Patrick Callaghan – Tom Palmstierna – Henk Nijman - Nico Oud

Proceedings of the 5th European Congress on

VIOLENCE IN CLINICAL PSYCHIATRY

KAVANAH

Violence in Clinical Psychiatry

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Editors

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Introduction

I would like, in my capacity as Chairman of the European Violence in Psychiatry Research Group (EViPRG), to welcome you to this 5th. European Congress on Violence in Clinical Psychiatry. EViPRG is pleased to support this major international event and we anticipate that three interesting and inspiring days lie ahead.

Violence in mental health services and the measures used by staff to prevent and therapeutically manage it have now moved up the national agenda in many countries around the world. We are all aware that some mental health problems are associated with an increased risk of violence and that violence by some service users has a serious negative effect on other service users, on care staff and on the general public perception of people with mental health problems. It also significantly restricts the liberty and life chances of the perpetrator. Furthermore, we know that practitioners working in mental health services around the world are committed to trying to deal safely and effectively with violence directed against themselves and others. Now we are learning much more as well about how to move away from reliance on highly coercive measures such as restraint and seclusion toward more collaborative and preventive measures. This is based on a better dialogue between practitioners and service users, an important development which will be reflected in some of the presentations here.

Violence is an intractable and hugely complex problem with roots in the brain, the mind and the way society operates. We will learn here from the work of researchers studying at all three of these levels and from practitioners working in all the disciplines that make up a comprehensive high-quality mental health service. It is paradoxical that whilst the expression of violence and ideas on its therapeutic management vary widely across cultures, we all share a common goal of reducing violence and coercion in mental health services and will gain much from hearing about cutting edge developments from around the world.

Once again, welcome to this event and I hope that you will return to your service recharged with new ideas for moving toward this common goal.

Richard Whittington

Preface

Proceedings of the 5th European Congress on Violence in Clinical Psychiatry Best Evidence Based Practice: "Prevention, Treatment and Management of Violence at the Individual, Institutional and Governmental Level". 25 – 27 October 2007.

This book contains the expertise and information provided by the contributors to the 5th European congress on Violence in Clinical Psychiatry. The volume of the book clearly suggests a marked increase in scientific interests and research initiatives in the last few years on how to prevent and manage violent behaviour within mental health settings.

The large number of participants and contributions to the European congresses on Violence in Clinical Psychiatry, however, also seem to reflect the severity of the problem violence poses for people working in mental health; it is one of the major occupational health hazards they face. Repeatedly hostile and violent behaviour in patients will be often a major impediment to successful rehabilitation and treatment.

The expanding number of participants and scientific contributions to these biannual congresses on violence in clinical psychiatry further suggests that psychiatric practitioners and researchers put great value in being able to share expertise on how to manage aggression across disciplines and borders. We feel that the strong traditional focus of these European violence congresses on practical, clinically relevant interventions is very visible in these proceedings and we are very grateful to all who made the 5th European congress on Violence in Clinical Psychiatry into a sound collection of "evidence-based best practices". We hope these proceedings will be helpful in improving the care and quality of life of patients who exhibit aggression whilst using mental health services.

Patrick Callaghan
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Content

1. – Keynote 1 – Violent behaviour by people with schizophrenia: causes and remedies

Prof. Sheilagh Hodgins (Head of Department of Forensic Mental Health Science, IOP London)(UK)

The prevalence of criminality among persons with severe mental illness

Persons with severe mental illness (schizophrenia, schizo-affective disorder, major depression, bipolar disorder, and other non-drug and alcohol related psychoses) (SMI) (Hodgins, Mednick, Brennan, Schulsinger & Engberg, 1996) and most particularly those with schizophrenia and schizo-affective disorder, are at increased risk, as compared to the general population, to commit violent crimes. This is a robust finding. It has been reported by several independent research groups working in industrialised (Arseneault, Moffitt, Caspi, Taylor, & Silva, 2000; Brennan, Mednick, & Hodgins, 2000; Tiihonen, Isohanni, Rasanen, Koiranen, & Moring, 1997; Wallace, Mullen, & Burgess, 2004) and underdeveloped countries (Volavka, Laska, Baker & Meisner, 1997) with distinct cultures, health, social service and criminal justice systems, who have examined different cohorts and samples using various experimental designs including prospective, longitudinal investigations on birth cohorts (Arseneault et al., 2000; Brennan, et al., 2000; Tiihonen, et al,. 1997) and population cohorts (Wallace, et al., 2004), follow-up studies comparing patients and their neighbours (Belfrage, 1998), random samples of incarcerated offenders (Fazel & Danesh, 2002), and complete cohorts of homicide offenders (Erb, Hodgins, Freese, Müller-Isberner & Jöckel, 2001). A recent study showed that among people living in the community, the presence of psychotic symptoms in the absence of a psychotic disorder was associated with increased risk of aggressive behaviour (Mojtabai, 2006). Much less is known about the prevalence of violent criminality among persons with major affective disorders than among those with schizophrenia. The few existing studies suggest a weak relationship (Arseneault et al., 2000; Brennan et al., 2000).

