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Roger Almvik - Frans Fluttert - Sabine Hahn
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Proceedings of the

12th EUROPEAN CONGRESS
On Violence in Clinical Psychiatry

ROTTERDAM | 6 – 8 OCTOBER 2022

Violence in Clinical Psychiatry

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Preface

Rotterdam: a young, dynamic metropolis in continuous renewal of itself at a rapid rate. A city with sparkling skyscrapers, a world-class port, famous museums, awesome festivals, stylish restaurants, fabulous food markets and now in 2022 hosts of the 12th 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 (ENTMA[08]).

Since its inception 30 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, aggression, and coercion, reducing their incidence and impact, managing their consequences and understanding how and why they occur. 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 carers.

"Co-creating research, education and practice responses within contemporary mental health", is this year's Congress theme and reflects our commitment to partnership working between clinicians, researchers, educators, service users and carers. The range of evidence generated over many years, often by delegates at this congress, has aided our understanding of violence, aggression, and coercion in mental health. Nevertheless, much remains to be unravelled, and knowledge that we thought was well understood, continues to be 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, aggression and coercion in their day-to-day lives, experts by experience.

Our keynote papers have once again attracted leading lights from across the globe.

Prof Dirk Richter from Germany examines the ethical and legal justifications for coercion in mental and revisits the idea of the very existence of mental disorders, drawing from a range of neuropsychological and neurophilosophical evidence and perspectives. If the existence of mental disorders is questionable, is there a place for coercion?

Prof Paula Reavey from England present her seminal work examining the contribution of the design and architecture of mental health settings to the prevalence and incidence of violence, aggression, and coercion. People are violent, are they not? Prof Reavey's "psycho-ecological' approach examines *'how environments 'afford'* greater risk, through increasing anxiety, closing off relations between staff and patients, and reducing a sense of agency and meaning'. Perhaps, it's the design and architectural flaws inherent in mental health settings that foments episodes of violence, aggression, and coercion.

Prof Joy Duxbury is welcomed back to the Congress to share her insights into the disproportionate use of force in mental health among different populations, including those from *'minoritised'* communities. Prof Duxbury exposes the scandal of these inequities (iniquities?) and suggests how these can be addressed to ensure a more inclusive care environment.

Sidsel Jakobsen, a mental health consultant and expert by experience invites us to *'meet the person, not the patient'* and brings her many years' experiences of mental health to guide delegates on how to enable a better and more tolerable life for those using services. Sidsel brings her open and honest thoughts about her many years in psychiatry and discusses what helped and hindered her recovery.

Dr Owen Price from the University of Manchester, UK presents his research from the EDITION project an evidence-based intervention to enhance de-escalate violence, aggression, and coercion in adult and forensic inpatient settings. The project, funded by the UK's National Institute of Health and Care Research, took a trauma-informed, multi-method approach drawing from patients' interpersonal trauma histories to develop, and test the feasibility of the approach in forensic settings in the UK.

Prof. José Miguel Caldas De Almeida, President of the Lisbon Institute of Global Mental Health examines the influence of mental health policy, legislation, and services organisation on the use of compulsory treatment and other coercive measures in mental health services. Prof Caldas De Almeida discusses how

international human rights instruments, strategies and interventions were developed to reduce the use of coercion, and these in the global mental health settings, especially in higher and low-income countries.

In addition to our keynote addresses and concurrent sessions, we will for the first time at the Congress present a range of masterclasses by eminent people in the violence, aggression, and coercion fields.

We have expanded the sub-themes to truly capture a wider range of presentations. Of note this year are concurrent sessions examining trauma-informed approaches, the application of Artificial Intelligence, as well as Augmented and Virtual reality, and somewhat topically, how the Covid -19 pandemic impacted violence, aggression, and coercion.

Our sometimes-provocative array of posters, workshops, and symposia remain an important part of the Congress, and again are evident in this year's programme. We continue to 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, aggression and coercion are notable. It is also evident that mental health service users and carers continue to play a key role in co-designing interventions, and the structure, organisation, and delivery of services. This remains an important dimension to the Congress.

Prof. Patrick Callaghan

Henk Nijman Award

It was with great sadness that we learned of the death of our scholarly colleague and good friend Prof. Dr. Henk Nijman [RIP] who passed away in February 2021.

Henk was a founding member and co-chair of the European Congress on Violence in Clinical Psychiatry, positions which reflected both his status as an internationally acknowledged and widely published academic on workplace violence prevention, and his commitment to best practice.

Since 1992 Henk was a stalwart researcher investigating the causes, prevention, and measurement of aggression within mental health settings, and evaluating treatment effectiveness within forensic settings.

Henk obtained his PhD from the Faculty of Psychology of Maastricht University in 1999 with his thesis *"Aggressive behavior of psychiatric inpatients. Measurement, prevalence, and determinants"*. He held the position of professor of forensic psychology by special appointment at Radboud University in Nijmegen since 2004. He was also principal investigator at the Aventurine Division of Altrecht Mental Health Care.

Henk's contribution extended beyond theory, to practice and teaching. His scholarly work inspired many in the violence prevention community in fostering collaboration and positive change, and his contribution to practice will continue to enhance the care of service users to whom he was deeply committed.

Henk will be missed by all, not only for his intellect and scholarly contributions, but also for his cheerful disposition, encouragement, and generosity to both accomplished and emerging researchers and clinicians.

The prize for the best abstract of the congress will now be named the *'Henk Nijman Award'* in honour of Henk's immeasurable contribution as founder and co-chair of this congress over many years. The best abstract will be decided by the scientific committee, and the winner will receive a fee waiver for the 13th European Congress on Violence in Clinical Psychiatry to be held in 2024.

Welcome and historical background

The scientific committee welcomes all delegates and presenters to the 12th European Congress on Violence in Clinical Psychiatry, in Rotterdam, the Netherlands, 6 – 8 October 2022. It is thirty years since the inaugural congress in 1992 in Stockholm, initiated by Prof. Börje Wistedt, at the Karolinska Institute in Stockholm, Sweden.

Following this first congress, the passion for a global congress was ignited by Prof Tom Palmstierna and Prof. Henk Nijman, in partnership with Nico Oud and colleagues. Together this trio of visionaries created a unique bi-annual forum attracting clinicians, researchers, leaders, managers, policy makers and mental health service users and carers from Europe and beyond. The 12th Annual Congress and those that have preceded it in the last 30 years is a testament to these efforts. Today the European Congress on Violence in Clinical Psychiatry is widely recognised as one of the pre-eminent conferences distilling cutting edge research and education in the prevention, assessment, and management of coercion, violence, and aggression in mental health and intellectual disabilities. We owe a debt of gratitude to Tom, Henk and Nico for their initial vision, the latest fruits of which will be evident at the 12th Congress in Rotterdam.

Over thirty years, and many cities travelled, the congress has remained true to its original aim to present the latest research and education in the prevention, assessment, and management of coercion, violence, and aggression in mental health and intellectual disabilities, working in partnership with a wide range of stakeholders, including those using services, and carers. Our work has remained of interest and relevance to mental health service users, carers, clinicians, researchers, leaders, managers, and policy makers. The work presented at the various congresses has also sparked the interest of the media, and wider populations in many parts of the world.

Due to the COVID-19 Pandemic it is three years since we met in Oslo. Finally, we can meet face to face again, socialize and network with each other, as well as enjoy the vibrant city of Rotterdam, and the warmth of our Dutch hosts. The Congress remains the perfect opportunity to learn and exchange ideas with your colleagues, and to benefit from discussions in an open and interactive setting.

In 2022 the congress will be held in Rotterdam, The Netherlands and will be organized by Sympopna Leids Congres Bureau. Since the inaugural event, the Congress has expanded rapidly in terms of the number of scientific contributions and participants. Some congresses attracted 600 participants from 36 countries worldwide.

In line with previous congresses all contributions to this year's event will be published in a book of proceeding reflecting the current state of knowledge about, and research into the prevention and management of violence, coercion and aggression in mental health and intellectual disability settings and the training and education of staff.

The 12th 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 (ENTMA[08]) The 12th European Congress on Violence will focus strongly on clinically relevant and clinically useful interdisciplinary scientific and practical knowledge about interventions aimed at treating and reducing violence, aggression. And coercion. The overall congress theme: *"Co-creating research, education and practice responses within contemporary mental health"* 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 Congress is evidence in the various subthemes that will be addressed in Rotterdam 2022:

- Epidemiology and nature of violence against staff in mental health
- Epidemiology and nature of violence against patients / victimisation
- Violence prevention, care, and treatment
- Trauma informed practice
- Assessment of risk, prevention, and protective factors
- Humane safe and caring approaches to coercive practices
- Neurobiological and pharmacological interventions
- Psychosocial interventions

- Service users and family perspectives
- Intersectional perspectives (gender, race, culture, and ethnicity)
- Ethical, human rights and legal perspectives
- Sexual offending violence
- Specific populations: forensics
- Specific populations: intellectually disabled / learning disabilities
- Specific populations: children and adolescents
- Specific populations: older persons and those living with dementia
- Specific populations: community and outreach care
- Specific populations: displaced people
- Specific populations: psychiatric patients in emergency services
- Staff training and education
- Application of new technologies (Artificial Intelligence, Augmented Reality, Virtual Reality)
- Arts and humanities approaches
- Architecture, design, and aesthetics
- Covid-19 pandemic and violence (lockdown, confined environments, domestic violence, coercion, deprivation of treatment, suicide, and self-harm)
- 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 programme reflects multiple perspectives including clinical/ service, organizational, educational, research and regulatory. To maximize the potential contribution of networking opportunities the congress will include social activities:

- Optional clinical visits on Wednesday afternoon the 5th of October 2022.
- A complimentary welcome reception on Thursday the 6th of October 2022.
- A special social evening event / Congress Gala Dinner on Friday the 7th of October 2022. (Congress Gala Dinner is at additional cost).

Rotterdam: a young, dynamic metropolis in continuous renewal of itself at a rapid rate. A city with sparkling skyscrapers, a world-class port, famous museums, awesome festivals, stylish restaurants, and fabulous food markets – each the product of Rotterdammers and their celebrated *"can-do"* attitude to life.

Experience the city's extraordinary attractions and tours – by bike, bus, boat or on foot – and you'll see why Rotterdam' was once voted one of the world's top ten cities by Lonely Planet's Best in Travel guides.

We cordially welcome you to Rotterdam, the Netherlands in October 2022.

Congress Organising Committee

- Dr. Roger Almvik (Norway) (Chair)
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- Prof. Tilman Steinert (Germany)

Supporting Organisations

- European Violence in Psychiatry Research Group (EViPRG)
- the European Network for Training in the Management of Aggression (ENTMA[08])
- Oud Consultancy & Conference Management

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 congress 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 119 abstracts from 25 different countries worldwide, of which 1 (0,8%) were rejected, 23 (19%) were withdrawn mainly due to financial reasons or not getting funding in time.

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Keynotes

Is Coercion in Mental Health Care Any Longer Justifiable?

Thursday 6 October 2022, 09.15-10.15 Hrs.

Prof. Dirk Richter
Professor for psychiatric rehabilitation research

Medically legitimized coercion is ethically and legally justified by the simultaneous occurrence of a risk of self-harm or harm to others and a defined illness/mental disorder. The issue of the definition of a mental disorder has not yet become a topic for coercion-related research. A closer look into the latest neuroscience and taxonomic research reveals that the existence of mental disorders as defined by current classification systems (DSM/ICD) has come under much scrutiny. The main reasons for becoming sceptical about conventional notions of mental disorders are the extensive co-morbidity of diagnostic entities and the dimensionality of mental phenomena which necessarily leads to arbitrariness when it comes to separate health from illness. Additionally, there is increasing uncertainty about the characteristics and even the existence of a human mind or consciousness in neuropsychology and neurophilosophy. This state of research suggests that we can no longer be confident about the definition or existence of mental disorders and, therefore, can no longer justify coercion as a means of mental health care. Consequences and dilemmas of this conclusion need to be addressed.

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Safety and Psychologically Informed Environments (PIEs): exploring design, relationships, and emotions from a psycho-ecological perspective.

Thursday 6 October 2022, 10.15-11.00 Hrs.

Prof. Paula Reavey
Professor of Psychology and Mental Health

People not places are violent, surely? But what if aspects of the environment create conditions where risk is increased, and violence more readily ignited? In this presentation, I bring together evidence-based insights from design, architecture, and psychology, to create a system level appraisal of escalation, violence, and seclusion use. This perspective I have termed *'psycho-ecological'* to represent the theoretical and empirical synthesis of environments and people, to examine how environments *'afford'* greater risk, through increasing anxiety, closing relations between staff and patients, and reducing a sense of agency and meaning. This theoretical aperture invites closer inspection on how to work collaboratively with experts by experience, architects, and designers to create environments that are safer, physically, and psychologically.

Correspondence

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Exploring the extent and implications of the disproportionate use of force in mental health and related settings: Time to flip the narrative!

Thursday 6 October 2022, 16.00-16.45 Hrs.

Prof. Joy Duxbury
Professor of Mental Health

The disproportionate use of force in mental health settings and beyond is a significant issue in the modern-day care of the most vulnerable individuals in society. A range of inequalities are evident and impact upon the quality of care that certain populations experience.

The disparities are extensive and include matters pertaining to ethnicity, age gender, and disorder. These clearly affect the experiences of those involved and need to be addressed. To do this, we need not only to understand the extent and nature of the problem in terms of accurate reporting but also how to understand the challenges faced by all parties. Clearly participatory action approaches such as experience-based co-design can help drive the changes required going forward.

I will present the evidence base on the current position and highlight some research we have been working on to co-create new ways of working. Some examples include the experiences of Black Afro-Caribbean men about being detained and research on those with learning disabilities and autism around restrictive interventions.

Both populations experience disproportionately in the use of force when engaging with mental health services. It's time to flip the narrative.

Correspondence

Joy Duxbury
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Masterclass A: Covid 19, Mental Health Care and Critical Incidents: What Can We Learn for the Next Pandemic?

Thursday 6 October 2022, 16.50-17.50 Hrs.

Prof. Dirk Richter
Professor for psychiatric rehabilitation research

The Covid-19 pandemic has hit mental health care services unexpectedly in early 2020. Many services were shut down, inpatient capacities were reduced, and services had to deal with outbreaks within their service user populations and staff. This Masterclass session will provide an overview on the impact of the pandemic on mental health issues in the general population and in mental health care service users. A particular focus will be made on critical incidents such as aggression and suicide attempt and how institutions have dealt with these issues under stressful circumstances.

The session will include a presentation and an interactive part with participants who are asked to share their personal and institutional experiences on how to deal with critical incidents during a pandemic and what can be learned for future infectious outbreaks.

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Masterclass B: The bulldozer and the ballet dancer – exploring nurses' caring approaches in acute psychiatry

Thursday 6 October 2022, 16.50-17.50 Hrs.

Anna Björkdahl
Researcher, Head of care development

The bulldozer and the ballet dancer are metaphors for opposite ends of nurses' different caring approaches that can often be observed on acute psychiatric wards. The bulldozer is recognized by a rather low level of interest in getting to know, understand and support patients but is often active and fearless in acute violent and controlling situations. The ballet dancer on the other hand is frequently seen interacting with patients, almost like a form of art, imagining the patient's situation and constantly trying every option to building rapport. The ballet dancer, however, is rarely seen involved in violent and controlling situations since it is frightening and may challenge his or her values and beliefs.

In this interactive and slightly provocative masterclass, we will dig deeper into nurses' different caring approaches and specifically discuss the impact on violence prevention and management from a realistic as well as idealistic perspective. Are both bulldozers and ballet dancers needed in acute psychiatry? Or a hybrid nurse with a little bit of both?

Reference

Björkdahl, A., et al. (2010). The bulldozer and the ballet dancer: aspects of nurses' caring approaches in acute psychiatric intensive care. J Psych Ment Health Nurs. 17:510-518.

Correspondence

Anna Björkdahl
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Violence from a service user perspective – meet the person, not the patient, cooperate and include.

Friday 7 October 2022, 09.00-09.45 Hrs.

Sidsel Høgenhaug
Former service user

We want a psychiatry where we help the patients towards a better and more tolerable life, and therefore it is important to listen to them.

We want to reduce violence, coercion and increase the possibility of recovery, but is it even possible if we don't know the person it's all about?

Based on her own experiences, Sidsel talks openly and honestly about her many years in psychiatry, what helped and what hindered recovery.

Correspondence

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The EDITION study: developing and evaluating an intervention to enhance de-escalation in adult acute and forensic settings

Friday 7 October 2022, 09.45-10.30 Hrs.

Dr. Owen Price
Mental health nurse

EDITION developed and evaluated an evidence-based intervention to enhance de-escalation in adult and forensic inpatient settings. Intervention development involved qualitative inquiry with multidisciplinary professionals, patients, carers, ward staff and violence reduction specialists, systematic reviews and co-design events informed by behaviour change and implementation science methodology.

The EDITION intervention aimed to modify aspects of inpatient care experience that mimic aspects of patients' interpersonal trauma histories. Components included:

1) de-escalation training;
2) collaborative prescribing and patient-centred ward rounds;
3) sensory modulation;
4) peer support to improve admission experience,
5) conflict formulation and restrictive intervention debriefing;
6) an intervention to enhance critical reflection on limit-setting practices, interpersonal boundaries and attitudes to staff vulnerability;
7) an intervention to enhance ward staff's psychological safety and relationships with clinical leaders and
8) an intervention to involve service users in shift handovers and nursing documentation.

Ten wards in two NHS Mental Health Trusts trialled the intervention. Wards included male high secure wards (n=2), male and female medium secure wards (n=2), male and female low secure wards (n=2), mixed PICUs (n=2) and male and female acute wards (n=2). Data collection was feasible, the intervention

was acceptable and significant pre-and-post reductions in both conflict and containment occurred.

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Masterclass C: Toward a shared understanding and best practice in post occurrence reviews

Friday 7 October 2022, 12.00-13.00 Hrs.

Prof. Sabine Hahn & Dr. Kevin Mckenna

There is universal acknowledgement that the prevention and recognition, and the safe, effective, and therapeutic management of conflict occurrences poses a serious challenge within mental health settings. Such occurrences, and the utilisation of emergency restrictive interventions, are associated with potentially serious physical and psychological risks for all concerned.

Beyond the immediate risks, evidence suggests that the impact of such occurrences endures beyond the incident, can impoverish the therapeutic environment, and diminish the quality of the care experience for both recipient and provider. Furthermore, witnessing such occurrences is distressing to others, and costly to services.

Professional and regulatory guidance impose explicit imperatives for some form of *'post incident review'* to ameliorate potential distress and restore/preserve therapeutic relationships, while coercive minimisation initiatives consistently include *'debriefing'* as one critical component of overall strategies (Huckshorn 2005 Colton and Xiong 2010; MHCI 2014; UK NICE (2015) Duxbury et al 2019).

Despite these mandates, there remains some confusion as to the specific purpose and function of *'debriefing'* and/or *'post incident reviews'*, and considerable variance in practice reflects the paucity of evidence as to what constitutes evidence-based best practice.

During this highly interactive masterclass participants will:

- Actively explore the function and purpose of post occurrence reviews for all stakeholders.
- Actively clarify and describe the specific needs of, and desired outcomes for, each stakeholder

- Actively appraise a tentative best practice model of post occurrence review, with particular emphasis on application to everyday practice, within mental health settings.

Each stage of the masterclass will involve active engagement among participants.

Learning Outcomes

- Participants will have the opportunity to broaden their understanding of the role purpose and function of 'post occurrence reviews' with emphasis on both the challenges and opportunities.
- Participants will have the opportunity to consider a 'practice' model of 'post occurrence reviews' with emphasis on application within mental health settings.

References

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Correspondence

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Masterclass D: Reduction of coercion in the Netherlands: no effect without ethics!

Friday 7 October 2022, 12.00-13.00 Hrs.

Dr. Yolande Voskes
Assistant professor and senior researcher

From an ethical perspective coercion is a problematic issue. The autonomy of the patient has become more important. On the other hand, coercion provided effective means for preventing injury. There is clearly a tension between autonomy on the one hand and safety on the other. The focus is on whether seclusion is justified at a certain moment. Little attention is paid to everyday ethical issues in contact with patients and the dilemmas involved, which may result in recourse to coercive measures. Moreover, the morality of care relationships and the mutual expectations and moral obligations of the patient, the professional and other stakeholders are not addressed. In this presentation an argument will be made for an ethics that goes beyond the focus on autonomy and security: an ethics of care! This different way of looking at coercion gave the opportunity to develop some best practices in the Netherlands.

Correspondence

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Influence of mental health policy, legislation, and services organization on the use of compulsory treatment and other coercive measures in mental health services

Saturday 8 October 2022, 09.00-09.45 Hrs.

Prof. José Miguel Caldas De Almeida
President of the Lisbon Institute of Global Mental Health

In the last decades, significant efforts have been made, both at national and international levels, to reduce the use of coercion in mental health services. New international human rights instruments were created, innovative strategies and interventions were developed to reduce the use of coercion, many countries promoted important changes in their mental health legislations, policies, and services to scale up rights of persons with mental disorders, and in some places the active participation of people with lived experience of severe mental health problems was strengthened.

In this presentation, we will discuss the results of these efforts, based on the available evidence. We will analyse, with special attention, the data that can help us understand the real impact of new mental health legislation and policies on reducing compulsory treatment and the use of other coercive measures in mental health care, and we will present some examples of initiatives and Programmes that have shown encouraging results both in high- and low-income countries.

Finally, after discussing the main challenges we are currently faced with in promoting more human rights and recovery-oriented services, we will share some thoughts on how research could contribute to respond to these challenges.

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Topic 1 – Epidemiology and nature of violence against staff in mental health

Prevention of psychotic murders: consider severe bipolar disorders; a role for psychiatry

Paper presentation

C. Ray Lake, University of Kansas Health System, Kansas City, Kansas, United States.

Keywords: Bipolar / Psychotic / Mass Murderers / Familicide

Abstract

Mental health professionals are at high risk for violence, even murder, by their psychotic clients. Psychotic perpetrators also commit mass murders of unknowns as well as killing their family and friends. These perpetrators differ from non-psychotic murderers, killing innocent strangers in volume, seemingly at random; act alone; attack during daylight; remain, often suiciding on site; are not intoxicated, radicalized, or gang members; give prior warnings of their plans; have prior psychiatric contact; sometimes prior successes, even exceptional; and are motivated by paranoid, grandiose, delusional logic.

Non-organic psychoses are caused by severe bipolar disorders. Details from the media show that psychotic murderers suffer with severe mania or depression. The current paper presents an epidemiology of such murders and exemplary cases to support this contention that a psychotic Bipolar Disorder is responsible. Prior mental health attention typically produces misdiagnoses of Schizophrenia. Correct diagnosis results in more effective pharmacologic treatment and, potentially, prevention.

Summary

Background

Mass murders, killing of mental health professionals, family, and friends by psychotic perpetrators are horrific tragedies that warrant intense preventative efforts. Psychotic murders by manic psychotic perpetrators have been recorded for over 2,000 years: *"When the depressive phase is over, such patients go back to being gay, they laugh, they joke, they sing…sometimes they laugh and dance all day and all night…sometimes they kill and slaughter the servants."* (Aretaeus, CE 150).

Aims

The aim is to identify the epidemiology of psychotic murderers to better understand behaviours and motivations commonly associated with their lethal actions yielding more accurate diagnoses and improved psychosocial and pharmacologic management.

Methods

The methods involve ongoing review of the literature and tabulation of characteristics, behaviours, diagnoses, and treatments of psychotic murderers.

Results

The psychotically mentally ill are at the highest risk of both sustaining and inflicting violence to include suicide and murder. Some estimate that 14% perpetrate violence, including murdering hundreds of innocent victims each year, usually with firearms. Although psychotic mass murderers often kill at random, other psychotic perpetrators threaten violence and even murder of their mental health professionals, families, and friends. About half of psychotic murderers had prior of mental health contact but less than half were adequately treated, partially because of misdiagnoses.

Fifty-six cases of violence, murder, mass murder, and familicide committed by psychotic individuals were reviewed. Each case involved a single perpetrator, with mean age 32.5 years, ranging from 18 to 64. Most were male, except

for cases of familicide; Caucasian; and unemployed. Some had exceptional premorbid successes.

All developed a delusional, paranoid, and often grandiose psychosis that was the motive for their murders and a reason for the misdiagnosis of Schizophrenia. Some psychotic delusional mothers killed their children believing they had to save them from the devil or hell on earth with plans of meeting in heaven after their own suicides. Surviving mothers, such as Ms. Yates, were initially deemed sane and imprisoned. Another theme among the familicides was the delusion of killing the devil in the *"possessed"* victim. Details of selected cases will be presented.

Conclusions

Based on available details of cases, diagnoses of mania or depression, severe with psychotic features, seemed warranted.

Although antipsychotic medications were needed in all cases, the misdiagnosis of Schizophrenia prevented the use of concomitant mood-stabilizing medications. Psychotic murderers deserve a correct diagnosis and the most effective pharmacologic and psychosocial treatments.

Educational goals

1. Following the presentation of this paper, the audience will be able to recognize clear as well as subtle signs of dangerous levels of psychotic mania or depression, based on their appreciation of facts and intuitions regarding the behaviours, activities, and thoughts of these potential psychotic killers.
2. Once the audience has accomplished recognition of bipolarity, they will be able to formulate the most effective treatment plans including medications and psychotherapy to reduce the likelihood of violence and murder.

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Association between characteristics of nursing teams and patients' aggressive behaviour in closed psychiatric wards

Paper presentation

Paul Doedens, Amsterdam University Medical Centres, Amsterdam, Netherlands; Jentien Vermeulen, Amsterdam University Medical Centres, Amsterdam, Netherlands; Gerben ter Riet, Amsterdam University of Applied Sciences, Amsterdam, Netherlands; Lindy-Lou Boyette, University of Amsterdam, Amsterdam, Netherlands; Corine Latour, Amsterdam University of Applied Sciences, Amsterdam, Netherlands; Lieuwe de Haan, Amsterdam University Medical Centres, Amsterdam, Netherlands.

Keywords: Aggression / Nursing / Personality / Mental Health Care

Abstract

Aim

To estimate the effect of nursing, shift, and patient characteristics on patients' aggression in clinical mental health care.

Design and methods

A follow-up study was performed to estimate the effect of nursing characteristics at shift level and patient characteristics on the incidence of aggression.

Findings

The incidence of aggression was higher in teams with only female nurses. Teams scoring high on extraversion experienced more verbal aggression and teams scoring high on neuroticism experienced more physical aggression. Younger patients and/or involuntarily admitted patients were more frequently aggressive.

Implications for practice

Our study is, to our knowledge, the first to investigate the influence of Big Five personality traits of nurses and aggressive behaviour of patients. These findings should stimulate support for nursing teams to prevent aggression on psychiatric wards. Information of their personality might serve useful for training purposes.

Summary

Background

Aggressive behaviour on psychiatric wards imposes a high risk of adverse outcomes for patients and staff. Most previous studies focussed on patients' predictors of aggressive behaviour. Although highly relevant, concentrating solely on patient characteristics is a one-sided strategy. The role of nursing characteristics can provide further insight on the risk or aggressive behaviour.

Aims

To investigate the influence of nursing team, shift, and patient variables on verbal and physical aggressive patient behaviour on closed psychiatric wards.

Methods

We performed a prospective two-year follow-up study on a closed psychiatric ward. We included all patients admitted to a closed psychiatric ward in the data collection period. We gathered data on nurses using a case record form and with a personality test (NEO-FFI-3). We gathered data on patient and shifts using the electronic health record. We analysed the data by constructing a cross-classified multilevel logistic regression model with occurrences of aggressive behaviour as the dependent variable and nursing team, shift, and patient characteristics as independent variables.

Results

During the data collection period, we observed 98 individual nurses and 224 patients. These patients were responsible for 802 aggressive incidents, of which 438 were verbal aggression and 364 incidents of physical aggression. We found that during shifts with teams composed of >75% males, there were fewer incidents

of patients' aggression than in shifts with teams composed of females only, OR .56 (95% CrI .34–.82). Higher team scores on personality trait extraversion were associated with more verbal aggression, OR 2.47 (95% CrI 1.56–3.58). Higher team scores on neuroticism were associated with more physical aggression, OR 1.40 (95% CrI 1.00–1.90). We observed less aggressive behaviour in the night shift compared to the day shift. Patient characteristics (higher age, involuntary admission, bipolar disorder, and psychiatric comorbidity) showed strong associations with aggressive behaviour of patients.

Conclusions

Nursing teams composed of >75% male nurses were associated with more aggressive behaviour of patients. High team scores on extraversion were strongly associated with verbal aggression, but not with physical aggression. In contrast, high team score on neuroticism was associated with physical aggression, but not with verbal aggression. The reported associations may raise nurses' awareness about factors that may increase the probability of aggressive behaviour. We deem it inappropriate to use current findings for selecting staff members. However, improving insight of nurses in their own personality could serve as a starting point for training and development of nurses' interactional skills.

Educational goals

After this presentation, participants can,

1. Reproduce the scientific findings concerning the influence of staff members on aggressive behaviour.
2. Rationalize the practical implications of the scientific findings on the participants own clinical situation.

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Staff and ward factors associated with aggression development: an experience sampling method study

Paper presentation

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Keywords: Aggression / psychiatry / inpatient / experience sampling

Introduction

Aggression on acute psychiatric admission wards is problematic for staff, nurses, and other admitted patients. A recent systematic review showed that development of aggression is founded in three main factors; patient related factors, ward related factors and staff related factors (1). In contrast to patient related factors, ward and staff related factors have only been studied to a limited extent, but they may offer valuable information for targeted prevention and intervention of aggression. Ward factors that are more likely to contribute to aggression development are the level of bed occupation and the number of admissions (1). Also places with increased patient–patient or patient–staff interaction is a risk for aggression development (2-5).

Staff factors that are related with aggression development are male gender, job strain, job dissatisfaction, overwork, dissatisfaction with leadership, tiredness, lack of good introduction of a new nurse, poor collaboration between nurses, more temporary staff, and more anxiety in nurses (1). The interaction between nurses and patients is also a factor in the development of aggression on the ward and seems important since aggression arises in the interaction between people. All these factors have been described, but prospective research is lacking.

Nurses are common victims of patient aggression. About 10% of nurses report missing work at some point due to aggression and 60% report some posttraumatic symptoms (6).

During a day on the acute ward, nurses show a great variation in behaviour and affect towards the patient in preventing agitation, as well as in possibly escalating aggression in patients by setting limits or discussing ward rules (5). A more personalised understanding of the behaviour and the moment-to-moment variation of the effect of nurses in experiencing agitation and subsequently aggression development in a patient, offers opportunities for in time prevention of an aggressive outburst. Various personal and environmental factors changing between persons and over time define the personal reaction of nurses towards aggression. Given the interactive nature of variation in behaviours and affect in nurses varying from moment-to-moment, this calls for an ecological valid assessment procedure addressing the behavioural and emotional variations (7). The Experience Sampling Method (ESM) is used to assess a multitude of thoughts, affects and behaviours in the ever changing contexts of daily life and to study the dynamics of multiple subjective states of a nurse in changing wards and private related contexts (8). ESM provides a naturalistic insight of the actual staff and ward factors contributing to both the development and the de-escalation of aggression.

Objective

As the environment (including both staff present on the ward and the ward itself) is thought to be an important factor in explaining aggression development, we aim to study ward dynamics and behavioural and emotional interaction between patients and nurses in the development of aggression, within a dynamic naturalistic (ecologic valid) setting.

Design

A prospective naturalistic experience sampling method (ESM) study.

Setting and participants

All nurses working on the Highly Intensive Care (HIC) of a mental health institution in the Netherlands were asked to fill in the PsyMateTM app, an application that can be downloaded to the participant's mobile phone. This app sends a beep 16 times in 24 hours for 7 consecutive days and at that moment they answer the presented questions, which takes approximately 2 minutes. Nurses are instructed to answer the beeps any time they are awake, whether at work (day- and nightshift) or at home. All participants signed informed consent.

Main outcome measures

Associations were established between different staff and ward factors and the occurrence of aggressive incidents on the ward.

Results

Risk for aggression was associated with the nurse being with a patient (OR=2.26, confidence interval (CI)=0.99-5.15, p=0.05), but no significant association was found between discussing with the patient and setting a limit or physical absence of the nurse on the one hand and aggression on the other. More experienced nurses encountered more aggression (OR=3.5, 95% CI=1.32-8.26, p=0.01). Age and gender of the nurse were not associated with aggression development. Exceeding the maximum bed capacity showed a greater risk for aggression (OR=5.36, CI= 1.69-16.99, p=0.004). There was no significant association when analysing a more positive atmosphere on the ward or positive affect of the nurse, but negative affect of the nurses showed a trend for encountering less aggression.

Conclusion

Aggression can be managed. For both nurses and management these findings imply important lessons: there should be a reasonable number of nurses present and nurses need to be trained to be present on the ward but need to apply the appropriate de-escalation techniques and use a respectful and empathetic way of interacting with the patient. Management should also take care that maximum bed capacity is not exceeded. It opens the way to more research on this topic with momentary assessment to enhance power and draw more definitive conclusions.

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What can we learn from registries of violent incidents and coercive measures in clinical psychiatry?

Paper presentation

Tilman Steinert, Zentrum für Psychiatrie Südwürttemberg, Ravensburg, Germany; Sophie Hirsch, Zentrum für Psychiatrie Südwürttemberg, Biberach, Germany.

Keywords: violence / SOAS-R / coercion / epidemiology

Since 2015, we have conducted a registry for coercive measures in the 32 psychiatric hospitals in the German Federal State of Baden-Wuerttemberg with 11 million inhabitants. Case-related data of each measure (restraint, seclusion, involuntary medication on any legal base) is collected. Aggressive incidents, recorded by the SOAS-R, are collected in part of these hospitals. Most relevant outcomes are percentage of cases subjected to coercion or showing aggressive behaviour, respectively, and mean cumulated duration of coercive measures per case. To date, we can rely on a data base of more than 1 million admissions. Recently, we conducted a series of studies on different epidemiological research questions related to violent incidents and coercive measures in psychiatric hospitals (1-5), some of them still unpublished. An overview on these studies will be presented. Such registries are very valuable for cross-sectional and longitudinal evaluations in clinical units such as wards or departments, in entire hospitals, regions, and countries. However, they underlie the limitations of observational data to make causal conclusions. Comparisons between hospitals or countries require caution. Data of the kind probably do not allow us to discriminate between “good “and “bad “hospitals.

Educational goal

Understand how registries of violent incidents and coercive measures can contribute to our knowledge of causal conclusions in clinical psychiatry?

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Using participatory action research to address violence against staff in mental health care

Paper presentation

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Keywords: work-related violence / psychosocial work environment / participatory action research / prevention

Abstract

Preventing work-related violence (PREWVI) is a participatory action research project that aims to develop and implement an employee-driven intervention in mental healthcare. A pilot project was established at Lovisenberg hospital March 2021. Data on work-environment, employee health, work-related violence and utilization of preventive tools were collected from 360 clinical employees working in one of seven wards (response rate 74 %) and were used to develop ward-specific action plans for workplace improvement. To evaluate implementation of action plans and effects on improved work-environment, increased use of preventive tools and reduced levels of violence against staff, we used a mixed methods approach (focus group interviews and survey-questionnaires one year after baseline measures). Both qualitative and quantitative results from the pilot project will be presented at the congress.

Summary

There is a lack of published evaluations of workplace interventions aimed at reducing violence in acute psychiatric wards. Using a participatory action research method, the PREWVI project implemented and evaluated a violence prevention and management intervention in seven wards in acute psychiatric hospitals. The pilot phase of this project started in March 2021 and collected data from employees using survey-questionnaires and focus groups.The overarching aim of the PREWVI-project is to develop a survey-feedback intervention to promote a safe and healthy work environment in mental healthcare hospitals and evaluate its effectiveness on improving psychosocial work environment,

employee health, increase utilization of already existing preventive strategies, and to measure impact on levels of work-related violence.

The development and evaluation of the survey-feedback intervention comprised the following steps:

1) A baseline survey including validated questions and instruments measuring work environment, employee health, work-related violence, and utilization of preventive tools distributed personally to all eligible respondents in June 2021.
2) Based on the results from the baseline survey, feedback on survey results was provided directly to the respondents and in-ward task groups from September-October 2021. Each ward established a working group with representatives from clinical staff. The feedback was given orally to each group followed by group discussion and problem-solving. In addition, wards received a written summary of the findings and a template for how to design their action plan.
3) After feedback was provided, each ward developed their own action plans to overcome the problems revealed through that ward's specific feedback. In addition, a joint seminar for all wards was arranged in December 2021 to share experiences and strategies. Ward-specific action plans were implemented in December 21 and January 22.
4) A follow-up survey including the same measures as the baseline survey was conducted in June 2022. In addition, a qualitative process evaluation was performed in May 2022. Through focus group interviews, potential obstacles of the implementation of the intervention will be identified. Results from focus group interviews and the follow-up survey will be used in further development of the survey-feedback intervention.

Results from both qualitative evaluation of implementation and quantitative data on violence reduction will be presented at the congress.

Educational goals

1. Participants are expected to explain the relationship between psychosocial work environment and violence against staff
2. Participants are expected to use principles from the survey-feedback intervention to create a pilot project of their own.

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A Study of Aggression and Violence as Experienced by Doctors in Psychiatry in Ireland

Paper presentation

Israa Elkashif, HSE, Galway, Ireland; Kevin McKenna & Catherine Mc Donough.

Keywords: Qualitative / Psychiatrist / Violence

Abstract

Background

A compelling body of evidence consistently identifies aggression and violence as a complex hazard within the health sector. Despite universal recognition, the problem remains understudied, particularly in relation to psychiatrists.

Aims & Objectives

Formal recording systems are relied upon to monitor and respond to occurrences. While such quantitative records provide valuable data, they provide little insight into the doctor's experience. The aim of this study was to explore and describe psychiatrists experience of encountering work related aggression and violence.

Methodology

This study utilised a focus group research design. Participants included psychiatrists of all grades within one large Irish regional mental health service. Data collection involved two audio recorded synchronous virtual focus groups, one for consultant, and the other for non-consultant grades.

Findings and Discussion

Thematic analysis of transcripts revealed four major themes - a) the phenomena b) reporting c) aftermath and d) support. The presentation will discuss inductively identified themes and implications.

Summary

A compelling body of evidence consistently identifies aggression and violence as a complex sector-specific hazard within the health sector generally, and in psychiatric services. There is consensus that such aggression and violence diminish the care experience of both recipients and providers, and compromises organisational effectiveness in delivering person-centred services of high quality. Despite universal recognition, the problem remains understudied in an Irish Context, particularly in relation to medical doctors generally, and psychiatrists.

Within an Irish context, formal recording systems including the National Incident Management System are relied upon to inform the monitoring and responding to occurrences of work-related aggression and violence. While useful from a systems perspective, recording systems provide very little, if any, insight into the experience of the doctor encountering such occurrences. The aim of this study is to explore and describe psychiatrists' experience of encountering occurrences of work-related aggression and violence.

This qualitative study utilised a focus group research design. Participants included a purposive sample of psychiatrists of all grades within one large Irish regional mental health catchment area. Data collection involved two audio recorded synchronous virtual focus groups, one for consultants, and the other for non-consultant grades with each grade attending a single group.

The study revealed that encountering aggression and violence is a normative reality for many doctors working in mental health services and that the manifestations of the problem vary across service settings. Participants showed reticence in reporting and the impacts of encountering events were multifarious. It seems clear that the supports needed during an occurrence and in the aftermath are related but distinct, and that there is potential for improvement in both. Training and support were revealed with the perception that there is potential for much improvement in both.

Educational goals

1. To provide insights into the lived experiences of psychiatrists about work-related aggression and violence
2. To consider the use of qualitative enquiry in psychiatry

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Topic 3 – Violence prevention, care, and treatment

Implementing the German Clinical Practice Guidelines - Preliminary Results of a nationwide RCT

Poster presentation

Sophie Hirsch, ZfP Suedwuerttemberg / Ulm University, Biberach, Germany; Erich Flammer, PreVCo group PreVCo group, Tilman Steinert.

Keywords: RCT / Implementation Science / Clinical Practice Guidelines / Complex Intervention Programmes

Abstract

The PreVCo study (Prevention of Violence and Coercion) is a nationwide RCT on the implementation of German Clinical Practice Guidelines *"Prevention of Coercion – Prevention and Treatment of Violent Behaviour in Adults"*. 12 implementation recommendations were derived from the guidelines. These were presented with the help of external consultants in multidisciplinary workshops on 55 wards throughout Germany. Implementation then took place in a randomized matched-pair design with an intervention and a waiting list group over a total of 2 years. The main outcome is coercive measures per month and bed number. Secondary outcome will be cumulative duration of seclusion and restraint per bed number and year as well as the change before and after the intervention in the waiting list group. Aggressive incidents are also reported. Degree of implementation ofthe single recommendations are assessed by Likert Scales.

Summary

Background

There is a large discrepancy between the amount of evidence- and consensus-based guidelines on the one hand and the small number of scientifically driven implementation programmes on the other hand. However, working as closely as possible to guidelines and thus maximizing the benefit to users requires of recommendations in practice.

Aims

We want to scientifically investigate the operationalized implementation of the German Clinical Practice Guidelines on the Prevention of Coercion throughout Germany. We aim to show whether the application of recommendations obtained under study conditions can also lead to a reduction in coercion in routine clinical practice.

Methods

Out of a set of 12 interventions offered, wards are free to choose three interventions they want to implement (e. g. risk assessment tools, employment of peers, complex Programmes as Safewards). The main outcome is coercive measures per month and bed number. Secondary outcomes will be cumulative duration of restrictive measures per month and bed number as well as changes before and after the intervention. The degree of implementation of the single recommendations are assessed by Likert Scales (PreVCo-Score). The most important control variable is the number of aggressive incidents. We recruited 55 wards in Germany treating detained patients. Implementation took place in a randomized matched-pair design (stratified by for coercive measures per month and bed number and the fidelity to the guidelines at baseline) with an intervention and a waiting list group over a total of 2 years.

Results

The participating wards had between 6 and 30 occupied beds (median 19), and between 11 and 132 patients were admitted per month (median 41). The percentage of patients in involuntary treatment ranged from 3.4 to 88.9% (median 19.9%). There were between 0 to 5.8 coercive measures per occupied bed (median 1). There were between 0 to 1.8 aggressive assaults per occupied

bed (median 0.3). The PreVCo-Score varied between 28 and 106 points, with a possible range of 0 to 135 points. There were considerable differences not only between the wards but also between the individual items of the score. The median for the individual items was between 0 (employment of peers) and 8 (continuous care during a restraint measure), with a possible range of 0-9 points. Preliminary results on the RCT-part of the study will be available in summer/fall 2022.

Educational goals

1. After the presentation, participants should be able to name possibilities to research even safety-relevant and complex interventions with a randomized-controlled design. Participants should be able to explain and evaluate advantages and disadvantages as well as limitations of randomized controlled designs in the social sciences and the use of routine data for research
2. Participants should be able to name the most important contents of the German Guidelines for the Prevention of Coercion and for the Prevention and Treatment of Violent Behaviour in Adults and relate them to the requirements for appropriate implementation.

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Application of the Good Lives Model to street gang membership: new framework for violence intervention

Poster presentation

Jaimee Mallion, London South Bank University, London, United Kingdom.

Keywords: Good Lives Model / Gangs / Intervention / Violence

Abstract

With high levels of violence and mental distress, street gangs have been classified as a global public health problem requiring immediate attention. However, current interventions suffer from poor theoretical foundations and risk focus. As such, the applicability of an innovative and strengths-based approach to gang intervention (termed Good Lives Model [GLM]) was explored. The GLM assumes offending results when limited prosocial alternatives prevent attainment of 11 universal human needs (e.g., inner peace and community). This study examined the GLM's etiological assumptions through interviews with 17 gang members; exploring how gangs provide a space to enable attainment of universal needs and factors preventing these being achieved through prosocial means. Findings supported the GLM's etiological assumptions: participants aimed to achieve all universal needs, with gang membership occurring when prosocial methods were unavailable (e.g., lack of employment opportunities, poor emotion regulation). These supports implementing GLM-consistent interventions to prevent, care, and treat gang-related violence.

Summary

Background

Street gangs have grown globally, with countries including the UK, USA, China, and Sweden reporting a marked increase in membership. As gang membership is associated with long-term negative consequences (e.g., poor mental and physical health, violence, and unemployment), the World Health Organization (2020) classified gang membership as a global health emergency, requiring immediate international response.

Aims

Current approaches to prevention, care and treatment for gang membership and gang-related violence suffer from a limited evidence-base, lack of theoretical foundation and are overly focused on risk factors. Therefore, this research aimed to examine the applicability of an innovative and strengths-based approach, termed the Good Lives Model (GLM), to gang members. The GLM assumes offending results when a lack of prosocial alternatives, due to internal and external barriers, prevents attainment of 11 universal needs (e.g., Pleasure and Relatedness).

As such, the following research questions were explored:

What factors prevent gang members attaining universal needs through prosocial methods?
How do gangs enable individuals' fulfilment of universal needs when these are unattainable through prosocial means?

Methods

Semi-structured interviews were conducted with 17 adult male gang members incarcerated within a UK Category C prison. Gang membership was established using the Eurogang criteria. For each of the 11 universal needs, participants were asked what factors preventing them attaining these in a prosocial manner, and how they felt gang membership enabled fulfilment of these needs.

Results

Findings from thematic analysis of the data supported the GLM's etiological assumptions: participants aimed to achieve all 11 universal needs. However, gang members experienced a multitude of internal (e.g., emotion regulation difficulties, perfectionism, and mental distress) and external obstacles (e.g., poor social support and exposure to violence) across five risk domains (individual, peer, family, school, and community), which prevented attainment of universal needs through prosocial methods. As such, gangs provided an alternative means through which members could attempt to meet their universal needs. For example, the universal need of Relatedness (feeling emotionally connected to another) was attained by developing strong emotional bonds with gang peers, when familial relationships were poor.

Conclusions

As the GLM's etiological assumptions were upheld in this population, this supports the implementation of GLM-consistent interventions to prevent, care, and treat gang membership and gang-related violence. GLM-consistent interventions should build on clients' strengths, supporting development of internal skills and access to external resources which enable attainment of universal needs through prosocial methods, reducing reliance on the gang to fulfil these.

Educational goals

1. By the end of the presentation, attendees will be able to identify and define the 11 universal human needs and describe the etiological assumptions of the Good Lives Model. The 11 universal human needs are: (1) Inner Peace, (2) Relatedness, (3) Life, (4) Excellence in Work, (5) Knowledge, (6) Excellence in Play, (7) Excellence in Agency, (8) Community, (9) Pleasure, (10) Creativity, and (11) Spirituality.

2. Based on the findings of the research, attendees will be able to discuss and evaluate the applicability of the Good Lives Model to street gang members as an intervention framework to prevent, care and treat gang-related violence.

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I Feel Your Pain: violence prevention through shared body-state facilitated by the insula

Interactive workshop

Kellie Rhodes, Limbic Legacy, Denver, United States; Aisland Rhodes, Limbic Legacy, Denver, United States.

Keywords: Violence / Body-state / Homeostasis / Insula / Limbic / Dopamine

Abstract

The aim of the research was to assess the applicability and efficacy of a practice that aligns the instruments and methods used within the mental health community to prevent and treat violence, with those employed by the human body to initiate and inhibit violence. Presenters assayed the applicability and efficacy of this practice through a feasibility study with mental health staff (n=750), and a pilot study with males in residential treatment with primary diagnoses associated with violence (n=10). Pilot data were subjected to Chi-square and ANOVA testing revealing statistically significant impact on violence-related outcome measures with 99% certainty. Capitalizing on homoeostatic processes honed over millennia invites the potential to join with biology to prevent violence at its origin and transform treatment. We are on the cusp of a revolution as interdisciplinary research and practitioner experience collide into a vanguard response to the age-old challenge of violence prevention and treatment.

Introduction

"One Saturday morning in a secure youth prison, residents on my unit were doing chores. We had just finished a great morning group. Everyone was on task and cooperating. It was a lovely morning. Suddenly my supervisor opened the door to my unit and began to walk across the floor. He was looking for extra linen in the cupboards in the back of our unit. I felt that supervisor's anger in my torso before I turned to see who it was. So did the residents. When he was halfway across the unit, a fight broke out between two residents who had been getting along well all morning. The two residents shifted their focus from each other to the supervisor; the source of the aggression. That supervisor called for backup on his radio. Meaning he intended to restrain one, or both, of the

residents. I found out later, that supervisor had an argument with the facility director just before walking onto our unit. He carried the sensations his body generated during that argument, from the director's office onto my unit. It was as if he was delivering visceral survival instructions. The youth's bodies picked up those visceral instructions, reciprocated that threat and helped spread those instructions throughout the milieu. Our unit went from peaceful to panic in under a minute. That argument between the director and the supervisor nearly changed the trajectory of those resident's lives. Whether the contagion begins with a client, staff, or visitor, these common events are implicated in aggression, violence, the use of behaviour sequence', restraints, isolation, riots, and staff and client injuries. These responses are recorded in the resident's chart and inform their psychotropic medication prescriptions, level of placement, and length of sentencing or stay. Events like this are happening in residential facilities around the world."

"This specific event happened decades ago, but I knew in that moment that the language of human survival systems needed to be entrenched in the training and daily conversation of residential treatment. If the biological instruments and methods creating the chaos in that moment had been taught to staff and residents those events could have been prevented. More importantly, they could have been used to create a therapeutic roadmap".

