observation plan with specific interventions connected to each of the warning signs.

The main paper

ERM aims at improving collaboration between staff and patients to prevent aggression in forensic psychiatric care (Fluttert et al., 2010). This method strongly focuses on early warning signs of aggression. This focus is important because patients in the first phase of psychosis may be able to recognise the onset of relapse. It is therefore helpful to train the patient to signal the need for early preventive actions.

ERM strongly focuses on early warning signs of aggression. This focus is important because patients in the first phase of psychosis may be able to recognise the onset of relapse. It is therefore helpful to train them to signal the need for preventive actions in time. When recognising early signs, patients and staff can contribute to preventing further escalation. ERM is a method of detecting and discussing these early warning signs with the patient based on an established protocol. ERM is in that way aimed at increasing self-awareness and their self-management skills to decrease the likelihood of behaving aggressively. The protocol is a description of the feelings, core beliefs and behavioural responses associated with aggressive incidents in the past. Patients must learn to be alert and aware of their reactions to specific triggers. Patients can then practice alternative responses and develop more positive skills to avert trouble. It is best to practice and reflect on early warning signs in minor stress situations.

Based on her earlier history and our experience with the patient we developed an ERM observation-plan with specific interventions connected to each of the warning signs. The staff were educated in how to observe and record the early warning signs on a daily basis and apply recommended interventions on time.

BEFORE ARRIVAL, A TEMPORARY ERM OBSERVATION PLAN WAS CARRIED OUT. THE PLAN WAS BASED ON OUR OWN EXPERIENCE FROM PREVIOUS TREATMENT AND CLINICAL SUMMERY AFTER DISCHARGE FROM SECURE UNIT.

- ERM observation-plan conducted on each shift.
- Report in the electronic journal system on every shift.
- ERM reports as part of daily report.
- Staff tracks the reports with their own observations or statements from the patient.
- The plan is dynamic and continuously evaluated.
- Opens up for the staff's own observations.
- Important to record the effect of interventions and change intervention if needed.
- Always give the patient opportunity to express herself.

- Be able to switch between weekly conversation and observation-plan, in order to see context.
- All staff receives guidance and training within ERM as method.
- ERM often the agenda at treatment meetings and other meetings.
- ERM implemented as part of the environmental management.
- Part of a criterion-triggered intervention plan.
- ERM based on early warning signs. Crisis plan based on later warning signs, when crisis occurs.

Method

Case illustration, narrative study and unstructured interviews with staff. Identification of early warning signs and evaluation of the observation-plan, conducted on regular basis. In this case, the patient did not collaborate on her warning signs. Although the staff followed an ERM observation-plan, they were educated to let the patient express herself if possible to promote user involvement.

Data collection

In this single case example, we used hand searches in journal and medical index cards, focusing on incidents of violence, damage to staff, admittance to acute psychiatric units and damaged items. We used the Staff Observation Aggression Scale – Revised (SOAS-R) to measure incidence of violent acts as well as severity of aggressive incidents (Nijman, Muris, Merckelbach, Palmstierna, Wistedt & Vos, 1999).

Results

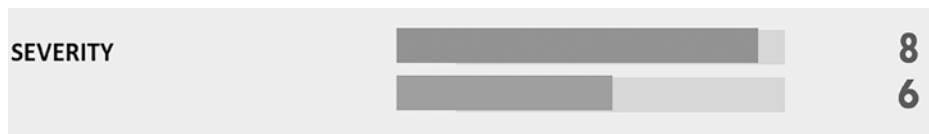
We focussed on an overview of events, personal injuries, destruction of objects and admissions before and after ERM. Staff Observation Aggression Scale – Revised (SOAS-R) was used to measure prevalence and determinants of inpatient aggression as well as severity of aggressive incidents.



The number of violent incidents decreased slightly after introducing ERM, but there is still ongoing violent incidents.



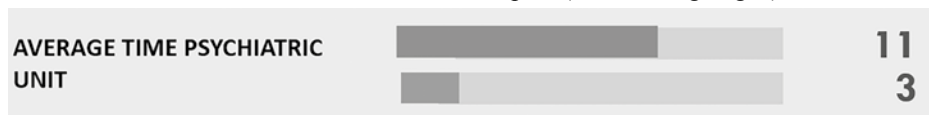
We found a significantly lower number of serious injuries on staff after ERM. The staff still reports injuries, but to a lesser extent.



Staff expressed their opinion about the severity of the incidents on a visual analogue scale (VAS) scored from 1-10. The numbers are based on the average score from SOAS-R before and after the ERM. Serious violent incidents still occur, but VAS scores were lower after the ERM. One violent event pulls the average slightly up, after the ERM program.



The number of times the patient had to be transferred to acute unit. This number also indicates the times when we had to use the crisis plan (late warnings signs) for admission.



This shows the average number of days in the acute psychiatric unit. The numbers indicate faster recovery and a shorter time after discharge from acute unit, after introduction to ERM.



The reported number of damaged items of high value, such as two TVs, two laptops, one iPad and crockery and glassware. After ERM, the staff more advised the patient more frequently on the use of electronic equipment when recognizing change in early warning signs.

The results indicate that the number of violent incidents decreased after introducing ERM. There is a lower reported number of serious injuries on staff and no reported damaged items after introducing ERM.

Impact on staff

- Easier to get to know the patient and her individual warning signs due to the observation plan.
- Earlier intervention when the staff know more about the patient's signature risk in the plan.
- The staff feel safer in interactions with the patient by avoiding escalating situations.
- The staff will explain the reason why the intervention was necessary and instruct her in the use of interventions when early warning signs occur, for more effective coping.
- An empirically based common method, independent of section or profession.
- The patient gets better treatment, is better understood and followed up more closely. The staff feels more relaxed in the environment and that affects the patient in a positive way. More satisfied personnel may lead to safer employees.

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Correspondence

Email: magne.ultvedt@sfps.no

An Integrated Intervention for Forensic Settings: Addressing the needs of a heterogeneous population

Paper

Rebecca Gillham, Claire Gatley, Grace Crawford, Gavin Evans, Virginia Kelland, Karen Orpwood, James Van-Lint, Sara Asensio & Christopher Harrop (UK)

Keywords: integrated intervention, forensic, modular group, maladaptive coping.

Introduction

Evidence for the effectiveness of psychosocial interventions in reducing risk among secure hospital populations is limited. Practitioners must base their decisions around interventions on evidence that, with some exceptions (TARRIER, et al., 2010; Evershed et al., 2003), is generated with non-forensic populations. Additionally, interventions tend to be '*disorder specific*' (theorised for a specific diagnostic category) and evidenced with homogenous research populations meeting diagnostic category for one disorder. These participants are markedly different from populations in forensic settings, who tend to have numerous difficulties and multiple diagnoses (Blackburn et al., 2003; Coid, 2003). This implies more than one therapy is needed. This leads to problems both resourcing the necessary skills mix to deliver several interventions and deciding the order of interventions. There are further challenges with diagnosis-oriented treatment, as the evidence supporting categorical models of mental illness and personality disorder is not unequivocal (Livesley, 1998; Read & Dillon, 2013). It could be argued that for evidence-based practice, it is not appropriate to base interventions on diagnosis. The psychological problems encountered in forensic settings could be better encapsulated in a model applying across diagnostic categories. This treatment frame would be concerned with causal and maintaining factors, framing diagnoses as a product of the problems rather than an explanation of them. The solution presented here was to develop an integrated intervention based on a pragmatic model of the psychopathology seen in the secure hospital context that meets the needs of most service users.

Treatment Frame

The model begins with the assumption there are genetically determined traits that are amplified or moderated in the care-giving environment through adverse childhood experiences (Linehan, 1993). These adverse experiences range from neglect, physical or sexual abuse, to invalidation, rejection of attempts to seek care, self-soothe, or experience and express emotion. These disrupt the attachment relationship,

which impacts the achievement of tasks referred to in the literature as life tasks, developmental stages or core emotional needs, for example, attachment and safety, self-regulation, emotional expression, limits and boundaries, a sense of competency, autonomy and separation, acceptance, and development of a self (Livesley, 1998; Young et al., 2003). Evidence shows maltreatment or adverse experiences are associated with vulnerability for various psychopathologies in adulthood (Varese et al., 2012). Research populations meeting diagnostic criteria for schizophrenia and some personality disorders report experiencing childhood trauma (Varese et al., 2012; Garety & Freeman, 2013; Zanarini et al., 2000; Kingdon & Turkington, 1998; Read et al., 2005). Therefore, research indicates maltreatment in childhood creates vulnerabilities to personality problems, potentially specifically to hearing voices, and impedes the achievement of life tasks, particularly the development of a stable, coherent sense of self.

One mechanism for this is through the impact of childhood adversity on the development of a range of constructs or intra-psychic structures. These are variously called cognitive-affective units, knowledge structures, representational networks, cognitive-emotional networks, mental representations, Internal Working Models, and schemas (Livesley et al., 2016). These representations of the self and other form in the care-giving environment. Research of these internal representations in clinical populations show common themes. For example, in populations with personality disorder diagnoses, others are viewed as dangerous, uncaring, and abandoning, and the self as defective and socially isolated (Barazandeh et al., 2016). People meeting diagnostic criteria for schizophrenia view themselves as defective, socially isolated, dependent, vulnerable to harm, and others as dangerous, untrustworthy and exploitative (Bortolan et al., 2013). These internal representations predict positive symptoms of psychosis, for example people who hear voices and have a negative self-view (as defective or failure), are more likely to believe the voices are omnipresent and malevolent (Thomas et al., 2015).

These internal representations are triggered by external or internal events. When triggered, the individual experiences overwhelming and intolerable emotions. One example of an internal event is a hallucination. Congruence is assumed between the hallucination and the maltreatment. For example, voice hearing might represent verbal fragments of the abuse, while visual hallucinations might represent visual fragments (Rieff et al., 2011). Derogatory, abusive or commanding voices may be memory fragments, or internalised, symbolic self-perceptions reflecting events in childhood (Rieff et al., 2011). Thus, internal events trigger mental representations of self and other. Delusional beliefs about the power, identity and meaning of the voice (Chadwick & Birchwood, 1994) reflect internal representations of the self as failure, worthless or vulnerable (Thomas et al., 2015). Responses or coping reactions are also related to these internal representations, as responses are mediated by beliefs about the voices (Chadwick & Birchwood, 1994). For example, doing what the voice

instructed, based on a belief it represented a 'god', which in turn was based on the self as powerless and defective, and others as abusive and controlling.

The assumption is that coping reactions were acquired in childhood when the maltreatment was occurring, and were effective in the short term for survival. They were reinforced by the impact on emotions, by the environment or by the care giver, and would have been effective for survival. Coping reactions in adulthood are proposed to mirror childhood strategies. Avoidance or distraction when hallucinations occur mirrors dissociation in childhood when abused; complying with a voice mirrors doing what the abuser said; fighting back or resisting the voice might reflect a child's attempts to defend themselves. The assumption is the coping reaction has been fused with the mental representation, so when an event occurs that is thematically related to the past, a variation of the same coping reaction effective in childhood also occurs. These coping reactions are the problem behaviours bringing people to services. The same process is hypothesised in personality problems. The behaviour bringing people into services is the end result of a sequence beginning with an interpersonal event, which triggers a mental representation due to a similarity to a childhood memory. The problem behaviour is the way of coping with the emotion contained in that representation. For example, a threat of rejection reminds the person of an abandonment event in childhood, to which they respond with anger and violence because that was effective for preventing abandonment in childhood. Again, the coping reaction has been fused with the mental representation.

In summary, a model of psychopathology has been presented to encapsulate the diagnoses and problems present in a secure forensic population. The model posits that problem behaviours in forensic populations are strategies to cope with internal (hallucinations, intrusive thoughts, strong emotions) and external events (interpersonal). These trigger internal about self and others, which in turn are the result of various traumatic experiences in childhood.

Intervention

The group intervention based on this frame uses a modular approach, drawing on the work of Morrison et al (2004) and Livesley, DiMaggio and Clarkin (2016). The group sequentially explores internal and external triggers, to support group members to understand their current coping, begin to problem-solve, and apply more adaptive coping. Through this process, patients are helped to identify their internal representations of self and others, and the origin of these representations. The intervention supports the acquisition of adaptive coping, and the internalisation of an individualised formulation. The group comprises of four domains of treatment, starting with those more available and responsive to change and working towards representations of the self and others (Livesley et al., 2016). So, the group focuses on symptom experiences, before exploring emotions, and then interpersonal difficulties. The modules are linked by the use of

problem chain analyses. Each begins with psychoeducation about the topic, helping members acquire a general theory about their problems. Members complete diary cards about their experiences and subsequent coping, which help them develop a specific, personal understanding of their problems and coping. Lastly, each module focuses on skill acquisition, with group members encouraged to practice skills outside of the group. A Self and Identity module is interspersed between the others, to support group members to develop increasingly in-depth formulations of their difficulties and coping.

In addition, the group attends to the factors common to effective interventions (Bateman & Kravitz, 2013; Livesley, 2008). Team supervision ensures facilitators are adhering to the model, developing therapeutic alliances within the group, and attending to the relational or generic aspects occurring between members and facilitators. Therefore, the group addresses interactions and difficulties occurring within the group, for example completing chain analyses of a member's urge to say something off-topic, or a member's anger towards a facilitator. Members are encouraged to support each other, for example helping a peer think more deeply about their formulation.

The group was piloted at a medium-secure unit in England with nine male patients with a variety of diagnoses and presenting problems (see Table 1). One was removed from the group after the first module due to non-attendance. All had a primary diagnosis of psychosis. The average age was 30 (range=22-37) and members represented a range of cultural and ethnic backgrounds. The use of violence ranged from a single significant event to a life-long pattern of serious and persistent violence. Some members had a range of other convictions. They varied in past contact mental health services. For some this was their first hospital admission, others had multiple and / or long admissions. Therefore, as expected the members represented a complex and heterogeneous group.

Table 1: Characteristics of pilot group members.

Characteristic	Frequency
Substance misuse	100% (9/9)
Personality difficulties	56% (5/9)
Childhood trauma (known)	100% (9/9)
Self-harm or suicide attempts	67% (6/9)
Cognitive difficulties	56% (5/9)
History of violence	100% (9/9)
History of sexual violence	22% (2/9)

Outcome

Outcome data will be presented including idiosyncratic measures completed by the patient and their multidisciplinary team and the Coping Styles Questionnaire (Roger, Jarvis & Najarian, 1993). Reflections on the group will also be explored, including

issues creating safety in a system experienced as controlling, problems creating and maintaining motivation over 30 weeks, and challenges maintaining a modular structure.

Conclusions

Questions about the relevance and suitability of applying standard diagnosis-specific interventions to secure forensic populations has led to the development of a transdiagnostic treatment frame and integrated intervention. The group intervention aimed to increase insight into presenting problems and coping, to support members to acquire more adaptive coping and develop a more coherent sense of self. It was hoped this group would facilitate safe and meaningful progress through services, and represent a more resource-efficient approach for practitioners. Outcome data and experiences from the pilot delivery of the group at a medium secure unit in England will be discussed.

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Correspondence

Email: Rebecca.gillham@gmmh.nhs.uk

PreARMEd: Pre-incident Anticipatory Resilience and Mindfulness Education

Workshop

Kerry McCubbin, Helen Clothier, Andrew Curran, Nadia Burman, David Britton, Steve Noone & Keith Reid (UK)

Keywords: Mindfulness, resilience, violence, aggression, staff, training

Background

This study evaluated brief mindfulness and resilience training course in a secure unit using wellbeing, patient Violence and Aggression (VA), mindfulness knowledge, teaching feedback and attempted measures of staff sickness. We saw high satisfaction, a trend towards reduced VA, against a background increase in violence.

Mindfulness aims to teach people to purposefully pay attention, in the present moment and non-judgmentally (Siegel, 2007) and requires attention to internal experiences, such as body sensations, thoughts and emotions (Groves, 2016). Those that utilise mindfulness training argue that it leads to improvements in anxiety, depression and stress (Grossman et al., 2004; Tang et al., 2007), however mindfulness has also been used in the regulation of emotions, impulsive behaviours and aggression (Chilvers et al, 2011).

Studies have demonstrated that psychiatric staff are at an increased risk of experiencing violence in the workplace, with Owen and colleagues (1998) finding 78% of aggressive acts are directed towards nursing staff. Studies investigating ward violence on staff have found psychological and emotional consequences, and an impact on physical health and perceptions of workplace safety (Kelly et al 2016). Stress and burn out within the NHS currently accounts for 30% of staff absences per year, with 38% of staff stating that they have suffered with work-related stress, an increase from 36% in 2016 (NHS Employers "*Stress and its impact*" 2019).

Research has shown that teaching mindfulness techniques to staff led to a reduction in restraint use by staff as well as challenging behaviours displayed by patients (Singh et al. 2006). Furthermore, a study conducted by Shapiro et al (1996) found that those trained in mindfulness techniques showed increased levels of empathy, with Groves (2016) suggesting that training in mindfulness may enhance the therapeutic relationship and benefit clinical outcomes.

Aims

The current pilot study aimed to evaluate the effectiveness of mindfulness and resilience training in a secure inpatient unit as part of a CPD programme using patient and staff outcomes.

Method

The participants were secure unit staff who volunteered to partake in the study. The course was developed by SN, a Senior Lecturer / Clinical Psychologist, for parents of children with learning disabilities with behaviour that challenges. We implemented a modified version of this training package to participants in this study. It was adapted by the team authorised by SN. This package was called PreARMEd: Pre-incident Anticipatory Resilience and Mindfulness Education.

The PreARMed training was planned over 3x 90 minute sessions, delivered over a 6 month period, with a combination of didactic teaching, group tasks and discussions. It was intended that staff would attend all three of the sessions.

The General Health Questionnaire GHQ was developed to screen for respondents likely to have, or be at risk of developing, psychiatric disorders (Bruin et al., 2012). A higher score on the GHQ indicates worse wellbeing.

The *Five Facet Mindfulness Questionnaire (FFMQ)* developed by Baer et al., (2006) was administered to participants in order to measure the degree to which they utilise the key underlying dimensions of mindfulness.

Anonymised self-report questionnaires were provided to staff in order to collect evaluative data on each session as well as the course as a whole. These questionnaires included four Likert scales asking staff to rate their experience of training as well as a space to record any further comments for qualitative data.

The measure of patient violence towards staff was a 2x2 pre-course vs post course analysis of independence of frequency of violence against staff who did two sessions of the course vs un-enrolled staff. The event was that a staff member or their matched control was named in any “*violence and aggression*” incident report from the clinic. This terminology is the trust term and includes verbal aggression and threats. The period under examination were taken from the three weeks prior to the commencement of the course for the attendee, in order to determine a baseline, and then from the six weeks post completion of the last session they attended. The same period was analysed for the matched control. A priori, a two tailed Fisher’s exact test was used, to avoid presuming direction of effects and to tolerate small numbers. Controls were blindly matched against attendees, for grade, age, level of security and gender, by a receptionist

who knew staff in the clinic but did not know the context of the control, other than that it was a service evaluation. Matching was facilitated but not unduly influenced by KR, who remained blind to outcome data at the time.

All staff who work directly with patients were invited to participate. The mindfulness sessions were conducted on a different floor to the wards. Each session consisted of a mindfulness exercise, a relevant technique to practice and a section for reflection. Feedback was collected after each session. Participants could only attend sessions 2 and 3 if they had attended session 1.

Results

We achieved a sample of 28 participants for session one, 10 participants for session two and 1 participant for session three (one participants scores were removed due to incomplete data). Of these participants, 8 attended both session one and two and this data was used in the analysis, one participant attended all three sessions. Participants did not show significant changes in mindfulness use of awareness nor wellbeing given the small pilot sample, using paired two samples t-tests.

Table 1 shows a non-significant effect in the hoped-for direction. Incidents were higher for the attendees of the course in the three weeks prior to the course but lower in the six weeks after the course and the control group had the opposite tendency. This Fishers exact $p = 0.464$ and so we are not presenting odds ratios.

For pilot purposes we report that post-hoc analysis revealed significance would have been reached with a larger sample size of 30 attendees given the trend. The results therefore indicate an interesting trend towards significance in an underpowered sample. Post hoc, the general clinic-wide patient violence towards staff increased, thought to be due to a service change towards more custodial patients, but not for attenders of at least one session.

Table 1. Table showing incidents of patient violence against staff pre and post mindfulness sessions.

	Violence Pre-sessions	Violence Post-sessions
Attended sessions	2	1
Control	1	4

Qualitative Feedback

Feedback from all participants was analysed and three main themes were identified. Benefit of shared experiences: *“really helpful to sit in a room with other people who are feeling the same about their jobs – the pressures and stresses. Don’t feel like it’s just you!”*

Reflection

“helped to focus on what’s important and also why I’m in the job in the first place”, “relevant and beneficial to job role, helping me to reflect and improve well-being when work life is demanding”,

Enjoyment of the course

“well presented and engaging, made me intrigued to know more”, “I have really enjoyed this training, looking forward to part 2”,

Suggestions for course improvement covered whether the course could be accessible weekly, repeated yearly, more sessions, or longer sessions.

Staff Sickness

Health and sickness records could not be obtained for analysis due to being unable to consent and match controls. This could be achieved in an RCT.

Discussion

In our very small pilot sample violence was higher in attendees in the three weeks before the course and lower in the six weeks after when compared to matched controls, with an opposite trend in non-attendees. We speculate an increase in staff observation and non-intervention may mean that as staff interventions to control aggressive behaviour decreased, the number of incidents may have also decreased. This is further supported in research conducted by Singh and colleagues (2007) who found that mindfulness training led to a shift away from trying to control and manage behaviour and towards more person-centred care.

Staff Wellbeing and Mindfulness use

Feedback on the sessions was positive, with all participants scoring the sessions as 4 or 5 on the questionnaire Likert scales with 5 being the highest possible score. Although this demonstrates the sessions were well received, scores on the GHQ and FFMQ showed no significant change following group attendance. One explanation that could explain these results was discussed by Eke and Rutkauskaitė (2018) who found participants becoming more mindful of tension in the short term.

An alternative explanation could be that the trend associated with the mindfulness training is an artefact of inherent ability. In other words, working within mental health may require a particular set of skills that enable successful practice, and be affected by selection and training, and that they were saturated.

It cannot be concluded that the reduction violence against our attendees was a result of the mindfulness sessions, however, these findings are consistent with a treatment effect albeit in an underpowered pilot.

Limitations

The sample size and dropout rate impacted upon power. However, as this study's main purpose was to be a pilot, these points can be taken as learning opportunities and corrected for the future RCT.

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Correspondence

Email: keith.reid@ntw.nhs.uk

Treatment of Aggression in People with Intellectual Disabilities in Secure Hospital: A Randomised Controlled Feasibility Study of Interpersonal Art Psychotherapy

Paper

Simon Hackett (UK)

Keywords: Aggression, Feasibility study, Art Psychotherapy, Intellectual Disability, Secure care, Forensic

Background

There are 900,000 adults with intellectual disabilities in England, and estimates suggest that only around 3,035 (0.3%) receive treatment in psychiatric hospital settings, with about half of them being in secure (forensic) hospitals. The health expenditure for this population in secure hospitals in England is estimated at over 300 million pounds sterling per annum [1].

In England in 2014, out of a population of 3,230 adults with intellectual disabilities treated in hospital 1,780 patients (55%) had one or more recorded incident of self-harm, accidents, physical assault, restraint or seclusion. Within this 55% of patients 5,460 separate types of risk were recorded for either violence, self-injury, or damage to property [2]. Patients in secure (forensic) settings are likely to be more violent than those in other types of psychiatric units [3].

There is a continuing need to develop and test evidence based treatments and technologies in secure (forensic) care to address the high rates of risk incidents and reduce rates of aggression and violence.

Art psychotherapy is currently recommended for use in a range of NHS healthcare settings in patient groups with schizophrenia and depression [4, 5]. Art psychotherapy has greater potential for use with adults with mild to moderate intellectual disabilities as it places less of a burden on verbal interaction. The interpersonal art psychotherapy treatment manual is informed by the core conflictual relationship theme approach [6, 7, 8].

Feasibility study objectives

The objectives for the feasibility study published in the protocol [9] included the assessment of recruitment and consent, procedures and materials, suitability of study information, suitability of outcome measures, and maintenance of data integrity collected from multiple sites. It was also important to accurately describe routine secure care and identify characteristics of treatment as usual across multiple sites. Treatment fidelity, identifying therapist adherence to the treatment manual, and piloting the treatment fidelity checklist procedures were completed.

Methods

Twenty participants from three medium-high secure hospitals in England were randomly assigned to one of two treatment groups - (a) fifteen 1-hour individual sessions of manualised interpersonal art psychotherapy, or (b) treatment as usual waiting-list control group. The Modified Overt Aggression Scale [10] was administered to both treatment arms. Participants in the waiting-list control group were then reallocated to interpersonal art psychotherapy after 18 weeks.

Results

The study recruited to time and target. A future full RCT of interpersonal art psychotherapy for the treatment of aggression in people with intellectual disabilities in secure care is feasible with minor adjustments to study procedures. Interpersonal art psychotherapy was shown to moderate the social determinants of aggression and aggressive behavior. The intervention also showed promising results in the reduction of patient distress in relation to psychiatric symptoms. An estimate of the sample size for a future definitive trial was completed.

Conclusion

Interpersonal art psychotherapy for the treatment of aggression in people with intellectual disabilities in secure care shows benefits to patients in reducing risk incidents and personal distress. This completed study indicates that progression towards the definitive testing of this intervention within a full RCT is feasible.

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Biography of the paper presenter(s) to be used by the chair of your session

Dr Simon Hackett is Principal Art Psychotherapist at Northumberland Tyne and Wear NHS Foundation Trust and Honorary Senior Clinical Lecturer at Newcastle University in the UK. Dr Hackett has worked for 20 years with people who have intellectual disabilities. His clinical work has been based in secure hospitals and his research sets out to develop and test arts based and creative methods that make psychotherapy accessible to people who have intellectual, interpersonal, and communication difficulties.

Correspondence

Email: simon.hackett@newcastle.ac.uk

Effectiveness of Behavior Emergency Response Team Recommended Interventions for Inpatient Assault and Physical Aggression

Paper

Della Derscheid & Judy Arnetz (USA):

Keywords: medical inpatient units, workplace violent events, inpatient aggression, inpatient violence, adult inpatient, assault, physical aggression, recommended interventions, Behavior Emergency Response Team

Abstract

Problem

Clinical violence in hospitals is common and difficult to manage. A novel approach, the Behavior Emergency Response Team (BERT), comprised of a Registered Nurse and security officer, assists bedside staff with patient de-escalation and provides intervention recommendations for continued patient behavior management.

Purpose

The purpose of this study was to evaluate the effectiveness of BERT-recommended interventions for management of assault and physical aggression by hospitalized patients.

Procedures

Assault was defined as actions (i.e., hit, kick, bite, spit) that made direct contact with a staff person. Physical aggression was defined as acts (i.e., flailing of arms/legs, throwing objects) that did not make direct contact. The study was conducted in 2017 in a large hospital in the Midwestern U.S. Violent patient BERT calls in 2014 were identified from the BERT administrative database from seven medical units with the highest and lowest rates of BERT calls.

Analysis

Chi-square was used to identify the most common BERT-recommended interventions for patient assault and physical aggression, respectively. Effectiveness of recommended interventions was determined by percentage of patients who were non-violent

immediately following the BERT call, at a 4- hour post BERT follow-up, and who did not require another BERT call throughout the hospital stay.

Results

The majority of violent patients (N= 82) were older (72 median, 18-97 range) and male (75%). They received 253 total calls, 50 related to assault and 158 due to physical aggression. The most common BERT recommended interventions for both assault and physical aggression were environment changes ($p<.0001$), and decreased stimulation ($p = .05$ for assault; $p<.0001$ for aggression). Additional recommended interventions for physical aggression were relaxation techniques ($p=0.05$), individual assignment ($p=0.03$), and '*as needed*' medication use ($p=0.03$). Recommended interventions for assault and physical aggression-related calls were effective, in most cases, immediately (87-98%) and at 4-hour follow-up (67-84%), but 40-54% of the initial calls received at least one repeat BERT call within the same admission.

Implications

Recommended interventions for assault and physical aggression generally decreased these behaviors in the immediate time frame and in the short term when BERT staff were on site. However, a 50% chance of repeat BERT calls during the same admission may reflect intervention implementation barriers such as inconsistent use, treatment plan communication differences, varying de-escalation skill levels of bedside staff, ineffectiveness of recommended interventions in the long term, or the refractory nature of violent behavior.

Conclusion

Management of patient violence requires ongoing assessment of both complex patient behavior and the patient's response to interventions throughout the hospital stay.

2 Educational Goals

Participants will describe the importance of continuous patient behavior assessment for potential intervention throughout a hospital admission.

Participants will identify two effective recommended interventions used for both patient assault and physical aggression.

Correspondence

Email: derscheid.della@mayo.edu

Measuring de-escalation by using the De-escalating Aggressive Behaviour Scale (DABS)

Workshop

Johannes Nau, Gernot Walter & Nico Oud (Germany)

Keywords: Psychological de-escalation, measurement of staff's performance

Background

Analysis of aggressive episodes has changed within the last decade with a move from a focus on patient behaviour towards an integrated model, with an added focus on staff behaviour especially their attitude and de-escalating skills.

Up to date staff training is addressing this and giving de-escalation skills a special focus. However, the quality of de-escalation performance is difficult to assess, and therefore, a viable assessment instrument is needed. The DABS was developed to fill this gap (Nau, Halfens, Needham & Dassen, 2009; Nau, Halfens, Needham & Dassen, 2010). The original research and instrument were in German. The publication in English provided a thorough translation. However, the wording in English itself was not tested in English speaking countries. In 2016 research colleagues in Canada looked into this and built additional evidence for its use in English (Mavandadi, Bieling & Madsen, 2016).

The 2018 Guideline on “*Coercion reduction and Prevention and therapy of aggressive behaviour in adults*” (S3-Leitlinie „Verhinderung von Zwang: Prävention und Therapie aggressiven Verhaltens bei Erwachsenen“) by the German Society of Psychiatry, Psychotherapy and Neurology published the Canadian item description and highlighted the 7 components and their description as a way to assess de-escalation behaviour of staff (Deutsche Gesellschaft für Psychiatrie und Psychotherapie Psychosomatik und Nervenheilkunde e. V. (DGPPN), 2018, 114).

Methods in the development of DABS and EMDABS

The original DABS was developed on the basis of a qualitative study. In this seven topics pertaining to de-escalation behaviours were identified. Consequence, the wording of items was tested. The properties of the items and the scale were investigated quantitatively. A total of 1748 performance evaluations by students in a skills laboratory were used to check distribution and to conduct a factor analysis. Likewise, 456 completed evaluations by de-escalation experts of videotaped performances at pre- and post-tests were used to investigate internal consistency, interrater reliability, test-retest reliability, effect size and factor structure.

Six years later the investigation of an English Modified De-escalating Aggressive Behaviour Scale (EMDABS) followed. For this the wording in English was based on extended evidence by using support literature. In addition, the items were clarified by descriptions of least desirable practice, acceptable practice and most desirable practice. In order to test the scale 50 staff–patient interactions in conflict situations were reviewed, summarized and cross-referenced with the literature. Three raters then used the English Modified DABS (EMDABS) to evaluate 272 simulations depicting these interactions (Mavandadi et al., 2016).

Results

a) DABS:

The 7 items were factor analysed by using forms which were used by nursing students. Through this a one-dimensional seven-item scale with good factor loadings emerged. Cronbach’s alphas of 0,87 and 0,88 indicated good internal consistency of the DABS irrespective of rater groups. A Pearson’s r of 0,80 confirmed acceptable test–retest reliability, and interrater reliability Intraclass Correlation 3 ranging from 0,77 to 0,93 also showed acceptable results. (Nau et al., 2009).

b) EMDABS:

The investigation on the EMDABS confirmed the 7 items of de-escalation. The overall internal consistency was excellent (Cronbach’s alpha = 0.901). A factor analysis confirmed that the seven items were – like the German version - best represented by a single factor. The factor-loadings pooled around similar values (Table 1).

The EMDABS also demonstrated very good interrater reliability (ICC 3.1 = 0.752) which is quite similar to the results of the German DABS (Mavandadi et al., 2016, 358).

Table 1:

Items	Factor Loadings of the German DABS (Rating forms n= 1748 used by students)	Factor Loadings of the German DABS (Rating forms n= 456 used by experts)	Factor Loadings of the English EMDABS (Rating forms n= 272 used by undergraduate psychology students)
Valuing the client	0.764	0.777	0.881
Remaining calm	0.699	0.722	0.814
Reducing fear	0.792	0.884	0.764
Working out possible agreements	0.800	0.843	0.735
Inquiring about client’s queries and anxiety	0.760	0.819	0.678
Providing guidance to the client	0.807	0.848	0.513
Risky (reversed coded)	-0.546	-0.481	-0.589

The best practice descriptions of EMDABS developed by Mavandadi et al. (2016, 360-362) consist of:

1. Valuing the client:

Genuine acknowledgement that the client's concerns are valid, important and will be addressed in a meaningful way

2. Reducing fear:

Listens actively to the client and offers genuine empathy while suggesting their situation has the potential for positive future change.