The results of the studies reviewed above are remarkably consistent. They tell us four important facts about offending by persons with SMI. One, while the increase in the risks associated with SMI (that is the odds ratios comparing crime rates among persons with SMI and persons in the general population) for non-violent and violent offending, and for homicide reported in various studies are similar (Hodgins,1998), the proportions of persons with SMI who offend differ across countries and time periods. For example, in a Swedish birth cohort, 14.6% of the men and 6.3% of the women with SMI were convicted for at least one violent crime before their 30th birthday (Hodgins, 1992). In a larger Danish birth cohort followed for 13 years longer, 11.3% of the men and 2.8% of the women with schizophrenia had at least one conviction for a violent crime (Brennan, et al., 2000). In a more recent study of a large cohort of patients with schizophrenia in Denmark, 68% had at least one conviction for a violent crime (Kramp, 2004). In a study of a series of cohorts of patients with schizophrenia studied in the state of Victoria, Australia from 1975 to 1995, between 15% and 25% had at least one conviction for a violent crime. Therefore, the proportions of people with SMI who commit crimes varies by place and time period. Two, while studies consistently report that the prevalence of SMI among incarcerated offenders exceeds the prevalence for gender and age matched subjects in the general population, the proportions of inmates with SMI vary from country to country, and from one time period to another, depending on the laws and policies that are in place concerning diversion of persons with SMI from prisons (Hodgins & Côté, 1995). Three, while many more men than women with SMI commit crimes, SMI, and most particularly schizophrenia, confers a greater risk for violent crime among women than among men (Brennan, et al., 2000). Four, while people with schizophrenia are responsible for approximately 10 times more homicides than people without schizophrenia (Erb et al., 2001), few offenders with SMI

have committed homicides and most have committed repeated assaults (e.g., Hodgins, Tiihonen, & Ross, 2005).

The prevalence of aggressive behaviour among persons with SMI

In concert with the evidence showing that persons with SMI, and most particularly those with schizophrenic disorders, are more likely than those without these disorders to commit violent crimes, there is a growing body of evidence on aggressive behaviour towards others by people with schizophrenia. In these studies aggressive behaviour is reported by patients, treatment staff, and/or collateral informants using detailed protocols (see for example, Steadman et al., 1998). The prevalence of assaultive behaviour varies depending on sample characteristics and length of the study period. For example, in a British study of outpatients with psychosis, 20% assaulted another person in a two-year period (Walsh, et al., 2001). In a US study of men with schizophrenic disorders admitted to psychiatric wards, 40.2% had assaulted in the 10 weeks prior to admission (Monahan et al., 2001). In another US study of patients with schizophrenia recruited into a recent trial of medications, 19.1% had committed an assault in the previous six months (Swanson et al., 2006). In a recent study of a UK sample of inpatients with SMI, the prevalence of assaultive behaviour was high with 41.7% of the men and 21.2% of the women reporting that they had committed one serious assault over their life-span, and 36.7% of the men and 20.0% of the women reporting having assaulted another person in the previous six months (Hodgins, S., Alderton, J., Cree, A., Aboud, A., Mak, T. (in press). While rates vary from one study to another, they demonstrate that a significant minority of people with psychotic disorders, and most particularly with schizophrenia, present persistent aggressive behaviour.

Society's response to crime and aggressive behaviour among persons with SMI

Despite this growing body of evidence, mental health policies fail to recognise that aggressive behaviour and violent criminality are problems for a proportion of persons with SMI, and most particularly for those with schizophrenia. For example, in the UK neither the National Service Framework for Mental Health (Department of Health, 1999) nor the NICE clinical guidelines for schizophrenia (Royal College of Psychiatrists & British Psychological Society, 2003) take account of the evidence concerning the increased vulnerability associated with SMI for engaging in violent crime or assaultive behaviour. While policy remains mute on the topic, health services in the UK and throughout Europe have responded to the situation by dramatically increasing the number of forensic beds (Priebe et al., 2005) and incarcerating large numbers of persons with SMI in prisons (Davies, 2004a, 2004b, 2004c). Most patients in forensic services are men with schizophrenia who have been in-and-out of general adult psychiatric services for many years while they were committing criminal offences (Hodgins & Müller-Isberner, 2004). Mental health care for persons with SMI that is provided by general adult services does not address antisocial and criminal behaviour, but rather focuses, almost exclusively, on providing medication to reduce psychotic symptoms.

Why are persons who develop schizophrenic disorders at increased risk to commit crimes and to engage in aggressive behaviour towards others?

Similar to offenders in the general population, offenders with schizophrenia constitute a population that is heterogeneous with respect to both criminal offending and the correlates of offending. Knowledge about the origins of criminal offending in the general population has exploded since investigations began to focus on sub-groups defined by age of onset and persistence of antisocial behaviour. Available data suggest that a similar approach to the study of offenders with schizophrenia may prove useful for beginning to unravel the aetiology of both the violence and the schizophrenia and for the development of effective treatment programmes (Hodgins, Coté, & Toupin 1998; Hodgins, 2004).