- Kellie Rhodes, first author

Contemporary neuroscience reveals neurobiological instruments and physiological methodology underlying violence, inviting novel approaches in the prevention, and treatment of violence. From an evolutionary standpoint the goal of an organism is to survive and thrive and pass on our genes. Survival requires continual adjustments toward optimal survival parameters. Homeostasis is the process by which our physiology is maintained within optimal survival parameters.(Damasio & Carvalho, 2013) Emotions and behaviours, including aggression and violence, begin as body-states, driven by homeostasis. Just as wrinkled fingertips indicate prolonged exposure to water, violence indicates prolonged exposure to the unpredictability of a survival resource (food, safety/safe shelter, conspecific/survival partner, well-resourced survival partner, and a survival purpose). There is a dose-response relationship between experiences of perceived resource-specific availability or omission, and aggression and violence. Acute or chronic doses of resource-specific omission can reach a saturation point in the body which presents as aggression and violence. The

longer a human body goes without homeostatic predictability the more intense the emotion, and the more extreme the behaviour. Survival relevant experiences are reflected in the spate of research regarding Adverse Childhood Experiences (ACE)(Ellis, Bianchi, Griskevicius, & Frankenhuis, 2017; Provencal, Booij, & Tremblay, 2015; Simpson, Griskevicius, Kuo, Sung, & Collins, 2012), and mental illness, psychotic experiences, and psychosis.(Bórquez-Infante et al., 2022; Kelleher et al., 2013)

Homeostasis is a system-wide endeavour. Several neurobiological instruments – the nervous including limbic and interoceptive, the immune, and the endocrine including dopaminergic systems – continuously coordinate to achieve homeostasis, keep us alive. The dopaminergic system tracks resource predictability. The predictability of resources is so vital to our survival that features of predictability, including contextual cues and what actions have been successful or unsuccessful in acquiring those resources in that individual's experience, are tracked by the dopaminergic system.(Eagleman & Montague, 2006; Glimcher, 2011; Kishida et al., 2016; Montague, Eagleman, McClure, & Berns, 2006; Niv & Montague, 2008; Schultz, 2016; Tobler, Dickinson, & Schultz, 2003) The limbic system, long recognized as the survival emotion behaviour system(P. Morgane, Galler, & Mokler, 2005; P. J. Morgane & Mokler, 2006; Panksepp, 1982; Papez, 1937; Phan, Wager, Taylor, & Liberzon, 2002; Roxo, Franceschini, Zubaran, Kleber, & Sander, 2011)¬, incorporates this information from the dopaminergic system with information from other neural and nonneural systems(Carvalho & Damasio, 2021), assesses body-states and enlists emotions to create behaviours to meet specific missing survival requirements(National Institute of Limbic Health, 2020a). Throughout human evolution, our survival often depended upon the coordinated efforts of others to alert us to threats in our environment and help us fend off predators. A biological instrument that performs this function is the insula. The insula, a component of the limbic system, is a key neural structure facilitating shared body-states through multiple embedded physiological instruments and processes; mirror neurons(Carr, Iacoboni, Dubeau, Mazziotta, & Lenzi, 2003; Fabbri-Destro & Rizzolatti, 2008; Iacoboni, 2005; Iacoboni & Mazziotta, 2007), facial expressions(Levenson, 2003; Wicker et al., 2003), affective empathy(Eres, Decety, Louis, & Molenberghs, 2015), and autonomic mimicry(Hatfield, Cacioppo, & Rapson, 1993; Prochazkova & Kret, 2017). Shared body-state is such a common occurrence, like fish in water, we rarely recognize our exposure to it.

Yet *"we humans catch each other's emotions like we catch a virus"*(National Institute of Limbic Health, 2020b), so much so that *"people are walking mood inductors continuously influencing the moods and then the judgements and behaviours of others"*(Barsade, 2002), which can synchronize group behaviour(Hatfield et al., 1993) and increase the potential for individual and species survival(Carr et al., 2003; Hatfield et al., 1993). These collective homeostatic processes create experience-dependent neurocircuitry. The *"experience-induced sculpting of emotional and cognitive pathways allows a more selective, precise, and efficient neuronal processing of environmental stimuli and thereby forms the lifelong neuronal basis for intellectual and socio-emotional competence… this early synaptic reorganization process may reflect the formation of a principal emotional template"*(Braun & Bock, 2011), also known as a limbic template.(Rhodes & Rhodes, 2017) Presenters introduced background and methodology of a non-intrusive, strength-based intervention founded on practitioner experience and rigorous interdisciplinary research that capitalizes on these biological processes and instruments in a literature review, The Pursuit of Homeostasis: closing the gap between science and practice in the treatment of aggression and violence, published in Elsevier Journal of Aggression and Violent Behaviour.(Rhodes & Rhodes, 2017)

Violence intervention requires awareness and working knowledge of homeostatic processes. Emotions and behaviours are embedded in the homeostatic trajectory. Although homeostasis is an ever-present life-sustaining process, its interoceptive nature impedes our awareness of it.(Damasio & Carvalho, 2013; Khalsa et al., 2018) Intentional exposure to homeostatic processes can heighten practitioner's awareness of homeostasis.(Ainley, Tajadura-Jiménez, Fotopoulou, & Tsakiris, 2012) Guided practice in how the limbic and dopaminergic systems, and the insula coordinate to optimize individual and group survival, provides the visceral working knowledge required to track, restore, and maintain homeostatic predictability. These skills increase practitioner's capacity to recognize and track homeostatic fluctuations inviting the potential to intervene prior to homeostatic initiation of violence. The absence of immersive training to increase staff awareness and visceral working knowledge of homeostasis has hindered its application as an intervention.(Rhodes & Rhodes, 2017; Rhodes, Rhodes, Bear, & Brendtro, 2021)

In the present study we hypothesize a homeostatically-informed treatment modality capitalizing on these neurobiological instruments and physiological

methods has the potential to reduce aggression and violence and increase the therapeutic quality of residential milieu.

Methods:

The aim of the pilot study was to assess the efficacy of a homeostatically-informed treatment modality in the prevention and treatment of aggression and violence. Pilot data revealed statistically significant reductions in aggression and violence. Pilot study methods and results are presented in detail at the European Congress on Violence in Clinical Psychiatry, however, are omitted from this article, as they are presented in depth in a forthcoming pilot study article. We present here the methods and results of the feasibility study conducted as a preliminary to the pilot study.

Feasibility Study

Objective: Presenters conducted a feasibility study to determine the applicability and teachability of a homeostatically-informed treatment modality with practitioners working with clients demonstrating and experiencing aggression and violence.

Procedure: Participants were introduced to a homeostatically informed treatment modality through two-day workshops hosted by government and private agencies. Post-training, participants completed a Likert scale questionnaire.

Participants: Participants were employees spanning the child welfare-criminal legal services continuum (n=750). Participants included; Psychiatrists, Psychologists, Child Youth and Family Treatment Specialists, Residential facility licensing and monitoring directors and specialists, Directors and staff of Residential and community based youth treatment Programmes, State Division of Human Services research specialists, State Division of Youth Corrections administrators and staff, Director and staff of County Human Services, Director and staff of County foster care, Adult and youth probation, Emergency Medical and Assistance Services eligibility staff, Child Placement Directors and staff, Child protection staff, Temporary assistance for needy families staff, Family and criminal court staff, County Attorneys, supervisors, managers, directors, Healthcare Policy and Financing professionals, and State administrative personnel, as well as felons in community re-entry Programmes.

Modality: The modality assessed employs homeostasis, the limbic system, the dopaminergic system, and shared body-state facilitated by the insula. Participants learn to therapeutically employ the neurobiological instruments and physiological methods of the body to (1) track the predictability of homeostatic survival resources, (2) increase their familiarity with their own baseline body-state to prepare them to recognize changes or additions, (3) recognize body-states, emotions and behaviours as mechanisms facilitating homeostasis, (4) identify appropriate event-specific restorative body-states, and (5) utilize personal experience and recall to generate the restorative body-state to foster therapeutic application of shared body-state with clients. Utilizing hand-held representations of neurocircuitry (grooves) and limbic templates during training, invites participants to visually and tactilely experience how they and their co-workers perceive their client's primary body-state. The tools provide a tangible, malleable, perspective through which staff can objectively understand their own and their co-worker's experience of their clients.

Assessment: Participants completed a 5-point Likert scale questionnaire post-training. The assessment was self-report, with the option of anonymity. Responders specified their level of agreement with a series of statements regarding the modality on a scale from (1) Strongly disagree, to (5) Strongly agree. Scores of 4 or above were coded as positive statements.

Results

Ninety-three percent of survey respondents indicated the modality was applicable, clear, and valuable. Eighty-four percent indicated the content was relevant to their work, and 80% felt they improved their skills because of the training. Most respondents selected the highest possible option, a score of 5, for statements indicating the applicability and value of the content. Results demonstrated that the modality is highly applicable and teachable to employees working with clients demonstrating and experiencing aggression and violence.

Discussion

Our feasibility and pilot studies appear to demonstrate an absence of knowledge within direct-care staff regarding the biological instruments and methods generating emotions and behaviours including aggression and violence, as well as the improvement possible when staff are trained in these processes. While the pilot study of the homeostatically informed treatment modality provides

valuable insight into the applicability and efficacy of such training, it is important that additional and more rigorous studies continue to add to the data. Almost two decades ago UCSD Neuroscientist V.S. Ramachandran presciently stated, "[m]mirror neurons will do for psychology what DNA did for biology. (Ramachandran, 2000). Based upon the results of our feasibility and pilot study we whole heartedly agree.

Educational goal

1. Understand the biological instruments and methods generating emotions and behaviours including aggression and violence

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Safe skill station in de-escalation. Sociological and practical training approaches

Poster presentation

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Keywords: De-escalation / Liason / Safety / Violence and restraint reduction

Abstract

Frequent staff exposure to violence and aggression can be a traumatic experience and may cause several problems in patients and in the workforce. For all parties it can lead to secondary traumatic stress.

The aim was to develop and test a skill-station in de-escalation and explore how this can improve safety in hospitals The aim was to improve the safety of all patients and staff by addressing underlying risk factors that increase the likelihood of an individual becoming a victim or a perpetrator of violence.

The skill- station was co-created together with nurses (from psychiatry and general hospitals), researchers and service user. The skill station was tested in various units at three hospitals (Psychiatry, Emergency department and Neurology). Focus groups with participants were used to refine the different parts before it was released for general use.
Safe skill-station in de-escalation is helpful in regards of gaining knowledge of how to cope with agitated behaviour among patients and their relatives.

The skill station replaces classroom teaching and applies a way of learning familiar to clinical staff. We anticipate that skill-station in de-escalation will prevent the use of coercive measures and staff injuries and enhance the collaboration between psychiatry and general hospitals.

Educational goals

1. To gain knowledge about how a skill station in de-escalation can develop social de-escalation competences

2. To reflect upon how knowledge developed in a mental health care context can be transformed into a general hospital context

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Validation of the dynamic appraisal of situational aggression (dasa) instrument in Estonian psychiatric inpatient care

Paper presentation

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Keywords: Aggression / Inpatient / Risk assessment / Management

Introduction

The aggression of patients remains a serious concern in inpatient psychiatric care, as it endangers the health and safety of everybody involved and has a negative impact on the quality of care. Recognized strategies for improving the management of aggression include the use of structured aggression risk assessment instruments to identify individuals at high risk of becoming aggressive, followed by interventions aimed at preventing and mitigating aggression escalation

(NICE Guideline, 2015). One of the recommended instruments for assessing aggression risk is the Dynamic Appraisal of Situational Aggression – Inpatient Version (DASA-IV), which assesses the likelihood of aggression within the subsequent 24 hours (Ogloff & Daffern, 2006). Since Estonian psychiatric clinics lacked an instrument for assessing aggression risk, the DASA-IV was chosen for validation and implementation based on prior research demonstrating its clarity, relevance, and utility (Dumais et al., 2012).
The aim of this study was to evaluate the predictive validity of the Estonian version of the DASA-IV for aggression in the subsequent 24 hours in psychiatric inpatient settings.

Methods

Adult (≥18 years) inpatients with any diagnosis from subacute and acute treatment wards at four of Estonia's largest psychiatric clinics (North Estonia Medical Centre, Tartu University Hospital, Pärnu Hospital, and Viljandi Hospital) were enrolled in the study. After receiving training in aggressive risk assessment and

DASA-IV scoring, nurses assessed the risk of each patient once daily, around midday, using the Estonian version of the DASA-IV scale. The DASA-IV consists of seven items (irritability, impulsivity, refusal to follow directions, sensitivity to perceived provocation, easily angered when requests are denied, negative attitudes, and verbal threats), which are scored on a dichotomous scale (each item is scored for its presence (1) or absence (0)) based on information from the preceding 24 hours. Additionally, nurses recorded aggressive acts that happened within the subsequent 24 hours.
Analysis, all DASA-IV reports from patients discharged between October and November of 2020 were collected. The characteristics of the sample, as well as the DASA-IV scores and patient aggression incidents categorical variables, were reported using descriptive statistics. To determine the predictive accuracy of the DASA-IV the receiver operating characteristics (ROC) curve was generated and the area under the ROC curve (AUC) was calculated.

Results

DASA-IV assessments were obtained from 381 inpatients ranging in age from 18 to 93 years (median age of 43 years, SD= 17.4). A total of 6097 risk assessments were completed, 2908 of them from male patients. There were 542 DASA-IV assessments from 151 patients (male N= 68) who had acts of aggression recorded within the subsequent 24 hours.

The total daily score for the DASA-IV ranged from 0 to 7, with a median score of 0. The DASA-IV total daily score significantly ($p<0.0001$) predicted aggressive acts in the subsequent 24 hours for both the whole sample and subsamples of males and females. According to the odds ratios, for every one-point increase in the DASA-IV total score, there were 2.01 times increased odds that the patient would behave aggressively during the subsequent 24 hours. For the DASA-IV total daily score, the value of the AUC for the subsequent 24 hours was 0.86 (95% CI= 0.84–0.88, $p< .001$). Male subsamples had an AUC of 0.87 (95% CI= 0.84–0.89, $p < .001$), and females had the AUC of 0.85 (95% CI= 0.82–0.87, $p < .001$).

Conclusions

The Estonian version of the DASA-IV was found to have high predictive validity. The DASA-IV is a valid tool for assessing and managing aggression risk in subacute and acute psychiatric settings in Estonia.

Educational goal

Understand how to evaluate the predictive validity of the Estonian version of the DASA-IV for aggression in the subsequent 24 hours in psychiatric inpatient settings.

Acknowledgements

The authors are grateful to the nurses who participated in the study by daily assessing the aggression risk of patients using the DASA-IV.

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Development of interventions catalogue to reduce mechanical restraint in forensic mental health services

Poster presentation

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Keywords: Mechanical restraint / Interventions / Interviews / Qualitative study

Background

This research project addresses the national and international call for a reduction in the use of coercive measures, such as mechanical restraint, in forensic mental health settings (Hui et al., 2016, Ministry of Health 2013, Steinert 2016). Even though research-based interventions, such as *"Safewards"* (Bowers et al., 2015), have been implemented, the frequency and duration of mechanical restraint use remains a significant clinical problem in Denmark (Danish Health Authority 2021).

Aim

To develop and validate a targeted interventions catalogue based on previous research for use in the reduction of mechanical restraint in forensic mental health services (FMHS).

Methods

The methodology of American pragmatism (Blumer 1986) will be applied as the overall research approach, using the following sub-studies:

Sub-study 1. Development of interventions catalogue draft: Data gathered to develop knowledge about patients (Tingleff et al. 2019a), carers (Tingleff et al. 2019b) and staff's (Gildberg et al. 2021) perceptions and ascription of meaning to conflict situations and mechanical restraint episodes will be re-analysed with a qualitative, thematic analysis approach (Gildberg et al. 2015). The aim of the

analysis is to explore, respectively, forensic mental health patients', carers and staff's perceptions and perspectives on reasons for MR and on interventions that reduce the use and duration of MR.
Sub-study 2. Development of interventions catalogue: Systematic literature searches of evidence-based interventions to reduce coercive measures. Results will be evaluated by the research team and peers and finally, integrated into the interventions catalogue.

Sub-study 3. Content validation of the interventions catalogue: Qualitative focus group interviews with staff members and carers in FMHS and individual interviews with patients in FMHS – all with rich, first-hand experience on MR episodes – with the aim of investigating whether the items in the interventions catalogue are relevant and sufficient or require any adjustment.

Conclusion

The results of sub-study 1 and 2 will be presented at the congress.

Significance for practice: The results are expected to contribute to a safer environment in FMHS.
Relevance for theme: This study develops knowledge of patient, carer and staff perceptions of violence and mechanical restraint prevention.

Educational goals

1. To describe patients', carers', and healthcare professionals' perceptions on reasons for mechanical restraint episodes and on interventions reducing its use in FMHS.
2. To explain how an intervention catalogue can be developed and validated.

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Clinical decision-making in cases of rapid tranquillisation in mental health inpatient settings: an integrative review

Poster presentation

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Keywords: Chemical restraint / Clinical judgment / Nurse / Psychiatry

Abstract

Aim

To advance our understanding of nurses' clinical decision-making concerning the use of rapid tranquillisation in adult mental health inpatient settings.

Methodology

An integrative review was conducted using the methodological framework described by Whittemore and Knafl (2005).

Findings (preliminary)

Altogether 151 meaning units were abstracted from 10 included studies; 11 categories were generated. Of these categories, five were related to the clinical decision-making process; six, to factors influencing and/or associated with nurses' clinical decision-making.

Significance for practice

Nurses play a crucial role in decisions regarding the use of rapid tranquillisation. Therefore, increased understanding of their clinical decision-making can inform interventions aimed at reducing use of rapid tranquillisation. Relevance for theme: This study synthesises knowledge about nurses' use of rapid tranquillisation and thus how they use it in their daily nursing care and treatment.

Summary

Background

Rapid tranquillisation remains widely used in mental health inpatient settings worldwide although reducing and/or eliminating restrictive practices in mental health practices has been an international priority. Nurses are the health professionals most likely to perform rapid tranquillisation in mental health inpatient settings.

Aims

To advance our understanding of nurses' clinical decision-making concerning use of rapid tranquillisation in adult mental health inpatient settings. Specifically, literature concerning the decision-making process and factors influencing and/or associated with nurses' clinical decision-making were reviewed.

Methods

An integrative review was conducted using the methodological framework described by Whittemore and Knafl (2005). The Reporting Checklist for Systematic Reviews (PRISMA) and qualitative-research-specific guidelines (ENTREQ and eMERGe) were used for reporting the findings. A systematic search was conducted in APA PsycINFO, CINAHL Complete, Embase, PubMed and Scopus. Additional searches for grey literature were conducted in Google, OpenGrey and selected websites, and in the reference lists of included studies.

The study selection process was guided by the following inclusion criteria: primary studies describing situations and/or clinical decision-making concerning use of rapid tranquillisation; addressing causes and/or reasons for such use; or presenting perceptions, attitudes and/or experiences about clinical

decision-making related to the use of rapid tranquillisation. Studies from a nurse perspective and with rapid tranquillisation used in adult mental health inpatient settings were included. The Mixed Methods Appraisal Tool was used for critical study appraisal.

Results (preliminary)

A process of manifest content analysis inspired by Graneheim and Lundman (2004) was conducted. Altogether 151 meaning units were abstracted from 10 included studies; 11 categories were generated. Of these categories, five concerned the clinical decision-making process: 1a) to become aware of and consider alternatives, 2a) to negotiate voluntary medication, 3a) to end in an impasse, 4a) to implement the use of rapid tranquillisation and 5a) to be out on the other side. The remaining six categories concerned factors that influence and/or are associated with nurses' clinical decision-making: 1b) to see rapid tranquillisation as part of the job, 2b) to experience the clinical decision-making process differently, 3b) to take on the dual role, 4b) to divide restrictive practices into a hierarchical order, 5b) to be affected by local conditions and 6b) to be the good nurse.

Educational goals

1. To describe nurses' decision-making process concerning rapid tranquillisation in adult mental health inpatient settings.
2. To explain factors influencing and/or associated with nurses' clinical decision-making about rapid tranquillisation in adult mental health inpatient settings.

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Expanding Community Capacity: Using the World Café Method to Increase Suicide Gatekeeper Self-Efficacy

Interactive workshop

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Keywords: Suicide Prevention / Suicide Gatekeeper Training / Suicide Prevention Policy / The World Cafe

Community Connections Cafe: A Workshop Using the World Café Method to Supplement Suicide Prevention Gatekeeper Training

"Democracy is a critique of centralized power of every sort—charismatic, bureaucratic, class, military, corporate, party, union, technocratic. It is the antithesis to all such powers."

--C.D. Lummis, Radical Democracy (p.103)

Background

Suicide is a leading cause of death with a scarcity of available trained mental health service providers and services in the community. Worldwide, over 700.000 persons die from suicide annually and is a major public health concern and suicides are preventable, but only if there is a systems approach that includes multiple interventions (WHO, 2022). Prevention requires a range of interventions beyond advanced mental health treatment (e.g., eliminating stigma, public awareness, preparing laypersons to perform as gatekeepers (GK), schools and healthcare systems developing effective policies, etc.).

The workshop uses the World Café method (WC) to take advantage of deep democracy as a concept to create a safe environment that empowers all persons to share perspectives, experiences, and insights regardless of educational or professional levels. Considering that most decisions are made at the point of care, strategic planning, policy development and implementation that excludes the perspective of those most present at the point of care minimizes a

comprehensive knowledge base, risking an anaemic decision-making process. Suicide prevention strategies and policy are often determined by traditional agents such as governmental employees, direct service providers, and legislators with input from citizen advisory councils. Meaningful relationships and authentic engagement between those experiencing suicidal thoughts and their family, friends, and peers are crucial elements in the constellation of care for those at risk. These laypersons may have completed gatekeeper education (GK) that gives them a foundational understanding of best practices when intervening in a crisis, there are few opportunities for supplemental and continuing education. A direct service provider such as a psychiatrist, psychologist, or therapist may have periodic and limited interactions, the family, friends, and peers do not have the luxury of office hours and may very well have interactions each day. Yet, they receive little if any preparation and support for their role.

Method

The World Café method (The World Café, 2022) is a proven approach to identify practical solutions to complex social problems and was used as the workshop structure. The approach empowers laypeople and professionals alike to gain new insights through mutual learning, constructive dialogue, reframing and sensemaking. The workshop format follows the seven WC principles: a) Clarify the context; b) Create hospitable space; c) Explore questions that matter; d) Encourage contributions; e) Connect diverse perspectives; f) Listen together for patterns and insights; g) Share collective discoveries. The conceptual model for the primary activity is based on Bandura's (2001) social cognitive theory positing that personal interactions, modelling, and environmental factors impact how a person learns and applies new behaviours.

The physical environment sets the stage for a safe and robust sharing of ideas and experiences. Participants are individually welcomed by one of the facilitators and invited to sit down. Tables have a small flower arrangement, coloured pencils and crayons with paper covering the tabletop to encourage participants to use it to write notes and doodle ideas. Each table will have four chairs and a three-page note taking template that has each of the three discussion starter questions at the top. There are also several packages of sticky note pads for participants to write one primary take away from the discussion. One of the facilitators will use a PowerPoint (PPT) to guide the activity. The focus is on participant discussion, but the PPT will set the context with a brief overview the

state of suicide, the format of the WC, and then during closure review findings and take questions and answers.

Self-efficacy is a proven concept describing how likely a person will perform a particular behaviour (Bandura, 2001) and was evaluated pre- and post-activity using five Likert-type items from the Brief Suicide Intervention Tool (Becker & Cottingham, 2018). The qualitative aspect of the café explored and examined participant experiences as they sought out support for their role as responder painted an especially rich picture of community system enhancers and diminishers. Dialogue was initiated by providing with three starter open questions: (a) Share a personal experience (not one that you have heard about second hand) and what you recall when seeking help in the role of a GK; (b) Talk about specific barriers to receiving care; (c) Describe what people did making the process of seeking help or resources successful or caused a barrier. These data were collected from each participant's written notes and from the note taken by the PI during the Harvest review. Changes in participant's perceived self-efficacy were measured using the validated Brief Suicide Intervention Training instrument (Becker and Cottingham, 2018).

Discussion

The WC can be a powerful approach to social problem solving by including people who are typically not included in policy development and implementation. Because the WC format is based on interpersonal interaction and discussion, it validates the concept of deep democracy that values all input as necessary to painting a complete picture of complex social issues. With modest amounts of preparation, a layperson can conduct Community Connections Cafés. Future cafes can be applied to the support of participants and trainers as well as discussions related to trauma informed principles, and virtually all community issues.

Educational goals

1. Understand Increase Suicide Gatekeeper Self-Efficacy
2. Examine the possibilities and pitfalls of using the World-Café method to understand Increase Suicide Gatekeeper Self-Efficacy

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Community of Practice in implementing High and Intensive Care (HIC): Lessons Learned and Perceived Effects

Paper presentation

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Keywords: community of practice / implementation science / reduction of coercion / high and intensive care

Abstract

In the Netherlands, the High and Intensive Care (HIC) model has been developed as a national approach to improve quality of care of acute psychiatric admission wards and to reduce coercion. To support the implementation of this approach throughout the Netherlands, a Community of Practice (CoP) was created consisting of auditors from participating institutions. Audits served as an important vehicle to activate the CoP and stimulated the implementation of HIC. The CoPs stimulated quality improvement and reduction of coercive measures. Moreover, audit results show that wards that obtain a higher audit score use less coercion than lower scoring wards. The findings may help others in creating a CoP when it comes to the implementation of best practices and improving healthcare: lessons learned, and perceived effects of the CoP will be presented.

Summary

Background

In the Netherlands, the High and Intensive Care (HIC) model has been developed as a national approach to improve quality of care of acute psychiatric admission wards. Central to the HIC model is to work proactively to reduce the use of coercion, to foster contact between professionals, service users and significant

others, and to improve cooperation between outpatient care and the clinic. To support implementation, a Community of Practice (CoP) was created, including mental health nurses, psychiatrists, and managers. CoPs are increasingly used in healthcare, but they vary greatly in form and objective, and more insight is needed in their organization and facilitation.

Aims

To gain insight into the lessons learned and perceived effects of the CoP used for HIC. Moreover, results on the effects of implementation of the HIC model will be presented from the overarching research project on the HIC model.

Methods

Between 2014 and 2018, 79 audits were organized in two phases within 25 mental health care institutions to measure the development of the degree of implementation of HIC using a model fidelity scale, the HIC monitor. A CoP was formed consisting of auditors. A qualitative approach was used to evaluate the CoP. Data were collected through focus groups (n = 3) with participants in the CoP, feedback meetings with teams implementing HIC (n = 78), and observations by the researchers. Data were analysed thematically. HIC monitor scores were compared to data on coercion to determine the relationship between implementation of the HIC model and coercive measures.

Results

Lessons learned from the use of the CoP are: 1) create an ambassador role for CoP participants, 2) organize concrete activities, 3) ensure multidisciplinary collaboration, and 4) foster shared responsibility and work on sustainability. Perceived effects of the CoP were: 1) support of HIC implementation, 2) creation of a national movement, and 3) further development of the HIC approach. Results concerning effects on the reduction of coercion are positive, showing that wards that score high on the HIC monitor, use less coercion than units that score low on the HIC monitor.

Conclusion

Audits served as an important vehicle to activate the CoP and stimulated the implementation of HIC. This also means that the CoPs stimulated quality

improvement and reduction of coercive measures. The findings may help others in creating a CoP when it comes to the implementation of best practices and improving healthcare.

Educational goals

1. Knowledge on the use of a community of practice in an implementation process
2. To learn about research results focusing on implementation and effects of High and Intensive Care (HIC) in psychiatry

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Toward a shared understanding of effectively responding in the opening minutes of a potentially conflictual encounter.

Interactive workshop

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Keywords: Violence / Training / Safety / Co-production

Introduction

There is little consensus regarding the content or teaching methodology of training frontline personnel in the management of aggression within mental health. The fidelity of translation of classroom teaching to practice is uncertain, as is the effectiveness of the training in improving safety of all concerned.

This workshop describes the development and practice of a collaboration of trainers, researchers, and educators from Denmark, Netherland, and Ireland. The collaborators were engaged in virtual sessions that included interactive dialogues about best practice interventions that should emphasizes psychological and physical safety, and minimize risk for staff and patients, and reflection of how to create new knowledge about practical training in psychiatric settings.

The core mission of these sessions was to exchange expertise, knowledge, and leadership aspects in relation to creation of a care-full and safe inpatient environment to minimize coercive intervention in services that deal with people with psychiatric issues. The collaboration was based on mutual equality and the principles of co-creation by means of joint action research methodology. In this integrative approach we balanced theory, practice, and structured reflection for all participants to achieve learning. This group have been engaged in virtual meetings for two years.

In this workshop, we will invite new participants to be included in this network to co-create new knowledge about the opening minutes. This knowledge will help front line workers to effectively respond in the opening minutes of a potentially conflictual encounter.

Background

The therapeutic management within mental health settings impose potentially serious physical and psychological risks for service users, professionals, family members and others (1)(2).

It is widely accepted that aversive interactions between service users and staff contribute to occurrences of aggressive behaviour (3). Conversely however, it is also accepted that therapeutic staff-service engagements can mitigate the likelihood of occurrences of aggressive behaviour (4).

Staff training in patient-staff interaction (e.g. verbal de-escalation) is now acknowledged in professional and regulatory guidance, and considered a practice norm (5) (7) (8). However, the theoretical underpinning of such training remains poorly understood, and this deficit has education, research, practice and policy implications (9). Specifically, the absence of an evidence based shared understanding limits the potential to achieve consistency in the teaching of core requisite skills, and the possibility of reliable studies of the effectiveness of the application of learning in practice (6) (10).

There is some agreement in the application of widely accepted models which describe sequentially progressive stages of an *'escalation/crisis continuum'* (11) (12) (13), with the proposition of the need for *'stage-specific'* responses. Key to this cycle are the five phases (trigger, escalation, crisis, recovery, and post-incident depression) of a crisis, each in need of a different approach of service users and staff members to de-escalating the situation.

Some trainers (e.g., in Denmark, Ireland, the Netherlands and USA) have developed models to increase the application of this knowledge for training of clinical staff members. One example of such an extension is the *'First Five Minute'* model first described in the Netherlands which proposes a best practices approach for humane treatment and the prevention of aggressive behaviour and/or use of coercive interventions 2009. The fundamental proposition of the *'First Five Minutes'* model (14) is that the first moments of each encounter, whether it

be a hospital admission, home visit, or crisis contact, are critical for the further course and outcome of events. The focus on the first five minutes is on an interaction preventing escalation through emphasizing healing and cordiality, while minimizing triggers and observing early warning signs.

The opening minute of a crisis aims to restore the contact and support the service user to regain control and move on with their personal recovery process. Refinement of the opening minute place emphasis on maximizing the therapeutic value, and psychological and physical safety, while minimizing risk for staff and patients.

Aim

The aim of this workshop is to describe and discuss how the international collaboration of trainers, researchers, and educators seek to explore and critically appraise a shared best practice model of interventions in the opening minutes of a potential conflictual encounter.

Research questions

- What are the best practice interventions in the opening minutes?
- What are the similarities and difference in European violence prevention training?
- How can we learn to improve local training practices from dialogues about differences?

Method

This collaboration has utilized an action research approach, grounded in the central idea of a group achieving democratically informed practice improvements through stakeholder participation while proceeding in sequential iterative cycles of data, action, and reflection.

Potential results

Potential results will be co-created with the participants in the workshop. Initially data show that frontline workers must be aware of, and train following tasks: The task of leadership; the task of safety, and the task of communication.

These aspects will be unfolded and further developed in the workshop.

Discussion and conclusion

The workshop has the potential to co-create new knowledge about the opening minutes of a potentially conflictual encounters. However, this will depend on the participants willingness to engage in interactive dialogues about their local best practice interventions. The workshop can lead to an international collaboration of trainers, researchers, and educators.

This international co-creation of theoretically underpinned training will advance the state of knowledge and enhance the practice effectiveness of engagement during the opening minute of a potentially difficult encounters in everyday practice.

This will help front line workers to effectively respond in the opening minutes of a potentially conflictual encounter.

Educational goals

Examine what are the best practice interventions in the opening minutes?
Investigate similarities and differences in European violence prevention training?
Consider how can we learn to improve local training practices from dialogues about differences?

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Preventing aggression: Evaluation of prevention and support measures on aggression incidents in high-security forensic psychiatry

Poster presentation

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Keywords: forensic psychiatry / violence prevention / policy / interventions

Abstract

The current study sought to recognize the needs of health care staff in avoiding violent incidents and to identify areas of improvement in the current violence prevention policy and the policy regarding a safe transfer of the patient to a seclusion room. Four focus group interviews were conducted with 26 employees of the two high-security forensic psychiatric centres in Flanders, consisting of nursing staff, department heads, psychologists, psychiatrists, and in-house trainers of aggression prevention techniques resilience. Inductive content analysis was applied to analyse the focus group transcriptions. Health care staff emphasise the importance of self-confidence in one's own abilities to detect, prevent and act appropriately on violent incidents. Different measures are suggested that could improve self-confidence, which can be subdivided into different prevention levels. Practical interventions were formulated that respond to the existing gaps in violence prevention policy and to the needs of the employees.

Summary

In forensic psychiatry, prevention of patient violence towards health care staff is a challenging but necessary since it can have a major effect on the physical and mental health of employees. This is especially the case in high-security patients as the risk of patient violence is high, as most patients have multiple mental disorders, typically accompanied by violent and aggressive behaviour. Therefore, the current study sought to recognize the needs of health care staff in avoiding violent incidents and to identify areas of improvement in the current

violence prevention policy and the policy regarding a safe transfer of the patient to a seclusion room. Four focus group interviews were conducted with 26 employees of the two high-security forensic psychiatric centres in Flanders, consisting of nursing staff, department heads, psychologists, psychiatrists, and in-house trainers of aggression prevention techniques. Inductive content analysis was applied to analyse the focus group transcriptions. Health care staff emphasise the importance of self-confidence in one's own abilities to detect, prevent and act appropriately on violent incidents. Different measures are suggested that could improve self-confidence, which can be subdivided into different prevention levels. On a primary prevention level, a more systematic procedure for case discussion was suggested, so that a clear and integrated approach can be applied when a specific patient shows early warning signs of violence. Furthermore, supporting measures for new employees and the presence of department heads on the service were deemed valuable. On a second prevention level, to reduce stress-levels when department leadership is absent, a checklist could be helpful, listing the necessary coordinating actions that must be taken during an aggression incident that requires seclusion of the patient. Additionally, more training should be offered to employees who want to improve their leadership skills during a seclusion procedure, as well as to department heads regarding the coaching of the nursing staff. These educational interventions could create a calmer environment during aggression incidents and ultimately strengthen self-confidence. On a third prevention level, more attention should be given to the course and structure of the debriefing after an aggression incident. In conclusion, several areas of improvement were found in the current prevention policy of patient violence towards health care staff. Practical interventions were formulated that respond to the existing gaps in violence prevention policy and to the needs of the employees.

Educational goals

1. Identify the needs of health care workers regarding the prevention of patient violence towards employees.
2. Formulate interventions that respond to the existing gaps in violence prevention policy and to the needs of the employees.

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Community Connections Cafe: Using the World Café Method to Supplement Suicide Prevention Gatekeeper Training

Paper presentation

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Keywords: Suicide Prevention / Suicide Gatekeeper Training / Suicide Prevention Policy / The World Café

Community Connections Cafe: Using the World Café Method to Supplement Suicide Prevention Gatekeeper Training

"As human beings, our greatness lies not so much in being able to remake the world as in being able to remake ourselves."

--Mahatma Gandhi

Suicide is a leading cause of death with a scarcity of available trained mental health service providers and services in the community. Worldwide, over 700.000 persons die from suicide annually and is a major public health concern. Suicides are preventable, but only if there is a systems approach that includes multiple interventions (WHO, 2022). Prevention requires a range of intercessions beyond advanced mental health treatment (e.g., eliminating stigma, public awareness, preparing laypersons to perform as gatekeepers (GK), schools and healthcare systems developing effective policies, etc.) The Community Connections Café is a quality improvement project to explore focused discussions among GK as a method to supplement initial training and increase perceived self-efficacy to perform learned interventional behaviours during a crisis. Secondarily, the project sought to use GK experiences in that role to evaluate the community prevention system. The pilot project adapted the World Café (WC) method in an online focused small-group discussion using three starter questions summarized in a full group Harvest. Self-efficacy was measured pre- and post-intervention using the Brief Suicide Intervention Tool (BSIT) with permission from the author.

The purpose of the quality improvement project was to investigate the value of the World Café method (WC) as an educational activity to increase perceived self-efficacy in performing suicide prevention gatekeeper (GK) behaviours. A GK responds to a crisis and recognizing warning signs that someone may be contemplating suicide, disrupts the attempt, persuades the person to seek help and then supports help seeking activities. The GK closes the gate to suicide and opens the gate to care and hope. Because suicidality is often associated with disrupted interpersonal processes such as thwarted belongingness and perceived burdensomeness (Van Orden et al, 2012), the simple act of a gatekeeper's authentic engagement can rescue the person by diminishing the emotional and cognitive intensity of crisis. This critical interpersonal event establishes an important shielding factor that can protect the person at risk from future crisis. Family members, friends, and peers are typically the first responders to someone in crisis yet are often limited to a single 60–90-minute GK training—if they have any training. The Community Connections Café may fill the gap of continuing education and support the GK role by providing a safe environment for mutual learning and dialogue and result in an enhanced perception of self-efficacy leading to better outcomes

Performing successfully as a gatekeeper requires knowledge, beliefs and attitudes about suicide, awareness of stigma, and self-efficacy to act (Burnette et al., 2015). Bandura's social cognitive theory frames this behaviour and was used to inform the project intervention (Bandura, 2001). The WC (World Café Method, 2022) has been used worldwide as a valuable participatory assessment and learning tool to articulate difficult social problems and solutions for small and large groups (Löhr et al., 2020). There are seven principles in the WC method: a) Clarify the context; b) Create hospitable space; c) Explore questions that matter; d) Encourage contributions; e) Connect diverse perspectives; f) Listen together for patterns and insights; g) Share collective discoveries.

Method

The quality improvement pilot project was conducted during the COVID-19 requiring the café to take place using the online Zoom application and limiting the number of participants (n=7). Participants were invited by email from a list of more than 200 persons who had completed GK training over the past year. The Aspen University IRB approved the project as exempt from review and all participants completed a consent form.

The cafe activity consisted of a review of etiquette for communicating within a group online, an overview of the WC method, and an overview of the current state of suicide in the community and region. Participants were then randomly assigned into a breakout room and given three discussion questions to set the context and initiate the conversations. Participants were encouraged to take their own notes both graphical and in prose and then encouraged to share those notes with the primary investigator (PI) for a more complete data set to analyse and synthesize. The PI also took notes during the activity. After these three 15-minute rounds of discussions and a short break, participants returned and shared their take-aways with the entire group Harvest.

Table 1 - Results from Brief Suicide Intervention Tool: Items 1-5

Respondent	1. Recognize when someone might be at risk of suicide		2. Ask directly about suicide		3. Be with someone while they talk about suicide		4. Help someone at risk choose safety		5. Know how to find more help using resources	
	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
1	4.00	8.50	1.50	10.00	5.00	10.00	5.00	6.70	1.00	5.50
2	8.00	8.00	8.00	8.00	9.50	9.50	9.50	9.00	7.80	9.00
3	4.00	5.00	2.00	6.00	4.00	8.00	10.00	10.00	8.00	9.00
4	8.00	8.00	7.00	7.00	9.00	9.00	5.00	5.00	0	6.00
5	4.00	5.00	4.00	6.00	4.00	8.00	4.00	8.00	4.00	7.00
6	3.00	5.00	8.00	9.00	8.00	9.00	6.00	7.00	5.00	8.00
7	6.00	7.00	7.00	10.00	7.00	9.00	7.00	8.00	7.00	8.00
M	5.29	6.64	5.36	8.00	6.64	8.93	6.64	7.67	5.40	7.50
SD	1.91	1.48	2.60	1.60	2.15	0.68	2.15	1.51	2.29	1.28
Mean Change	1.36		2.64		2.29		1.03		2.10	
% Change	26%		49%		34%		15%		39%	

Self-efficacy is a proven concept describing how likely a person will perform a particular behaviour (Bandura, 2001) was evaluated pre- and post-activity using five Likert-type items from the Brief Suicide Intervention Tool (Becker & Cottingham, 2018) (see Table 1). The qualitative aspect of the café was to explore and examine GK experiences as they sought out support for their role as responder painted an especially rich picture of community system enhancers and diminishers. Dialogue was initiated by providing with three starter open questions: (a) Share a personal experience (not one that you have heard about second hand) and what you recall when seeking help in the role of a GK; (b) Talk about specific barriers to receiving care; (c) Describe what people did making the process of seeking help or resources successful or caused a barrier. These data were collected from each participant's written notes and from the note taken by the PI during the harvest review. The transcript was entered into

NVIVO qualitative research data analysis tool and depicted in Figure 1. With a world cloud image.

Results

Participants

The seven participant ages ranged from 26 to 70 (mean=50.14; SD=16.42), and six of the seven were females. Five were nurses, one worked in retail, and one was a Child Welfare Specialist. All participants reported their ethnicity as being white.

Statistics and Data Analysis

The BSIT was developed to measure changes in the gatekeeper's confidence to perform essential QPR interventions before and after the training. Participants self-completed the five-item survey before and after the café (see Table 1). Overall, the results were promising with respondents reporting that after the café, they increased their perception of self-efficacy for all five items with the most being an overall 49% increase for being able to ask the person in crisis directly about suicide and a 39% increase in self-efficacy for knowing how to find more help using resources. This may be because the discussion with peers elicited either new resources or validated their personal experiences.

The secondary purpose of the café was to identify gaps and enhancers to the system of suicide prevention as experienced while the GK was responding to a crisis. While the discussion starter questions were intended to focus the dialogue to some degree, the direction of conversation was not strictly prescribed allowing for a Black Swan of unintended or unpredicted content. The top five most frequently used words were resources (used 27 times and weighted at 3.38%), care (was used 14 times and weighted at 1.75%), person (used 13 times and weighted at 1.63), gatekeeper (was used 9 times and weighted at 1.13), and support (used 9 times and weighted at 1.13).

Three principal themes that emerged from these discussions included: (a) Need for there to be more education for all community partners including laypersons; (b) Increased advocacy for developing and implementing optimal public policy including resource improved accessibility; (c) Enhancing the use of teleconferences such as the café to provide support and education to caregivers

of all types. This option to attend education or support one another virtually is convenient and provides a safer environment to encourage conversation from the safety of one's home.

Discussion

Preliminary findings of a pilot quality improvement project included a significant positive difference in pre and post evaluations measuring perceived self-efficacy in performing GK behaviours. The discussions were rich in identifying gaps/enhancers in the care system as well as empowering participants to be valued as partners in the system of care. There were no real surprises identified since the it has been well established that there are insufficient resources such as psychiatrists or trained therapists in school systems and the community.

Three of the participants were school nurses and reported feeling overwhelmed with the number of students and not being able to attend adequately to psychiatric-mental health needs. This observation was likely intensified by a recent rash of student suicides in their school district. They also reported a lack of trained therapists available for referral if the nurse identified an at-risk student. Using the WC method as supplemental education may close a gap in GK ongoing education and effectively functions as a tool to inform policy makers as they develop and implement suicide prevention strategies.

Generalizability

The World Café method has a definite process that can be successfully replicated with the number of participants being in the hundreds. At the time of this study, there was no published literature describing the use of the WC virtually, but recently Maloney and Harper published an excellent depiction of this adaptation. There is an opportunity for future investigation.

Implications

The WC revised for use online can be a powerful approach to social problem solving by including people who are typically not included in policy development and implementation. Adapting the WC principles to a virtual format such as preparing the participants with sensory and cognitive enhancers (e.g., using an opening ice breaker, encouraging the use of essential oils, guided visual and tactile imagery, etc.).

Because the WC format is based on interpersonal interaction and discussion, it validates the concept of deep democracy that values all input as necessary to painting a complete picture of complex social issues. With modest amounts of preparation, a layperson can conduct Community Connections Cafés. Future cafes can be applied to the support of participants and trainers as well as discussions related to trauma informed principles, and virtually all community issues.

Limitations and Strengths

Using the Zoom format instead of the original WC face-to-face format restricts important meta-communication interactions which makes the WC successful. However, one strength of the virtual café is that people who avoid in person discussions are more likely to participant because of convenience (the time it takes to get ready, driving and parking, child-care, etc.) and a gentle sense of security. There was an insignificant number of participants for the café to serve as a reliable source of evidence and more investigation into the virtual café is warranted.

Conclusion

The WC provided a rich picture of the challenges GKs found when seeking help in a crisis and simultaneously supported supplemental education and perceived self-efficacy in GK perception for performing GK behaviours. Gaps and enhancers to the current policy and resource availability were identified informing policy makers in new ways. As a nurse policy entrepreneur, the PI is continuing to apply the WC to other community development issues including raising awareness of impact past trauma has on the physical, mental, emotional, and spiritual wellbeing of all people. The ongoing evaluation of each café can guide facilitators in optimizing future cafes. Psychological and mental health issues are marginalized by poor funding for direct service providers and systems. The community connections café offers a valuable means to expand the community capacity to prevent suicide by respecting the layperson GK as a full partner in the cascade of suicide prevention strategies.

Educational goal

1. Understand how to use GK experiences to evaluate community prevention systems
2. Understand how to use GK experiences to evaluate community prevention systems to reduce suicides

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The evolution in managing aggressive episodes in an Italian acute psychiatric ward

Paper presentation

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Keywords: Mechanical restraint reduction / aggressive behaviour / acute psychiatric ward

Background

Violent and aggressive behaviour by patients constitutes a significant problem in clinical psychiatry, with important ethical, legal, psychological, and physical consequences. One in 5 patients admitted to an acute psychiatric ward in high-income countries commits an act of physical violence during hospitalization.[1] The severity of acute disorders associated with the absence of disease awareness could amplify the expression of aggressive episodes during hospitalization, especially in compulsory treatment (in Italy according to Law 180 of 13 May 1978).[1]

Aggression in a psychiatric ward can be related to:

- the severity of psychiatric pathology, substance abuse and/or a history of convictions for violence[2,3]
- environmental factors such as ward structure, lack of privacy, locked ward, over-stimulation, overcrowding[4,5]
- the model of care (regional and hospital policies, internal rules of the ward, attitudes towards patients, cultural factors)[6]
- the skill and experience of care staff (communication level, de-escalation capacity, attitudes towards aggression, stress levels).[7,8]

In a psychiatric ward, the first condition which contributes to containing aggressiveness can be represented by the institution or setting itself, with its rules and standards, closely related to the purposes of clinical activity. The containment of aggression is carried out through interventions aimed at reducing and counteracting it, with the therapeutic aim of resolving the condition

that caused it. The following types of containment can be distinguished: psychological, pharmacological, physical, and mechanical. It should be born in mind that they do not have a consecutive sequence relative to the seriousness of the situation, but they are often overlapping and inseparable from each other.

"Mechanical restraint means any procedure designed to prevent freedom of movement and / or free access to a person's body. To achieve this, any means directly applied (or only adjacent) to the body of the person is used. It cannot be easily controlled or self-removed ".[9]

Mechanical restraint is an extreme but still used procedure for managing these episodes. In recent years several international and local policies have introduced strategies for reducing this ethically controversial practice in mental health settings.[10] It can represent a traumatic and degrading experience[11] and involve physical[12] and psychological risks4 for the patient, without any scientific evidence of efficacy.[10]

In several countries, including Italy, the use of mechanical restraints is not clearly regulated by specific laws. The Italian Supreme Court of Cassation ruled that their use must be limited to extremely exceptional situations[13] where the health and safety of the patient or others is imminently endangered, in accordance with Article 54 of the Criminal Code, the *"state of necessity"*, and Article 40 which imposes on health professionals a *"position of guarantee"* towards the patient.

The Federations of the health professions have in turn focused attention on the phenomenon. The Code of Ethics for Nursing Professions in Article 35 states that *"The nurse recognizes that restraint is not a therapeutic act"*.[14]

A previous retrospective study analysed the use of mechanical restraints in the psychiatric ward Service of Psychiatric Diagnosis and Care (SPDC) in Modena, highlighting its most frequent use in the first 72 hours of hospitalization with the aim of containing the aggression of individuals with schizophrenia and other psychotic disorders.[15]

Aims

To describe the evolution in managing aggressive episodes in an acute psychiatric ward during the last 9 years, evaluating the frequency of mechanical restraint

application and all the variables which can have significantly influenced the use of this procedure.

Methods

This retrospective analysis was conducted in the Service of Psychiatric Diagnosis and Care, the 15-bed public psychiatric ward in a Northern Italian town (Modena), as a continuation of a previous study.[4] All instances of mechanical restraints applied from 01/01/2013 to 12/12/2021 were evaluated. Demographic and clinical variables concerning patients undergoing mechanical restraints and organizational variables related to restraint application, the concomitant occupation of beds and incident frequency reports during the observation period were collected.