3. Inquiring about client's queries and anxiety:

Can communicate a thorough understanding of the client's concerns, and works to uncover the root of the issue.

4. Providing guidance to the client:

Suggests multiple ways to help the client with their current concerns, and recommends preventative measures.

5. Working out possible agreements:

Takes responsibility for the client's care and concludes the encounter with an agreed-upon short-term solution and a long-term action plan.

6. Remaining calm:

Maintains a calming tone of voice and steady pace regardless of the client's responses.

7. Risky (reverse scored):

Maintains a moderate distance from the client to ensure safety, but does not appear guarded or fearful.

Discussion

It is noteworthy that the one scale written in German and then transferred into English got very similar results. However, the German version got good results on interrater reliability without further explanation. Still, a short training procedure for the raters by item descriptions and explanation seem to enhance the reliability. The Canadian colleagues concluded: "*the EMDABS has potential to be the first English quantitative measure of de-escalation. The EMDABS offers seven items, with associated best practice descriptions, that may be used to inform de-escalation practice. The EMDABS can be used to evaluate training and education programmes and inform how these programmes and independent de-escalation practice may be improved.*" (Mavandadi et al., 2016, 358). But as Misitano (2017) stated utilization of the tool is difficult in real acute settings because of its isolated and chaotic nature. However, deriving from the experience in Germany one could add that the scale and its items are suitable for self-supervision or group discussion after an aggressive situation occurred in order to gather, analyse and discuss ideas for the improvement of de-escalation.

Conclusion

DABS and its English version EMDABS are useful instruments for assessing de-escalating behaviour but also useful to foster discussion and reflection on improving de-escalating behaviour. It's time to increase awareness of the scale.

Aims and content of the workshop

The workshop aims to acquaint delegates with the scale and its utilization. The interesting point for the workshop will be, what will emerge, when international research colleagues rate de-escalation behaviour having watched 4 videos.

The discussion of the scale's usefulness will be part of the workshop. In order to do this in a profound way, 4 short video-sequences will be shown (with subtitles in English). Delegates will rate staff behaviour. The results will become public to the workshop-delegates and foster discussion.

Educational goals

1. The participants will understand the applicability of the 7-item scale DABS e.g. EMDABS in principle.
2. By using the results of ratings, which will be produced during the workshop, participants will develop their own opinion concerning the transferability of the scale for their own field of practice.

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Correspondence

Email: j.nau@gmx.de

Implementation of the revised action plan to reduce forced fixation at the psychiatric center Copenhagen

Poster

Kristina Schwartz (Denmark)

Keywords: Joint revised action plan for the reduction of belt fixations at psychiatry Centre Copenhagen 2019

Abstract

Background

Psychiatric Center Copenhagen has 7 closed wards, 3 intensive care units and an emergency ward. Also, the center Copenhagen has 256 beds, 5000 admissions a year, and serves 454,000 people in Copenhagen

To work with each of the intensive care and closed wards regarding in reducing mechanical restraints, the center has set up a taskforce that works across the 4 locations with representatives from all professions, to ensure optimal cooperation between different professions and cultures.

A changed culture, with patient participation and professional staff evaluations, shall contribute to a decline in number in use of mechanical restraints.

The preparation and implementation of the action plan will give us a common basis to work in a structured and systematic way with the reduction of forced restraints in the psychiatric center Copenhagen

Process

The taskforce meets once a month, where data can be reviewed, challenges can be discussed and initiatives for further examinations can be decided.

The taskforce will look curiously and critically at the available data, and from the data produce knowledge against which to develop further, agreed actions.

The taskforce has developed an action plan

The action plan must be part of a holistic approach to good psychiatric treatment and includes:

adequate processes for reducing forced mechanical restraints to ensure good follow-up of the impact of staff efforts and provide staff with an overview of the process. An ongoing follow-up to the action plan must ensure that the plan's objectives are continuously evaluated.

Goals

Implementation of the action plan at the Centre

Implementation of an analytical guide for use with repeated mechanical restraints that must be initiated in all sections when a patient is considered to need mechanical restraints more than once

Continued reduction of mechanical restraints

Working with common tools to reduce the use of mechanical restraints in every intensive care and closed wards.

To change the culture in intensive care and closed wards, with the use of Safewards, to gain knowledge about the patient experience and staff evaluations on mechanical restraints, to prevent mechanical restraints earlier and ensure and faster action, towards adverse events.

Focus on forced admissions

Training of special trainers.

Establishment of intervention teams

Intervention teams consist of the personel that are summoned across sections by alerts when additional staff are needed. Teams consist of employees from the sections, which ahave additional training in conflict management and prevention of coercion, they will be role models for good collaboration with the patient and the staff when violent episodes may be looming.

Sensory modulation by OT

Result

Since the effort to reduce belt fixations on PCK started 2014, the number of mechanical restraints has declined from 553 episodes in 2014 to 242 in 2018, -a decrease of 311

mechanical restraints over 4 years. Numbers of administration of sedatives dropped from 1081 in 2014 to 1016 in 2018, but the number of maintenance prescriptions has risen from 172 in 2014 to 336 in 2018

2 Educational Goals

1. Focus from management on all levels to ensure dialogue on prevention
2. Ongoing data monitoring is important for detailed implementation and plan

Correspondence

Email: kristina.schwartz@regionh.dk

Chapter 9 – Service users & family perspectives

Patients experience of coercion in adult and adolescent mental health care - A new measurement scale and a model of experienced coercion

Paper

Olav Nytingnes (Norway)

Keywords: Perceived coercion, patient experience, measurement scales, severe mental disorders

Introduction

Coercion in mental health care can be divided into compulsion, informal coercion and experienced or perceived coercion. Research has repeatedly shown that compulsion is a predictor of experienced coercion, but that lots of variation remains unexplained. Importantly, a substantial number of patients in involuntary care report low experienced coercion [1].

Scales of experienced coercion are important in the study of the relationship between compulsion and experienced coercion, and a few measurement scales for experienced coercion have been utilized in research on coercion in mental health care. The Admission Experience Scale and its subscale, the MacArthur Perceived Coercion Scale (MPCS) [2] constituted a groundbreaking development in the early 1990s. The MPCS contains items of perceived autonomy, in the form “*I had more influence than anyone else on whether I came into hospital*”, with a true/false answer format [2], and is essentially an operationalization of perceived coercion as self-reported absence of autonomy. MPCS was developed for the admission process and has not been validated for other inpatient care situations. The scale has been adapted to outpatient treatment and CTO, such as in the MacArthur Modified Admission Experience Survey [3], but it is not obvious that autonomy during admission is similar or parallel to the pressure and coercion common in CTOs.

Later, the Nordic Coercion Study [4] developed the single item Coercion Ladder (CL) based on Cantril's one-item self-anchoring approach [5]. The CL is a one-item visual analogue scale that asks the patient to rate their experience of care from 1 (minimum use of coercion) to 10 (maximum use of coercion). Other single-item scales are shown to have lower reliability than multiple-item scales [6].

The MPCS and the CL have repeatedly shown bimodal distribution in patient samples. While experienced coercion may be truly bimodal, this contrasts with the observation that *"perceived coercion clearly varies from patient to patient, and philosophically this experience has many shades of grey"* [1]. If the theoretical variable *"experienced coercion"* is truly continuous, it should be possible to construct a scale that reflects this in an even or normal score distribution.

Methods and results

The Norwegian Directorate of Health funded the development of a new scale for experienced coercion. They wanted such a scale to be short and easy to use, to be able to compare experienced coercion across different care settings and care situations, or to measure experienced coercion throughout a patient's pathway of care.

First, we studied the experience of coercion through a qualitative analysis of statements from 35 persons with personal experience of being subjected to coercion in mental health care. Data was notes from 15 dialogue seminars on Coercion and Voluntariness, held in Oslo, Norway, from 2006 to 2009. The notes included strong, negative descriptions of coercion in mental health care, such as violation, humiliation and getting worse from the treatment[7]. Several descriptions were emotional, and implied that experienced coercion can be seen as the *'evaluational'* and emotional result of a process. We therefore looked at models for emotions, and used a simple three-step appraisal model that links perception and emotion [8]. For experienced coercion, a preliminary model could be: 1) A restriction of freedom is registered through the senses of a person; 2) the sensation is appraised, interpreted, or evaluated; and 3) the person experiences either little or much coercion and is able to report this. A self-report scale of experienced coercion should then avoid items regarding patient-reported use of coercion by staff (likely a cause), or acts from staff that are thought to convey procedural justice (likely a moderator), and rather look for items that cover possible feelings or sentiments that accompanies feeling or considering yourself coerced. In addition to better conceptual clarity, such items could apply across different modes and measures of coercion.

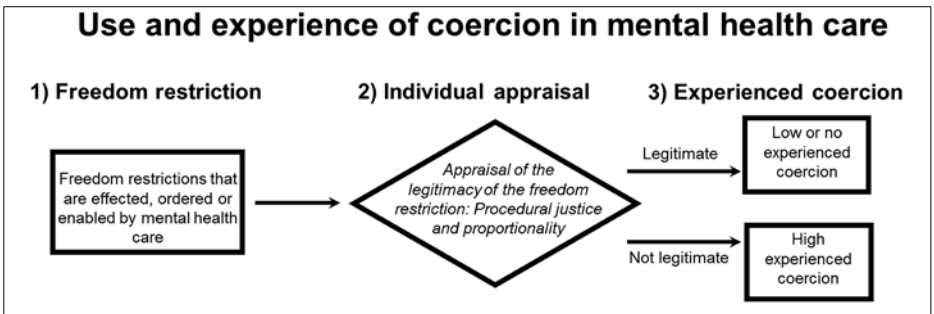
We used descriptions and categories from the dialogue seminars and the relevant literature to develop statements within several possible domains of experienced coercion.

We tested eighty-four statements in a cross-sectional study with 212 patients in five different care settings. We then selected 20 candidate items based on an evaluation of factor analysis results, number of missing answers, overlapping content, and items that discriminated between patients in typically coercive and typically voluntary care arenas. These 20 statements were then tested in 219 patients in four different care settings with additional information from staff about treatment, compulsion, and diagnosis. We used factor analysis to select 15 items in the final version of the Experienced Coercion Scale (ECS). The sum scores in the sample approached the normal distribution, and the scale showed high internal consistency ($\alpha = .948$). In a linear regression model, involuntary admission and continued involuntary antipsychotic medication significantly predicted high experienced coercion, while demographic and clinical variables did not [9].

In another study, we used the ECS in a cross-sectional study of 96 patients in 10 adolescent acute and combined acute and sub-acute wards. The patients responded to questionnaires with two scales for experienced coercion (the ECS and the Coercion Ladder), and rated the relationship with parents and staff. Staff reported information on compulsion, diagnosis, and psychosocial functioning. One third of the adolescent patients reported high experienced coercion. Patients diagnosed with eating disorder reported the highest experienced coercion, while patients diagnosed with psychosis reported the lowest. This might be explained by few adolescents with psychoses being under compulsion and treatment of eating disorders being associated with more restrictive care arrangements. A mixed effects model that included compulsion, eating disorders, relationship to parents and psychosocial functioning as predictors, showed that high levels of experienced coercion were significantly predicted by compulsion, a worse psychosocial function, and a poor relationships with parents. The overall level of experienced coercion in committed patients was strikingly similar in adolescent acute wards and adult acute wards, and for voluntary patients they were identical.

Discussion and conclusion

Using the data presented above, and existing research, that studies other factors than use of coercion that predicts experienced coercion, a model can be suggested:



Existing findings on predictors of experienced coercion can be separated in the use of coercion, variables related to individual appraisal, and demographic and clinical variables. Current research indicates that several variables are taken into account in the appraisal process, including the therapeutic relationship [10], humiliation [7, 11] and decision-makers' intent [12]. To make the model simple, I suggest grouping these variables under the sub-headings of *proportionality* and *procedural justice*, which have a parallel in the analytical separation between substantive law and procedural law [13]. If most of the different aspects involved in the appraisal process can be subsumed under proportionality and procedural justice, then a possible common denominator for these two headlines is the *experienced legitimacy* of the freedom restrictions. Patient-evaluated legitimacy can serve as a common denominator of several of the findings of the relationship between freedom restrictions and experienced coercion.

The model may shed light on the weak and ambiguous findings of whether the patient's demographic and clinical variables predict experienced coercion. Current legal standards imply that compulsion should only be used when necessary, and in the least restrictive way [14]. This is also mirrored by acceptance of containment measures, but only to contain dangerous or severely disruptive behavior [15]. Some patient variables can contribute to such behaviour, and thus to compulsion, which in turn predicts elevated experienced coercion. If we had not measured and controlled for compulsion in the adolescents, we could have ignored compulsion as a mediating variable, and wrongly concluded that eating disorders predicted experienced coercion. When a patient is under mental health care, the totality of informal pressure and different forms of compulsion will be influenced by patient characteristics. While it is feasible to measure and control for compulsion, it seems difficult to control for all restrictive aspects of the care situation, especially less noticeable events that may accumulate over time or influence the self-image, such as the minor coercive incidents described by Nytingnes et al [7]. The influence of patient variables on the milder forms of treatment pressures is illustrated by the finding that lower psychosocial functioning was associated with more use of all kinds of leverage and coercion studied, such as economical, housing, reduced penalties, or treatment orders [16]. In another study, patients with lower psychosocial functioning, addiction problems, or longer outpatient treatment orders reported higher experienced coercion than other patients. However, after a stepwise variable exclusion process using logistic regression, where the final step was added the number of warnings and reminders from case managers, these patient variables lost significance [3].

The model can also suggest reasons why humiliation seems closely connected to experienced coercion [7, 11, 17]. There are lots of freedom restrictions with an underlying coercive threat such as fines or prison, that are accepted, and where people seldom think of coercion when they obey, such as driving regulations, paying the metro ticket, or filing tax reports. These are accepted for similar reasons that make a sizeable proportion of mental health care patients accept involuntary care

and report low experienced coercion: Procedural justice and proportionality. If I was forced or threatened to submit under freedom restrictions that did not pass my deep-felt standards of procedural justice and proportionality, I think I would feel “*unjustly degraded ... or put down*”. If I was ascribed a stigmatized status during the process, I might easily feel ridiculed, and that my “*identity had been demeaned or devalued*” – essentially feeling humiliated as defined by Hartling & Luchetta [18]. This can be understood in the light of Honneth’s [19] view of moral injury, arising from an unpredicted lack of affirmation from others. This will be a frequent experience during involuntary admission, which may constitute apparent lack of procedural justice, and therefore experienced coercion, while simultaneously foster a feeling of humiliation.

This explanation may also suggest an explanation of why scores on the Coercion Ladder and the MPCS are often bimodally distributed – with most persons scoring very low or very high experienced coercion, and fewer in the middle values [2, 4]. Høyer et al. (2002) suggested that experienced coercion resembles violations of integrity – which are usually absent or present. Violation of integrity is closely connected to humiliation. The feeling of humiliation is also a strong motivating force, and influences the self-image and the whole person [18]. Therefore, the presence or absence of humiliating aspects in a coercive episode may direct the evaluation strongly towards the upper or lower part of the scale. Fortunately, these results from existing research could be taken into account when we developed the ECS. We therefore deliberately used items of humiliation, and the strong patient descriptions from Paper 1 and studies with similar results to coin items that we thought could have the potential to distinguish between different degrees of experienced coercion. The resulting scale, available at <https://www.tvangsforskning.no/forskning/forskningsverktøey/> therefore contains strong and negative items, which are able to discriminate between the most intense negative experience of coercion and the less intense ones, which apparently is difficult with MPCS and Coercion Ladder.

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Correspondence

Email: olav.nyttingnes@ahus.no

A narrative study: the experiences of mental health service users

Poster

Pauline Cusack (UK)

Keywords: narratives, service user experiences, physical restraint, mental health

Abstract

Internationally, policy and legislation exists around the management of restrictive interventions, including physical restraint. From a European perspective, the Convention on Human Rights (2003) addresses such issues, with physical restraint being implicitly addressed via several of the articles within this convention. For example, Article 3 prohibits inhumane and degrading treatment, Article 8, is concerned with respect for private life, whilst Article 5, sets out the conditions which challenges a deprivation of liberty/unlawful detention. There are international differences around the management of violent behaviour and any subsequent restraint. However, in England and Wales a code of practice under the Mental Health Act 1983, exists for staff in managing such incidences (Department of Health, 2015). Additionally, best practice guidance is available for both health and social care staff for the management of violence and restrictive interventions (Department of Health, 2014; NICE, 2015). However, research suggests physical restraint use continues to raise concerns for service users and professionals alike, with uncertainties surrounding the potential for restraint to be used inappropriately at times. Additionally, the potential for psychological and physical harm because of physical restraint has caused unease. This presentation reports findings from a narrative study exploring the experiences of mental health service users, in England. In addition, findings from an Integrative review exploring the physical and psychological impact of physical restraint for mental health in-patients, will also be included.

2 Educational Goals

1. An appreciation of service user perspectives resulting from physical restraint
2. An understanding of the physical and psychological harm resulting from physical restraint

Correspondence

Mrs. Pauline Cusack
Email: pcusack@uclan.ac.uk

Chapter 10 – Race, gender, cross-cultural & ethnicity perspectives

Predicting recidivism and death in female forensic psychiatric patients. A multicentre follow-up study

Paper

Vivienne de Vogel (Netherlands)

Keywords: gender, females, risk assessment, psychopathy, mortality, recidivism

Abstract

Most violence risk assessment tools have been validated predominantly in males. In order to improve current risk assessment and management practices in forensic psychiatry, our knowledge and understanding of female patients and their risk of relapse needs to be enhanced.

The current study aims to evaluate the predictive accuracy of multiple tools for recidivism in a female forensic population. Five risk assessment instruments – the Female Additional Manual (FAM), HCR-20 Version 2, HCR-20V3, SAPROF, START - as well as the Psychopathy Checklist-Revised were coded based on file information for 78 women who had been discharged between 1993 and 2012 from one of four forensic psychiatric hospitals in the Netherlands. The ratings on the different tools were related to official re-conviction data. The mean follow-up period was 11.8 years.

Notable was the high rate of mortality (17.9%) and readmission to psychiatric settings (11.5%) after discharge. Official re-conviction data was retrieved from the Ministry of Justice and Security for 71 women. Twenty-four women (33.8%) were re-convicted after discharge, including 13 for violent offenses (18.3%). Overall, predictive validity was moderate for all types of recidivism, but low for violence. The START Vulnerability scores, HCR-20V3, and FAM showed the highest predictive accuracy for all recidivism. With respect to violent recidivism, only the START Vulnerability scores and the Clinical scale of the HCR-20V3 demonstrated significant predictive accuracy.

Considering the high mortality rate, we also examined predictive validity of the tools for death. Interestingly, in these pos-hoc analyses, we found that PCL-R Facet 1

Interpersonal was a significant protective factor for mortality. An explanation could be that interpersonal psychopathic features like conning and manipulative behaviour, glibness and grandiose sense of self-worth make these women less vulnerable for early death by severe self-destructive behaviour including suicide.

We strongly recommend more research, but based on the results of the present study, we cautiously recommend the use of the HCR-20V3 for violence risk assessment in forensic mental health care and the START for more general risk assessment, especially when short to medium term assessments are needed or when only recent information to code dynamic risk factors is available. The FAM may be a useful addition to the HCR-20V3 for more gender-sensitive risk assessment and management, mainly for clinical purposes, but not for improving predictive power.

2 Educational Goals

1. To learn more about rates of recidivism and mortality in female forensic psychiatric patients.
2. To learn more about the predictive accuracy of (violence) risk assessment tools in female forensic psychiatric patients.

Correspondence

Ms. Vivienne de Vogel
Email: vdevogel@dfzs.nl

Nursing staff talk about violence - a matter of care and equality in forensic psychiatric care

Paper

Esa Kumpula (Sweden)

Keywords: Forensic psychiatric care, equality, gender, violence nursing staff

Abstract

There is a need for more knowledge about how violence in Forensic psychiatric care (FPC) affects relationships within the group of nursing staff and the care given to patients. The aim of this study was to deepen the understanding of nursing staff talking about violence and the impact for equality between women and men with consequences for the care given to patients. Violence occurs in FPC and is well documented. Yet there is a need for further studies that explore how gender is integrated in nursing staff's talk about violence and the consequences for shaping their relations with the patients.

An ethnographic approach was used to collect data. This study was conducted at two different maximum-security forensic psychiatric clinics in southern Sweden. These clinics were organised to care for demanding patients with enhanced security to meet the demands of protecting society. The method provided opportunities to gain rich and various data such as participant observation, field notes and individual interviews. Different types of data sets reveal various parts of nursing staff practise and contributes to a comprehensive understanding of how nursing staff talk about violence. We analysed data using thematic analysis.

The tentative results show a mutual interaction between the FPC goal of protecting society and the construction of gender. When male nursing staff consider the body as important to preventing violence, their talk corresponded with dichotomies of beliefs about men and women. As a result, this gave men a privileged position over women. If the overarching goal of FPC is to protect society, it should be considered how it produces differences between genders among nursing staff with consequences for the care given to patients.

Further, when gender is ignored it could be consider how nursing staff conceptualize FPC as equal rather than reflect on how their talk about violence generates unequal conditions for womens and men's tasks.

A tentative conclusion from the study is that how nursing staff talk about violence may cause problems for the care given to patients. While men focus on safety issues

women tend to give priority to relations with patients, the relationship was mostly framed as female nursing staffs' responsibility. If gender is overlooked in FPC it might lead to unequal care for patients leading to ineffective prevention and management of violence in FPC.

2 Educational Goals:

To better understand:

1. How to integrate gender into the curriculum for nursing studies/practise in psychiatric care
2. How to visualize FPC as an institution, create different prerequisites for patient care, depending on nursing staffs' gender.

Correspondence

Email: esa.kumpula@mdh.se

Acute mental health readmissions in a rural multicultural community with violence exposed refugees and migrants

Poster

Subhash Das, Vivek Phutane, Saji Joseph, Raju Lakshmana & Rafiqul Islam (Australia)

Keywords: Hospital readmission, acute mental health, multicultural, rural community, Australia

Abstract

Background

Hospital readmission for any reason including mental health conditions can increase years of lost life and may compromise quality of life. We have yet to understand whether readmission can be an indicator for evaluating the quality of inpatient care and to determine factors related to mental health readmissions in a multi-cultural rural Australian community where a higher proportion of people from refugee and trauma or violence exposed backgrounds are residing.

Methods

A retrospective review of medical records was conducted for patients readmitted between November 2017 and November 2018 in the acute mental health inpatient unit of Goulburn Valley Health, Shepparton and Victoria. Readmission was considered if the patient was admitted again to the acute inpatient unit as an unplanned admission within 28 days of discharge. All adult psychiatric patients re-admitted any reason during the above mentioned period were included. All required clinical data were coded and entered in Ms. Excel and analysed using STATA 11.0.

Results

During the data reviewing period, a total of twenty-nine patients were re-admitted within 28 days of discharge. Their median age was 42 and the mean was 43 (± 14.1) years. Among the patients, 55.2% (16) were male and 86.2 % (25) identified as non-indigenous, while 3.4% (1) were indigenous. Severe Mental Illnesses (SMI) such as schizophrenia and related psychotic disorders (51.6%) and affective disorders (27.6%) were the commonest diagnoses. The vast majority (90%) of the patients were unemployed, while 7% were employed. Average re-admissions/patient/year was 3.3

(± 2.0) with the median re-admission/patient/year was 2 (min 2, max 9). Among patients, around 59% (17) were unmarried, 13.8% (4) were married and the remaining had other types of relationships. All the re-admitted patients received community follow-up within seven days of discharge with a discharge plan. About two-thirds (62%) of these patients received non-clinical support such as Peer Support, Drug & Alcohol Services, Well Ways, Work Agency, Aboriginal Liaison Worker, etc. Substance abuse accounted for 48.3% (14) of patient diagnoses.

Conclusion

Unemployed and unmarried people aged 40 or over from non-indigenous backgrounds are more likely to be re-admitted. Although all the re-admitted patients received a discharge plan and non-clinical support, it is important to look at whether the patients received this support at their initial discharge. Further studies with all admissions and re-admissions would be valuable for identifying associated factors for re-admission, and their improvement.

2 Educational Goals

1. To understand that the reasons for acute mental health inpatient re-admissions are multi-factorial
2. The effect of a comprehensive discharge plan, non-clinical support involving family and carers at the initial admission and their discharge may reduce the number of readmissions

Correspondence

Email: Subhash.Das@gvhealth.org.au

Chapter 11 – Ethical, human rights and legal perspectives

Forensic detention and the principle of proportionality – clinical impacts of legal change in Germany

Paper

Herbert Steinboeck (Germany)

Keywords: forensic psychiatry, normativity, principle of proportionality

Abstract

Background

As a consequence of a high court jurisdiction, in particular regarding with questions of proportionality on the duration of detainment, the German Federal Parliament passed a legal reform of forensic psychiatric commitment (section 63 of German Penal Code) in 2016. One year ago, the laws of Germany prescribing the details of forensic psychiatric care were reformulated.

Aims

The talk aims to clarify what does the principle of proportionality mean theoretically, and what is the practical impact of focussing on this principle in forensic psychiatry.

Method

In order to answer both questions, we first reconstruct the legal term of proportionality by its roots in the philosophy of law. As a second step, relating to the principle of proportionality, we consider three fields of practice in forensic psychiatry: risk assessment, decision-making in relaxation of confinement, and pretrial detention.

Results

The term “*proportionality*” proves to be a normative one, nevertheless often used in the way we use empirical terms. Because of this, we find confounding legal and clinical competencies:

1. In risk assessment, in order to estimate proportionality of detainment, legal systems claim to very concrete empirical prognosis not realistically achievable;
2. responsibility to relax laws is clinicians although responsibility is a normative term.
3. And although the decision whether pre-trial detention will end in release or in unlimited forensic confinement is a juridical one, the juridical decision making depends considerably on clinical decisions concerning the principle of proportionality like the decision to aim at discharge by several psychiatric measures (e. g. effective and compliant medication, preparation of an adequate cared flat and outpatient treatment etc).

Conclusion

The three fields of practice mentioned above reflect the competitive role of normative and empirical aspects, illustrating the need of active communication between the representatives of legal and clinical systems. This is a sound reason for the importance of risk communication as the only means of drawing transparency for all involved parties, the professionals as well as the patient.

2 Educational Goals

1. Recognize the principle of proportionality as a theoretical as well as a clinical challenge to current forensic psychiatry;
2. Critically reflect on the prejudice of a dichotomy of empirical psychiatry on the one hand, and normative justice system on the other.

Correspondence

Email: herbert.steinboeck@kbo.de

Social inclusion and prevention of violence. Patients', staff members' and ward managers' descriptions of meetings in psychiatric inpatient care in Sweden

Paper

Veikko Peltto-Piri & Lars Kjellin (Sweden)

Keywords: Social inclusion, values, psychiatry, inpatient care, violence prevention.

Abstract

The professionals' beliefs about the meeting with the patient have a crucial impact on the framing of the situation and thereby on patient's possibilities to participate in the process. It is possible to identify three ethical perspectives through history in the normative medical and psychiatric ethics literature: paternalism, autonomy and social inclusion, which reflect a historical development of complementary values in psychiatry. The latest of these perspectives, social inclusion can be defined as a process to improve the terms of participation in society; to enhance the opportunities for people who are disadvantaged to get access to resources, get their voice heard and rights respected. The meetings with caregivers should be characterized by participation of the patient. Research into prevention of violence have been quite instrumental, it has focused on "what works". Interestingly, this empirical perspective has essentially given recommendations that have been in line with the values in social inclusion and the recovery approach.

The aim of this presentation is to investigate the possibilities and obstacles for patients to be socially included in his/her own care in the psychiatric inpatient environment.

The empirical material comes from the project "*Prevention of violence in psychiatric inpatient care, aspects of ethics and safety in encounters with patients*". Included participants in this study is 13 patients, 17 staff members in three focus groups, and six ward managers on three clinics, a general psychiatric, a psychiatric addiction and a forensic psychiatric clinic. We will analyse all interviews with stakeholders with the framework method in order to describe inclusion and exclusion processes in psychiatric inpatient care.

Through a literature review and pre-study of the material four main areas were identified:

- Interpersonal meetings: to have respectful meetings and "see the patient" was important according to all stakeholders.

- Patient involvement in care: Staff stress the importance of patient involvement and being honest to the patient, they seem to describe a more inclusive care than patients.
- Organizational conditions for care: Delayed care, the competence of the present staff and other organizational issues could affect the relation between patients and staff.
- Coercive measures. All stakeholders tried to minimize these in various ways, even though there were suspicions that some staff members wanted to provoke patients into conflicts.

At the conference we will present the results from the analysis and discuss how stakeholders look at the possibility of social inclusion in the limited environment of a psychiatric ward.

2 Educational Goals

1. Learn about the possibilities of social inclusion of patients in the limited environment of a psychiatric ward.
2. To gain understanding of the role of social inclusion in primary prevention of violence.
3. To get some ideas and facts to the discussion on values in primary prevention of violence.

Correspondence

Email: veikko.pelto-piri@regionorebrolan.se

Needs and dilemmas of caretakers who have been victimized by violence in psychiatry

Paper

Joke Harte, Ingrid van Houwelingen & Mirjam van Leeuwen (Netherlands)

Keywords: Victims' needs and dilemmas, reporting to the police, legal reaction

Introduction

Caretakers in psychiatry encounter a lot of aggression that can have severe mental as well as physical consequences (Arnetz & Arnetz, 2001; Abderhalden et al., 2004; Nijman, Bowers, Oud & Jansen, 2005; Needham, 2006; Foster, Bowers & Nijman, 2007). Some groups of professionals appear to have an increased risk of being victimized (Van Leeuwen & Harte, 2015). Nurses and socio-therapists working on a closed psychiatric ward have a relatively high risk to become the victim of a severe violent incident.

In society, violence against public workers is a subject of great concern. In the Netherlands, for example, the Public Prosecutor can file triple penalties for assailants of public officers. However, regardless of the high numbers of severe violent incidences that take place in mental health care facilities, a violent psychiatric patient is seldom prosecuted (Van Leeuwen & Harte, 2011). A criminal procedure starts with reporting the violent act to the police. Victims in psychiatry, who consider reporting an incident, face several obstacles. For example, they might fear breaking professional secrecy, to disrupt the therapeutic relationship with the patient, or retaliation by the patient or the patient's network (Harte, Van Houwelingen & Van Leeuwen, 2017).

In the Netherlands, several policies and covenants have been drawn up in order to support the victimized mental health care workers. In this presentation we focus on the nurses' and socio-therapists' perspectives on violence that takes place in psychiatric wards. We summarize the results from our empirical research on the attitude of care workers towards the violence that they encounter and their opinion on the desirability of a judicial reaction. Subsequently, we describe the needs and dilemmas of the victims. Practical recommendations to support caretakers in psychiatry who have been victimized by a violent patient are presented.

Method

For this research, empirical studies were gathered that provide information on the prevalence of violent incidents that take place in psychiatric facilities in The Netherlands. Subsequently, in-depth interviews were conducted with 17 mental health care workers

who had been victimized by violence caused by a patient. We also interviewed other stakeholders: 10 persons with a management function in a mental health care institute, 6 police officers, 3 public prosecutors, 1 lawyer and 1 judge.

Results

In The Netherlands three studies have been published that provide information on the prevalence and nature of violent incidents care workers in psychiatry encounter: Van Zwieten e.a. (2015), Evers, Jettinghoff & Van Essen (2015), and Harte, Van Leeuwen & Theuws (2013). Regardless of the fact that these three studies used different research designs and sampling methods, they do provide similar results. Each year, about 30 to 40 percent of the care workers in psychiatry are victimized by physical violence or a serious threat of physical violence (see Harte, Van Houwelingen & Van Leeuwen, 2017).

With regard to the advisability of prosecuting psychiatric patients for violent acts against staff, there seems to be different points of view. From one perspective, a judicial reaction does not make sense as the patient cannot be held responsible for their behavior. Psychiatric patients are regarded as fully irresponsible. It is also argued that a psychiatric patient belongs in a psychiatric hospital, and not in jail. Another argument not to prosecute is that aggressive psychiatric patients are already incarcerated and do not pose a danger to society. From another perspective, excluding psychiatric patients from prosecution and from punishment may promote stigmatization of psychiatric patients as irresponsible and unpredictable persons. Another argument against not prosecuting is that this might give offenders the idea that they can get away with the violence. Moreover, care workers in psychiatry have the right to protection and a safe workplace.

Nurses and socio-therapists who had been victimized by severe violence on the psychiatric ward and who were interviewed, all stated that, to a certain extent, violence is part of their job. Immediately after an incident, they prefer to be supported by their own colleagues and managers. Their perspective on the violent act strongly 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 their behavior. A decision to report a violent act to the police is mostly driven by rational arguments. Victims want to protect themselves, as well as their colleagues and the other patients. They want to build a file against the patient; this information might enable the judge to transfer the patient to a high security hospital. In the psychiatric setting the victim is often confronted with the perpetrator. The victims would like to see the employer to take measures in order to prevent such a confrontation.