We have proposed a typology of offenders with schizophrenic disorders based on age of onset and persistence of antisocial behaviour. Type I, the early-start offenders, display conduct problems from a young age that escalate in severity and frequency as they grow up (Hodgins et al, 2005; Mueser et al., 2006; Naudts & Hodgins, 2005; Swanson, et al., 2006). A second type of offender with schizophrenia displays no antisocial behaviour prior to illness onset, but a stable pattern of aggressive behaviour thereafter. A third type displays no antisocial behaviour before illness onset or for many years thereafter, and then engages in very serious violence towards others. The available evidence suggests that these three types differ as to both aetiology and response to treatment.

Conclusions

There is now robust evidence that persons with SMI, particularly those with schizophrenia, are at increased risk for engaging in aggressive behaviour towards others, non-violent and violent crime. Currently, mental health policy and practice in most countries does not take account of this evidence. Consequently, large numbers of patients in general adult psychiatric services are committing crimes, assaulting others, and experiencing victimisation. A few are transferred to very expensive forensic inpatient services and after discharge, criminal recidivism is low. Future research into the causes of the vulnerability for crime and aggressive behaviour needs to be theoretically driven and test hypotheses. The typology of offenders presented here may prove to be a useful heuristic tool. Studies of the effectiveness of various interventions will also advance knowledge more quickly if they fully characterise the patients who benefit and those who do not from the intervention being tested.

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Table 1: Comparisons of five groups of men with schizophrenia based on age at first crime

Age at first crime	No crimea (n=57)	< 18 yearsb (n=39)	18-22 yearsc (n=51)	23-30 yearsd (n=53)	31 and oldere (n=41)	Test
Mean age (in years)	34.52 (SD=9.57)	35.38 (SD=9.34)	36.15 (SD=11.60)	39.01 (SD=8.71)	48.21 (SD=10.63)	X2(4, N=238)=41.04, p=.000 e>a,b,c,d d>a
Co-morbid diagnoses						
% Alcohol abuse/dependence	40.7% (22)	66.7% (26)	64.7% (33)	56.6% (30)	61.0% (25)	X2(4, N=238)=8.82, p=.066
% Drug abuse/ dependence	27.8% (15)	64.1% (25)	66.7% (34)	47.2% (25)	22.0% (9)	X2(4, N=238)=30.74, p=.000 b>a,e c>a,d,e d>a,e
% Antisocial personality disorder	9.3% (5)	53.9% (21)	35.3% (18)	9.4% (5)	9.8% (4)	X2(4, N=238)=41.50, p=.000 b>a,d,e c>a,d,e
Psychosocial functioning						
Mean score Global Assessment of Functioning	43.86 (SD=10.76)	47.10 (SD=11.70)	48.40 (SD=14.77)	52.66 (SD=11.60)	52.46 (SD=13.67)	X2(4, N=232)=15.52, p=.004 d>a,b e>a
% Never employed (excl sheltered workshop)	68.5% (37)	35.9% (14)	27.5% (14)	17.0% (9)	14.6% (6)	X2(4, N=238)=7.96, p=.093
% had intimate partner	37.0% (20)	28.2% (11)	25.5% (13)	49.1% (26)	61.0% (25)	X2(4, N=238)=16.27, p=.003 d>b,c e>a,b,c
% successfully completed obligatory military service	50.0% (14)	90.0% (18)	69.0% (20)	55.2% (16)	34.4% (11)	X2(4, N=138)=17.88, p=.001 b>a,d,e c>e

Psychiatric history						
Mean age at onset of schizophrenia (in years)	22.96 (SD=7.15)	21.03 (SD=6.70)	21.60 (SD=4.81)	23.02 (SD=6.29)	32.10 (SD=9.65)	$X2(4, N=203)=36.71$, p=.000 e> a,b,c,d
Mean age at first hospitalisation (in years)	24.02 (SD=7.62)	21.00 (SD=6.07)	22.47 (SD=7.49)	24.32 (SD=6.38)	33.20 (SD=10.16)	$X2(4, N=237)=46.87$, p=.000 e> a,b,c,d
Mean length of all hospitalisations (months)	3.15 (SD=3.00)	15.41 (SD=13.84)	11.26 (SD=11.55)	15.63 (SD=21.48)	21.49 (SD=31.06)	$X2(4, N=238)=57.40$, p=.000 b>a c>a d>a e>a
Criminal history						
% with at least one non-violent offence	0	100.0% (39)	84.3% (43)	58.5% (31)	53.7% (22)	$X2(4, N=238)=116.57$, p=.000 b>a,c,d,e c>a,d,e d>a e>a
Mean number of non-violent offences	0	22.85 (SD=29.02)	11.20 (SD=20.15)	4.45 (SD=9.31)	2.05 (SD=3.01)	$X2(4, N=238)=116.78$, p=.000 b>a,c,d,e c>a,d,e d>a e>a
% with at least one violent offence	0	87.2% (34)	78.4% (40)	88.7% (47)	90.2% (37)	$X2(4, N=238)=139.78$, p=.000 b>a c>a d>a e>a
Mean number of violent offences	0	5.69 (SD=6.18)	4.35 (SD=7.81)	2.53 (SD=2.64)	1.95 (SD=1.92)	$X2(4, N=238)=103.39$, p=.000 b>a,d,e c>a d>a e>a