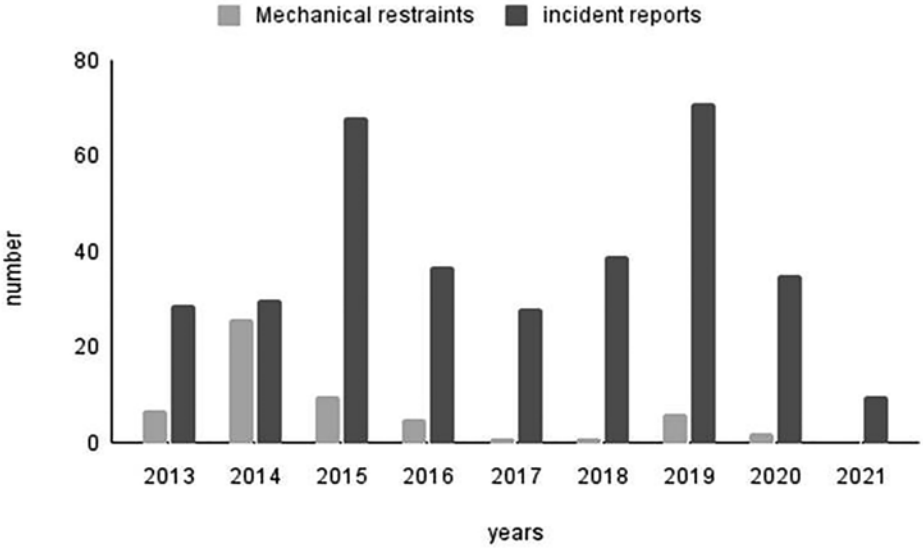
Results

In the study period, we collected 58 instances of mechanical restraints (MRs) applied to 42 individuals (8 females and 32 males) with a mean age of 37.5 years [± 15.62 Standard Deviation (SD)]. The most frequent reason for restraint application was represented by extremely aggressive behaviour (64%), followed by the need for drug administration (22.41%) and prevention of dangerous behaviour (13.79%). In 51.72% of cases, MRs were applied during afternoon shift, in more than half (55.17%) MRs were used in compulsory treatments and more often on the third day of hospitalization. MRs were applied during hospitalizations with long duration [37.14± 41.11 (m ± SD) days]. We found a statistically significant correlation between hospitalization duration and number of MRs applied (Spearman's rho = 0,53; p=0,000). MRs were applied when the occupation of beds in the ward was 15.36 patients on average (± 2.14 SD).

Among the variables collected, only the psychiatric diagnoses, in particular Intellectual disability, bipolar disorders, and Substance use, were significantly related to mechanical restraint application (linear regression: coeff:0.49; p=0.001; 95% CI: .18 .69). A significant reduction of mechanical restraint application was observed after the application of more restrictive guidelines on its use in 2015 (linear regression: coeff.: -12.93; p=0.033; 95% CI: -24.44 -1.41). Concomitantly, an increase of incident reports concerning all unusual events occurring in the ward, such as the consequences of physical violence, was reported in 2015 (n= 68) and 2019 (n=71). Successively, a regular 12-hour

work shift of hospital guards was implemented inside the ward and, in 2021, mechanical restraints decreased to zero and incident reports decreased by 87% (Fig.1).

Fig. 1



Discussion

Restraint application can be reduced by appropriate policies which allow us to change our way of thinking on managing the patient with aggressive behaviour but only the presence of guards on staff can prevent the aggressiveness, reducing its physical and psychological consequences on both patients and professionals.

Our results suggest that alternative procedures to mechanical restraint in the management of aggressive behaviours can be applied after a profound cultural change, initially imposed by guidelines and procedures, as recently highlighted by some authors,[16] and subsequently accepted by healthcare professionals and implemented in clinical practices.

If restraint has been drastically reduced by the introduction of new health policies, which have allowed us to change our way of thinking about the management of episodes of aggression, the presence of internal security force in the ward has made it possible to prevent aggressive and violent behaviour,

so reducing the physical and psychological consequences on both patients and professionals.

Our results lead us to interpret that the safety of psychiatric care and treatment without any recourse to a coercive procedure, such as mechanical restraint, can be achieved by delegating to others the task of controlling violence, such as to the hospital guards, largely exempting Psychiatry from the task of social protection that has been attributed to it over the centuries.

This delegation avoids the symmetrical response of the operators to the patient's aggression and favours the therapeutic relationship, also based on the recognition of the existence of aggression as a trans-sonographic phenomenological psychiatric dimension.

Conclusions

We conclude by underlining the importance of preventing mechanical restraint which, if applied to avoid an imminent and otherwise unavoidable risk, can itself lead to complications not only of a physical type, but also and above all a psychological type, potentially triggering a perverse circuit of addiction to this procedure and to the institution, especially if applied routinely, as some clinical cases teach us.

Educational Goals

1. To describe the evolution in managing aggressive episodes in acute psychiatric wards
2. Evaluate the frequency of mechanical restraint variables which can significantly influence the use of this procedure

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The role of forensic vigilance in maintaining safety in forensic psychiatric institutions

Paper presentation

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Keywords: Forensic vigilance / incidents in forensic psychiatric institutions / forensic psychiatric professionals

Introduction

Forensic vigilance indicates a central competency that forensic professionals need to work in the highly specialized and complex field of forensic psychiatric settings. The term originated in the Netherlands as *"forensische scherpte"*, but represents an internationally relevant construct (Clercx et al., 2021). Forensic vigilance is a specialist competency needed by all forensic psychiatric professionals, regardless of specific professional roles (e.g., nurse or psychiatrist). Forensic vigilance is often considered pivotal in maintaining safety and preventing incidents in forensic psychiatric settings. However, it is unknown precisely how forensic vigilance relates to incident prevention, and whether different types of incidents (e.g., aggression towards others, suicide, absconsions, unprofessional relationships with patients) require different aspects of forensic vigilance.

The current study aimed to study the relationship between forensic vigilance and incidents in high secure forensic hospitals. A combination of thematic and interpretative was used to analyse incident reports on incidents that occurred in 8 high secure forensic psychiatric hospitals. We developed a model of forensic vigilance and identified key attributes and differences in these between different types of incidents and refined this model in expert meetings with forensic psychiatric professionals.

Method Dutch forensic hospitals are required by law to report incidents and are required to carry out an investigation into possible causes of the incident. These investigations are carried out by professionals independent of the treatment of the patient(s) involved, and usually contain a chronological timeline of the period leading up to the incident. The current study utilized reports of incidents that occurred between January 2010 and December 2020.
In total 8 medium and high secure forensic hospitals participated in the study, contributing a total of 139 anonymized incident. We included four types of incidents: physical aggression, unprofessional relationships between professional and patient, absconsions/withdrawal from (un)supervised leave and suicide/auto mutilation, resulting in 69 incidents.

The remaining incidents were analysed with thematic and interpretative analyses by three independent observers (two with and one without a forensic background) in 5 rounds. After three rounds a conceptual model was formulated, which was tested and further refined in subsequent rounds. The final model was presented to 20 forensic psychiatric professionals in two expert meetings.

Results and conclusion the developed model show that forensic vigilance is a cyclic process during which the professional, while interacting with the team, constantly integrates and weighs observed signals considering forensic professional knowledge, forensic context, and knowledge of the specific patient to create and maintain a safe environment for themselves and others. The model, which includes steps of observation, integration, communication and action, and several specific aspects which are needed in each of the steps, will be discussed in detail.

Knowledge about forensic vigilance is useful for forensic psychiatric professionals (see for example submission for this congress by Van der Lem, Kortmann & Boschma).

Educational goal

Understand the relationship between forensic vigilance and incidents in high secure forensic hospitals.

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Consultations for refractory cases in mental health services: a descriptive study

Paper presentation

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Keywords: challenging behaviour / refractory cases / consultation / disharmonic developmental profiles

Abstract

The Dutch Centre for Consultation and Expertise (CCE) is available to support refractory cases in Mental Healthcare Services.

This descriptive mixed methods study gains insight into the commonalities underlying the reasons of 472 consultations and the solutions proposed that play roles in (the reduction of) refractory cases for which consultation has been requested.

83% of cases in the sample could be explained with four situations involving self-harm (24.2%), aggression (21.8%), self-neglect (24.4%), and socially unacceptable behaviour (12.5%), respectively.

The main conclusion is that refractory situations involve interaction patterns that inadvertently perpetuate or even exacerbate them.

Professionals' adoption of an interpersonal behavioural style with attention to daily routines and meaningful activities was an essential part of all possible solutions to the refractory situations in this study. This behavioural style can be challenging for professionals because they are sometimes counterintuitive. The presented solutions to refractory situations imply profound relevance for clinical practice.

Summary

Mental health services (MHSs) usually contribute to patients' recovery and improved quality of life. However, practice guidelines do not provide solutions when patients' improvement is insufficient. Several authors have described preconditions and models for consultation in such situations, but research on the results of such consultation is limited and mental healthcare consultation content has not been evaluated systematically. The Dutch government established a Centre for Consultation and Expertise (CCE) in 1989 to provide support for exceptionally challenging clinical situations involving patients dependent on long-term professional care. Individuals requiring long-term care whose quality of life is at risk of being seriously compromised, or their caregivers or next of kin, can apply to the CCE for independent consultation. An analysis of CCE consultations may therefore provide valuable insight into situations in which MHSs are unable to provide adequate care and consultation is sought.

The results of our descriptive study of 472 MHS consultations will be briefly presented in this workshop. We calculated descriptive statistics for the quantitative data on situations for which consultation was requested. Using thematic content analysis8, we distilled exemplary situations from the qualitative data. Four exemplary situations centered on self-harm, aggression, self-neglect, and socially unacceptable behaviour. Our findings were that 1) the cause of refractory mental health–related situations lies in patient–healthcare professional interaction, in which misjudgement plays a major role; 2) autism spectrum disorder and disharmonic developmental profiles are major factors in these interactions because of the risk of overestimation and incomprehension; and 3) healthcare professionals can improve these situations by consistently applying an interpersonal behavioural style based on unconditionality and closeness, which sometimes can be counterintuitive.

The emphasis in this workshop will be on the presentation of the four refractory situations and their possible solutions. Consequently, we will have an interactive discussion about the CCE's view on challenging behaviour: it is not a patient factor perse but should always be seen in terms of interaction with the patients' physical and social contexts. The focus is on understanding the refractory situation from multiple perspectives and searching for dysfunctional patterns in the patient–healthcare team–next-of-kin triad.

As a spinoff of our study, we developed tools for mental health care teams to get started independently on a CCE consultation with refractory cases. In this workshop we will try out these tools in subgroups related to case histories of the participants.

Educational goals

After attending this workshop participants:

1. Can recognize situations of refractoriness in Mental Health Care based on its underlying interaction patterns in the patient-healthcare team-next of kin triad.
2. Gain insight into related factors to refractory situations and their possible solutions and understand the value of independent consultation.

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A pilot exploration of the implementation of music intervention in adolescents living with mod disorders.

Poster presentation

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Keywords: music intervention / mood disorder / adolescent

Abstract

Due to the COVID- 19 pandemic, isolation and distance learning are more likely to cause mood disorder in adolescents. Evidence shows listening to music is the most common stress management strategy, and it can improve mood status and increase well-being. However, there is a lack of systematic empirical research in adolescents. Evidence-based research forms the basis for clinical implementation. Using a music intervention improves mood, enhances well-being, and helps adolescents focus more on activities

Summary

Background

In Taiwan, 50 to 66% of mental illnesses develop in adolescence. Due to the COVID- 19 pandemic, isolation and distance learning have increased mood disorders in adolescents.

Aim

This study aims to seek stronger evidence to provide guidance for clinical practice and offer more appropriate care for adolescents living with mood disorder.

Method

Music intervention is performed in groups combined with classical, light and one self- choice song by each participant; and the effect of emotional improvement is evaluated.

Result

The music intervention was beneficial to promoting socialization and cooperation. Although adolescents are unfamiliar with classical music and some light music it enhances its effects by giving users a choice of preferred music.

Conclusion

To deliver music intervention to adolescents could benefit mood disorder and well-being. Although further study is required, the results of this study highlight the potential of a music intervention.

Educational goals

1. To recognize the effect of different types of music on adolescents' mood and well-being
2. To demonstrate the effect of a music intervention on mood-disorder in adolescents

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Developing a designed safety intervention for acute mental health wards: An evaluation

Paper presentation

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Keywords: Patient safety / Milieu

Abstract

The safety of patients and staff on acute mental health wards is a significant issue. Safety incidents (self-harm, violence, coercion) occur frequently. These cause harm and trauma to patients and staff. We think we can predict when incidents are more likely to occur through real time monitoring of the ward milieu. Intervening early may prevent incidents and social contagion. We have co-designed a monitoring tool which asks patients on mental health wards to input their perceptions of safety into a tablet. This provides real time data on the ward to both patients and staff. The technology interface has been co-designed with people who have lived experience by design (Thrive by Design) and industry (Ayup) partners and is in open-source code. The study used focused ethnography to explore how the technology was implemented on the wards, and routine data to examine its effect on safety.

Summary

Evidence shows there are large numbers of safety issues on acute mental health wards, frequently involving violence and self-harm, associated with increased costs, physical and psychological harm. Safety data is currently only collected retrospectively and very little is collected from the service user perspective. This study aims to co-design with service users and staff a technological intervention that collects data about the perception of safety from service users, to support staff to anticipate and avoid developing incidents.

The project has two phases and uses different methods during each phase. Phase 1 uses a co-design approach to developing the intervention, supported by an *'environmental scan'* consisting of a scoping review and the collection and qualitative analysis of interview data. Phase 2 will be a mixed methods process evaluation. A focused ethnography will explore how staff communicate

and use safety data supported by interviews with service users and staff to further understand feasibility and acceptability. We will simultaneously collect routine data including incidents, NHS mental health safety thermometer (if available), workforce and ward occupancy. Measures relating to safety culture and ward atmosphere will be completed pre and post intervention, as well as real-time measures of these concepts on three occasions. The synthesis of these data will assess the impact of the intervention on outcome measures, enhanced understanding of feasibility and acceptability.

Stakeholder and lay input have informed the development of this project, specifically through discussions with service users and co-applicant representation. We will link to existing stakeholder groups hosted by Leeds and York Partnership NHS Foundation Trust to support the project via co-app WALKER. The key outputs of the research will be a new intervention in the form of a licenced product to enable the collection of and response to real-time service user generated safety data. The research will produce traditional and non-traditional publications in a variety of media. Dissemination will target key stakeholders: mental health service providers, commissioners, regulators, practitioners, policy makers, and academic researchers and make effective use of social media. We will publish in high-impact open access academic journals and present and discuss our findings at conferences to a wide range of practitioners, academics, and service users. We will also devise and host a digitally supported dissemination event and invite representation from all stakeholders. The resulting product has the potential to improve safety and well-being for service users and staff on acute mental health wards.

Educational goals

1. By the end of this session, the student will be able to determine how considering patient safety could reduce restrictive practice.
2. By the end of this session, the student will be able to compare the patient and staff perceptions of safety.
3. By the end of this session, the student will be aware of the complexity's digital interventions on mental health wards.

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Topic 4 – Trauma informed practice

"My past will not dictate my future" Short-term trauma treatment for a forensic psychiatric patient

Paper presentation

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Keywords: trauma / mental health / forensic mental health care / trauma-informed care

Abstract

The prevalence of trauma exposure is high within the forensic psychiatric population, making it a relevant factor for the treatment of forensic patients. The present study focuses on the implementation of an intensive short-term trauma treatment within a Dutch forensic psychiatric hospital, using both quantitative and qualitative research methods. Insights from this study show that trauma treatment could be an essential part of forensic mental health care in promoting patients' resilience and responsivity.

Summary

Background

To promote a more rapid recovery from post-traumatic stress disorder (PTSD) symptoms and to decrease the chance of drop-out, a new short-term treatment for PTSD has been developed (De Jongh et al., 2020) consisting of an 8-day Programme featuring EMDR therapy, exposure therapy, physical activities, and psychoeducation. As rates of trauma exposure are high within the forensic patient population, it can be hypothesized that these patients will benefit from short-term trauma treatment.

Aim

Results from studies looking into the effectiveness of short-term trauma treatment have shown a significant decline in symptom severity (Van Woudenberg et al., 2018). However, these studies have been conducted in samples of general psychiatric patients suffering from PTSD. There are currently no known studies into the use of short-term trauma treatment within the forensic psychiatric population. The aim of this case study is to examine how successful short-term trauma treatment is in reducing PTSD symptoms in a 40-year-old forensic psychiatric patient admitted to a Dutch forensic psychiatric hospital after being sentenced for child molestation. The patient had experienced multiple trauma's, namely childhood sexual and emotional abuse and neglect.

Method

Clinically relevant symptom change was assessed by examining differences in PTSD symptomology before and after treatment, using the Dutch version of the PTSD checklist for DSM-5 (PCL-5; van Praag et al., 2018). To measure PTSD diagnosis the Dutch version of the Clinician-Administered PTSD Scale for DSM-5 (CAPS-5; Boeschoten et al., 2018) was used. Furthermore, the patient was questioned about his experiences with this short-term treatment by means of a semi-structured interview.

Results

Outcomes on the questionnaires were analysed using the reliable change index (RCI: Jacobson & Truax, 1991), the interview was analysed with ATLAS.TI using Thematic Content Analysis. The results indicate that PTSD symptomology decreased from pre- to post-treatment. By treating past trauma, the patient found that he could be more open about how he felt in his communication with staff and other patients. He also mentioned that he felt he was now more aware of the needs of others', whereas before treatment he repeatedly crossed boundaries of others to fulfil his own goals.

Conclusions

This case study showed promising preliminary results for the use of this new treatment in forensic mental health care. By treating trauma-related symptoms this patient's resilience and responsivity to his treatment programme is

heightened. Further exploration incorporating this treatment within forensic mental health care is needed.

Educational goals

1. Participants will be able to describe the importance of trauma-informed practice.
2. Participants will be able to explain what short-term trauma treatment consists of.

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Patient experiences of victimization during mandatory psychiatric treatment

Paper presentation

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Keywords: victimization / forensic psychiatry / inpatient aggression / justice-involved persons

Summary

Forensic psychiatric inpatients are frequently exposed to aggression from fellow patients during their treatment, but research on how this impacts patients' well-being and treatment progress is lacking. The present study aimed to increase insight into patient experiences with victimization during clinical forensic psychiatric treatment. Given the lack of studies in this area, we conducted an exploratory qualitative study on this subject.

Semi-structured interviews were held with nine patients on their experiences of victimisation during mandatory psychiatric treatment. Patients were selected based on a purposive cell sampling strategy aiming to include both male and female patients from diverse ward types and with different types of psychopathology and treatment trajectories to explore the topic from different angles. The interviews were analysed using a Grounded Theory approach combined with elements from Consensual Qualitative Research and Interpretative Phenomenological Analysis. Ethical approval for this study was obtained from the Ethics Committee Social Sciences of the Radboud University in the Netherlands with number ECSW-2019-008.

Three main themes emerged from the data, namely situational descriptives, intrapersonal and interpersonal consequences. Patients were not only exposed to both physical violence and verbal aggression by other patients, but also to a more ubiquitous flow of micro-aggressive comments. Options to escape these situations were limited. This means that victimization processes, which for most patients started much earlier in life, continue during forensic psychiatric treatment. Intrapersonal consequences include fear, hypervigilance,

reactive aggression, flashbacks and avoidance and withdrawal. Interpersonal consequences include increased power differences between patients and adverse treatment consequences, such as difficulties with self-esteem. Victimization processes are not always timely noticed in an environment that focuses on risks and treatment of delinquent behaviour.
Although exposure to aggression is, at least to some extent, inevitable in closed psychiatric settings, preventing patient victimization is pivotal and minimizing its consequences should be prioritized in forensic psychiatry. However, victimization processes are not always timely noticed in an environment that focuses on risks and treatment of delinquent behaviour. A higher level of trauma sensitivity in forensic mental health care is thus required. Recommendations for the implementation of trauma informed care are provided.

Educational goals

1. At the end of the presentation, participants will have increased insight into patients' experiences with victimization during mandatory psychiatric treatment.
2. At the end of the presentation, participants will have a better understanding of principles of trauma informed care and why it is important to implement these principles.

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Trauma-informed care vs coercion and violence

Interactive workshop

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Keywords: Trauma-informed / Connection / Best-practice / User-based

Introduction

Service users often experience or witness traumatic events such as aggression, seclusion, and restraint at acute inpatient wards, (Freuh 2005; Cusack 2018). Moreover, a lack of understanding of previous trauma is a barrier to reducing the use of coercive measures (Brophy 2016). The use of coercion can in turn also be traumatizing for staff, which emphasizes the need for alternative approaches. To prevent the use of coercion and to adequately respond to distress, rising tension and agitation, effective training of staff in de-escalating techniques is essential. A de-escalating intervention can be the provision of one-to-one guidance, during which several communication techniques can be used to stay in contact, or to restore contact with service users. Making contact however can be challenging in times of crisis and failure to do so can result in aggression and coercion. Integrating trauma-informed practices with de-escalation techniques during crisis situations can be an effective opportunity to make a connection with service users in crisis to avoid violence and to minimize coercive measures (Sweeney et al., 2018). This integration requires the development of a best practice programme for training of staff.

The integration of trauma-informed practices with de-escalation techniques first requires knowledge of Trauma Informed Care (TIC). TIC is a systems development model that shifts the focus from the traditional individual diagnosis model of *"what's wrong with you"* to a systemic story-based approach of *"what happened to you?"* (Sweeney et al., 2018). The approach is based on the idea that problems never standalone but occur in a complex web of interactions and exchanges, in which lies the basis for development and recovery. TIC is a way to be more equal in contact with each other to build a good therapeutic relationship. Previous research has shown the effectiveness of TIC approaches on reductions in symptoms and in the use of coercive measures such as seclusion and restraint,

and improvements in coping skills, physical health, retention in treatment and shorter inpatient admissions (Sweeney 2016).

To use TIC at times of crisis, elements of the Emotional Connecting, Empowering, Revitalizing (eCPR) method are used. eCPR is a TIC approach focusing on emotional presence, awareness of the feelings of the other person and connecting with the emotionally harmed identities of service users. It is based on the recovery model, emphasising that recovery is fostered through relationships, respect, and hope (Myers et al., 2022). Previous research on eCPR training showed an increase of skills to deal with mental health crises (Myers et al., 2021; Myers et al., 2022). The eCPR approach contributes to sensitivity of service users' emotions and behaviour thereby reducing coercive measures and aggression.

ECPR offers possibilities for non-verbal connection and connection through feelings. It can offer the safety needed to persons with emotional stress to enable them to engage with care and foster collaboration.

The new intervention and training are being developed in the context of care on High and Intensive Care (HIC) wards in the Netherlands. The HIC model, which is widely being implemented in acute psychiatry in the Netherlands, was developed to restore and maintain contact with service users, improve quality of care and prevent coercion (Voskes et al., 2021; van Melle et al., 2021). The provision of one-to-one guidance is an important element of the care process on an HIC unit. The HIC model is based on the principles of stepped care, which is visible in the combination of the *'high care function'* (HC) and the *'intensive care function'* (IC). The moment the service user cannot stay on the regular closed ward (High Care) with other service users, care can be temporarily scaled up to the IC, where intensive care units (ICUs) are located. When a service user is transferred to the IC, a nurse will accompany the service user to provide one-to-one guidance. The design of the ICUs follows that of many PICUs as found in the UK and Scandinavian countries. In the PICU model this is referred to as the Extra Care Area, used as an intensive nursing intervention to manage acute disturbance as an alternative to seclusion (Beer, Pereira, & Paton, 2008; Dix & Williams 1996). In Norway, the use of Intensive Care is known as the practice of *'shielding'* (Haugom & Granerud, 2016; p. 1). In the HIC model, the focus on service user contact in the ICU is particularly important. A service user in crisis is not left alone, but care can be scaled up to ensure that contact can be

re-established and that the service user can return to their own room as quickly as possible.

This workshop introduces a new best practice intervention and training regarding trauma-informed care in crisis situations. The aim is to offer emotional connection and safety in emotional crises. Training of staff in elements of this practice can possibly increase the quality of contact with service users and may result in reduced aggression and coercion.

About the workshop

In the workshop, (emotional) situations of clients are selected, in the setting of one-to-one guidance on the ward, in ICU's and in seclusion rooms. The workshop focuses on elements of the eCPR approach that suit different care situations and can be integrated in existing practices. The trauma-sensitive elements of eCPR will be discussed and demonstrated. This includes safety awareness, trustworthiness and transparency, peer support and mutual self-help, collaboration, and mutuality - empowerment, voice, and choice, cultural, historical, and gender issues in the contact with clients.

The workshop agenda is in short:

1. Sharing knowledge about the eCPR approach and addressing familiarities with other methods, Trauma Informed Care, and principles from the Dutch (legal) practice
2. Sharing knowledge about actual elements of the eCPR approach which can be practiced with staff
3. Practice with selected elements of the eCPR approach using concrete examples
4. Evaluation of the shared knowledge and practice, and creation of the possibility for collaboration in practice and research

Conclusion

The complexity of certain care situations in acute psychiatry demands a range of approaches to de-escalate different situations and to foster contact with service users. This requires a certain flexibility by professionals to choose communication styles mapped to the situation at hand. This training aims to enhance professionals' knowledge and skills in trauma sensitive communication

in acute situations. Training of staff in elements of this practice can increase the quality of contact with service users and may result in reduced aggression and coercion. The best practices and training are currently still in the developmental phase, and we are open to other approaches and work together to further refine it.

Educational goals

1. Introduce Trauma-informed approaches to mental health care in high-intensity services
2. Examine the possibilities and challenges in using trauma-informed approaches to reduce aggression and violence in high-intensity services

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Topic 5 – Assessment of risk, prevention, and protective factors

Enhancing risk assessment and intervention: Linking the DASA risk assessment to an Aggression Prevention Protocol

Paper presentation

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Keywords: Aggression / restrictive interventions / risk assessment / nursing intervention

Background

Aggression is an enduring and significant problem faced by healthcare professionals, particularly in mental health settings (Daffern et al., 2015; Renwick et al., 2016). Restrictive interventions such as seclusion, restraint and pharmacological treatment are often relied upon to prevent and manage aggression in acute mental health settings, despite significant risk to individuals (Haefner et al., 2021; Weightman et al., 2020).

Risk assessment instruments can help staff identify consumers at elevated risk of aggression. There are several short-term risk assessment instruments that can be used in mental health inpatient settings to assess the risk of imminent aggression. Two of these instruments, the Brøset Violence Checklist (BVC; Almvik et al., 2000), and the Dynamic Appraisal of Situational Aggression (DASA; Ogloff & Daffern, 2002) have been recommended by the National Institute for Health and Care Excellence (NICE, 2015). A recent meta-analysis indicates the DASA and BVC are equally predictive, and *"in clinical practice, consideration should be given to the use of the BVC and the DASA"* (Ramesh et al., 2018, p. 52). Both the BVC and the DASA are comprised of dynamic items (Chu et al., 2013). Ratings are generally made by nurses and require review of clinical notes and

observation (Ogloff & Daffern, 2006). This paper focuses on the DASA. DASA is comprised of seven items (impulsivity, irritability, unwillingness to follow directions, sensitive to perceived provocation, easily angered when requests are denied, negative attitudes, and verbal threats), all of which are independently moderately related to aggression within the following 24 hours. The scores are summed, and the total score yields three risk categories: low, moderate, or high risk (Maguire et al., 2017).

While the assessment of aggression risk is important, assessment is insufficient to prevent harm; it is vital that following assessment, efforts are focused on intervening to prevent aggression and that interventions are timely and if possible, do not rely on restrictive practices (Maguire et al., 2019). Although there has been considerable research investigating the predictive accuracy of the DASA and BVC, little of this work is focussed upon interventions following risk assessment (Maguire et al., 2017; 2018; Martinez, 2016). By assessing the level of risk, nurses can be assisted to identify which consumers might engage in aggression, and prompt coordinated and appropriate intervention (Kaunomäki et al., 2017; Maguire et al., 2019). Against this background, this paper will discuss a Programme of research designed to enhance risk assessment using the DASA, and a linked Aggression Prevention Protocol (APP) designed to reduce aggression and reliance on restrictive interventions. The APP was designed to be used in conjunction with the DASA, to provide nurses with guidance about how to intervene to prevent aggression for consumers presenting with different levels of risk.

Methods

This paper describes three studies that were designed to enhance the DASA and develop the APP to support nursing risk assessment and intervention. Study one involved a retrospective analysis of data derived from consumers admitted to three acute units in a secure forensic mental health service, to assess whether the level of risk (as measured by the DASA) corresponds with different aggression prevention strategies, and to review the original DASA risk bands (0-1 low risk, 2-3 moderate risk, >3 high risk), as well as testing the predictive validity of the DASA in a sample of women. Results from this study, in conjunction with a literature review on nursing interventions to prevent aggression were used to develop the APP.

The second study involved a prospective quasi-experimental study that was conducted on a forensic mental health acute unit for women, testing an electronic version of the DASA (eDASA) incorporating a Clinical Decision Support System (CDSS) linked to the APP (known as the eDASA + APP). Surveys were conducted to explore the nurses experience of using the eDASA + APP.

Finally, the eDASA + APP was tested in a cluster-randomized controlled trial (RCT) incorporating a crossover design with baseline, intervention, and washout periods on two acute forensic mental health units for men. Measures included DASA, and the APP to guide nursing intervention for aggression prevention. The primary unit of analysis was frequency of incidents of aggression, and the secondary unit of analysis was the frequency of use of restrictive interventions. Surveys were conducted to explore the nurses experience of using the eDASA + APP.

Results

In study one, Receiver-Operator Characteristics were used to test the predictive accuracy of DASA, and Generalized Estimating Equations (GEE) were used to account for the repeated risk assessments. Results revealed modest predictive validity (AUC of 0.773, 95% CI: 0.727, 0.819). There was no statistically significant difference in the DASA's predictive validity for females as compared to males. GEE analyses suggested the need to adjust DASA risk bands to 0 = low risk; 1, 2, 3 = moderate-risk OR, 4.70 (95% CI: 2.84–7.80); and 4, 5, 6, 7 = high-risk OR, 16.13 (95% CI: 9.71–26.78). The most documented nursing intervention to prevent aggression was Pro Re Nata (PRN) medication 35.9% (n = 733), followed by reassurance 18.1% (n = 369), distraction 10.9% (n = 223), limit setting 10.5% (n = 214), one-to-one nursing 9.7% (n = 198), increased observations 9.1% (n = 185) and de-escalation 5.8% (n = 119). GEE was also used to analyse nursing interventions where PRN medication, limit setting and reassurance were associated with an increased likelihood of aggression in some DASA risk bands (low and moderate), leading to the development of the APP in conjunction with a literature review exploring the commonly used nursing interventions.

In study two the DASA + APP was tested prospectively. Following the introduction of the eDASA + APP, there were reductions in verbal aggression in phase two (n = 33, 6.6%) as compared to phase one (n = 37, 7.1%), reductions in the administration of PRN medication (phase two had less PRN medication

(n = 33) compared to phase one (n = 135) Wald X2 (df = 1) = 17.16 P = <0.0001) and reduction in seclusion per 1,000 occupied bed days (OBD), where the overall rate of seclusion per 1,000 OBDs was 151.5 when the DASA was used, and 122.2 when the eDASA + APP was used. There was also an increase in documented nursing interventions with a significant association between the phase of the study and the number of interventions provided, with more interventions documented when using the eDASA + APP (n = 275, 55.2%), as compared to when staff were only using the DASA (n = 211, 40.6%). Data collected from the survey suggested that nurses were supportive of using the DASA + APP in practice.

Finally, in the cluster RCT, eDASA + APP implementation was associated with a significant reduction in aggression (OR 50.56, 95% CI 50.45-0.70, P = 0.001), and a significant decrease in the use of PRN medication (OR 50.64, 95% CI 50.50-0.83, P =0.001). There was also a reduction in the use of seclusion with 22.3 seclusion episodes per 1,000 OBDs when staff were only using DASA, and 16.2 seclusion episodes per 1,000 OBDs when staff were using the eDASA + APP.

Discussion

Examination of the DASA using appropriate statistical techniques provides robust evidence of the predictive validity of DASA for both males and females. GEE was used instead of more traditional methods of analyses (e.g., logistic regression) to address some of the concerns in the literature about potential biases regarding the predictive accuracy of risk assessment methods when repeated assessments are not considered in the analysis (see Coid et al., 2015). The new risk band ratings also demonstrated higher AUC values than the original risk band ratings (Maguire et al., 2017).

Regarding study two, when nurses were using the eDASA + APP there was a significant increase in the number of interventions documented. Other studies examining the effectiveness of CDSS' have also found improvements in consumer care (Kawamoto et al., 2005; Pengli et al. 2016). Using the DASA + APP may have prompted staff to intervene according to the protocol, and this may have also encouraged staff to document the way they intervened (Maguire et al., 2019). Finally, the decrease in the use of PRN medication without an associated increase in aggression is a promising finding, given that the administration of PRN medication has been linked with inpatient aggression

in some studies (Bowers et al. 2015; Nicholls et al. 2009). This finding also shows that restrictive practices can be reduced without an increase in aggressive behaviour.

Further and more sophisticated testing to the eDASA + APP in the RCT, demonstrated an increase in *'appropriate'* (according to the APP) interventions. A reduction in aggression and reduced use of restrictive interventions was also observed when nurses used the eDASA + APP. The high rate of completion of the DASA risk assessment during this study and use of interventions recommended by the APP, suggests that nurses were willing to use the eDASA and eDASA + APP, which was also confirmed by surveys indicating that nurses found the instrument and direction for intervention helpful (Griffith et al., 2021).

Conclusions

Inpatient aggression remains a significant issue. Risk assessment and intervention using validated risk assessment instruments is one way of intervening to prevent aggression and reducing reliance on restrictive interventions. Enhancing the DASA by adjusting the original DASA risk bands assists by prompting nurses to engage in aggression-prevention interventions when the level of risk is elevated. Re-examination of the DASA also shows that DASA is valid for the assessment of risk for aggression among male and female consumers.

Use of the DASA can also be enhanced by using an electronic CDSS to link the DASA assessment with nursing interventions as suggested by the APP. Testing of the eDASA + APP on an acute female, and two acute forensic mental health units for men produced a reduction in aggression, use of PRN medication, and reliance on restrictive interventions. There was, correspondingly, an increase in documented nursing interventions. Further, nurses reported positive experiences with the eDASA + APP, and results from the study suggest that nurses were adhering to the APP in practice.

The studies detailed in this paper have devised and tested a method to advance DASA assessment from purely focusing on risk prediction, to integrating the DASA assessment with nursing intervention. The results from these studies show promise for enhancing nursing practice and consumer care. The eDASA + APP is easy and quick to use and can be integrated into daily nursing practice. Importantly the eDASA + APP appears to be accepted by nursing staff. Most importantly, testing of the eDASA + APP has produced reductions in aggression and restrictive interventions. Moreover, this research has produced several

findings that contribute to the assessment and management of aggression in a mental health inpatient setting and provides several nursing interventions to prevent aggression focused on intervening early.

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Educational goals

1. Better understand a programme of research designed to enhance risk assessment using the DASA (Dynamic Appraisal of Situational Aggression), and a linked Aggression Prevention Protocol (APP).
2. Examine the effect of DASA and APP to reduce aggression and reliance on restrictive interventions.

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Preliminary results of cross-validating the MR-CRAS in Danish general psychiatry

Poster presentation

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Keywords: MR-CRAS / Risk Assessment / Mechanical Restraint / Cross-validation

Abstract

The Mechanical Restraint Confounders Risk Alliance Score (MR-CRAS) assesses readiness to be released from mechanical restraint. MR-CRAS was developed and validated in 2018 in forensic psychiatry in Denmark. However, the scale has not been validated on other clinical samples or in other cultural contexts. The current study examined the content validity of the MR-CRAS in a general psychiatric setting.

An interdisciplinary expert panel (N=8), representing four psychiatric wards in the Region of Southern Denmark, rated the relevance and comprehensiveness of MR-CRAS items and sub-scales for a general psychiatric context.

All items were considered relevant (I-CVI≥0.78), except for two items (I-CVI=0.75 and 0.38). The item with the lowest I-CVI value is being refined. All subscales had excellent content validity (S-CVI/Ave≥0.90), apart from one (S-CVI/Ave=0.82).

Overall, preliminary results suggested that MR-CRAS is applicable in the assessment of the readiness of general psychiatric patients to be released from MR.

Summary

There is a lack of empirically validated initiatives shortening mechanical restraint (MR) duration.

The Mechanical Restraint Confounders Risk Alliance Score (MR-CRAS) is a risk assessment tool used to assess the readiness of patients to be released from MR. MR-CRAS was developed and validated in a forensic psychiatric context in Denmark. The purpose of MR-CRAS is to ensure a systematic and transparent assessment of patients' readiness to be released during MR.

The current study is part of a larger project that is cross-validating the MR-CRAS in a general psychiatric context. In the current study, we examined the quantitative and qualitative content validity of MR-CRAS.

An expert panel of eight multi-disciplinary clinical professionals from four psychiatric wards in the region of Southern Denmark used a 4-point scale to rate the relevance and comprehensiveness of MR-CRAS items and subscales. Qualitative feedback was given in relation to potential revisions or the addition of items.

Quantitative analysis of Item-Content Validity Index (I-CVI) and Scale-Content Validity Index/Average (S-CVI/Ave) were conducted for all panel responses. Items with I-CVI$\leq$0.78 were candidates for revision, while items with I-CVI$\leq$0.50 were candidates for removal. Subscales with scores of S-CVI/Ave$\geq$0.90 were considered as having excellent content validity. All but one subscale reached scores well above 0.90. The last one generating a score of 0.82, likely due to the presence in that subscale of a contested item.

The preliminary results demonstrated an overall good content validity of items and subscales for the general psychiatric setting. However, one item divided the expert panel (I-CVI score=0.38). This was the item *"the patient wants to be restrained"*. Because this was the only item about which clinicians raised serious issues, a qualitative approach was adopted for a deeper understanding. Interviews with each expert on their reasons for their rating of the item revealed several broad themes, such as the lack of clarity, relevance, risk of misuse and ambiguity of the item. The research group is currently addressing these themes and revising the item in accordance with panel responses.

The cross-validation represents an important prerequisite for applying MR-CRAS to general psychiatric patients in Denmark. Further research is needed to examine the reliability and validity of MR-CRAS in other settings.

Educational goals

1. To generate knowledge about the similarities and differences in factors influencing clinicians' evaluation of mechanically restrained patients in the contexts of forensic versus non-forensic adult psychiatry, thus also shedding light on the applicability of MR-CRAS across these settings.
2. To establish a knowledge base for the wider implementation of MR-CRAS, thus potentially allowing for the consolidation of a uniform idea of what constitutes best practice in the evaluation of the readiness of patients to be released from MR.

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The relationship of substance uses and abuse issues with students in Inclusive Higher Education Programme

Poster presentation

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Keywords: Inclusive / substance use / substance abuse / Programme

Abstract

Presenters will provide a poster on the qualitative research done on this topic. The issue is well substantiated in the literature, but no intervention literature or studies exist. the researchers will be creating an intervention Programme based on the findings

Summary

Findings of the qualitative pilot will be shown

Educational goals

1. To create interest and interventions on the topic of use and abuse of substances by young adults with intellectual and developmental disabilities
2. To improve the state of quantitative research in this area

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A study of associations between lack of information on risk factors and future violence

Poster presentation

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Keywords: Screening tool / V-RISK-10 / Uncertainty / Acute psychiatry

Abstract

We explored associations between risk items scored Don't know, indicating lack of information, and subsequent violence when using a 10-item risk screen (Violence risk screening - 10; V-RISK-10) in a sample from three acute psychiatric wards (N = 1435). V-RISK-10 was scored at admission and prior to discharge. Violence was recorded during hospital stay and three months post - discharge. For most items, a significant proportion of patients were scored Don't know at admission, and don't know scores at admission were significantly associated with inpatient and post-discharge violence. Substantially fewer risk items were scored Don't know before discharge, and for most items, don't know scores were not significantly associated with post-discharge violence. These preliminary findings are relevant for acute psychiatric admissions when information on risk factors may be sparse and indicate that lack of information at time of admission should be taken into consideration in violence risk assessments.

Summary

Background: Except preliminary findings from a study from acute psychiatry on Violence risk screening - 10 (V-RISK-10), which reported on associations between Don't know scores (indicating lack of information) and inpatient violence (Eriksen et al., 2016), most research on violence risk tools have not focused on Don't know (Hartvig et al., 2011; Roaldset et al., 2011).
Aims: To explore associations of Don't know scores at admission with inpatient and post-discharge violence, differences in numbers of patients scored Don't

know at admission and prior to discharge, and associations of Don't know scores before discharge with post-discharge violence.

Methods

Prospective naturalistic study from acute psychiatry. V-RISK-10 was recorded at admission and prior to discharge. Violence was recorded during hospital stay (N = 1435) and the first three months after discharge (N = 461).

Preliminary results

More patients were scored Don't know at admission than pre-discharge. Area under the curve (AUC) for V-RISK-10 sum scores at admission were around 0.7-0.8 for both inpatient and post-discharge violence, and slightly higher when don't know was weighted as increased risk. At admission, binary logistic regression resulted in significant Odds ratios (ORs) for Don't know for most items both for inpatient and post discharge violence. ORs for Don't know before discharge were non-significant for post-discharge violence for most items.

Conclusions

According to our preliminary findings, when using a violence screen at admission, don't know scores may be associated with violence during hospital stay and after discharge, suggesting that such scores should not be treated as no risk. Findings may be especially relevant in acute psychiatry where information on risk factors of violence may be sparse at time of admission. More research is needed to confirm our findings.

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Educational goals

1. To describe some challenges and potential limitations to current violence risk assessment tools in acute psychiatry.
2. To describe preliminary research findings regarding Don't know scores potential association with violence when using a violence risk screening tool, and to discuss how lack of information on violence risk factors may be taken into consideration when using violence risk screening tools.

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Coercion registration: 15 years of Dutch experience. Learning how to feedback findings.

Interactive workshop

Eric Noorthoorn, GGNet Centre of Mental Health, Warnsveld, Netherlands.

Keywords: Coercive Measures / Mental Health Law / Registration definition / Calculation principles

Abstract

Violence and aggression occur frequently on admission wards. In the last 20 years a vast body of literature was developed showing the effect of risk assessment, ward environment, personnel, law, and many other factors determining ward policy contribute to the reduction of coercion. In the workshop we will present the main principles of a tool, which is currently used at all wards throughout the country. The registration tool argus covers all coercive measures in a way the substitution of one measure by another can be investigated. Date of time of start and end contribute to a precise calculation of the time patients are subject to any form of coercion. In the workshop we present the main calculation techniques. We show how to tap into hospital registration systems. We also show how data from these systems are included in a relational database allowing a standardised calculation of coercion use.

The main goal of the workshop is teaching participants how to interpret the effects of ward policy on the use of coercion. An overview of the main policies is given. The author will contribute with 15 years of practical experience in this field, both in the Netherlands and abroad. Participants are advised on the best way forward for similar situations in their wards.

Educational goals

After the workshop participants will know

1. how to address coercion in a reliable and valid way
2. how to check data from several sources
3. how to calculate meaningful outcomes, such as the number of measures per admissions or admission hours

4. how to feedback the findings to the wards
5. how to improve care quality using this tool

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Another psychotic maniac kills – why do they let them out

Paper presentation

Stål Kapstø Bjørkly, Molde University College, Molde, Norway.

Keywords: Psychotic symptoms / Negative emotional distress / Criminality / Violence

Background

Individuals with psychotic disorders face profound challenges as they attempt to maintain identity through the course of illness. A small proportion of them commits violence. This presentation will address some challenges and discuss the violence stigma attached to persons with psychosis.

Aims

The first aim is to present the main groups of risk factors of violence: Dispositional, Historical, Contextual and Clinical. I will address the three last main risk assessment groups. First, I will focus on one historical and contextual factor, criminality, that often is ignored in risk assessment research. Substance use is an established risk factor for violence, still, research has not settled an agreement of what drug are most violence-triggering. In the third aim I will scrutinize dynamic aspects of psychosis that are empirically associated with risk of violence. By using results from the empirical research literature on the link between psychotic symptoms and violence the presentation will analyze what level of symptoms that are associated with violence. I will present findings from empirical research concerning emotional negative distress (END) as a catalyst for delusions and hallucinations to act violently.

Methods

This is results from structured literature reviews of the empirical research concerning the psychosis – violence link with focus on emotional catalysts in imminent violent hallucinations and delusions. I also build on my former publications on this topic. My first review on the link between psychotic

symptoms and violence was published in 2001 (Bjørkly, 2001). Since then I have published two review papers and a systematic review on the same topic is on its way now.

Results and Conclusion

Winsper and colleagues' prospective study (2013) followed 670 first-episode psychosis (FEP) cases at 6- and 12-months post-discharge. Latent class growth analyses identified four subgroups of premorbid delinquency: stable low; adolescent-onset high to moderate; stable moderate; and stable high. Risk of violence was partially motivated by psychotic symptoms in the moderate delinquency group, while being in the stable high delinquency group had a direct effect on violence. They concluded that there seemed to be different trajectories to violence during FEP, but also emphasized previous criminality as a strong risk factor of violence. Prince and Wald (2018) found that to focus on criminality appears to be a strong risk factor, even stronger than psychosis alone after being released from criminal services and followed up (n=10,855: National Survey of Drug use and Health, 2006–2014). The results showed that psychosis had the lowest risk for new criminality (OR=1.84) versus substance abuse diagnosis (OR=5.32), and comorbidity (OR=7.47). Other research has found the criminality factor as a potent risk of violence (e.g Witt, et al., 2015). Specific psychotic symptoms, such as persecutory delusions and violent auditive command hallucinations appear not to be automatically associated with violent acts. Still, the strongest catalysts for perpetrating violence in persons with psychosis appear to be persecutory delusions and violent command, auditory hallucinations, are negative emotional distress (NED). Without negative emotional distress the risk of violence appears to drop. More research with focus on the association between specific psychotic symptoms with NED and violence is called upon.

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A taxonomy of risk for restrictive physical interventions

Paper presentation

Chris Stirling, Crisis Prevention Institute, Newcastle under Lyme, United Kingdom.

Keywords: manual restraint / risk taxonomy / patient safety

Abstract

Notwithstanding the potential for restrictive practices to be misused and abused, there is a specific concern related to manual restraint and the potential for adverse physiological and psychological impacts including pain, injury, and, in some rare cases, fatal consequences. Rather than continue a debate largely based on professional or personal opinion, this presentation aims to introduce an evidence-based taxonomy of risk which has been developed to enhance an organisation's ability to make decisions regarding which restrictive interventions (restraint) are suitable for use within their settings so that effective governance can be enacted so that front line staff authorised and approved to use restraint fully understand the risks and are aware of any mitigating factors that need to be used to maximise patient safety.

Educational goals

1. To raise participant understanding related to the risks associated with all physical interventions (restraint)
2. To dispel the myth that certain restraint techniques/positions are safe and certain restraint techniques /positions are unsafe - all interventions carry risk
3. To provide a taxonomy of risk that supports organisational decision-making when authorising and approving what restraint techniques/positions are suitable for use in front service settings
4. To highlight the risk associated with pain-inducing techniques

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Challenging the perspective that wrist flexion techniques are not pain-inducing

Presentation

Chris Stirling, Crisis Prevention Institute, Newcastle under Lyme, United Kingdom.

Keywords: pain inducing techniques / patient safety / risk mitigation / human rights

Abstract

An Investigation into the Range of Movement and Forces Involved by the Application of Wrist Flexion Restraint Techniques - Pain Inducing or Not?
This workshop will share recent research which demonstrates that wrist flexion techniques are pain-inducing and as such, should be recognised as a potentially abusive and a breach of human rights as a method of containment

Educational goals

1. To show that published evidence demonstrates that wrist flexion techniques, as a method of restraint/containment, are likely to result in the inducement of pain
2. To explore an ethical and human rights perspective regarding the use of wrist flexion techniques
3. To progress the debate regarding whether the use of pain-inducing techniques as a method of containment within mental health settings is acceptable

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Topic 6 – Humane safe and caring approaches to coercive practices

The implementation of mandatory training standards in mental health/ learning disability settings in the UK

Paper presentation

Katie Miss Goodall, Manchester Metropolitan University, Manchester, United Kingdom; Alina Haines-Delmont, and Joy Duxbury,

Keywords: Training standards / Reducing restrictive practices / Mental health / Learning disabilities

Abstract

In 2020, the first national mandatory standards for training in restrictive practices were launched in England. The Restraint Reduction Network (RRN) Training Standards apply to any organisation delivering training on restrictive practices (including restraint) in mental health and learning disability settings. This presentation will outline the findings of a research study funded by the Burdett Trust for Nursing, examining the views and experiences of organisations who implemented the Standards. A sequential mixed method design was used, involving an online survey, in-depth interviews, and consultation workshops. Quantitative data were analysed using descriptive statistics, while qualitative data were analysed in NVivo using thematic analysis. In this session, we will outline key findings and implications for future training and practice. Mandatory standards are one piece of the puzzle towards reducing restraint – we will reflect on challenges and advantages of such standards and how they could be transferred to other settings or countries.

Summary

Background

In 2020, the first mandatory standards for training with a restrictive practices' component were introduced in England, to encourage a positive change in practice and provide a legal framework on which training can become more standardised across health and social care services. Despite training being an integral part of Programmes aimed at reducing restrictive practices, there is evidence to suggest that there is too much inconsistency regarding quality of training and quality assurance across healthcare settings.

Aims

The aims of this study were to (1) explore the extent to which the RRN Training Standards have been adopted and implemented in training organisations in the UK; and (2) examine views and experiences regarding the process of implementation and certification of the Standards, with the view to identify barriers and facilitators to implementation and inform future iterations of the Standards.

Methods

A sequential mixed methods approach combining an online survey, in-depth semi-structured interviews, and consultation workshops. Survey respondents were representatives of organisations either certified or working towards to certification against the Standards (n=114). Interview participants were selected from four key sites to capture the experiences of both larger and smaller training providers and organisational type (in-house, commercial and affiliate) and were professionals with a key strategic role regarding training and the reduction of restrictive practices in their organisation (n=12). Quantitative data was analysed using descriptive statistics and qualitative data was analysed using thematic analysis (Braun and Clarke, 2021) to identify patterns of meaning across the dataset. Emerging results were then validated with other stakeholders, including people with lived experience (n= 77) in consultation workshops to identify and refine recommendations, as well as to discuss the feasibility and reality of implementing them in the short and long term.