When victims do decide to report an incident to the police, they face a number of obstacles and dilemmas. As the regulations on professional secrecy are complicated, it is unclear which information can or cannot be communicated with the police and the public prosecutor. If legal steps are taken, victims are in need of information and legal support. Other victims fear retaliation by the patient or the patient's network. The available covenants and protocols provide insufficient guidance. Those who do report a violent act to the police seldom receive any information on their case.

Conclusion

To a certain extent caretakers who have been victimized by aggression on the psychiatric ward consider violence as an occupational hazard. It is, however, unclear in which situations certain types of violent behavior can be tolerated. After an incident victims are mainly in need of support and recognition from their colleagues and manager. Reporting the incident to the police is considered if the victim believes that the violence was intentional and he or she hopes that reporting might help to stop the patient from being violent again. Victims do not seem to strive for retribution or revenge; they contact the police in order to protect themselves, colleagues and other patients against the perpetrator.

Prosecution should not be seen as the solution for violence that takes place in psychiatric settings. In order to reduce these acts it is crucial to have experienced staff and to invest in their de-escalation skills as well as in control and restraint techniques. In certain cases criminal prosecution might be desirable. In psychiatry there seems to be a lack of consensus on which cases a judicial reaction is an appropriate response to inpatient violence.

Protocols and covenants insufficiently address the problems care workers who have been victimized by a patient face. Their needs and dilemmas need to be heard, taken into consideration and incorporated in policies. This will contribute to an efficient and consequent reaction to violence that, if implemented in a consequent way, supports the victims and perhaps prevent future violence.

Acknowledgements

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Correspondence

Email: j.harte@vu.nl

A conceptual framework for evaluating informal coercion and the use of treatment pressures in psychiatry

Paper

Matthé Scholten, Jakov Gather & Jochen Vollmann (Germany)

Keywords: informal coercion; treatment pressures; ethical analysis

Abstract

Background

Though there is few scientific data available on the use of informal coercion and treatment pressures, the data that is available suggests that their use is widespread; that professionals (unwittingly) use these measures in practice while disavowing them in theory; and that the stronger the type of treatment pressure, the more professionals tend to underestimate its level of coercion. At the same time, guidelines on the use of treatment pressures are largely, if not completely, lacking.

Aims

The aim of the study is to develop a conceptual framework for the evaluation of informal coercion and treatment pressures in psychiatric practice and to operationalize it for clinical and research purposes.

Methods

Conceptual analysis. The proposed conceptual framework is based on the so-called baseline approach to coercion developed in philosophy. This approach is amended to accommodate psychiatry-specific demands, such as the fact that treatment pressures are often used in relation to persons with impaired decision-making capacity. Furthermore, a first attempt is made to operationalize the conceptual framework to facilitate further empirical research.

Results

The study draws conceptual distinctions between threats and offers, between threats and unwelcome predictions, and between objective and subjective treatment pressures,

showing why these distinctions are ethically and clinically relevant. It also highlights the importance of transparent communication in psychiatry.

Conclusions

More research on informal coercion in inpatient settings is needed, and guidelines for the use of treatment pressures must be developed. Conceptual clarity regarding these issues can improve clinical practice from an ethical perspective and is likely to yield better treatment outcomes.

2 Educational Goals

After attending this talk, participants are able to

1. understand why critical reflection on the use of informal coercion and treatment pressures in psychiatric care is important both from an ethical and a clinical perspective
2. distinguish between threats and offers, threats and unwelcome predictions, and objective and subjective treatment pressures, and enhance their clinical communication skills based on these insights

Correspondence

Email: matthe.scholten@rub.de

Just Culture in mental health care: creating a learning environment after severe incidents

Paper

Sven Rooijackers, Laura Hartman, Iris Wallenburg, Eva van Baarle, Yolande Voskes, Roland Bal & Guy Widdershoven (Netherlands)

Keywords: Just Culture, Learning environment, Open Dialogue, External Control

Abstract

Background

Dealing with incidents and fostering quality of care is not only and not primarily a matter of external control (e.g. the Dutch Health care Inspectorate), but requires ethical reflection, internal motivation and a willingness to learn. A concept that provides a framework for a learning environment is '*Just Culture*', referring to a culture of trust in which professionals feel free to be open about insecurity and fallibility.

Aims

Our research project aims to investigate how mental health care organizations can foster a just culture.

Methods

Three Dutch mental health care organizations have set up experiments trying to foster a just culture in their organizations. These experiments were studied through observations, interviews and focus groups.

Results

Fostering a Just Culture is difficult for health care organizations because of power dynamics within and outside the organization. For instance, health care executives showing vulnerability is essential and they should take a leading role in facilitating a culture of open dialogue in the institution. However, open dialogue conflicts with external control since full disclosure affects privacy and may, in essence, lead to sanctions by the inspectorate. Potential prosecution disrupts a learning environment and the documentation of sensitive information may restrain health care employees from being open. Fostering a Just Culture implies a focus on the context of healthcare whilst the current legal process is mainly focused on the individual. We also found

that mental health care organizations are more inclined to be accountable to external control rather than to learn of occurred incidents. In terms of a Just Culture, reports for improvement should focus on the people and the organization involved instead of the external context. Hence, more flexibility in report formats and timelines provided by the Health Care Inspectorate are needed.

Conclusions

We suggest that a Just Culture provides a promising framework to stimulate learning after severe incidents. This asks for a new, comprehensive approach on how mental health care organizations respond to severe incidents, also in interaction with the Health care Inspectorate.

2 Educational Goals

1. Participants gain knowledge and understanding of the Just Culture concept
2. Participants understand how a learning environment can be fostered in mental health care organizations in the Netherlands

Correspondence

Email: s.rooijackers@vumc.nl

Exploring the Case for Truth and Reconciliation in Psychiatry

Poster

Mick McKeown, Helen Spandler (UK)

Keywords: Mental health services, Epistemic injustice, Psychiatric harm, Psychiatric survivor movement, Transitional justice, Truth and reconciliation

Abstract

The aim of this poster is to present and explore the case for a truth and reconciliation (T&R) process in the context of mental health services. The impact of coercive and restrictive practices are central to the impetus for considering the appropriateness of a T & R process. The approach is a conceptual review of T&R approaches; a consideration of why they are important; and how they might be applied in the context of mental health services and psychiatry.

There are some notable recent examples of how this might work in practice. Our case takes account of potential objections which complicate any simplistic adoption of T&R in this context. T&R would involve bringing together service users, survivors and refusers of services, with the staff who work/ed in them, to begin the work of healing the hurtful effects of experiences in the system. We see this as part of a wider project concerned with challenging, reforming and transforming mental healthcare. In the absence of an officially sanctioned T&R process a grassroots reparative initiative in mental health services may be an innovative bottom-up approach to transitional justice.

We have been involved in various mental health movements, predominantly as allies of psychiatric survivors/service users, and have reflected upon the value of such conjoint activism. However, we have been frustrated with tendencies for polarisation and splitting which can derail progress by oversimplifying complexity, stifling debate, and preventing further exploration and mutual understanding of different perspectives. For alliances to embody genuine solidarity, rather than temporary instrumentality (for example defending services, which may be inadequate, or even harmful), we need a way to heal prior damage and provide restitution.

A companion paper was the first in a peer-reviewed journal to explore the case for T&R in mental health services. We describe an innovative T&R process as an important transitional step towards accomplishing reparation and justice by acknowledging the breadth and depth of service user and survivor grievances. This may be a precondition for effective alliances between workers and service users/survivors. As a result, new

forms of dialogic communication and horizontal democracy might emerge that could sustain future alliances and prefigure the social relations necessary for more humane mental health services.

2 Educational Goals

1. Deepen appreciation of the potential harms attendant upon experiencing coercive psychiatry and associated restrictive practices.
2. Develop a critical understanding of the potential benefits of a truth and reconciliation process for psychiatry.

Correspondence

Email: mmckeown@uclan.ac.uk

Chapter 12 – Sexual offending violence

Addressing Patient-to-Nurse Sexual Harassment in Nursing: Educational Training

Paper

Erin Micale (USA)

Keywords: Patient-to-Nurse, Sexual Harassment, Nursing, Sexual Harassment Training, Sexual Harassment Prevention, Workplace Violence

Introduction

Workplace violence is a growing concern in the healthcare field, with healthcare staff facing threats from patients, visitors, and even co-workers (Draucker, 2019). It is often categorized as physical or non-physical and includes actions such as: hitting, biting, verbal threats, gender or racial discrimination, inappropriate sexual comments and behaviors, and degrading or manipulative comments (Bronner, Peretz, & Ehrenfeld, 2002; Hibino, Ogino, & Ingaki, 2006; Phillips, 2006). This paper will focus on sexual harassment, a form of non-physical violence, and how to best equip nurses to prevent and cope with such occurrences.

Background

Sexual harassment in nursing is a documented concern dating back to the times of Florence Nightingale, who implemented strict rules to prevent her nurses from being sexually harassed (Strauss, 2019). In the late 1980's to early 1990's this issue gained momentum as policies and laws were enacted to protect women in the workplace. During this time, literature also called for sexual harassment trainings to be implemented in the health care setting (Dan, Pinsof & Riggs, 1995; Finnis, Robbins, & Bender, 1992).

Since then, the effects of sexual harassment in the workplace has been well documented. Most research supports that unaddressed sexual harassment can lead to both physical and emotional consequences for the nurse, impaired patient care and satisfaction, and significant financial and cultural consequences for the hospital (Jacobowitz, 2014; Rodwell, 2014; Strauss, 2019; Wei, Chiou, Chien, & Huang, 2015; Yang, Stone, Petrini,

& Morris, 2018). Nurses that have been exposed to sexual harassment often develop anxiety, depression, fatigue, burnout, decreased self-esteem, and increased chance of calling in sick or quitting their jobs (Azar, Badar, Samaha, & Dee, 2015; Ebrahimi, Hassankhani, Negarandeh, Jeffrey, & Azizi, 2017; Smith, 2018). In addition, a study by McNamara (2012) found that 67% of medical errors and compromised patient safety, 58% of impaired quality of care, and 28% of patient mortality was connected to the effects of disruptive behavior and workplace violence in the healthcare setting. Lastly, the effects of sexual harassment in the workplace can lead to avoidance of individuals, impaired communication and teamwork, poor motivation and work performance, and continued or worsening harassment (Nielsen et al., 2017; Rodwell, 2014; Wei, Chiou, Chien, Huang, 2015).

While the effects of sexual harassment in nursing is well documented, the actual scope of the issue is much less clear. Statistics drastically differ ranging from 15 to 63% of nurses admitting to being sexually harassed in the workplace (Najafi, Fallahi-Khoshknab, Ahmadi, Dalvandi, & Rahgozar, 2017; Yang, Stone, Petrini, & Morris, 2018). This wide range is mostly due to region and setting, but is also reflective of the poor rates of formal reporting. It is estimated that between 70 and 80% of sexual harassment occurrences in the healthcare setting goes unreported (Azar, Badar, Samaha, & Dee, 2015; Draucker, 2019; Jacobowitz, 2013). This is because many nurses consider it part of their job, lack knowledge on who to report to and what resources are available, fear job loss, bullying, judgement, or feel shame and responsibility for the harassment (Draucker, 2019; Hall, Klein, Betts, & DeRanieri, 2018; Magnavita, & Heponiemi, 2011). In addition, many nurses feel that reporting the occurrence will result in no change or won't be taken seriously (Lux, Hutcheson, & Peden, 2013). According to Draucker (2019), almost half of the reported cases go unaddressed or receive no intervention.

Current research and organizations like the American Nurses Association place rates of sexual harassment at about 30% worldwide (Cipriano, 2018; Kameg, & Constantino, 2018; Nelson, 2018). These rates are even higher in Anglo-Saxon, English speaking, regions, estimating that closer to 40-60% of nurses are sexually harassed in the workplace (Azar, Dadar, Samaha, & Dee, 2015; Draucker, 2019; Nelson, 2018; Spectro, Zhou, & Che, 2013). Although female nurses are more at risk for experiencing sexual harassment, male nurses also experience it, especially in certain settings where sexual harassment is higher: the emergency department, psychiatric units, ICU, and geriatrics (Azar, Badar, Samaha, & Dee, 2015; Cipriano, 2018; Spectro, Zhou, & Che, 2013; Yang, Stone, Petrini, & Morris, 2018). It is well documented that patients are most commonly the perpetrator of sexual harassment towards nurses (Azar, Badar, Samaha, & Dee, 2015; Draucker, 2019; Jacobowitz, 2013; Park, Cho, & Hong, 2015; Spectro, Zhou, & Che, 2013). Reasons patients are more likely to engage in sexually inappropriate behaviors is due to altered mental status, substance abuse, extreme stress, long wait times, fear, lack of knowledge on what is sexual harassment, impaired awareness and judgement, and poor impulse regulation (Garcia, Lechner, Frerich, Lust & Eisenber,

2011; McNamara, 2012; Najafi, Fallahi-Khoshknab, Ahmadi, Dalvandi, & Rahgozar, 2017; Nielsen et. all, 2017; Yang, Stone, Petrini, & Morris, 2018).

Methods

A literature review was conducted for this study. An original search resulted in 5,295 articles. These were then narrowed to full text, scholarly articles, within nursing, and in English, resulting in 35 articles that were deemed relevant, reliable, and applicable to patient to nurse sexual harassment prevention and intervention training. These articles included literature reviews, quantitative, qualitative, and mixed-methods studies, and scholarly reports.

Results and Discussion

Since the early 1990's research has been recommending that nurses receive sexual harassment training (Dan, Pinsof, & Riggs, 1995; Finnis, Robbins, & Bender, 1992). Current literature still recommends this, as few hospitals have implemented such trainings (Lux, Hutcheson, & Peden, 2013; McNamara, 2012; Nielsen, et. all, 2017; Rodwell, 2014; Strauss, 2019;). The healthcare organizations that do provide workplace violence training often have it in the form of a module, and rarely include sexual violence, especially that perpetrated by patients.

While most articles reviewed agreed that a training is necessary, the setting and content of the training differs. Many of the articles recommend that the training be educationally based, while the others report hands-on training is more effective. Educational based trainings should include a definition of sexual harassment and abuse, gender discrimination, risk factors and identification of improper sexual behavior and statements, how to prevent and address the behaviors, and how to cope with exposure to sexual harassment (Lux, Hutcheson, & Peden, 2013). Both Nielsen et. all (2017) and Azar, Badar, Samaha, & Dee (2015) found that those with more education and experience were more likely to stand up for themselves and were more prepared to identify, prevent, address and cope with sexual harassment in the workplace. In addition, Lee, Song, & Kim (2011) identified that individuals with misunderstanding or lack of knowledge on sexual harassment are less likely to report. Recommended hands on training includes practices that will improve communication skills, assertiveness, culture and behavior changes, active prevention, intervention, self-defense, coping, and reflection (Hibino, Ogino, & Ingaki, 2006; Jacobowitz, 2013; Koskinen, Mikkonen, & Jokinen, 2011; Long, 2014; Najafi, Fallahi-Khoshknab, Ahmadi, Dalvandi, & Rahgozar, 2017). The trainings were shown to reduce acute symptoms, risk for PTSD, and increased confidence and self-esteem (Jacobowitz, 2013).

Of the articles reviewed, many focused on training nurses specifically, however other articles believe that proper and effective change starts with training those in leadership

positions (Azar, Badar, Samaha, & Dee, 2015). This is because managers, educators, administrators, and other leaders have a unique responsibility and opportunity to positively change the culture through enforced zero tolerance of disruptive behaviors, policy enactment, resource provision, and encouragement to report, feel supported, and advocate for oneself and nursing as a whole (Hall, Klein, Betts, & DeRanieri, 2018). In addition, when individuals feel more supported and empowered by management or others in leadership, they are more likely to report instances of patient to nurse sexual harassment and use more effective coping strategies and resources (Garcia, Lechner, Frerich, Lust & Eisenber, 2011; Lux, Hutcheson, & Peden, 2013; McNamara, 2012)

A third approach is to educate and train nursing students. Studies show that nursing students are more vulnerable for exposure to sexual harassment than nurses and could benefit from education on sexual harassment in healthcare (Cogin & Fish, 2009; Hibino, Hitomi, Kambayashi, & Nakamura, 2009). This is because they have more frequent environment changes, decreased confidence and autonomy, increased dependence on those in power, and limited experience with disruptive behaviors (Ebrahimi, Hassankhani, Negarandeh, Jeffrey, & Azizi, 2017; Magnavita, & Heponiemi, 2011). According to Lux, Hutcheson, & Peden (2013), BSN students only receive an average of 2 hours of education on disruptive behaviors in the workplace and this rarely includes sexual harassment from patients. Nursing students do report experiencing sexual harassment from patients during clinical, and receiving training can help to reduce shock and insecurity in their practice and can increase their resilience to cope with disruptive sexual behaviors from patients (Hoeve, Kunnen, Brouwer, & Roodbol, 2018)

Lastly, some articles focused on bystander intervention training. This includes learning to recognize disruptive behaviors, intervene, stop rumors and judgement of the victim, hold leaders accountable for enforcing a culture of safety, and model support and positive behaviors (Hellebrand, 2018; MacCurtain, Murphy, O'Sullivan, MacMahon, & Turner, 2018). Research shows that nurses are more likely to report instances of sexual harassment and cope more effectively when they feel supported by peers, management and staff (Garcia, Lechner, Frerich, Lust & Eisenber, 2011; Hall, Klein, Betts, & DeRanieri, 2018; MacCurtain, Murphy, O'Sullivan, MacMahon, & Turner, 2018). In addition, Bunkers (2014) specifies that bearing witness to injustice is a fundamental aspect as caring, and therefore nurses should be well equipped to stand up against disruptive situations. Salvage & Stilwell (2018) also discusses how nurses have a unique opportunity to be "*silence breakers*" and stand up for safety towards nurses and women in the workplace (p. 1302).

Conclusion

Patient to nurse sexual harassment is a growing concern in healthcare that affects nurses worldwide. Currently the education and hospital systems do not adequately prepare health professionals to identify, prevent, address, or cope with sexual harassment in the

workplace. Increased training and education is necessary to improve nurse's confidence, assertiveness, support, and overall health.

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Correspondence

Email: erin.micale@yale.edu

Autism Spectrum Disorder and Sexual Offending

Paper

Julian Gojer, Monik Kalia, Caroline Kerjikian, Julie Magritte, Sanjeevan Athavan, Iva Giljanovic & Jane Koh

Introduction

Autism spectrum disorder (ASD) first made its way into the DSM-5 as an all-encompassing diagnosis that includes four disorders that were previously separate: autistic disorder, Asperger's disorder, childhood disintegrative disorder and pervasive developmental disorder not otherwise specified¹. The two central features of ASD include impairments in social functioning and communication, and fixated and/or repetitive interests and behaviours. The previously separate disorders mentioned above are now considered to fall along a spectrum with different levels of severity of the two central features⁽¹⁾.

The core features of ASD can result in individuals becoming involved with inappropriate sexual and aggressive behaviour. The relationship between ASD and violent and sexual offending is highly debated. This paper reviews the nature of the social communication problems and fixated interests in relation to aggressive and sexual behaviour, as well as delves deeper into the suggested mechanisms of the potential relationship. Moving past the relationship itself, we discuss how some of these individuals can be managed from a psychotherapy point of view and a legal perspective.

What Does the Literature Say?

The relationship between ASD and offending has received increasing attention in the last decade, and this association has proven to be complex. Research methods implemented have not been rigorous and thus, firm conclusions cannot be drawn from small sample sizes and inadequate measurement techniques (2). In conducting our literature search, the research dilemma of obtaining a uniform sample became clear due to the broad spectrum of the disorder itself, as well as the high prevalence of comorbidity (3). The findings of the studies that we did come across are contradictory. Some research findings report that individuals on the spectrum are no more likely to violently offend than individuals without ASD (3,4), whereas other findings suggest that ASD-related challenges in social functioning, impulsivity and poor emotional regulation make individuals more likely than the general population to commit certain types of violent offences such as sex offences and assaults (5).

Further, secondary to media reports, the public has adopted a perception that there is a direct link between ASD and violent offending. Adam Lanza who was responsible

for the Sandy Hook Elementary School mass murder in Connecticut in December 2012, and Alek Minassian, who is accused of killing 10 people during the van attack in Toronto last year, were both said to have a diagnosis of ASD (6,7). It is essential to better understand the ASD-related social and emotional challenges mentioned above, as well as to consider the role of comorbidity in cases where individuals with ASD commit violent offences (3). It appears that multiple factors have an interactive and potentially additive effect on the prevalence and magnitude of violent offending, and thus we must adopt an individualized lens. Nonetheless, some of the common challenges and suggested mechanisms for the relationship between ASD and offending will be reviewed below and used as specific indicators for the types of counselling that are needed.

ASD-related Challenges

Social, emotional and cognitive abilities and deficits in the context of ASD are highly complex due to the broad spectrum of the disorder itself as well as the fact that the course of the strengths and impairments are largely unpredictable over one's lifespan. The social and emotional environments in which an individual exists are not static. For instance, social relationships become more complex as one enters the adolescent and early adult years. Symptoms of ASD may go unnoticed until these years due to adequate camouflaging (8), compensation through high intelligence, and confusion with other disorders (9). Although strategies such as camouflaging, where one uses learned strategies to mask social challenges, may help them "*fit in*" with the crowd, the long term effects actually aggravate social difficulties as will be explored below. With regards to the social communication and functioning challenges in ASD, we must revisit the concepts of Theory of Mind, emotional regulation, and executive functioning.

Theory of Mind. One of the prominent features of ASD is some degree of impairment in social interaction, which may be due to difficulties in reading non-verbal social communication and understanding social nuances due to deficits in Theory of Mind (ToM) (10). ToM is considered to be a cognitive perspective taking ability which allows one to interpret social intentions and understand the unwritten rules of society(11). While empathy is considered to be emotional-perspective taking, ToM is more so cognitive. It is our view that empathy and ToM are intertwined and interdependent. Therefore, it is not that individuals with ASD lack empathy and are thus more prone to violent offences. Rather, their difficulties with ToM may prevent them from understanding the mental state of others, processing others' body language and reading others' emotions, thus inhibiting the development of societally appropriate responses and behaviours.

When these societally deemed inappropriate behaviours are sexual/romantic or violent in nature, involvement with the criminal justice system becomes more likely. Further, violent offences encompass a broad range of behaviours including those that are intrusive, harassing negligent, assaultive and in the extreme case, homicidal. For instance, in one of our cases, Mr. AB, who has high functioning ASD, failed to read the complainant's

nonverbal cues of not being interested in a romantic relationship, and he continued to pursue her through social media platforms and letter writing. The complainant became afraid and interpreted the persistent attention and pursuit as harassment. The client, who had no previous criminal history, was charged with criminal harassment.

Emotional regulation. Building on the implications of Theory of Mind, one's ability to regulate their emotions in frustrating social situations (or otherwise) is crucial. Poor tolerance for frustration, for example, may result in maladaptive or impulsive outward manifestations of strong emotions (12). Therefore, in individuals with ASD, poor emotional regulation may present itself as lacking impulse control or being violent. Emotional disturbance is not a central feature of autism spectrum disorder, however, there has been increasing evidence that individuals on the spectrum have elevated levels of anger and anxiety that can materialize as meltdowns, irritability and aggression (13-14). Some of the theories that explain the elevated levels of negative emotions revolve around difficulty relating to peers and making friends. An inability to recognize and process social cues may lead to increasing frustration. These circumstances can also give rise to social anxiety and produce feelings of anger, inadequacy and isolation.

A slightly more complex theory that combats and yet aggravates the anxiety is the phenomenon of '*camouflaging*' which is a potential source of increased emotional distress (15). Specifically, it involves masking social communication and relating challenges by using learned or practiced phrases, making eye contact and copying others' gestures and facial expressions. Maintaining these efforts throughout the day can be cognitively taxing and lead to increased stress responses and negative emotions (16). In other words, many individuals with ASD may be either avoiding socially challenging interactions or using strategies to mask the challenges. Mazefsky et al. (17) suggest that an impaired ability to use adaptive emotion regulation strategies such as goal-directed behaviours and seeking support elevates emotional disturbances in individuals with ASD.

Executive functioning. Cognitive processes such as inhibition, planning, and switching between tasks are examples of mental processes that make up executive functioning (18). Deficits in these capacities can be seen in various disorders such as ADHD, schizophrenia, OCD and ASD (19). Impairments in executive functioning may contribute to the ASD-related behaviours and challenges such as rigidity, difficulty with transitions, specific fixated interests and need for sameness (20). With regards to specific fixated interests, the content of the interest is crucial. For example, if an individual with ASD has a fixated interest in downloading and organizing child pornography, then involvement with the criminal justice system becomes almost inevitable. In addition to the content of the interest, the intensity of the pursuit, regardless of the implications or consequences, is often a product of the need for routines and an inability to switch to another task. Continuing to engage in the behaviour irrespective of the consequences

presents as being impulsive, although arguably the more appropriate description would be ritualistic.

Similarly, being focused on a certain aspect of an event or item as opposed to the greater picture is another deficit in executive functioning. For example, Mr. XY, a middle-aged male with ASD was charged with negligent driving causing death. His presentation post-incident appeared to be non-empathetic and “cold.” When asked about the incident, he spoke at great lengths about the logistics of the accident, using detailed estimates of the distance between him and the victim. He did not talk about the victim losing their life. This combination may have led one to believe that this individual had no remorse for what he did. However, upon greater interviewing it became clear that this individual was fascinated and fixated with metric measurements and that it was his norm to think about things in this way. When probed and asked about the victim, it became evident that he was, in fact, greatly remorseful and that he had been thinking about the incident every night.

The brief case examples presented above, and the alternative presentations of some of the classic ASD-related symptoms truly illuminates the need for more research in this complex relationship between ASD and violent offending. Regardless of whether there is a relationship, this paper will focus on practical and actionable steps that can be taken to better support individuals with ASD who are involved in the criminal justice system.

The Role of Counselling

Referring back to the difficulties of ToM, emotion regulation and executive functioning, there is considerable room for teaching these concepts and nurturing these skills in individuals with ASD. Psychoeducation and specific coaching about appropriate conduct is essential. Specifically, teaching individuals how to identify nonverbal cues and to provide them with explicit rules for establishing and maintaining appropriate relationships will help address social skill deficits. Further, to help with cognitive perspective-taking, it is crucial to encourage individuals with ASD to recognize facial expressions as a window into emotional states and to practice these skills in a structured manner with feedback (21). With regards to improving emotion regulation, adaptive skills can be taught such as adopting cognitive reappraisal strategies for alternative responses to anger, stress and frustration (22). It is our experience that clients who have come into contact with the law due to sexual behaviours have benefited from in-depth psychoeducation about consent, maintaining appropriate boundaries, appropriately expressing sexual interest, and redirecting sexual urges in socially acceptable manners and outlets.

A Legal Perspective

The management of individuals with ASD can be a difficult task after they have run afoul of the law. It is the experience of the authors that, while severe cases of ASD

are easily identified, many clients have been wrongly diagnosed as suffering from a psychosis, social anxiety disorder, a learning disability, or with a personality disorder, and the more serious underlying problem with ASD is missed when the above problems do not exist or are comorbid.

Standard risk assessment tools like the Violence Risk Appraisal Guide, the Sex Offender Risk Appraisal guide, the Static 99, HCR 20, and RVSP, simply do not capture the myriad of problems these individuals have, and they produce results that are felt to be unreflective of the underlying problems and the management strategies that are required. Reports written are focused on idealized and hypothetical management plans in the community that are often unlikely applicable to the client when they return to their home community with little resources. Many such clients have serious problems with low self-esteem, and have difficulty expressing empathy, which do not appear to be present but, only with careful evaluation, are evident. Such problems, if not explored fully, could result in judges being told that the offender has no remorse and suggestions of psychopathic traits run the risk of the individual being perceived a higher risk and receiving a higher sentence.

Lastly, managing such offenders in standard jails is a recipe for disaster. Often these individuals who were traumatized by being bullied all their life in the community, find themselves in jails where they are seriously traumatized by offenders looking for such targets to vent their frustrations on. Many a time, such individuals end up in segregation for long periods of time, receive little help in custody and come out worse for the experience and are further hampered with the stigma of a criminal record and their poor employability becomes abysmal.

Recent high-profile cases where young people with ASD have committed heinous crimes simply adds fuel to the fire in how the public view such offenders as opposed to calls for specialized treatment and management. Trauma can beget trauma and educating the courts about the pitfalls of punishing such individuals can help with creative sentencing.

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Correspondence

Email: juliangojer@themanasaclinic.com

Chapter 13 – Specific populations: forensics

Keeping in contact voluntarily: A study on service-users' experiences and criminal recidivism in forensic psychiatric care

Paper

Petra Schaftenaar (Netherlands)

Keywords: Forensic care, criminal recidivism, service-user experiences, contact after (inpatient) treatment

Abstract

In a forensic psychiatric hospital, an educational program in relational care was developed, with special attention to the ward-climate. A non-repressive atmosphere, trust and doing things together were important aspects. Also, the workers provided voluntary contact after treatment. Every discharged patient was offered to keep in contact with the person he/she wanted (nursing staff or therapist). Care-ethics and the theory of presence provided the philosophy of relational care on which the new paradigm was built. In this presentation we will present the results of a qualitative narrative study on the experiences of service-users and a quantitative study on criminal recidivism.

The aims of this study are

1. Giving voice to the forensic service-user and his story and perspective
2. Giving insight in the meaning of care by these stories, to develop or maintain (new) policies and practices
3. Giving insight in the criminal recidivism of three groups of service-users

This research aims to answer the question what is the contribution of a relational way of working and keeping contact after treatment means to service-users and if there are benefits in terms of reduction of criminal recidivism.

Methods

The qualitative study was conducted in a narrative tradition.

A quantitative multi-center research was conducted into the criminal recidivism of service-users who received contact after treatment. This group (n=45) was compared to two groups (n=43 and n=23) who did not receive contact after treatment.

Results

Narrative analysis revealed multiple values of this practice for ex-service users. It is a breakthrough in the common experiences of constantly ending relationships with caregivers. The effect on the service-user is the experience of being taken into account. It gains trust.

The research into the criminal recidivism shows a significant drop of recidivism (two years after treatment, ($\chi^2=11.421$ (df=2), $p=.003$)) for service-users who had contact after treatment.

Conclusion

This research shows that in the group of service-users who were offered contact after treatment, a decrease of criminal recidivism had taken place, compared to two other groups who did not receive contact after treatment. The research also gives insights in the value and meaning of contact after treatment from the perspective of the service-users. The voluntary contact as a way of informal care bridges the gap in the healthcare chain when service-users are discharged and admitted to a new hospital or '*supported living home*'. The results needs new studies to explore the specific efficacy of this practice.

2 Educational Goals

1. After attending this presentation participants will have insight into the value of '*contact after inpatient treatment*' from the perspective of ex-service users.
2. The mixed methods research design that is presented in this study deepens the knowledge gained in this research and can be interesting for other researchers in forensic practice.

Correspondence

Email: p.schaftenaar@ziggo.nl

Effectiveness of the Galya Individualized Competency Restoration Program (Galya-ICRP) on Competency to Stand Trial in Forensic Psychiatric Patients

Poster

Utaya Nakcharoen & Phawinee Butsaen (Thailand)

Keywords: competency to stand trial, forensic, psychiatric patient

Abstract

Object

To study the Galya Individualized Competency Restoration Program (Galya-ICRP) on competency to stand trial in forensic psychiatric patients.

Materials and methods

The sample of this study consisted of 20 forensic psychiatric patients who were under criminal procedure code section 14 and sent for mental examination and competency to stand trial evaluation at the forensic psychiatric institution. The participants were allocated to two equal groups, experimental and control. The experimental group received four sessions of the Galya-ICRP. The control group received the care as usual. The instruments used in this study included the demographic data form and the Galya-ICRP which were developed by the researchers and the Galya-ICRP, developed by researchers. The Independent t-test and Pair t-test were used for data analyses.

Results

The results showed that after the completion of the four sessions of the program, the experimental group had the mean scores of the competency to stand trial significantly higher after receiving the program ($p < .05$).

Conclusions

Enhancing the competency to stand trial among forensic psychiatric patients who were found incompetent to stand trial is essential. The Galya-ICRP should be implemented as the legal rehabilitation standard of practice in the forensic psychiatric inpatient setting.

2 Educational Goals

- goals regarding the cognitive and affective domains of learning.

Correspondence

Ms. Utaya Nakcharoen

Email: utayaa@yahoo.com

Trauma exposure in a high secure male forensic population

Paper

Grainne McKenna, Neil Jackson & Claire Browne (UK)

Keywords: Trauma, forensic, secure, trauma-informed care, inpatient

Abstract

Background

Trauma exposure in individuals with SMI and/or PD is linked with a range of negative clinical and hospital outcomes, and is a well established explanatory risk factor for the perpetration of violence. Although high levels of exposure to traumatic events are noted within the histories of non-forensic mental health populations, few studies have explored the nature and extent of trauma exposure among high secure male forensic patients.