% who committed at least one homicide	0	15.4% (6)	13.7% (7)	18.9% (10)	36.6% (15)	X2(4, N=238)=23.78, p=.000 e>a,b,c d>a b>a c>a

Aggressive behaviour

% hurt victim so badly that in hospital treatment was required	17.3% (9)	63.2% (24)	40.4% (19)	50.9% (27)	52.5% (21)	X2(4, N=230)=23.19, p=.000 b>a,c c>a d>a e>a

Parents and Siblings

% with a mentally ill father or brother(s)	28.9% (15)	21.1% (8)	39.1% (18)	17.0% (8)	25.0% (10)	X2(4, N=223)=6.71, p=.152
% with a mentally ill mother or sister(s)	40.7% (22)	21.1% (8)	47.8% (22)	40.4% (21)	32.5% (13)	X2(4, N=230)=7.34, p=.119
% with a criminal father or brother(s)	20.8% (11)	31.6% (12)	36.2% (17)	11.5% (6)	12.2% (5)	X2(4, N=231)=13.16, p=.011 b>d,e c>d,e
% with a criminal mother or sister(s)	5.7% (3)	13.2% (5)	6.4% (3)	3.9% (2)	2.4 (1)	X2(4, N=231)=4.78, p=.311
% with father or brother(s) with substance abuse	38.9% (21)	55.3% (21)	48.9% (23)	38.5% (20)	39.0% (16)	X2(4, N=232)=4.04, p=.400
% with a mother or sister with substance abuse	24.5% (13)	18.4% (7)	28.6% (14)	25.0% (13)	12.2% (5)	X2(4, N=233)=4.23, p=.376

Childhood and adolescence

% below average in elementary school	26.9% (14)	28.9% (11)	42.6% (20)	21.2% (11)	12.5% (5)	X2(4, N=229)=11.09, p=.026 c>d,e
% with conduct disorder	5.6% (3)	48.7% (19)	37.3% (19)	13.2% (7)	7.3% (3)	X2(4, N=238)=39.89, p=.000 b>a,d,e c>a,d,e

Mean number of CD symptoms before age 15	0.65 (SD=1.22)	3.13 (SD=2.85)	2.12 (SD=2.07)	1.08 (SD=2.00)	.68 (SD=1.61)	X2(4, N=241)=44.76, p=.000 b>a,d,e c>a,d,e
Substance abuse before 18	33.3% (17)	73.7% (28)	57.5% (27)	46.2% (24)	12.5% (5)	X2(4, N=228)=35.54, p=.000 b>a,d,e c>a,e d>a,e a>e
% Treatment before age 18	25.5% (13)	34.2% (13)	31.9% (15)	21.2% (11)	7.3% (3)	X2(4, N=229)=10.33, p=.035 a>e b>e c>e

Table 2: Statistically significant predictions, expressed as Odds ratios, of aggressive behaviour in the community

	Odds ratios (95% confidence intervals) for aggressive behaviour			
Stage 1 Stable characteristics (n = 773)				
Forensic/General	2.20 (1.12, 4.35)			
APD	5.01 (2.53, 9.95)	5.37 (2.55, 11.29)	5.43 (2.38, 12.39)	6.07 (2.64, 13.95)
Stage 2 Alcohol and/or drug use (n=705)				
Alcohol self-report				
Ilicit drug use*				
Stage 3 Symptoms (n=675)				
Positive symptoms				1.49 (1.20, 1.84)
Negative symptoms				
TCO symptoms				
Depression symptomsA				
Anxiety symptoms			1.58 (1.13, 2.21)	1.58 (1.13, 2.22)

Stage 4 Change in symptoms (n = 672)	
Change in Positive symptoms	1.45 (1.23, 1.71)
Change in Negative symptoms	
Change in TCO symptoms	
Change in depression symptoms	
Change in Anxiety symptoms	

A. Square root of the total score on the Hamilton Rating Scale for Depression

Figure 1: Number of non-violent and violent crimes as a function of the number of Conduct Disorder symptoms

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2. – Keynote 2 – Organizational readiness for reducing seclusion and restraint: From theory to practice

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Key Words
Organizational change, organizational culture, cultural change, seclusion and restraint

Purpose
Mental health providers tend to be client/patient focused and may not be cognizant of the influence that organizational factors play in the quality and delivery of treatment. (Yoo, Brooks, and Patti, 2007) This paper describes how organizational development can lead to cultural change within mental health settings and the influence this has on efforts to reduce use of seclusion and restraint.