Results

6 key themes were identified, including barriers and facilitators to implementation and benefits or challenges regarding involving people with lived experience. The Standards were recognised as an important contributor towards a wider organisational cultural shift needed in the use of restrictive practices in mental health settings and beyond. They have supported the change in priority from skills only training to a wider, person-centred, trauma informed care approach with more emphasis on prevention and de-escalation, which is in line with the use of training approaches internationally.

Educational goals

1. To understand the benefits and challenges of implementing a national framework to standardise training with a restrictive practice's element.
2. To consider how the Training Standards might be practically applied in other settings and other countries.

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The patients' view on mechanical restraint in Austrian adult psychiatry

Paper presentation

Florian Wostry, University of Vienna - PhD Student / Wiener Gesundheitsverbund, Vienna, Austria; Hanna Mayer, Karl Landsteiner University of Health Sciences, Krems, Austria; Sabine Hahn, Bern University of Applied Sciences, Bern, Switzerland.

Keywords: Mechanical restraint / experience / patients / psychiatry / improvements

Background

According to the VertretungsNetz, in 2020 a total of 25,513 inpatients in Austria were involuntarily hospitalized in psychiatry. Of these, 34.1% were restricted in their freedom of movement by being restrained or by having their hospital room locked [1]. Data on the type, duration, and frequency of coercive measures are incomplete and there is no benchmarking. Mechanical restraint is a primary intervention used in Austrian adult psychiatry.

Detailed descriptions of how mechanical restraints work in practice seldom appear in the literature. This is probably due to the taboo nature of the subject. If a psychiatric patient poses an acute danger to him- or herself or to others and if mechanical restraint is the last option, a high number of nursing staff is deployed in Austria. Ideally, two nurses hold the patient by the upper extremities with a special painless holding technique and accompany the patient to the hospital bed where the restraint belts are located. With the help of three additional nurses, the patient receives mechanical restraint to the bed. Some patients passively endure this procedure, others put up moderate to fierce resistance as soon as they are held by nursing staff. This can include kicking, punching, biting, head butts, and spitting at nurses. In such cases, two to three other nurses may be needed to lie over the lower extremities of the person to be restrained, two to four nurses are necessary to immobilize the upper extremities and shoulders, and one nurse to hold the head of the patient. During this procedure, it's important that no pressure is exerted on the affected person's joints and that adequate breathing is ensured. Ideally, two other nurses are needed to put on and close

the restraint straps. One nurse is in constant verbal contact with the restrained person, gives information about the situation, and tries to have a calming and de-escalating effect. This procedure can take several minutes. Afterwards, the patient in mechanical restraint receives a prescribed medication with a calming and sedative effect. Sometimes the patient and the nursing staff are injured during mechanical restraint. Occasionally the nursing staff cannot withstand the physical force of the person being restrained. In such a case, additional nursing staff is needed in the background as a reserve to replace the injured or exhausted colleague if necessary. In some cases, there is not enough nursing staff available, or the physical strength and aggressive danger potential of the person to be restrained are so great that the nursing staff must alert security staff or the police for self-protection. As this description shows, mechanical restraint is a coercive measure that represents an extraordinary and highly emotional situation for the patient and nursing staff alike. Experience takes a central role during mechanical restraint [2]. Therefore, it is important to learn more about the use of mechanical restraint and its effects from the patients' points of view. Since the experience of coercive measures is culturally different [3], previous results of international studies regarding the experience of mechanical restraint from the perspective of the patients can only be transferred to Austrian psychiatry to a limited extent.

Aim

The aim of this study was to identify the experience of mechanical restraint from the patients' perspective and their suggestions for improvement.

Method

As part of a qualitative study in 2020 twelve guided individual interviews were conducted with psychiatric adult inpatients in Vienna. All participants had experienced mechanical restraint. The transcription of the interviews was guided by Kallmayer and Schütze [4]. Initial coding was used as the coding method in the MAXQDA 2020 software (Saldaña) [5],. The interpretive, reductive analysis approach of Mayer [6] and the creation of prototypes following Murphy [7] served as orientation for the analysis of data. The ethics committee of the City of Vienna approved the study.

Results

The analysis of the interviews shows that patients experience mechanical restraint predominantly negatively and as an extremely exceptional situation. Of the twelve participants, only one reported a consistently positive experience of mechanical restraint. Every mechanical restraint situation has different characteristics and its own individual dynamics. The behaviour of patients, nursing and medical staff, communication, nursing care, architecture, and environment seems to influence the experience of mechanical restraint.

A total of three prototypes were identified. Prototype 1 with psychological stress has three subcategories: fear & horror, loss of control & panic, and traumatization: *"It (,) it destroys you. It makes a creature out of you and nothing more. It's absolute worthlessness that I felt"* Interview_9_S, pos. 27-30. *"The traumatization is definitely there if you have experienced restraint. That's the drama"* Interview 9_S, pos. 115-116. Prototype 2, physiological stress, includes the subcategories of violence from within, violence from without, and pain. *"There is really beating around and raving"* Interview 9_S, pos. 29-30. *"You have pain all over your back when you lie on your back for hours on end…"* Interview 1_F, Pos. 56-58. In prototype 3 a feel-good effect reflects the experience of a single interview participant and includes three subcategories: super feeling, security, and satisfaction. The participant describes it as, *"the feeling of a gift of protection"* Interview 8_M, pos. 26.

General categories describe a lack of understanding, disregard for basic needs, bad and good medication experience, unpleasant atmosphere, and loss of trust: *"You develop extreme anger and then you're just against everything. That's when you hate everybody that's there"* Interview 12_T, pos. 107-109. Categories of positive experiences are empathic care, relief from falling asleep and feelings of calmness, protection, safety, and understanding: *"I also understand now why I was fixed, I don't like the restraint, but I would have run away otherwise"* Interview 7_L, pos. 58-60.

Patients describe important improvements to reduce the use of mechanical restraint by reviewing and breaking up old structures, the mechanism of control, and improving communicative de-escalation techniques. Dignified treatment and debriefings are required.

Calming touch and participatory decision-making were mentioned as alternatives to break restrictive practices: *"The patient should have something to say, and the handling of the act should be much more dignified"* Interview 9_S, pos. 27-28. *"Then I immediately calmed down, he just touched me gently"* Interview 12_T, pos. 183-184. Furthermore, when coercion is unavoidable, some of the patients want at least a choice of coercive measures such as isolation or physical restraint.

Discussion

The results of this research show some similarities to international evidence. In this regard, a systematic review [2] shows that an international comparison also reveals a precarious experience of mechanical restraint, which is associated with negative feelings and trauma. Only a small number of patients experience protection and safety during mechanical restraint. Prototype 3 Great feel-good is only rudimentary mentioned in the current literature. In particular, the experience of a super feeling during mechanical restraint seems to be unique in these research findings. Possibly this patient has developed a fetish for mechanical restraint. In the interview, the patient euphorically describes how pleasant the restraint is and that the mechanical restraint was desirable. The subcategory satisfaction, in which the patient is all around agreeing with the mechanical restraint, is only found in one study [8] where a patient intentionally provoked a mechanical restraint and describes it as pleasant. The subcategory of security of prototype 3, where the patients report calmness and protection, is also reflected in other studies [8] [9] [10]. Another new finding of this research is the importance of calming touches that patients experienced as positive and helped to feel human and safe during restraint. If coercive measures are unavoidable, the results of this study show that a part of the patients would like to have a choice, and isolation and physical restraint may be an alternative to mechanical restraint. The possibility that a patient can choose between coercive measures may help to reduce trauma and loss of the therapeutic relationship. However, in Austrian adult psychiatry, it has not been possible until recently to choose between different types of restraints.

Some nurses see mechanical restraint as an integral, unavoidable, and culturally shaped part of psychiatric care [11]. However, some nursing staff reject such practice. The experiences of patients should support this attitude. Nevertheless, nurses are often trapped in an institutional setting that creates powerlessness

and makes change difficult [12]. Not only are legislative changes needed, but a fundamental change in the culture within psychiatry seems urgent [13].

Conclusion

The description of the three prototypes enables nurses to better reflect on their role and actions during coercive treatment. As recommended in international guidelines [14], it is also evident in the results that patients prefer de-escalation and shared decision making, and if there is no other possibility, to have a choice between different coercive measures. Regarding loss of trust [15], it is pointed out that coercive measures can damage or destroy therapeutic relationships. This increases the risk of patients dropping out of treatment, which in turn increases the risk of coercive treatment. The primary singular application of mechanical restraint in Austrian adult psychiatry seems to be traditionally characterized and should be questioned. On an international level, many health care institutions are trying to reduce the use of coercion and to find alternatives in this regard. The emergence [16] of moral doubts in coercive measures is the first approach of critical reflection and rethinking the culture and attitude towards mechanical restraint.

Educational Goals

1. To uncover and comprehend that mechanical restraint is predominantly a physiological and psychological stressful situation for patients.
2. To give examples that there are many suggestions for improvement which could be established for optimizing the care practice.
3. To better reflect the own role and action as a nurse during coercive treatment.

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An ethnography of coercion: capturing the processual dynamics

Paper presentation

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Keywords: figurative approach / institutionalized processes / ethnographic fieldwork / qualitative research / coercion and relationships

Background

This paper presents an excerpt from an ongoing PhD project which is employing process- and relational theory and ethnographic fieldwork to explore coercion in psychiatry as a historically situated phenomenon emerging through institutionalized practices. By arguing for how coercion may be related to societal and historical aspects of the psychiatric practice, the PhD will contribute with valuable insights to scientific as well as practice-oriented discussions, which can benefit the patients and professionals in the psychiatric practice by pushing to academia and policy.

An ethnography of coercion: capturing the figurative dynamics of patient-professional relationships

Integral to the care of mental illness, is the possibility of coercion (The Danish Psychiatry Act, 2019). Coercion and aggression in mental health care are topics highly debated in Danish policy, by patient-organizations and amongst practitioners and scholars of psychiatry (Epinion for Bedre psykiatri, 2010; Høyer, 2000; Klitfod et al., 2021; The Danish Council on Ethics, 2012). However, efforts to reduce and prevent coercion in Danish mental health care do not seem to bear fruit: coercion, in general, has not decreased from 2008-2018 (Danish Health Authority, 2018).

Much research on coercion gives primacy to a good relationship between patients and professionals when discussing efforts to reduce coercion. Relationships are often conceptualized as a *"therapeutic alliance"* (Cookson et al., 2012; Langberg et al., 2019; Lawrence et al., 2019; Moreno-Poyato et al., 2018)but the concept is not well-defined. This study aims to provide an overview of how

patient-centredness has been defined in the literature since Mead and Bower's review in 2000, and to provide an updated definition of the concept. Method & design: We performed a systematic literature search in PubMed to identify original articles with a sufficient definition of patient-centredness. We analysed extracted data defining patient-centredness. Results: Eighty articles were included. The dimensions *"biopsychosocial"*, *"patient-as-person"*, *"sharing power and responsibility"* and *"therapeutic alliance"* corresponded to four of five dimensions described by Mead and Bower. *"Coordinated care"* was a new dimension. Conclusion: The identified dimensions are encompassed by three elements: the patient, the doctor-patient relationship and the framework of care i.e. the health care system. The additional focus on coordinated care could reflect increasing complexity of the health care system. Practice implications: Narrowing down the understanding of patient-centredness to these three focus areas, viz. 1 and as *"positive social interaction"* (Berring, 2015, p. 14). A good relationship is believed to be a protecting factor of aggression and coercion, both as a de-escalating mechanism and also as a way of preventing aggression in the first place (Berring, 2015; Gilburt et al., 2008; Vistisen et al., 2016).

Recognizing these findings, the relationship between the patient and professional is key when aiming at reducing coercion. The troublesome issue is, as was stated above, that we in Denmark have not managed to consistently reduce coercion across measures and regions. From a social psychological perspective, this calls for a curious and critical look at the processes around coercion – one of which is the patient-professional relationship.

Aims

Through an ethnographic field case study, this paper aims to explore the patient-professional relationship (PPR) as embedded in institutionalized processes in psychiatry. In this way, the paper aims to move beyond a look at PPR as the quality of positive interactions and individual qualifications. Through a figurative ontology (Elias, 2009), I aim to account for the relevance and value of looking at relationships and coercion in psychiatry as institutionalized processes. Further, the hope is that the potential of a figuration approach to relationships and coercion can elicit further discussion on the complex phenomena that relationships and coercion are.

Introducing figurations

The ontological premise for this paper, is that the PPR is figuration. *'Figuration'* is a concept coined by late sociologist Norbert Elias to describe the *'modes of living'* that are particular to human beings (Elias, 2000, 2009). These modes include an ontological human dependency, meaning that humans are socially interdependent. We are all embedded in networks of interdependency. In this approach, any relationship in any social world will always be historically contingent and will always be a part of a process of networks of interdependency.

I assert the claim that PPRs are figurative because their very existence (ontologically as well as practically) is bound upon a strong interdependency: they cannot exist without one another. If there were no patients, there would be no doctors (or other professions), and vice versa. Further, the professionals and patients have many interdependencies outside of the concrete PPR. An example could be, that a doctor is hired at the ward, and is therefore dependent of the requirements of that employment. When approaching the PPR this way, it is crucial to give attention to the things around the concrete PPR.

One way this can be done analytically is to look at PPRs as institutionalized processes. The term institution is very much embedded in our everyday life language, but *'institution'* is also a key concept in sociology (Durkheim, 1966, p. lvi). I view institutions to be both *"concrete buildings and businesses with a well-defined purpose"* (Gulløv, 2004, p. 55), and a social phenomenon with certain logics and connections, that are maintained through individual's actions (Jenkins (1996) in Holen, 2011, p. 41). I *'break down'* the concept by looking at how institutions are to be found on different levels of social reality, that being a microlevel, a mesolevel and a macrolevel.

At the microlevel, the encounter is the basic unit. An encounter is the form of action patterns that shape the flow of face-to-face interaction (Turner, 2004). The mesolevel focus on *"organizations in their cultural environments"* (Turner, 2004, p. 12). Corporate and categoric units are the key structures (Scott, 2014). Finally, on the macrolevel, the focus is on the larger systems of societal values, ideologies, and norms (Turner, 2004).

Combining a figurative ontology with institutional theory, enables the investigation of how PPRs are conditioned on the three levels of social reality and how the levels are interlinked figuratively.

Methods

The PhD is designed as a qualitative explorative ethnographic field study (Hviid Jacobsen & Jensen, 2018; Kyed & Pedersen, 2018), comprising of five months participant observation in three in-patient wards in Denmark and 11 interviews with staff and patients from the same wards. In participant observations, the overall idea is to be both a participant with the practice and an observer of the practice (Hviid Jacobsen & Jensen, 2018).

The aim is to *"subject yourself"* to the practice by *"accept[ing] all of the desirable and undesirable things that are a feature of their life"* (Goffman, 1989, p. 125).

Field notes were taken every day spent on the wards on a paper notepad, and these were gathered, written through, and elaborated at the end of each day on my computer. Whenever it was possible the exact wordings were written down as quotes. I developed my own coding system comprising of abbreviations of names, roles, and technical terms, allowing for fast and precise note taking.

The interviews were conducted as semi-structured case-oriented interviews (Kvale, 2011; Wandall et al., 2018) with three doctors, two psychologists, one nurse, two assistants, one social worker and one patient advisor. The interviews were recorded (audio only) and all informants signed consent forms. The field notes and the transcribed interviews have been anonymized and, for this paper, I chose an exemplary case for the analysis (Flyvbjerg, 2006; Valsiner, 2019)

Analysis

I will now introduce and analyse a case from my fieldwork, which I believe is exemplary to understand PPR figuratively. The case is about the young patient William. William was 18 when I met him and had been known to have mental health problems since childhood. According to a recent medical record from a private ward, he had been *"strongly impaired in functioning"* for over a year and had dropped out of high school. William was involuntary hospitalized. I will now show how William's PPRs were challenged in different ways; first, at the microlevel, then mesolevel and lastly at the macrolevel.

"Here, we talk without talking with each other"

This quote is from a nurse, who in frustration said this to me a day in the staff office. She was referring to the communication between the staff at the ward, but I think it's representational for the some of the communication between patients and staff too. I will from a micro perspective look at the interaction between William and a psychiatrist as it played out in a patient meeting, where a nurse and myself were also present. The background of the meeting is that the chief psychiatrists had 24 hours to re-evaluate Williams involuntary detention. This was also their first encounter after William was admitted. This excerpt is after the first few minutes:

William: *"Many of the things, that the other psychiatrist has written, she has misunderstood"*

Psychiatrist: *"It says here [in the discharge summary], that it wasn't possible with voluntary measures"*

William shook his head, and with a small smile, he said: *"I am embittered about the way all this with the hospitalization has been going on"*

Psychiatrist: *"In the discharge summary, it says, that it would be irresponsible not to treat you and your psychosis-similar symptoms medically"*

So, William feels misunderstood. The psychiatrist then refers to the discharge summary and the unobtained voluntariness, and not to his feeling of being misunderstood. In return, William does not refer to the discharge summary nor (in)voluntariness. Instead, he talks about a more general frustration. The psychiatrist again turns to the discharge summary, only this time she refers to the irresponsibility of not treating William.

In this short conversation, the statements from the psychiatrist make isolated sense; her *'job'* is to re-evaluate the involuntary hospitalization. Therefore, it is only logical, that she refers to the discharge summary. The statements from William also make isolated sense: he tries to communicate his experience. The psychiatrist ended the meeting after almost an hour, and William left the meeting, clearly frustrated.

Looking from the micro level, the problem of this encounter and its potential as a relationship builder is that their statements only make sense isolated from the other part's response. Neither the psychiatrist nor William responds to

each other's questions or statements. Instead, they both talk past each other, in what seems more like two monologues than a dialogue. It is also clear, that the psychiatrist has a very specific goal with the conversation; to re-evaluate the involuntary hospitalization. In this way, her communication is what Habermas (1970) calls *"work"* rather than *"interaction"*, because the focus is strategic rather than democratic. William is thereby communicatively objectified. They were talking, without talking with each other.

Governing mental illness

We begin this meso-section reflecting on the everyday life at the ward. During weekdays, the hallways would be buzzing with small talk, typically performed while walking from a to b, and, as such, the ward could feel almost like a busy train station where it was sometimes difficult finding the right train, track, and your fellow passenger for the ride. On the atmosphere in the common areas, a member of the staff told me: *"Sometimes patients simply get discharged. Because they are afraid and couldn't stand the noise. People hospitalized because of anxiety, I mean, to be here must be horrible, really"*. I discovered that the patients' rooms served as an almost sacred place of calm. During an outside walk, William shared with me how he often withdrew to his room, because there could be too much chaos in the hallways – despite, that he wished to be more social in the ward.

The point here is, that it seems that the ward was governed in a way that did not encourage encounters between patients and professionals. The patients *'hid'* away in their rooms until there was a formal patient meeting scheduled, and the treatment staff (doctors and psychologists) were busy with other tasks than talking to patients. Some days, the entire morning until midday was occupied with staff meetings and conferences, and, thus, every meeting with patients were running on a tight schedule. In this way, the way the organization was governed, gave difficult conditions for building PPRs.

Human ideas and patient ideas

What I wish to show here in a macro perspective is how there existed certain ideas about the type of patient William was, which had nurturing and inhibiting conditions for the PPR's he could form. To do this, we will take another look at the meeting between William and the psychiatrist:

William: It is uncomfortable to be here coercively. I want to do what's best for myself. I would like to elaborate on that about the psychotic symptoms.
The psychiatrist interrupted: I need to think of fundamental human rights in this. That all humans have the right to autonomy. But I also must think about your life and your future. You have had low functioning for a long time, and you are still young. Your brain is so young, and we must begin treatment fast. We must take advantage of your potential as young adult. Therefore, my judgement is that you need to be here coercively. The risk of a voluntary hospitalization is that you can walk away. Then your obsessive thoughts will be allowed to decide, and I won't risk that.

Here, the psychiatrist's argument for maintaining the involuntary hospitalization is William's young brain. They must begin treatment fast – with or without William's consent. From other conversations I had with other staff, it became clear that there were certain hopes and expectations related to young patients concerning their possibility of recovery. This type of patient, stood in contrast to the *'chronics'*. These patients had a long history with psychiatry, often a schizophrenia-related diagnosis and there were not many hopes for recovery. Their stay at the ward was more considered a comforting help at a moment of crisis, than treatment. These patients were, however and contrarily to William, not given much attention in staff meetings or in conferences.

The interesting thing here is that the different approaches to different patients sometimes begin before there had been much, if any, interaction; they were, it seemed, based on certain ideas about being a certain type of patient. Ideas about e.g., a *'democratic citizen'*, a *'caring mother'*, a *'conscientious employee'* or a *'nice patient'* are underlying assumptions that guide research and practice. These are general and concrete ideas about humans-in-society which manage and develop societal institutions (Budtz Pedersen et al., 2018). These ideas of humans allow for and invite to very different ways of being a patient in psychiatry, exist across personal characteristics. They have impact on how different *'types'* of patients are approached differently. Others have shown such a tendency e.g. in relation to gender (Oute et al., 2018). William was young and new to the ward, and therefore there were high hopes of his recovery, which gave him much diagnostic attention. In the small excerpt, it seems that there were ideas about William as a certain type of patient and therein his future, which were stronger ideas, than the PPR.

Conclusion and discussion

The results suggest that efforts to establish relationships between patients and professionals in psychiatric practice, which have the potential to reduce coercive measures, are challenged on all three levels of social reality. On the microlevel, I presented how a meeting can turn into two monologues, creating frustration for both parties. The interactions in these meetings are important for building a PPR, since (as we saw on the mesolevel) there is not much patient-professional interaction outside of these meetings. On the mesolevel, we also saw that the PPR was challenged by organizational demands, requiring the staff to optimize their encounters with patients. Bearing this in mind, it is understandable why the psychiatrist in the case is so focused on the re-evaluation; she has limited time to reach the formal and legal requirements. Consequently, the relationship is backgrounded. Another potential explanation for the two-monologues-example is the ideas the psychiatrist has – almost a priori – about William. He has a young brain, and, therefore, she must begin treatment immediately regardless of William's feelings of being misunderstood. The generalized ideas about young, individuals on the ward for the first time can be strong enough to, again, background the PPR.

I suggest that if we wish to nurture PPRs in psychiatry to decrease coercive measures, we should be attentive to the figurations of that relationship.

Future research on this topic should also, I believe, include discussions about 1) ethics of PPRs as a *'function'* and 2) the risk of individualizing the problem. Regarding 1), I see a risk of the PPR becoming a manipulative practice, where the efforts to have a good relationship to a patient, become a means to reach a goal that has nothing to do with that relationship. If the *'function'* of a PPR is to prevent coercion, it becomes paramount to consider the ethics when approaching patients with these efforts. Along this line is 2). If we accept the idea that a good relationship can be de-escalating and even prevent coercion, then we can ask: does the relationship then fail, when coercion does happen?

Was the relationship then not good enough, and whose fault is this? I argue that these questions are important to consider when discussing PPR and coercion, and a way out of a potential individualization is to look figuratively at the problem.

A potential limitation of the current study is that this approach can, I'm aware, seem far away from clinical application. The knowledge interest is, however, not to formulate interventions or find a *'truth'* about e.g., 'why coercion happens". Rather, as Foucault has put it: *"the primary task [for researchers] is to fight tendencies that one, single approach becomes hegemonic to a degree that strangles all other approaches to reality"* (René Jørgensen, 2007, p. 595). In line with the aim of this paper, I hope that this approach can elicit further discussion on the complex phenomena that relationships and coercion are.

Educational goals

1. To explore the patient-professional relationship (PPR) as embedded in institutionalized processes in psychiatry.
2. Examine the application of figurative ontology for assessing relationships and coercion in psychiatry as institutionalized processes.
3. Understand how PPRs are conditioned on the three levels of social reality and how the levels are interlinked figuratively.

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An RCT of a co-created open-door policy versus usual-treatment in acute psychiatric ward care

Paper presentation

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Keywords: Acute psychiatric ward treatment / Open-door policy / Violent events / Coercion prevention

Abstract

Open-door policy (ODP) is a flexible framework for acute psychiatric hospital care that emphasises patients' recovery and personal freedom to reduce coercion. Evidence is debated as RCT data is lacking. Researchers, managers, staff, and service user representatives co-created a Nordic ODP and evaluation project, the Lovisenberg Open Acute Door Study (LOADS). The aim of the RCT evaluation was to investigate whether ODP was non-inferior or superior to usual treatment (TAU) ward care by randomly allocating 550 admissions to either arm for 12 months. Two ODP wards were open 09-21 daily but closed in case of acute crises. Preliminary analyses suggest no difference between ODP and TAU in violent events or coercive practices. LOADS is relevant to *'Humane, safe, and caring approaches'* by being the first RCT on ODP in 25+ years, with results suggesting acute psychiatric wards can reduce door-locking, an informal type of coercion, without compromising safety.

Summary

Open-door policy (ODP) is a flexible and humane approach to acute psychiatric mental health services recommended by the Council of Europe Committee on Bioethics and the World Health Organization's guidelines to reduce coercive practices. A lack of RCT data means the state of knowledge on ODP's ability to prevent aggressive events and coercive practices has been debated.

Aims

Compare adverse events between ODP – and TAU acute wards Compare coercive practices between ODP and TAU wards

Methods

This RCT was a non-inferiority trial of all adult patients admitted to regular acute psychiatric ward care at the Lovisenberg Diaconal Hospital in Oslo, Norway. The sample included all patients admitted to acute psychiatric care and referred to regular (non-forensic) ward care over the course of 12 months. Participants were randomly assigned in a continuous manner to either two ODP or three TAU wards using an open, pragmatic paradigm for random allocation. Outcomes included all coercive measures and clinical data, and the primary outcome was the proportion of acute admissions 1+ coercive measures. Peer support workers were employed in the ODP wards. The Covid-19 pandemic caused minor problems to implementation of parts of the ODP intervention, such as patient network meetings, and caused minor changes to the planned involvement of staff in ODP development and implementation.

Results

Analyses

Cleaning and extraction of data for the main outcome of coercive measures per admission could not completed by the date of abstract submission, meaning non-inferiority analyses were also not feasible. Instead, a preliminary analysis was conducted based on clinical data on coercive practices using a significance level of 95% analysed by an ordinary T-test. Data from the wards were from the calendar year (Jan-Dec) 2021, that could differ from the study period (Feb2021-Feb2022). Congress-presented results may differ.

Key findings

For all coercive events per study arm, there was no statistically significant difference between ODP (Mean: 91.5) and TAU wards (Mean: 106.7). For individual measures, the results were similar. There were no statistically significant differences in mechanical restraints (ODP: 3,5; TAU: 7.3), short-

acting sedatives (ODP: 14,5; TAU: 16), isolation (ODP: 12; TAU: 13), or physical restraints (ODP: 28; TAU: 30).

Conclusions

Open-door policy is a less restrictive approach to acute psychiatric ward treatment that in the LOADS trial appears equally safe compared to usual-treatment for acute, hospital-based mental healthcare.

Educational goals

1. Describe the state of knowledge on Open-door policy in acute psychiatric hospital ward
2. Discuss the risks and benefits of Open-door policy versus usual-treatment hospital services

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FOSTREN: building a European network to help prevent coercion in mental health services

Paper presentation

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Keywords: Coercion / Restrictive practices / Implementation science

Abstract

FOSTREN is a network of mental health service stakeholders funded by the European Cooperation in Science and Technology (COST) framework for the period 2020-2024. The network is focused on bringing together experts with understanding and experience of successful methods for reducing coercion and restrictive practices in mental health services. There are representatives from 32 European countries and the work Programme is organised along five interconnected themes within an implementation science paradigm. The network organises and supports several international collaborative activities in line with its objectives. These include Training Schools for early-career researchers and innovators, and short-term scientific missions (STSMs) involving international visits between research teams. This presentation will outline the FOSTREN Programmeme and review progress at the midway point.

Summary

Background

FOSTREN is a network of mental health service stakeholders funded by the European Cooperation in Science and Technology (COST) framework for the period 2020-2024. The network is focused on bringing together experts with understanding and experience of successful methods for reducing coercion and restrictive practices in mental health services. There is a particular emphasis on taking forward state-of-the-art research by using implementation science as a foundation for ensuring effective interventions are adopted as widely as possible by services across Europe.

Aim

This presentation will outline the FOSTREN Programme and review progress at the current midway point.

The network has representatives from 32 countries and activity is organized around five workstreams: Risk Factors, Alternative Interventions, Recovery & Outcomes, Implementation Science and Dissemination & Exploitation. Key deliverables for completion by 2024 include a mapping survey of relevant expertise and datasets, a glossary of key terms in coercive practice based on consensus across countries and a comprehensive implementation model tailored to reflect the diversity of European mental health services. Engagement with the public through a variety of dissemination routes is a high priority. In line with COST principles, involvement of early-career researchers and innovators and equal representation across all regions of Europe are key strategies.

As a project based entirely on international mobility, FOSTREN has been particularly affected by the COVID pandemic and alternative approaches for communication and sharing expertise have been essential to ensuring progress. The first of four Training Schools for early-career researchers and innovators have been held and several short-term scientific missions (STSMs) have occurred. Several expert teams have been convened to establish current best practice in coercion prevention and to report on this through open access channels.

Conclusion

As a COST Action FOSTREN is an open network and welcomes new members who have an interest in the issue of coercion in mental health services, some professional or personal expertise relevant to the topic and a willingness to share ideas and to collaborate positively to help us to achieve our objectives. Further information is available at the Action website: www.fostren.eu.

Educational goals

1. To gain understanding of some opportunities and challenges when developing a European network focused on the issue of coercion prevention.

2. To be aware of the importance of implementation issues for mental health services when introducing novel interventions.

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High and intensive care in psychiatry: a care model in motion

Paper presentation

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Keywords: HIC model / compulsory care / complex cases / developments in acute psychiatry

Abstract

Previous research has shown progression in implementation of the High and Intensive Care (HIC) model and a decline of compulsory care by the level of implementation. Securing implementation has proven to be challenging, among others by a national shortage of mental health care staff. Systematic evaluation of compulsory care is necessary. This follow-up research aims to optimize the development and implementation of the HIC model in the current mental health care context. Focus will be on 1) developments of influence on the HIC monitor, 2) developments in compulsory care, aggression incidents and complex cases, 3) experiences of clients, family, and professionals on previous topics, and 4) professionals' motivation to work on HIC wards. Both qualitative and quantitative methods will be used, including interviews, focus groups, case studies, questionnaires, and an arts-based method. This presentation highlights the research design and how creative methods can be used in research to optimize HIC care.

Summary

Since previous research on the implementation of High and Intensive Care (HIC) many developments have taken place: the introduction of a new mental health care law, a changing target population that shows more violence and more complex problems and shortages in institution budgets and (trained and experienced) mental health care staff. Together with these developments previous research has shown that HIC practice is ever moving and therefore further research into the model and the current HIC practice is necessary. The

aim of this study is to determine how the development and implementation of the HIC model can be optimized in the current acute mental health care context. To find out, four domains will be addressed. First, focus will be on the developments of the past nine years that were of influence on working to the HIC model and how the model may be adjusted. Second, developments in compulsory care, aggression incidents and complex situations at the HIC wards will be addressed. Third, experiences of clients, family and HIC professionals of compulsory care, aggression-incidents, complex situations, and safety will be gathered. And fourth, motivations of HIC professionals on working at HIC wards are investigated. The design comprises different research methods; quantitative, qualitative, and mixed methods. Participants include HIC professionals, clients, and families of 24 different HIC wards across the Netherlands. Data collection consists of interviews, focus groups, literature review, questionnaires, and an arts-based method. The latter will be in the form of a confession booth, a new way of data collection and will be highlighted during the presentation. The confession booth is a private room close to the HIC ward that HIC professionals can visit during the day to talk in private about their motivations and feelings about working at an HIC ward by means of four questions. The confession booth was used at a London university to ask students about their failures and was very well received. The current research contributes to improvement of the quality of care at acute mental health care wards and provides recommendations to assure constant implementation of the HIC model.

Educational goals

1. Attendants gain insight in the need for further research on the HIC model and monitor, in line with the developments that have taken place in the Dutch acute mental health care.
2. Attendants gain understanding in a variety of research methods, in particular an arts-based method to collect data on professionals' motivations.

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Preserving a therapeutic environment within inpatient mental health settings during COVID-19. Lessons learned.

Interactive workshop

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Keywords: Therapeutic / Milieu / Co-created / Delphi

Abstract

In response to COVID-19, an international group of mental health professionals and service managers collaborated to mitigate the potential conflict anticipated as being inherent in enacting restrictive public health measures.

The group utilised a Delphi approach of four iterative stages to develop a strength -based, person-centred and recovery-oriented framework to support services in preserving a therapeutic milieu specifically within inpatient mental health settings during situations of pandemic.

The framework incorporated the core principles of *'therapeutic community'*, Safewards, recovery, and trauma informed care with emphasis placed on preserving a safe supportive environment, while promoting the principles of trust, safety, collaboration, choice, and empowerment.

The lessons learned from this pandemic-imposed initiative have the potential to enrich the quality of the care experience, for both care recipients and providers, within inpatient settings beyond the pandemic.

Summary

Background

The genesis of this project was mental health practitioners need for practice focussed guidance in how to enact COVD-19 public health measures specifically within inpatient settings, while preserving a therapeutic milieu which promoted

harm-reduction, stress management, and recovery, while minimising potential conflict and/or the associated use of coercive measures.

Aim

The aim was to implement a strengths-based, person-centred, trauma informed and recovery-oriented framework to mitigate conflict, prioritising physical and psychological safety, while minimising risk for both service recipients and staff.

Method

The collaborative project by a multidisciplinary team from Ireland, Denmark, and Netherlands, utilised a Delphi approach of four iterative stages.

Stage 1 involved a review of international COVID-19 related public health and ethical guidance, and a narrative review of pertinent literature, from which the themes *'doing the thing right'* (ethical) and *'doing the right thing'* (practical) were synthesized into an actionable formative framework.

Stage 2 involved engagement with frontline staff and senior leadership in mental health services in Ireland, Denmark, and Netherlands, which sought to establish the face validity of the framework.

Stage 3 involved presenting a formative draft of the framework for plenary discussion at a scientific symposium of the European Violence in Psychiatric Research Group (EViPRG 2020)

Stage 4 involved the structured evaluation by a panel of 15 multidisciplinary subject experts from 9 countries, to assess content validity. Participants completed a structured survey using the five criteria of: *'relevance'*, *'simplicity'*, *'clarity'*, *'practical application'* and *'ease of implementation'*. In addition, open text responses elicited evaluation of both the ethical and practical components of the framework, and opinions regarding any errors and/or omissions.

Findings

The iteratively developed framework provides a structured approach to integrating pandemic related public health and ethical guidance specifically within an inpatient mental health context. The framework preserves the

centrality of person centredness, and adopts a preventive approach of primary, secondary, tertiary and recovery measures to support those whose distress may present as behaviours which services find challenging.

The framework has several strengths including the aligning ethical, clinical, and organisational perspectives and strategies, the inclusion of staff supports measures, and the extension of the primary prevention approach to include the recovery phase following C19 infection.

Limited-service user engagement to date remains a weakness, although such engagement is planned to enhance the validity of the framework and to exploring how the learning might enhance inpatient care beyond the pandemic.

Educational goals

1. Participants will have the opportunity to understand how pandemic related public health and ethical guidance can be the enacted within inpatient settings in a way which preserves a therapeutic milieu.
2. Participants will have the opportunity to understand how a strengths-based, person-centred, trauma informed, and recovery-oriented framework might mitigate conflict, prioritising physical and psychological safety, while minimising risk for both service recipients and staff.
3. Participants will have the opportunity to actively consider the framework documents and explore how learning from implementation during COVID-19 might enrich care within inpatient settings beyond the pandemic.

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Monitoring the implementation process of psychiatric High and Intensive Care in Belgium.

Paper presentation

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Keywords: high and intensive care / implementation process / epidemiological profiles / patient-centered clinical outcomes

Abstract

The psychiatric High and Intensive Care (HIC) model is an innovative healthcare Programme in Belgium for inpatient treatment for severely distressed psychiatric patients, focusing on intensive patient-centered integrated care with minimal coercive measures (van Mierlo et al., 2013). Our study is a multi-method approach of the implementation process of HIC across Belgium, as well as a longitudinal clinical-epidemiological approach to study patient profiles, changes in clinical outcomes during treatment at 6 and 12 months. Data are weighted to represent general patient profiles admitted to HIC units across Belgium. We present preliminary results on epidemiological profiles and clinical outcomes (aggression, suicide risk, psychiatric crisis, (perceived) coercion) among the first 240 participants. We discuss implementation processes and generate hypotheses on factors related to decreases in clinical symptomatology and the use of coercive measures. We add to the knowledge on organizing services for severely disturbed psychiatric patients from innovative patient-centered perspectives.

Summary

Background

The innovative High and Intensive Care (HIC) model focuses on intensive patient-oriented integrated care, with minimal coercive measures, promoting collaboration between caregivers, patients, and relatives (van Mierlo et al.,

2013). Units have been gradually implemented in 9 Belgian psychiatric hospitals since 2019. The systematic monitoring and evaluation of innovative healthcare programmes are essential to develop long-term sustainable solutions that respond to the health needs in the population (Porter & Teisberg, 2006).

Aims

To describe (1) implementation processes of HIC across Belgium, (2) clinical profiles of patients, (3) changes in clinical outcomes in a longitudinal study.

Methods

We use multi-method approaches, with qualitative and quantitative methods, collecting data during 18 months in 9 HIC pilot projects. After patients have given their informed consent, data are collected using well-validated instruments, at admission and discharge, including clinical characteristics, pathways to and after care, and clinical outcomes measures (e.g., aggression risk, suicide risk, psychiatric crisis, motivation for treatment and motivation for change, and satisfaction with treatment. At ward level, the implementation of HIC was assessed by peer-audits in the 9 HIC wards. Baseline peer-audits will be repeated after 18 months.

Results

In this presentation we focus on the following outcomes: risk of aggression, risk of suicide, psychiatric crisis. After 6 months we collected a sample of 240 questionnaires completed by HIC caregivers and patients at admission and discharge. Preliminary results show a significant decrease in aggression risk, suicide risk, psychiatric crisis, and increased motivation for treatment from caregivers' views. Patient-reported motivation for change did not increase significantly throughout the hospitalization. During the presentation we will also present the evolution in use of coercive measures and present bivariate and multivariate correlates of change in these outcomes.

Conclusions

Preliminary results show positive evolutions in risk of aggression, risk of suicide, and degree of psychiatric crisis throughout a HIC hospitalization. These multivariate correlates on the use of coercive measures will generate several

hypotheses regarding the question of how to deal with such issues on a clinical level.

Educational goals

1. To understand the implementation process of psychiatric High and Intensive Care.
2. To understand patient-centered outcomes in a context of High and Intensive Care.

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Fear of losing control – Practical guidance towards forced tube feeding patients with eating disorders.

Interactive workshop

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Keywords: Forced tube feeding / eating disorders / Trauma informed care / Stepped care

Abstract

A small sample of patients with severe eating disorders are at acute risk of adverse outcomes due to a critical somatic condition. An intervention of last resort for these patients is forced tube-feeding. In the Netherlands, most patients that receive this highly complex, intrusive intervention are admitted at medical psychiatric units. If forced tube-feeding is deemed necessary, staff members lack clear guidelines or best practices on the use of this intervention.

In this workshop, we discuss the absence of clinical guidelines and introduce a stepped-care approach to reduce the use of force during tube feeding. The workshop starts with an outline on the population, setting, necessary tools and skills for forced tube feeding, focused on clinical practice. We demonstrate our stepped-care approach (both theoretical and physical) and invite participants to elaborate on their experience and practice on de-escalation, reduction of force, attitude, and safe physical interventions.

Summary

Background

A small group of patients with severe eating disorders suffer from a critical somatic condition, resulting in a high risk of death due to malnutrition. For this population, forced tube feeding is an intervention of last resort.

Aims

To prevent (or reduce) patient trauma after coercive practices with a stepped-care approach to forced tube-feeding.

Giving both physical and verbal intervention guidelines to reduce coercive practices.

Content

On our medical psychiatric unit, a selection of patients with severe eating disorders are admitted regularly in need of forced tube-feeding. When we first encountered this practice, no clinical guidelines or best practices were available to explain how to perform this intervention in potential life-threatening situations. To reduce the use of force and other coercive measures for assisting forced tube-feeding (e.g., mechanical restraint), we developed a stepped-care approach. For the development, we used literature searches, interviews with experts by experience and field research at other institutions, multiple training sessions and trial and error in clinical practice. The objective of the stepped-care approach was to find a way to perform forced tube-feeding as humanely as possible, which was evaluated by follow-up discussions with patients, next of kin and staff members.

Description of the workshop format:

Outline with a theoretical framework of the population, setting, necessary tools and staff skills for forced tube-feeding focusses in clinical practice.

Elaboration on the development and use of the stepped-care approach (i.e., de-escalating communication, and reducing of force during forced tube-feeding). Discussion with the audience about their experiences with forced tube-feeding, the choices that are necessarily made before, during and after the intervention and suggestions to improve our stepped-care approach.

Demonstration, interchange, and practice of verbal and physical techniques when performing forced tube-feeding.

Evaluate the stepped-care approach and the demonstrated techniques and elaboration on future innovation and research.

Educational goals

After the interactive workshop, the participant can/knows:

1. A model for necessary conditions to develop a suitable environment for the inpatients in need of forced tube feeding.
2. Our vision on reducing coercive practice for patients with severe eating disorders.

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"Unplugged": Exploring benefits of wireless headphones and music streaming services in acute inpatient psychiatry.

Poster presentation

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Abstract

Exposure to relaxing music has shown positive results among a variety of populations including elderly people with dementia, post-traumatic patients and patients diagnosed with schizophrenia or mood disorders. The aim of this study is to decrease anxiety, agitation, and other psychiatric symptoms using wireless headphones and music streaming services in an adult inpatient psychiatric unit. Patients used wireless headphones and music streaming services at designated intervals throughout the day. Pre and post use questionnaires were complete by each patient that used the wireless headphones. Anxiety, agitation, and self-identified symptom levels were tracked before and after headphone use. Restraint and seclusion data was tracked. Survey results suggest a significant positive association between listening to music and decrease in self-report level of agitation, anxiety/ distress, and level of symptoms (p-value: .000054). Restraint and seclusion rates significantly declined the 3 quarters following implementation (3Q2020, 4Q2020 and 1Q2021).

Summary

Background

Structured music therapy, led by a trained therapist has known benefits for psychiatric patients in an acute setting but most hospitals do not have a music therapist because of insufficient funding and competing organizational priorities. Exposure to relaxing music has shown positive results among a variety of populations including elderly people with dementia, post-traumatic patients and patients diagnosed with schizophrenia or mood disorders.

Aims

The aim of this study is to decrease anxiety, agitation, and other psychiatric symptoms using wireless headphones and music streaming services in an adult inpatient psychiatric unit.

Methods

The clinical nurses completed a literature review and identified benefits of music in reducing anxiety and agitation related to auditory hallucinations and racing thoughts. Project proposal was submitted for approval and leadership support. Budget allocated and wireless headphones were purchased for patient use. Guideline and informational binder developed with staff input. Patients had access to wireless headphones and music streaming services at designated intervals throughout the day. They were no restrictions on music genre or content.

Pre and post use questionnaires were complete by each patient that used the wireless headphones. Anxiety, agitation, and self-identified symptom level were tracked before and after headphone use. Nursing staff also discussed patient observations during their monthly project evaluation meeting. Restraint and seclusion data was tracked.

Results

Survey results suggest a significant positive association between listening to music and decrease in self-report level of agitation, anxiety/ distress, and level of symptoms (p-value: .000054). Restraint and seclusion rates significantly declined the 3 quarters following implementation (3Q2020, 4Q2020 and 1Q2021).

Conclusions

Wireless headphones can be used as a non-pharmacological intervention to reduce anxiety and agitation in an inpatient psychiatric setting. It also assists patients identify use of coping skills to regulate emotions prior to discharge.

Educational goals

1. Identify wireless headphones as a safe and effective intervention to help decrease anxiety, agitation, and other psychiatric symptoms
2. Analyse the benefits of music in an adult acute inpatient psychiatric setting.

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Topic 7 – Neurobiological and pharmacological interventions

The effectiveness of Transcranial Direct Current Stimulation as an intervention to reduce aggressive behaviour

Paper presentation

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Keywords: Neuromodulation / tDCS / Aggression / Forensic Patients

Abstract

Aggression posed by violent individuals is a major public health concern and to date, interventions to reduce aggression are found to be insufficient in doing just that. Aggressive behaviour is associated with dysfunctions in the prefrontal cortex, of which the Dorsolateral Prefrontal Cortex (DLPFC) and Ventromedial Prefrontal Cortex (vmPFC) are two of the most studied areas. There has been a growing interest in using Transcranial Direct Current Stimulation (tDCS) as an intervention to modulate brain regions of interest and increasing activity in damaged brain areas that show blunted activity.

In this presentation, I will discuss the current state-of-the-art with respect to studies on tDCS and aggression. Moreover, I will discuss our recent findings that have not only shown that tDCS can be effectively used to modulate brain activity and aggression, it also has shown that it is effective in increasing synchronization of neural activity in the brain of violent offenders.

Educational goals

1. Participants will learn about neurobiological mechanisms in aggression

2. Participants will learn why using tDCS as a neuromodulation tool advances research on aggression
3. Participants will learn if tDCS can be used as an intervention tool to reduce aggression

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Effects of multivitamins, minerals, and n-3 PUFAs on aggression among long-stay psychiatric inpatients: randomised trial

Paper presentation

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Keywords: Aggression / supplements / nutrition / psychiatric inpatients / n-3 PUFA

Introduction

Aggression and violent incidents are highly prevalent in psychiatric inpatient care, varying from 9 to 90 incidents per patient per year depending on the type of ward.(1-3) Although pharmacotherapy and psychotherapy may help to mitigate feelings of irritability, anger, or overt aggression,(4) clinical guidelines emphasize the need for additional treatment options.(5)

Previous literature has explored whether multivitamin, mineral, and n-3 PUFA supplementation may help to reduce aggressive behaviour. Hitherto, researchers in this field have studied young male prisoners(6-9) and children with behavioural problems,(10-12) some of whom were diagnosed with autism spectrum disorder (ASD),(13) attention deficit hyperactivity disorder (ADHD),(14) conduct disorder (CD), and oppositional defiant disorder (ODD).(15) In total, five out of six randomized controlled trials showed reductions in aggression, and there were 26% to 47% less aggressive-related incidents in the group receiving nutritional supplements compared to those receiving a placebo.(6-10) In addition, one of these studies demonstrated that participants with the lowest nutrient concentrations seemed to have benefited the most from nutritional supplements.(8) Reductions in aggressive behaviour based on the number of disciplinary incidents were not found in a study among schoolchildren.(12) In the same study, however, an observer-rated scale was also included that did show a significant reduction in these behaviours in the intervention versus control groups. Trials that assessed subjective feelings of aggression as an outcome showed consistent findings. (11, 13-15) Thus, nutritional supplementation may help to reduce aggression, but this needs to be confirmed in a sample of long-stay psychiatric inpatients. A

randomized, double-blind, placebo-controlled trial was initiated to determine the effectiveness of nutritional supplements in reducing aggressive incidents among long-stay psychiatric inpatients. We hypothesized that nutritional supplementation would reduce aggressive incidents, feelings of aggression, and affective symptoms and would increase the patients' quality of life.

Methods

Design

This pragmatic, multicentre, randomized, double-blind, placebo-controlled, intervention trial was coordinated in the department of psychiatry at the Leiden University Medical Centre (LUMC). Participants were recruited between 25 July 2016 through 29 October 2019 from 8 local sites for mental healthcare in the Netherlands and Belgium. Data collection took place at the ward where the participants resided. Written informed consent was obtained from all participants, in some cases from a relative or legal representative, where appropriate.
All procedures contributing to this work complied with the ethical standards of the relevant national and institutional committees on human experimentation and with the Helsinki Declaration of 1975, as revised in 2008. The trial protocol was approved by the Medical Ethical Committee of the LUMC with reference number P14.332.

Participants

Inclusion criteria were (1) being 18 years or older and (2) expected to reside at a facility for long-term psychiatric inpatient care for at least 6 months, irrespective of their specific psychiatric disorder. Exclusion criteria were (1) pregnancy, (2) breastfeeding, (3) contra-indication for nutritional supplements, (4) expected discharge or transfer within eight weeks, (5) restrictions against the consumption of pork gelatin, and (6) continuous use of other nutritional supplements (within the preceding eight weeks).

Intervention

A 2-week placebo run-in phase was followed by a 6-month nutritional intervention, during which participants daily received two capsules containing multivitamins and minerals and one capsule containing n-3 PUFA (i.e., eicosapentaenic acid [EPA] and docosahexaenic acid (16)). The control group received three placebo capsules per day containing the neutral n-9 oleic acid.

Randomization

Participants were randomized in a 1:1 ratio using blocks of 12 participants and were stratified for gender and ward type (open or closed).

Measurements

Primary outcome variable

The primary outcome in this study was the number of aggressive incidents registered using the Staff Observation Aggression Scale – Revised (SOAS-R), created originally for use in inpatient psychiatric wards.(17) The SOAS-R is a quick and easy-to-use tool, which comprises five columns recording (1) provocation, (2) means used, (3) the target, (4) consequences, and (5) measures taken to stop aggression.