Aims

Clinical experience suggests that the level of trauma within our patient population was high; however, no data to empirically support this presumption, and thus guide service delivery, had been systematically obtained. In addition to exploring trauma exposure, the evaluation also sought to compare data on a number of hospital outcomes, including admission length, adverse incidents and seclusion and segregation stays, for patients with and without a childhood trauma history.

Method

The service evaluation used a file review procedure to ascertain from clinical records patient exposure to trauma amongst a high secure male forensic population. Data capture sheets were developed based on the Childhood Trauma Questionnaire (CTQ) and the Trauma History Questionnaire (THQ). Patients' own offending behaviour was included as a further source of potential trauma. Records for all patients placed within the hospital (n=194) were reviewed.

Results

Descriptive statistics indicated that 100% of patients were exposed to a traumatic event over the lifespan, with 75% of the sample having been exposed to trauma during

childhood. Sixty-five percent of patients had experienced more than one type of trauma during childhood; the mean number of trauma types experienced during this period being 2.31. In adulthood 63% had been exposed to one trauma type while 29% had been exposed to two or more trauma types. No patient had a primary diagnosis of PTSD. Non-parametric Mann-Whitney U tests highlighted no significant difference between those with and those without childhood trauma histories on the hospital variables considered.

Conclusions

Given the extent of exposure to trauma in childhood and/or adulthood in High Secure Hospitals, it is clear that trauma-informed care is needed. Recognition of the impact of trauma on psychiatric symptoms, violence risk and interpersonal functioning will enable more responsive and safer delivery of treatment and care. In order to create this cultural shift, listening to patients on the aspects of hospital care which are experienced as supportive, useful and containing is necessary. This can then be used to inform and enhance staff knowledge, confidence and competence.

2 Educational Goals

1. To achieve a greater awareness of the prevalence of trauma within male high secure forensic services
2. To begin to consider the implications of trauma informed care within forensic services

Correspondence

Email: Grainne.McKenna@merseycare.nhs.uk

Nighttime treatment in forensic psychiatry

Paper

Marike Lancel, Jorien Engberts, Gretha Boersma & Maaike Van Veen (Netherlands)

Keywords: Forensic psychiatry, Sleeplessness, Prevalence, Maintaining factors, Treatment

Abstract

Background

Chronic insomnia (sleeplessness) is common in psychiatric populations. In forensic psychiatric patients insomnia has been shown to increase impulsivity and aggression, thereby increasing the risk for aggressive incidents and recidivism.

Aim

To improve prevention and treatment of chronic insomnia in forensic hospitals by investigation of insomnia maintaining factors in this setting.

Methods

281 patients from multiple (10) forensic hospitals completed self-report questionnaires assessing sleep quality, acute insomnia, chronic insomnia and other clinical sleep disorders, sleep habits and sleep hygiene, as well as dysfunctional beliefs and attitudes about sleep. The patients were subdivided into three groups: the good sleepers (n=124), those with acute (n=53) and those with chronic insomnia (n=44). Differences between these groups were tested with Kruskal-Wallis and Mann-Whitney U non-parametric tests.

Results

15.7% of patients suffered from chronic insomnia. With increasing insomnia severity (none, acute & chronic), participants experienced more problems falling and/or staying asleep, slept much shorter and felt more tired during the day. Frequently reported sleep disturbances were too warm/cold room temperature, stress, rumination, nightmares and pain. Insomnia severity was significantly related to poorer sleep hygiene, particularly 'improper sleep scheduling', 'bed activities other than sleep' and 'adverse environmental conditions'. Some inadequate behaviors were rather general, like watching TV in bed, drinking coffee and smoking cigarettes in the hours before bedtime. Insomnia

severity was also associated with many dysfunctional beliefs and attitudes about sleep, specifically concerning '*perceived consequences of insomnia*', '*worry/helplessness about insomnia*' and '*medication expectations*'.

Conclusions

In line with earlier studies, chronic insomnia appeared more prevalent in forensic than in the general population (15.7 vs. 4-10%). Most of the insomnia maintaining factors demonstrated in this study can be dealt with, either by environmental changes, specific interventions e.g. for pain and nightmares, or adaptations/extensions to the standard treatment: cognitive behavioral therapy for insomnia (cbt-i).

2 Educational Goals

1. The observed prevalence of chronic insomnia and knowledge on its impact on daily functioning stresses the importance of consistently paying attention to the sleep quality of forensic psychiatric inpatients
2. Interventions directed at the sleep-adverse behaviors and cognitions and the insomnia maintaining factors may improve prevention and treatment efficacy of chronic insomnia in the forensic psychiatric population

Correspondence

Email: marike.lancel@ggzdrenthe.nl

Poor sleep is associated with aggression in forensic psychiatric patients

Paper

Maaïke Van Veen, Julie Karsten, Robert-Jan Verkes & Marike Lancel (Netherlands)

Keywords: Forensic psychiatry, sleep, sleep quality, aggression, hostility

Abstract

Background

Studies consistently demonstrate a relation between poor sleep and impulsive and aggressive behaviour. These findings are clinically relevant for psychiatric populations, for whom co-morbid sleep problems might negatively affect behavioural and emotional inhibition and enhance the risk of aggression. However, most studies do not account for the role of psychopathology when assessing relations between poor sleep and aggression.

Aim

To investigate the association between poor sleep and aggression in a forensic psychiatric population.

Methods

Self-report questionnaires were used to measure sleep quality, levels of impulsivity and aggression and general psychopathology in a sample of male forensic psychiatric inpatients (n=166). A single-item from a risk taxation instrument was used to assess the level of clinician-rated hostility. Linear regression models controlled for general psychopathology level.

Results

Sleep quality was negatively associated with self-reported aggression. Both total aggression scores and subscale scores (physical aggression, verbal aggression, anger and hostility) were higher with worse sleep quality. These associations were not accounted for by general psychopathology. Poor sleep quality was associated with higher clinician-rated hostility also, however, this association was much weaker than that for self-reported aggression.

Conclusions

This study replicates previously found associations between poor sleep and aggression in a forensic population, and stresses that sleep problems are not merely a part of general psychopathology. Targeted treatment of sleep disturbances in this population might not only ameliorate sleep, but also reduce the risk of impulsive and aggressive behaviour. This possible contribution to risk reduction in forensic psychiatry is a promising direction for future research, in which especially treatment studies are warranted.

2 Educational Goals

1. Gaining understanding of the possible impact of poor sleep on violence, through emotional, cognitive and behavioural dysregulation
2. Enhancing awareness on the specific implications for forensic psychiatric treatment, both on individual and general levels.

Correspondence

Email: maaike.van.veen@ggzdrenthe.nl

Variation of Forensic Psychiatric Systems across the EU: Concepts, Legal Frameworks and Practices in European Union Member States

Paper

Hans Joachim Salize, Harald Dressing, Barbara Horten & Andrea Giersiefen (Germany)

Keywords: forensic psychiatric care systems, legal frameworks, placement and treatment of mentally ill offenders

Abstract

Background

The placement and treatment of mentally ill offenders is a challenge for every country, but approaches or services differ widely worldwide. Detailed descriptions of forensic psychiatric care across systems or nations are lacking, as is epidemiological data on forensic care or forensic patients. However, such data is essential for identifying models of best practice or developing forensic psychiatric care further.

Method

On the basis of a standardized overview of forensic care in 15 European Union Member States done in 2004/2005 by the authors of this presentation, in 2018 a European multi-center study on forensic psychiatric care (“*EU-VIORMED*”) conducted a new survey on basic features of forensic psychiatric care in 28 European countries. Information on basic legal concepts, services, capacities, routine practices and epidemiological data (admission, mean length of stay etc.) was collected by a questionnaire completed by forensic psychiatric experts from each country. Items and questions were chosen and adapted to cover the wide variety of approaches and systems.

Results

The data provide a standardized overview of European models of forensic psychiatric care and show the variety of systems and approaches. The results support the need for a regularly updated health reporting system providing essential epidemiological data on placement and treatment routines of mentally ill offenders internationally.

2 Educational Goals

1. To understand the variety of concepts to detain and treat mentally ill offenders in Europe
2. To understand the lack of an international debate on the best practice for this specific patient-group

Correspondence

Email: hans-joachim.salize@zi-mannheim.de

A network of forensic psychiatric services in an urban setting in the Netherlands to manage violence

Workshop

Udo Nabitz, Melina Kappeyne van de Copello-Rakic, Jeroen Zoeteman, Thoma Marquant, Valentijn Hollander & Rogier Van Bemmelen (Netherlands)

Keywords: Forensic services, Manage violence, Urban setting, European exchange

Abstract

In one of the urban multicultural settings in the Netherlands (Amsterdam), with a liberal and broad social support tradition a chain of organizations, treatment facilities, services and activities was implemented to manage violence, to treat forensic patients and to contribute to safety of citizens.

In the last few years we

- established an outpatient forensic treatment service (FAZ) including systematic family treatment (MDFT), Forensic Assertive Community Treatment (ForACT), Aggressionmanagement (AHT), Delict analyses, Relapse Prevention, Cognitive behavioral Therapy, Schema therapy
- implemented a treatment line for acute psychiatric admissions in coordination with the police department (Verwarde verdachten, Safe house and Psycholance)
- ran an inpatient forensic clinic for long- and short-term admissions (FPK and FPA)
- cooperated with housing and support services (Regenboog, Qurido etc)
- innovated our treatment delivery by Electro Convulsion Therapy, Biofeedback and Buddy systems
- participated in a community prevention project to manage youth violence (top 600).

The focus of our endeavor is to deliver fast, effective and sustainable treatment and services in order to reintegrate patients in our urban setting and to reduce violence in our city. Regular Outcome Monitoring results demonstrate the value of our approach.

2 Educational Goals

1. To learn about a network of forensic services in an urban setting.
2. Exchange experiences with colleagues of other European urban settings such as Oslo, Stockholm, London, Dublin, Berlin, Vienna and south European cities.
3. Discuss approaches and benefits for patients and citizens.

Correspondence

Email: Udo.Nabitz@Arkin.nl

Forensic High and Intensive Care: the validity of the FHIC monitor

Paper

Sylvia Gerritsen, Yolande Voskes, Petra de Leede, Savannah van Bodegom, Renske de Zwart, Laura van Melle, Sven Rooijackers & Guy Widdershoven (Netherlands)

Keywords: Forensic psychiatry, crisis, stepped care, safety in contact, High & Intensive Care, best and evidence based practices, reduction coercive measures, theory of open ward climate, theory of limit setting, national research, implementation

Abstract

Introduction

Forensic High and Intensive Care (FHIC) aims to provide stepped care in order to deal with crisis situations. Recently, the FHIC model was developed, inspired by the High and Intensive Care model in Dutch acute psychiatry. Based on best practices and evidence based practices, FHIC aims to provide safety by contact instead of control. The focus is on an open ward climate and limit setting, and prevention of repression and coercive measures. Currently, the FHIC model is being implemented in practice. Professionals in the wards are being supported by a model fidelity scale; the FHIC monitor. Research is needed to study the validity of the FHIC monitor and to gain insight into the implementation process and the effects of FHIC.

Methods

A mixed methods design was used to gain insight into the validity and reliability of the FHIC monitor, the implementation process and effects of FHIC on ward climate and safety. In total, sixteen wards with a low ($n=6$), medium ($n=3$) or high ($n=7$) security level are participating in the study. Data has been collected from September 2017 till June 2019. Audits and focus groups were organized to study the validity and reliability of the FHIC monitor, and to gain insight into the implementation process. Surveys were conducted to measure effects, such as an open ward climate and safety experiences.

Results

Preliminary results indicate that the FHIC monitor is a good instrument to support the process of implementation. Data on the validity of the FHIC monitor, ward climate and safety are still being collected. The final analysis of data will be carried out this summer. We will present our results during the congress in October.

Conclusion

The FHIC model is developed for the forensic field to prevent further disruption and to provide safety by contact in crisis situations. FHIC asks for a new vision on care and safety, and the need to prevent coercive measures within forensic psychiatry. The results of the study aim to gain more insight into the value of the FHIC monitor in implementing the model and its effects.

2 Educational Goals

1. To gain knowledge and understanding of the Forensic High and Intensive Care model and its intended value for the forensic psychiatric field
2. To understand the value of the FHIC monitor in the context of implementation

Correspondence

Email: s.gerritsen1@vumc.nl

Neurodevelopmental disorders and responsivity to treatment in forensic outpatient psychiatry

Workshop

Rosalind van der Lem & Nathalie Kruit (Netherlands)

Keywords: Intellectual disability, ADHD, Autism Spectrum Disorder, Responsivity, Forensic outpatient psychiatry

Abstract

Neurodevelopmental disorders (Attention Deficit Hyperactivity Disorder, Autism Spectrum Disorder and learning disabilities) are quite common in forensic psychiatry. 30-40 Percent of the prison inmate-population suffers from one or more neurodevelopmental disorders. A significant proportion of the forensic population has an IQ of 80 or less. People with an intellectual disability relapse more often into criminal behaviour. Delinquents suffering from ADHD are punished earlier, more often and more severely by the justice system than delinquents without ADHD. When treated with medication, delinquents with ADHD commit significantly less crimes compared to the periods when they do not take medication. The association between Autism Spectrum Disorder (ASD) and criminality is less clear; some studies state that patients with ASD show less delinquent behaviour, other studies show that ASD is associated with specific types of delinquent behaviour such as arson or sexual delinquency. Inmates who suffer from a combination of neurodevelopmental disorders show more behavioural problems and have more severe symptoms than the ones with a single disorder.

In forensic psychiatry, the Risk Needs Responsivity model by Andrews and Bonta (2007) is often used as a theoretical background for reducing the forensic risk (the chance that someone will fall back into delinquent behaviour, the risk of recidivism) by treatment. The risk of recidivism in serious crimes depicts the intensity/frequency of the treatment. The criminogenic needs are the primary targets of the treatment. The treatment itself has to match with the learning style and learning capacities of the forensic patient. In our opinion, patients with neurodevelopmental disorders suffer primarily from a responsivity-problem. Due to their disorder, they cannot benefit enough from regular behavioural therapies such as aggression-regulation-therapies. Patients with neurodevelopmental disorders have problems in their executive functions such as planning, working memory and impulse control. They might also have different learning styles. They may have problems in generalizing the lessons learned in therapy to daily life, have an impaired theory of mind or problems in moral reasoning. It is important that the practitioner aligns with the patients' skills by adapting language, using pictures or other tools that positively influence the treatment.

In this workshop we will present several cases. We will discuss several techniques to enhance responsiveness. The audience will be asked to present their own cases and we will discuss them as a group. We will show that apparently small interventions will have high impact. These interventions are based in practicing patience, endurance and creativity and enjoying the achievements together with the patients. We learned from our patients that the use of language, which can mean speaking too slow or too long, being sloppy in our expressions, using difficult sentences can be a large barrier for motivation, adherence and treatment outcome. In this workshop we will share our experiences and hope to learn from the ones from colleagues in the audience.

2 Educational Goals

1. Early recognition of the specific barriers of response to treatment in patient with a neurodevelopmental disorder
2. Debate on “*what works*” when adapting existing therapies for patients suffering from neurodevelopmental disorders

Correspondence

Email: rosalind.van.der.lem@fivoor.nl

Forensic Aspects of Sleep

Paper

Jon Carey, Anne Aboaja & Rachel Steele (UK)

(Authors: Dr Jon Carey; Dr Anne Aboaja; Dr Lindsay Dewa)

Keywords: Sleep, violence reduction, recovery, inter-disciplinary, secure psychiatric hospital, forensic

Introduction

There is a paucity of research on sleep in secure psychiatric settings, particularly in the UK. In the Netherlands, a cross-sectional study found half of secure inpatients had poor sleep quality and a third had more than one sleep disorder, [1]. Similarly, there is also high prevalence of poor subjective sleep quality (88.2%) and insomnia disorder (DSM-V) (61.6%) in UK prisoners; both significantly associated with suicidality, depression and problematic prison environmental factors (i.e. noise, light and extreme temperatures),[2]. The intellectual disabilities version of the Structured Assessment of Protective Factors, SAPROF-ID, [3] showed sleep as a potential protective factor in violence reduction, but there is a lack of evidence to confirm this hypothesis. Applied health research in sleep is aligned to at least one of the research priorities listed by the Forensic Service Development Group at Ridgeway Psychiatric Hospital, UK. Moreover, invited speakers and delegates at a sleep conference held in January 2019 showed strong support to examine sleep in a secure psychiatric setting because of the particular issues, such as observation methods, high stress levels and noise levels (including doors being locked and unlocked on a night). They felt that improving sleep quality could improve motivation for recovery based endeavours such as therapeutic interventions and leave programmes in the community for work and leisure.

The study aim is to establish a cross-disciplinary forensic sleep research group comprising of clinicians and others at Ridgeway Forensic Services, including inpatient and carer groups, library, pharmacy along with academics from the University of York and Imperial College London to understand and research priorities on sleep in secure psychiatric settings and to subsequently develop associated research protocol and grant application.

Method

To achieve our study aim, we will meet up five times over a year period, communicate regularly through a series of media (e.g. face to face, Skype and email) and will:

1. Form a healthy, connected, active and responsive sleep research group that adds to the research field

The group will be diverse, have extensive experience of research in psychiatric settings and sleep research in other populations, and include inpatients with experience of sleep problems as well as carers. The group chair will use John Adair's action-centred leadership model,[4], to ensure the aim and objectives are achieved, the group is motivated and maintained, and group members are supported in meeting development needs aligned to the overall aim. Terms of reference for the group will also be agreed; the group will visit and meet teams in secure inpatient settings at Ridgeway Psychiatric Hospital and the sleep lab at the University of York. The group will also network with others in the field and strengthen links with a Dutch research team studying sleep and violence in the forensic setting which issued the invitation to collaborate with them in this sleep symposium. Further networking is planned. Social media (#forensicsleepresearch) and communications capability of the group will be developed to communicate the progress of the group and to develop further partnerships. Depending on the agreed research questions, additional people may be involved such as pharmacists and allied health professionals.

2. Systematically review relevant sleep literature

The review question(s) will be agreed by the group. Specific group members will be tasked with designing and undertaking the review that will inform the proposal and strengthen the grant application.

3. Clarify the research question and sub-questions

The group will utilise findings from the literature review, research suggestions from the sleep conference held in January 2019, information obtained through consultation, the experience of group members and knowledge of current research in other centres to identify the research question.

4. Involve key stakeholders including service-users, carers and clinicians

The group will agree a strategy for involving individuals and groups who can help to refine the research question and shape the development of the proposal. Specific involvement tasks will be assigned to group members. Service users and carers from the forensic directorate are now members of the group.

5. Identify an appropriate funding stream

The group will identify the most appropriate funding stream using intelligence from academic partners and advice from Tees, Esk & Wear Valleys NHS Foundation Trust Research & Development Team and the National Institute for Health Research, research design service. An NIHR RDS advisor suggested that we considering Research for Patient Benefit funding for a feasibility study prior to seeking a larger grant for a multi-site study.

6. Explore the feasibility of measuring sleep objectively and subjectively in a forensic setting

The challenge of measuring sleep in a secure environment was highlighted at the sleep conference held in January 2019. Discussions with the psychiatric hospital security team, senior managers, service users and clinicians, will be essential in addressing the theoretical feasibility of undertaking a study involving the measurement of sleep among forensic inpatients. Review of relevant literature and lessons from other settings will also inform this element.

7. Develop a research proposal for a feasibility study and complete a grant application

All members of the forensic sleep research group will contribute to the research protocol, ethics and grant application and research documentation. However the two clinicians will obtain necessary ethics approvals. Statistics, patient and public involvement (PPI), intellectual property and data storage and management advice will be given from appropriate groups. The sponsors for this study will be Tees, Esk & Wear Valleys NHS Trust and the University of York and the grant application will be completed by members of the Forensic Sleep Group.

Discussion

We expect our study will i) identify the current literature and research gaps in the forensic sleep field, ii) increase awareness and explore the feasibility and acceptability of how to measure sleep subjectively (e.g. self-report, nightly electronic observations) and objectively (e.g. networked Fitbits, actigraphy) in a secure psychiatric hospital setting, and iii) bring together a connected, active and responsive research group that develops a thorough understanding of the forensic sleep field in order to conduct research. Sleep as a protective factor, ward design and night time protocols around observation are potential areas of interest. However, we expect that our research group will focus on developing a feasibility study of an evidence-based intervention to improve sleep in secure psychiatric settings, which if deemed feasible, will be piloted as part of a future randomised controlled trial. The ultimate potential impact of this study will help improve sleep in secure psychiatric populations, increase patient motivation for physical and psychological treatments and reduce length of stay.

Acknowledgements

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Correspondence

Email: jon.carey@nhs.net

The Gray Zone in Forensic Mental Health Practices: A Delphi Study and a National Survey

Paper

Akihiro Shiina (Japan)

keywords: Forensic Mental Health, Administrative Involuntary Hospitalization, Criminal Responsibility, Mental Health and Welfare Act, Delphi Study, National Survey in Japan

Introduction and/or Background

The manner of dealing with offenders with mental disorders is a source of debate. Many developed countries have a diverse system for offenders with mental disorders. Thus, people who have committed crimes in a state of insanity are not punished, instead, they are sent to a psychiatric hospital to reduce recidivism.

According to many experts, however, it is often difficult to distinguish the offense caused by psychiatric illnesses and those caused by the person's free will.

In 2017 in Japan, a man who had been working in a facility for disabled people intruded into the facility and killed 19 residents and injured 27. This incident, the so-called "*Sagamihara Massacre case*," was identified as the worst crime committed by a single person after WWII. The defendant had a twisted ideology that disabled people did not deserve to survive. On the other hand, he had been hospitalized by the prefectural governor's order just a few months before the massacre, with a diagnosis of psychosis. This case remains under trial.

After investigating the case, the government published an official report. In this paper, the term "*Gray-zone cases*" is defined as people whose criminal acts are thought to be caused by psychiatric illness. In this study, psychiatric practitioners, and the police, were encouraged to understand the nature and characteristics of the '*gray-zone cases*'. Experts of forensic mental health in Japan have a consensus that the gray-zone cases have risks of recidivism, and collaboration between medical practitioners and other sectors such as the police and probation office are needed for proper treatment. However, many gray-zone cases are so complicated that many practitioners are often confused when standing in front of each case because of their lack of knowledge and experience.

The main study

This study was composed of two phases. In phase one, we attempted to create a series of case reports each of which were recognized as a gray-zone case. In phase two, we gathered the opinion of designated psychiatrists regarding how they would treat each gray-zone case.

In the first step of phase one, we developed a Delphi panel composed of eleven forensic psychiatrists in Japan. We asked each of the members to submit some Vignette cases reports they believed were gray-zone cases. We then modified each case report so that the submitters could not identify each case. After this, 32 of fictional case reports were examined by the members of the Delphi panel. Each panelist answered the three questions: (1) Do you believe this case is a gray-zone case? (2) Do you believe this case should be given psychiatric treatment even if against his or her will? (3) Do you believe collaboration with a non-medical resource (e.g. police and probation office) is needed to improve this case's social prognosis? After the first round, we disclosed the answers to all panelists. Then, we had a discussion about each case and put each question once again to the panelists. Finally, we gathered data about how the panelists recognized each case.

In the second phase, we edited each case report controlling for the format of preadmission reports by the public health center. Then we delivered 4 of the all 32 cases randomly to designated physicians in Japan, requesting them to reports answers to questions on each case. The answer form included the three questions: (1) Do you believe this case meets the requirement for admission under the prefectural governor's order? (2) Do you believe this case should be given involuntary psychiatric treatment? (3) Do you believe collaboration with a non-medical resource (e.g. police and probation office) is needed to improve this case's social prognosis? We analyzed the gathered data statistically.

Conclusion and/or Discussion

As a result of the first phase, a total of 32 mock '*gray zones cases*' were constructed. Each case was examined by the panelists, and identified as realistic and valid as a gray zone case. However, their characteristics were different from each other.

We learned how Japanese psychiatrists consider which cases are '*gray zone*'. In most cases, the opinion of the psychiatrists resembled those of experts. Thus, in cases where experts had difficulty in deciding treatment, many psychiatrists also had similar difficulties. Also, they had trouble in collaborating with other sectors such as police and the prefectural government. Better understanding with each other and open-minded discussion is needed for intersectoral collaboration in the treatment of '*gray zone cases*'.

Acknowledgements

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Correspondence

Akihiro Shiina

Email: olreia@yahoo.co.jp

The influence of optimal arousal and hostile attribution bias on the effectiveness of Virtual Reality Aggression Prevention Training in forensic psychiatric patients

Poster

Linda Jansen & Sarah Van IJzendoorn (Netherlands)

Keywords: aggressive behaviour, virtual reality, forensic psychiatry, SIP model, arousal, hostile attribution bias

Abstract

Background

Many patients residing in forensic psychiatric centers have difficulties regulating their aggression. We have developed a Virtual Reality Aggression Prevention Training (VRAPT), providing virtual environments, in which patients can practice controlling their aggressive behaviours. Principles of VRAPT are built on the six steps of the Social Information Processing model of Crick and Dodge (1994). We assumed that patients who experienced just-high-enough arousal during VRAPT or on baseline measurements before VRAPT, would show a significant decrease on (reactive) aggression, impulsivity and hostility. Secondly, we assumed that patients who showed a low level of hostile attribution bias (HAB) would show a significant decrease on (reactive) aggression after VRAPT compared to patients with a high level of HAB. Finally, we expected that practicing with facial recognition during VRAPT causes a decrease of HAB.

Methods

Four forensic psychiatric centers in the Netherlands participated in this study. The primary outcome was level of aggressive behaviour, consisting of staff-reported and self-reported measures. Secondary outcomes were self-reported impulsivity and hostility. Arousal was measured with self-report and with physiological measurements. HAB was measured with a computer task.

Results

A significant decrease on the self-report of reactive aggression after VRAPT training was found, but no decrease of aggression measured by staff with the observation scale (SDAS). No mediation or interaction effect was found on arousal on the association

between reactive aggression pre- and post-test. We found no significant decrease on impulsivity and hostility and no effect of arousal as a covariate. The HAB results are expected in August and will be included on the poster.

Discussion

The decrease of reactive aggression was in line with our expectations, but we have no evidence that this result can be attributed to VRAPT. Most results were not in line with our expectations. This can mean that our theory-driven hypothesis must be rejected, but can also be the result of a lack of power or other limitations. Future research is recommended to clarify if VRAPT is effective and to better understand the role of arousal in this process. The HAB results are expected in August and will be included on the poster.

2 Educational Goals

1. To inform people about a new method of aggression treatment using virtual reality
2. To provoke a discussion about the influence of optimal arousal and hostile attribution bias on aggression treatment

Correspondence

Email: linda.jansen@fivoor.nl

Implementing aggression registration in forensic psychiatric care

Poster

Leen Cappon, Manon Heyndrickx, Frank Van Steenkiste & Femke Hanssens (Belgium)

Keywords: systematic registration, aggressive incidents, preconditions for implementation

Abstract

Available research emphasizes the importance of getting a systematic overview of inpatient aggression in forensic psychiatric care, given the impact on the ward climate. However, the same research does not focus on how systematic aggression registration should be introduced in clinical practice. Therefore, the aim of this study is twofold: (1) investigating how the implementation of a systematic observation instrument (i.e., Modified Overt Aggression Scale) is experienced and (2) identifying the necessary preconditions for successful implementation in clinical practice.

Both research objectives are examined by interviewing staff members of a high security forensic unit for women at two points in time (six months and two years after the introduction of the MOAS). The interviews were structured based on: (1) introduction of the MOAS at the unit (June 2016), (2) the process and evolution of using the MOAS and (3) and expectations towards the future use of the MOAS. A focus group was organised in order to follow up on the experiences of staff members with the MOAS, in terms of its use and relevance.

The results describe three main themes: (1) recognizing and reducing barriers to create the right context for implementation, (2) relevance of the MOAS and (3) embedding the MOAS in clinical practice. Systematic aggression registration has proven its value and requires an institution to reflect on aggression management and create a positive group living climate. At the end, three preconditions, supported by staff members, are discussed.

2 Educational Goals

1. Gain insight into the preconditions for successful implementation of a systematic aggression registration tool
2. Understand guidelines on keeping the registration going

Correspondence

Email: leen.cappon@fracarita.org

Characteristics of aggressive behavior and impact on ward climate at a high risk forensic unit for females

Poster

Manon Heyndrickx, Leen Cappon, Frank Van Steenkiste & Femke Hanssens (Belgium)

Keywords: aggressive behaviour, characteristics, forensic psychiatry

Abstract

Although aggression is stated to be prevalent in forensic psychiatry, it is not yet systematically registered in most institutions. However, registration is crucial if one wants to adapt and evaluate treatment as well as improve the ward climate. Therefore, the goal of this research was to provide detailed information about the aggressive behavior in a group of high-risk female forensic inpatients based on systematic registration using the Modified Overt Aggression Scale. The aggressive behavior of a group of high-risk female patients was registered during the first two and a half years of the unit. Results show aggression to be highly prevalent in the sample. Furthermore, a small group of patients was responsible for the majority of the aggressive incidents. During group discussions about the ward climate, the patients indicate that aggressive behavior negatively affects the group climate. It thus appears crucial to register both the perceived ward climate and the aggressive incidents if one wants to gain full insight into the complex interactions between aggressive behavior and ward climate.

2 Educational Goals

1. Gaining insights into the characteristics of aggressive behaviour
2. Understand, using examples, how to analyse data from systematic aggression registration

Correspondence

Email: manon.heyndrickx@fracarita.org

Chapter 14 – Specific populations: intellectually disabled / learning disabilities

The relationship of behavioral symptoms in autism spectrum disorders with types of parental education in the family

Poster

Severin Grechany & Elena Lyakso (Russia)

Keywords: autism spectrum disorders, behavior disorders, types of improper upbringing

Abstract

Background

Behavioral manifestations in autism spectrum disorders include a wide cluster of symptoms, some of which appear to be the result of the underlying disease, others due to comorbidity, and others - the reaction of the autistic child to adults and educational requirements.

The aim of the study is to find out which behavioral manifestations of autism spectrum disorders are associated with certain types of parental education and with other symptoms of autism.

Methods

93 patients diagnosed under Pervasive Developmental Disorders (F 84) aged 2–17 years, 68 males and 25 females whose parents complained of behavioral abnormalities were examined using The Autism Treatment Evaluation Scale, The Nisonger Child Behavior Rating Form, Family Relationship Analysis.

Results

The largest number of significant correlations is between the ritual behavior (“*Self-isolation/Ritualistic*” scale) and such manifestations of autism as “*Sensory skills and cognitive abilities*” ($\rho=0.547$), “*Health, physical health, behavior*” ($\rho=0.425$) and “*Socialization*” ($\rho=0.453$). The scale “*Self-isolation/ Ritualistic*” had no significant interrelations with types of education. It can be assumed that ritual behavior is directly related to the manifestations of autism and depends little on the educational attitude of the parents. Behavioral disturbance (“*Insecure/Anxious*” scale) inversely correlated with the “*Speech, language, and communication*” scale ($\rho=-0.419$).

Thus, the higher communicative and speech activity of the child was, as a rule, associated with anxiety and arousal. The scale “*Conduct problems*” had a significant correlation with such educational characteristics as “*Projection on a child of its own undesirable qualities*” ($\rho=0.524$). The most significant correlations were found between the “*Self-Injury/Stereotypic*” behavioral scale and the scales: “*Hypoprotection*” ($\rho=0.420$), “*Indulgence*” ($\rho=0.408$), and “*Underdevelopment of the parent feelings*” ($\rho=0.445$). That is, self-harm and stereotypical actions of patients, having, as a rule, demonstrative and manipulative components, are realized in conditions of parental confusion and ignorance of effective methods of influencing a child.

Conclusion

The data obtained allow us to recommend the following: when protesting and destructive behavior requires an explanatory conversation with parents, aimed at understanding the motives of the child’s behavior. It is necessary to change the attitude towards destructive behavior. It is necessary to find effective ways of positively impacting the child. The assessment of the level of speech development and the communicative nature of an autistic child should depend on the behavioral context.

This research is supported by the Russian Science Foundation (project No. 18-18-00063).

Educational Goals

1. To better understand behavioral symptoms in autism spectrum disorders
2. To correct improper upbringing in case of autism spectrum disorders

Correspondence

Mr. Severin Grechanyi
Email: svgrechany@mail.ru

Causes of challenging behaviour: attributions and attributional styles of support staff

Paper

Petri Embregts, Kim van den Bogaard & Henk Nijman (Netherlands)

Keywords: Challenging behaviour, attributions, attributional styles, perspective of support staff

Abstract

Introduction

People with ID are at greater risk for showing challenging behaviour. Challenging behaviour (CB) is often seen as the product of interaction between the person showing the CB and the environment (Banks et al., 2007). Attributions (i.e., causes) and attributional styles of CB are likely to shape one's behaviour regarding CB. In this study we compared the attributions and attributional styles of support staff working with people with mild intellectual disabilities (MID) or borderline intellectual functioning for aggressive, self-injurious and harmful sexual behaviors.