Introduction

Concern about the use of restrictive treatment interventions – restraints and seclusion – has led to an international effort to reduce and even eliminate their use in hospitals and centers treating mental illness. In the United States several studies have identified factors that influence efforts to reduce use of these interventions. (Colton, 2004, Gunn, 2000, Huckshorn, 2005, and Delany, 2002). The Checklist for Assessing Your Organization's Readiness for Reducing Seclusion and Restraint (Colton, 2004) provides a systematic approach for assessing organizational readiness and progress addressing organizational factors that influence S/R reduction. The Checklist is based on a literature review which identified underlying theory, reoccurring themes and the elements that help to operationalize those themes. During instrument development, it became apparent that, more than a process of initiating specific activities, programs that successfully reduce use of seclusion and restraints undergo a process that transforms the organization's underlying culture – shared belief systems and values that are ingrained and therefore difficult to modify.

Theory

Providers setting out to improve quality of care and treatment effectiveness, with the goal of reducing seclusion and restraint, should be cognizant of theories of organizational change and development and how their actions may help or hinder their efforts. For example, the work of social psychologist Kurt Lewin has provided the prevailing theory of change for much of the twentieth century. Lewin posited that organizational change required unfreezing – the current equilibrium needs to be destabilized; moving – an iterative approach to moving action forward; and refreezing – effort put forth to stabilize change. (Burnes, 2004, pp. 985-86) This suggests the need for leadership and guided action to move the organization from one stage to the next, as well as leadership that is responsive to the impact that change can have on caregivers; for example, assuring that new structures are put into place as old program structures are changed or removed. Indeed, for organizations attempting to reduce seclusion and restraint, leadership may be the most pivotal ingredient:

"…rather than facility demographic or patient clinical characteristics, it is the treatment preferences and practices of administrators and clinical staff which are the predictors of low rates

of seclusion and restraint. The Commission found such facilities have administrators who believe strongly in minimal use of restraint and seclusion and have instituted practices and promoted efforts to keep usage low." (Commission on Quality Care, 1994, p. 3)

The work of Edgar Schein (2004) has influenced organizational development in two ways: first the acknowledgement that organizational culture is deeply rooted and therefore difficult to change, and when it does occur it is a long-term process. The structure and process of inpatient mental health services is imbedded in a program's treatment philosophy and operationalized through rules and routines and the character and quality of staff-patient interactions. This shapes the culture by providing structural stability and influences how staff makes sense of their roles and how work is performed. Because seclusion and restraint reduction activities incur changes to organizational structure and process, they impact on the existing culture and staffs' willingness and ability to accept change.

Second, Schein observed that leadership and culture are intertwined. Whereas culture influences decision making and action, leadership in turn helps to shape culture: "…it can be argued that the only thing of real importance that leaders do is to create and manage culture; that the unique talent of leaders is their ability to understand and work with culture…" (ibid, p. 11)

Systems theory is based on the principle that organizations are made up of interrelated and interdependent subsystems. (Beitler, 2006, Gordon, 1999) These subsystems interact with each other and with other systems external to the organization. In a mental health setting, the ability to reduce seclusion and restraint can be influenced by internal factors such as staff training, staff turnover, and program structure as well as external forces such as societal expectations, regulations, or workforce availability.

In addition to theories of organization development, models have evolved which help to explain and guide the systems change process. In the book Good to Great (2001), author Jim Collins refers to the "fly wheel" principle: implementation of many actions over many years to propel change within the organization. Ultimately, a critical point is reached when these actions start to produce tangible and sustained results. Duck (2001) describes stages of change – stagnation, preparation, implementation, determination, and fruition – which the organization travels in order to carryout organizational change and development. A similar model was used in development of the Checklist, which adapts the Transtheoretical Model of Change (Miller, 1999): no action/no discussion, espoused, intermittent/inconsistent action, action, and sustained action/maintenance. When this model is applied to organizations, change is also perceived as a longitudinal process occurring in stages, which depending on circumstances may not proceed in a linear fashion. The model also serves as means of identifying appropriate interventions based on the organization's stage of change. For example, in regard to seclusion and restraint reduction, an organization that is in the espoused stage would benefit from identifying key members of the organization that can function as change agents and by developing a strategic plan or blue print to guide organizational members and activities.

Thematically, these theories and models suggest that while organizational and cultural change is a fluid and iterative process, it is also something that can be purposeful and directed. The implication for seclusion and restraint reduction is that the change process is not haphazard, rather it is strategic and organizational leadership is responsible for creating the foundation on which change is established. When actions are taken in response to perceived gaps, the organization's values, processes, and outcomes may substantially evolve from the current situation, thus leading to cultural change.