Secondary outcome variables

The 11-item Social Dysfunction and Aggression Scale (SDAS)(18) was completed by nurses at baseline and after 2 weeks, 2 months, and 6 months. Additionally, patients were asked to complete several questionnaires at baseline, 2 months, and 6 months: A Dutch version of the shortened 12-item Aggression Questionnaire (AQ),(19, 20) the 26-item World Health Organization Quality of Life (WHOQOL-BREF),(21, 22) and the abbreviated 25-item version of the Comprehensive Psychopathological Rating Scale (CPRS).(23, 24) The CPRS included the Montgomery-Åsberg Depression Rating Scale (MADRS, 10 items),(25) the Brief Anxiety Scale (BAS, 10 items),(26) and an inhibition subscale (5 items).

Other variables

Non-fasting blood samples were collected to determine nutritional status and to monitor compliance in those who consented to blood collection (in 82.6% of participants in the Netherlands). Samples were analysed for Vitamin A (retinoids), E (tocopherol), B12 (cobalamin), and D (calciferol), folic acid and iron in blood serum. Vitamin B1 (thiamine), B6 (pyridoxine), and a fatty acid spectrum to yield n-3 FA levels (ALA, EPA, and DHA) were analysed in EDTA blood samples.
Sociodemographic covariates were age, gender, level of education (categorized into low [primary education, lower secondary education], medium [upper secondary education, post-secondary non-tertiary education], and high [tertiary education,

bachelor, master, doctoral]), marital status (never married/ever married [married, widow/widower, or divorced]), ancestry (European/Non-European ancestry), smoking (yes/no), any use of recreational drugs (never/ever/current [past month]), and the use of alcohol (>14 units per week). Body Mass Index (BMI) was calculated based on measured height and weight. Ward type (open/closed), primary diagnosis, and medication use were obtained from the treating psychiatrist.

Statistical analyses

Sociodemographic and clinical characteristics were summarized per allocation using independent samples t tests and chi-square (2). Micronutrient status was assessed using linear mixed models. The frequency of aggressive incidents was presented as the back-transformed geometric mean number of incidents per month. Negative binomial regression analyses were performed to analyse the number of aggressive incidents, as overdispersion was anticipated. An offset was used to take the log number of days into account that a patient participated in the trial. We applied triple masking, which ensured that the treatment was unknown to the participants and to the nurses and physicians, as well as the epidemiologist (JMG) who analysed the effect on the primary outcome but who was not part of the coordinating centre.

To investigate the trend of the incidence rate ratio (IRR), a negative binomial regression was performed for each month separately, plotted over time. Incidents were studied in total and individually according to their level of severity and type. Sensitivity analyses were performed in subgroups excluding patients with an extreme number of incidents (i.e., either 0 incidents/month or >10 incidents/month), adjusting for baseline SDAS. Post hoc subgroup analyses were performed for sociodemographic and clinical variables. Differences between the randomized groups on the secondary outcomes were performed following intention to treat (ITT) using multilevel regression (mixed) models. In the case of missing data, we used last observation carried forward (LOCF) for the ITT analyses. Chi-squared tests were performed to check whether participants and nurses gave the correct answer more often than expected by chance, excluding the ones who gave the answer *"I do not know."* Chi-square tests were also performed to compare the number of side effects among the randomized groups. A two-tailed significance level of $p < .05$ was considered statistically significant. Negative binomial regression analyses were performed using R within RStudio (R version 3.6.0; R Foundation for Statistical Computing, Vienna, Austria, 2016. URL: https://www.R-project.org/) and using the main package MASS (version

7.3). All other analyses were performed using IBM SPSS statistical software (version 25, IBM Corp Released 2017, IBM SPSS Statistics for Windows).

Results

We assessed 1,121 patients for eligibility and excluded 945 of them. In total, 176 participants were randomized in the trial (supplements, n = 87; placebo, n = 89), most of whom suffered from a psychotic disorder (60.8%). The mean age of the participants was 49.3 years (SD = 14.5), and 64.2% were male. No significant demographic or clinical group differences were observed at baseline (Table 1).

Table 1 - Baseline characteristics of study participants (N = 176).

	Supplements (n = 87)	Placebo (n = 89)	p value
Demographics			
Male gender, no (%)	54 (62.1%)	59 (66.3%)	0.56
Age in years, mean (SD)	49.1 (14.2)	49.4 (14.8)	0.88
BMI (kg/m2), mean (SD)	28.9 (6.0)	28.5 (7.9)	0.73
Closed ward, no (%)	56 (64.4%)	55 (61.8%)	0.72
Never married, no (%)	63/82 (76.8%)	69/85 (81.2%)	0.49
Education low, no (%)	49/79 (62%)	47/79 (59.5%)	0.74
European ancestry, no (%)	71 (81.6%)	70 (78.7%)	0.62
Current smokera, no (%)	61/86 (70.9%)	64/86 (74.4%)	0.61
Alcohol ≥ 14 U/wk[a], no (%)	9/76 (11.8%)	7/82 (8.5%)	0.49
Recreational drugs[b], no (%)	46/85 (54.1%)	48/85 (56.5%)	0.76
Clinical data			
Primary diagnosis, no (%)			0.97
Psychotic disorder	52 (59.8%)	55 (61.8%)	
Mood disorder	8 (9.2%)	9 (10.1%)	
Personality disorder	9 (10.3%)	9 (10.1%)	
Other	18 (20.7%)	16 (18.0%)	
Medication use			
Antipsychotics	76/80 (95.0%)	70/80 (87.5%)	0.09
FGA	42/80 (52.5%)	33/80 (41.3%)	0.15
SGA	60/80 (75.0%)	54/80 (67.5%)	0.29
Antidepressants	31/80 (38.8%)	31/80 (38.8%)	1.00
Benzodiazepines	61/80 (76.3%)	67/80 (83.8%)	0.24
Mood stabilizers	38/80 (47.5%)	35/80 (43.8%)	0.63

Note. Data are number of participants (with percentages in parentheses) or means (with standard errors in parentheses). BMI=Body Mass Index; First Generation Antipsychotics=FGA; Second Generation Antipsychotics=SGA.
[a] Based on last month. [b] Ever used.

Protocol adherence

In total, 114 participants agreed to blood sampling (82.6% of 138 participants from the Netherlands) at baseline, endpoint, or both.

Expected increases were found in the intervention versus placebo groups, which were statistically significant for vitamin B6 ($p = .005$), folic acid ($p < .001$), vitamin B12 ($p = .04$), vitamin E ($p = .02$), EPA ($p < .001$), and DHA ($p < .001$).

Primary outcome measures

The primary outcome of SOAS-R incidents was similar in those assigned to supplements (1.03 incidents/month; 95% confidence interval [CI]: 0.74-1.37) and placebo (0.90; 95% CI: 0.65-1.19), with a rate ratio of 1.08 (95% CI: 0.67-1.74; $p = .75$). Also, no significant effects were found according to the severity or type of aggressive incidents. Sensitivity analyses in subgroups according to the number of incidents (i.e., either 0 incidents/month or >10 incidents/month) did not influence these results, which also applies to the analysis adjusting for baseline SDAS score.

Secondary outcome measures

As seen in Table 2, an ITT approach showed that nutritional supplementation did not significantly affect any of the secondary outcomes. In detail, no differential effects for supplements versus placebo were found for either self- and observer-rated aggression, quality of life, depression severity, anxiety severity, or inhibition.

Blinding

Blinding was successful among participants, who guessed no more often correctly than incorrectly whether they had been taking the supplements or placebo ($p = .44$). Nurses who distributed the supplements, however, more often guessed the randomized condition of the participants correctly (n = 38 of 55; 69.1% correct; $p = .005$). Still, most of both participants (n = 48 of 116; 41.4%) and nurses (n = 75 of 130; 57.7%) answered with *"I do not know."*

Table 2 - Intention to treat analyses of the effectiveness on secondary outcomes.

		n	Baseline	2 weeks	2 months	6 months	Interaction: score * time	
							Test	P
SDAS	Supplements	84	9.2 (0.9)	8.2 (0.9)	7.9 (0.8)	7.7 (0.8)	F(df. 1)=0.016	0.90
	Placebo	84	9.6 (0.9)	8.0 (0.7)	8.4 (0.8)	7.8 (0.7)		
AQ	Supplements	84	30.4 (1.2)	–	28.7 (1.2)	30.1 (1.2)	F(df. 1)=0.576	0.45
	Placebo	84	32.0 (1.1)	–	30.9 (1.0)	30.8 (1.0)		
Anger	Supplements	82	7.5 (0.4)	–	7.0 (0.4)	7.2 (0.4)	F(df. 1)=0.006	0.94
	Placebo	84	8.2 (0.4)	–	7.8 (0.4)	7.9 (0.3)		
Hostility	Supplements	84	9.0 (0.4)	–	8.6 (0.4)	8.8 (0.4)	F(df. 1)=0.319	0.57
	Placebo	82	9.5 (0.4)	–	9.6 (0.4)	9.0 (0.4)		
Physical aggression	Supplements	82	7.3 (0.4)	–	6.8 (0.4)	7.0 (0.4)	F(df. 1)=0.052	0.82
	Placebo	83	7.1 (0.4)	–	6.8 (0.3)	6.8 (0.4)		
Verbal aggression	Supplements	81	6.4 (0.4)	–	6.4 (0.4)	6.8 (0.4)	F(df. 1)=0.958	0.33
	Placebo	82	7.4 (0.3)	–	7.0 (0.3)	7.4 (0.3)		
WHO-QOL	Supplements	77	87.4 (2.0)	–	85.2 (2.1)	85.8 (2.0)	F(df. 1)=0.596	0.44
	Placebo	79	83.5 (1.9)	–	83.6 (1.8)	84.0 (1.8)		
Physical health	Supplements	78	13.2 (0.4)	–	13.0 (0.4)	13.2 (0.4)	F(df. 1)=0.001	0.98
	Placebo	78	12.6 (0.4)	–	12.7 (0.3)	12.8 (0.3)		
Psychological health	Supplements	78	12.6 (0.4)	–	12.7 (0.4)	12.4 (0.4)	F(df. 1)=0.952	0.33
	Placebo	77	12.4 (0.4)	–	12.4 (0.3)	12.7 (0.4)		
Social relationships	Supplements	78	12.9 (0.4)	–	12.6 (0.4)	12.6 (0.5)	F(df. 1)=0.687	0.41
	Placebo	74	12.6 (0.4)	–	12.5 (0.4)	12.9 (0.4)		
Environment	Supplements	78	14.4 (0.3)	–	13.8 (0.4)	14.1 (0.3)	F(df. 1)=0.105	0.75
	Placebo	79	13.7 (0.3)	–	13.8 (0.3)	13.5 (0.3)		
MADRS	Supplements	69	13.0 (1.3)	–	12.2 (1.3)	12.5 (1.2)	F(df. 1)=0.021	0.89
	Placebo	71	13.3 (1.3)	–	13.0 (1.3)	13.2 (1.2)		
BAS	Supplements	69	12.0 (1.0)	–	10.7 (0.9)	11.5 (0.9)	F(df. 1)=0.033	0.86
	Placebo	68	11.8 (0.9)	–	11.6 (0.8)	11.6 (0.8)		
Inhibition Scale	Supplements	70	4.7 (0.5)	–	4.0 (0.5)	4.1 (0.4)	F(df. 1)=0.462	0.50
	Placebo	71	4.7 (0.5)	–	4.6 (0.5)	4.6 (0.5)		

Note. Data are means (with standard errors in parentheses). SDAS=Social Dysfunction and Aggression Scale, observer rated; AQ=Aggression Questionnaire; WHO-QOL=World Health Organization Quality of Life; MADRS=Montgomery-Åsberg Depression Rating Scale; BAS=Brief Anxiety Scale.

Discussion

Our findings provided no support for the effectiveness of multivitamin, mineral, and n-3 PUFA supplementation in reducing the number of aggressive incidents among psychiatric inpatients during a 6-month intervention. Post hoc analyses according to the severity or type of aggressive incidents corroborated this

conclusion. No differences were found between the randomized groups regarding the secondary outcomes, including self- and observer-rated aggression, quality of life, and affective symptom severity.

The current study is the first to investigate the effect of nutritional supplements in inpatients suffering from chronic psychiatric disorders. These patients are often not included in clinical trials, leading to a lack of evidence for effective care and treatment.(27) In previous trials that investigated the effect of nutritional supplements on aggressive incidents, patients with psychosis were often excluded(11, 12, 14, 15) or no information on the use of psychotropic medication was given.(6, 10) Our sample included participants with psychotic disorders (60.8%), a vast majority of whom were using antipsychotics (91.2%). The extensive use of antipsychotics in our population may have led to a ceiling effect, as antipsychotics are prescribed to mitigate agitation and aggression,(28) creating a situation in which no additional effect of a nutritional intervention could be found. Note that an exploratory analysis of the subsample of patients with psychosis who did not use antipsychotic agents in the current study did suggest a reduction of incidents among the patients with psychosis who had taken the nutritional supplements. Furthermore, an exploratory trial including acute patients with schizophrenia treated with antipsychotic medication found no effect of n-3 PUFA supplementation on hostility compared to the control group.(29)

In addition, the incidents of the patients with psychosis in the current study may comprise different forms of aggression than those expressed by participants in previous trials, such as aggression resulting from the nature of their psychiatric disorders, like paranoid delusions.(30) Moreover, aggressive behaviours in psychiatric patients may be masked by the complex interaction of different causal factors.

In summary, this is the first randomized controlled trial that studied the effect of nutritional supplementation among long-stay psychiatric inpatients. Despite some promising effects of nutritional supplementation on aggressive incidents found in previous studies, we found no evidence of effect in chronically ill psychiatric inpatients.

Educational goal

Understand a method determining the effectiveness of nutritional supplements in reducing aggressive incidents among long-stay psychiatric inpatients.

Acknowledgments

We would like to thank all members of the Diet and Aggression study for their highly appreciated work.

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Topic 8 – Psychosocial interventions

From model to practice: implementing Active Recovery Triad (ART) in Dutch long-term mental health care

Paper presentation

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Keywords: Implementation / Active Recovery Triad / Long-term mental health care / Serious mental illnesses

Abstract

The recently developed Active Recovery Triad (ART) model aims to provide a new perspective for people with serious mental illnesses, who are dependent on 24h care and support for extended periods. ART is currently being implemented in teams of eighteen mental health care organizations in the Netherlands. The aim of this study was to create insight into the key factors of implementing the ART model into the long-term mental health setting. Fourteen group interviews with teams were conducted. In this presentation, the results of this implementation study will be discussed. Teams can learn from the key factors important in the implementation process of ART. In this presentation, these key factors will be illustrated in addition, these findings are also interesting for teams that want to start implementing other (comparable) care models or interventions.

Summary

Introduction and aims

Considerable effort, over many years has been invested in the implementation of recovery-oriented care, patient-centered care and innovative practices and interventions in mental health care. The recently developed Active Recovery Triad (ART) model aims to provide a new perspective for people with serious mental illnesses, who are dependent on 24h care and support for extended periods. ART combines an active role for professionals, service users and families (A), a focus on recovery (R), and cooperation between service user, families and professionals in the triad (T). ART is currently being implemented in teams of eighteen mental health care organizations in the Netherlands, in a variety of settings; from long-stay (closed) wards to residential care facilities. The implementation of new approaches in mental health care can be a major challenge. Teams are often struggling to successfully adopt or implement new interventions and treatments in daily practice. A valuable contribution to teams implementing the ART model is the exchange of knowledge and experiences regarding the implementation process within different organizations. The aim of this study was to create insight in the key factors of implementing the ART model into the long-term mental health setting.

Methods

Data were collected using a qualitative approach. Fourteen group interviews with teams in the process of implementing care according to the ART model were conducted. A thematic analysis was used to retrieve key factors in the implementation process. To illustrate the themes that emerged from the data into different contexts in long-term mental health care, the implementation course of one team was selected as an *'illustrative case'*.

Results

In this presentation, the results of this implementation study will be discussed, using the implementation course of one team as an illustrative case study . The key factors are clustered into three categories following the process of implementation, namely (1) the start of implementation, (2) step by step execution, (3) long-term perseverance.

Conclusions

The implementation of the ART model into long-term mental health care is a challenging process. Nevertheless, teams in the Netherlands are motivated to make it a success and overcome the barriers they face during this process. Teams can learn from the key factors important in the implementation process of ART. In addition, these findings are also interesting for teams that want to start implementing other (comparable) care models or interventions.

Educational goals

1. Understand the Active Recovery Triad model in Dutch long-term mental health setting.
2. Understand the key factors important in the implementation process of the ART model, that can help teams at the start or in the process of implementing the ART model or other (comparable) care models or interventions in mental health care.

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Barriers and facilitators for Assertive community treatment (ACT) implementation in Latvia

Poster presentation

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Keywords: severe mental illness / outpatient department / ACT / mental health policy

Abstract

Assertive community treatment (ACT) is an integral part of mental health care in many countries for providing treatment to individuals with severe mental illness (SMI) and to prevent their hospitalization in case of deterioration in their mental health. In Latvia, measures to implement community based psychiatric care have been adopted, however there is no ACT and the problem of continuity of treatment for persons with SMI has not been resolved. The aim of study to determine the current level of preparedness in implementation of ACT in Latvia. The largest outpatient departments in Latvia were evaluated according to the ACT criteria of the Dartmouth assertive community treatment scale. The study revealed insufficient preparedness of mental health centres to implement ACT in Latvia. The need to amend mental health policy, plans and strategies to ensure the continuity of treatment for persons with SMI to implement ACT were identified.

Summary

Background

In Latvia, measures to implement community based psychiatric care have been adopted, however there is no ACT and the problem of continuity of treatment for persons with SMI has not been resolved.

Aims

To determine the current level of preparedness in the implementation of ACT in Latvia

Methods

The largest outpatient departments in Latvia were evaluated according to the ACT criteria of the Dartmouth assertive community treatment scale. Data obtained through semi-structured interviews with team leaders and clinicians working in the ACT team with statistical data provided by the centres.

Results

The study revealed insufficient preparedness of mental health centres to implement ACT in Latvia.

Conclusions

The need to amend mental health policy, plans and strategies to ensure the continuity of treatment for people with SMI and to implement of ACT were identified.

Educational goals

1. Describe the practice and criteria of ACT for persons with SMI using Dartmouth assertive community treatment scale. Get recommendations and advice on improvement and implementation outpatient health care in Latvia.
2. Demonstrate the absence of unified standards for the provision of outpatient psychiatric care in Latvia. Demonstrate insufficient preparedness to provide continuity of outpatient psychiatric care.

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A Randomized Clinical Trials of Cognitive-Behavioural versus Supportive Psychotherapy for Intermittent Explosive Disorder

Poster presentation

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Keywords: Intermittent Explosive Disorder / Cognitive behavioural therapy / Supportive therapy / Randomized Controlled Trial

Abstract

Despite its prevalence, chronicity, and clinical impact few clinical trials have evaluated the efficacy of psychotherapy for Intermittent Explosive Disorder (IED). In this randomized clinical trial, participants with IED completed twelve 50-minute individual sessions of either a multi-component cognitive behavioural intervention for IED (n=19) or a time equated supportive psychotherapy (n=25). At baseline, post-treatment and three-month follow-up, all participants received the Overt Aggression Scale–Modified. During these visits, participants also completed self-report measures of relational aggression, anger, cognitive biases, and associated symptoms. Primary study outcomes were aggressive behaviour and anger. Though participants in both treatments tended to improve over time, the cognitive behavioural intervention was superior to supportive psychotherapy in decreasing aggressive behaviour and relational aggression. These findings support the efficacy of a multi-component cognitive behavioural intervention in treating aggression in IED.

Summary

Background

Intermittent Explosive Disorder (IED) is a common and serious disorder existing in about 2%-5% of the population (Coccaro & McCloskey, 2019). IED is also associated with considerable psychosocial impairment (Kulper et al., 2015; Rynar & Coccaro, 2018), and long-term health problems (McCloskey et

al., 2010). Despite the prevalence, chronicity, and clinical impact of IED, few clinical trials have evaluated the efficacy of psychotherapy for this disorder.

Aims

To evaluate the efficacy of a 12-session cognitive behavioural intervention as compared to a dose equated supportive psychotherapy control among adults with IED. Primary study outcomes were aggressive behaviour and anger.

Methods

The study was a randomized clinical trial of 44 participants with a diagnosis of IED (based on DSM-V criteria) assessed via clinical interview. At baseline, post-treatment and three-month follow-up, all participants received the Overt Aggression Scale–Modified, which was conducted by an interviewer who was blind to the participant's study condition. During these visits, participants also completed self-report measures of relational aggression, anger, cognitive biases, and associated symptoms.

Analysis

Participants with any outcome assessments were included in the analysis (intent-to-treat analysis). Missing data were determined to be missing at random. Linear effects mixed model (LMM) analyses provide robust estimates when data are missing at random. LMM was conducted using SPSS 28 with maximum likelihood model estimation.

Results

The cognitive behavioural intervention was superior to supportive psychotherapy in decreasing aggressive behaviour and relational aggression. Participants in both conditions showed significant reductions in anger with no significant difference in improvement between treatments. About secondary outcomes, participants in the cognitive behavioural condition tended to show significant improvement from pre-treatment to posttreatment/follow-up, whereas this was less true for participants in the supportive psychotherapy. However, treatment x time interactions for these secondary outcomes were largely non-significant.

Conclusions

These findings support the efficacy of a multi-component cognitive behavioural intervention in treating aggression in IED.

Educational goals

1. Understand the current research on psychosocial interventions for Intermittent Explosive Disorder (IED).
2. Learn the results of a recent randomized clinical trial comparing cognitive behavioural intervention to a dose equated supportive psychotherapy comparison treatment for IED.

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Topic: 9 – Service users and family perspectives

Towards patient engagement in violence risk assessment and management: a patient perspective

Paper presentation

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Keywords: Participatory research / Service user / Violence / Interview

Abstract

The aim of this research was to describe inpatients' ideas on how they would develop current violence risk assessment and management practices. The data collection took place in one PICU unit specialising in the treatment of patients with psychosis and violent behaviour. A qualitative descriptive design was adopted with individual interviews (n=13). Patients' views centered on concrete ideas for developing patient engagement in care and violence risk management methods. Developing patient engagement involved noticing patients' individuality and collaboration between patients and staff. Developing violence risk management methods included themes about providing alternative risk management methods and developing nursing staff's work. Patients had clear ideas on how violence risk assessment and management methods could be developed further. They also want to be involved in both practices. These findings indicate that patients need to be given a more active role in their care related to violence risk assessment and management.

Summary

Background

In current clinical practice, few methods exist that allow patients to be truly engaged in violence risk assessment and management. This may hinder an individual's experience of basic psychological needs, autonomy, competence, and relatedness.

Aims

To describe patients' ideas on how they would develop current violence risk assessment and management practices.

Methods

The data collection took place as part of a larger project in one PICU unit specialising in the treatment of patients with psychosis and violent behaviour in Finland. A qualitative descriptive design was adopted for this sub-study. Individual interviews were conducted with volunteer inpatients (n=13) and focussed on the development of violence risk assessment and management.

Results

The data were analysed using inductive content analysis. Patients' ideas focused on themes related to developing patient engagement in care and violence risk management methods. Developing patient engagement involved noticing patient's individuality and collaboration between patients and staff: for instance, by shared risk assessment and individualized risk management. Developing violence risk management methods included themes about providing alternative risk management methods and developing nursing staff's work. Suggestions were, for example, related to providing ways how to remain calm, having meaningful activities during treatment days, and ensuring the realisation of patient's rights.

Conclusions

Patients having treatment in the PICU unit have clear and concrete ideas on how violence risk assessment and management methods could be developed further.

They also want to be involved in both practices. These findings indicate that patients need to be given a more active role in their care and thus ensure that basic psychological needs are promoted.

Acknowledgements

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Educational goals

1. To recognize ways to promote patient engagement in violence risk assessment and management.
2. To use the information to analyse whether their own clinical practice or research allows patients to be truly active participants in different aspects of inpatient care.

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Service users' perceptions of Safewards implementation fidelity on an acute psychiatric in-patient ward

Paper presentation

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Keywords: Safewards / Implementation / Service users / Prevention

Abstract

Safewards is a model that aims to reduce conflict and containment on psychiatric wards. Fidelity of implementation is often assessed by using the Safewards Fidelity Checklist (SFC). However, SFC does not include the perspective of service users. The aim of this study was to investigate the service users' perceptions of Safewards implementation fidelity on an acute psychiatric ward.

The ward had, according to its own follow-ups, succeeded well with the implementation of Safewards. An independent fidelity assessment using SFC was conducted along with a detailed ward walk-though. Ten service users were interviewed about their observations of manifest signs of Safewards as well as quality aspects of the interventions.

Preliminary findings indicate that there was a high implementation fidelity, both according to the SFC and the service users' observations of Safewards and its implementation. Some interventions were perceived as demanding by some service users and several suggestions were made about improvements.

Summary

Background

Safewards is a model that aims to reduce conflict and containment on psychiatric wards. There are only a few studies about Safewards from the service user's perspective, often from a general point of view rather than on the effects of the ten interventions. Fidelity of implementation is often assessed by using the Safewards Fidelity Checklist (SFC). However, SFC does not include the perspective of service users.

The aim of this study was to investigate service users' perceptions of Safewards implementation fidelity on an acute psychiatric ward.

Methods

The design of this study is an interview study with service users, supplemented by a measurement of fidelity with SFC. The setting is a ward for service users with affective disorders and the staff consisted mainly of nurses, half of whom were registered nurses. The ward had, according to its own follow-up, succeeded well with the implementation of Safewards. Independent fidelity assessment using SFC was conducted along with a detailed ward walk-though. Ten service users were interviewed about their observations of manifest signs of Safewards as well as quality aspects of the interventions. The interviews were analysed with qualitative content analysis.

Results

Preliminary findings indicate that there was a high implementation fidelity, both according to the SFC and the service users' observations of Safewards and its implementation. Some interventions were perceived as demanding by some service users, like attending the Mutual help meeting. Several suggestions were made about improvements, such as information through simplified text or the use of pictures. There were service users, with previous experience from other wards, who felt unaccustomed to being in a ward where so much communication was expected between patients and staff, but also between patients, for example through Mutual help meeting and Discharge messages.

Conclusions

Safewards is a model that affects how service users perceive the staff's behaviour and the climate in the ward. Some service users compared the staff's work style with staff they met in other wards; they reported that staff in this ward had a more positive work style when interacting with service users. Despite Safewards, staff sometimes had difficulties in dealing with certain situations. Service users observed this and perceive the ward as a challenging environment.

Educational goals

1. The study provides a description on how the interventions of Safewards can be perceived by service users in a psychiatric ward.
2. The study provides a basis for a broader discussion of how method fidelity of Safewards and other models aiming to reduce coercive measures could be evaluated.

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Informal coercion and psychological pressure in mental health care: a contextual model

Paper presentation

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Keywords: informal coercion / psychological pressure / voluntariness / qualitative mental health research

Abstract

Although informal coercion is present in the everyday life of service users, it is neither conceptually clear nor sufficiently represented in research. To gain insight from multiple perspectives, we conducted semi-structured qualitative interviews with 14 people with mental illness who have experienced coercive measures and 11 relatives of people with mental illness. We analysed the data using grounded theory and performed an empirically informed conceptual analysis.

The analysis shows that the various communicative means subsumed under informal coercion cannot be considered in isolation, but that diverse contextual factors must be considered. For example, power imbalances and the possibility of the use of formal coercion play a crucial role in the perception of informal coercion. The inclusion of these contextual factors as well as non-verbal and implicit modes of interaction into our concept allows for a more comprehensive understanding and recommendations on how to reduce informal coercion.

Summary

Background

The use of coercion in the treatment of people with a mental illness raises important ethical challenges. Formal coercion involves interventions such as involuntary commitment, involuntary medication, seclusion, and restraint that are exerted against the will of service users and without their consent.

Informal coercion, on the other hand, refers to communicative strategies used to influence the decisions and behaviour of service users to obtain consent and improve their adherence to recommended treatment or social rules. These strategies include persuasion, interpersonal leverage, inducements, and threats. The use of informal coercion is prima facie morally problematic because it can compromise the voluntariness of consent. Although informal coercion is very present in the everyday life of service users, it is neither conceptually clear nor sufficiently represented in research.

Objective

Current conceptions of informal coercion, which have mainly emerged from theoretical considerations, are to be differentiated and further developed based on empirical results, considering the perspective of service users and their relatives. This allows us to form an appropriate conceptual basis for a thorough ethical evaluation and to identify potential risk factors that could contribute to a reduction of informal coercion.

Methodology

Conceptual analysis based on semi-structured, qualitative interviews with (a) 14 people with a mental illness who have experienced coercive measures and with (b) 11 relatives of people with a mental illness. Analysis using grounded theory.

Results

The analysis shows that the various communicative means subsumed under informal coercion cannot be considered in isolation, but that diverse contextual factors must be considered. For example, power imbalances and the possibility of the use of formal coercion play a crucial role in the impact and perception of informal coercion and are omnipresent due to environmental factors like closed ward doors or beds used for physical restraint. The inclusion of these context factors as well as non-verbal and implicit modes of interaction into our concept of informal coercion allows for a more comprehensive understanding and challenges previous hierarchizations of different forms of informal coercion within psychiatry.

Conclusions

To avoid and reduce informal coercion, mental health professionals should reflect critically on their communication by considering implicit meanings and contextual factors and ensuring the greatest possible transparency.

Educational goals

1. Being able to identify context factors and modes of interaction that influence the perception and impact of informal coercion.
2. Understand why informal coercion poses a problem to the voluntariness of consent and understanding the necessity of being aware of using informal coercion in clinical practice

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The role of carers in reducing restrictive practices for people with learning disabilities

Paper presentation

Rachel Whyte, Manchester Metropolitan University, Manchester, United Kingdom; Alina Haines-Delmont, Elaine Craig, Beth Morrison.

Keywords: Learning Disabilities / Carers / Restrictive practices / Behaviour that challenges

Abstract

Restrictive practices are often used in response to a breakdown in communication. Despite carers having unique insight into what their loved ones are attempting to express, closed service cultures mean they are often silenced. The aims of this project were to understand why carers' involvement is important in the care of people with learning disabilities, what it means for them to be involved and how can their involvement lead to the reduction/prevention of restrictive practices. An online focus group was conducted with 25 carers of people with learning disabilities, exploring their direct involvement in reducing restrictive practices on their loved one. Findings showed that the vital role of carers in reducing restrictive practices is underrepresented and undervalued within systems of care. This in turn, raises critical questions around the quality of fully informed provision and support. Significantly, this project highlights that carers' play a direct role in reducing restrictive practices.

Summary

Restrictive practices (RP) are often used in response to behaviour that challenges; however, this is often the manifestation of an unmet need being expressed, compounded by an inability to translate due to learning disability (LD) communicative limitations. Carers play a key part in understanding their loved one's communication style. If utilised, this insight can de-escalate a situation by fully understanding and meeting that expression of need, prior to a RP thus reducing RP use.

The overarching aim of this project was to inform a larger realist review that could be utilised to prevent and reduce the use of RP on adults with LD in NHS and independent sector settings. In the context of this NIHR review, the paper presentation for this congress is looking specifically at the findings in relation to carers' role in preventing/reducing RP. This complementary workshop with carers had three aims: 1) to understand why carers' involvement is important in the care of people with LD 2) what it means for carers to be involved and 3) how carers involvement can lead to reduction/prevention of the use of RP on loved ones with LD.

A focus group was conducted online (to facilitate better attendance and in line with the COVID-19 restrictions at the time) and consisted of 25 carers, all of whom had a loved one with LD who has been affected using RP. The discussion was hosted by Beth Morrison, the mother of a child with LD who sustained life-threatening injuries during restraint and a passionate advocate for the reduction of restrictive practices. The dialogue from the focus group then allowed for themes to be identified.

It was found that If carers are involved in the care pathway of their loved ones, staff are more likely to de-escalate an event involving behaviour that can harm. This is because staff will gain insight into the service user's communication style and will better understand what behaviour corresponds with what expression of need. This will help them see everyone in a unique way and identify potential triggers to distress and behaviours that can harm, allowing for RP to be prevented.

Educational goals

1. To understand how the input/involvement of carers can be transformative to learning disability service users care when utilised
2. To critically discuss how services are lacking in family participation and how things can be improved

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Topic 10 – Intersectional perspectives (gender, race, culture, and ethnicity)

Hearing the Silences: Putting lived experience at the heart of mental health research

Interactive workshop

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Keywords: Inequality / Mental Health Detention / Black experiences / Black male mental health

Abstract

This interactive workshop discusses the co-produced findings of a systematic review for the NIHR funded project ImprovE-ACT. The focus of the review was to explore the lived experiences of Black males who have been detained under Mental Health legislation. Through our partnership with experts by experience, we have identified some of the *'silences'* that do not currently feature in the academic literature. During the workshop, we will: introduce you (by video) to some of our Experts by Experience, encourage you to think about the silences we have identified, and support you to identify issues within mental health detention that need to change.

Summary

We address the reasons why Black males are disproportionately over-represented and detained under Mental Health legislation.

The workshop will include videos from EbEs and their family members to provoke discussion. There will be a *'World Café'* round table exercise where small group discussions on each of the silences will take place. The idea of a

café vibe is to be relaxed, a safe space for people to discuss complex issues that could otherwise be seen as contentious. We will create group rules to ensure confidentiality and respect throughout the session. There will be one silence per table and each person will get to sit at each table during the workshop. Paper and colourful pens in the middle of each table will remain for people to creatively express their thoughts. These papers, alongside a further group discussion, will form the conclusion of the workshop.

Educational goals

1. Participants should consider the importance of lived experience and understand how to discuss *'silences'*.
2. Participants should consider how to embed best practice around culture, racial identity and other current inequalities that affect their patients.

Based on Serrant's (2010) Silences Framework, the areas identified by Experts by Experience (EbEs) are important to consider when representing real-life in psychiatric practice to improve the patient experience. The Silences framework seeks to create research and generate findings that gives the experiences and perspectives of patients the importance it deserves, and a voice that can be heard among mental health professionals. The workshop aims to highlight the relationship between co-produced research evidence and psychiatric practice.

The research is part of a larger project that aims to understand the experiences of men of Black African-Caribbean (BAC) descent, including those of mixed-heritage and who self-identify as Black, or Black British. An exploration of this topic will facilitate a group discussion to consider what is best practice and how we can develop alternate ways of working. Learning from this workshop will be able to be applied to other marginalised individuals and under-researched areas.

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Ethnicity and the use of restrictive practices in mental health inpatient settings: a scoping review

Paper presentation

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Keywords: Coercive measures / Ethnic disparities / Hospitalised patients / Psychiatry

Abstract

Aim

To identify and summarise existing knowledge about patient ethnicity and use of restrictive practices in adult mental health inpatient settings.

Methodology

A scoping review was conducted using the methodological framework recommended by Arksey and O'Malley (2005), Levac and colleagues (2010) and the Joanna Briggs Institute [JBI] (2020).

Findings (selected)

Altogether 38 studies, mostly European, were included. Ethnicity was mostly divided by migrant/national status in primary studies but not comparable across reviews. Categorising the reported restrictive practices, seclusion was widely reported across studies, followed by multiple concurrent restrictive practices.

Significance for practice

Mental health practice needs to focus on patient ethnicity as evidence suggests that some ethnic minorities were more likely to experience restrictive practice than others.

Relevance for theme

This review summarises knowledge about ethnicity and use of restrictive practices.

Summary

Background

Little effort has been devoted to the study of mental health inpatient settings where certain ethnic minorities are internationally reported to be subjected to more restrictive practices than others. Efforts to reduce the use of restrictive practices may benefit from focusing on ethnicity and seeking to improve mental health practices for ethnic minorities.

Aims

To identify and summarise existing knowledge about patient ethnicity and use of manual restraint, mechanical restraint, rapid tranquillisation, and seclusion in adult mental health inpatient settings.

Methods

A scoping review was conducted using the methodological framework recommended by Arksey and O'Malley (2005), Levac and colleagues (2010) and the JBI (2020). The Reporting Checklist for Scoping Reviews (PRISMA-ScR) was used for reporting the findings. A systematic search was conducted in APA PsycINFO, CINAHL with Full Text, Embase, PubMed and Scopus. Additionally, grey searches were conducted in Google, OpenGrey and selected websites, and the reference lists of included studies were reviewed. Covidence was used to screen and select relevant studies. Data were extracted using a charting table.

Results

A two-fold analysis process described by Arksey, and O'Malley (2005) was adopted, first summarising study characteristics. Afterwards, the use of four different types of restrictive practice in relation to reported ethnicity was analysed. Altogether 38 studies were reviewed; 34 were primary studies; four, reviews. The geographical settings were as follows: Europe (n=26), Western Pacific (n=8), Northern America (n=3) and Asia (n=1). In primary studies, ethnicity was reported according to migrant/national status (n=16), mixed categories (n=12), indigenous vs. non-indigenous (n=5), region of origin (n=1), sub-categories of indigenous people (n=1) and religion (n=1). In reviews, ethnicity was not comparable. The categories of restrictive practices included seclusion, which was widely reported across the studies (n=20), multiple restrictive practices studied concurrently (n=17), mechanical restraint (n=8), rapid tranquillisation (n=7) and manual restraint (n=1).

Conclusions

Ethnic disparities in use of restrictive practices in adult mental health inpatient settings has received some scholarly attention. Evidence suggests that certain ethnic minorities were more likely to experience restrictive practices than other groups. Extant research is characterised by a lack of consensus and continuity. Furthermore, widely different definitions of ethnicity and restrictive practices are used. Further research in this field may improve mental health practice.

Educational goals

1. To differentiate between the most used definitions for ethnicity and restrictive practices in research literature.
2. To appreciate the influence of patient ethnicity on the use of restrictive practices in mental health inpatient settings.

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Topic 11 – Ethical, human rights and legal perspectives

Ranking Psychiatric Formal Coercive Measures – Patients' and Staffs' Perspectives of the Least Restrictive Alternative

Poster presentation

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Keywords: Coercive measures / Least restrictive alternative / Patients' perspective

Abstract

Aim

To investigate which formal coercive measures, (described by law), mental health patients and staff experience as least restrictive and how patients and staff rank various types of coercive measures.

Methodology

The project consists of three sub studies: 1) a systematic review; 2) translation and validation of the CES questionnaire followed by a questionnaire study using the CES; and 3) an interview study with staff.

Finding

Preliminary findings from the systematic review will be available for presentation at the congress.

Significance for practice

Knowledge of patients' experiences with different coercive measures -and which of these are least restrictive are fundamental to practicing the essence of the least restrictive alternative principle. It may also be crucial in formulating future legislation.

Relevance for theme

The least restrictive alternative is a principle of health legislation. Psychiatric coercive measure use is an important human rights concern.

Summary

Background

Formal coercive measures described by law, such as mechanical and physical restraint, seclusion and acute tranquilization are widely used during psychiatric inpatient care in several countries, including Denmark (Bak et al 2012, Gildberg et al 2015). These measures are considered as a last resort (Huckshorn et al 2006), and have serious consequences to the patients, whose experience of these coercive measures can be both intrusive and potential traumatic (Huckshorn et al 2006, Hui 2017, Britain 2014, Steinert et al 2013). This implies that the use of coercive measures must be avoided where possible, but also that when using coercive measures, the least restrictive alternative must be used. To better acknowledge the rights and autonomy of psychiatric patients, more knowledge of which coercive measures patients experience as the least restrictive is required.

Aim

To investigate which formal coercive measures, described by law, mental health patients and staff experience as least restrictive, and how patients and staff rank various types of coercive measures.

Methods

1. A literature review of the empirical research on which coercive measures patients' experience as least restrictive.

2a. Translation and validation of the Coercion Experience Scale (CES). The CES is an instrument developed for measuring patients' subjective experiences of psychiatric coercive interventions and comparison of various types of coercive measures.

2b. A Survey using the CES among Danish mental health patients, who have previously been exposed to coercive measures.

3. Interviews with psychiatric staff in both forensic- and general psychiatric units, on their experiences of which coercive measures are the least restrictive alternative.

Results (preliminary)

None of the studies have been conducted at this point. Preliminary findings on the systematic review will be available at the congress.

Educational goals

1. To identify knowledge on adult mental health patients' and staff's experiences of formal coercive measures, as described by the law, in terms of restrictiveness.
2. To list formal coercive measures, as described by the law, in terms of restrictiveness from the perspective of adult mental health patients and staff.

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Ethical issues in co-creating research on coercion in mental health care

Poster presentation

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Keywords: Ethics / Co-creating / Service users / coercion

Summary

The co-production of knowledge by diverse stakeholders, including experts, researchers, and service users, is becoming of increasing interest in mental health care. Ethical issues could arise at all phases of research involving service users. Prior to the research study, it may be important to clarify motives for including service users as there are reports of academics involving service users for the sole reason of obtaining funding (Tokenism). The ethical issue of inclusivity may also arise in the recruitment of service users as co-researchers because factors such as age, gender, ethnicity, and sexual orientation still matter. It may become problematic if co-creating with service users empowers a particular demographic of service users at the expense of others. This is especially problematic in research related to the use of coercion as the people most likely to experience coercion are people with psychosis and may be systematically excluded as co-researchers in studies on coercion. Recruiting service user co-researchers at the hospital may be an ethical dilemma for lead researchers who are also caregivers. During the research on issues of coercion in mental health care, both anticipated and unanticipated ethical dilemmas may result. Service user co-researchers may be potentially retraumatized during data collection, especially in qualitative studies. Thus, in addition to doing no harm to participants, lead researchers must also take care not to do harm to co-researchers. After the research, there could be ethical issues around the publication and presentation of study findings. There could be potential difficulties as to how tasks performed by service users may be weighed against each other, and whether they fulfil authorship criteria. Also, there may be a need to assess the risk of harm that may arise in service user co-researchers revealing their identity in publications and conference presentations. After the research ends, it is important to consider how the ending is managed. It may

also be unethical for the lead researcher to cut all contacts with the service user co-researchers after the research as they may have invested in their relationships with the lead researcher and other co-researchers during the research process. Service user co-researchers have also raised the issue of payment, especially for service users on welfare benefits who may have restrictions on earnings for those in receipt of welfare benefits. It is essential that researchers anticipate and make plans for navigating these potential ethical dilemmas.

Educational goals

1. The Participants will develop ethical awareness and reflexivity on research involving service users. They would be able to identify and evaluate ethical issues when they read or review papers with service user involvement.
2. The participants will employ ethical reflexivity in their own research involving service users and propose ways to navigate ethical dilemmas that may arise.

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Health professionals` experiences when community treatment order was revoked following capacity-based mental health legislation

Poster presentation

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Keywords: Capacity-based legislation / Increased autonomy / Community treatment order / Health professionals

Abstract

In 2017 Norway introduced capacity-based legislation in mental health care with the aim of increasing patient autonomy and legal protection and reducing the use of coercion.

The aim of the study was to explore health professionals' experiences of how capacity-based legislation affects healthcare services for patients whose community treatment order (CTO) was revoked because of having capacity to consent.

Nine health professionals from specialist and primary healthcare services were individually interviewed in 2019-2020. We used a hermeneutic approach to the interviews and analysis of the transcripts.

The participants found that capacity-based legislation raised their awareness of their responsibility for patient autonomy and involvement in treatment and care. The study shows that personnel now focus more on adapting care and treatment to patients` wishes and condition to enable them to maintain their capacity to consent and prevent a new CTO. This requires close collaboration between primary and specialist level.

We have performed a study with a qualitative design using individual interviews. The aim was to explore health professionals' experiences of how capacity-based legislation introduced in 2017 in Norway affects treatment and following up to patients whose community treatment orders (CTO) had been revoked according to the amendment. The participants found that capacity-based legislation raised their awareness of their responsibility for patient autonomy and involvement in treatment and care. They felt a need for more frequent assessments of patient's condition and closer dialogue with patients where information and guidance form an important part to enable patients to maintain their capacity to consent and prevent a new CTO. This requires more collaboration between personnel in different health care services at primary and specialist level.

Educational goals

1. The participants will get acquainted with health professional`s experiences of giving treatment and care to patients whose community treatment order was revoked following capacity-based mental health legislation.
2. The participants will learn how capacity-based mental health legislation led health professionals to become more aware of their responsibility for patient`s autonomy thus helping patients maintaining their capacity to consent preventing a new community treatment order.

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Topic 13 – Specific populations: forensics

Treating women in forensic mental health care: a profession in its own right?

Poster presentation

Vivienne de Vogel, Van der Hoeven Kliniek, Utrecht, Netherlands.

Keywords: gender / gender-responsive / gender-sensitive / forensic mental health care

Abstract

Substantial differences have been found between female and male forensic psychiatric patients, relating to trauma, offense history and mental health needs. However, not many clear policies or gender-responsive treatment Programmes are currently available for working in mixed gender forensic mental health settings. In the present project, practical guidelines were developed for treating women in mixed-gender forensic mental health care. The literature into gender-responsive working was studied and experiences of both practitioners and forensic psychiatric patients were collected and analysed by means of an online survey (N = 295) and interviews with 22 professionals and 8 female patients and 3 male patients. Based on these results, the guide Treating women in clinical forensic mental health care was written. This guide was subsequently presented in several expert meetings and its revision was tested for usability in a pilot study.

Summary

Background

The current body of knowledge leads to the conclusion that there are several notable differences between females and males in forensic services that assessors need to consider. Although advances have been made with respect to gender-responsive treatment, there remain substantial gaps in knowledge and debate regarding mental health needs of female forensic mental health patients and it is necessary to provide concrete guidelines for the best possible treatment for both males and females.

Present study

The aim of this project was to develop guidelines for treating women in forensic mental health care. We did this by studying the literature on gender-responsive working in forensic mental health care and by systematically inventorying the knowledge and experiences of practitioners, policymakers, researchers and female and some male patients.

Results

An online survey about working with women in mixed-gender forensic settings was completed by 295 respondents. The following themes appeared most relevant: 1) trauma treatment; 2) risk assessment and diagnostics; 3) the role of children. Furthermore, it emerged that most professionals, especially those who work in a clinical setting, prefer treatment in mixed-gender hospitals. However, disadvantages are seen, such as the risk of re-traumatization, and it is important to set clear conditions and to guarantee safety as much as possible. It was reported that there is currently too little attention for gender-responsive (trauma) treatment in Dutch forensic mental health care. Subsequently, in-depth interviews were held with 22 professionals and 11 patients: eight females and three males. The guideline Treating women in clinical forensic mental health care was written based on the literature, survey, and interviews analyses. These guidelines were subsequently presented in several expert meetings and its revision was tested for usability in a pilot study.

Conclusions

Acknowledgement of gender differences in the forensic mental health care should result in gender-informed policies and practices. In the present project, practical guidelines were developed for treating women in gender-mixed forensic mental health care based on the current literature, and experiences of both practitioners and forensic psychiatric patients.

Educational goals

1. Learn more about gender differences in forensic psychiatric patients and being aware of possible gender bias in assessment and treatment procedures.
2. Learn about gender-sensitive risk assessment and gender-responsive treatment in forensic mental health care and how to use these in daily practice.
3. Learn more about gender differences in forensic psychiatric patients and being aware of possible gender bias in assessment and treatment procedures.
4. Learn about gender-sensitive risk assessment and gender-responsive treatment in forensic mental health care and how to use these in daily practice.

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Forensic High and Intensive Care: lessons learned from the implementation of a new care model

Oral presentation

Sylvia Gerritsen, Amsterdam University Medical Centre (UMC), Amsterdam, Netherlands; Guy Widdershoven, Amsterdam University Medical Centre (UMC), Amsterdam, Netherlands; Yolande Voskes, Amsterdam University Medical Centre (UMC), Amsterdam, Netherlands.

Keywords: Forensic psychiatry / contact-based care / implementation / complex care practice

Abstract

Several years ago, a new care model was developed in Dutch forensic psychiatry called Forensic High and Intensive Care (FHIC). FHIC aims to foster the transition from control-based care, including the seclusion of patients, to contact-based care in forensic psychiatry. The core elements of the FHIC model are care ethics, stepped care, the premise that a crisis is relational, safety in contact, and the inclusion of (family) peer providers in the team. In this presentation, the focus will be on the development and implementation of FHIC. A mixed methods study was performed at many forensic care wards. Among others, challenges in and lessons learned for daily practice and the implementation process of the FHIC model are identified. These lessons are relevant to initiate such change in a complex healthcare practice such as forensic psychiatry.

Summary

In the Netherlands, a strong need was felt to shift away from control-based care, including the seclusion of patients. In response, the Forensic High and Intensive Care (FHIC) model was developed in collaboration with more than 80 experts, using the results of scientific research and experiences from practice. The purpose of a large national research project was to consider what is needed for such a change in the complex practice of forensic psychiatry, by studying the development and implementation of FHIC. The PhD dissertation on this research will be presented.

Several research methods were used to study the development and implementation of FHIC. First, the focus was on complex situations by learning from the experiences of High and Intensive Care (HIC) wards. FHIC is inspired by the High and Intensive Care (HIC) model in acute psychiatry. Qualitative research with HIC care professionals (n=19) was performed. This research shows that complex situations can be better understood and detected earlier when shifting the focus from the patient to the entire situation.

Second, the development and elements of the FHIC model were studied and described. Doing justice to complexity implies trying a wide range of (practice and evidence based) practices. The FHIC model therefore consists of practices like stepped care, safety in contact, and the inclusion of (family) peer providers. Furthermore, the measurement properties of a developed model fidelity scale, called the FHIC monitor, were examined. Trained FHIC care professionals conducted audits (n=17), and focus groups were held (n=17). The findings indicated that the instrument was insufficiently aligned with practice and the FHIC monitor was revised. New audits and focus groups showed acceptable measurement properties. After final adjustments, the FHIC monitor proved to be a useful tool to measure the implementation of the FHIC model and support care professionals in the implementation.