Method

Support staff members were interviewed using a semi-structured interview schedule. In this schedule support staff were asked to describe three incidents regarding the three types of CB, which they remembered most. The interviews were analyzed using the Leeds Attributional Coding System (Munton et al., 1988). The LACS differentiates five attributional dimensions: stable-unstable; global-specific; intern-extern; personal-universal; controllable-uncontrollable. The attributional styles (i.e., the patterns on these five attributional dimensions) were also analyzed.

Results

A total of 19 support staff members were interviewed about incidents of three types of CB. Support staff mostly mentioned clients as the cause of all three types of CB. The scores on the attributional dimensions global/specific and internal/external are similar for all three types of CB. The scores on the stable/unstable, personal/universal, and controllable/uncontrollable attributional dimensions differed between aggressive behaviour, SIB, and HSB. Four attributional styles differed significantly between the three types of CB.

Discussion

The results indicate that the attributions and attributional styles for the three types of CB from the perspective of support staff differ. For support staff to understand their own attributions and related behavior, and more specific what their influence it has on the existence and maintenance of CB, can help them to react in a more effective way to prevent CB in future.

2 Educational Goals

1. People will understand the added value of comparing the causes of three types of challenging behaviour
2. People will understand what attributions and attributional styles are and in what way this relates to behavior

Correspondence

Email: p.j.c.m.embregts@uvt.nl

Causes of aggressive behavior: attributions of people with a mild intellectual disability in a forensic psychiatric setting

Paper

Kim van den Bogaard & Petri Embregts (Netherlands)

Keywords: Aggressive behavior, attributions, mild intellectual disability, client perspective, forensic psychiatry

Abstract

Introduction

People with a mild intellectual disability (MID; IQ 50-70) and people with borderline intellectual functioning (BIF; IQ 70-85) who receive care within a forensic psychiatric setting, often display challenging behavior (CB), like aggressive or self-injurious behavior. Causes of CB research mostly focusses on the perspective of support staff, while CB is often seen as the result of an interaction between the person showing CB and its environment (Banks et al., 2007). It is thus, valuable to also examine the views of people with MID and BIF regarding the causes of CB.

The present project, financed by Quality of Forensic Care, consists of two studies. In the first study a systematic review will be conducted to synthesize the evidence on the attributions people with ID have concerning their own or other clients' CB. In the second study people with MID or BIF will be interviewed to investigate the causes of aggressive behavior based on their perspective.

Method

Study 1

A systematic review of qualitative studies was executed using six databases. Studies focusing on people with ID who reported on attributions of their own or other clients' actual CB were included.

Study 2

Four semi-structured group interviews were conducted with people with MID or BIF within a forensic psychiatric setting. The group interviews consisted of three themes: 1) Antecedent of CB; 2) Characteristics of CB; and 3) Consequences of CB.

The group interviews were analyzed using the Leeds Attributional Coding System (Munton et al., 1988).

Results

Study 1

The systematic review resulted in 12, 882 studies of which 10 studies were included. In these ten studies four different types of CB were apparent: aggressive behavior, self-injurious behavior, criminal behavior and other behavior. The participants mentioned three different factors as potential causes of CB: interpersonal factors (e.g., interaction with support staff), environmental factors (e.g., characteristics of the ward) and intrapersonal factors (e.g., experience emotions). The causes mentioned differed per type of CB.

Study 2

In the group interviews participants gave 127 attributions regarding aggressive behavior, related to interpersonal, environmental and intrapersonal factors. The causes participants gave were almost equally attributed to their environment and themselves. Aggressive behavior was attributed as unstable, internal and personal. If the client was mentioned as causing aggressive behavior, this was mostly attributed to global and uncontrollable causes. If their environment was mentioned as causing aggressive behavior, this was mostly attributed as specific and controllable.

Discussion

Based on the systematic review it can be concluded that the perspective of people with MID or BIF regarding the causes of CB is often not taken into account. Both studies do however show the added value of incorporating the views of people with MID or BIF regarding CB. More insight from the perspective of this population can help support staff to attune support and treatment to their wishes and needs and can help people with MID or BIF to improve their understanding of their own behavior.

2 Educational Goal

1. People will understand the added value of asking clients about their perspective regarding the causes of CB
2. People will understand what attributions and their causal dimensions are and in what way attributions relate to behavior

Correspondence

Email: k.j.h.m.vdnbogaard@uvt.nl

Victimisation and Criminality of Individuals with Intellectual Disability: A Qualitative Research on a Dutch Perspective

Paper

Amber Averens, Ann-Sophie Haspel & Elizabeth Wiese-Batista Pinto (Netherlands)

Keywords: Intellectual Disability; Victimisation; Criminality; Criminal Justice System

Background

Over the last decades, limited attention has been given to the study of individuals with Intellectual Disability (ID) that have contact with the Dutch criminal justice system (CJS), as victims or offenders. Since this population is highly present in the CJS, it is relevant to conduct studies, in order to understand their situation and to develop preventive measures to decrease risks of victimisation and criminal behaviour.

Aims

Two pieces of research were developed with the following goals: 1. to provide an overview of the current international literature on vulnerabilities, characteristics and behaviour of victims and offenders with mild to moderate ID, and their position in the Dutch criminal justice system; 2. to conduct interviews with specialised professionals, working in the Netherlands, who had contact with victims and/or offenders with ID, in order to understand the present situation; 3. to provide indications for the development of preventive measures to decrease risks of victimisation and reduce criminal behaviour in that population.

Method

Internationally and Dutch focused literature of the past 20 years was investigated thoroughly, in relation to victimisation and criminal behaviour of people with ID. Additionally, 8 semi-structured interviews with professionals, from the fields of psychology, coaching, management and law, and whose jobs were related to this population, were conducted. The interviews were recorded, transcribed and analysed using qualitative methods.

Results

The literature review indicated that some cognitive, psychological and social characteristics make people with ID exceptionally vulnerable to being victims of crime or being criminal offenders. Within the Netherlands, offenders with ID are highly overrepresented in the prison population, and victimisation of individuals with ID occurs more frequently compared to the general population. People with ID may experience difficulties in navigating the Dutch CJS, often due to the failure of professionals in detecting the victim's/offender's limitations. The analysis of the interviews tended to be in line with the literature findings. A list of suggestions for preventive measures for that population was created and presented.

Conclusion

More research should be done to obtain more precise prevalence rates of victims/offenders with ID in the Netherlands. This would also aid in creating awareness for this group, which is often lacking. Furthermore, structural changes in the CJS are needed in order to aid individuals with ID who are brought into contact with it, including the training of professionals to support this population in every step of the process.

Educational Goals

1. To provide the development of knowledge of international research on the victimisation of people with Intellectual Disability (ID);
2. To provide the development of knowledge of international research on the criminal behaviour of people with ID;
3. To provide the development of knowledge on the situation of people with ID who are brought in contact with the Dutch Criminal Justice System;
4. To be stimulated to reflect on preventive measures in relation to victimisation and criminal behaviour of people with ID.

Correspondence

Email: amber.averens@gmail.com

Adaptive functioning and risk management in (forensic) patients with mild intellectual disabilities or borderline intellectual functioning

Paper

Henk Nijman, Diana Polhuis & Femke Jonker (Netherlands)

Keywords: aggression, adaptive functioning, mild intellectual disabilities, risk management

Abstract

In this presentation the results are described of an empirical study in which, among others, the psychometric properties of a relatively new instrument to assess the level of adaptive functioning of patients with Mild or Borderline Intellectual disabilities (IQ in the range of 50-85) are investigated. This instrument, which is called the the '*Adaptieve Vragenlijst Verstandelijk Beperking*' (AVVB; Jonker, Goedhard, Kruisdijk & Nijman, 2016) in Dutch, exists of 65 items which assess various commonly needed skills to function independently. Besides that, the associations were studied between the level of adaptive functioning (as assessed with the AVVB) and the level of emotional functioning (as assessed with the SEO-R2 of Morisse & Dosen, 2016) with (proxy) measures of recidivism risks. These proxy measures of recidivism risks were: 1) recent risk assessment scores of the included patients (i.e., HKT-R, HCR-20v3 and / or the DROS) and 2) information about aggressive incidents and indicators of relapse during the last two years of treatment.

In total, data were collected concerning 157 patients (130 males and 27 females) residing in ten Dutch institutions. The average IQ of the included patients was 68.8. The interrater reliability of the AVVB total score was found to be fair-to-good (0.77) and the internal consistency of the instrument was high (0.97). Furthermore, both the AVVB scores and the SEO-R2 scores were found to correlate with risk assessment scores in the anticipated directions, which suggests that lower levels of adaptive and emotional functioning are associated with higher recidivism risks. The AVVB and SEO-R2 scores also turned out to be correlated with the likelihood that the patient had engaged in physically aggressive behaviour during the last two years of hospitalization.

Taking these findings together, the results suggest that deficits in adaptive skills and a low level of emotional functioning go hand in hand with more (externalizing) behavioural problems and higher risks. On the basis of these findings, it is recommended to incorporate assessments of adaptive functioning and the level of emotional functioning in designing

individualized risk management plans for (forensic) psychiatric patients and clients, particularly when they have limited intellectual capacities. In the presentation our initial experiences on how this is done in practice in the Netherlands are shared on the basis of case studies.

2 Educational Goals

1. To learn about the associations between adaptive functioning, emotional functioning and IQ on the one hand, and aggressive behaviour and risk assessment scores on the other hand.
2. To learn how adaptive and emotional functioning of patients with mild intellectual disabilities can be incorporated in risk management plans.

Correspondence

Email: h.nijman@fivoor.nl

Clinical characteristics of individuals with intellectual disability in forensic psychiatric services

Poster

Hanna Edberg, Tatja Hirvikoski, Qi Chen, Henrik Larsson & Peter Andiné (Sweden)

Keywords: intellectual disability, mental retardation, disorder of intellectual development, neurodevelopmental disorder, criminal offense, forensic psychiatric assessment, pre-trial assessment

Abstract

Background

Previous literature on the prevalence of intellectual disability (ID) in forensic contexts has shown ambiguous results and little is known about the clinical characteristics of the forensic ID population compared to the general population of individuals being subject to forensic psychiatric assessment.

Methods

We conducted a population-based retrospective observational study on 8442 individuals subject to forensic pre-trial psychiatric assessment in Sweden in 1997-2013. By linking to several Swedish national registers we conducted a characterisation of individuals with ID ($n = 537$), compared with their non-ID counterparts ($n = 7905$).

Results

The prevalence of ID among individuals subject to pre-trial forensic psychiatric assessment in Sweden in 1997-2013 was 6.4%. Individuals with ID were significantly younger and less socioeconomically independent than their non-ID counterparts. Taking both clinical history and results from the forensic psychiatric assessment into consideration, individuals with ID were less frequently diagnosed with drug abuse and severe mental disorders such as psychotic or bipolar disorders. However, a similar prescription rate of antipsychotics was observed among individuals with and without ID. In addition, individuals with ID had more often been prescribed antihormonal treatments that can be used for sexual disorders. This finding was not evidently correlated to a higher prevalence of sexual disorders in clinical history or during the forensic psychiatric assessment.

Conclusion

The prevalence of ID among pre-trial individuals being subject to forensic psychiatric assessment was about twice as high as assumed in the general population. Individuals with ID were sociodemographically more vulnerable than their non-ID counterparts. Remaining challenges in the clinical management of individuals with ID were indicated by the discrepancy between incidence of psychiatric diagnoses and pharmacological treatment patterns. Structured diagnostic assessments and adequate treatment programs are crucial in order to improve health and prevent criminal recidivism.

2 Educational Goals

1. Enhance knowledge about clinical characteristics of individuals with intellectual disability who commit criminal offences, which can guide psychiatric and/or forensic psychiatric treatment programs
2. Raise awareness regarding sociodemographic differences between pre-trial individuals with and without intellectual disability, in order to improve risk assessments

Correspondence

Email: hanna.edberg@sll.se

Chapter 15 – Specific populations: elderly / dementia

Cannabinoids for the Treatment of Neuropsychiatric Symptoms of Dementia: A Systematic Review & Meta-Analysis

Poster

Anees Bahji, Arthi Chinna Meyyappan & Emily Hawken (Canada):

Keywords: Dementia, Cannabis, Meta-Analysis, Aggression

Abstract

Background

Cumulative evidence suggests that the cannabinoid system may regulate neurodegenerative processes in dementia indicating that cannabinoids may be clinically useful in the treatment of people with dementia.

Methods

The Cochrane Library, MEDLINE, EMBASE, PsycINFO, CINAHL and PubMed databases were searched in December 2018 using combinations of the following terms: “*cannabis*”, “*THC*”, “*marijuana*”, and “*dementia*”. All randomized and quasi-randomized intervention studies assessing the effectiveness of cannabinoids for the treatment of people with dementia we considered eligible.

Results

Seven studies met the inclusion criteria. There was sufficient data to further analyze the effectiveness of cannabis for the neuropsychiatric symptoms of dementia, cognitive status, functional status, and tolerability. Overall, cannabis was well-tolerated, with few serious adverse events reported; however, there was inconsistent evidence for the effectiveness of cannabis in reducing neuropsychiatric symptoms or improving cognitive and functional status in people with dementia.

Conclusions

Currently available studies provide an interesting basis for the innovative use of cannabinoids as a therapeutic approach to dementia in older people. This review finds little evidence that cannabinoids are effective in the improvement of disturbed behaviour in dementia or in the treatment of other associated symptoms. The lack of population-based studies justifies further research, and especially, adequately powered randomized controlled trials, in order to assess the safety, efficacy, pharmacokinetics, and pharmacodynamics of cannabinoid-based drugs in this population.

2 Educational Goals

1. To apply recent evidence on the effectiveness of cannabis preparations in the management of aggression in individuals with dementia.
2. To appraise the comparative utility of different pharmacotherapeutics in the treatment of aggression in individuals with dementia.

Correspondence

Mr. Anees Bahji

Email: 0ab104@queensu.ca

Chapter 16 – Training and education of (interdisciplinary) staff

Safer Environments via Collaborative Unified Response to Emergencies (SECURE Training for Clinicians and Safety Officers)

Workshop

Diane Allen, Frank Harris & Lisa Mistler (USA)

Background:

Emergencies involving violence and aggression are becoming increasingly common in healthcare settings. It is imperative for healthcare professionals and community safety personnel to collaborate in order to develop plans and policies, conduct exercises and assure a clear, orderly and effective response during violent events that cannot be managed with clinical interventions. SECURE training was developed to bring nurses and other healthcare clinicians together with safety/law enforcement officers to plan for a unified response to emergencies involving violence and aggression in healthcare settings.

Aims

SECURE training actively engages healthcare and safety professionals in discussions aimed at fostering mutual understanding, forging collaborative relationships and developing shared strategies to prevent and mitigate violence.

Methods

The training highlights factors that contribute to violent episodes and interventions that decrease the likelihood of injury for all those involved from a clinical and safety perspective. Patient-centered, trauma-informed, recovery-oriented strategies, as well as modified law enforcement responses that have been effectively used to decrease violence in a dangerous healthcare setting are described. Decision drivers, levels of authority, roles and expectations are explored and clarified. Discussions are facilitated between clinicians and safety personnel to share knowledge, increase mutual understanding and

better prepare participants for a unified response to emergencies involving violence. An interactive conference workshop will employ strategies used to engage participants in discussion about their own challenges and successes managing violence in healthcare settings with assistance from safety officers.

Results

SECURE integrated training increases familiarity and mutual understanding of processes and decision drivers that promote a higher level of collaboration before, during and after emergencies involving violence. Evaluations and feedback from SECURE training sessions, as well as testimonials from participants, provide evidence of increased communication and collaboration between hospital clinicians and safety officers. In addition to the opportunity to establish face-to-face relationships, specific outcomes of SECURE trainings are better understanding of each other's roles and expectations, improved lines of communication and establishment of sustainable, dynamic, working relationships. Participating hospitals and law enforcement agencies are now working together to build a shared database of common measures that may be used for future research on management of violence and aggression.

Educational Goals

1. Compare and contrast aims, decision drivers and roles for clinical staff and safety personnel during emergencies involving violence in healthcare settings.
2. Identify common knowledge gaps, areas for improvement and strategies for reducing injuries during a unified clinical and law enforcement response to violence.

Correspondence

Email: safeandsecure603@gmail.com

Evaluating the effectiveness of a designed patient aggression management programme for nurses in Singapore

Paper

Kalaivanan Dakshnamoorthy, Ziqiang Li, Bee Cheng Ong, Kee Huang Ng, Hao Yin, Yanan Hu, Warric Ng & Yujun Lai (Singapore)

Keywords: Aggression Training, Patient and Staff Safety, Nurses' Perception and Attitude, Care and Response (C&R), clinical competency

Abstract

Patient aggression poses serious impact on nurses' physical, psychological and spiritual wellbeing, which may affect nurses' attitude that could influence aggression management outcomes. Aggression training was reported to improve nurses' capacity of coping and attitude towards patients' aggression. The Care & Response Programme (C&R) was designed and implemented to enhance nurses' competency in knowledge, skills and attitude in managing aggressive individuals.

This study aimed to explore nurses' knowledge, attitude and perception in patients' aggression following C&R. Post-training evaluation is crucial to ascertain the programme's relevancy and applicability. A 26 4-likert scaled Care and Response Evaluation Questionnaire (C&REQ) was developed to evaluate the gain of cognitive, skills-based and affective outcomes post-training (CVI, $n=11$; $\alpha = 0.963$, $n=16$) Five sub-domains were established by factor analysis ($\alpha=.973$, $n=305$): personal attributes (5 items), personal competency (4 items), prevention strategies (3 items), physical intervention techniques (3 items), and behavioural initiative (2 items).

A mixed method design with cross-sectional survey and phenomenological approach was adopted. Nurses who received the C&R were randomly selected to participate in an online survey ($n=338$), including the C&REQ, Attitude Towards Aggression Scale (ATAS), Impact of Patient Aggression on Carers Scale (IMPACS) and the Management of Aggression and Violence Attitude Scale (MAVAS).

Nurses reported higher satisfaction level on their knowledge, skills and attitude post C&R ($M=84.18$, $SD=10.33$, $95\%CI=$). Longer working experience predicted better C&R training outcome ($F(1, 304)=7.43$, $p=.007$). The psychological impact of aggression is greater on male ($M=2.38$, $t(303)=3.16$, $p=.002$). However, there were 15-30 % nurses reported negative attitude towards patient aggression post training.

Cultural misunderstanding and differences in attitude was reported by 17%. Some participants (40%) have guilt conscience towards patients. Semi-structured focus group interviews (n=25) was conducted by an independent party. Thematic analysis revealed seven themes: course benefits, programme curriculum, manpower, training facilities, instructors' competency, culture and attitude and translation to practice.

Findings showed that the programme was essential in improving nurses' clinical competency, promoting therapeutic attitude and perception towards patients' aggression, and enhancing clinical outcomes and overall safety. Participants perceived that this programme not only augmented their approach, it had also been integral in paving the translation of theory to practice via clinical simulation drills. This study provided evidence that the C&R competency remains paramount for all mental health providers towards managing aggression. It provided insight into the impact of C&R and added new knowledge on nurses' perception.

Future study could expand on the mechanism and enabling factors of the programme to enhance it further and have positive clinical outcomes. It is recommended to explore and expand training components to further enhance patient and staff safety.

2 Educational Goals

1. Share & exchange contextual information regarding patient aggression management in various clinical setting from differing cultures / countries.
2. Share the expected effective components of the Care & Response Programme (C&R).

Correspondence

Mr. Kalaivanan Dakshnamoorthy
Email: kalaivanan_d@imh.com.sg

The effects of training interventions on enhancing the competence of nursing staff in managing challenging patient behavior

Paper

Sirpa Tölli, Pirjo Partanen, Raija Kontio & Arja Häggman-Laitila (Finland)

(Authors: Sirpa Tölli, Raija Kontio, Pirjo Partanen, Arja Häggman-Laitila)

Keywords: aggression, behaviour management, challenging behaviour, effective interventions, patient safety, staff competence

Introduction

Nursing staff face great risks at work from violent and aggressive patients and visitors (Estryn-Behar et al., 2008; Wassell, 2009). Verbal and physical violence from patients has been shown to distress nursing staff, make them feel threatened and lead to non-somatic symptoms (Foster et al., 2007, Gates et al., 2011; Needham et al., 2005a; Waschglar et al. 2013). Furthermore, violent incidents have a negative impact on work productivity (Gates et al., 2011) and can make nursing staff want to leave their profession or workplace (Estryn-Behar et al., 2008).

In this review, patient violence and aggression is called challenging behaviour and it is defined as behaviour that “*threatens the quality of life and/or the physical safety of the individual or others and is likely to lead to responses that are restrictive, aversive or result in exclusion*” (Royal College of Psychiatrists, 2007). Challenging behaviour is a socially constructed and dynamic concept and the feelings it invokes in others can be intolerable or overwhelming. Patients may exhibit challenging behaviour because of pain, stress, lack of privacy and long waiting times (Gacki-Smith et al., 2009).

Healthcare staff have to manage challenging behaviour by using communication or by using physical or mechanical restraints to hold a patient against their will (Paterson et al., 2003). Using restraints requires nurses to balance two responsibilities, namely ethics and safety. Patients deserve to be treated with the utmost dignity, even in difficult situations, and professional nursing codes state that respect is an ethical requirement (Moynan, 2009).

Background

Restrictive interventions often make a major contribution to delays in recovery and have been linked to causing serious physical and psychological trauma to people who use healthcare services (Department of Health, 2014). Managing challenging behaviour can risk patient safety and violence has been associated with delays in completing nursing

tasks and increases in medication errors (Roche et al. 2010). The physical interventions that are used to manage aggression are known to cause injuries to patients and even restraint-related deaths have occurred (Aiken et al., 2019, Cusack et al. 2018).

Interventions that enhance staff competence in behaviour management usually include information about the types of aggression, prevention and communication and/or physical skills for behaviour management (Heckeman et al. 2015) It is generally acknowledged that effective and safe interventions are needed to manage the challenging behaviour that is generally acknowledged to occur in health care. Despite this, there is little comparable evidence available about the overall effectiveness of such interventions. There is a need for more systematic information on managing challenging behaviour, based on the standardized scales that are used for assessments. There is also a need for more research that uses versatile research designs to identify the specific aspects of training programmes that are the most effective (Wassell, 2009). These include the ethical, legal and safety aspects of managing challenging behaviour (Nelstrop et al., 2006).

Design

We carried out a systematic review, which was conducted and reported according to the guidelines of the Centre for Reviews and Dissemination (CRD, 2008) and the principles of the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) statement (CRD, 2008; Moher et al., 2009). No meta-analyses were conducted, due to the diversity of the different interventions, study designs and measurements used by the included studies. A narrative summary was chosen to describe the content of the studies due to the methodological diversity of the included studies (EPOC 2015.)

Aim and research questions

The aim of this systematic review was to identify and summarize the current knowledge and effects of training interventions for managing challenging behaviour in nursing. The research questions for this review were:

1. What kinds of training interventions have been conducted to improve the competence of nursing staff to manage challenging behaviour?
2. What kinds of measurements have been used to evaluate the competence of nursing staff to manage challenging behaviour?
3. What kind of effects do training interventions for managing challenging behaviour have on the competence of nursing staff, the rates of violent incidents and the use of restraints?

Search methods and inclusion criteria

The following databases were searched for original qualitative and quantitative papers published in English from 2005–2015: CINAHL, Scopus, PsycInfo, PubMed

and Cochrane. The key search terms were: aggression, aggressive, violent behaviour, challenging behaviour, dangerous behaviour, patient assaults, prevention, physical holding, aggression management, restraint and manual restraint. The search strategy used identical search terms for all the databases to identify titles, abstracts and keywords. Reference lists from the retrieved articles were also manually searched. A search alert in the Scopus database produced one paper from December 2015. The studies had to meet all of the following criteria to be included in this review:

1. Population: participants had to be nursing staff working in health care.
2. Intervention: the intervention had to provide training to enhance the competence of staff when they were managing challenging behaviour.
3. Comparators: the study design included systematic before and after measurements.
4. Outcomes: The study examined how training interventions affected how healthcare staff managed challenging behaviour.

Results

We included 17 studies that described and evaluated 16 different training interventions. All studies were quantitative. Two of the studies evaluated the same intervention using different scales.

The interventions were divided into four categories based on the way that the challenging behaviour was managed: communication skills (eight interventions), restrictive measures (four interventions) controlling behavioural symptoms (three interventions) and disengagement skills (one intervention) (Tölli et al. 2017).

A total of 11 scales were used in the studies to measure how competent staff were to manage challenging behaviour on their own. Five scales measured how confident staff were to cope with challenging behaviour. Three scales examined staff attitudes and perceptions of violence and what caused it and another three explored their knowledge of good practice in managing challenging behaviour. None of the scales defined how much competence needed to be developed or what constituted comprehensive competence in managing challenging behaviour. Most of the scales were fairly new when the studies were carried out and three had been developed just before the original research that was included in the review was conducted. Separate scales were used in most of the studies. (Tölli et al. 2017.)

A number of primary outcomes emerged from the evaluations of training interventions and these were: elements of competence, violent incident rates and the use of restraints. The most effective training interventions were based on communication and most of these had a significant positive impact on staff confidence. All of the studies had a low or unclear risk of bias. Weak evidence was found that training interventions reduced violent incident rates. One study reported strong evidence for the use of the use of restraints (Tölli et al. 2017).

Discussion

The top priorities for most of the interventions were preventing violence, communication skills and de-escalation techniques. Our review showed that interventions were more likely to decrease violent incident rates and increase staff confidence than change staff attitudes or increase their knowledge. Most of the evidence from this review was weak. Only four of the studies provided strong evidence and only two provided moderate evidence. Based on this review, we recommend that interventions that focus on communication and controlling challenging behaviour should be used, as they were most likely to increase staff confidence than the other interventions.

Using confidence to indicate how effective training interventions are at managing challenging behaviour is somewhat contentious. Confidence is related to how sure or unsure a staff member feels about handling an aggressive situation, but what is the optimal amount of confidence needed to manage challenging behaviour? Confidence and competence are not necessarily the same thing, which raises a question about whether training creates false confidence or whether the person's actual competence has actually increased (Stubbs, 2009). Self-confidence is not a reliable predictor of performance (Nau et al. 2011).

Surprisingly, none of these studies evaluated patient safety. Managing challenging behaviour involves interventions that a patient does not, or cannot, consent to (NICE, 2015). Any restrictive intervention should be based on an assessment that intervening is likely to cause less harm than not intervening, and the focus in the care should be on the minimization of the use of restrictive interventions (Ridley & Leitch 2019). Patient safety should be considered by any future studies that evaluate the effectiveness of any interventions used to manage challenging behaviour (NICE, 2015). That evaluation should include the reasons for any physical interventions that are being taught to healthcare staff (Nelstrop et al., 2006) as well as ethical, legal and safety issues. It is also important to note that physical interventions can lead to potential misuse or overuse in negative care cultures (Stubbs et al., 2009).

Conclusions

Various measurements were used by the studies we reviewed and this made comparing the actual effectiveness of the training interventions difficult. It is important to define an individual's competence to manage challenging behaviour and we need a comprehensive scale to evaluate their competence to manage challenging behaviour. Patient safety should be included in any future evaluations.

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Correspondence

Email: sirpa.tolli@oamk.fi

Organizational measures against violence: The aftermath of the death of an employee

Paper

Kurt Elvegård (Norway)

Keywords: Organizational measures, Work-violence, public services, psychiatry, child welfare, intellectual disability

Introduction

In 2013 an employee was brutally killed at a social service office in Norway (NAV). NAV is a short for the Norwegian Labour and Welfare Administration. NAV delivers public services such as unemployment benefit, work assessment allowance, sickness benefit, pensions, child benefit and cash-for-care benefit. After the killing an initiative against work-violence was launched in NAV (NAV 2014). The initiative focused on organisational measures. In 2017-2018 NTNU Social Research conducted a research project on this initiative (Elvegård and Gjørund 2018). Findings from this project are of high relevance for other organizations and workplaces, especially those working with the development of systemic approaches and manuals in the management of violent behaviour.

Aims and research question

The aim of this paper is to raise awareness of organizational measures against work-violence. The paper presents key findings from the aforementioned research project and makes them relevant for other organizations, work places and institutions. We are looking at what characterizes the initiative against work-violence in NAV and what others might learn from it. The research question answered in this paper was:

What are possible organizational success factors in the management of work-violence?

The paper uses the concept *work-violence*, meaning all kinds of violent behaviour against employees at work. Included are also threats of violence and acting out at the office. We did not include incidents through internet, such as harassments, hate speech or similar. Even though there might be a difference between the concepts of work-violence and managing aggressive behaviour, the measures on an organizational level could still be the same.

Methods

The methods we used were group interviews, structured telephone interview, case study and document study. To begin with we interviewed a select number of people in The Norwegian Directorate of Labour and Welfare – who was in charge of the initiative against work-violence. We also talked to NAV's most important co-partners to get their experiences. The purpose was to get an overview of the organization, the initiative and the forthcoming data collection. Later we conducted 42 structured telephone interviews with managers and employees at 22 offices spread across Norway. These people were also interviewed by NAV themselves back in 2013, and that gave us the opportunity to look at development over time.

In the case study we visited eight social service offices. In this project it was crucial to be on sight in order to see and observe how the offices were organized and handled visitors. We were shown what kind of security measures they had inserted and how these measures worked for them. We also interviewed managers and employees at these offices. The interviews focused on experiences with the different measures against work-violence. All together in the project we did 70 interviews with 100 employees at different levels in the organization.

Finally, we studied different documents: a report of measures, routine descriptions, e-learning materials, internal statistics from NAV and several others documents.

Results

Our findings can be split into three different areas: Findings related to humans in the organization, findings related to design and characteristics of the initiative and findings related to the delivery of services.

Findings related to humans in the organization

Project management and management support

The first finding that became evident early in the project was how the initiative was led and supported by higher levels in the organization. As many other projects this initiative consisted of specific work tasks, deadlines, milestones and so forth. It was characterized by a very systematic work from start to finish. A capable project management made sure that the initiative progressed. At the same time the top management in NAV was committed. The decision to prioritize work-violence came from top management and the support from them lasted throughout the project.

Recognition and legitimation of employees' needs

As a result of good project management, management support and what was done during the initiative the employees felt a greater recognition of their needs. For a long

time focus had been on service users and how to deliver good services. Now employees experienced that their needs and work situation was important. The recognition and legitimation came because of the killing of an employee. Such an incidence could not be ignored and led to an acceptance of the needs and the work situation of the employees. Today it is fully accepted to talk about their needs as employees even though their job is to help other people in difficult life situations. Recognition and legitimation seems to just as much a reason why the work against work-violence went forward as it was a result of the initiative.

The commitment from management and the feeling of recognition among employees combined seems to be important reasons why the initiative against violence and threats was met with such a positive attitude in the organization.

Findings related to design and characteristics of the initiative

Focus on routines, not individual level of tolerance

The initiative resulted in a major shift of approach in the management of work-violence. Before violent behaviour was often a matter of individual level of tolerance and experience. Now it was about common definitions and ground rules. Personal experiences still matters, but the main focus is upon routines and what kind of behaviour that is acceptable from service users. This means a shift from personal to collective responsibility. The whole matter of work-violence is lifted to an organizational level.

Generally increased focus on work-violence

Not only is the matter of work-violence lifted to another level in the organization. The general focus on work-violence is also lifted to another level of recognition and priority. Work-violence is now an area of high priority at all levels in the organization. Everyone is aware of this matter as an important part of the work. The management has this issue on their agenda employees talk about. It is mentioned in important internal and public documents. It was evident that this increased attention on work-violence in general was just as important for the employees as specific measures. This point must also be seen in relation to what has been said about recognition and legitimisation of employees' needs.

Mix of standardized and differentiated measures

The initiative consisted of several different measures. Some were measures that could be matched to local needs. Others were measures that applied to everyone in the organization. One such measure was the so called minimum standard with a set of requirements for the shaping and furnishing of the public service offices. Every office had to abide by these standards. At the same time this measure was wide enough so that each office could make their own adjustments according to local circumstances and needs. Finding common measures across so many offices, work tasks and employees is not easy. They have to be specific enough and also not too strict or fixed.

For instance, issues and challenges at a big office in a big city might be different to a small office in a rural area. The initiative had to cover a variety of situations and circumstances. NAV managed to find a good balance between standardized and differentiated measures.

Findings related to delivery of services

A good provision of general services staunches violence

Many of our informants mentioned a factor that wasn't related to the initiative itself, but rather to the whole provision of general services in the organization. They told how they had been working hard to deliver more suitable and better services, services that took into consideration the service users' needs. Better services they said, led to more satisfied service users which in its turn led to less violence and threats. This suggests that the issue of reducing work-violence has to be integrated into the overall way of working and delivering services.

Conclusion and/or Discussion

In this paper, we are focusing on the characteristics of an initiative against work-violence. The organization we have studied did not engage physically with violent people. Their work task was not to handle violent behavior, but to deliver certain public services. At other workplaces engaging violence, even by physical intervention, might be a part of the job. Therefore, comparing NAV with for example psychiatry or child welfare services is not always possible. Nevertheless, the organizational measures – or the principles for engaging with organizational measures – might be similar. It is about how to approach work-violence and what to do on an organizational level.