Practice

Five mental health organizations participated in a study focusing on progress made to reduce seclusion and restraint. Interviews were conducted with key informants to identify factors they believed influenced the change process. (Colton, 2007) This information helped to validate the factors identified in the Checklist. Organizations that were the most successful achieving

results shared several attributes consistent with the literature on organizational and cultural change including: decisive and focused leadership; a change process that was purposeful, guided, and goal-based; and multiple factors were addressed simultaneously, which in the case of S/R reduction included issues related to program structure, staff development, and staff support.

For this presentation, the author was able to obtain longitudinal data from four of the five organizations participating in the original study. The first program revisited was the Children's Assessment Unit at Cambridge Hospital, Massachusetts. The program director, Kathy Regan, RN, did not request anonymity because, due to their success, the program has become a resource center and she has even documented the process in her own book. (Regan, 2006) A thirteen bed unit serving children ages 2 to 12, Ms. Regan reported that the organizational changes they initiated several years ago have been sustained and in 2006 there were no seclusions, mechanical restraints or use of chemical restraints and only four physical holds.

The second program, a residential program and day treatment center has worked diligently during the past two years to reduce the use of physical holds. Direction for the restraint use reduction program (they had discontinued use of seclusion in 2005) comes from a quality improvement team consisting of a core group of staff and parents. Multiple approaches are being used resulting in a 70% reduction in holds – from an average of 330 a month to 50 a month.

The third program, a children's psychiatric inpatient unit implemented a treatment model and intensive staff training around that model. Support for the change process has come from the unit's clinical leadership including psychiatrist, psychologist, and nurse program director. Between 2004 and 2006, this program experienced a 92% reduction in physical holds (from 140 a year to 10 a year) and a 20% reduction in seclusion use (from 399 to 318 episodes a year). The duration of physical holds decreased by 38% - from an average of 44 minutes to 27 minutes.

Finally, the fourth program, a public psychiatric hospital, continues to struggle with the process. This organizational still has not developed a plan to guide the process nor has it identified key individuals to serve as change agents. The facility has not adopted a specific program model and its philosophy of care – strengths-based treatment – is only now being integrated into the training process. As a result, there has been no reduction in the use of restrictive treatment interventions; for example, the facility averaged slightly more than 700 seclusion episodes a year during the past three years. Referring to the Checklist, this organization would be characterized as being in the "espoused" stage:

"There is growing recognition of a problem at the individual member level, but still no consensus in regard to the depth or breadth of the problem and what might be done about it. …there is still a tendency to accept seclusion and restraint as a necessary evil and some members may argue for the therapeutic benefits of these actions. The lack of consensus may result in continued vacillation, even when there is growing evidence that failure to act may be compromising the quality of care. Management may espouse the need to reduce the use of seclusion and restraint, but takes no immediate action." (Colton, 2004, p. 8)

Conclusion

Understanding theories and models of organizational change can guide human service providers as they take action to reduce use of seclusion and restraint. The Checklist is a tool that operationalizes the change model and provides structure to the process by identifying factors in need of improvement.

As demonstrated by the stories of several organizations, leadership that ensured the change process was focused, planned, and purposeful were the most successful reducing seclusion and restraint. These leaders encouraged a rethinking of the treatment philosophy and approaches to service delivery including changes in program structure and training to enhance staff skills. Those organizations engaged in the process over the long-term have experienced deep, sustained change in organizational culture. Conversely, with a lack of clearly delineated leadership, one organization continues to struggle with the process and continues to use seclusion and restraint at a high rate.

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3. – Keynote 3 – Preventing the Use of Seclusion and Restraint: A National Initiative to Transform Mental Health Systems of Care

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Introduction

The controversial and potentially dangerous interventions known as seclusion and restraint (S/R) have received an extraordinarily increased level of oversight and regulation in the United States in recent years. Following the 1998 release of The Hartford Courant series titled "Deadly Restraint: A Nationwide Pattern of Death," public outrage and legislative concern elevated these interventions from relative invisibility to a high national priority. (Weiss, Altimari, Blint, & Megan, 1998; USGAO, 1999; Mildred, 2002; Lieberman, Dodd, & DeLauro, 1999; Masters et al., 2001).

In 2001, the National Association of State Mental Health Program Directors (NASMHPD) staff and national experts performed a comprehensive literature review on the use of S/R They found a growing body of knowledge about approaches effective in preventing the use of seclusion and restraint (NETI, 2003; Mildred, 2002; Hardenstine, 2001; Honberg & Miller, 2003). These strategies are readily available at low or no cost, are replicable, and have been agreed upon by key U.S. mental health stakeholders. (LeBel, Stromberg, Duckworth et al., 2004; NETI, 2003; Hardenstine, 2001; Success Stories, 2003; Honberg & Miller, 2003).

The Public Health Prevention Approach Applied to Seclusion and Restraint

The public health prevention model is a model of disease prevention and health promotion and is a logical fit with a practice issue such as S/R (NASMHPD, 1999). The applicability of this model focuses on identifying risk factors for conflict and violence along with early intervention strategies so that S/R can be prevented. This approach directs efforts to minimize conflicts, immediately resolve situations when they arise, and learn new prevention strategies from an analysis process when these events do occur. This model is best understood by the public health constructs of universal (primary) interventions, selected (secondary) interventions, and indicated (tertiary) prevention interventions as these guide in framing reduction activities (NASMHPD, 1999).