Third, the implementation of FHIC was studied by means of qualitative research. These results show that the implementation of FHIC is not easy, as it requires a change at the level of culture, structure, and way of working within a complex healthcare practice.

In conclusion, the research provides insight into the development and implementation of FHIC. Based on the findings, three lessons were formulated for initiatives aimed at shifting from control to contact in complex care practices. These lessons are: 1) pay attention to complexity, 2) use reflection to dealing with complexity, and 3) promote collaboration in complex care.

Educational goals

1. After following this presentation, one is aware of the incentive for the development of a new model of care in Dutch forensic psychiatry and can describe how the FHIC model was developed and what the FHIC core elements are.

2. After following this presentation, one understands which challenges may go along with change in a complex healthcare practice such as forensic psychiatry, and understands the lessons learned to deal with these challenges

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Use of assessment instruments in forensic evaluations of criminal responsibility in Norway

Poster presentation

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Keywords: Criminal responsibility / Forensic evaluations / Assessment instruments / Violent crimes

Abstract

We explored the use of instruments in 500 Norwegian reports of forensic evaluations of criminal responsibility from 2009-2018, in cases with serious violent crimes; specifically, whether this use was associated with diagnostic and forensic conclusions.

The first author coded data from all reports. Two co-authors then coded a random sample of 50 reports, for inter-rater reliability. We present descriptive measures and associations between use of instruments and diagnostic and forensic conclusions.

Instruments were used in 50.0% of reports. The Wechsler's Adult Intelligence Scale (WAIS), Historical Clinical Risk-20 (HCR-20), and the Structured Clinical Interview for DSM disorders (SCID I), were used in 15.8, 13.8, and 9.0% of reports, respectively. The use of instruments increased over the years. Instruments were more often used by teams with both psychologists and psychiatrists. The use of instruments was strongly associated with both diagnostic and forensic conclusions.

Summary

Objectives

Assessment instruments are often used to enhance quality and objectivity in therapeutic and legal settings. In evaluations of criminal responsibility, the use of instruments is more disputed. We explored the use of instruments in Norwegian reports of forensic evaluations of criminal responsibility; specifically, whether this use was associated with diagnostic and forensic conclusions.

Methods

Our study had an exploratory cross-sectional design. We examined 500 reports filed with the Norwegian Board of Forensic Medicine in 2009–2018 regarding defendants indicted for the most serious violent crimes. The first author coded data from all reports according to a registration form developed for this study. Two co-authors then coded a random sample of 50 reports, and inter-rater reliability measures were calculated. The first author coded 41 reports for calculation of intra-rater reliability. Descriptive statistics are presented for the use of assessment instruments, and a generalized linear mixed model (GLMM) was used to estimate associations between the use of instruments and diagnostic and forensic conclusions.

Results

More than 30% of the reports were written in cases where the indictment was murder or murder attempts, while more than 50% were severe violence. Instruments were used in 50.0% of reports. The Wechsler's Adult Intelligence Scale (WAIS), Historical Clinical Risk-20 (HCR-20), and the Structured Clinical Interview for DSM disorders (SCID I), were used in 15.8, 13.8, and 9.0% of reports, respectively. The use of instruments increased from 36% in 2009 to 58% in 2015; then decreased to 49% in 2018. Teams of two experts wrote 98.0% of the reports, and 43.4% of these teams comprised two psychiatrists. The proportion of teams with both psychiatrists and psychologists increased significantly over the years. In 20.0% of reports, the diagnostic conclusion was schizophrenia, and in 8.8% it was other psychotic disorders. A conclusion of criminal irresponsibility was given in 25.8% of reports. The experts agreed in their conclusions in 99.2% of the reports. Instruments were more often used in reports written by teams that comprised both a psychiatrist and a psychologist,

compared to reports by two psychiatrists. The use of instruments was strongly associated with both diagnostic and forensic conclusions.

Conclusion

Instruments were used in 50% of reports on forensic evaluations of criminal responsibility in Norway, and their use increased during the study period. Use of instruments was associated with diagnostic and forensic conclusions.

Educational goals

1. To inform the public on the use of instruments in forensic evaluations of criminal responsibility in court cases of serious violent crimes. This use is disputed, as these evaluations are retrospective, in contrast to clinical evaluations, which are focused on the present, and to risk assessments, which are focused on future predictions.
2. There are few studies that explore the use of instruments in these evaluations, and none have explored how this use is associated with diagnostic and forensic conclusions. This is important, as instruments should be used in cases where the results may give added information on the issue in question.
3. To give an overview over important descriptive data regarding forensic evaluations of criminal responsibility in Norway. This is a field with limited research, and even if different countries have different forensic and legal systems, all empirical information gathered through research add to the general information base in this field.

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Topic 14 – Specific populations: intellectually disabled / learning disabilities

Preventing and reducing restrictive practices on adults with learning disabilities: A realist review

Poster presentation

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Keywords: Realist review / learning disabilities / Reducing restrictive practices

Abstract

This poster will present the methodology and early findings of a realist review of approaches to prevent and reduce the use of restrictive practices on adults with learning disabilities in healthcare organisations. A realist synthesis encompasses a theory-driven interpretation to make sense of complex approaches. The review iteratively progressed through four steps: step 1 – locate existing theories and approaches; step 2 – a systematic search of evidence; step 3 – data extraction and organisation; and step 4 – synthesising the evidence. A project stakeholder group and patient and public involvement were convened to advise throughout. An initial Programmeme theory (IPT) consisting of four subcomponents including interpersonal interactions, service user involvement, carers' role and invested organisation were outlined that postulated the reduction in restrictive practice use. Fifty-three relevant articles, thus far, have been identified that will

be used to refine the IPT. Findings will provide recommendations for practice and policymaking.

Summary

Background

Evidence syntheses often focus on ascertaining the prevalence or effectiveness of approaches in prevention or reduction of restrictive practices. No review has yet pursued to understand how and why approaches achieve their outcomes.

Aims

The aim of the review is to understand how approaches used in healthcare organisations work in preventing and reducing the use of restrictive practices on adults with learning disabilities. The specific objectives were to: i) uncover the causative mechanisms by which approaches prevent and reduce the use of restrictive practices and ii) develop and provide recommendations for healthcare organisations and policymakers in the implementation of approaches.

Methods

Design

Realist review is a theory-driven and explanatory approach to evidence synthesis. An integral part of a realist review is the development of a Programmeme theory, which is a conceptual description that delineates the key aspects and activities of an intervention that produce their outcomes and the mechanisms that contribute to outcomes. A realist logic of analysis was applied to produce an explanatory account of how intended outcomes are produced in the form of context-mechanism-outcome configurations. A crucial aspect of the realist review method is its iterative process that often necessitates going back and forth between different steps as the Programmeme theory develops.

Four-step procedure

Step 1: Locating existing theories and approaches
The aim of this initial step was to identify theories that explain how approaches designed to prevent and reduce the use of restrictive practices are supposed to

work. An informal search of the literature and consultation with our stakeholder group and PPI were key aspects that developed the initial Programmeme theory.

Step 2: Searching for evidence
The purpose of this step was to identify a landscape of literature that contained relevant data to further develop and test the initial Programmeme theory developed from step 1.

Step 3: Extracting and organising data
The coding related to contexts, mechanisms and/or their relationships to outcomes was conducted. The coding was both inductive (i.e., creation of codes deriving from the data in included articles) and deductive (i.e., pre-developed codes informed by the initial Programmeme theory).

Step 4: Synthesising the evidence
A realist logic of analysis was then applied to make sense of coded data that focused on explanations in how approaches prevent and reduce the use of restrictive practices. The purpose was to understand how mechanisms operate in different contexts.

Educational goals

1. To explain coherently how the prevention and reduction of restrictive practices might be achieved in realist terms. That is, what interactional relationship between context and mechanism(s) might lead to that outcome.
2. To outline practical advice to optimise and tailor the implementation of existing approaches used to prevent and reduce the use of restrictive practices in healthcare organisations for adults with learning disabilities.

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Aggressive behaviour of psychiatric patients with Mild and Borderline Intellectual Disabilities

Paper presentation

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Keywords: Aggression / Risk factors / Analysis / Mental health care

Summary

Purpose

Little is known about the associations between Mild Intellectual Disability (MID) and Borderline Intellectual Functioning (BIF) and aggressive behaviour in general Mental Health Care.

Aim

To establish the association between aggressive Behaviour and MID/BIF, analysing patient characteristics and diagnoses.

Method

1174 out of 1565 consecutive in-and outpatients were screened for MID/BIF with the Screener for Intelligence and Learning Disabilities (SCIL) in general mental health care in The Netherlands. During treatment, aggressive behaviour was assessed with the Staff Observation Aggression Scale-Revised (SOAS-R). We calculated the Odds ratios and performed a logistic regression to calculate the associations of MID/ BIF, patient characteristics and diagnoses with the probability of aggression.

Results

Forty-one percent of participating patients screened positive for MID/BIF. Patients with assumed MID/BIF showed significantly more aggression at the patient and sample level (Odds Ratio of 2.50 for aggression and 2.52 for engaging in outwardly directed physical aggression). The proportion of patients engaging in 2-5 repeated aggression incidents was higher in assumed MID (OR=3.01, 95% CI 1.82-4.95) /BIF (OR=4.20). Logistic regression showed that patients who screened positive for BIF (OR 2,0 95% CL 1.26-3.17), MID (OR 2.89, 95% CI 1.87-4.46), had a bipolar disorder (OR 3.07, 95% CI 1.79-5.28), schizophrenia (OR 2.75, 95% CI 1.80-4.19), and younger age (OR 1.69, 95% CI 1.15-2.50), were more likely to have engaged in any aggression.

Conclusions

We found an increased risk for aggression and physical aggression in patients with assumed MID/BIF. We recommend screening for intellectual functioning at the start of treatment and using measures to prevent and manage aggressive behaviour that fits patients with MID/BIF.

Educational goals

By the end of this presentation participants will be better able to:

1. Understand why it is important to know about the intellectual capacity of patients
2. Discuss what the risks are and what more knowledge of the intellectual capacity implies for care.
3. Discuss wat the prevalence of aggression in MID and BIF patients is.
4. Identify factors contributing to more aggression, at ward and individual patient level.

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Parental Sense of Coherence, Dispositional Optimism, and Quality of Life in Children with Intellectual Disability

Paper presentation

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Keywords: Sense of Coherence / Optimism / Quality of Life / Intellectual Disability

Abstract

Families and caregivers of children with intellectual disabilities must deal with both the typical struggles that every household faces and those adjustments unique to these children including greater challenges in caregiving, more health problems, and feelings of isolation which results in poor quality of life (QOL). This study examines the relationship between a sense of coherence, dispositional optimism, and quality of life among parents of children with intellectual disability. The study used purposeful sampling with 30 parents who attend general services at NIEPID, Secunderabad, Telangana, India. The results indicated that a positive correlation was found between a sense of coherence and dispositional optimism, and coherence also correlated positively with parents of children with intellectual disabilities' psychological well-being. As a result, it suggested that a sense of coherence has an impact on quality of life and that a high sense of coherence correlates with a higher level of quality of life.

Summary

The present study suggests that parents of children with intellectual disabilities have a higher sense of coherence and dispositional optimism. A sense of coherence was positively related to psychological health, but a buffering effect was found only among men for dealing with strenuous life events.

Sense of Coherence (SOC) appears to influence and predict quality of life, with the stronger SOC leading to a better quality of life. Previous studies have also

suggested that people with a strong SOC cope better with chronic health issues and mental health conditions.

Dispositional optimism and Quality of life among parents of children with intellectual disability. The dispositional optimism of parents of children with intellectual disabilities is not significantly correlated with quality of life. A statistically significant difference exists between the perceived quality of life of parents of children with intellectual disabilities and those of typically developing children.

Educational goals

1. Psychological research has been focused on understanding how parents of children with disabilities can mobilize their appropriate resistance resources towards problem solving and coping strategies.
2. As far as cognitive aspects are concerned, this study can determine one of the several cognitive constructs relating to a generalized, relatively stable tendency to expect good outcomes that is related to motivation in individuals.

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Topic 15 – Specific populations: children and adolescents

What makes the difference? Reduction of restrictive interventions in an adolescent psychiatric ward.

Poster presentation

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Keywords: adolescents / reduction of restrictive interventions / inpatient

Background

Although many interventions have been implemented to reduce the incidence of restrictive practices in adolescent psychiatric wards, it often remains unclear which have the greatest impact.

Aim

The aim of the study was to investigate the significance of the different changes made to the environment in an adolescent psychiatric ward for the prevalence of restrictive interventions.

Methods

In a retrospective study, information from the last ten years on interventions targeting reduction of the use of restrictive practices was collected from documents in an adolescent psychiatric ward. In the same period, incidence of restrictive interventions was registered on patient level in the region's electronic register. Using descriptive statistics and time series analysis, the information

on interventions in the ward and the incidence of restrictive practices will be compared.

Results

Preliminary inspection of data suggests that there has been a significant effect of the interventions. In connection with COVID-19, some of the interventions were suspended, and it appears that this has had a negative impact on the incidence of restrictive practices in the ward.

Hopefully, it will be possible to identify interventions that are effective in reducing the need for applying restrictive practices in adolescent psychiatry.

Educational goals

1. Participants will be informed about potentials for reduction of restrictive interventions in own practice.
2. Participants will be inspired to identify the active interventions in own practise.

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Experienced feasibility of a violence risk screening instrument in adolescent psychiatric inpatient care - a pilot study

Paper presentation

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Keywords: Aggression / checklist / utility / emergency psychiatry / risk assessment / youth

Introduction

Violence is acknowledged by the World Health Organisation (2002) as a major global public health issue. Assessing the risk of violence is challenging but has become increasingly important within mental health institutions (Helsedirektoratet, 2018). Its importance is also highlighted through its inclusion in mental health laws, making violence risk assessment a part of health professionals' regular clinical practice.

Development of risk assessment instruments

In adult psychiatry risk assessment instruments has been developed since 1980´s, challenging the traditional paradigm of unstructured clinical judgements when assessing violence risk (Monahan, 1984). Out of this, instruments like HCR-20 (Webster et al., 1997) have emerged, and later, its adolescent equivalent, SAVRY (Borum et al., 2006). They have been formulated to identify risk factors and targeted protective measures, to counter the identified risk. These instruments are comprehensive, time-consuming, and often require special training. In settings more pressured for time, instruments like these are not always feasible. In emergency psychiatric inpatient settings, for example, there is a demand for important decisions being made within a short timeframe. Three studies showed that a brief checklist of warning signs could reduce the use of coercive measures and violence by 30-70 % (Abderhalden et al., 2008; Hvidhjelm et al., 2016; van de Sande et al., 2011).

Screening tests for violence are not considered diagnostic but can be used to identify a subgroup of the population who should have additional monitoring to prevent violence (Anderson & Jenson, 2019). Violence Risk Screening-10 (VRISK-10) was developed in adult psychiatry to aid in swiftly assessing imminent risk of violence or individuals that need further risk assessment (Hartvig et al., 2011; Bjørkly et al., 2009). It consists of 10 items: 1) previous or current violence, 2) previous and current threats, 3) previous and current substance abuse, 4) previous and/or current major mental illness, 5) Personality disorder, 6) lack of insight to illness 7) expressed suspicion, 8) lack of empathy, 9) unrealistic planning, and 10) future stress situations. A review found that V-RISK-10 was among the most accurate instruments in predicting the risk of violence in the adult acute psychiatric context (Anderson & Jenson, 2019).

In a lack of validated screening instruments VRISK 10 has been used within adolescent treatment settings. To our knowledge there is no brief screening instrument for violence risk among adolescents. In this void there is a potential for a more accurate risk assessment by creating a brief standardized instrument, which would be more adapted to the adolescent population. A challenge is to develop an instrument that has good predictive validity, and health professionals will find feasible enough to use. To increase its potential use, the instrument needed to be simple, easy to use, no requirements for pre-training, and could be administered by staff regardless of prior experience. This is the backdrop of the development of VRISK-YP, and this pilot study.

VRISK-YP

The pilot version of the Violence Risk Screening for Youth (V-RISK-YP) is based on V-RISK-10, which was already in use at the unit. Five items in the V-RISK-YP are identical to the V-RISK-10 (items 1,2,3,7,8). Items 4 and 5 were altered to encompass the developmental aspect of violence risk among adolescents. Two items were added 11) «previous experience of current trauma» and 12) «the adolescents' own perception of violence risk». Each item is encoded: No = does not fit, maybe = maybe fits, Moderate = present to a moderate degree, yes = definitely, do not know = too little info. In addition, V-RISK-YP contains an assessment of each item's relevancy for the overall violence risk. Finally, based on V-RISK-YP, individual clinical judgement and other available information, the risk of violence is coded as Low, Moderate or High, followed by a suggestion of more comprehensive violence risk assessment and suggestions for immediate implementation of preventive measures.

Method

The naturalistic prospective designed pilot study was conducted at the Emergency unit, Department of Child, and Adolescent Psychiatry at Oslo University Hospital in Norway. For a year all admitted adolescents was scored with V-RISK-YP at admission. The scoring was done after the clinical interview without the patient present and based solely on the information at hand (clinical interview, medical records, current observations). Each assessment was compared with recorded episodes of threats or violence during hospitalization. The healthcare professionals completed an evaluation form regarding the instrument.

Results

Ninety-two patients were scored on admission; 67 had sufficient data to be included in the analysis, out of which 55 were girls (82 %) and 12 boys (18 %). The transition to VRISK-YP was easier since the unit already had been using V-RISK-10 as a standard procedure at admission. The VRISK-YP 6-7 minutes to complete. Nearly all the healthcare professionals found the instrument's utility either good or very good and recommended the instrument for use within mental health institutions.

The health care professionals expressed difficulties in scoring each items relevancy for potential violence. There was a substantial number of VRISK-YP assessments where this question of relevancy was incomplete or missing. This corresponds with the feedback given.

V-RISK-YP showed good predictive validity for recorded violence and threats of violence during the hospital stay.

Discussion

VRISK-YP was considered feasible at the unit. Formulations in the VRISK-YP were more relevant to the adolescent population, with reports of this making the instrument more relatable to the health professionals *'daily practice. A clear advantage of the implementation of VRISK-YP was the internal communication of violence risk, and how could it be used to improve the unit'*s communication of this risk with external parties?

The units staff consists of health professionals from different occupational groups and most work shifts.

This represented challenges in communication pertaining to the implementation of VRISK-YP. Measures was taken to secure staffs' understanding of the new procedure of scoring VRISK-YP at admission and understanding the instrument. An interesting observation in the pilot study was the health care professionals 'difficulty in scoring the relevancy criterion. Assessment of each items relevancy for violence seemed more time-consuming, as it involves more elaborate thought beyond confirming/refuting an items presence. Furthermore, it was harder to assess the items relevancy to new patients as it requires more information about the patient, that assessors might not have to hand.

The inclusion of the relevancy criterion in the pilot version was meant as a structured aid in the overall assessment. However, it seemed to reduce the feasibility of the VRISK-YP

Conclusion

The study showed good predictive validity for the presence of the items. Staff found it feasible for use. The relevancy criterion did increase the predictive validity slightly, but a significant number of missing assessments and low adherence to the instructions compromised the feasibility of the instrument. The results provide a basis for further testing of a revised version of the instrument.

Educational goals

Examine the feasibility of the VRISK-Y as a violence risk predictor

Acknowledgements

We gratefully acknowledge the participation of the management team, mental health professionals and administrative employees of the Emergency unit, Department of Child and Adolescent Psychiatry, Clinic for Mental Health and Addiction, Oslo University Hospital.

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Topic 17 – Specific populations: community and outreach care

Co-creating a comprehensive intervention for primary mental health care to reduce involuntary admissions

Paper presentation

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Keywords: Involuntary admission / Primary health care / Co-creation / the ReCoN intervention

Abstract

Internationally there has been a call for a shift in mental health services towards a decrease in involuntary treatment and an increase in community-based care. So far, most research on reducing coercion has focused on services at the specialist health care level, and knowledge on how primary health care can facilitate and contribute to such a decrease is lacking. Through dialogue conferences and feedback meetings in five medium-sized municipalities in Norway, we have developed a comprehensive intervention for primary mental health care aimed at reducing involuntary admissions. Representatives from primary mental health care, specialist mental health care, GPs, police, people with lived experience, and family carers participated in the co-creation of the intervention together with the research team. In this presentation, the process of developing the intervention is presented.

Summary

Background

Given primary health care's central role in treating and caring for individuals with severe mental illness, they can be an essential provider of services to prevent involuntary admissions. However, knowledge of primary health care's role in pathways towards involuntary admissions is sparse, and comprehensive interventions developed for this care level to reduce such admissions are lacking. The objective of this study was to co-create, with relevant stakeholders, a comprehensive intervention for primary mental health care.

Aims

The presentation will describe the process of developing a comprehensive intervention together with relevant stakeholders and outline the resulting ReCoN intervention (Reducing Coercion in Norway).

Methods

The study had a qualitative design. Participatory research methods were employed, including dialogue conferences and feedback meetings. In five medium-sized Norwegian municipalities, a total of 117 persons participated in dialogue conferences. The participants represented primary mental health care, specialist mental health care, GPs, police, persons with lived experience, and family carers. The material from the dialogue conferences was subject to thematic analyses. Primary mental health care managers, people with lived experience, and family carers gave feedback during the analytical process on the validity and importance of the different themes.

Results

The co-creation process resulted in the ReCoN intervention - a comprehensive intervention for primary mental health care aimed at reducing involuntary admissions. The intervention includes six strategic areas: (1) Management, (2) Involvement of people with lived experience and family carers, (3) Competence development, (4) Collaboration between primary and specialist health services, (5) Collaboration between primary services, and (6) Individual service needs.

Each strategy area comprises specific measures for the services to implement that are believed to collectively reduce the use of involuntary admissions.

Conclusions

The co-creation process of the ReCoN intervention, together with multiple stakeholders, ensures relevance to practice. Further research is needed to assess the implementation and the effectiveness of the intervention.

Educational goals

1. To recognise the potential for reducing involuntary admissions by intervening at the primary mental health care level.
2. Reflect on the potential for reducing involuntary admissions by intervening at the primary mental health care level.
3. Recognise the potential of co-creation in research aimed at service development.At the end of this session, you should have gained insight on:
   - The advantages of applying co-creation in research aimed at service development.
   - Dialogue conferences as a method for co-creation in research.
   - The ReCoN intervention – a comprehensive intervention for primary mental health care aimed at reducing involuntary admissions.

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Compulsory psychiatric admission: geographic variation and opportunities for prevention

Paper presentation

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Keywords: Compulsory admission / coercion / geographic variation / ReCoN study

Abstract

There is significant variation in the levels of compulsory psychiatric admission between countries and between different geographical areas within countries. This suggests that some areas use more compulsory care than is necessary. By exploring the international literature and reporting on the ReCoN register study that included all compulsory admissions in Norway between 2014-18, this presentation argues that even if the observed variation is not fully explained, inventions at the primary care level hold potential for reducing coercion.

Summary

Background

Despite policy ambitions to reduce the use of compulsory mental health care, the level of compulsory admissions remains stable or increased in most European countries. There is significant variation in these levels between countries and between different geographical areas within countries, which suggests that some areas use more compulsory care than is necessary, and that this might be associated with the organisation of services.

Aims

This presentation will first outline key studies of variation in the use of compulsory admission between countries, including associations with legislative and socio-economic characteristics. Second, results from the Reducing Coercion in Norway (ReCoN) project will be presented that investigates in detail, variation

between areas in one jurisdiction over time and examine associations with local service organisation.

Methods

The empirical work took the form of a quantitative register study. Data the National Patient Registry was obtained on all episodes of compulsory admission in Norway between 2014-2018, amounting to 16,189 individuals and 36,153 admissions. Population based rates used data from Statistics Norway. Data were standardised by gender and age and analysed by a combination of small-area analysis, correlation analysis, linear regressions, and exploratory random effect within–between analysis.

Results

There is vast variation between countries, but these cannot be attributed to differences in legislation or socio-economic factors. The analysis of registry data from Norway showed that there is significant variation between areas, but that measuring events, individuals or duration give different pictures of this variation. The variation was associated with several characteristics of the primary mental health services when comparing areas cross-sectionally and comparing each area with itself over time. Increases in years of GPs and mental health nurse' experience, as well as public housing, are associated with lower levels of compulsory hospitalisation. In total, the groups of variables tested accounted for 40% of the observed variation.

Conclusions

There are large differences in the level of involuntary admission between and within jurisdictions. This variation is insufficiently explained by existing research. Our findings suggest that strengthening primary mental health care –particularity GP services- and public housing might help to prevent the need for some compulsory admissions. This indicates that inventions at local level hold potential for meeting the policy goals for reducing coercion.

Educational goals

At the end of this session, you should be able to:

1. Recognise the importance of investigating geographic variation in health and how different ways of measuring it can produce different patterns
2. Reflect on the potential impact service organisation might have on the existing geographical variation in compulsory admissions, and in turn on an individual's risk of being subjected to coercion

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User involvement in an intervention to reduce compulsory admissions (ReCoN)

Paper presentation

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Keywords: User involvement in research / Coercion / Mental Health services / The ReCoN intervention

Introduction

ReCoN is a Norwegian research council-funded project aiming to identify the potential for reduction of compulsory admissions (CA) in mental health care from a municipal perspective in Norway [1, 2]. The project has a strong focus on co-creation and user involvement. Here we will limit the review to describing how we worked with user involvement in the project. (This paper is based on a paper written in Norwegian [3].)

The data collection included mapping the *"roads to coercion"* through qualitative interviews [1]. Participants in five municipalities were interviewed to collect different perspectives on why CA occur and what can be done to prevent it. Furthermore, we co-created an intervention to prevent CA at municipal level. The intervention was co-created in collaboration with service managers, professionals, people with personal experience and relatives.

Solveig H. H. Kjus (first author, *"I/me"* in this text) is employed as a co-researcher and is mainly responsible for user involvement in the project. I have personal experience with CA, and still use several services in the municipality and the specialist health service where I live. In addition, I am a trustee in a local team of Mental Health (MH), have a PhD in space physics, and have completed education in collaborative research in mental health work (VIDSAM). How these experiences have been relevant and useful in the job as a co-researcher will be explained.

Trond Hatling (*"he"* in this text) is a RN and worked early in his career at Reitgjerdet Hospital. Among other reasons, Reitgjerdet was closed down in

1987 due to the extensive use of coercion [4]. Trond later trained as a sociologist and has many years of experience from research into services for people with mental disorders. Since the mid-90s, he has been concerned with coercion as a field of practice and research with various roles related to the topic nationally and internationally. He leads the part of the intervention part of ReCoN.

All the researchers involved in ReCoN, including us as authors (*"we"* in this text), collectively have extensive experience from research into coercion that involves a user perspective nationally and internationally. Most of the people involved in the project are also employed by or are members of the Norwegian coercive research network.

We thus knew the field and many of the central discussions and participants were also part of user and relatives' organizations. Thus, it was in many ways well suited to think about involving people with personal experience in the project.

Background

A slogan within co-research is *"Nothing about us without us"* [5]. This means that users of the services want to influence and decide what is researched on, how it is researched and how the results are interpreted and implemented in the services.

Today, the major research funding institutions in Norway require user involvement in all projects [6, 7], and this is supported by the authorities [8] and user organizations, for example Mental Health [9].

User involvement is particularly important in research on coercion, as coercion is perceived by many as harmful [10]. User experiences are therefore important to highlight the consequences of the services' actions. Previous research [10, 11] shows that professionals and those who have personal experience of coercion have very different perspectives on coercion, and this underpins the need for user involvement.

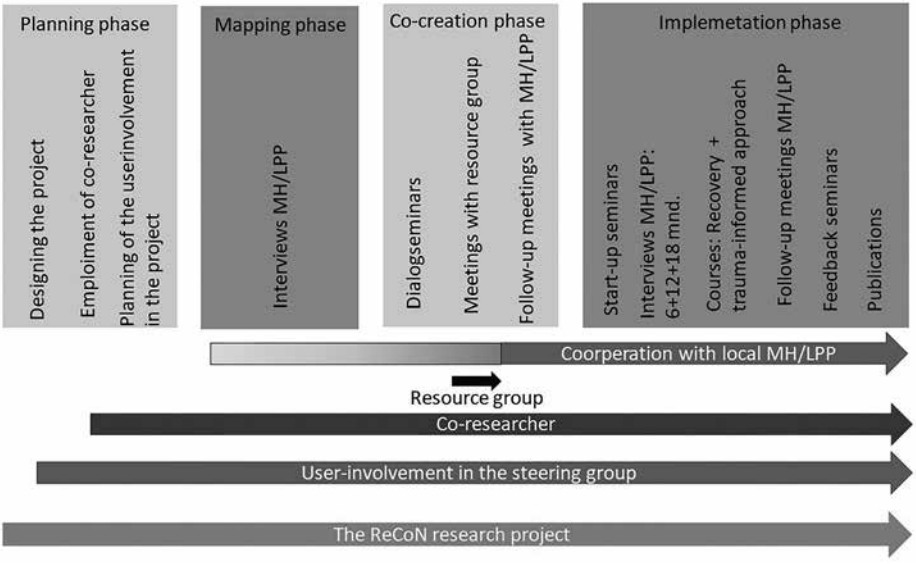
Ensure involvement in all phases

To get the user perspective worked early into the thinking in ReCoN, the then head of Mental Health Norway (MH) joined the group that developed the project application. The person has since also been part of the project's steering

group. We also budgeted for a co-researcher for 20% and for other forms of user participation throughout the project period.

Figure 1 shows how we realized user involvement in different phases and for different purposes and how this includes many processes.

Figure 1 - Schematic representation of user involvement in the research project ReCoN. The top part of the figure shows the various phases of the project with associated activities relevant to user involvement. The bottom part of the figure indicates the start and end of involvement.



Employment of co-researcher

A key point in the planning phase was to hire a co-researcher for the project. In the job advertisement, we pointed out that the co-researcher should contribute to all parts of the project, from planning, via development of interview guides, analysis, and publication of data to policy development and knowledge transfer to the field of practice. Qualifications requested in the announcement were relevant and processed own experience from mental health services and from compulsory practices. It was also desirable to have experience from discussing perspectives and experiences with others with such personal experience, for example through participation in a user organization. We also wanted

knowledge of research methods. Although several of the 16 applicants met most of our criteria, Solveig was the one who satisfied all our criteria, and had also completed: *"Course in collaborative research in mental health work"* (VIDSAM).

Research interviews

In the project's mapping phase, the aim was to clarify the paths leading to CA and what could have been done to avoid it. For this, it was important to include those with personal experience in the interview study. We therefore conducted focus groups with representatives from MH and the National Association for Relatives in Mental Health (LPP). Not all of them had their own experience with CA and relatives' experience of CA, but they had experience in local services.

In addition to me, two researchers took part in these interviews. They asked the questions, I took notes and asked supplementary questions. We interviewed a total of 37 people from MH and LPP, while for comparison 65 service providers were interviewed [2].

Important as contributors

In the co-creation phase of the project, I suggested establishing a resource group to ensure greater involvement of more people with their own experience, but it first became difficult to get the other researchers on board due to the extra work. The solution was that the two of us took the main responsibility for this contact. However, we only managed to find two persons and we shut down the resource group after only 2 meetings because one then withdrew for personal reasons.

We then chose to involve representatives of MH of LPP from the ReCoN municipalities more extensively. The pandemic enabled frequent electronic follow-up meetings both before the start of the intervention (how to make it most effective) and during the intervention period (does it work as intended; do they see changes?). We had separate follow-up meetings for MH and LPP. Relatives and those with personal experience of coercion quite often have conflicting perspectives, those from the same organization often know each other well and it becomes a safer arena for the exchange of opinions. Fewer people in each follow-up meeting also helped to make it easier for everyone to speak.

We also conducted digital interviews with representatives from MH, LPP and some peer experts to monitor the development for each municipality several times during the intervention period. The interview guide was the same as for the coordinators in the municipalities.

In each municipality, we held physical dialogue, start-up and feedback seminars and digital courses as part of the intervention. We were concerned that MH and LPP should participate in all this. However, it proved difficult to ensure full participation, despite offers of compensation for lost earnings.

We asked the municipalities themselves to invite MH and LPP to the courses and seminars, to stimulate better cooperation between MH/LPP and the municipality. For most municipalities, this did not seem entirely natural, even though they agreed that there were good reasons for the user organizations to be represented. We therefore had to make a few extra rounds and ask the user organizations themselves to press for an invitation.
In an article describing the intervention [12], a representative from MH and one from LPP are co-authors together with representatives from the municipalities and us in the research team. I am also a co-author on two other publications in the project [2, 13].

Why is it difficult to recruit?

Recruiting people with their own experience with CA turned out to be more difficult than we had anticipated. We might have been naive, we knew both from our own experience and from others who had tried that this was very demanding [14].

To recruit user representatives for the project, there were several qualities/experiences we wanted; people with personal experience or relatives' experience with CA, local knowledge from the participating municipalities, and that they could accept the premises of the research project, that the project did not have a zero vision towards CA.

Our experience is that it is more difficult to recruit informants/representatives for a research project dealing with coercion than for other research projects within mental health.

Also, between users and user organizations, the coercion debate can appear polarized, even if there is agreement on the negative consequences for the individual. From a human rights perspective, there are strong advocates for a zero vision and that this must be followed up through legislation. Others believe that coercion is sometimes necessary, where qualitative and resource-wise strengthening of services are highlighted, in addition to legislative changes, to reduce the use of coercion. Therefore, for someone with personal experience of coercion, it may have been difficult to participate in the ReCoN project due to its lack of a zero vision. With the opposite perspective, this would also be the case if the project had a zero vision. For others, the polarization itself can be a burden that prevents participation. We do not know how this polarization has turned out for ReCoN in the participating municipalities, but it is a backdrop for all user involvement in this area.

Our experience is that many local teams in MH have few active members, and they do not necessarily know which members have experienced CA or who could be interested in participating in a research project.
We also asked the employees in the ReCoN municipalities if they could help with recruitment but found that this did not yield anything more. The employees were then left in a dilemma as to who could be considered *"healthy enough"* to be asked. It is also uncertain whether the employees were sufficiently motivated and had the time and resources to be able to follow this up [15].

The co-researcher role – a complex role

I have a PhD in physics and experience from other research projects in mental health. These academic experiences gave me greater confidence to be able to take the place as co-researcher in the project.

Through the education in collaboration-based research (VIDSAM), I felt more confident in my own knowledge and my own contributions. The study gave me knowledge about different ways to resolve the co-researcher role [16, 17] and about different research methods within health research [18]. I also shared publications about co-research with the other ReCoN researchers.

Using one's own experiences - strength and challenge

My own, fresh, experience with coercion, meant that I could understand from an inside perspective what those with personal experience reported. But this fresh

experience could also be demanding at times. I have a great need to plan well and tolerate stress poorly and need somewhat more facilitation and more emotional support than my colleagues. The fresh experience could therefore occasionally be a challenge for my colleagues. This must be understood, recognized, and handled so that it does not become negative.

That I was open about what was needed to be able to contribute and about possible obstacles was important. We had a *'Plan B'* when important tasks should be carried out. The emotional support from colleagues has been crucial for being able to contribute even during bad periods of my own illness. I felt that my expertise was just as important as the other researchers.

My security in the role of co-researcher also grew during the project because I experienced that my colleagues constantly expressed that my contribution meant something.

Since I was open my own experiences could be used in lectures and seminars and in teaching during the intervention and it was entirely my own decision to share. Using my own experiences in the project has turned these mostly negative experiences, into something useful.

Responsible for ensuring the involvement perspective

I was asked in the employment interview to outline the user participation in the project, an exciting but relatively demanding exercise, that took many rounds between Trond and me before the tasks were defined. I then benefited from a previous project where I had been part of the advisory group [19].

It has also been my job to find the right people from MH and LPP and it has mainly been my responsibility to keep in touch with these representatives. I have also been a *"watchdog"* and made sure that words and expressions were not stigmatizing and ensured that the perspective of those who have experienced CA has been given sufficient weight in the research.

Conclusion

The representatives from MH and LPP expressed satisfaction about their involvement in the project. They wish that we had been of greater help in

strengthening user involvement locally in the project., for example through a greater degree of guidance of the municipalities.

We had hoped for even more participation and contributions from those involved from MH and LPP. It may be that the contribution would have been different if we had paid a fee to the participants from MH and LPP. The project had money that could have been used for this. I didn't think that was a possibility, and therefore I did not problematize it with the project management.

There was a lot of interest in the position as co-researcher, but we experienced a lot of trouble getting user involvement through the intervention project. The co-researcher position is, after all, a job that gives a completely different position in the research team in relation to participation. Also, such a position may appeal to those with an interest in the compulsion field, while others do not want to focus on that part of their experience.

Educational goals

1. Understand the value of co-production models of designing and delivering research
2. Understand the role of ReCon in reducing compulsory admissions

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Recovery-oriented prevention and management of staff-directed aggression in community mental health services

Paper presentation

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Keywords: Community mental health services / Practitioners / Staff-directed aggression / Recovery-oriented practice

Abstract

Little is known of how recovery can be utilized in the prevention and management of staff-directed aggression in community mental health settings. The paper presents results from two studies of competence development among staff in community mental health services partaking in education and training in the prevention and management of staff-directed aggression afforded by the Agency of Health in the Municipality of Oslo. In the studies we found that the most competent and *'powerful'* conceptions of practice corresponded to a large extent with principles of practice known from the recovery and person-centred approach. The findings add to the existing knowledge of staff's perceptions and experiences of violence in community mental health services. Additionally, the findings describe recovery as a particularly promising route to decrease workplace violence in mental health services. The findings will also have practical use for practitioners in devising applicable and effective practices in handling staff-directed aggression.

Summary

Recovery has long been endorsed as a powerful approach to promoting health and social inclusion among people with mental health problems worldwide. There is yet a substantial gap in our knowledge on how recovery-oriented practices can be utilized to prevent service users' aggression against staff in mental health services. This paper draws on findings from two published studies (Maagerø-Bangstad et al., 2019; 2020) exploring competence development among mental health workers in the Municipality of Oslo, Norway participating

in education and training in the prevention and management of staff-directed aggression. Both studies found that the most competent ways of seeing practice corresponded with principles of recovery-oriented and person-centred practice.

The paper explores the descriptions of prevention and management of staff-directed aggression in community mental health and how they relate to principles known from recovery-based and person-centred practice. Additionally, an aim is to explore how recovery principles could be utilized to decrease workplace violence in community mental health services.

The two studies conducted (Maagerø-Bangstad et al., 2019; 2020) were qualitative. The data consisted of two-step semi-structured interviews with 23 staff-members in mental health and substance abuse services in Oslo. Phenomenography (Marton, 2015; Marton & Booth, 1997) was utilized to analyse the data. The outcomes of our analyses are presented elsewhere (Maagerø-Bangstad et al. (2019; 2020).

We found that the most expedient and competent ways of understanding the prevention and management of aggression and violence among staff in mental health services are highly complex and multifaceted. Compound ways of seeing enable the most powerful handling of aggressive exchanges between service users and community mental health staff. Our studies further suggest that the most efficient and adaptive ways of seeing practice in prevention and management of service user aggression corresponds notably with principles known from both recovery-based and person-centred practice.

The findings suggest that recovery-oriented practices are related to particularly competent and applicable interventions in encounters with staff-directed aggression. Such practices seem to enable professionals to maintain own safety, but at the same time be sensitive and adaptive to the requirements of a situation and service users' individual needs, thus increasing the likelihood of successful handling of interpersonal conflicts in the helping relationship. Our findings suggest that compared to traditional, controlling, and reductive approaches that have been found to increase the risk of reactive violence, contextually sensitive, holistic, recovery-oriented understandings are more adept and efficient in handling staff-directed aggression.

Educational goals

1. Participants will learn about principles of recovery in relation to the prevention and management of staff-directed aggression in community mental health services.
2. Participants will be introduced to the meaning in complex conceptions of prevention and management among community mental health staff, and how such conceptions are structured in practitioners' awareness and utilized in practice.
3. Participants will be able to discern the qualitative differences between risk-tolerant vs. risk-aversive services and will learn about the former is related to recovery-oriented practice and should be preferred over the latter.

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Impact of assertive community treatment on the use of coercive measures: a French study

Paper presentation

Mael Pulcini, CHU Saint Etienne, Saint Etienne, France; Yvonne Quenum, CHU Saint Etienne, Saint Etienne, France; François Noilly, CHU Saint Etienne, Saint Etienne, France; Eric Fakra, CHU Saint Etienne, Saint Etienne, France.

Keywords: Community mental health services / Assertive community treatment / Mobile team Outpatient care / Seclusion / Mechanical Restraint

Background

Explanations of the French situation on psychiatric healthcare without consent
The French Law in 2002 states that: *"consent to healthcare is a necessary condition except for psychiatric care"*. These situations had to remain *"the exception"*. In 2011, medical certificates were added to authorize psychiatrists to force psychiatric healthcare by compulsory admission. For now, the obligation is to write 3 different certificates, from 3 different medical doctors. All patients who are subjected to these measures must meet *"judge of liberties"* with an advocate before the twelfth day of forced hospitalization. Also in 2011, the *"Ambulatory Healthcare Programme"* was created. This permits psychiatrists to force ambulatory care, as a unilateral contract. If the terms are not fulfilled by the patient, it permits the psychiatrist to make only one certificate to force the patient into full time hospitalization care again.

In 2018, the French government published directives *"to search for less use of seclusion and mechanical restraint in psychiatric healthcare"*.

Since 2019, The General controller of places of deprivation of liberty, independent authority in charge of searching for any violation of fundamental right for people in any place of deprivation of liberty, reported frequent misuse of measures of forced healthcare, especially seclusion and mechanical restraint. This authority found that great variability existed between French hospitals, differences not supported by population or financial differences.

Finally, in 2022, the new decree obligates psychiatrists to write 4 certificates a day if mechanical restraint is used. 2 a day for seclusion, and to inform the *"judge of liberty"* if these means are used more than 24 hours for restraint, 48 hours for seclusion. At the same time, psychiatrists also must inform at least one relative of the patient of the use of seclusion or mechanical restraint.

Moreover, hospitals now have an obligation to record in a specific journal all use of seclusion or mechanical restraint. The objective, clearly announced, was to make the use of seclusion or mechanical restraint administratively complicated, with the aim of forcing the Psychiatric institution to evolve into using fewer of these means.

For law details:
These are 2 categories of coercion measures for psychiatric healthcare in France: Relative asking for psychiatric healthcare (SPDT), and state representative asking for it (SPDRE). The 2011 law added to the SPDT process the possibility to force psychiatric care on full time hospital services when it's impossible to find a relative.

This measure, again, was to be used *"exceptionally"*, in case of an *"imminent peril"*. In fact, since 2012, the use of this measure increased more than 182% when compared with 2012 to 2022.

The common point with all these protocols were explained previously: having 3 different certificates from 3 different medical doctors in 4 days then monthly, seeing the judge of liberty before day 12 then six-monthly.

All these measures can be transformed in" ambulatory healthcare Programme" with monthly certificate from a psychiatrist whose use also saw an increase of 42% since 2012.

All these protocols can only be used in state hospitals and consultation centres (public service).

French data:
Prior to the main point of the intervention, an international study found in 2019 the median rate of involuntary hospitalization at 106,4 for 100.000 people. France increased from 108/100.000 in 2010 to 140/100.000 in 2016. In Saint Etienne Hospital, in 2020, the rate was 128/100.000.

5% of all psychiatry patients, 26% of all psychiatry patient in full time hospitalization were involuntary detained. For 71% of them, the diagnosis was psychosis or bipolar disorder. Regarding seclusion, 30% of patients involuntary detained experience and 33% of them are physically restrained.

French organization of psychiatric care:
Since 1986, for psychiatric care, the country is divided into *"catchment areas"* with a. mean population of around 70.000 inhabitants. Each of these catchment areas (*"secteurs"*) oversees its own organization, with a fixed amount of money – varying from one sector to another, regardless of the size or type of population concerned. Most commonly are full time hospitalization services and ambulatory care with consultation centres, day hospitals and outreach teams. For several years, the French government has supported the idea of allowing fewer budgets for full time hospitalization services and more for ambulatory care, and the organisation of mobile teams has grown.

Saint Etienne new organization of psychiatric care, and paper abstract:
In this context, the Saint Etienne catchment area – 132.000 inhabitants – decided to transfer human resources from 5 full time hospitalization beds to a psychiatric outreach team based on the Assertive Community Treatment (ACT) model.

The aim of this study was to assess the impact of this specific ACT team on days spent in full time hospitalization for people with severe psychiatric disorder Secondary objectives were to evaluate impact on the number of full-time hospitalizations, consultations in emergency services, and days spent with seclusion or physical restraint during hospitalization.

We decided to use a two-year pre-post study design. Each patient was his own control, comparing data for the year before ACT intervention to the first-year post intervention.

Sixty-seven people were included. There was a significant decrease in days spent in full time hospitalization from 91[42;175] to 27[0;102], (T-test, $p<0.0001$). We found a significant decrease in the number of hospitalizations and days spent with coercion for one year (4[0;22] to 0[0;9.5]). In a context of the closure of 10 inpatient beds, there is a real bias concerning these two points: fewer beds in full hospitalization implies fewer hospital stays. However, it could have been due to an increase in consultations in emergency departments, but we did not observe any increase in emergency services use. These results confirm ACT

results in other countries and, so far as we are aware, is the only study that exists for ACT mobile teams in specific French psychiatric organizations. It confirmed that switching from full time hospitalization to ambulatory care, particularly with community-based Programmes, is a good strategy for the healthcare system for psychiatry. Beyond the beds closure, implementing new practices by cooperating with all parties involve, could improve autonomy, quality of life and better prognosis by avoiding violent episodes related to the use of coercion in psychiatry.

And after that:
Despite the reduction in the number of hospital beds in France, the use of coercive measures continues to increase. This study suggests that beyond removing beds, using resources to support intensive community treatment for people experiencing severe mental disorder could be a way to reduce seclusion and physical restraint. Moreover, contrary to national data, Saint Etienne has seen its use of *"ambulatory healthcare Programmes"* (a form of coercive ambulatory care) decreased in recent years.

We know little about the impact of the transformations of French organizations and legislative changes on the use of coercive measures, and there are few studies on the subject. Nevertheless, in France, some hospitals do not use, or very exceptionally use, seclusion and mechanical restraint. They are public hospitals; their resources and their population are like the others. France now has regulated by law a national recording of the use of care without consent, seclusion, and restraint use. The country has a lot of unused data. To claim a reduction in coercive measures, we need more research that would explain the disparities between hospitals. Thus, the coming results of the Plaidcare study (study of the least coercive psychiatric hospitals in France) could provide elements of understanding the levers of a discipline more respectful of individual freedom and implementing better practices in French mental healthcare.

Educational goals

Understand the impact of assertive community treatment on the use of coercive measures: a French study

Acknowledgments

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Together on psychiatry – More extended collaboration in the most complex courses

Poster presentation

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Keywords: Community care / Involuntary admissions / Solution based / Common understanding

Aim

To improve the citizens' life situation through strengthened cooperation and coherent efforts. In more countries in Europe, community-based care is a substantial part of mental health. In the past decades, increased efforts have introduced community-based care to decrease involuntary admissions. Few projects focus on the most complex mental health situations.

Methods

The project includes a collaboration between five hospitals and 22 communities. The included sectors meet regarding patients with the most complex situations over one year. The consent was to create a common understanding, goals and solutions based on a holistic understanding of the patient/citizen.

Primary outcome is Fewer admissions and (acute) readmissions including involuntary admissions.

The collaboration model includes a *"Start-up workshop"* with relevant actors and evaluations at five follow up periods. The collaboration works when new possibilities are explored in reciprocity and agreed solutions

Results

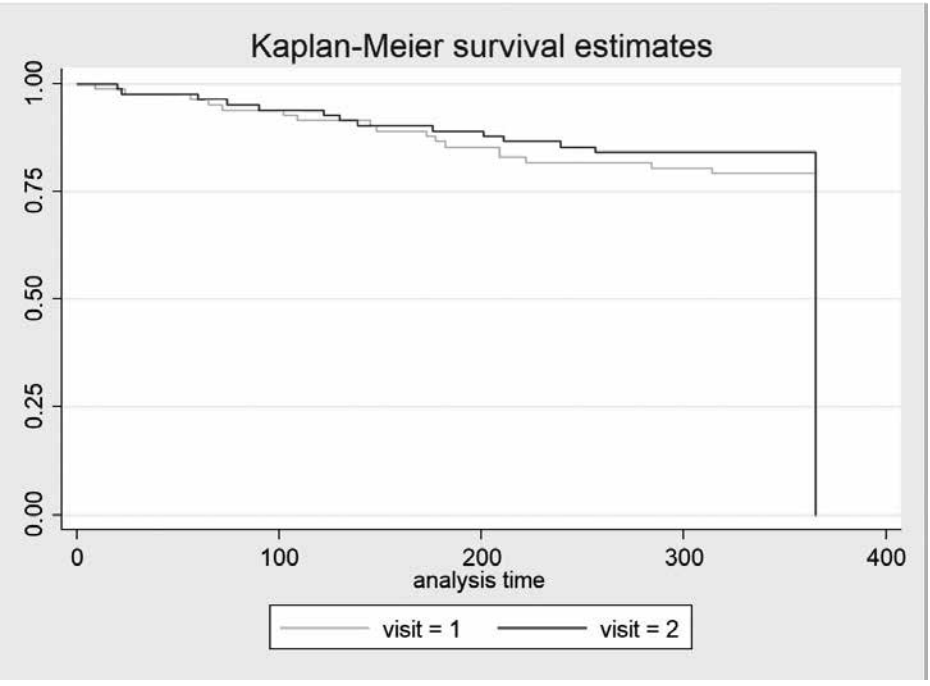
The number of involuntary seclusions decreased, and the number of admissions decreased significantly in the project period compared to the previous period. The number of re-admissions decreased significantly.