When it comes to findings concerning humans in the organization, they are not revolutionary. Every project needs to be governed correctly in order to make progress. What we want to emphasize is that working with work-violence is something management at higher levels should engage in. Especially if the vision is to introduce a new standard. It can be argued that managing violence and aggressive behavior is often handed over to employees and lower levels in an organization – despite the fact that employees want more engagement and support from management in these matters (McMahon et al. 2017; Tan, Lopez and Cleary 2015). Also, the fact that barriers for change often is related to issues on an organizational level (Spector, Revolta and Orrell 2016), should raise awareness for organizational factors and measures in the management of work-violence and aggressive behavior. Still, a study of 12 training programs in the US showed that no one had organizational measures as part of the repertoire (Arbury, Zankowski, Lipscomb and Hodgson 2017). As far as we are concerned this is the situation in Norway and many other countries as well.

Our conclusion is that we see a development over time in which employees not only accept recognition of their needs, but they will demand such recognition. This applies for many different organizations, work places and institutions. People tend to accept violence and poor work conditions less in the future. The same attention we believe will be seen considering the treatment of service users and patients. In other words; violent behavior from whoever is less and less accepted in our society today. This is something we all should take into consideration.

Overall, whether we talk about the needs or rights of the employee or those we deliver services to, we will have to realize that a higher level of focus on violence in general is coming. Workplaces that are dealing with violence and aggressive behavior must be able to heighten the focus on management on these matters at a general basis that influence the whole way of working. Specific measures are important. A rise of an overall focus on violence is just as important. The task will be on heightening the focus, not only introducing measures one by one. The implication is that measures upon measures are not enough; you have to be able to get the feeling and evidence of work-violence are being taken seriously on a day to day basis. From our point of view, doing this makes it easier if we shift the focus from individual preferences, experiences and opinions about violent behavior, to an organizational question of what to accept and what to do about behavior that is not acceptable.

Furthermore, an implication of our findings is that an organizations must figure out what kind of measures that are going to be standardized and which to be differentiated. Is it an idea for all other areas, whether it is psychiatry, schools, child welfare or others, to have some kind of minimum standards in order to deal better with aggressive behavior? The question for top management will be where to start, what kind of measures to introduce. Maybe this will be one of the most difficult questions in an attempt to do something on an organizational level.

Good news from our study is that good services staunch violence. We don't claim that this is something new, but maybe we can say that this is a difficult spot as well. It might demand that we look at our attitude towards the human beings we deliver service to in hospitals, institutions, group homes, class rooms and others places. Maybe we can start by asking: What is really the main service at our workplace? And in what way can we deliver services that make the service users more satisfied, at the same time as we acknowledge the personnel working with them? The last question here can partly be answered by looking at some possible organizational success factors or measures mentioned in this paper.

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Correspondence

Email: kurt.elvegaard@samfunn.ntnu.no

Empowerment and increased recognition of “feminized” skills in community mental health services following competence-development

Paper

Erlend Rinke Maagerø-Bangstad (Norway)

Keywords: Community mental health services, collaboration, education, competence, practice

Abstract

Since 2016, a qualitative research project investigating the contribution of education and application of tools on staffs' competence and practices toward potentially aggressive service-users in non-institutional mental health settings in Oslo has been undertaken. This is a presentation reporting of our findings with particular significance for the collaboration between community mental health services and psychiatric services.

In Norway, traditionally, there has been a clear delineation between institutionalized treatment and home-based care for people with mental health problems, the first being the psychiatric services' responsibility and the latter being the responsibility of municipal mental health services. Although, structured professional judgement of risk has been increasingly implemented in psychiatry, actuarial methods still enjoys a hegemonic standing in the prevention and management of aggression. Schön's (1991) near classical description of “*high-ground*” technical rationality as consisting of solvable technical and theoretical problems can be seen as a potent imagery of such practices, historically associated with the biomedical model and ideals of masculinity. The “*swampy lowlands*” of messy and confusing problems defying technical solution, of which human life and human interaction is full, and to which he himself allotted most importance, is often associated with “*feminine*”, tacit, contextual and relational skills, and as such disregarded as unscientific and unreliable. Baines (2004) and Godin (2004) have shown community based caring work being primarily committed to the latter view of practice.

Two studies have been completed, exploring respectively practitioners' conceptions of prevention and management practice in aggressive encounters with service users (Maagerø-Bangstad, Sælør, Ness, 2019), and leaders of mental health and substance abuse services' perceptions of impact from competence development activities (unpublished) on staff and services. Our findings indicate that increased insight into formal, actuarial methods and vocabulary contributed to empowering collaboration with

specialist mental health services and in bolstering confidence in and promotion of the practitioners' close, contextualized and life-world sensitive knowledge of the service user. This again allowed for perspectives closer to the service user being included in risk and management assessments. In addition to experiencing being more recognised as skilled and valuable collaborative partners by the psychiatric services, we found that the most elaborate conceptions of practice among practitioners entailed what can be seen as a *'baseline'* of formal, evidence-based risk assessment and management knowledge, complemented with personal, experience and communally based relational strategies and skills.

Based on our findings, we argue education and the promotion of shared understanding to be one way to promote a more apposite practice in prevention and managing violence and aggression in mental health. The *"masculine-feminine"*-dichotomy of practice, might for educational purposes serve as a pragmatic heuristic device in this regard.

2 Educational Goals

1. Aquisition of aspects of community mental health practices in encounters with staff-directed aggression and violence
2. Insight into obstacles for between service-levels collaboration and strategies to overcome these

Correspondence

Email: erlend.rinke.maagero-bangstad@usn.no

MAP (Management of aggression problems) - a step towards a Norwegian standard regarding staff training programs

Paper

Thomas Nag & Gunnar Eidhammer (Norway)

Keywords: Staff training, standardization, collaboration, MAP

Abstract

Since 2014, extensive work has been done to prepare a new Norwegian staff training program for the prevention and management of aggression and violence. This project has been named MAP (Management of Aggression Problems). The purpose of the project has been to prepare a standardized, evidence-based and quality-assured training of employees related to this problem. MAP is a collaborative project between the SIFER network, the three regional high security forensic units, Helse Stavanger and Helse Fonna.

MAP consists of ten chapters that can be communicated as a whole (the basic course) or communicated as an individual, independent module.

MAP is a program that aims to give the staff a comprehensive framework for how to understand, prevent and manage aggressive situations in a caring and safe manner. MAP has a strong ethical foundation where attitudes such as empathy, equality and respect are central concepts in our philosophy of effective violence prevention and management. MAP has recently been completed, and the staff training program will be implemented in Norway this autumn.

2 Educational Goals

Learning objectives:

1. To understand the Norwegian staff training program 'MAP'
2. To understand the methodology behind the program

Correspondence

Mr. Thomas Nag
Email: tasn@helse-bergen.no

Evaluation of staff training in de-escalation - a cluster randomized controlled trial

Paper

Thomas Nag & Bente Sundby (Norway)

Keywords: Staff training, RCT, de-escalation, evaluation

Abstract

More and more employees in Norway are subjected to violence and threats of violence in the workplace (Arbeidstilsynet, 2016). 6.3% of all working persons state that they have been subjected to violence or threats of violence. Health and social services are among the most vulnerable industries with an incidence of violence and threats of 17% (Factbook on working environment and health, 2011, NOA). Health workers who work within mental health are among the people most often exposed to violence and threats in the workplace (Kunnskapssenteret, 2015).

Violence poses a significant challenge for health workers and patients in mental health care (Lowe et al. 2003, Bowers 2006, Lauvrud et al. 2009, Martin & Daffern 2006, Nicholls et al. 2009).

Since late 2014, a national Norwegian collaboration project has been going on which aims to standardize, evidence-based and quality-assured training in prevention and management of aggression and violence in mental health care (MAP-model).

Much time and resources are used for this type of training, and it is of course desirable to gain knowledge about whether and how this type of program affects the participants. Despite the weak evidence of this type of training program, researchers and experts recommend that this type of training is clearly needed (Nice, 2005; Richter et al., 2006). They suggest that the question should not be whether this type of exercise should be offered, but whether the chosen training is appropriate and effective (Zarola and Leather, 2006).

De-escalation is a key competence in relation to the prevention of violence. De-escalation is an professional action tailored to the situation, the patient and the environment, which is performed by healthcare professionals with special knowledge.

It is a method of averting immediate danger, gradually leading a patient to a calmer mental and physical condition (Berring, 2015).

Despite the fact that de-escalation techniques are recommended as first response in the management of aggression, the use of more invasive, risky approaches persists. Research from the patient perspective clearly emphasizes that patients want to be met by employees with good de-escalating skills (Price et al., 2017).

The purpose of the study is to evaluate one of the chapters of the new Norwegian staff training manual (MAP). The chapter that is selected to be evaluated is the chapter on de-escalation. Effective training in this topic should not only lead to changes in the level of knowledge and attitudes, but also changes in behavior and skills (Nau et al., 2009). Experiencing better preparedness does not necessarily entail a change in behavior.

This study seeks to test whether training in de-escalation changes the participants' skills and experience of self-confidence, security and coping in threatening situations.

2 Educational Goals

Learning objectives:

1. To understand preliminary results from this study
2. To reflect on different methodological issues regarding this study

Correspondence

Mr. Thomas Nag

Email: tasn@helse-bergen.no

Can health professionals be a source of aggression? Reflection about self regulation

Paper

Lone Viste & Kjell Kjaervik (Norway)

Keywords: Self regulation, stress, triggers

Abstract

Since 2014, extensive work has been done to prepare a new Norwegian staff training program for the prevention and management of aggression and violence. This project is called MAP (Management of Aggression problems). The purpose of the project is to prepare a standardized, evidence-based and quality-assured training of employees related to the prevention and management of aggression and violence. MAP is a collaborative project between the SIFER network, the three regional high security forensic units, Helse Stavanger and Helse Fonna.

This new model contains a whole module focusing on the importance of self regulation. MAP considers staff self-regulation as an undervalued, key component regarding prevention and management of aggression.

We are biologically programmed to respond in three ways when facing threatening situations; fight, flight and freeze. These are natural responses from an evolutionary perspective, but they are not necessarily suitable in our context where we are expected to meet patients with mental illnesses and prevent and reduce aggression (Harris, 2018).

A therapeutic encounter with aggression is therefore demanding. We need mechanisms to counteract the biological programming. We should be able to tolerate the uncomfortable feelings of the other human being, we should remain calm and at the same time try to say and do something that can help the other person to become calmer.

Stress can narrow the cognition and enhance access to good alternatives (Harris, 2018). If you are unable to maintain professionalism and are conscious of your opportunities and options to action, the situation will soon lead to chaos and coincidence. Emotions are contagious, and your own stress and discomfort can easily contaminate the interaction. Effective conflict management begins with one's self - one must have control of oneself to have control of the situation.

2 Educational Goals

Learning objectives:

1. To learn principles of self regulation
2. To learn concrete exercises which can assist with self regulation

Correspondence

Email: lone.viste@sus.no

Restraint position - which one is the best?

Workshop

Torill Fotland, Marius Engen, Thor Egil Holtskog & Gunilla Hansen (Norway)

Keywords: Restraint position, physical techniques, standardization, MAP

Abstract

There is a broad international consensus that where any form of coercion is used, preference should be given to the least restrictive and least dangerous measure. Physical restraint is sometimes used as a discrete intervention, separate to the use of other coercive interventions such as mechanical restraint, enforced medication and seclusion, but where such options are available restraint will almost invariably be used to facilitate their application. Coercive interventions exist in a dynamic clinical context, where the availability of one intervention may have an impact on the frequency and nature of another (Sethi et.al, 2018).

Since 2014, extensive work has been done to prepare a new Norwegian staff training program for the prevention and management of aggression and violence. This project is named MAP (Management of Aggression problems). The purpose of the project is to prepare a standardized, evidence-based and quality-assured training for employees related to the problem of prevention and management of violence. MAP is a collaborative project between the SIFER network, the three regional high security forensic units, Helse Stavanger and Helse Fonna.

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 was facilitated resulting in a common repertoire of physical techniques between the 5 different staff training programs.

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.

Conclusions: A standardization of physical techniques in a mental Health setting has implications both clinically and organizationally, but first and foremost; it results in a system where patient and 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 others' techniques to the common good of the patient.

The workshop will consist of an introduction to the new MAP-model, and the methodological approach of achieving a collaborative portfolio of techniques. The latter part of the workshop will consist of participants trying out the two different restraint techniques. The participants will also be asked to evaluate them.

2 Educational Goals

1. The participants will better understand a methodology of how to evaluate physical techniques in a mental Health context
2. The participants will have the opportunity to experience two different restraint positions and rate them

Correspondence

Mr. Torill Fotland

Email: tosf@helse-fonna.no

Safety and security – a training programme for employees working in youth residential care in Norway

Workshop

Marte Katrine Weng, Daniel Lund & Robin Karlsen (Norway)

Keywords: Verbal skills, de-escalation, safety training, conflict management, understanding anger, stress regulation

Abstract

We are presenting a workshop where we introduce our 13 professional recommendations for the “*preventing and managing conflicts in child welfare institutions*”.

The purpose is to ensure safer practice for both employees and youths. We will also present some results that have been reported back to us, from institutions that have completed the training programme and started training locally.

One of the main focuses during the training programme is for employees to be aware of their own stress, how that affects conflict management, and how verbal skills may de-escalate a conflict, and thereby reduce the risk of physical interventions.

We will present one of our models and connect it to one of our scenario exercises, the “*green/red*”. This exercise focusses mainly on verbal communication skills, and how that may reduce the risk of physical intervention, preventing conflicts with high risk, and how they contribute to increasing safety for youths and employees in residential care. We will engage our audience with the “*green/red*” scenario exercise to practice verbal communication skills, and how we use verbal skills to de-escalate a situation.

2 Educational Goals

1. The participants will experience how their own stress affects them, and how they regulate themselves in stressful situations by participating in different exercises.
2. The participants will practice verbal skills, and may experience for themselves how verbal skills may increase or de-escalate a verbal conflict.

Correspondence

Email: marte.katrine.weng@bufetat.no

Education at the point of care: Building facilitation capacity among clinical staff and service users

Paper

Asha Maharaj, Faisal Islam, Katie Hodgson & Oliver Ho (Canada)

Keywords: education, facilitation, safety, inter-professional

Introduction

In 2018, the Centre for Addiction and Mental Health (CAMH) launched a staff training program called TIDES, which stands for trauma-informed de-escalation education for safety and self-protection. The program strengthens the relationships underlying crisis prevention, de-escalation and physical intervention. It is holistic, foundational and grounded in a patient-centred philosophy of care. It is part of the hospital's broader strategy to reduce and safely manage risk in mental health settings. A key element of TIDES training involves its delivery, which uses a group of facilitators that includes clinicians and service users, and who receive specialized training to build their skills in this area.

To be flexible and responsive, the TIDES program considers the diverse needs of staff and patients across an array of interventions and treatment approaches, including acute care, inpatient, outpatient and aftercare services. Its development has been motivated and informed by direct feedback from CAMH staff, patients and leaders, as well as reviews of literature and best practices. Parts of the program have been adapted from Safewards, an evidenced-based, open source model developed by Len Bowers (Institute of Psychiatry Health Service and Population Research, 2018). This model of care has been proven to reduce conflict and containment in mental health settings.

Delivered across three days of training, TIDES emphasizes continuous learning, quality improvement and reflections on practice. Participants explore real-world practice enhancements in the classroom and implement them in the workplace. Each day includes opportunities for team discussions and simulation training to enhance practical and physical skills.

Facilitation

TIDES training uses a unique co-facilitation model consisting of:

- an education specialist with expertise in trauma-informed de-escalation training
- a point-of-care facilitator (POCF), who is a clinician with expertise in the experiences of the clinical staff

- a service user educator (SUE) with lived-experience as a client or family member in the mental health care system.

A key component of the TIDES program is the diversity of the facilitation group, which highlights and supports multiple viewpoints that contribute to learning. In post-training surveys, 97 per cent of participants said it was beneficial to their learning to have a variety of voices represented in facilitation.

With diverse clinical backgrounds and expertise in adult education, education specialists lead curriculum development and instructional design. In alignment with evaluation results, education specialists ensure ongoing adaptations occur, and sustain program quality through continuous improvement strategies.

POCFs and SUEs have several responsibilities:

- Co-facilitate training for teams of clinical and non-clinical staff.
- Engage teams in discussions to support effective learning and the application of content in practice.
- Learn the content in detail and relay it effectively using facilitation skills.
- Liaise with education staff to co-create training programs, protocols and processes.
- Manage group dynamics and behaviours with the support of the education team.
- Support and motivate CAMH staff in the classroom and on the unit (if applicable).

In addition to their clinical work, POCFs complete a train-the-trainer (T3) program. POCFs join it when they show leadership skills among their team, have expertise in crisis management and express interest. Having them in the classroom allows for true front-line perspective and expertise. They also contribute to facilitation guides, which ensures inclusive and consistent messaging. POCF recruitment efforts are ongoing with the goal of having representation from each inpatient program.

SUEs are facilitators who identify as having lived experience, which can include being a mental health or addiction service user, or having a family member who is a service user. SUEs bring the unique perspectives and voices of clients, patients and families. They ensure the presence of these experiences in the classroom and they advocate for their perspectives within the curriculum. SUEs also complete the T3 program and contribute to the development of facilitator guides.

Currently, the TIDES program has seven education specialists, 43 POCFs and six SUEs.

Methods: Training the trainers

TIDES education specialists design and facilitate Train the Trainer (T3) programs for all program facilitators. For each day of TIDES training (TIDES is a three-day program),

facilitators must complete four days of the T3 program. This amounts to 12 days of facilitator training.

The T3 program ensures all facilitators can:

- experience the curriculum
- practise facilitation of the TIDES program
- receive feedback and mentorship to improve and adapt to classroom dynamics
- review and practice adult education skills.

Mentorship includes preparation of lesson plans and briefing prior to each day of TIDES training. After each day of TIDES, mentors debrief facilitators and focus on quality improvement, celebrating positive aspects and planning future skills development.

For TIDES Day 1, the T3 program covers these topics:

1. Conducting team-building activities
2. Reviewing the TIDES implementation plan
3. Reviewing roles and responsibilities
4. Reviewing practice enhancements and their implementation plans
5. Practising adult education, group facilitation and facilitation skills
6. Practising simulation and debriefing facilitation
7. Experiencing Day 1 as a participant
8. Practising co-facilitation of the curriculum
9. Presenting the curriculum to a group of peers
10. Receiving feedback and time to reflect

For TIDES Day 2, the T3 program covers these topics:

1. Experiencing Day 2 as a participant
2. Debriefing and aligning the curriculum with adult education and facilitation skills
3. Practising co-facilitation of the curriculum
4. Presenting the curriculum to a group of peers
5. Reviewing and practising physical self-protection interventions
6. Reviewing theories of psychomotor skill facilitation
7. Receiving feedback and time to reflect

For TIDES Day 3, the T3 program covers these topics:

1. Experiencing Day 3 as a participant
2. Debriefing and aligning the curriculum with adult education and facilitation skills
3. Practising co-facilitation of the curriculum
4. Presenting the curriculum to a group of peers
5. Reviewing and practising team control and restraint interventions
6. Practising facilitation of the physical interventions
7. Receiving feedback and time to reflect

During each T3, facilitators also contribute to development of:

- educational tools
- facilitator guides
- instructional design modifications
- talking points for facilitators.

During this process, POCF and SUE feedback ensures their voices and perspectives are heard. They aim to reach consensus on messaging to ensure consistency in the classroom.

Evaluation and results

Approach

TIDES incorporates evaluation components to support iterative quality improvement, curriculum refinement and facilitation. TIDES evaluation takes a two-pronged approach:

1. Conduct pre- and post-training evaluations to capture feedback from staff receiving TIDES training. These evaluations measure engagement, level of knowledge and understanding, and overall confidence in implementing the skills learned in the program.
2. Conduct a series of focus groups with POCFs and SUEs after they received T3 training and have garnered experience implementing the TIDES program across the hospital. These focus groups collect POCF and SUE experiences, identify areas to further support their facilitation skills, and gather TIDES curriculum feedback. To date, 35 POCFs and 12 SUEs have participated in six focus groups.

Results

The focus groups have highlighted three elements that made T3 training successful:

1. Engaging activities: A majority of responses described the T3-Day 2 activities as more engaging and easier to deliver than those for Day 1. In particular, they specified these activities as being beneficial to delivering successful training and recommended they remain as part of the curriculum: Code White, Card One, HALTII, simulations, physical skills, practical training, de-escalation models, flash cards, and comfort items.

Quote from the focus groups: *“In Day 2, there was so much opportunity to practice the content during T3...if there were last-minute chances on the day of facilitation, I was comfortable with the material. I like the SIM training and practical training.”*

2. Ongoing communication and practice opportunities with Education Specialists: All focus groups agreed that Education Specialists who were engaged and provided

ongoing communication to support POCFs and SUEs leading up co-facilitation for the CAMH staff was crucial to a successful delivery. Education Specialists who checked-in, allotted ample time for practice, and hosted external facilitator meetings to ensure POCFs and SUEs understood the content helped build confidence and comfort for POCFs and SUEs to successfully co-facilitate the training. Three focus groups expressed there were more opportunities to practice T3-Day 2 content compared to T3-Day 1 content. POCFs and SUEs were able to adapt any last minute changes in the training content with the extra time.

Quote: *“Simulations in Day 2 were great and allowed preparation.”*

3. Staff uptake of skills and training tools: Staff who had already applied the training tools in their units helped support the ongoing facilitation by POCFs and SUEs. This also reinforced POCF and SUE confidence in their facilitation skills. POCFs reported witnessing units that proactively scheduled TIDES in their workflow (e.g., TIDES Tuesdays), used comfort items and TIDES tools (e.g. flash cards, leaflets), and were more engaged and supportive of POCFs and SUEs delivering training in the unit.

Quotes: *“De-escalation models and flash cards are useful. We put the tree leafs as part of the discharge package in our unit to help keep things going.”*

“We spend 5-10 minutes during the huddle to cover TIDES.”

“We use the laminated cards. We pick a card and we talk about it. Finding it useful.”

4. Continuous quality improvement and implementation: A key theme involved operationalizing POCF and SUE feedback to improve process and logistics-related issues in T3 training. The focus groups solved many of these issues through real-time feedback from POCFs and SUEs. This was part an iterative process to actively incorporate their feedback into TIDES training. These quotes below illustrate how feedback provided in focus groups solved issues in real-time:

Quotes: *“We don’t have keys or access cards to enter the building to set-up and prepare for training.”*

“The Dropbox link is not working for some of us and some of us find it very confusing to find information in the folders.”

All focus groups agreed that the education specialists were engaged and provided ongoing communication to support POCFs and SUEs, and that this was crucial to a successful delivery of TIDES training. Education specialists checked-in, allotted ample time for practice, and hosted external facilitator meetings to ensure POCFs and SUEs understood the content, which helped build their confidence and comfort and helped them successfully co-facilitate TIDES training.

Overall feedback has been positive through the rollout of the TIDES program, including the T3 process. Formally and informally, facilitators have been engaged in feedback opportunities through daily debriefings, focus groups and evaluation surveys. Based on evaluation results, the education team continues to incorporate changes in each iteration to improve the quality of the TIDES and T3 programs.

Conclusion

TIDES aims to support staff confidence and competence in preventing conflict escalation, building strong therapeutic relationships and using trauma-informed interventions to prevent self-harm or to others, and when that immediate possibility or risk exists. This begins with building a strong facilitation team, who ensure the curriculum and delivery aligns with organizational priorities and the needs of participants.

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- Emily Johnstone: CAMH Project Manager
- Annie Lok: CAMH Community Health and Engagement Coordinator
- Stephanie Sliemers: Manager, CAMH Digital Innovations
- Aileen Sprott: CAMH Clinical Risk Specialist
- TIDES curriculum committee

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Correspondence

Email: katie.hodgson@camh.ca

Trauma-Informed De-escalation Education for Safety and Self-Protection (TIDES): Building Organization-Wide Safety through Interprofessional Training

Workshop

Asha Maharaj, Katie Hodgson, Graham Vardy, Steven Hughes, Emmanuel Bratsalis, Anna Palaganas, Stephen Canning, Faisal Islam & Kiran Patel (Canada)

Authors

Dr. Kiran Patel, BSc (Hons), MBBS, DipFMH, DipAB (Dist), MAcadMed, FRCPsych, MCPsychI, FRCPC

- Clinical Head, Forensic Early Intervention Service (FEIS) and Medical Head, Criminal Justice Interface, Complex Care and Recovery Programme, Forensic Services, Centre for Addiction and Mental Health (CAMH)
- Assistant Professor, University of Toronto

Asha Maharaj

- Director, Community and Continuing Education, CAMH

Faisal Islam

- Manager, Evaluation, CAMH

Katie Hodgson

- Community Health and Engagement Specialist, CAMH

Oliver Ho

- Education Editor, CAMH

Introduction

In 2018, the Centre for Addiction and Mental Health (CAMH) launched a staff training program called TIDES, which stands for trauma-informed de-escalation education for safety and self-protection. The program strengthens the relationships underlying crisis prevention, de-escalation and physical intervention. It is holistic, foundational and grounded in a patient-centred philosophy of care. It is part of the hospital's broader strategy to reduce and safely manage risk in mental health settings.

To be flexible and responsive, the program considers the diverse needs of staff and patients across an array of interventions and treatment approaches, including acute care, inpatient, outpatient and aftercare services. Its development has been motivated and informed by direct feedback from CAMH staff, patients and leaders, as well as reviews of literature and best practices. Parts of the program have been adapted from

Safewards, an evidenced-based, open source model developed by Len Bowers (Institute of Psychiatry Health Service and Population Research, 2018). This model of care has been proven to reduce conflict and containment in mental health settings.

Delivered across three days of training, TIDES emphasizes continuous learning, quality improvement and reflections on practice. Participants explore real-world practice enhancements in the classroom and implement them in the workplace. Each day includes opportunities for team discussions and simulation training to enhance practical and physical skills.

TIDES supports staff confidence and competence in preventing conflict escalation. This includes building strong therapeutic relationships and using trauma-informed interventions when people harm themselves or others, and when that immediate possibility or risk exists. Its fundamental principles include knowing and understanding patients, families, our teams and ourselves, and translating this into enhanced prevention, safety and collaboration.

Staff return to their units and programs with enhanced skills and practical ideas to promote safety. The expectation is that they will use these skills in day-to-day practice and will hold one another accountable for the same. TIDES is available where staff deliver care. It involves theory, interactive learning and simulation training, and prioritizes interprofessional team learning.

Methods

TIDES is required for all direct-service staff. This interprofessional group includes all staff who serve clients and patients: physicians, clinicians, practice leads, managers, security, environmental and food services. Please note: To date, TIDES training has rolled out for inpatient settings only. TIDES for outpatient settings will begin in 2019-2020.

TIDES consists of three components:

1. Three days of training in one year, and simulation based training the following year on an alternating basis.
2. Ten practice enhancements adapted from Safewards interventions.
3. On-unit monthly training in prevention and intervention strategies, provided by peer clinicians who have received additional specialized training.

TIDES Day 1 develops knowledge and introduces strategies that set a common foundation for staff, which will help prevent escalated situations and increase safety for everyone. There are six sections:

- 1-1: Practice dimensions

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- 1-2: Knowing your patient
 - 1-3: Trauma-informed practice
 - 1-4: Communication and conflict styles
 - 1-5: Rights, autonomy and advocacy
 - 1-6: Communicating with the unit community

TIDES Day 2 is about continuing to collaborate and build relationships with patients, families and staff to help manage rapidly changing situations. There are five sections:

- 2-1: Self-awareness and self-management in the moment
- 2-2: Assessing risk and responding in the moment
- 2-3: Code White team response (note: Code White is the emergency code designed to initiate a cautious and prescribed response to a client, patient, visitor or CAMH personnel member who is displaying extreme agitation or otherwise represents a threat of aggression or violence or immediate risk of serious bodily harm to themselves or others)
- 2-4: Practical and trauma-aware self-protection skills
- 2-5: Post-event staff debriefing

TIDES Day 3 covers the use of trauma-aware interventions and restraints in rapidly changing situations that become emergencies. Staff reflect on how these events affect the well-being of patients, families and staff members, whether or not they were directly involved. There are five sections:

- 3-1: Moral conflict, distress and residue
- 3-2: Trauma-aware use of emergency restraints
- 3-3: Trauma-aware physical interventions
- 3-4: Patient and weekly team debriefing
- 3-5: Self-care

Please note: To date, Day 1 and 2 training have been rolled out across the organization. Day 3 is still in progress.

The training is delivered using a unique co-facilitation model consisting of:

- an education specialist with expertise in trauma-informed de-escalation training
- a point-of-care facilitator, who is a clinician with expertise in the experiences of the clinical staff
- a service user educator with lived-experience as a client or family member in the mental health care system.

TIDES facilitators include people with lived experience and direct service staff who have been trained to enable collaborative learning in the classroom and directly where they work. This combination ensures a variety of perspectives in the classroom. It

helps clinicians with reflective practice and with seeing the effects of practice on all stakeholders.

An interprofessional committee developed the curriculum in collaboration with unions and leadership. A thorough literature review ensured the program aligned with current evidence and best practices. Alignment with CAMH practices and policies helped tailor the program to the needs of our staff and clients.

The program aims to create a learning environment that is inclusive to a variety of learner needs. The curriculum uses a variety of modalities, including didactic learning, interactive group activities, case-based learning and simulation. This establishes the classroom as the first step in moving theory into practice.

A large part of the program's success involved support at an organizational level from executive leadership, in partnership with the local and provincial unions. This helped ensure resourcing, internal prioritization and promotion. The program goals aligned with the CAMH strategic plan and the organization's commitment to reducing rates of workplace violence for staff and clients.

Results

As mandatory training, TIDES includes strong evaluation processes and a commitment to quality improvement. This ensures the program meets the needs of staff and clients. Overall feedback has been positive through the Day 1 and Day 2 rollouts. In between each training day and through each rollout period, there are mechanisms that bring training to the point of care for each inpatient team, and these have also been evaluated. Rollout structure and timeline:

- September-December, 2018:
 - Day 1 training
 - Integration of 10 practice enhancements
- December, 2018-April, 2019:
 - Day 2 training
- June-November, 2019:
 - Day 3 training
- Throughout the year:
 - On-unit and program-specific trainings, including physical interventions and simulation based learning, facilitated by education and point-of-care facilitator groups.

Key results:

- More than 1080 staff trained during Day 1 and Day 2.
- Approximately 117 physicians were trained in a version of day 2 that was accredited through the University of Toronto.

- Among surveyed respondents, 94% reported satisfaction with TIDES Day 1 training.
- 95% reported satisfaction with TIDES Day 2 training.
- 97% felt it was beneficial to their learning to have a variety of voices represented in facilitation.

Evaluation

Preliminary findings focused on measuring the level of confidence and knowledge from in-class sessions. An in-depth analysis will be conducted to determine the skills acquired by staff who attended the training and how the training has affected their practice. Results of the evaluation will support TIDES program development and identify areas for improvement. Conclusions will allow TIDES facilitators to tailor the program to further support staff development and practice.

Methodology

Three types of evaluation were completed for Day 1 and Day 2:

- Baseline and post evaluations
- Facilitator debrief feedback
- End-of-the-day feedback

Selected findings from Day 1

Compared to baseline, respondents reported increased understanding across all TIDES Day 1 topics. (Note: Baseline n=792, post n=136.) In particular, respondents showed a 23% increase in their understanding of trauma-informed practice (71% baseline, 94% post) and a 32% increase in knowledge about practice dimensions (44% baseline, 76% post).

Compared to baseline, survey respondents reported increased confidence across all TIDES Day 1 topics. (Note: Baseline n=836, post n=136.)

- There was an 8% increase in the level of confidence to communicate collaboratively with patients (82% baseline, 90% post).
- There was also an 8% increase in the level of confidence to communicate collaboratively with their team (85% baseline, 93% post).
- 82% indicated there were no barriers to implement the skills gained from training into their workplace, and 20% requested additional organizational support.

Overall, surveyed respondents indicated group discussions, simulations and group discussions for TIDES Day 1 Training were very effective compared to other modalities delivered in the training.

Selected findings from Day 2

Compared to baseline, survey respondents reported an increased level of understanding across all TIDES Day 2 topics. (Note: Baseline n=897, post n=966.) In particular, there was a 19% increase in their understanding of trauma-informed practice (72% baseline, 91%) and a 24% increase in understanding about concepts of self-protection (68% baseline, 92% post).

Survey respondents reported an increased level of confidence across all TIDES Day 2 topics. (Note: Baseline n=895, post n=970.) There was a 29% increased level of confidence in using self-protection skills (53% baseline, 82% post), and a 24% increase in confidence around using de-escalation skills (66% baseline, 90% post).

Overall surveyed respondents indicated group discussions, simulations and debrief for TIDES Day 2 Training were very effective compared to other modalities.