With regard to S/R reduction, universal precautions or primary prevention interventions speak to the development of treatment environments that minimize the potential for conflict to occur. Strategies include the implementation of a vision, values, and principles of care that are trauma-informed; a thorough analysis of organizational values to ensure they are reflected in current practices; and an ongoing revision of policy and procedures and early individualized assessments of a variety of risk factors for violence, injury or death.

Selected or secondary prevention activities, with regard to S/R, speak to the immediate and effective use of early interventions to mitigate conflict or aggression when these do occur. These interventions include staff training focused on attitudes and behaviors when faced with a conflict situation, competency-based negotiation and de-escalation skills, and the use of individually developed crisis plans that assist in teaching emotional self management (NETI, 2005).

Indicated or tertiary prevention interventions address the most effective ways to minimize the damage done to consumers, staff, and others witnessing a S/R event once it occurs. These strategies include rigorous problem-solving activities in event analyses and include the mandatory

involvement of the involved service recipient. These type interventions are also focused on identifying people who may require specific treatment for trauma.

Development of a Formal Plan to Reduce Seclusion and Restraint

Mental health facilities are encouraged to develop their own individualized comprehensive seclusion or restraint prevention plan. Creating a comprehensive, written S/R prevention plan is the first step in reducing the use of S/R in a manner that will be sustainable, respect all participants, and maintain a safe environment. The development of such a plan includes the assignment of responsible parties, due dates and expected outcomes. Facilities are encouraged to review the six core strategies that are presented in this work (NETI, 2005).

The seclusion and restraint reduction strategies suggested are not meant to replace evidenced-based and other clinical approaches, meaningful treatment activities, or effective pharmacological management, but rather they are to be used in conjunction these methods. The Six Core Strategies© will be summarized here and are based on the training curriculum developed by NASMHPD staff and national experts for the National Executive Training Institutes; funded by SAMHSA in 2002-2007. These strategies are listed as follows:

1. Leadership toward Organizational Change outlines the role of the executive director or facility administrator and other executive staff. Reducing S/R starts with clear leadership and a formal plan. The plan must define and articulate a mission and philosophy about S/R reduction and outline the roles and responsibilities of all staff in the facility (Huckshorn, 2006). This work entails full and consistent participation by a facility administrator or CEO who is firmly committed to this project. The reduction plan must be presented in a continuous quality improvement framework that understands that culture change takes time and that we "learn as we go." (NETI, 2005)

   A core activity for leadership includes the elevation of oversight of every S/R event by executive management. This activity speaks to the very different level of attention paid to these events than was historically expected (Huckshorn, 2006). It includes, at least weekly, a senior administrative review of all incidents that is sincerely interested, individually focused, takes into consideration the details of each event, and captures information valuable in determining prevention activities. It takes advantage of the fact that facility leadership can implement policy changes quickly due to their formal power and influence. No one else in the facility has the ability to make change happen as fast as the senior executives.

   Leadership strategies also include the development of a facility-wide policy that outlines the prevention/reduction approach to the use of seclusion for all staff, determines data-driven goals to reduce use, announces a "kick-off" event and routinely celebrates successes, identifies S/R reduction champions at all horizontal and vertical organizational layers, and assigns these staff to specific prevention roles (NETI, 2003). Leadership must also assure for the inclusion of consumers, family members, and advocates in all aspects of the project and create mechanisms so that this involvement will happen, be understood by staff, and be viewed in a positive manner (NETI, 2003; Bluebird, 2004).

2. Using data to inform practice assures the use facility-generated data on S/R usage in a non-punitive manner, provides for healthy competition among facility units or wards, and elevates the general oversight and knowledge of S/R use in real time for everyone involved (Hardenstine, 2001; NETI, 2003).

   The use of data includes an analysis of facility seclusion and restraint usage by unit, shift, day, and by staff member involved. Individual staff specific data is designed to identify over-users of S/R so that they can receive additional training and supervision (Huckshorn, 2006; NETI, 2003). The facility also needs to highlight data on S/R use by graphing and posting this data on all units so that it is clearly visible for staff and consumers of service.

   The identification of the facility's baseline use is important so that performance improvement goals can be set, use can be monitored over time, and progress (or lack thereof) can be tracked (Hardenstine, 2001). This includes tracking core measures such as S/R incidents and hours,

and tracking supplemental measures that include the use of emergency, involuntary (usually intramuscular) medication administration, incidence of both consumer and staff injuries, and qualitative reports of consumer and staff satisfaction (Bluebird, 2004). The transparent use of data has been identified as one of the most important strategies used by successful projects (NETI, 2005).