Implications

The results support additional efforts in preventing involuntary admissions through better collaboration between sectors. More research is needed on the cost-effectiveness of collaboration models.

Educational goals

1. To present and discuss the results with the audience at the congress so they find the project relevant in preventing coercion.
2. To increase the implication of a project by involving all relevant partners and the service users in the research process.



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Topic 19 – Specific populations: psychiatric patients in emergency services

The Compulsory Care Act: early observations and expectations of in- or outpatient involuntary treatment

Paper presentation

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Keywords: Coercive Measures / Mental Health Law / Trend data / Community treatment orders

Background

On January 1st, 2020, the Dutch Compulsory Care Act (WvGGZ) replaced the Special Admissions Act (BOPZ). Whilst the old law only allowed compulsory treatment in hospital, the new law allows it both in inpatient and outpatient settings. Moreover, new the law prioritises the patient's own opinion on coercive measures. By following patients' own choices, the Compulsory Care Act aims to lead to fewer admission days and less inpatient compulsory treatment in involuntarily admitted patients.

Methods

We studied the seclusion and enforced medication events before and after January 1st, 2020, using coercive measures monitoring data in a Mental Health Trust in the East of the Netherlands. Trends in hours of seclusion and number of enforced medication events per month from 2012 to 2019 were compared to 2020. We used Generalized Linear Models to perform time series analysis. Logistic regression analyses and Generalized Linear Models were performed to investigate whether patient compliance determined some of the observed changes in seclusion use or enforced medication events.

Results

The mean number of hours of seclusion between 2012 and 2019 was 27,124 per year, decreasing from 48542 in 2012 to 21,133 in 2019, and to 3,844 hours in 2020. The mean incidence of enforced medication events between 2012 and 2019 was 167, increasing from 90 in 2012 to 361 in 2019, and then fell to 294 in 2020. In 2020, we observed 3844 hours of seclusion and 294 enforced medication events. Almost no outpatient coercion was reported, even though it was warranted. The time series analysis showed a significant effect of the year 2020 on seclusion hours (β= -1.867; Exp(β)=0.155, Wald=27.22, p=0.001), but not on enforced medication events (β= 0.48; Exp(β)=1.616, Wald=2.33, p=0.13).

Discussion

There was a reduction in number of seclusion hours after the introduction of the Compulsory Care Act (2020). The number of enforced medication events increased from a very low baseline, but this increase started in 2017. To see whether these findings are consistent over time, they need to be replicated soon.

Conclusion

We observed a statistically significant increase of enforced medication use and a decrease in seclusion hours. 2020 predicted seclusion hours, but not enforced medication events. In due course, we will implement this study in five Mental Health Trusts in the Netherlands.

Educational goals

1. In the presentation the basic principles of the Dutch law are explained. An analysis model is presented, allowing a weighed evaluation of trends, correcting for patient compilation.
2. The analysis model is based on automated checks and controls in four source data, the coercive measures at a day-to-day basis, the admission data at a month-to-month basis, patient diagnosis and judicial status at a more yearly level. The basic principles of the checks and controls are explained. For receiving coercive measures, one needs to be in care, and have a diagnosis. Medical charts are checked, but also software was designed to detect errors.

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Topic 20 – Staff training and education

Co-production, reduction, and rights -Developing a best practice model for restraint training

Interactive workshop

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Keywords: Coproduction / Rights / Restraint reduction / Training

Abstract

The Restraint Reduction Network (RRN) training standards (2019) were developed in response to concerns about quality and safety of physical restraint training in the UK. They have a human rights and prevention focus.

The standards support co-production through Standard 1.5 which states that people with lived experience of being restrained must be involved in the development and delivery of training. Before staff are taught any restraint techniques, they must hear what it is like to be restrained.

An independent evaluation by Manchester Metropolitan University (MMU) revealed that most training organisations believed this standard would lead to less restraint. However, they felt that this was a challenging standard to meet.
As a result of this feedback the RRN is developing a toolkit to help training organisations and people with lived experience work together effectively, equally, and safely. The tool will be developed over two workshops and will be available in 2023.

Educational goals

Aim of the workshop is to develop guidance and a toolkit to provide a model of best practice for co designing and co delivering restraint training.

The RRN standards support co-production through Standard 1.5. The standard states that people with lived experience of being restrained should be involved in the development and delivery of training. Before staff are taught any physical restraint techniques, they must hear what it is like to be restrained. This connects them with the human experience and gives insight into the potential of the psychological as well as physical harms that can result.

An evaluation by MMU revealed that most training organisations believed that this was the standard most likely to lead to less restraint. However, they felt this was the most challenging standard to meet.

The RRN also heard from people who have been restrained and who have been involved in training, some experiences were good and some not so good.

This workshop will be used to support the development of a toolkit to help training organisations and people with lived experience work together effectively, equally, and safely.

The workshop will be co facilitated by Alexis Quinn who has lived experience of being restrained and Sarah Leitch author of the RRN Training standards

The workshops format will be as follows:

Introduction to the standards and the results of the 2021 evaluation by MMU. Training organisations perceived barriers to implementation of standard 1.5 will be discussed Qualitative feedback from workshop in the UK where people with lived experience of restraint people told us their experiences of being asked to co design and / or co deliver restraint training. The ladder of co-production will be introduced, and attendees will work in groups to discuss what good practice is at each level. The aim is to develop some principles for practice and generate some good examples on flip charts Practicalities of co-production, for example consent, payment, additional support needed and the reasonable adjustments that need to be made to existing working practices will produce a draft tool

kit based on feedback from both workshops. Attendees will be invited into a working group to comment on the draft pre-publication.

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The influence of mental health professionals' attitudes on decision-making around coercion.

Paper presentation

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Keywords: attitudes / personality traits / SACS

Abstract

Research on coercion in mental healthcare has recently shifted to the investigation of subjective aspects, both on the side of the people with mental disorders affected and the staff members involved. In this context, the role of personality traits and attitudes of staff members in decision-making around coercion is increasingly assessed. We developed and validated a German version of the Staff Attitudes towards Coercion Scale and then used it in an experimental case vignette study. Results from both studies showed that attitudes towards coercion ranging from rejecting to approving the use of coercion, and significantly influenced decisions around coercion in individual cases, resulting in a greater likelihood to approve of the use of coercion. Strategies to reduce coercion in mental healthcare institutions should focus more on the role of staff attitudes and encourage staff members to reflect on them critically.

Summary

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. To assess mental health professionals' attitudes towards the use of coercion the Staff Attitudes towards Coercion Scale has been developed by Husum and colleagues. It has been used in several studies, but so far, no clear association with the actual use of coercion could be found. The aim of our studies was to develop and validate a German version of the SACS. The original English version of the SACS was translated into German. Subsequently, it was empirically validated on a sample of 209 mental health professionals by conducting an exploratory

factor analysis. The three-factor structure in the original version of the SACS, consisting of critical, pragmatic, and positive attitudes toward the use of coercion, was not replicated. Instead, the German version revealed one factor ranging from rejecting to approving the use of coercion. Furthermore, we used this version along with other measures of personality traits to assess mental health professionals in a psychiatric hospital within a quantitative survey (n = 103). Furthermore, we developed case vignettes representing cases in a *'grey zone'* and included them in the survey to assess staff members' decisions about coercion in specific situations. A general approving attitude towards coercion significantly influenced decisions around coercion in individual cases, resulting in a more likely approval of applying coercion in the cases described in the vignettes. Personality traits did not seem to be relevant in this regard.

Educational goals

After attending this talk, participants can:
1. Outline the relevant features of the German version of the SACS in comparison to the original version.
2. Understand the role of staff attitudes in the decision-making around coercion and other factors influencing this relationship.

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Staff perspectives on an extended Safety-Training-Programme at four Forensic Psychiatric Wards in Region Zealand, Denmark

Poster presentation

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Keywords: Staff safety training / De-escalation / Violence prevention / Risk assess

Background

Forensic Psychiatry in Region Zealand has four medium secure wards, all located in the psychiatric hospital in Slagelse. To deliver care and treatment, it is necessary to train staff in a specific way. We have revitalized our previous training and developed an extended Safety Training Programme lasting 12 days targeting our patients. The Programme includes interaction between practice in the clinic and the acquired theory and training obtained during the education. The Staff members will gain knowledge of topics such as psychopathology, psychopathy, ethics - ethics in everyday life and ethical dilemmas, mentalizing as well as legal material, rules, legislation, and guidelines and through theory in combination with casework, the students will learn to risk assess a patient. The Programme 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.

Aims

1. The first aim of the Programme was to create safety for patients and staff members.
2. The second aim was to give the staff a comprehensive framework for how to understand, prevent and manage aggressive situations in a caring and safe manner.

Method

To evaluate the Programme, we prepared an electronic questionnaire, which all participants were asked to complete immediately after completing the course. 26 Staff members had participated in the Safety Training Programme

The aim of the study was to explore how staff perceived the Programme including their own ability to 1) deescalate a violent situation and 2) customize physical restraint intervention specified the individual patient.

Preliminary Results

21 percent of the participants indicated that they were satisfied, and 79 percent of the participants indicated that they could to a large extent use the theoretical knowledge and the practical skills that they had acquired on the Safety Training Programme to understand, prevent, and manage violent situations in a caring and safe manner.

Of the participants 47% who reported their satisfaction with the programme, 47% stated that the Safety Training Programme had changed their professional understanding in relation to solving their daily work tasks to prevent and manage aggressive situations as well as to create safety for patients and staff members. In response to the item about whether staff felt more confident in their work after completing the Safety Training Programme, 30% answered that they felt safer, and 60% answered that they felt much safer at work.

Of the participants, 90% reported the Safety Training Programme had strengthened the cooperation across the wards in prevention, de-escalation, and handling of violent situations.

Preliminary conclusion

Implementation of extended Safety Training Programme at the four medium secure wards in Forensic Psychiatry 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 be better able to prevent and manage conflicts and aggressive situations.

Finally, participants indicated that the Safety Training Programme had strengthened the cooperation across the wards in prevention, de-escalation, and handling of violent situations.

Educational goals

1. Participants will receive inspiration and input on how Safety Training Programmes can be developed and implemented in an organization.
2. The presenters receive feedback on their Safety Training Programme

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How training with actors, can help psychiatric staff in Denmark achieve non-technical skills

Interactive workshop

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Keywords: Actors / training / de-escalation / non-technical skills / cognitive and affective learning.

Abstract

Introduction and background

In the period 2015-2018, interdisciplinary graduate education was established for psychiatric staff in the Central Denmark Region. Approximately 2100 employees from in-patient and out-patient departments were taught de-escalation skills, in a training programme that combined oral presentation and practical training with specially trained actors.

The primary purpose of the de-escalation programme was to simultaneously reduce the use of coercion while providing staff with the necessary skills to assure security and a calmness, when facing potentially violent situations. The primary reason for choosing practical training with actors, was based on the belief that the de-escalations skills staff needed to learn, would be best acquired if they were experience-based. The set-up of the training was inspired by the work of neuro-psychologist Susan Hart, whose course the programme teachers attended in June 2019. When working with emotions Hart encourages educators to not only address the emotional reactions of the prefrontal cortex, but also direct learning experiences at the limbic system as well as the autonomous nervous system, exactly as we aim to do, when using actors in learning set-ups. Following the interdisciplinary education programme in 2018, the senior management of the Psychiatry Department in Central Denmark Region, decided that all induction courses for new psychiatric staff should involve training of de-escalation with professional learning actors. This decision was made based on some very positive evaluation on the effect of training de-escalation situations with actors. I (Stine Horn Gade) was assigned to make the change in the induction courses together with a co-worker from my team.

In the following paper we will describe; Why we use actors when training non-technical skills, how we go about it, which subjects are especially suitable for training with actors, some pointers for creating a learning set-up with training with actors as the main component, acknowledgements and results and a final discussion, in which we raise questions about the overall tradition of using simulation in the training of health care professionals.

Main paper

Why train non-technical skills?

In the American report form 2000 called" To Err is Human: Building a Safer Health System" by Kohn, Corrigan, & Donaldson, it is emphasized that around 75% of all unintended events in hospitals are caused by human error. Technical skills do not cause unintended events, rather it is the non-technical skills such as how we communicate, act, and make decisions that can lead to unintended events. Non-technical skills cannot be achieved by cognitive learning alone. Therefore, we must combine elements of cognitive learning with a degree of affective learning, when we wish to integrate non-technical skills in our course participants.

In Lene Lauge Bering's PhD-thesis from 2016 *"De-escalation – management violence and reducing coercive measures in mental health care settings. A Co –operative Inquiry"*, she emphasizes that the main goal for the psychiatric staff to work with de-escalation as a method, is to help the upset and potentially violent patient towards a calmer psychical and mental state of mind, thus making it possible for the patient to regain their self-control. Bering states, that the capacity of health professionals to remain calm and use de-escalation skills, is crucial to succeed.

If a staff member has little or no knowledge, of how their mind and body react under pressure, they will not notice an elevation of their arousal level and will have only limited opportunities to act according to the demands of the situation. In the training scenarios with actors, we train our course-participants to notice their bodily response as they occur, and to place importance on recognising this. Course participants learn that the actual registration of what occurs when the arousal level alters, causes a mental pause, that allows for access to cognitive parts of the brain, and the chance to not be wholly captured by emotions and fight/flight-responses. If staff can gain access to their thinking brain in heated

situations, they are more likely to remember what they have learned about de-escalation and ultimately help their patients in a safe manner. In training sessions with the actors, participants train in spotting changes in their personal arousal state and in their co-workers, because these registrations make us able to access to re-elective actions and decisions making instead of them acting re-active.

On our courses we approach the subject, training registration of arousal, both from the affective domain, when training with the actors, but also from the cognitive domain. The cognitive approach is used when we reflect over the previous case (point 5 in our training set-up), and when the course participants are presented with slides, as the one above, that illustrates how the human brain works when aroused.

Our training recipe

The one-day training course with actors is part of a three-day introduction course for new psychiatric staff. On the training day, the participants train roles specifically assigned for use in de-escalation, when de-escalation is used as a collaborating method in escalating situations.

The set-up of the training is as follows:

1. Presentation on the framework of the training, case, and patient
2. All participants are assigned a role (either as active participant in the case, or as active spectators with an assigned learning focus)
3. The participants who are assigned an active role in the case, are given 3 minutes in which to plan, that must include: How the meet the patient, which safety-issues to address, and how to cooperate with each other during the case
4. The case plays out for 7 minutes
5. From specific facilitation-guidelines, the facilitator facilitates learning perspectives of the training, ending with the actor giving feedback from the patient's perspective

We typically enrol 20-25 course participants when we train de-escalation. We split the group up in two teams, each with one actor. There is only one facilitating teacher pr. course, which means that the facilitator switches between the two groups, leaving one actor alone with a group at a time. The actors have guideline in how to facilitate learning in the group after the case ends.

Our sessions with the actors are always a dynamic between cognitive and affective learning. When participants interact with the actors, their feelings and the autonomic nervous system are activated. This is followed by cognitive reflections on the action they just experienced.

Examples of non-technical skills, that are suitable for training

My experience as a specialised practitioner, who has worked with actors in learning set-ups since 2005, has shown me that some learning topics and skills are far easier to work with and subsequently integrate, if we use practice training with actors, as the main component. These topics/skills such as conflict management, communication, cooperation (especially interdisciplinary cooperation), learning individual trigger-points, learning individual bodily responses to changes in arousal level, and how to handle emotions and feelings while acting under pressure (self-regulation).

In our de-escalation courses with new psychiatric staff in the Central Denmark Region, all the above-mentioned skills must be addressed, and almost all of them are in our training sessions with the actors.

The topics mentioned above are all characterized by a great deal of complexity. They all involve; a high level of self-awareness, openness towards other ways of perceiving the world, empathy, and self-regulation skills. Finally, they all occur in interaction with others. Therefore, we argue that to address these topics in a learning context, with the purpose of integrating new skills (change) in the course participants, you must address the topics both from the cognitive and affective domain, in a set-up where you are free to explore how you interact with people. In our opinion the best way of doing this is by training with actors. This argument is supported by the learning theory of Donald Schön. He states that the most essential element when creating learning and development is the ability to create reflection in practice.

In the learning theory by Schön he states that participants in a simulation set-up, are getting their framework of experience challenged, and therefore must seek new ways of doing things. In the simulation the students are given a space in which they can practice, without the consequences of reality and patient safety.

Things to consider when using actors in learning set-ups

It is key to have a professional learning environment when you choose to create a learning set-up where training with actors is the main component. Regarding this, we wish to highlight three elements, which we have found particularly important in creating a professional learning environment:

1. A professional team of learning actors and teachers, specifically educated for the task
2. A clear framework for the learning set-up.
3. A team-leader with a specific focus on the training sequences with the actors.

In this paper we have chosen only to elaborate on element number two, A clear framework for the learning set-up.

The framework consists of different written guidelines made especially for each group of contributors (learning actors and facilitating teachers). These guidelines are explained during the ground training that the groups receive and describe what to do, when and why. The guidelines aim to unify the training and exercises with the actors, so the learning outcome of the course participants ultimately are similar.

Some of the most important elements that the guidelines aim to support are:

- A secure learning environment. A place where the participants can try new ways in communication strategies and ways of acting, without being afraid of being judged by the teachers of the course or their fellow course-participants. In conjunction with this, the guideline offers a specific way of giving feedback, at the end of the cases-plays with the actors.

- A specific teaching role, where the teachers practice what they teach. This means that the way we facilitate our courses, acts as a practice example of the most important learning points of the course. For example, a learning point on the course is Better late than never (in Danish: Bedre sent end aldrig, som vi på kurset har omformuleret til; Gå ALTID tilbage til en fuser). Meaning that if you do or act in a way towards patients or co-workers that you afterwards regret, you are obligated to act upon this notion. At the course I always make sure to do or say something “wrong”, so I can demonstrate to the participants examples of how to address or correct a mistake I have made.

Another important tool for the framework is the cases we use. In 2014 I started conducting interviews with patients, patient relatives and psychiatric staff in different in-patient and out-patient departments in the Central Denmark Region. I asked them which situations they found to cause the most problems where they worked/were admitted, and as an educated playwright, I took these stories and made them the foundation of the cases we now use in our courses.

We always emphasize, that the actor portrays a person in distress and not a specific illness. When we started using actors to train de-escalations skills, we found that telling health professionals that: *"The person you will meet in this case is a young girl, who suffers from schizophrenia…"* their focus on how to handle the conflict, would be somewhat fixated on the specific disorder and specific treatment techniques, rather than working together to help the patient in distress.

Finally, we would like to mention, that we developed a clear guideline on what to do, if course participants where re-traumatized during training. The guideline covers who should do what if this happens. Since 2015, we have trained approximately 5000 health professionals, and there have only been 4 instances, in which we had to use this guideline.

Acknowledgements and results

After each de-escalation course we collect anonymous evaluation-reports from the participants. Some of the questions were directly focused on the outcome of training de-escalation skills with the actors.

Here are two questions asked, combined with a summary of the answers we got from 1200 of 3400 participants.

1) To what extent, did you experience that the training with actors has contributed to your de-escalation skills?

Answers:
Considerably: 73,33 %
To some degree: 26,66 %
To a lesser degree: 0
Not at all: 0

2) Comments on the practice-training with the actors:

Answers:

- It was good, fun, and exciting. They made the situations become so much more real.
- (In the process after the training) It was good to discuss concreate situations and the handling of these, without it being real-life-situations where you often have emotions in a pinch.
- Educational but it also transgressive. The actors were extremely talented.
- It was nice with the exercises and the following discussions. It was good it was professional actors that portrayed the role of the patients.
- It was educational both to experience the training with the actors one-on-one, and to experience cases as a spectator.
- Talented and believable actors that also were responsive towards correction about the cases and patient behaviour.
- The feedback from the actors on how they as patients experienced us as health professionals was very rewarding

When we meet former course participants, they very often refer to the training with the actors as being something they remember and something that taught them a great deal.

Finally, we will mention that several articles have been written about our method of using actors for training health professionals' de-escalation skills. They are mentioned in the references.

Discussion

In conclusion, we end this paper by reflecting on the attention paid to training technical-skills versus non-technical skills, both in the educational system of health professionals, and in postgraduate courses – at least in Denmark. In Denmark, there is a great tradition of training technical skills, which is almost non-existent when it comes to non-technical skills. Is this something other congress-participants can recognise from the educational systems of their countries? If they do, why is this so, and what can we do about it? These are some of the questions we hope to discuss, at the end of our workshop at the European Congress on Violence in Clinical Psychiatry this year.

Educational goal

Understand the use of actors when training non-technical skills, how we go about it, which subjects are especially suitable for training with actors, some pointers for creating a learning set-up with training with actors as the main component, acknowledgements and results and a final discussion, in which we raise questions about the overall tradition of using simulation in the training of health care professionals.

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Evaluating restraint positions

Interactive workshop

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Keywords: Retention position / physical techniques / standardization / MAP / coercive interventions / professional and ethical guidelines

Background

Violence and threats pose a major challenge for both patients and staff in psychiatric wards. (1-5). 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. Coercive interventions exist in a dynamic clinical context, where the availability of one intervention may have an impact on the frequency and nature of other interventions (6).

Since 2015, extensive work has been done to prepare a new Norwegian mental health staff training programme for prevention and management of aggression and violence in the mental health sector.

The aim of the project was to standardize, and quality assure such training to staff in the mental health sector. The project resulted in the staff-training programme *"MAP"*. (Managing aggression problems) (7). The MAP model was created as a recognition that the existing training Programmes were deficient - both in terms of content and knowledge base.

MAP has been a collaborative project between the SIFER network, the four regional high security forensic units, Helse Stavanger and Helse Fonna who could see the potential and usefulness of a possible summary of each other's knowledge and experience.

The MAP model was nationally launched in September 2019 in Oslo. The programme consisted of 10 chapters put together into a two-day course. Chapter 9 dealt with physical techniques and a separate manual for physical techniques

was prepared (8). Here, among other things, abdominal position and lateral position that are included in the course are described. The MAP model was well received in most mental health clinics in Norway implementing MAP. There has been broad professional agreement on the theoretical content of the manual and MAP is recommended in national professional councils (9). Some clinics are still hesitant to introduce MAP based on the technique's repertoire in the MAP model. Due to this, there have been several requests from clinics whether it is possible to select the theoretical MAP basis and keep their already existing physical techniques. Most resistance is expressed regarding the MAP retention techniques from these clinics.

Some of these clinics already use and want to continue using a variant of supine position. There were several local descriptions of retention in the supine position, but documentation of the suitability of the technique was lacking. This will be further investigated and explored in detail in an ongoing master's project.

Through a project that involved several workshops, MAP has examined different supine position variants and gained more knowledge and experience about these. This project has developed a variant of supine position according to the same methods that were used in the development of lateral and abdominal position. There are now descriptions of three different restraint techniques and MAP wants to examine further the possibility of achieving a nationally agreed technique.

Methods

Knowledge and experience from this project are based on an upcoming master's project. This project was designed as a convergent mixed methods study (10). Quantitative data were obtained from a workshop in November 2021, using the scoring form *"Evaluation of physical techniques"*. Qualitative data were obtained from participants in two consecutive focus group interviews. This combination of methods sought to provide a wider and better understanding of data. The study used a strategic sample of participants with different experiences with physical techniques. This sample included twelve healthcare personnel recruited for the study, all of them experienced with restraint interventions. Four participants had experience with restraining patients in the supine position, four were using the abdominal position while the last four used the lateral position. Four users with personal experience from being physically restrained were also recruited for the study.

Four variants of supine position techniques were demonstrated and tested between the different staff training programmes. They were 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. Two focus group interviews were also conducted where the participants shared experiences of performing and being exposed to supine position. This became the starting point for the development of a consensus regarding supine position.

Results

The data were used to find which physical techniques the various training instructors and user representatives, followed by a consensus discussion, perceived as the most appropriate. Abdominal position and lateral position are defined in the MAP programme, which was launched in 2019. Regardless of the ongoing master's study, the professional communities have managed to agree on a variant of supine position through experience and ability to adapt and improve each other's techniques. This was done through further testing in the spring of 2022. A variant of the supine position is developed according to the same structure in 2022 and it is desirable to investigate which is perceived more appropriate compared to the existing positions in MAP. The variant of supine positions was developed based on the same structure as the abdominal and lateral positions and it is desirable to investigate which of these three is perceived as most appropriate from a professional and ethical standpoint.

Conclusions

A standardization of physical techniques in mental healthcare will have implications both clinically and organizationally, but most importantly, it will contribute as a quality assurance from a patient, and staff safety perspective. The conclusion from the workshop is that there is great motivation to adapt and improve each other's supine position techniques to improve patient safety and comfort. The workshop will consist of an introduction of the new MAP-model, and the methodological approach of achieving a collaborative portfolio of the different techniques. The latter part of the workshop will consist of participants trying out the three different restraint techniques: lateral position, supine position, and abdominal position. Evaluation forms will be collected, and the participants will be asked to evaluate the different restraint techniques according to seven parameters based on professional and ethical guidelines (effectiveness,

easy to learn, easy to use, potential for pain inducing, offensive for the patient, and injury potential for both the patient and staff).

Educational goals

1. The participants will get to know a methodology of how to evaluate physical techniques in a mental health context.
2. The participants will test and evaluate the three different restraint positions based on professional and ethical guidelines.

Acknowledgments

We would like to thank the various professional communities and representatives of supine position for great willingness to adapt and improve each other's techniques for the common good of the patient. Furthermore, thanks must also be extended to the SIFER network and the regional competence centres that support the project on the development and quality assurance of physical techniques in coercive use.

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Pilot study on the Management of Aggression Programme (MAP) in primary health care

Paper presentation

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Keywords: Aggression / Prevention / Primary health care / Violence / Management of Aggression Programme (MAP)

Introduction and background

Violence is acknowledged by the WHO as a major global public health issue (World Health Organization, Dahlberg, & Mercy, 2002). Between 8% and 38% of health workers suffer physical violence at some point in their careers. Many more are threatened or exposed to verbal aggression (World Health Organization, 2019). Twenty-seven percent of health care workers in Norway state that they have been exposed to violence and threats in the past year (STAMI, 2022). When the reported figures are categorized according to workplace, 34 % of employees in primary health care services are exposed to violence and threats (STAMI, 2022).

Aggression and violence committed by service users are associated with great costs and can cause injuries, absence, dissatisfaction, and high turnover among employees, and hence negatively influence quality of services (Edward, Ousey, Warelow, & Lui, 2014; STAMI, 2022; Wolf, Delao, & Perhats, 2014). The Norwegian Working Environment Act requires that employees are protected from violence and threats as far as possible (*"The Norwegian Working Environment Act,"* 01.01.2006). Furthermore, the standard for safety, health and work environment is to be developed and improved in accordance with developments in society (§ 4-1 first paragraph). Working with aggression and violence can cause physical and mental injuries, sick leave, dissatisfaction, and high turnover among staff. In the long run, this may have consequences for the quality of the services. Workplace violence is associated with large costs for society, for the organizations and for the individual employee who may be affected.

The Management of Aggression Programme (MAP) is a comprehensive module-based staff education programme developed to help prevent and manage aggression and violence within the health and social services (SIFER, 2019). The programme is a result of a national collaborative project from 2015 to 2019 between the four Regional Health Authorities in Norway and the National competence network on forensic psychiatry in Norway (SIFER). The aim of the national collaborative project was to develop a standardized, knowledge based, evidence based and quality assured programme for health care workers. The MAP which consists of ten different chapters was officially launched in September 2019, and since then all the different Norwegian health regions has implemented MAP in their mental health sector. During this implementation, there were frequent requests and interest from other service areas, such as the primary health care.

Due to the frequency and severity of reported aggression and violence committed by health care service users (STAMI, 2022), SIFER and the MAP main instructors initiated a pilot study on MAP in primary health care with funding from the Norwegian Directorate of Health.

Aim

The pilot study aims to investigate whether the implementation of MAP municipal version in primary health care impacts on registered deviations, sick leave and staffs' experienced degree of safety and security.

The main paper

Design, setting, and participants

The naturalistic intervention pilot study is currently being conducted in two municipalities, Stavanger, and Bergen, in Norway. The data collection period at each department lasts for one calendar year, in Bergen from September 2021 to September 2022, while Stavanger had a varied starting date from December 2021 to March 2022 due to delays caused by pandemic restrictions.

Departments within mental health, substance abuse, nursing homes and intellectually disability units, and which prior to the study had a particularly high frequency of challenging exhibited by service users, were selected, and included in the pilot study. The selection of units in Bergen were based on data from

deviation reports from 2019, selecting units with a particularly high frequency of challenging behaviour. Included units are three from the Department of social services and 9 from the Department of mental health and substance abuse. The 6 departments in Stavanger were also included due to a particularly high frequency of challenging behaviour. The departments represent mental health, substance abuse, nursing homes and intellectually disabilities units.

The target group is employees from the included departments. The target group consists of employees who work user-oriented, and in a 20 % position or higher, approximately 700 employees in Bergen and 550 in Stavanger. The study sample consist of employees who complete the standardized MAP basic course (approximately 1200 employees).

Intervention

The intervention in this pilot study consists of training MAP instructors (10-day course), completing a standardized MAP basic course (2 days), maintenance training based on the content in MAP, selection of MAP resource persons and establishing a local MAP network in each municipality.

Measures

To analyse possible changes during the data collection period, the following outcome measures are registered:

(i) Quarterly deviation reports within Health Safety and Environment (HSE) regarding: (a) Personal injury data on healthcare staff or fellow service users; (b) Extent (frequency and severity) of sickness absence and sick leave reports.
(ii) Quarterly staff turnover
(iii) Documented MAP training to reduce HSE-related deviations
(iv) A questionnaire at baseline, after six month and at the end of the data collection period, that concerns employees' perceived degree of safety and security at work.

Additionally, participants in Bergen score Thackrey's confidence in coping with aggression scale twice, at baseline and post-implementation after completing the MAP basic course. Participants in Stavanger complete digital evaluation forms with both closed and open-ended questions to evaluate the completed basic course.

Data analysis

Statistical analyses of quantitative data will be conducted using IBM SPSS Statistics for Windows, while qualitative data will be analysed using thematic analysis.

Preliminary results

Both municipalities finished their scheduled basic courses in the middle of June 2022 and both municipalities are conducting a mid-term evaluation that will be completed in July 2022. The mid-term evaluation presents preliminary findings and an evaluation of the implementation of MAP thus far.

Preliminary findings show that the project organization, management anchoring, and organization of education, impacts the participants' perceived usefulness, transfer value, relevance and their experience of safety and security when facing aggression and violence.

Covid-19 challenges

Due to the pandemic, there were several postponements affecting the start dates in both municipalities. The national guidelines changed on short notice and had a regional variety. In Bergen the instructors finished their training in September 2020, but the MAP basic courses were delayed until September 2021. In Stavanger the instructors finished their training in November 2021 and started the courses in December 2021. Due to national guidelines, only a few courses finished in December and the rest of the MAP basic courses started in February 2022. By the middle of June 2022 all the scheduled courses where completed.

Conclusion and/or Discussion

Preliminary findings show that the organization of project management, anchoring of MAP in the organization and how the MAP courses are organized, has impact on how the participants experience usefulness, transfer value, relevance in their own work and perceive security when facing aggression and violence. Preliminary findings also indicate a change in how employees formulate deviations including suggestions on measures to prevent similar future incidents from occurring.

As MAP is now implemented in the Division of Mental Health Care in Bergen Hospital Trust, it is believed to be a positive additional benefit to Bergen municipality's service users are met by employees with the same approach in both the primary and specialist health care.

Based on the mid-term evaluation, there is a need to conduct further evaluation, both qualitative and quantitative data, including interviews and surveys aimed at employees in various positions. The topics in the further evaluation can deal with how implementation of MAP affected employees, organization during implementation, degree of anchoring in management, how MAP can contribute to reducing the severity of deviations and at a later stage to look closer at compliance with principles in MAP, etc.

The pilot study will describe how the MAP municipal version might be a possible staff training programme that can prevent, reduce, and deal with aggression and violence in primary health care. The pilot study will also describe how implementation of the MAP municipal version can affect the deviation reports, absence, and turnover within primary health care. However, the pandemic led to a change in sick leave, leading to a disruption in the collection of data. Thus, it will be challenging to distinguish between sick leave due to MAP and what is due to the pandemic.

Educational goal

Understand whether the implementation of MAP municipal version in primary health care impacts on registered deviations, sick leave and staffs' experienced degree of safety and security.

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Evaluation of a training programme to manage patients 'aggression – the modified Thackrey Scale

Paper presentation

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Keywords: Evaluation / training / aggression / scales / Thackrey / Programme

Introduction

Staff on psychiatric wards are not only victims of aggression, but also contribute to the occurrence of aggression since aggression is interpersonal. Aggression is a serious issue in mental health care, where the safety of both patients and staff needs to be protected (1). Violence against healthcare workers (HCWs) is described as a worldwide phenomenon with serious consequences. Aggressive and violent behaviours are major public health problems. The association of these behaviours with severe mental illness has been controversial and supported by some but not all research (2). Aggressive or violent behaviour can be the endpoint of various causes of mental disorders (distress, frustration, cognitive impairment, substance misuse, low self-control, and high trait anger) related to intrinsic as well as distal processes, including the person, the environment, and the person's social networks. The possible association with mental illness might, in part, drive public negative perceptions and stigmatisation of people with these mental disorders, and the mandated imposition of treatment to avert further risk of interpersonal violence might even exacerbate stigma (3).

On psychiatric wards, aggressive behaviour displayed by patients is common and problematic. The mean prevalence of aggressive events is 54 %, with a wide prevalence range between studies (7.5 % to 75.9 %). Interaction is an important factor in the occurrence of aggression, especially communication in general between staff and patients (3). Poor communication between staff and patients and a perceived lack of empathy, respect and distance or a lack of shared decision-making led to aggression (4). Less aggression was also reported when a team scored better on team functioning, had more positive attitudes to

difficult patients, lower burnout and had more order and organization on the ward (5). Staff on psychiatric wards are not only victims of aggression, but also contribute to the occurrence of aggression since aggression is interpersonal. Aggression is a serious issue in mental health care, where safety of both patients and staff needs to be protected (6).

Within the literature, it is frequently recommended that employers implement education and training programmes for high-risk workers to prevent workplace violence. These programmes generally aim to help workers develop skills to better recognize and react to violent situations, and to better cope with their consequences (7).

Previous studies of findings are based on pre-test/post-test measurement only (often without a control group) and few studies followed the long-term effect of training. An additional difficulty of these studies has been the ad hoc nature of the measurement procedures (instruments used have not been described, and their psychometric properties - e.g., reliability are unknown). Thackrey (1987) developed a psychometrically sound instrument for assessing clinician confidence in coping with patient aggression and for the evaluating the immediate and long-term effects of a training programme (Thackrey confidence scale in coping with patient aggression) (8).

Several training programmes followed Thackrey's scale in evaluation of their training of de-escalation (9, 10). The studies also measured confidence in coping the psychological distress or level of exposure to different forms of violence. Thackrey's scale measured (in 10 items) comfort, training, and ability to intervene in psychological and physical aggression, effectiveness, safety, ability to meet needs of aggressive patients and ability of self-defence. We have tried to adapt and validate that scale. Our scale measures all domains used by Thackrey, but studied variables were expanded from two (psychological and physical) into eight domains. We have assessed the above-mentioned domains in 1/non-responding stuff personal space, 2/ agitating, 3/verbal aggression, 4/ auto aggression, 5/ aggression against subjects, 6/ violence against stuff, 7/ violence against patients, 8 violence against strangers (visitors).

The bulk of the literature on education and training programmes for the prevention of workplace violence is limited by the short duration of evaluation periods. Among the cited reviews most of the studies did not provide information on the duration of the evaluation period, and only four were based on a follow-up

period of one year or more. Therefore, literature regarding intermediate and long-term effects of these programmes is scarce (11, 12, 13, 14).

Our pilot study had two aims:
1. To examine the internal consistency of 3 questionnaires (Thackrey scale self-confidence, A global measure of perceived stress and Modified Thackrey scale – Vevera Pekara).
2. To verify the convergent validity of Modified Thackrey scale – Vevera Pekara with the original Thackrey scale.

We tested questionnaires on our voluntary participants in our two-day training intervention for prevention on violence in psychiatry department. The main tool of that programme is simulation with actors as recommended in the literature (15, 16). The course has a modular structure. Before the start, we tested participants with the Modified Thackrey Scale (MTS), to determine which situations make the staff feel the least comfortable. Depending on the weaknesses found, we include these scenes from our repertoire and focus on these situations in detail.

1. First day of training: Screening by MTS, lectures on the theories of aggression; the main causes of aggression and violence, its triggers, which were identified in our previous research (17) and the basic principles of non-violent self-protection. Simulation scenarios with the actors - training of physical self-protection.
2. Second day of training: Simulation scenarios with actors - training of verbal self-protection. Training of verbal de-escalation methods and debriefing after the conflict. Simulation scenarios with actors - what can we do after the conflict.

The inspiration for our training involved experiences from international workshops and courses (18, 19).

Methods

One hundred and two employees of the Psychiatry Clinic at the University Hospital Plzen, Czech Republic, including enrolled nurses, registered nurses and psychiatrists participated in the study. Eleven attended a two day-long training programme on management of aggressive patients (the intervention group). The intervention as well as the control (n=91) group were presented with a survey before and (a week to a month) after the programme, consisting

of the Modified Thackrey scale – Vevera Pekara (MTS-VP), the Thackrey's confidence in coping with patient aggression scale (Thackrey, 1987), the Czech version of the Perceived Stress Scale (20) and the eight questions on the rates of different types of aggressive behaviours in patients observed during the last seven days.

To estimate internal consistency of the MTS-VP, Guttman's lambda and McDonald's omega are used along with popular but often criticised Cronbach's alpha. Linear correlation of the MTS-VP with the Thackrey's confidence scale was used to examine its criterion validity; convergent validity was further supported by correlation with the Perceived Stress Scale.

To test the effects of the training programme, the pre-and post-intervention results were compared using t-tests in the intervention group. The same procedure was repeated in the control group to rule out possible external factors. Since the Modified Thackrey scale Vevera Pekara is substantially longer than the other questionnaires it was divided into 9 subgroups. In future we are planning the use of factor analysis to lower this number significantly. Furthermore, we added a question regarding the number of incidents of aggressive behaviour reported. In tables we present the number of responses to this questionnaire.

Results

Question number / answer	Not answered	0	1	2	3	4	5	6	7	10	12	30	All the time
1	26	50	27	14	8	6	3	0	2	2	0	2	2
2	26	109	1	0	2	0	2	0	0	0	0	0	0
3	26	39	41	12	11	2	9	1	1	0	0	0	0
4	26	59	30	11	5	8	3	0	0	0	0	0	0
5	26	60	22	15	8	5	2	2	1	0	1	0	0
6	26	73	29	9	3	2	0	0	0	0	0	0	0
7	26	95	17	1	1	0	2	0	0	0	0	0	0
8	26	104	9	1	0	2	0	0	0	0	0	0	0

1. The internal consistency was assessed with Cronbach's alpha, Guttman's lambda and McDonald's omega. The results are in table 1. Literature suggest that Cronbach's alpha should be above 0.7. We can conclude that questionnaires are manifesting good level of internal consistency (Cronbach's alpha >= 0.8) or excellent level of internal consistency (Cronbach's alpha >= 0.9). Guttman's lambda and McDonald's omega are in accordance with this

conclusion (standard cut off is >=0.7) both measures are above that in all questionnaires. Therefore, we can conclude that questionnaires are internally consistent.

Questionnaire	Cronbach's alpha	Guttman's lambda	McDonald's omega
A global measure of perceived stress	0.8	0.88	0.83
Thackrey scale self confidence	0.92	0.94	0.95
Modified Thackrey – comfort	0.9	0.94	0.95
Modified Thackrey – knowledge	0.97	0.97	0.98
Modified Thackrey – physical intervention	0.96	0.96	0.98
Modified Thackrey – confidence	0.95	0.96	0.97
Modified Thackrey – communication	0.97	0.98	0.99
Modified Thackrey – safety	0.93	0.95	0.96
Modified Thackrey – efficiency of techniques	0.97	0.97	0.98
Modified Thackrey – fulfilment of tasks	0.96	0.97	0.98
Modified Thackrey – security	0.96	0.97	0.98

2. The correlation of Modified Thackrey scale with Thackrey scale are in table 2.

Modified Thackrey scale subcategory	Thackrey scale	A global measure of perceived stress
Comfort	0.178	-0.158
Knowledge	0.714*	-0.026
Physical intervention	0.719*	-0.155
Confidence	0.680*	-0.029
Communication	0.778*	-0.047
Safety	0.460*	-0.390*
Efficiency of techniques	0.844*	-0.093
Fulfilment of tasks	0.658*	-0.293*
Security	0.850*	-0.076

The two tailed Pearson correlation tests with a significance level of α=0.05 were performed. The statistically significant results are marked with asterisks in table. The correlation between all but first part of Modified Thackrey scale and Thackrey scale are positive and statistically significant with high values of estimate of correlation coefficients. This suggests that the Modified Thackrey scale is consistent with original Thackrey scale. The correlation with The A global measure of perceived stress is lower and in majority of cases not statistically significant.

Power analysis

The aim of this section is to estimate how many participants will be needed to achieve a power of a test $\beta=0.8$ for a null hypothesis that the training has 0 effect. We will be using a paired t-test on a standard significance level of $\alpha=0.05$. Our pilot study suggests that there is a difference between scores in questionnaires administrated before and after the training. With the estimates of the mean values and variances from our pilot study we have received the following minimum number of participants to achieve the power needed for a test of this nature.

Questionnaire	Minimum number of participants
Thackrey scale	9
Modified Thackrey scale - comfort	8
Modified Thackrey scale - knowledge	7
Modified Thackrey scale - Physical intervention	14
Modified Thackrey scale - Confidence	62
Modified Thackrey scale - Communication	18
Modified Thackrey scale - Safety	19
Modified Thackrey scale - Efficiency of techniques	15
Modified Thackrey scale - Fulfilment of tasks	74
Modified Thackrey scale - Security	19

The highest number of participants needed to achieve the needed power of a test was observed in the part of Modified Thackrey questionnaire regarding the fulfilment of tasks (the lowest observed effect of the training was observed in this subcategory). We conclude that the minimum number of participants in the study should be at least 74.

Conclusion

We can conclude that questionnaires are manifesting a good level of internal consistency (Cronbach's alpha >= 0.8) or excellent level of internal consistency (Cronbach's alpha >= 0.9). Guttman's lambda and McDonald's omega are in accordance with this conclusion (standard cut off is >=0.7) both measures are above that in all questions. Therefore, we conclude that questionnaires are internally consistent. The two tailed Pearson correlation tests with a significance level of $\alpha=0.05$ were performed.

The correlation between all but first part of Modified Thackrey scale and Thackrey scale are positive and statistically significant with high values of estimates of correlation coefficients. This suggest that the Modified Thackrey scale is consistent with original Thackrey scale. The correlation with The A global measure of perceived stress is lower and in majority of cases not statistically significant. We can state that our aims were verified. Further investigation is obviously required.

The Modified Thackrey scale – Vevera Pekara (MTS-VP) has not yet been related to actual clinician coping capacity, quality of clinical intervention, aggression incidence rates, and the like (such studies are currently in progress). Although the procedures just described have probably attenuated demand effects to the degree practicable in research of this kind, such a phenomenon can never be completely precluded in a self-report questionnaire. Although difficult to implement, alternative research strategies (such as observations during and interviews after actual episodes of aggressive patient behaviour) might also be used to assess staff confidence and other training effects. Although the pre-training/post-training gain in reported confidence is expected, we are not sure about significant gain in long term effect of our training intervention. If this pattern of effects proves to be replicable and valid, it may be that even a relatively brief training programme (two-day training) can have a robust, positive effect. We are sure that physical intervention motor skills might require periodic retraining or must be periodically supplemented with a brief physical technique refresher session could prove cost effective for a variety of mental health programmes and settings (21).

Educational goals

1. To examine the internal consistency of 3 questionnaires (Thackrey scale self-confidence, A global measure of perceived stress and Modified Thackrey scale – Vevera Pekara).
2. To verify the convergent validity of Modified Thackrey scale – Vevera Pekara with the original Thackrey scale.

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The experiences with the Simulation Education in psychiatry on prevention of violence

Paper presentation

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Keywords: Simulation / psychiatry / violence / training programme

Introduction

Experience of workplace aggression and violence directed towards healthcare workers in psychiatry is pervasive and there is need for education programmes aiming to prevent and minimize aggression and violence by improving the knowledge, attitudes, and skills of participants when facing verbal and physical violence by patients. The studies indicate that simulation method with real actors is an effective and appropriate education tool for these purposes. The main aim of the study is to describe the effect of the simulation training of psychiatry staff utilising simulation scenarios with actors and real patients and to evaluate the impact of the course on the confidence of psychiatry staff when dealing with violence.

This article describes a simulation training with real actors at the Bohnice Hospital (Prague, Czechia). This hospital is responsible for inpatient protective treatment of all types. The catchment area is approximately 1.2 miles, which covers 9% of the population and is demographically representative of the Czech patient population with protective treatment. The hospital offers forensic care in 36 medium secure beds, 35 low secure beds, and 18 low secure beds in a specialized ward with a sex-offender treatment programme (1).

The years ago, the hospital gained a Norway grant for a project: Practical training and procedures for managing crisis situations in care of children and adolescents with mental disorders in Bohnice psychiatric hospital. The reasons why we need that project is that from January 2018 to June 2020, there were 80 cases of children, or their carers being exposed to threatening situations in Bohnice psychiatric hospital. In the same period, restraints were reported

in 157 cases. Both issues were determined by analysing our own data. This project stems from the planned reform of psychiatry in the Czech Republic, where the National Action Plan for mental health 2020 – 2030 details the need for change in the education of health professionals. The goal is to build, by simulation training of entire medical teams, greater confidence in dealing with acute situations, and via a considerate approach reduce the incidence of cases. The simulations will operate in accordance with scenarios inspired by real events using child-like actors in a realistic environment, i.e., how medical teams would be forced to deal with those situations. First, we train 4 new lecturers of simulation medicine, create a methodology for the courses, and design 20 scenarios, e.g., self-harming, suicidal behaviour, aggression. The Simulation Centre, where courses will take place, will then be equipped and 3 child-like (adult) actors impersonating patients will be trained via internships in the children ward and by script rehearsals. Then we carry out a pilot course with 2 full teams from the children's ward.

Outcomes will then be used to realize 10 simulation courses, each of 12 hours (2 hours scene preparation, 8 hours course, 2 hours reaction feedback and further practice recommendations). Finally, we will verify course efficacy by comparative analysis of the occurrence of undesirable events and use of restraints after course completion and compare it with pre-project data (2).

As time goes, we did a preliminary pilot study for our simulation training during this project. The participants (120 psychiatric nurses) answered the questionnaire at the beginning of the course, immediately after the course (paper questionnaire) and 6 months after the completion of the course (an online questionnaire). All participants took part in a one-day course in the Simulation centre Bohnice hospital with real actors for prevention of violence. The course took 8 hours (2 hours of theoretical background about theory of violence and aggression and about de-escalation approaches), the remainder of the day was dedicated to simulation scenes with real actors.

Simulation may be particularly useful for training healthcare professionals in managing patients with mental health disorders in low-income countries or in places where very few psychiatrists are available. Moreover, it may enable the transformation of psychiatric training to adapt to changes in practices over the three past decades in many countries. Despite the change in emphasis from institutionalisation to ambulatory settings, psychiatric clerkships, internships, and residencies have remained inpatient based (3). Importantly, simulation is

an alternative to real patients (4). In the field of psychiatry, new conditions that require urgent clinical attention are behavioural and are different from other simulations in general medicine or surgery. Medical simulation in psychiatry is a relatively new field and continues to have ongoing development and changes. Simulation is used in the psychiatric community setting as well as with new mental conditions (5).

Simulation in psychiatry is not limited merely to the use of mannequins or even video training. Simulation in psychiatry also needs in vivo and human simulation to make the experience as realistic as possible. Simulated patients can produce the same as they provide in an environment where the learner can explore and understand the occurring psychiatric situation (6). There are opportunities for role play in psychiatry or the experience of learners attempting to simulate a real-life situation (7). Medical education in psychiatry has become more innovative, and different education systems in different countries have developed their curriculum around it.

The principal use for simulation is to improve formative training in psychiatry. Simulation as technical competence may be an opportunity to learn deliberative practice (8).

Methods

The simulation courses took place in year 2021 and 2020. Thackrey (1987) developed a psychometrically sound instrument for assessing clinician confidence in coping with patient aggression and for the evaluating the immediate and long-term effects of a training programme (Thackrey confidence scale in coping with patient aggression) (9). All course participants answered two questionnaires. The first one focused on their experience with violence in the past year – this questionnaire was used before the course or at its very beginning. The questionnaire was based on the World Health Organization questionnaire for the prevention of violence in the workplace in health care (10) and modified to better suit the actual environment (11). The second questionnaire was a Thackrey scale and participants answered it at the beginning of the course, immediately after the course (paper questionnaire) and 6 months after the completion of the course (an online questionnaire).