Discussion

Preliminary findings suggest that TIDES Day 1 and Day 2 training was well received by staff and had a positive influence in developing staff knowledge and confidence. Over the last four quarters, descriptive statistics also show a reduction in workplace violence (WPV) incidents against employees (which resulted in time lost): In the second quarter of the 2018-19 fiscal year, there were 0.29 WPV incidents per 100 full-time employees; in the fourth quarter, that number dropped to 0.18.

While there are many contributing factors, this timeline aligns with the rollout of TIDES for inpatient direct service staff. Further, staff who participated in TIDES Day 1 and Day 2 reported increases in their understanding and confidence around:

- communicating collaboratively for prevention
- trauma-informed practices, self-protection skills and using de-escalation skills.

Though no data is available to conduct a correlation or significance testing, the baseline and post surveys suggest that skills and confidence gained during TIDES may have contributed to reducing WPV incidence rates. Future staff training should consider incorporating a variety of voices, group discussions, simulations and debriefings to support staff engagement and provide value to their learning experience.

Conclusion

TIDES aims to support staff confidence and competence in preventing conflict escalation, building strong therapeutic relationships and using trauma-informed interventions when people harm themselves or others, and when that immediate possibility or risk exists. Now in the final stages of the first year rollout, it seems to be proving successful, and a key element of this rests with its interprofessional nature.

An interprofessional committee developed the curriculum. An interprofessional group of facilitators delivers training where people work. The training is mandatory across the organization for all staff who directly serve clients and patients. This is a diverse group that includes physicians, clinicians, practice leads, managers, security, and environmental and food services. The TIDES program serves as an example of how to build organization-wide safety through interprofessional training.

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- TIDES point-of-care facilitators
- TIDES service user educators

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Correspondence

Email: asha.maharaj@camh.ca

Safe De-escalation Training: The Concept of Relationships and De-escalation

Poster

Lene Lauge Berring, Katrine Brix, Demi Hansen, Rikke Juhl, Trine Marita Bjerre & Gitte Laugesen (Denmark)

Keywords: De-escalation, Staff training, Violence prevention

Abstract

Background

Coping with and understanding agitated, violent and threatening behaviour in mental health care settings is a challenging, nevertheless integral part of a caregiver's job. If not handled well, such situations can result in staff and patient injuries. Moreover, frequent staff exposure to violence can be a traumatic experience and can cause several problems in the workforce such as an intention to leave the profession and secondary traumatic stress in staff recognized as anxiety and sleep disturbance (1). However, there is no consensus about what kind of training caregivers need in order to create safe environments.

Aim

To Create a safe environment for patients and staff members

Method

The '*Concept of Relationships and De-escalation*' (2) is a new paradigm of violence prevention. It was co-created in a joint venture between managers, staff members and service users and includes organisational strategies that move the discussion away from blaming staff members towards identifying the structural and organizational roots of workplace violence. It has a person-centred values-based approach to care and aims to improve the safety of all patients and staff by addressing underlying risk factors that increase the likelihood that an individual will become a victim or a perpetrator of violence. It arises from the public health perspective and contains a series of inter-related targeted preventive activities designed to prevent violence. The program is mandatory and was implemented from 2016 – 2019. All new employees participate in the three days training course followed by two days of repetition.

In order to identify how the training program helped staff members to deal with workplace violence, questionnaires were distributed immediately after the course and three months later. Data from 2018 was analysed using multivariate regressions in Stata. Data collection was conducted using SurveyXact. Approximately 60 % of the participants responded (N= 390).

Preliminary results

Several benefits of the training program were apparent such as participants felt prepared to work and they appreciated the person-centred values-based approach. Moreover, staff members mostly reported (after 3 months) that the program promoted safety for staff members and patients. Differences were seen in the concept's impact (age difference and speciality differences).

Conclusion

Addressing underlying risk factors that increase the likelihood that an individual will become a victim or a perpetrator of violence, demand deep cultural changes. Even though staff members reported enhanced safety, the implementation still needs to show whether this public health inspired training approach influences work injuries, staff turnover and the use of coercive measures.

2 Educational Goals

1. The participants will acquire knowledge about the Concept of Relationships and De-escalation.
2. The participants will discuss the preventive activities designed to reduce the level of interpersonal violence and how this program is experienced by staff members.

Correspondence

Dr. Lene Lauge Berring

Email: lel@regionsjaelland.dk

Staff perspectives on an extended Safety-Training-Program at the ONLY Maximum Security Forensic Hospital in Denmark

Poster

Demi Erik Pihl Hansen & Marianne Friis Lindegaard (Denmark)

Keywords: Safety Træning Program, De-escalation, Staff training, Violence prevention, relation, risk assess

Abstract

Background

Only one Maximum Security Hospital is located in Denmark. The hospital houses 30 of the most dangerous psychiatric patients in Denmark. In order to deliver care and treatment, it is necessary to train staff in a specific way. We have therefore revitalized our previous training and developed an extended Safety Training Program lasting 15 days targeting our patients. The program includes interaction between practice in the clinic and the acquired theory and training obtained during education. The Staff members will gain knowledge of psychopathology, ethics, mentalizing as well as legal material, rules and guidelines and through theory in combination with casework, the students will learn to risk assess a patient.

The aim of the program was to create safety for patients and staff members

Method

In order to evaluate the program we conducted 12 semi-structured interviews. Staff members were included if they had participated in the Safety Training Program

The aim of the study was to explore how staff perceived the program including their own ability to 1) de-escalate a violent situation and 2) customize physical restraint intervention specific to the individual patient.

Preliminary result

- Staff members perceived their ability to de-escalate was improved
“We are more aware of our Body language and to use appreciative communication in meeting with the patient during staff and patients interactions”

- Staff members perceived their ability to prepare an intervention was improved
“I am more active and better at planning more solutions in escalating situations with a patient”
- Licensed staff members were able to transfer their knowledge to colleagues in everyday work
“I find it natural to communicate and share knowledge from the Safety Training Program through dialogue with my colleagues in the daily work”
- Two of the participants explained they wanted to take further education
“The education has inspired me to further education for instructors to convey new knowledge and to help develop my colleagues and my workplace”

Preliminary conclusion

Implementation of an extended Safety Training Program at the Maximum Security Psychiatric Hospital has (so far) shown that employees experience a greater degree of safety and security in their daily work. In addition, there is a tendency for the staff who have completed the training to meet, prevent and manage conflicts and violent situations.

Finally, several patients have noted that the staff is now better at listening to the patient and better at assisting the patient at an earlier stage in an escalated situation.

2 Educational Goals

1. Participants will receive inspiration and input on how the Safety Training Programs can be developed and implemented in an organization.
2. The presenters will receive feedback on their Safety Training Program

Correspondence

Demi Erik Pihl Hansen

Email: demi@regionsjaelland.dk

Application of the “Dealing with Violent Situations in Health Care in Practice course” in clinical practice

Poster

Jaroslav Pekara, David Peřan, Tomas Kovrzek (Czech Republic)

Keywords: Aggression. Program Evaluation. Safety. Simulation. Seclusion & Restraint

Abstract

Background

This article evaluated our experiences with the course “*Dealing with Violent Situations in Health Care in Practice*” (simulation course). This course is a single (simulation) course within the education of health care workers in the Czech Republic. We wanted to verify the benefit of our educational course “*Dealing with Violent Situations in Health Care Practice*”.

The main aim of the study was to ascertain the benefit of the methods covered by the course.

Methods

We evaluated two questionnaires with the attendees. The questionnaires focused on experience with a violent situation in reality and was linked with an evaluation scale of self-confidence during contact with a violent patient – this evaluation took place before and after the (simulation) course.

Results

Participants with secondary level of education were most exposed to violence, as were medical orderlies and hospital attendants. Participants with up to 1 year and from 1 to 5 years experience were more likely to be verbally attacked, as were those with 11–20 year’s’ experience. Those with with up to 1 year of experience had the highest rates of physical assault. We were successful in showing that participants who are exposed to verbal and physical violence are better-prepared to deal with these, after having been educated on the course.

Conclusions

The course has been beneficial for practice. The most significant development occurred in questions regarding physical intervention during contact with a violent patient, self-confidence in the presence of a violent patient, level of training required for dealing with violence, method development and efficiency, fulfilment of a violent patient's needs and protection against a violent patient.

2 Educational Goals

1. To understand how the teacher with the actor planned the simulated scenes according to the participants' experience (first questionnaire) and how we prepared situations with standard actor.s
- 2 . To showcase the benefit of our simulation/educational course "*Dealing with Violent Situations in Health Care Practice*" - to ascertain the benefit of the methods covered by the course (second questionnaire - The validated Confidence scale).

Correspondence

Mr. Jaroslav Pekara

Email: pekara@vszdrav.cz

Organization and implementation of Early Recognition Method (ERM) as preventive actions

Poster

Johnny Waerp, Magne Ultvedt, Audun Sundby & May Kristoffersen (Norway)

Keywords: Early warning signs, ERM, FESAI, preventive actions, staff education, ERM observation-plan

Abstract

Furukollen Psychiatric Center (FPC) at a general level of security, accepts patients from regional secure and medium secure units for further treatment and risk management. As part of the national programme for Mental Health, as a private service provider, we offer 30 beds for specialised Mental Health services for South-Eastern Norway Regional Health Authority. In 2016, FPC signed an agreement to use Early Recognition Method (ERM) with ERM Norway. The method focusses on risk signature, early warning signs of aggression and timely preventive actions.

The admission process starts at the first contact with the referring hospital. Before a patient arrives, a thorough assessment of the referral begins to identify early warning signs of aggression using an updated risk assessment, FESAI form. We integrate early warning signs into an ERM plan. We describe late warning signs in a criterion-triggered emergency plan, for use in emergencies. We introduce all patients to the ERM plan. We encourage them to contribute in weekly conversations with staff where the patients can evaluate their warning signs and discuss the need for interventions.

Patients who do not consent to participate in the ERM programme will get an observation-plan through which staff will observe and effect preventive interventions. It is important that the staff observe the patients' early warning signs at each shift and record the effect of interventions.

Staff receives feedback and guidance from supervisors in each section. The ERM Management Group summarizes monthly reports from supervisors and starts planning training and courses. The group offer courses, individual training and motivate supervisors to get more patients to accept the ERM protocol. The ERM Management Group seeks further advice in using the methods from ERM Norway.

The use of ERM as a method - ERM observation plan - indicates that patients feel safer in interaction with the staff, due to earlier intervention as the staff know more about the patient's risk signature. The staff effects interventions by degree of severity according

to the level of disturbance or degree of disturbed symptoms. By conceptualizing early warning signs by severity, we avoid escalating episodes. We rarely use emergency plans after implementation of the ERM.

2 Educational Goals

Learning Objective 1.

To use ERM observation-plan for a group of patients characterized by withdrawal, social isolation, and low communicative competence in order to develop expressiveness and evaluate their warning signs by an ERM protocol.

Learning Objective 2.

To establish an ERM Management group, as a prerequisite for operating and developing ERM as a method.

Correspondence

Email: johnny.waerp@sfps.no

Experiences of a training program for increased safety in youth residential care in Norway.

Paper

Ane Slaatto (Norway)

Keywords: safety for staff and youths, preventing and managing conflicts, understanding anger, powerlessness, physical intervention, effects and impacts of education

Introduction

There are about 600 children/adolescents living in state child welfare institutions and about 3,900 employees that are responsible for ensuring that they receive proper care. Creating good conditions for children/adolescents to grow up in, is an important area of responsibility for Children's Youth and Family Affairs (Bufetat). In addition, it is a goal to create health-promoting jobs. Statistics from STAMI (statens arbeidsmiljøinstitutt - translated to Norwegian Institute of Occupational Health) presented in 2018 show that child welfare officers, social educators and learning disability nurses are the occupational groups that are most exposed to threats and violence. A summary of the Norwegian Board of Health Supervision's nationwide investigation of child welfare institutions in 2018, shows that failure in the form of offenses and/or improvement needs was found in 45 of the 60 investigated child welfare institutions.

In 2017, Bufetat developed a four-day training programme for employees to increase safety and security. The aim is that employees get better at predicting, preventing and handling conflict-filled situations in a secure manner. One objective is to use the least amount of coercion, and when coercion must be used, it must be legal and least harmful. When using theory, scenario training and communication exercises, employees will be trained to act so that the risk of violence decreases. According to the plan, all employees in state institutions will have received the training programme by the end of 2019 and continue training at their own facilities. Oslo municipality and private institutions will be offered the training programme during 2020.

The intention of the training program is to give employees tools to prevent, and handle, situations involving aggression and physical interventions. The goal is that the program will contribute to less re-traumatization for the youths living in residential care, and fewer reports from employees considering physical and psychological violence at work. We presented the program at a workshop in Toronto 2018.

Paper

SKM-TS started in autumn 2018 by obtaining and systematizing experiences with the basic training program for safety and security training. The goal of this is to see if employees and leaders experience a change in the security and safety work they have on their local unit. It has been mapped to how they work on reflection, safety assessment, rights regulations, physical techniques before entering the training program, and again after about two months and 6-10 months after completing the programme. It also examined what training they have received in rights regulations and Total Quality Management (TQM) reporting. The aim is to get information about how the training has worked on, for example, documentation and focus, and whether the employees are experiencing increased security in conflictmanagement.

Participants

Experience has been obtained using 3 questionnaires from all 5 regions in Norway. All who were present, completed questionnaires.

First questionnaire:

3 units participated from region west. A total of 62 employees completed questionnaires; from region east, 2 units participated, . a total of 65 employees. From region middle, 3 units participated, a total of 66 employees. From region south, one unit participated, a total of 32 employees and, . from region north, 2 units participated, . a total of 25 employees.

A total of 250 respondents participated. Most are permanently employed social workers and work directly with youths. Only 19 respondents are temporary employees. Others who attended were unit leaders, professional consultants, department managers and school administrators. 170 of the respondents have a bachelor's degree in health or social studies. 61 people have different education and 29 do not have higher education. 202 of the respondents have more than 5 years of experience from working in an institution.

Second questionnaires:

2 units participated from region west. 44 employees completed the questionnaires; from region east, 1 unit participated, 53 employees; from region middle, 3 units participated, 48 employees, and, from region south, one region participated, 25 employees.

One hundred and seventy respondents from all regions have so far participated. Most are permanently employed social workers and work directly with youths who are placed in institutions. Only 12 people are temporary employees. Others who participated are unit managers, professional consultants, department managers and school administrators. 120 of the respondents have a bachelor's degree in health or social studies. 39 people

have different education and 14 do not have higher education. 132 of the respondents have more than 5 years of experience from working in an institution.

Third questionnaire:

So far only one unit from region middle has participated. During autumn and winter 2019 data will be collected from other units and regions. Results will be presented when registered.

Experience gained from youth - semi-structured interviews

Currently, 7 youths from 3 different institutions have been interviewed. They represent both care placements and emergency placements - based on coercive clause.

Results

Deviations - experiences and registration

Every unit report difference between how many times they have experienced something that qualifies for a writing deviation report (TQM) and how many they have written during 2018. The difference is greatest in the first questionnaire before the training program. Average experience that qualify as TQM for units is 2.3. Of reported TQMs, the average of units is 2.4. The experiences are mainly about violence, harassment, threats and HSE deviations.

In completing questionnaire 2, the difference between all units decreased. It seems that there is greater correspondence between experiences and reports. Experiences per person per unit are on average 1.1. The reports are an average for all units 0.6.

Reasons for the difference between perceived deviations and recorded deviations are reported in both questionnaires 1 and 2 as for high tolerance limits / trifling, frivolous / not real threats, oversight, lack of time and routines, downgrade, lack of training, uncertainty about what qualifies and is serious enough to report in the TQM. It is reported that they think it is part of the job to be subjected to violence and threats, that they get used to it, that there is high work pressure and a tough "*we must endure*" culture.

Conflict management and prevention training

Respondents state that the units have received varying degrees of training in prevention and management of conflict, aggression and violence / threats of violence, from no training, to systematic training based on theory and techniques from different private suppliers. Here we see that there is great variation in what training the various units have completed.

Before the training program, in questionnaire 1, the average score on to what extent the employee felt safe in handling conflicts was 4.3. About two months after the training

program (questionnaire 2), the average score was 4.7. When asked about the degree to which training in safety and security has contributed to increased security, the respondents responded on average of 4.6 on a scale of 1-6, where 1 is a small extent and 6 is a large extent. It is likely that the training program has affected this, as the difference of own perceived security has increased by 0.4.

The youths reported that it is person-dependent how conflicts are handled by employees. They mention a few examples of employees who have screamed at them and dealt with the conflict in an inappropriate manner. The youths also reported that they often experience being heard and seen. Some say they believe that the employees try to understand and want what's best for them, with some success.

Risk assessments

Regarding risk assessments, most respondents reported that they carry out risk assessments either daily or weekly, a few report monthly risk assessment. There are varying degrees of documentation. Many respondents report that few assessments are documented, with most being reported orally.

In questionnaire 2 it is reported that they had not used, or had not planned to use the risk assessment matrix they learned on the training program. Others write that they have their own matrices they still use. In addition, several write that they have gained greater awareness of the importance of documenting and carrying out risk assessments. With few exceptions, everyone reports that they participate in risk assessments that apply to their everyday lives.

Rights Regulations

Training in Rights Regulations varies from no training to regular courses. The youths who were interviewed have very little oversight of their rights, and state that this has not- or very rarely been the subject of discussions with employees. They state that they have received a

brochure when they moved into an institution, but that they had to read it themselves, which most had not done.

Physical Control and Scenario Training

It varies from unit to unit how much the employees had train on physical techniques and which structures for training they have. It varies what physical techniques they use in situations where physical control is required. In questionnaire 1, a question about how often respondents had training in physical techniques, 17% report weekly training, 29% report monthly, 25% report annual; 29% stated they never had training.

On the same question in questionnaire 2, many respondents stated they have begun training on security and safety techniques, or that local trainers have just completed a

trainers' program and are in the early stages of planning regular training structures. Two percent stated daily training, 37% weekly, 45% monthly, 5% annual and 11% stated they had no training.

The youth who had experienced coercion reacted particularly to decisions on limits on freedom of movement and want freedom back. These were placed on compulsory orders and had been subject to brief detention following attempted escapes.

When asked in questionnaire 2 if the unit has completed scenario training, 32% answered yes and 68% no. Most point out that they have not started training but plan to do so soon.

Reflection on practice

In questionnaire 1, 44% report reflecting on practice daily, 36% weekly, 11% monthly, 6% annual and 3% never. In questionnaire 2, 61% report that they reflect on practice daily, 25% weekly, 9% monthly, 2% annual and 3% never. Overall, there is a high score on the frequency of reflection on practice, but few reflections are documented.

Participants reported reflections take the form of discussions and guidance with colleagues and leaders. The informal discussions are usually not documented. In special events it can be documented in the child's folder/report. In questionnaire 2, many participants reported that they are planning to document more and will use the navigation wheel that they were introduced to during the training week.

Social Worker practice

In conclusion, it is particularly interesting to look at how the employees describe how the training week has influenced their social worker practices, thoughts and assessments. They report particularly increased awareness of prevention, risk assessment and their own role in conflict situations. They write that they are more defensive, think more and make well- founded assessments.

Quotes:

"More aware of how I behave in situations. Is more at the forefront".

"I think more often about how I speak to the youth myself and how this can affect a possible conflict".

"I am more aware of my intentions in the situations; what is my goal now? What can I do to calm down the situation? I'm more aware of the negotiation zone before the aggression curve goes up".

"Do not stress so much in stressful situations. Use time to map the situation more, change goals about what I want to achieve".

"Trying to be more << green >> in the approach to youth".

"Is more aware of TQM and threats"

*"I have become more aware of the dangers we are exposed to and expose ourselves to".
"Thinking more often about situations, talking more often. Thinking and considering more before I go into situations".*

"More aware in advance. More aware on STOP - and planning ahead". "Is more relaxed. Spends more time in discussions with youth".

"Trust in myself more".

"Gained more awareness about own safety and own influence".

"Don't take unnecessary chances. Considering whether it is wise and necessary to use physical control".

"More aware of reducing risk, to the greatest possible extent helping youth not losing control and resort to violence".

"I have gained more knowledge about youths functioning by stress". "More risk assessments. More aware of the safety of my own and others".

"Resolve conflicts with dialogue! Stay ahead. Easier to get the employees on such thinking when everyone has been on the same training program"- (dept. Leader).

"More confident on myself and colleagues that we are capable of handling challenging situations. Have learned to ask questions differently".

"Has become safer, more reflective, thinking preventively, ahead of time and reflecting on the situation better".

"Reflects and is more prepared when situations sharpen, more ethical discussions in everyday life".

"Have a common platform and starting point - important!"

"Better to predict events. Talk about it with colleagues and agree on what we do if something happens".

"Everyone has a greater focus on security. We have sneakers, back the car in, and everyone has alarm".

"Writes more than before. More systematic work on safety. Make safer decisions".

Most see the importance of regular training in physical control and scenario training, and are requesting to start this training. Several people find that they work more systematically on a common theme. They point out that all employees receiving the same training means that the staff group becomes more coherent. Some call for temporary employees to receive the same training as permanent employees.

Some report that the training fits well into their current practice as social workers and that they have been working this way for a long time. In addition, several point out that the approach to conflicts fits well with the trauma-sensitive approach. One says: *"Fine supplement to previous training, goes hand in hand with trauma-based care".*

Conclusion

These preliminary results show that there is a great deal of variation on the topics the survey covers. At the same time, some common features, such as under-reporting of the

TQM and a high degree of oral reflection are apparent. There is an increase in reflection on practice and physical control training in the units, with more training planned.

The quotations under - Social Worker Practice, reflect the main impression after reviewing all questionnaire responses. Words such as “*increased awareness*” and “*preventive work*” are frequently used and emphasize changes in practice. There are currently very positive reports and experiences from employees at child welfare institutions regarding the training program.

The plan for autumn of 2019 is to further collect and systematize the experiences, especially from questionnaire 3 which is distributed 6-10 months after the training.

In addition, there is a public PhD in social work and social policy at Oslo Metropolitan University, with the title: “*An evaluation of the training programme for increased safety and security for children/youth and employees in child welfare institutions*”. The objective of this project is to gain knowledge about the training programme and whether it has desired outcomes when interacting with adolescents, and what should be further developed and improved. For this purpose, we will highlight the theme with qualitative interviews and quantitative intervention research. In addition, we will also do a systematic search for literature. The results of the research project shall contribute to further developing effective quality care services for children/adolescents, as well as developing health-promoting jobs.

Correspondence

Ane Slaatto
Liaveien 2
1930 Aurskog
Norway. o.
Email: ane.slaatto@bufetat.no

Chapter 17 – Application of new technology (media – social networks – information technology – e-learning – virtual environment)

Learning to Engage with Individuals in Distress: Training for Inpatient Psychiatric Nurses

Paper

Kathleen Delaney & Jason Earle (USA):

Keywords: Inpatient nurses, interpersonal engagement, e learning.

Abstract

Background

While patient engagement is a cornerstone of keeping a psychiatric unit safe, there is scant literature around teaching nurses the skills employed when forging interpersonal engagement. Engaging with patients demands presence, empathy, attunement to the individual's experience, and deciphering the narrative and its meaning to the individual.

Aim

The purpose of this study was to test an e learning course on interpersonal engagement designed for inpatient psychiatric nurses. Using principles of adult learning the course contains experiential and activating, creative exercises around presence, empathy, attunement and deciphering the narrative; all designed to be delivered in a web-based educational format.

Methods

This pilot was conducted to determine the feasibility of web-based engagement training for inpatient psychiatric nurses via evaluation of participation rates, staff time, nurses' satisfaction, and effectiveness. Evaluation included nurses' feedback and pre-post

scores on the Combined Assessment of Psychiatric Environment (CAPE); an instrument that gathers nurses' perceptions of their practice, engagement and effectiveness with patients.

Results

Preliminary data includes participant feedback from three sites (N=22). Nurses were generally satisfied with the program and believed it clarified particular fundamental engagement skills. The modules took less than 2 hours to complete. One of the modules (on attunement) was viewed as difficult to understand. There were increases in the nurses' sense of confidence to engage with clients, but the change scores were not significant. It was difficult to recruit nurses in trials where involvement was optional versus at one site where participants were given an honorarium for participation.

Conclusions

E learning is a useful platform for cultivating inpatient nurses' engagement skills. It allows for learners to self-pace their movement through the material. While the principles of interpersonal engagement may be ingrained knowledge of seasoned nurses, new staff will benefit from explicit instruction around how to attune with and apprehend the patient experience. Staff engagement with patients during inpatient treatment is critical to maintaining a positive unit environment, reducing conflict and easing escalating situations. Nursing staff are the linchpins of engagement during inpatient treatment and the lack of current training in engagement skills impedes both patient recovery and the professionalism of inpatient nurses.

2 Educational Goals

At the conclusion of this presentation, participants will be able to

1. Explain how to cultivate the core skills of interpersonal engagement
2. Discuss the potential of e learning as a platform for building staff's engagement skills.

Correspondence

Email: Kathleen_R_Delaney@rush.edu

Virtual Reality Training for Professionals to Support Prevention of Patient Aggression in the Workplace

Paper

William Buitter, Anne Bakker, Ragnhild Blok-Bjornsen, Rene Wubs, Cato van Halem & Martine van Bennekom (Netherlands)

Keywords: Training, staff, Virtual Reality, VR, aggression, prevention, de-escalation

Abstract

Background

Patient aggression incidents are a major problem in healthcare settings. Training for healthcare professionals, including role-plays, on de-escalation techniques contributes to the prevention of aggression incidents. Conventional roleplaying with an actor is limited in terms of simulating particular patient and work-environment characteristics. In co-creation with end-users, we therefore developed a Virtual Reality (VR) training protocol including two interactive role-plays to practise de-escalation techniques.

Aims

To investigate the acceptability of the VR de-escalation training among healthcare professionals and trainers and its potential influence on confidence in coping with patient aggression in mental healthcare employees.

Methods

An experimental design was used with assessments at baseline (demographics, past year patient aggression experiences, and confidence in coping with patient aggression) and at post-intervention (self-reported learning effects, user satisfaction, and confidence in coping with patient aggression). Trainers who operated the avatar during the VR experiment completed the System Usability Scale and were interviewed on their experiences after study termination.

Results

Participants (N=31 mental healthcare employees, age 39±11 years) were mostly female (74%). The majority of participants (61%) had >10 years of work experience in mental

healthcare. They had experienced 9 ± 3 different types of patient aggression incidents in the past year which was positively related to confidence in coping with patient aggression ($r=.56$, $p<.01$). Participants valued role-playing in VR as realistic (100%), instructive (65%), and it contributed to increased awareness into their own behaviour towards patient aggression (81%). Confidence in coping with patient aggression significantly increased after VR role-playing ($t=-4.0$, $p<.01$). Less past-year experiences with patient aggression was related to a greater increase in confidence in coping ($r=-.48$, $p<.01$). Trainer ($N=4$) mean SUS score of 70 ± 2 points at satisfactory usability of the system. Trainers considered the VR as a valuable addition to existing aggression prevention training that could help achieve learning goals.

Conclusions

Practising de-escalation techniques in VR was associated with more awareness in participants and increased confidence in coping with patient aggression post-intervention. This applied in particular to participants that had experienced less aggression incidents in the past year. Trainers indicated opportunities of the VR training in addition to conventional training, pointing at potential for implementation. If replicated in a controlled setting, VR training is an acceptable and valuable training method for professionals.

2 Educational Goals

Two education goals:

1. Participants will gain knowledge on the application of VR software in addition to conventional aggression prevention training
2. Participants will learn about the experiences of study participants as well as trainers in regards to satisfaction with and self-reported learning effects of the VR training.

Correspondence

Email: w.buiter@ggz-nhn.nl

Development and Evaluation of the Computer Simulation-based Interactive Communication Education (ComEd) Program

Paper

Heeseung Choi, Ujin Lee & Tae Kyun Gwon (Korea)

Keywords: Communication skill, simulation, computer-based, nursing students

Abstract

Background

Therapeutic communication skills enable nurses to understand the needs of patients, foster therapeutic nurse-patient relationships and thus may reduce anxiety, fear, and aggression in patients. Simulation-based education designed to foster communication skills has become an essential part of nursing education. However, standardized patient simulation is limited in its consistency, repeatability, and cost-effectiveness. Standardized, interactive, and effective computer simulation-based education programs that focus on building communication skills are greatly needed.

Aims

The specific aims of the mixed-methods sequential exploratory design study were to 1) develop the Computer Simulation-based Interactive Communication Education (ComEd) Program; 2) test the efficacy of the program in improving the communication skills knowledge, self-efficacy in learning, and self-efficacy in communication skills among nursing students; and 3) explore learners-experiences with the new program.

Methods

Contents and the format of the ComEd program were developed based on the interviews conducted with 11 experts in nursing education and practice and nine nursing students recruited from one hospital and four nursing schools in Korea. Newly developed simulation scenarios were validated and tested by two nursing experts and 10 graduate nursing students. The final version of the ComEd program included two simulation scenarios (a patient experiencing hallucination and delusion and a depressive patient with a history of attempted suicide) and tailored debriefing sessions. Using one group pretest-posttest design, we tested the efficacy of the program with 30 nursing students (2 male and 28 female students). Each student completed the ComEd program installed

on a tablet PC in a private and quiet room. Assessment measures include a 15-item Communication Skills Knowledge scale, a 10-item Self-efficacy in Learning scale, a 21-item Self-efficacy in Communication scale, a 14-item Satisfaction scale and lastly six open-ended questions. In addition, 30 students participated in one of the five focus group interviews exploring learners-experiences with the program. Descriptive statistics, tests of homogeneity, t-tests, and content analysis were used to analyze quantitative and qualitative data.

Results

All measures had acceptable reliabilities (.88 $\hat{\alpha}$ $\hat{\alpha}$ 94). After the intervention, students demonstrated significant improvements in communication skills knowledge, self-efficacy in learning, and self-efficacy in communication skills (p $\hat{\alpha}$ 0.001). They were greatly satisfied with the new program and reported that the program was highly engaging, realistic, and effective in understanding the key concepts of therapeutic communication skills. Strengths and areas for improvement were identified from the qualitative findings.

Conclusion

The findings of the present study demonstrated that computer simulation-based interactive communication education is a promising approach to teaching communication skills to nursing students.

2 Educational Goals

Upon completion of the presentation, the participant will,

1. understand the education program development process; and
2. list the strengths and limitations of the computer simulation-based communication education program

Correspondence

Ms. Heeseung Choi

Email: hchoi20@snu.ac.kr

Chapter 18 – Other related themes

Dealing with patient and visitor aggression in healthcare: a workshop exploring future responsibilities in leadership

Workshop

Birgit Heckermann, Joanne DeSanto Iennaco, Joy Duxbury, Sanaz Riahi & Sabine Hahn (Switzerland)

Keywords: leadership, management, organizational safety, nurse leadership, aggression, violence, policy

Abstract

Patient and visitor aggression is a well-known, costly and worldwide problem. However, patient and visitor aggression is currently not adequately addressed at the macro-(policy) and meso-(organizational) levels in many countries. While some Anglo-Saxon countries have put considerable effort into addressing patient and visitor aggression at policy and organizational level, aggression in healthcare lacks sufficient attention in countries such as Germany, Austria or Switzerland. Moreover, leaders' responsibilities, competencies and engagement to successfully improve patient and staff safety at the organizational level receive, to date, little attention.

Using findings of a current research project as a starting point, this workshop aims to stimulate a discussion about roles, responsibilities and future directions for management and leadership in dealing with patient and visitor aggression in healthcare.

Nurse managers are in key leadership positions for establishing and sustaining safe and healthy work environments for the largest staff group in healthcare, nursing staff. Nurse managers also have experiential understanding of both the service provision and organizational structures. This perspective gives nurse managers unparalleled insight into both staff and team ability to prevent, de-escalate and debrief after aggressive incidents, as well as into the overall organizational safety culture against patient and visitor aggression. However, despite their key role, nurse managers' views on issues related to the prevention and management of patient and visitor aggression in healthcare have rarely been sought.

The PERoPA (Perceptions of Patient and Visitor Aggression) project examines patient and visitor aggression in healthcare from the nurse managers' perspective. We conducted a cross-sectional, open-access, web-based survey aimed at nurse managers at lower (e.g. ward manager), middle (e.g. divisional manager), and higher (e.g. director of nursing) management levels. The study included several countries: Austria, Canada, Germany, Switzerland, the United Kingdom, and the USA. The data were collected in two phases: in 2016/17 (German-speaking countries) and in 2019 (English-speaking countries).

In this workshop, we will present data from the countries included in this study and highlight differences and issues pertaining to different countries and their respective macro contexts.

In an interactive discussion, we will explore the implications for management and leadership.

2 Educational Goals

1. to recall at least three domains pertaining to organizational safety culture against patient and visitor aggression.
2. to critically discuss the leadership challenges associated with organizational safety culture from two different professional perspectives.
3. able to discuss commonalities and differences in the strategic approach to managing patient and visitor aggression in different countries.

Correspondence

Email: birgit.heckemann@bfh.ch

Maledictology, swearing, verbal abuse, Theory of Civilisation, Speech Act Theory, personal sensitivity

Workshop

Ian Needham, Lois Moylan & Kevin McKenna (Switzerland)

Keywords: Maledictology, swearing, verbal abuse, Theory of Civilisation, Speech Act Theory, personal sensitivity

Abstract

In many societies politeness is seen as a virtue whilst swearing and the use of crude, terse or offensive language is deemed a vice. Growing children are often fascinated by the use of offensive words and their parents' task is to guide and instruct them on how to socially navigate such utterances.

In this workshop we view the use of terse, offensive, strong language or verbal abuse from the vantage point of maledictology. Maledictology as a branch of psychology researches the usage of cursing and swearing as an integral part of human social interaction. We will review various forms of strong language – e.g. insults, curses and swears versus “*slurs*” – and explain the functions – e.g. power or social acceptance – these utterances serve. We will also review the development of terse language (verbal abuse) in the last 500 or so years based on the work of the sociologist Norbert Elias (1897-1990). We will also postulate that Speech Act Theory (Austin and Searle) may serve a pivotal role in an individual's sensitivity to terse language. We will also highlight some situations in which swearing, and cursing is appropriate and non-appropriate. The issue of trans-culturalism regarding swearing and cursing will be addressed.

Participant involvement in the workshop

Participants will...

1. Be conscient of possible positive functions of terse and abusive language of patients.
2. Reflect on their own personal sensitivity to terse and abusive language.
3. Understand the function of Speech Act Theory as a possible means to react to terse and abusive language.

2 Educational Goals

Participants will...

1. be prompted to reflect whether patients' swearing and cursing may be positively interpreted.
2. be able to reflect the use and functions of swearing and cursing related to the patients in their own setting.
3. be encouraged to reflect on whether Speech Act Theory may be used to disengage personal sensitivity regarding abusive language.

Correspondence

Email: needham@bluewin.ch

Community Treatment Orders for difficult to engage patients with psychosis: what does the evidence say?

Paper

Jorun Rugkåsa (Norway)

Keywords: Community coercion; Community Treatment Orders; community services; psychosis; readmissions

Abstract

Following widespread deinstitutionalisation of psychiatric services, Community Treatment Orders (CTOs) have been introduced in many Western jurisdictions to authorise extended periods of compulsory community care. A CTO requires the patient to adhere to outpatient treatment. The aim is to help 'revolving door' patients achieve stability, to control risk and violence, and to provide less restrictive alternatives to (repeated) involuntary hospitalisation. The main mechanism of enforcement is swift recall to hospital for treatment when required. Despite their wide-spread use, the evidence base for CTO effectiveness is weak. A number of case-control studies show discrepant results regarding hospitalisation outcomes and community tenure. RCTs and meta-analyses have shown no effect on these outcomes. Some evidence exists of reduced victimisation. This presentation will present and discuss current evidence for CTO and discuss this in light of evidence for other ways of supporting difficult to engage patients with psychosis.

2 Educational Goals

1. To gain an overview of the current evidence base regarding the effectiveness of community coercion
2. To distinguish the relative strength of different types of methodologies in that evidence base

Correspondence

Email: jorun.rugkasa@ahus.no

Violence Incident Assessment (VIA-Q)- development of an instrument to assess violence in psychiatric outpatient settings

Poster

Jenni Konttila (Finland)

Keywords: violence, assessment, nursing, psychiatric outpatient settings

Abstract

Background

A previous systematic review revealed that violence committed against nursing staff in psychiatric outpatient settings is a multidimensional phenomenon comprising the reasons for, forms of, and consequences of violence. There is no instrument to assess incidents of violence in Finnish psychiatric outpatient settings, but investigation of this phenomenon is justifiable because of the increased number of psychiatric outpatients and psychiatric outpatient services.

Aims

The aim of this study was to develop and pre-test an instrument to assess the incidence of violence in psychiatric outpatient settings and evaluate validity and reliability of the instrument.

Methods

First, theoretical structure of VIA-Q was based on a systematic literature review. The structure of instrument consists of nine factors. Items on factors were Likert-scale featuring closed and open-ended questions.

Secondly, the face-validity of VIA-Q was evaluated by a psychiatric nursing expert (n=1) and an expert in instrument development (n=1) who were also co-authors of systematic literature review. The content validity was evaluated by an expert panel (n=10) by using the Content Validity Index (CVI)-scale. The expert panel consisted of experts of psychiatric nursing, instrument development, and nursing science.

Thirdly, the pre-test was conducted in one hospital district's psychiatric division in Finland. Overall sampling was used as a sampling method. The sample (N=200) included psychiatric inpatient and outpatient units. The internal consistency of VIA-Q

was examined by Cronbach's alpha. Data was analyzed with statistical methods using IBM SPSS 25.0.

Results

The validity of VIA-Q was evaluated before and after the pre-test. Evaluations of face-validity were similar, and CVI-values indicated good content validity. The results of the pre-test were comparable with previous studies which strengthened the construct validity. Reliability was tested by Cronbach's alpha for six factors separately. Values varied between 0,509 and 0,910. Exploratory factor analysis was not appropriate because of small sample size.

Almost two of three participants completed the instrument. More than half of respondents were male, and most were nurses working in psychiatric inpatient units. Almost half of respondents had faced physical violence in the past 12 months. Almost three quarters had faced psychological violence and one quarter harassment. Nearly one fifth had no experiences of any kind of violence during his/her career. Almost three quarters hoped to have more education related to the management of violent situations.

Conclusions

Evaluations of instrument validity indicated it to be valid. The pre-test found VIA-Q applicable and reliable. It is important to examine how violence occurs in different kinds of psychiatric outpatient settings and the experiences with violence encountered by nursing staff. It would also be worthwhile to compare cultural and inter-country differences of violent exposure to violence in psychiatric outpatient settings.

2 Educational Goals

To understand:

1. The multi-dimensional processes of instrument development and the different phases therein.
2. The importance of validity and reliability in context of instrument development.

Correspondence

Email: jenni.konttila@student oulu.fi

Drug Induced Psychosis-A Complicated Relationship and a Diagnostic and Legal Conundrum

Paper

Julian Gojer, Monik Kalia, S. Athavan, C. Kerjikian, J. Magritte, J. Koh, & I. Giljanovic (Canada)

That drugs can cause a psychotic reaction is not new news. Both recreational drugs and prescription medication are known to be associated with psychotic reactions sometimes merging with a full-fledged and ongoing psychosis.

Psychoses induced by drugs or substances usually occur in the following scenarios: 1) psychotic symptoms presenting as features of an intoxication syndrome, which resolve soon after the excretion of the substance from the body; 2) psychotic symptoms whose origin can be linked to the ingestion of a drug or substance and may persist for a period of days to a few weeks, after cessation of the use of the drug; 3) a persisting psychotic illness that may emerge after a person uses a drug or substance once, or on multiple occasions, and persists more than a few weeks after the substance has been excreted from the body; 4) a triggering of a psychotic episode or worsening of a pre-existing illness following the ingestion of a drug or substance; 5) psychotic states resulting from withdrawal of a substance from the body.

Identifying the appropriate scenario for an individual's psychosis is often difficult. Accurate diagnosis can assist in treatment and management strategies and can also have implications for court matters. At this time, though the phenomenon is well known, it may be more accurate to call the episode a substance related psychosis.

The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) sets the diagnostic criteria for substance induced psychosis as: presence of delusions and/or hallucinations; evidence that these symptoms presented during or soon after the ingestion of a substance that is known to be able to cause these symptoms; the disturbance is not better explained by a psychotic disorder existing independent of the substance ingestion; the disturbance does not occur solely during the course of a delirium; the disturbance causes clinically significant distress or impairs functioning. The differential diagnosis for substance-induced psychosis versus substance intoxication or substance withdrawal is predominance of symptoms like delusions, hallucinations, disorganized thinking, negative symptoms and grossly disorganized or abnormal motor behaviour (2).

The International Classification of Diseases, 11th Revision (ICD 11) sets the diagnostic criteria for psychotic disorder induced by other specific psychoactive substance as: psychotic symptoms that develop during intoxication with or withdrawal from a specified psychoactive substance; psychotic symptoms whose duration or intensity substantially exceed what is characteristic of intoxication with or withdrawal from the specified substance; the amount and duration of use of the specified substance is sufficient to be capable of producing psychotic symptoms; the symptoms are not better explained by a primary mental disorder. While the criteria in both models are almost identical, the discrepancies between the two are significant when determining whether an individual can be diagnosed with substance related psychosis.

The lack of concrete universal agreement makes it harder to make a differential diagnosis. Caton et. al identified a few differences in symptomology as well as characteristics in patients between substance induced psychosis and early-phase primary psychotic disorders with concurrent substance use. Patients with substance induced psychosis had a significantly later age of onset of psychosis, greater conjugal ties, greater concurrent antisocial personality disorder comorbidity, more frequent homelessness, poorer family support and were more likely to have a parent who had a history of substance abuse than those with a primary psychotic disorder. Patients with primary psychotic disorders tended to have severe substance use disorders, more severe psychotic symptoms, less insight and were more likely to experience visual hallucinations. This was true of positive symptoms, negative symptoms and general psychopathology (4). Caution must be exercised, as there is really limited consensus on the above.

Psychotic episodes related to the use of prescription and non-prescription drugs

The most commonly used drug, and one recently legalized in Canada and in many jurisdictions in the United States, is cannabis. The use of cannabis has been associated with acute psychotic episodes, worsening of preexisting psychosis and chronic amotivational syndrome (20).

Cannabis stimulates dopamine signaling in the nucleus accumbens in the brain (5). It remains the most popular recreational drug of use. The United Nations Office of Drugs and Crime determined that approximately 4% of the global population, aged between 15 and 64 years old, used cannabis in 2015.

Rubio et. al found that patients who had a Cannabis Induced Psychotic Disorder diagnosis were more likely to be older and employed, were more likely to have been diagnosed with social phobia, were much heavier cannabis users and were more likely to have been diagnosed with cannabis dependence than those with a Primary Psychotic Disorder diagnosis. Their results suggested that the presence of depressive symptoms may be a key feature that can be used to distinguish CIPD from PPD.

Arendt et. al, conducted a longitudinal study of 535 patients diagnosed with CIPD. Almost 50% developed schizophrenia spectrum disorder, a significant majority of whom were diagnosed with paranoid schizophrenia. 77% experienced another psychotic episode. Younger male patients were more likely to develop a schizophrenia spectrum disorder and patients with CIPD were more likely to develop a schizophrenia spectrum disorder at a younger age.

We cannot yet confidently differentiate a diagnosis of substance induced psychosis from a diagnosis of a pre-existing psychotic disorder or an independent psychotic episode. However, there is enough evidence available to say that a history of CIPD must be considered a significant risk factor for schizophrenia spectrum disorders.

Cocaine is one of the most notorious drugs available in the world. Cocaine increases the levels of serotonin, dopamine and norepinephrine by blocking the receptors for the neurotransmitters (9). In North America and Europe, approximately 1.25% of the population used cocaine in 2015 (6).

As cocaine intoxication mimics the symptoms of psychosis, it must be ruled out before cocaine-induced psychotic disorder can be diagnosed. In intoxication, the user will experience perceptual phenomena that disappear with abstinence. Psychotic symptoms are also more severe and longer lasting in cocaine induced psychotic disorder than in intoxication. Once intoxication has been ruled out, the next hurdle is differentiating cocaine induced psychosis from an independent psychotic disorder (10). The first European study of cocaine induced psychotic disorder found that psychotic symptoms were reported by 53.8% of subjects while under the influence of cocaine, including paranoia, auditory hallucinations, visual hallucinations and tactile hallucinations (11). Vergara-Moragues, E. et al found that, when compared to primary psychotic disorders, cocaine induced psychotic disorder (CIP) was more likely to present with thought disorders, delusions and negative symptoms, and was less likely to present with Schneiderian auditory hallucinations (10). There was a higher correlation between patients diagnosed with CIP and patients who consumed cocaine intravenously and through smoking than patients who consumed cocaine intranasally. A correlation was also found between high cannabis use and CIP (11). More research is needed before these results can be used for differential diagnoses.

Amphetamines increase dopamine levels in the brain by interacting with the dopamine transporter, inhibiting dopamine re-uptake, and also interacting with the vesicular monoamine transporter 2, increasing the amount of dopamine in the cytosol. They also induce the release of norepinephrine in the synaptic clefts of the Nucleus Accumbens.

Studies have demonstrated that amphetamines can induce acute psychosis in healthy subjects, and that this psychosis can be blocked with the use of antipsychotics. Substance induced psychosis has been reported in 8-46 % of amphetamine users. The wide range

is likely a result of the studies focusing on different populations and demographics. No clear direct correlation between level of amphetamines in the body and development of psychotic symptoms has been found as only a very weak relationship has been reported between the two. This suggests that the risk of developing acute psychosis is dependent on individual vulnerability to developing amphetamine induced psychosis, not levels of amphetamines in the body. Some research suggests that there are shared genes that indicate increased susceptibility to amphetamine induced psychosis and schizophrenic psychosis. There is also research suggesting that amphetamines increase risk of later development of psychosis in users with increased vulnerability to developing psychosis, in a similar manner to cannabis (13). Research on methamphetamines has tentatively suggested that methamphetamine induced psychosis may cause less impairment to the grey matter in the orbitofrontal, prefrontal and temporal cortices and limbic system (14). Regardless, there is enough evidence to warrant exercising caution with patients that have been diagnosed with amphetamine induced psychosis and monitoring them for signs of chronic psychosis (13).

Many prescription medications have the known side effect of inducing psychosis during ingestion or during withdrawal. Along with psychosis, withdrawal has also been known to induce delirium. The presence of delirium is considered by the DSM 5 as a criterion that rules out substance induced psychosis, but not the ICD 11.

Corticosteroids have been observed to cause the development of psychotic symptoms in some patients. However, the finding of psychotic symptoms in patients being treated with corticosteroids have been inconsistent in studies (15).

Antipsychotics are known to cause the re-emergence of psychotic symptoms in patients during withdrawal. This has been much more prominent with older antipsychotic drugs. A rapid emergence of psychotic symptoms has been observed after discontinuation of older antipsychotic drugs and atypical drugs. Persecutory delusions and auditory hallucinations are the most frequent symptoms that develop (16).

Delirium has been linked to decreased acetylcholine activity and hyperactivity in the dopamine system. Delirium often accompanies withdrawal from substances, which is unsurprising when one takes into account how many drugs interact with the dopamine system. Of these drugs, anticholinergic drugs, especially those that penetrate the blood-brain barrier, and drugs with muscarinic receptor affinity, are a high-risk group of medication to cause delirium.

Lithium has been proven to induce delirium in high concentrations. In elderly patients and patients with dementia in therapeutic levels, it has been known to induce delirium even with regular therapeutic doses. Baclofen withdrawal has also proven to cause delirium, generally through abrupt cessation. As Baclofen is prescribed as a muscle relaxant, patients often stop as soon as they feel it is no longer needed.

Anti-parkinsonian drugs are notorious in causing psychosis by increasing dopamine levels in the brain (19).

Drug induced psychosis and Canadian law

Canadian law makes a distinction between voluntary intoxication and involuntarily intoxication. If it is deemed that someone should reasonably expect to become intoxicated or impaired when voluntarily consuming a substance, they are considered to be voluntarily intoxicated. If someone were to consume a substance and were to unexpectedly become intoxicated or impaired, or if they were to consume an intoxicating substance without knowledge or volition, they are considered to be involuntarily intoxicated. This distinction can have considerable import in culpability.

Legal systems also make a distinction between general intent crimes and specific intent crimes. In general intent crimes the person is understood to have intended the consequences of their actions. General intent crimes include such crimes as sexual assault or manslaughter. Specific intent crimes require proof of a clear intent when an offense is committed that is more than the requirement of general intent. Specific intent crimes include crimes such as forgery or murder. In many jurisdictions, intoxication may be a viable defense for specific intent crimes, depending on how intent was impacted on by the degree of intoxication. Intoxication, if severe enough, may be used as a defense for some general intent crimes and this matter is currently an issue before the courts in Canada. A psychotic episode can be a defense to a crime and this is a murky area of the law that has led to more confusion rather than clarity.

A diagnosis of substance induced psychosis would be admissible for an insanity defense if an accused can prove that they experienced a substance induced psychosis, that meets the legal definition (disease of the mind), at the time of the offense rather than intoxication, and also prove that the psychosis that they experienced prevented them from understanding that their actions were wrong. Substance induced psychosis resulting from voluntary intoxication (toxic psychosis) cannot qualify as a disease of the mind. This was established in the court's ruling in 2011 in *R v. Bouchard-Lebrun* (18). This case has led to some confusion as to what really is a drug induced psychosis. The uncertainty is exacerbated by the arbitrariness of the duration criterion. The DSM 5 sets a limit of a period of 30 days from cessation of ingestion of the drug as the demarcation between substance induced psychosis and other psychotic disorders. Although many patients have reported experiencing longer psychoses, these patients are currently diagnosed with psychotic disorder not specified, schizophreniform psychosis or schizophrenia, rather than substance induced psychosis. A further impediment is that individuals are medicated, thus clearing up the psychosis. It is currently unclear how long these psychotic episodes would last if they were to remain untreated.

Implications

The concept of drug induced psychosis is still vague and nebulous. However, the work that is being done is fruitful because prognoses may be quite different for individuals with drug induced vs non drug related psychotic illnesses. In particular, individuals with repeated drug induced episodes may have worse prognoses. Research suggests that benzodiazepines may be more useful as treatment during the early phases of a substance induced psychotic episode. During later phases, antipsychotics may be more useful for treatment. Greater clarity is needed with respect to treatment.

There are other implications for the use of these drugs especially when it comes to the interface between treatment and determination of criminal responsibility. This is a subject of a different paper.

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Correspondence

Email: juliangojer@themanasaclinic.com

Differences and similarities in attitudes and perceptions of coercion: Findings from research in India as compared to the European context

Workshop

Peter Lepping, Bevinahalli Nanjegowda Raveesh, Tom Palmstierna, Guru S Gowda, Eric O Noorthoorn (India)

Abstract

Coercion as a subject was significantly under-researched in India until recently. In the last four years a number of projects have researched attitudes to and prevalence of coercion in Indian psychiatric and other health care settings. We summarise the results and compare them with European psychiatric settings. The studies show that perceived coercion is a reality in India. Levels of perceived coercion by patients and the populations affected are remarkably similar to high-income countries. Caregivers and psychiatrists consider the lack of resources as one of the main reasons for coercion. Furthermore, they expressed that the need for early identification of aggressive behavior, interventions to reduce aggressiveness, empowering patients, improving hospital resources, and staff training in verbal de-escalation techniques.

63% of admitted patients were involved in violent incidents in one Indian inpatient study. The number of patients subjected to coercion is much higher in Indian psychiatric wards than in Europe, intravenous injections are common as a coercive measure. Accompanying relatives provoked 35% of the incidents and were the target in 56% of the incidents. Patients' relatives were involved in managing the aggression in 35% of the incidents. Doctors and nurses are less likely to be victims but aggression towards them leads more commonly to coercive measures. With regards to satisfaction with the existing mental health legislation respondents in England and Wales and Denmark expressed the highest approval for their national legislation (76% and 74%, respectively), with those in India and Ireland expressing the lowest approval (65% and 64%, respectively). Data were gathered from professionals and carers and before the changes to the Indian Mental Healthcare Act in 2017.

Patients and professionals in India have similar views about and experience coercion in a similar way to affected people in Europe. Prevalence of violence and coercive measures is, however, much higher in Indian inpatient settings compared to Europe. This may be associated with much lower inpatient bed numbers and staffing levels in India.

Correspondence

Email: PETER.LEPPING@wales.nhs.u

How to measure implementation of Safewards in clinical practice

Poster

Lene Svendsen, Jacob Hvidhjelm & Jesper Bak (Denmark)

Keywords: Safewards, measurement, implementation, scale

Abstract

Background

From 2016, the English model Safewards was implemented in psychiatric wards in the Capital Region of Denmark to improve safety.

Safewards is a model that explains variation in conflict and containment. It also offers 10 interventions with the purpose to reduce conflicts. It is based on 20 years of research in the field of psychiatric nursing with almost 1000 published research articles.

Aims

Despite the comprehensive research in Safewards, we still have not found an effective tool to measure the application's level of Safewards within individual departments. Therefore, the aim of this study was to develop a tool to measure and determine the implementation level of Safewards in clinical practice.

Methods

Research has demonstrated 23 positive changes in staff's behaviour in managing conflicts by using Safewards. These changes have been synthesized to four categories.

The next step is to utilise existing questionnaires to develop a scale that aims to specifically measure, if the caregivers are using Safewards, in collaboration with the patients.

Results

The respondents will be patients, and the results should be leaders, and caregivers, to measure to what extent the patients are experiencing the implementation of Safewards and point of where improvements in Safewards implementation. And point in the direction of where improvements to Safewards implementation can be directed.

Preliminary results, in the form of the developed scale/questionnaire, will be presented at the congress.

Conclusions

Conclusions cannot be drawn at this stage of the process.

2 Educational Goals

1. The participants will get an understanding of what changes in attitudes, competencies and behaviour as a result of Safewards implementation.
2. The participants will learn how the scale is constructed from already validated scales/questionnaires.

Correspondence

Email: lene.eldrup.svensden@regionh.dk

Understanding Coercion in Indian Mental Health Care: An EViPRG Collaborative Initiative

Poster & Paper

Raveesh Bevinahalli Nanjegowda, Guru Gowda, Peter Lepping, Eric Noorthoorn & Tom palmstierna (India)

Keywords: Coercion, Mental Health Care, India, Collaboration, EViPRG

Abstract

Introduction

Coercion is recognized as a problem in health services around the world. There is a growing desire to explore the reasons for the use of coercion and develop an evidence base of research to inform debates and discussion as well as change in practice. The EViPRG collaborative work was initiated with an international symposium at Mysore in 2013. India a group of experts from Europe and India came to a consensus and ratified “*Mysore Declaration*” on coercion in psychiatry, first of its kind in the sub-continent.

Background

Very little is known about the use and utility of coercive measures in psychiatry and other medical specialties in India. The existing evidence supports the view that informal coercion is widely used, although patterns of its use may differ. Some evidence suggests relatively high levels of cooperation between family members and clinicians in the use of coercive measures.

In India, psychiatric care is influenced by a complex web of social, economic, cultural and religious factors. The current Indian legislation does not include any specific provision or definition for involuntary treatment.

Thus, coercion by relatives in and outside hospital settings is much more widespread than in Europe, commonly seen as a family obligation and generally more acceptable than it is in high-income countries.

Collaboration

The initial phase of collaborative research work involved are as below; there are around 12 articles published in reputed journals

1. Raising awareness
2. Benchmarking, using validated tools to count and document coercive measures
3. Agreeing a definition of restraint and other coercive measures.
4. Development of Restraint Guidelines to India & Alternatives to restraint

Comparative understanding:

The contrasting approaches between the Indian and the UK experience highlight a number of key differences regarding individual autonomy. Notwithstanding differences in culture and health provision, the contrast illustrates an important dilemma for practicing psychiatrists in the UK and elsewhere: how highly do we regard the patient's autonomy in the context of other considerations? European psychiatry has historically been accused of overriding patient autonomy and practicing a form of paternalism. However, the Indian example suggests that decisions that go against the patient's wishes can be developed within a wider set of relationships, especially the patient's relatives. The Indian practice encourages outcome to be looked on as benefitting the patient as well as their immediate relationships. Taking into account the consequences of any treatment decision for the patient's relatives would not necessarily be seen as paternalistic by patients or relatives in India. In contrast, it would be seen as a legitimate aspect of striving for good outcome.

Long term plans

The most important long-term goals that will be taken up in near future are:

1. Active involvement of patients in decisions made about them
 2. When coercive measures are necessary, they should be undertaken by trained staff in a safe manner.
- Long term reduction in prevalence of coercive measures

2 Educational Goals

1. EViPRG role in supporting international collaboration and setting international uniform standards from academic, clinical & Ethico- legal perspectives
2. Mutual learning from Indigenous methods and cultural variations that play a vital role in providing quality humanistic mental health care

Correspondence

Dr. Raveesh Bevinahalli Nanjgowda

Email: raveesh6@yahoo.com

Prevention of both training- and patient-related work injuries. A 12-year register study in a forensic psychiatric hospital

Poster & Paper

Anu Putkonen (Finland)

(Anu Putkonen, Satu Kuivalainen, Hannu Kautiainen, Eila Repo-Tiihonen, Jari Tiihonen)

Keywords: violence, work injuries, prevention, sick leaves, Six Core Strategies, nurses, training, safety, aggression management, training

Abstract

Background

Prevention of work injuries is problematic for psychiatric hospitals. The preventive effect of physical aggression management training is unclear, and data on prevalence of injuries is scarce. We analyzed all person-related injuries and sick time during different preventive efforts to reduce injuries and coercion.

Methods

A retrospective analysis of 12 years (N= 1,7 million nurse days, 1, 2 million patient days) work injury notifications related to persons, i.e. with either physical training or patients (violence and restraining), in a state hospital for persons with psychotic disorders and violence in Finland (5,5 million inhabitants, N= 297beds). The patients were either forensic (over 50%), or too difficult/dangerous for local or prison hospitals (about 46%), and used novel antipsychotic medications. Annual and 3-year incidence and linearity of the sick time and reports of injuries (N) were analyzed with Poisson's regression models. A. 2005-2007: The commonly accepted model and training for aggressive situations; B. 2008-2009: RCT of 6CS + the model and 2010 no interventions C. 2011-2013: 6CS+ the model without high-risk holds D. 6CS+ AKO (A local training to prevent crises/restraint with 6CS and technical training of the necessary holds (2014-2016). Six Core Strategies for prevention of coercion (6CS) is development of leadership, staff, use of data, patient involvement, post-event analyses and preventive tools.

Results

The difference between baseline (2005-2007) vs. 6CS/AKO (2014-2016) was 100% (N=501 days) for training-related leaves; 83% (N=202 days) for patient-related; $\text{irr}=0.17$; $95\%CI=0.12-0.23$, $p<0.001$; and 94% (N=702 days) and for total ($\text{irr}=0.06$; $95\%CI=0.04-0.08$, $p<0.001$). The linearity of the decrease was significant for training-related, patient-related and total person-related sick time and injuries. Confounding factors did not explain the results. Nurses decreased; female-male-ratio, proportion of registered nurses and education increased.

Conclusions

1. It is possible to effectively prevent person-related work injuries and sick time in care of psychotic and violent in-patients during 6CS +AKO, without training of prone restraint.
2. The significant difference between the first and last period, the linearity of the decrease during 6CS interventions, weather measured of the annual data, 3-year data, reports or sick time; the time specificity of low and high rates, and the stability of the elimination during the last years, suggest an association between the results and 6CS/AKO.
3. Regular restraint-based training was neither preventive nor adequate for in-patient care of psychotic persons with violence. It may have increased fears, traumas and aggression.
4. Prevention of crises with 6CS/AKO was beneficial for nurses, patients, hospital and public health, and “*saved*” 702 work injury sick days during 3 years, including 501 training-related ones.
5. Effective prevention of person-related work injuries necessitates monitoring of both training- and patient-related sick time and injuries.

Disclosures

no conflicts of interest.

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Correspondence

E-mail: anu.putkonen@niuva.fi, anumarpu@gmail.co

Chapter 19 – Specific populations: community & ambulant care

Confused persons in mental health care: experiences of institutional cooperation in a 'safety chamber'

Paper

*Stephan Gemsa, Eddy Adolfsen, Eric Noorthoorn, Henk Nijman & Giel Hutschemaekers
(Netherlands)*

Keywords: Collaboration, Security, Confused persons, civil society

Abstract

Background

In 2014 a Dutch politician was murdered by a psychotic patient. Insufficient exchange of information between mental health services and public safety organizations was identified to increase the risk of similar incidents. This led to the setting up of multidisciplinary security meetings at a municipal level to discuss police reports of confused persons' incidents with police, municipal social services, mental health care and drug misuse services. These security meetings were called '*safety chambers*'.

Aims. This study aims to understand the characteristics of confused persons in order to support professionals and local and governmental policy makers on dealing with this challenging issue.

Methods

Confused persons identified as incident prone were entered in the so called E33 coding system. Information of people included in this register was combined with health care records in an anonymous database. In this way, we could identify to which extent such incidents were caused by psychiatric patients.

Results

Findings differ from assumptions that confused behaviour is not associated with psychiatric illness: 59 % of the confused persons described in police reports were currently in psychiatric care and another 16 % had been in psychiatric care. These findings are relevant for the recently adopted Mental Health Act. In the new act the possibility to treat such people is extended. To investigate the effect of the law on such incidents, we plan to repeat the study over several years.

In the presentation we will provide details of the study and discuss the relevance of organizing regular consultation with parties such as police and municipal authorities in gaining control of these people, many of who are (chronically) mentally ill. When we look into the case descriptions we observe most (66%) cases were associated with confused behaviour. Also, 66% of the cases were to associated with alcohol and drug abuse. Above one in four (28%) of the cases was related to conflict or violence. We discuss the ethical issues of the study, using a combination of data received from the police and our own digital medical charts.

Conclusion

Combining resources improves collaboration between police and mental health care, but needs to be secured by careful procedures to protect the privacy of individuals.

2 Educational Goals

1. Psychiatric disorders in the confused persons
2. Development of outpatient care in tune with society

Correspondence

Email: s.gemsa@ggnet.nl

Conditional authorization: an event sequence study

Paper

Stephan Gemsa, Eric Noorthoorn, Henk Nijman & Giel Hutschemaekers (Netherlands)

Keywords: Outpatient coercion, event sequence, Legislation

Abstract

Introduction

Regularly, psychiatric care is initiated in a too late point in time in psychiatric decompensation. Patients are often admitted acutely, discharged and readmitted. Until now Dutch law allows involuntary treatment only in a specialized hospital setting. January 2018 a new law was passed allowing a variety of involuntary treatment options in outpatient settings to an unprecedented degree.

Aim

To understand which changes and opportunities the law brings to the approach of involuntary care, it is important to investigate which measures in which order were taken under the current legislation and by what measures these were followed.

Methods

To understand this, an event sequence analysis was performed, in data over the years 2012 to 2014 over 9 mental health trusts. We identify a short term or long-term involuntary admission and conditional authorization. The first measure is allowed in case of acute psychiatric decompensation, and direct and imminent danger. The second measure is allowed in case of danger, disadvantage and harm of the patient and his family. The third, conditional authorization resembles community treatment orders, with the constraint that the patient may refuse treatment and must be consequently admitted if treatment is refused. Three year follow up data of all patients either or not involuntary admitted over 9 mental health trusts were included covering sequences of the various measures.

Results

In the sample 85654 admissions were observed over 39543 patients. In 8795 (22%) patients an involuntary admission occurred. The short term involuntary admission

occurred in 4615 (12%) patients. The long term involuntary admission occurred in 5691 (14%) patients, while the conditional authorization occurred in only 1154 (3%) patients. Analysed at the level of admissions, we observed involuntary admissions occurred in 20.4% of all admissions. More than one third (34.8%) of these involuntary admissions were short term involuntary admissions. Near to two third (56.4%) were long term involuntary admissions, where a conditional authorization occurred only in 8.8% of the patients in the sample. When we observe the event sequences, we see a conditional authorization was in only 7.9% of the cases the measure of first choice.

Conclusion

Conditional authorization as an outpatient way to negotiate treatment is a measure designed to prevent involuntary admissions. Outpatient involuntary treatment is a main part of the new law to be implemented shortly. Our data show such a measure, however useful and already in the current law is only scarcely part of current practice.

2 Educational Goals

1. Understand goals of mental health care legislation
2. Understand order of decisions regarding establishing involuntary treatment

Correspondence

Email:s.gemsa@ggnet.nl

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Announcement (with due reserve)

**The 12th European Congress on
Violence in Clinical Psychiatry will be
held in Rotterdam – The Netherlands**

14 -16 October 2021

Congress Venue: De Doelen – Rotterdam

Please save these dates in your diary

Supporting Organisations

Oud Consultancy



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

“Unravelling and understanding violence in clinical practice”

Velkommen til Oslo! The world's centre of peace, Norway's capital and most populous city, and host of the 11th Violence in Clinical Psychiatry Congress.

The Congress continues to present clinically relevant and practically useful interdisciplinary scientific and practical knowledge on preventing violence, reducing its incidence and impact, managing its consequences and understanding how and why it manifests itself.

We welcome an distinguished gathering of international experts from all corners of the globe researching violence and aggression, providing education, delivering, and managing, clinical care, as well as those living with the reality of violence in their day-to-day lives, experts by experience.

Additional themes this year include work examining violence in children and young people, those with dementia, and sessions investigating the role of new technologies, including virtual reality. Sessions seeking to develop more humane and safer ways of providing mental health care to reduce violence and aggression are especially welcomed.

Whatever your interest in violence in clinical psychiatry, this year's Congress will not disappoint. Thank you for joining us, enjoy the conference, and please make time to experience the delights of this great city.



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