Results

The number of attendees in the observed period was 120, there were 20 males and 100 females. The group characteristics included: age; marital status [64,2% attendees (n=77) had partners and 35,8% (n=43) attendees were without partners]; level of education [26,7% (n=32) attendees with secondary nursing school, 45,8% (n=53) attendees with nursing specialization in psychiatry and 29,1% (n=35) attendees with a university degree]; staff category [100 % (n=120) nurses].

The WHO questionnaire about verbal and physical violence uncovered participants experiences with verbal (80 %) and physical violence or both forms of violence (20 %) in the year before the course. The attacker was most often a patient (70.8%) or a patient's relatives (29.2%); the assaults took place more during the night-time (60%) than during day shifts (10%). Participants also reported the risk factors that can increase the occurrence of violence towards the staff and simultaneously reduce patients' safety (6) in a health facility as followed: the absence of security workers (88.3%), a long delay when calling a doctor (76.7%), insufficient training in violence prevention (83.3%), shortage of health care staff (75%), unprepared restraints (73.3%), and a long wait for the treatment (29.2%) as the most frequent risk factors leading to violence.

We tried to examine the correlations between the selected variables. A factor that proved to be important was partnership (employees without a partner were more often involved in a violent situation). In terms of education, the most exposed to violence were the participants with secondary education (verbal violence 100%, physical 68.8%). In terms of profession, the most frequently affected were the medical orderlies and hospital attendants (experience of verbal violence was reported by 100% of the attendees in both groups; experience of physical violence was reported by 100% of the medical orderlies and 50% of the hospital attendants). The subsequent research focused on reported self-confidence during the contact with a violent patient. All course participants have achieved some improvement. The confidence scale has 11 items with the range of values from 1 (minimum feeling of confidence) to 11 (maximum) and the maximum score on the scale is 110. We registered an increase in reported confidence in the male group ranging from 53 points (48,1%) to 70 points (63,6%), and in the female group from 49 points (44,5%) to 88 points (80%). As regards the length of practice, significant progress was registered among the attendees with less than one-year practice (p=0.001). Among the attendees with 1-5-year practice

the progress ranged from 39 (35.5%) to 65 points (59.1%), in the 6-10-years practice group the progress ranged from 67 points (60.9%) to 79 points (71.8%), and in the group with practice between 11-20 years, the progress ranged from 65 points (59.1%) to 76 points (69.1%). The average increase in reported self-confidence among all attendees ranged from 46.3% to 71.5%.

Conclusions

The participants achieved the most significant progress in the areas of physical intervention during the contact with a violent patient and in their perceived self-confidence when facing a violent patient. This course utilising simulation proved to be beneficial to the participating healthcare providers regarding their confidence in managing violent situations and in preparing them better for practice.

Educational goal

Understand how a simulation training with real actors can advance education and training of staff.

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Seclusion and restraint: an online education platform designed to promote the integration of care standards

Paper presentation

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Keywords: Restraint / Seclusion / Education / Innovation

Abstract

Background.

There is an international consensus supported by the World Health Organization (WHO) on the need to reduce and ultimately eliminate coercive measures used to manage aggressive and violent behaviours1. Healthcare professionals feel the pressure of the responsibility to provide the best possible care when using seclusion and restraint. They face various obstacles to continuous learning and improvement, from the theory-practice gap to the shortage of time, staff, and facilities2-3. In a systematic review on the effectiveness of seclusion and restraint reduction programmes (REF plus bas), data use as a strategy demonstrating organizational leadership and training were identified as two of their key components. Indeed, nursing leaders and educators need to think of new strategies to maintain and improve the quality of care. This presentation describes online quality of care assessment platform developed to give nurses the opportunity to declare and reduce the use of seclusion and restraint while learning how to apply national standards of care to real life clinical situations.

Aims

This presentation outlines the essential methodological steps of a research protocol5 in nursing sciences to develop, validate, and test an online quality assessment platform.

Methods

The review and/or development of the nursing quality standards and indicators (1st step) was based on a realist method for literature synthesis6. The content validation of the quality indicators for chemical restraint was performed using a Delphi technique (2nd step). Both monitoring and self-assessment platforms were pre-tested on the field for face validity (3rd step). A snowball sample of experts in nursing was formed (validation) in the province of Quebec, Canada, followed by convenience samples of nursing clinical advisors (pre-testing both tools). Data analysis was based on quantitative and qualitative methods, including agreement proportions, Chi-square, Friedman test and content analysis.

Results

The two main tools integrated into an online platform will be presented: (1) IsoCont: a restraint and seclusion recording system, then (2) E-value-action: a quality assessment and care improvement tool. Sufficient content validity and face validity were found in the contexts of psychiatry, acute and long-term care facilities. Specific results of the completed research will be presented and recommendations for future research protocols will also be discussed.

It should be noted that the first operational and consensual definition of chemical restraint was provided to support the development of quality indicators.

Conclusion

This innovation in healthcare education and administration effectively promotes organizational transparency and the integration of care quality standards to the clinical practice, in addition to enhance the learning experience of the nursing staff. Seclusion and restraint reduction and self-assessment of care practices can improve health outcomes, promote safety and person-centred care in mental health facilities. A subsequent large-scale pilot testing of the two tools is recommended, including the translation and adaptation for cross-cultural analysis, to support the numerous English-speaking jurisdictions which, like Quebec, have established regulations concerning the reduction or exceptional application of coercive measures.

Educational goal

Understand the essential methodological steps of a research protocol5 in nursing sciences to develop, validate, and test an online quality assessment platform.

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Aggression management training in a Malaysian academic hospital: a Low-and-Middle Income setting cased-based model

Poster presentation

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Keywords: Training / Education / Managing aggression / Hospital

Abstract

Violence and aggression in healthcare settings within and beyond psychiatric units are critical incidents that require proactive strategies. Early career aggression management training for all healthcare workers should start at the undergraduate level. Targeted training aims to equip healthcare workers in managing aggression and preventing violence. The National University of Malaysia Medical Centre (UKMMC) runs a training programme for undergraduate medical students, postgraduate psychiatry trainees and mental health clinicians since 2015. The undergraduate training is a half day Team-based-learning (TBL) workshop, conducted 4 times per year. The postgraduate/ mental health clinician workshop is a 2-day workshop conducted annually. The training is knowledge and skills based. *'De-escalation'* techniques are emphasised to reduce physical restraint. Main challenges include translation

of training hours into effective clinical practice. Future goals for sustainable implementation of aggression management training in a resource-challenged setting include engagement of institutional stakeholders and formal evaluation of violence prevention and cost-effectiveness.

Summary

Training for the undergraduate students is conducted in a team-based learning (TBL) manner. It has been conducted 4 times a year. Students are required to go through the online module individually before the workshop. During the workshop, students are required to answer 8 one-best-answer (OBA) clinical scenarios. At first individually and later discussion in a group of 3 – 5 students. This will later follow by overall discussion with the facilitator. The second half of the training involves hands-on breakaway techniques follow by demonstration of manual restraint. Due to the COVID pandemic, training has been modified to be conducted online.

Training for postgraduate psychiatry trainees and healthcare workers were conducted within a 2-day workshop. Topics such as human rights, *'Quality Rights'*, mental health acts and regulation, understanding of violence and aggression, prevention and management, special care in child and adolescent setting, de-escalation techniques, breakaway techniques, manual restraint techniques, debriefing skills, incident reporting, documentation, and root-course analysis skills. The training was knowledge- and skills-based. Booster training was planned every 6 monthly to further enhance learning. This workshop was done yearly from 2015 to 2018. The pandemic had prevented in-person workshop for the last 3 years. The challenges in conducting such workshops would be to ensure practicality in under-resourced, real-world settings and translation of the learnt skills in daily clinical practice. Thus, booster training was recommended. However, in real, the brief booster training had managed to be carried out only twice for staff nurses in the psychiatric department.

These trainings are being conducted by a team consisting of psychiatrists, medical officers, and nurses. The next challenge would be to provide continuous training for the team members and training of new trainers. It has been challenging due to the rotation of the staffs to other department or hospital from time to time. However, it possible to restart the training programme again in the endemic era with the remaining core team members and the addition of new members.

As the hospital aims to achieve accreditation in health quality standards, a special code (code grey) for emergency response to aggression has been introduced. New challenges arise in how to level-up the response and training from department level to hospital level. Training at hospital level would need further collaboration with other stakeholders such as emergency medicine and security department.

Educational goals

1. By the end of the reading of the poster, viewers will be able to incorporate relevant elements of this aggression management training model in their clinical setting.
2. By the end of the reading of the poster, viewers will be able to develop early-career aggression management training in undergraduate medical curriculum.

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Implementation and use of Clinical Joint Crisis Plans in acute psychiatry; a nurse-led seven-step method

Interactive workshop

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Keywords: Clinical Joint Crisis Plan / Acute inpatient psychiatry / Nurse led interventions / Reduction coercive measures

Introduction

Active use of Clinical Joint Crisis Plans (CJCPs) is strongly recommended in acute inpatient psychiatry. However, it is a real challenge to consistently implement, use, and personalize a CJCP. We developed a seven-step nurse-led method (KSP7s) for designing a CJCP for admitted patients in acute psychiatry that can easily be applied to other acute psychiatric wards.

Clinical Joint Crisis Plans in acute psychiatry

A Clinical Joint Crisis Plan (CJCP) aims to empower patients and strengthen the therapeutic relationship while preventing degeneration of a psychiatric crisis and reducing coercive measures. It contains personal and patient tailored interventions that are linked to personal characteristics of the various phases of a psychiatric crisis. The use of CJCPs is strongly recommended or mandatory by coercion guidelines in western countries. However, it is a challenge to consistently implement and design a CJCP in acute inpatient psychiatric wards. A cooperation of Altrecht (Mental Health Institution) and Hogeschool Utrecht (University of Applied Science) was created to develop best practice for Clinical Joint Crisis Plans in acute inpatient psychiatry. The KSP7s project (KSP7s – *"Naar een Klinisch Signaleringsplan in 7 stappen"*) has been granted by the Dutch Government (ZonMw). We performed an extensive literature search on the intervention and implementation of crisis plans that formed the basis of our KSP7s method. The method was tested in a pilot study on four High & Intensive

Care psychiatric wards (Altrecht). All healthcare professionals (including nurses, social workers, peer workers and practitioners) of these wards were approached for an interview to review and improve the seven-step-method. Questions were analysed through thematic analysis on *'points of interest during implementation'*, *'tips and tricks'* and *'inspiring experiences'* and helped to improve the KSP7s-method. The project led to a useful KSP7s method and a guideline for implementation. The intervention and implementation of the KSP7s method can be easily applied in other (acute) inpatient psychiatric wards. Subsequently, a national *"learn- and knowledge network"* was established to disseminate this method in the Netherlands.

The developed KSP7s method consists of seven steps that guides the multidisciplinary team in designing a personalized CJCP for patients admitted in acute psychiatric wards. These steps include the use of developed standardized CJCPs and the involvement of peer workers, family members, in- and outpatient practitioners and the patient.

Conclusion

The nurse-led seven step method (KSP7s) is useful in designing a personalized Clinical Joint Crisis Plan for inpatients on an acute psychiatric ward. The CJCP can empower patients and strengthen the therapeutic relationship. The implementation and use of the CJCPs can reduce coercive measures and prevent degeneration of a psychiatric crisis. It is recommended to allow time for implementation of the method and invest in a dialogue between healthcare professionals, the patient, and their loved ones.

Educational goals

1. To gain knowledge and understanding of a personalized Clinical Joint Crisis Plan and be able to formulate the benefits of using CJCPs on (acute) inpatient psychiatric wards
2. Be able to describe the KSP7s method and how the method can be implemented and applied in (acute) inpatient psychiatric wards
3. Be able to give examples for tips and tricks for the implementation of the KSP7s method

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BoevenBeesten! Stimulating forensic vigilance in outpatient forensic settings through persuasive gaming

Creative contribution

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Keywords: forensic vigilance / persuasive games / education / forensic outpatient settings

Abstract

Fivoor Ambulant (a large forensic outpatient facility with several locations throughout the Netherlands) offers an extensive educational programme for therapists. Part of the programme contributes to improving the forensic vigilance of Fivoor staff. By forensic vigilance (Clercx et al.,2021) we mean the ability of therapists to recognise risks that patients pose to others (like aggressive behaviour) and respond to these risks appropriately. Most of the forensic vigilance training aims to improve individual knowledge and skills. However, forensic outpatient care is mostly provided by teams of therapists who depend on each other's expertise and knowledge of the patient. Therefore, forensic vigilance has collective aspects too. To raise awareness in teams about their collective forensic vigilance and motivate them to participate in our forensic vigilance educational programme, we developed the persuasive card game BoevenBeesten. Fivoor Ambulant developed the game in close collaboration with the Gamelab at Delft University of Technology.

Summary

Background

Fivoor Ambulant offers an extensive educational programme for therapists (social workers, nurses, psychologists, and psychiatrists). It includes e-learning, lectures, and workshops and training days. The programme aims to improve forensic knowledge, risk assessment, skills in forensic therapies,

and the treatment of patients. Our current forensic vigilance training focuses on individual therapists. However, as a main characteristic of forensic outpatient care, treatments are usually offered by multidisciplinary teams, consisting of therapists with different professional backgrounds and expertise. In addition to the individual forensic vigilance of its members, teams display collective forensic vigilance, meaning that the team members strengthen each other. Teams need to be aware of their collective forensic vigilance and the need for improvement. Only then teams may be motivated and benefit from the forensic vigilance educational programme.

Aims of our project

We developed the persuasive card game BoevenBeesten for teams to increase awareness of their collective forensic vigilance. Persuasive games (Bogost, 2007; De la Hera et al., 2021) provide a safe environment for players to reflect on their attitudes and behaviour. A well-known example is *'Poverty is not a game'* in which players experience living in poverty (Van Looy, Wouters, and De Grove, 2010). This game allows players to challenge their prejudices about the underlying causes of being poor. Due to their nature, games may be more persuasive than other types of media. For instance, De la Hera (2019) proposes that games persuade players through different channels, such as sonic, visual, narrative, procedural, cinematic, and social channels. In contrast, other media, such as leaflets or posters, offer fewer channels. Therefore, they may be less effective in encouraging audiences to reflect upon and alter their attitudes and behaviour.

Our game

The BoevenBeesten card game is played by teams of therapists in several rounds supervised by a game facilitator/trainer (professionals from forensic outpatient care who received game facilitator training). In the game, players are therapists at a fictional forensic outpatient mental health care institution in a fictional city inhabited by animal characters. Such a fictional setting may create a safer and more attractive learning environment than a realistic setting. Each round features an animal who receives forensic care and displays certain behaviour. The players/therapists must assess the forensic risk posed by the animal and respond appropriately. After the game, a debriefing session provides a transfer of learning from the game to the players' daily practice.

Educational goals

1. Participants in the demonstration of our creative card game will be able to identify the benefits of exploring attitudes, convictions, and behaviour in (forensic) risky situations through persuasive gaming.
2. Participants in the demonstration of our creative card game will be able to evaluate the added value of the use of a methaphore in an inspiring learning environment. When playing in a fictional world, creativity and having fun in learning is stimulated. The learning environment feels more comfortable and safer to explore, as opposed to the real (and sometimes harsh) world of daily clinical practice.

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Efforts to reduce coercion in Mental Health Services of Denmark by organizing and training staff

Poster presentation

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Keywords: Staff training

Abstract

The poster illustrates efforts to prevent and reduce coercion by training staff. Three different kind of staff instructors, all with an extensive experience in clinical psychiatry, teach and train new staff in how to prevent and reduce coercion.

New staff members participate in a mandatory course in how to prevent and reduce conflicts and the use of restraint consisting of 5 days split over a period of 6 months, from the beginning of their employment.

The staff instructors train the new staff through bedside teaching from day one in the wards and continuously on the mandatory course.

The instructors contribute to the content and dialogue on the mandatory course, based on the latest research and knowledge on reducing coercion, best practice, and recent identified challenges in the work to reduce coercion.

Summary

The poster illustrates efforts to prevent and reduce coercion by training staff. Three different kinds of staff instructors, all experienced in clinical psychiatry, teach and train new staff in how to prevent and reduce coercion.

Background

In the Mental Health Services - Capital Region of Denmark the overall strategy to reduce coercion is based on the six core strategies by Kevin Ann Huckshorn

(2011). One of his main strategies is workforce development with the aim to create an environment that is less likely to be coercive or trigger conflicts (Huckshorn, 2011). Therefore, all new staff in the Mental Health Services - Capital Region of Denmark participate in a 5-day mandatory course from the beginning of their employment. The training of the new staff and the development of the environment that is less likely to be coercive or trigger conflicts begins on day one of employment when new staff meet with the instructors in the ward.

3 different instructors:

Key instructor
A staff member with a minimum of 4-years' experience in clinical psychiatry teaches and trains new staff on the course. The key instructor participates in a 12-day educational programme each year to enhance their knowledge and teaching skills.

De-escalation coach
A staff member with a minimum of 3-years' experience who coach their colleagues through bedside teaching, reducing conflict and coercion. The de-escalation coach does bedside teaching on day, evening, and night shifts.

Local instructor
A staff member with a minimum of 2-years' experience, trains their colleagues in the local units to maintain the skills learned on the mandatory course.

Educational goals

1. The educational goal is to show a movement from a concept of using external teachers from outside the organization to a teaching concept where different instructors, with many years of clinical psychiatric experience train new staff in working with reducing coercion, through bedside teaching in the clinic as well as on mandatory courses.
2. The educational goal is to exchange experience and share knowledge through dialogue with co-workers around the world.

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Topic 21 – Application of new technologies (Artificial Intelligence, Augmented Reality, Virtual Reality)

Practical application of machine learning in forensic psychiatric research and its clinical implications

Paper presentation

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Keywords: Machine Learning / Schizophrenia / Forensic Psychiatry / Aggression / Adverse Treatment Courses / Ethics

Introduction

Artificial intelligence (AI) is increasingly being used in medical research. Ultimately, AI can be defined as any system that adapts its performance based on its perception of the environment. This includes advanced statistics such as machine learning (ML), which allows a variety of variables and their relationship to one another to be analysed through complex mathematical algorithms, as well as the quantification of the quality of a statistical model (1, 2). In psychiatric research, statistical analyses are usually performed with null hypothesis significance tests or basic regression models. However, the development of psychiatric diseases and pathological behavioural disorders is a complex, multifactorial mechanism not yet fully understood. Here, the application of ML offers new possibilities: large data sets with numerous

variables can be processed and complex and non-linear relationships can be analysed. After differentiated quantification of the quality of a suitable statistical model, simple and precise prediction models can be derived from complex data sets. Particularly, in psychiatric research, poorly understood phenomena and complex multifactorial issues are investigated, and their data structures are therefore well suited for the use of ML and can provide feasible models for everyday clinical decisions and for prediction of events in clinical courses (3, 4). In the following paper, we will present our analyses of predictors of inpatient aggression as an example of ML application in forensic-psychiatric research and give an overview over future developments of ML models.

Main Paper (5)

Inpatient aggression is a common issue in forensic psychiatric institutions. Violent behaviour may negatively affect patient care, cause distress for patients and staff and lead to injury. Ideally, patients with an increased risk of violence could be detected at an early stage and appropriate preventive measures, such as closer monitoring, could be initiated. However, aggression is a complex construct with multifactorial aetiology, which has yet to be comprehensively understood. Due to its ability to analyse many influencing factors and their interactions, we used a suitable machine learning model on a dataset of 370 patients aiming to explore inpatient aggression in offender patients with schizophrenia spectrum disorder (SSD). With a balanced accuracy of 77.6% and an AUC of 0.87, support vector machines (SVM) outperformed all the other ML algorithms.

Negative behaviour toward other patients, the breaking of ward rules, the PANSS score at admission as well as poor impulse control and impulsivity emerged as the most predictive variables in distinguishing aggressive from non-aggressive patients. The present study serves as an example of the practical use of ML in forensic psychiatric research regarding the complex interplay between the factors contributing to aggressive behaviour in SSD. Through its application, it could be shown that mental illness and the antisocial behaviour associated with it outweighed other predictors. The fact that SSD is also highly associated with antisocial behaviour emphasizes the importance of early detection and sufficient treatment.

Discussion

Psychiatric disorders and resulting behavioural problems are complex phenomena driven by various, often interdependent factors. ML as modern statistical approach offers the possibility of more accurate analyses. We used this approach to examine over 500 variables of a population of Swiss offender patients with SSD in inpatient treatment, e.g., inpatient aggression as presented in our main paper. These variables included a variety of biographic, psychiatric, and treatment-related data. Results showed that different difficult treatment courses were all based on basically similar predictors: biographical information (e. g. age of onset of illness, substance misuse), severity of illness according to PANNS, and antisocial behaviours in the past. The models achieved notable AUC above 0.75 (6-11). Based on the findings from our current research, the authors are currently verifying the identified predictors of adverse treatment courses and complications (e. g. self-harm, inpatient aggression, escape and absconding) prospectively. The results will be compiled in a screening tool (Rheinau Inventory for the Prediction of Treatment Outcome in Schizophrenic Offender, RIPTOSO). If implemented, this tool may help in preventing complications, improving resource allocation, and decreasing the likelihood of difficult treatment courses. However, clinicians and researchers both need to be mindful of possible pitfalls and ethical implications of the application of ML models in clinical practice: At which point is an algorithm for assessing the risk of violence good enough for psychiatrists to derive consequences from it? Is a screening tool based on artificial intelligence in fact helpful in preventing unfavourable courses of therapy? Or does it stigmatize patients already prone to experience resentment? For patients as well as for practitioners, it is important to create a value system suitable for the application of ML.

Educational goals

1. Understand the application of machine learning to predict violence in mental health services
2. Examine the possibilities and pitfalls of using ML to predict and address violence in mental health services

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Wearables: R Package for Signal Analysis of a Wearable Device Targeted at Clinicians and Researchers

Paper presentation

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Keywords: Physiological reactivity / Psychosocial and Neurobiological integration / Forensic Psychiatry

Abstract

Physiological signals (e.g., heart rate, skin conductance) that were traditionally studied in neuroscientific laboratory research are currently being used in numerous real-life studies using wearable technology. Physiological signals obtained with wearables seem to offer great potential for continuous monitoring and providing biofeedback in clinical practice and healthcare research. The physiological data obtained from these signals has utility for both clinicians and researchers. Clinicians are typically interested in the day-to-day and moment-to-moment physiological reactivity of patients to real-life stressors, events, and situations or interested in the physiological reactivity to stimuli in therapy.

Researchers typically apply signal analysis methods to the data by pre-processing the physiological signals, detecting artifacts, and extracting features, which can be a challenge considering the amount of data that needs to be processed. This paper describes the creation of a *"Wearables"* R package and a Shiny *"E4 dashboard"* application for an often-studied wearable, the Empatica E4.

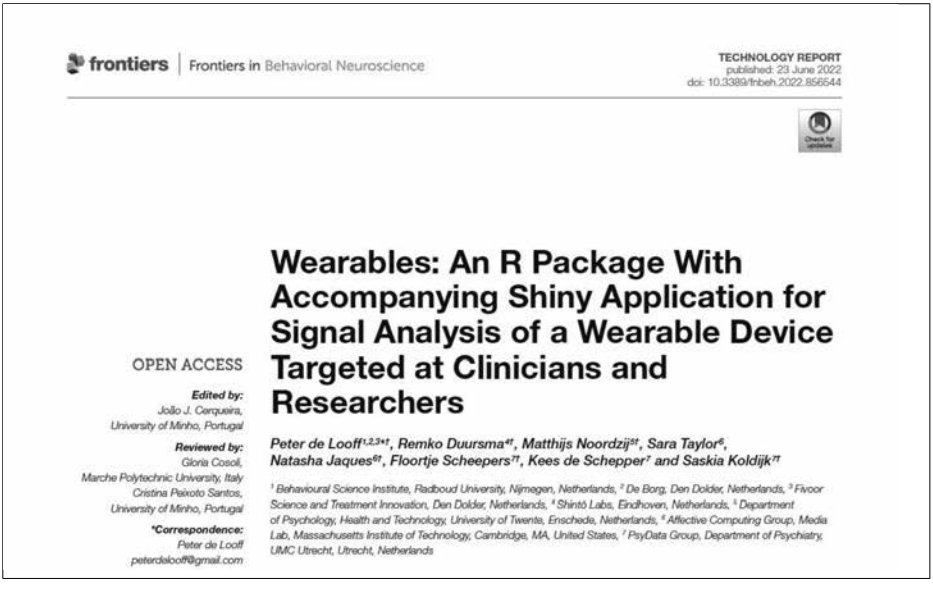
Summary

The software and application can be used to visualize the relationship between physiological signals and real-life stressors or stimuli, but can also be used to pre-process physiological data, detect artifacts, and extract relevant features for further analysis. The software accommodates users with a downloadable report that provides opportunities for a careful investigation of physiological reactions in daily life. Wearables seem to hold great potential for healthcare in disease monitoring, predict risk for dangerous behaviour, or provide continuous feedback

to stimulate emotional awareness and behavioural change. However, wearables also hold promise as an additional tool in the clinicians' current toolbox to provide opportunities for in-depth and careful investigation of physiological responses in daily life. This might be especially useful if clinicians do not see their patients daily, and therefore, most of the patients' physiological reactions in various daily life activities are hidden from the clinician.

Educational goals

1. Discuss the use of wearable technology in psychiatric treatment.
2. Integration of neurobiological information in psychiatric treatment.
3. Common pitfalls in working with wearable technology and neurophysiological information.
4. Learn how the open-source application can be used in clinical practice.
5. Learn how to associate psychosocial information with neurobiological information to discuss with patients and clients.
6. Clinicians can learn how to study the day-to-day and moment-to-moment physiological reactivity of patients to real-life stressors, events, and situations or carefully study the physiological reactivity to stimuli in therapy.
7. Researchers can learn about pre-processing physiological data, detect artifacts and extract features while also batch-process the (often large amounts of) information.



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Wearables: An R Package With Accompanying Shiny Application for Signal Analysis of a Wearable Device Targeted at Clinicians and Researchers

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Topic 24 – Covid-19 pandemic and violence (lockdown, confined environments, domestic violence, coercion, deprivation of treatment, suicide, and self-harm)

Domestic violence against children and adolescents in the Covid-19 pandemic in Brazil: a qualitative approach

Paper presentation

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Keywords: Domestic violence / Children / Adolescents / School health

Introduction

Violence against children and adolescents remains a challenge in low-income countries. According to the World Health Organization (WHO), violence is characterized as the intentional use of force or physical power, real or threatening, against a person, group, or community, which results in or has a high possibility of resulting in injury, death, psychological damage, deprivation, or alteration in development (1). Due to the specificities of the phenomenon, it affects some groups more severely that are considered vulnerable, such as children and adolescents. In Brazil, accidents and violence appear as the leading causes of mortality in children over one year old and adolescents. In addition, violence commonly occurs in a space of trust, responsibility, or power relationships – the domestic or intrafamilial context. In this study, we will use the term domestic violence (DV)(2).

The health emergency caused by the COVID-19 was characterized as a pandemic by the WHO in early 2020. One of the main recommendations and strategies of the international health agencies to prevent or reduce viral circulation and consequent disease was lockdown and, consequently, social isolation (3). International (4-5) and national (6-7) studies confirm the rise in violence against children and adolescents due to vulnerability, stress, economic shock, and social isolation to contain the spread of the SARS-CoV-2 virus (4-8).

Given the remaining gaps in the scientific literature, this study explored the perceptions of education professionals and families from a high social vulnerability area in Brazil, about violence against children and adolescents during the COVID-19 pandemic. The paradigm of complexity was be used as the theoretical framework. It proposes the approach of what is *'woven together'*, which implies considering the different and sometimes contradictory parts articulated in the phenomenon composition, inserted into a context in a dialogical perspective (9).

Methods

The authors used qualitative social research approaches (10) that are anchored in the Paradigm of Complexity. The methodological approach was guided by the notions of understanding and contextualization (9).

The location was a medium-sized municipality, a technological pole in the centre of the state of São Paulo, Brazil. It has 221,950 inhabitants according to the 2010 census, with an estimated population of 249,415 inhabitants in 2018. The specific field was a district with approximately 80,000 inhabitants. A school in this district was selected, characterized as a group exposed to high social vulnerability for an urban sector, being classified as category 5 (five) according to the 2010 São Paulo Social Vulnerability Index. The school has students from the first grades of elementary school to the last years of high school, with a total of 18 classes in both shifts and 578 regular enrolments.

The study participants were education professionals who had contact with elementary and high school students and families. The inclusion criterion was having access to the Internet and the consent criterion was met through the TCLE (Portuguese for *"Free and Informed Consent Form"*).

The participants (families) were invited online (WhatsApp), according to the suggestion and availability of contacts by the school board, data collection was also carried out via this virtual platform. In total, 15 professionals were invited to participate in the research, but only 7 of these agreed. Nineteen families were invited and agreed to participate, but only ten completed the interviews. The TCLE was included in the free online Google Forms platform, to be read by the potential participant after initial contact by the researcher using WhatsApp and expression of interest by the professional/family member.

Semi-structured interviews were used as data collection. To characterize the participants, a questionnaire was used via Google Forms. The interviews were conducted between September 2020 and May 2021 and lasted around 25 minutes. They were recorded in a mobile audio recording application and transcribed in full. The professionals were identified sequentially, in the order of the dates of the interviews with the letter *"P"* to represent professionals (*"P1, P2, P3..."*); for the family members, the letter *"F"* was used, and they were numbered similarly.

In this study, it was decided to seek code saturation; this was defined when no additional elements appear to answer the study question and these elements are understood (9). The participants' characteristics were presented by means of descriptive statistics. The data were analysed through the reflexive thematic analysis proposed by Clarke and Braun (11).

The research project was approved by CEP-UFSCar under the CAAE number 09272919.4.0000.5504, report No. 3,215,561, dated March 22nd, 2019, respecting the criteria set forth in Resolutions No. 466/2012 and No. 510/2016 of the National Health Council.

Results and discussion

The professionals were seven teachers in the fields of mathematics, geography, languages, chemistry, history, and physical education. The majority was aged between 31 and 40 years old (n=3, 42.8%). Four of the teachers had up to 6 years of training (57.15%) and the rest had more than 12 years of study.
Ten parents, participated in the interviews. The majority were between 41 and 55 years old (50%, n=5) and women (80%, n=8). Among the 10 interviewees, three had incomplete elementary school education, two had incomplete high school, and five had completed high school degrees. In addition, four participants were

married, two were single, one was divorced, and two declared a stable union. In the colour/ethnicity category of the participants, one declared himself/herself as indigenous, one as white, two as black, and six as brown.

Two final themes emerged: *"Violence and Covid-19 times: a new enemy"* and *"(Non)accessibility"*. In the first reported theme, due to the specificity that violence occurs more frequently in families, the life changes imposed by the pandemic, especially distancing from school, can lead to an increase in the number of DV against children and adolescents: [...] I'm sure that this has even doubled, most of them are in a situation of vulnerability and already lived ... in this environment of conflicts, added to this situation of the pandemic, lack of work, addictions, in short, this has certainly doubled (P4). I believe that the issue of violence has increased too much, especially this year, after almost a year and a half, I believe that many children, including children that we live with, have witnessed acts of violence, violence against them, violence against someone in the family… (F9).

The participants reported ambivalence, with a *"good and bad side"*. Children and adolescents stayed at home more since the pandemic started but they are more exposed to violence as well - a good thing was that it increased the interaction between the family and everybody at home, the bad thing is they cannot go out, they cannot do anything, so I think they became more anxious... (F1).

In this scenario, not only children and adolescents' mental health was affected, but also families' mental health; living in a high social vulnerability area in a less developed country can increase poverty rates. (...) mainly because we have many students with parents who are alcoholics, drug users, right? So, I think it was like a pressure cooker about to explode all the time, right? Because everybody, a lot of people indoors sometimes in small houses, with people sometimes drinking, using drugs, everyone together all the time, so I think it has been increasing. We saw cases of students in hunger situations so I think this must have also influenced a lot, you know? (...) (P6) As the children stay at home, and we also stay at home, and many times the father or mother gets angry and ends up spanking, I think this has increased a little (F3).

Studies have exposed the increase in violence against children and adolescents during the pandemic, despite underreporting (5-7). Being in a country with a high prevalence of inequities, living in regions of high social vulnerability,

can impact these situations (7). Moreover, such elements have a considerable impact on the mental health of families, who are farther from their social support networks and are more prone to psychological illnesses (8,12-13).

In the second theme, the professionals reported greater difficulty to identify violence against this population, because almost all types of violence against children and adolescents are perceived by school professionals. Because, unfortunately, in the school, we are the only contact of the State with this type of child, right? If we see that the child has some bruise, or that something strange happened, or that the student speaks to someone, it is through the school that we can trigger this, right? (P3)

The families reported difficulty in accessing health, education, and welfare services during Covid-19. In addition, they talked about the fragility of Brazilian public policies, besides being quite hard to access channels to report violations in the community. One of the suggestions I would give is having a little easier access to help when we need it, because, for example – today, because of the pandemic, depending on the police station you go to open an occurrence report, it is online, you go to the clinic to get psychological help and they have a reduced schedule... (F6).

School has been recognized as a primordial space in the lives of children and adolescents, beyond its educational function. Feeding, hygiene, and social protection functions have been reported in the international literature (14). Furthermore, at the same time, there is an increase in cases of DV, and several studies highlight a reduction or temporary closure of government services related to health, education, social protection, third sector, and community that welcome, identify, notify, and take care of children, adolescents, and their families involved in DV (12).

Finally, the Paradigm of Complexity recognizes the necessity to look at the DV phenomenon from a multidimensional perspective. The pandemic brought instability to all lives, but the most affected were certainly the most vulnerable and developing ones, such as children and adolescents (9). Interprofessional efforts must be made to overcome these situations, aiming for a healthy future for children, adolescents, and their families.

Conclusion

Despite the understanding of greater exposure to violence during the pandemic, the experiences showed there were no actions taken to protect children and adolescents. Furthermore, the families and communities should be empowered and mental health practices for them must be improved to support the care of children and the youth population.

Educational goal

Understand the impact of the Covid-19 pandemic on the health and well-being of vulnerable children and adolescents in socially and economically disadvantaged communities in Brazil

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Stigma and violence against healthcare workers during the COVID-19 pandemic and their mental health

Paper presentation

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Keywords: COVID-19 / violence / stigma / mental health / health care workers

Introduction

Stigma associated with COVID-19 poses a serious threat to the lives of healthcare workers, patients, and survivors of the disease (1). Aggression and violence are serious issues in health care area, where safety of both patients and staff need to be protected (2). The terms aggression and violence are often used interchangeably, consistently with our previous research (3, 4) as well as other studies (5) we use the term aggression for threatening behaviour, whereas violence involves physical harm to others. Health care staff are more vulnerable to workplace violence (WPV) than other professions (6). Moreover, studies show that emergency department workers and staff in psychiatry are at a higher risk for discrimination and violence, compared to workers in other health settings.

The increase in stigmatisation, discrimination, and violence towards healthcare workers during the COVID-19 pandemic highlights the urgent need to understand, prevent, and address these events, especially during pandemics. While high levels of psychological and physical WPV toward hospital workers during the COVID-19 pandemic has been studied in various countries (7), the

occurrence of WPV in Czech healthcare area during this period has not yet been assessed. Hence, our aim was to describe the association between exposure to stigmatization/discrimination, and violence against healthcare providers and their mental health during the COVID-19 pandemic in the Czech Republic.

Methods

Respondents were healthcare professionals (physicians, nurses, emergency medical technician and social workers) in the Czech Republic enrolled in one of the two waves of an international, multicentre prospective cohort study" The COVID-19 HEalth caRe wOrkErS" (HEROES)", which was supplemented with qualitative data from open ended questions. The first wave occurred in summer 2020 (n= 929) and the second during a large COVID-19 surge in the spring of 2021 (n=1206). Our main predictors were 1) experiences of stigma/discrimination and 2) experiences of violence due to being a healthcare worker during the pandemic. Three binary indicators of mental health were derived. First, an indicator of moderate level of psychological distress was operationalized based on scores from the Generalized Health Questionnaire (GHQ-12). Second, the presence of at least moderate depressive symptoms was derived from the Patient Health Questionnaire (PHQ-9). Third, the presence of suicide ideation was operationalized based on two self-reported items from the Columbia Suicide Severity Scale and one item in the PHQ-9. We obtained odds ratios (ORs) from logistic regression models within each wave to describe the relationship between the predictors and mental health outcomes. All models were adjusted for age, sex, and occupation.

Results

A similar proportion of respondents in each wave endorsed feeling stigmatized or discriminated against due to their profession (wave 1: 29.6%; wave 2: 26.2%). Experiencing violence was slightly higher at wave 2 (wave 1: 4.5%; wave 2: 5.1%). In both waves, exposure to stigma/discrimination was associated with substantially increased risk of at least a moderate level of psychological distress (wave 1 OR: 2.72 & wave 2 OR: 1.71), moderate depressive symptomatology (wave 1 OR: 3.44 & wave 2 OR: 2.38), and suicidal ideation (wave 1 OR: 3.55 & wave 2 OR: 2.02). The strongest observed association was between exposure to violence and suicidal ideation in the second wave (OR= 3.63; 95% CI: 1.83 to 7.22). Analysis of qualitative data revealed that healthcare workers experienced stigmatization and discrimination in families, leisure time activities, side jobs,

public life, and education of children. Violence was largely verbal aggression by patients and their relatives.

Conclusion and Discussion

Recent systematic reviews and meta-analyses and the World Health Organization condemnation of the attacks and discriminations against HCWs treating patients with COVID-19 have confirmed the seriousness of the situation regarding violence against doctors and nurses worldwide (8). Exposure to stigmatization/ discrimination or violence against healthcare workers (mainly physicians and nurses) was also reported in studies conducted in Switzerland (50 %), Germany has experienced severe discrimination and aggression towards 23% of primary care physicians, in Italy 50% of nurses were discriminated against in the workplace, 11% experienced physical violence, 4% were threatened with a weapon; 50% of physicians were verbally, and 4% were physically assaulted, in Poland many nurses have been physically attacked or discriminated in the workplace (7,8).

Various factors may be driving stigma, discrimination, or violence against healthcare workers during the current pandemic. First, healthcare workers were feared for spreading the disease (9). Second, inadequate resources (ICU beds, oxygen tanks, ventilators) to admit or treat patients with COVID-19 generated anger (10). Third, misinformation about the COVID-19 pandemic, especially when too much information, including false or misleading information in digital and physical environments during a disease outbreak (referred to as *'infodemics'*), led to panic, anxiety, and deep mistrust (11). Fourth, pre-pandemic problems such as bureaucracy, long waiting periods, inappropriate waiting areas, and a lack of communication with healthcare workers exacerbated as the pandemic progressed, with the pandemic fatigue and frequent changes in regulations (12). During the first wave of the COVID-19 pandemic, healthcare workers were applauded as heroes (8), but patients (and the public) no longer express their appreciation to the same extent. The COVID-19 pandemic presented new challenges and stressors for healthcare providers, including increased stigma and discrimination due to possible exposure to the virus. Violence and discrimination against healthcare workers was strongly predictive of poor mental health during the COVID-19 pandemic. The reasons people attack healthcare staff during health emergencies are many (e.g., fear, panic, misinformation, mistrust, etc.) and vary according to local contexts (14).

Implementation of intervention strategies to improve mental health of health care workers should be examined in future research.

Acknowledgements

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Educational goals

1. Understand the impact of the Covid-19 pandemic on violence and aggression towards mental health care workers in the Czech Republic
2. Examine the predictors of violence and aggression towards mental health workers during the Covid-19 pandemic in the Czech Republic.

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Coercion in inpatient psychiatric treatment during the Covid-19 pandemic in the Rhineland region, Germany

Paper presentation

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Keywords: Covid-19 pandemic / coercion

Abstract

We performed a retrospective analysis of the use of coercive measures in a large psychiatric hospital association in North Rhine-Westphalia (NRW), Germany, before and during the Covid-19 pandemic. We found an overall decrease in case numbers but increases of cases with involuntary hospitalisation due to Mental Health by 5% and cases with seclusion by 20%. Rates (relative numbers) increased from 12% for restraint and 22% for involuntary hospitalisation to almost 40% for seclusion.

These trends may reflect poorer mental health of the general population and/or deficits in outpatient mental health care during the Covid-19 pandemic. However, they may also reflect changes in inpatient mental health care including the impact of the need to enforce hygiene measures in acute psychiatric wards. Understanding the reasons for these trends may help us organize inpatient mental healthcare services in such a way that the quality of care returns to the pre-pandemic level.

Summary

Background: Anecdotal observations suggest that coercion in inpatient mental health care may have increased during the Covid-19 pandemic. However, empirical evidence is scarce and contradictory.

Aims: To analyse inpatient mental healthcare including the use of coercive measures in a large psychiatric hospital association in North Rhine-Westphalia (NRW), Germany.
Methods: We used the statistics database of the hospital association of the Rhineland Regional Council (Landschaftsverband Rheinland, LVR) in NRW. The nine psychiatric LVR hospitals provide mental healthcare services to 4.4 million inhabitants, i.e., to approximately half of the population of the Rhineland. The services delivered are representative of mental healthcare services in Germany. In a retrospective observational study, we compared the pandemic period from January 1, 2020, until June 30, 2021, with the pre-pandemic period January 1, 2018, until June 30, 2019. We analysed case numbers, changes in diagnostic spectrum and changes in cases and rates of coercion (involuntary hospitalisations according to the North Rhine Westphalia Mental Health Act, restraint, and seclusion).

Results: Case numbers decreased from the beginning and throughout the whole COVID-19 pandemic period. The average decline was 12.5 %. Changes varied between diagnostic groups, and there were increases of case numbers for acute psychotic disorders. We found a slight increase in absolute numbers for cases with involuntary hospitalisation according to the Mental Health Act by about 5% and a more marked increase for cases with seclusion by about 20%. The rates (relative numbers) increased for all three coercive measures ranging from about 10% for restraint, to almost 40% for seclusion.

Conclusions: The COVID-19 pandemic led to reductions of inpatient psychiatric hospital admissions and changes of the diagnostic spectrum accompanied by increased rates of coercive measures. In part, these effects may reflect an overall higher severity of mental disorders during the COVID-19 pandemic, or deferrals of inpatient admissions until a relatively high case severity was reached, or lower utilisation of outpatient mental healthcare services. In addition, they may reflect changes in inpatient mental health care including the impact of the need to enforce hygiene measures in acute psychiatric wards. Understanding the reasons for this critical trend may help us organize inpatient mental healthcare services in such a way that the quality of care returns to the pre-pandemic level.

Educational goals

1. To learn which is the empirical evidence for changes in coercion in inpatient mental health settings during the covid-19 pandemic.

2. To understand how the covid-19 pandemic may influence both outpatient and inpatient mental health care and how these changes may lead to increased use of coercion in inpatient mental health settings.

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A preliminary study of bullying on university campuses in Taiwan.

Poster presentation

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Keywords: adolescent / bullying / gender

Abstract

According to the COVID-19 pandemic progress, the increase in distance learning and online communication, the Children's Welfare Alliance survey (2021) shows that 36.3% of children have been bullied online in Taiwan, and the call for help with self-harm or suicide attempts was higher year by year during 2019-2021. It is generally believed that university students are relatively mature and have more freedom in taking courses. They believe that there are few bullying incidents that need attention on university campuses. An online questionnaire survey was administered to 2583 university students, 2570 of whom responded. Results show a relatively high incidence of bullying among respondents, with gender being a key factor in bullying incidents. The results suggest faculties should take immediate action to address bullying on campus. Campus bullying has a long-term impact on students' physiology and psychology and causes wider social problems. After a bullying incident, victims often show negative emotional changes and decreased impulse control, which causes them substantial harm.

Summary

Background

Campus bullying has long-term effects on students' physiology and psychology and could extend to society and become a wider social problem.

Aims

To understand patterns of bullying incidents on university campuses in Taiwan.

Method

An online survey of university students on campus experience and interpersonal Interactions was conducted.

Result

From 2570 valid responses, the incidence of verbal bullying was 38%, 42.9% of those surveyed declined to answer items in about their gender and bullying linked to it. Among those who had personally experienced bullying, it took several forms: *"the teacher used an object or their body to beat a certain part of my body"* (p=.000); *"suffering nicknames or joking about body and appearance"* (p =.012), *"spreading false rumours or personal slandering behind people's backs"* (p=.024), *"playfully imitating one's own voice or behaviour for the purpose of ridicule"* (p=.003), *"the teacher used words that insulted me"* (p=.013); it was *"deliberately framed to maliciously destroy my relationship with others"* (p=.009) and cyberbullying: *"posting my secrets and personal matters on the Internet without my consent"* (p=.000). Overall, gender was shown to be a statistically significant factor in students' experience of bullying (p=.017).

Conclusion

Bullying exists in different types of experiences on university campuses in Taiwan. The results suggest faculties should take immediate action to address bullying on campus.

Educational goals

1. To understand the effect of bullying on university students in Taiwan
2. To examine the link between gender and bullying in university students in Taiwan.

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Topic 25 – Other related themes

Self-harm on a closed psychiatric ward

Poster presentation

Anneke Jaspers, Fivoor / Parnassiagroep, The Hague, Netherlands; Nienke Kool

Keywords: Self-harm / Aggression / Closed ward

Background

Self-harming behaviour is a frequent problem seen at patients admitted to closed wards in psychiatric hospitals. People who self-harm have a higher risk of other forms of aggressive behaviour. Little is known about prevalence and characteristics of this behaviour in closed wards in the Netherlands, the preceding triggering factors, and the relationship with other aggressive behaviours.

Aims

To gain insights in the self-harming behaviour and the relationship of self-harm with other aggressive behaviour of patients admitted to a closed ward in a psychiatric hospital.

Methods

From September 2019 till January 2021 information on self-harming incidents and aggressive behaviour towards others or objects, of 27 patients admitted to the closed ward of the Centre Intensive Treatment (Centrum Intensive Behandeling), a specialist clinic on disrupted behaviour, was gathered. The Self-Harm Scale (SHS) and Social Dysfunction and Aggression Scale (SDAS) were used to gather the data.

Results

Descriptive analysis, Chi-square tests and Mann-Whitney test were used for the analysis of the data. Twenty of 27 patients examined (74%) showed self-harming behaviour. A total of 470 incidents were registered, an average of 23 incidents per patient (range 1 – 230). Head banging (40.9%) and self-harming using straps/ropes (29.7%) occurred most. Tension/stress as triggering factor was mentioned most (19.1%), followed by reliving (13.2%) and team interaction (11.5%). Self-harming behaviour occurred more in evenings. No statistically significant difference was found in the degree of aggressive behaviour towards others or objects between the group of patients harming themselves and the group that didn't.

Conclusion

The prevalence of self-harming behaviour is high in this specialist clinic. The most frequently used method is head banging and using straps/robes, with differs from most other studies. Patients admitted to a closed ward are confronted with many restrictions and imposed rules, therefore we expected to find an interaction as an important trigger for self-harm. Instead, tension and stress were mentioned most as triggers. There was a remarkably high overall score on the SDAS for the total sample. Therefore, staff working at this clinic is frequently confronted with different forms of aggressive behaviour, which can lead to stress (Schablon et al. 2018) and diminished physical, psychological, and emotional functioning (Lanctôt & Guay, 2014). Taking care of staff is necessary to enable them to take good care of the patients.

Educational goals

1. At the end of this presentation, you will know the prevalence of self-harming behaviour and the circumstances under which they occurred on a closed psychiatric ward in a specialized psychiatric clinic
2. At the end of this presentation, you will know why it is important to take care of staff who is confronted regularly with patients who react with different forms of aggressive behaviour, and you have some ideas about how you can do that.

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Police operations involving people with severe mental disorders.

Paper presentation

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Keywords: stigma / police / coercion

There is still a great stigma attached to mental illness today and media reports are often characterized by stereotypes of high levels of violence and dangerousness. Police operations involving mentally ill people represent a significant part of police activity and are associated with special demands on the police officers. Due to the vulnerability of the persons concerned, the use of coercion in the context of such operations should be considered in more detail. However, unlike among psychiatric professionals, this seldom happens in police work. Previous research suggests that police officers are not sufficiently trained in dealing with mentally ill persons, which makes a level-headed and unprejudiced approach in escalating situations even more difficult and can end up being life-threatening for the people concerned. To involve an additional professional group in addition to the viewpoint of police officers, who are frequently involved in such operations, mental health professionals from a psychiatric hospital were interviewed as part of a master's project. Mental health professionals are not only experts in dealing with mentally ill persons, but also sensitized to the use of coercive measures. The aim of the thesis was to work out possible opportunities as well as deficits in police operations with mentally ill persons and to capture evidence for improvement from these descriptions as well as from supplementary interviews with police officers. For example, there was a need for greater DE stigmatization of mental illness among police officers, including the provision of sufficient specialist knowledge and a reflection on how to deal with power and authority. In the use of coercion, it became clear that the way coercion is used can also influence the further course of the case and the processing by the person concerned in the sense of procedural justice. But also, the cooperation and the relationship between police and psychiatry showed a need for improvement on both sides, especially about communication and mutual understanding.

Educational goals

1. After attending this talk, participants can understand the role of police work in the context of mental health care, especially the use of coercive measures.
2. After attending this talk, participants can assess the difficulties that arise from the lack of training of police officers and stigmatization regarding people with mental disorders

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Supporting Organisations

Oud Consultancy

EViPRG
European Violence in Psychiatry Research Group

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Prof. Patrick Callaghan
Dr. Roger Almvik
Assoc. Prof. Frans Fluttert
Prof. Sabine Hahn
Mr. Trond Hatling
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