3. Workforce Development focuses on the creation of a treatment environment where policy, procedures, and practices are based on the knowledge and principles of recovery and the characteristics of trauma-informed systems of care (Huckshorn, 2006). This strategy is implemented primarily through communication, staff training, education, and human resource development activities.

This strategy assures that staff are given the opportunity to develop and practice individualized treatment planning and practice skills that integrate prevention strategies for specific, high-risk individuals. Included are activities that assure adequate staff education about the experiences of consumers and staff with S/R address the common myths associated with use, introduce the rationale and characteristics of trauma informed care, educate on the neurobiological and psychological effects of trauma, and describe a prevention-based approach to reduction (NETI, 2005).

Also included is facility leadership's understanding that many S/R events occur because of win-lose conflicts set up by facility rules and staff roles in enforcing these rules. Because of this institutionally-driven risk issue, leadership need to understand the value of allowing staff to "suspend" institutional rules and procedures, when necessary, to avoid or resolve conflicts when addressing individual needs (NETI, 2005). Examples of this important construct are rigid policies regarding attendance at activities, wake and sleep times, curfews, smoke breaks, meal times, and other rules designed to "keep order" and that do not take into account individual needs or the signs and symptoms of mental illness. Staff need to be empowered to make decisions, in the moment, to avoid the use of S/R through adapting rules in the face of real events and dealing with repetitive issues in the treatment team. Many incidents of S/R occur due to minor infractions and rule breaking and could be avoided with staff training and management flexibility.

Other important activities here include discussion of the facility's S/R reduction plan in new hire interviews, and incorporation of expectations in job descriptions, performance evaluations, and new staff orientation activities (NETI, 2005). It is the job of senior management to assure that the S/R prevention plan is communicated early and consistently reinforced; and that staff clearly understand their important roles in the plan and are supervised throughout the process so that real time learning can occur. The use of peers, as consultants or staff, is often significantly informative when reviewing rules, staff training needs and staff attitudes (NETI, 2005).

4. The use of S/R prevention tools includes the use of tools to identify risk for violence (including previous S/R history); tools to identify persons with medical risk factors for death and injury; tools to identify persons with histories of trauma; the development and use of de-escalation or safety plans (including psychiatric advance directives), creative changes to the physical environment that includes the development of comfort and sensory room, and meaningful and engaging treatment activities (Huckshorn, 2006).

5. The inclusion of consumers and advocates in operational functions in inpatient settings assures for the full and formal inclusion of peers or "persons in recovery," as well as family members and external advocates, in a variety of roles in the organization to assist in the reduction of S/R (Bluebird, 2004). These roles include using vacant positions to hire peers in full- or part-time jobs that include titles as the director of advocacy services, peer specialist, drop-in center director, and consumer advocate. These roles are immeasurably valuable if the facility and staff understand and are able to appreciate and be open to the depth and breadth of knowledge that consumers bring to an organization.

Peer staff should report to senior managers who understand and support these roles. The new role of a peer in an inpatient facility can be quite intimidating and difficult. It is critical

that all staff clearly understand this role and that attention is given to the orientation and training for people undertaking this new role. It is equally important that inclusion is not token and that consumers are empowered to do their jobs, including making mistakes or receiving additional training (Bluebird, 2004). The inclusion of family members and external advocates can be similarly valuable, especially in children's units where service recipients are too young to participate in these kinds of adult roles.

6. The use of rigorous debriefing procedures uses event analysis to reduce use of S/R through knowledge gained from a painstaking review of S/R events. This knowledge is then used to inform policy, procedures, and practices to avoid repeats in the future (NETI, 2005). A secondary goal of this strategy is to attempt to mitigate the potentially traumatizing effects of a S/R event for involved staff and consumers and for all event witnesses (NETI, 2005). Debriefing activities are separated into two distinct but equally important activities (NETI, 2005).

The first is an immediate, post-event debriefing that is usually led by a nursing supervisor or other senior staff person who was not involved in the event. This response needs to be an expectation of on-grounds supervisors and may be quite new. The purpose of this activity is to assure for the safety of all involved parties, to review the documentation, interview staff and others who were present, and to attempt as much as possible to return the unit to the pre-crisis milieu (NETI, 2005). The use of an interview or event guide and the documentation of activities immediately following the event are highly recommended.

The second debriefing activity is more formal, and often occurs a few days later. It includes the treatment team, the attending psychiatrist, and a representative from management. It uses rigorous problem solving methods such as root cause analysis to review and analyze the incident (NETI, 2005). The purpose of this activity is to identify what went wrong, what can be changed to avoid an event in the future, and to assure that, as much as possible, traumatic sequalae is mitigated for all involved parties.

The inclusion of the consumer's perspective is critical. It is potentially intimidating to expect a recently secluded or restrained individual to attend a large meeting and options need to be available. The service recipient's perspective can be represented by a peer advocate, if the consumer is able and willing to agree and communicate his or her perspective to the peer. This alternative is not meant to patronize or otherwise assume the inability of the service recipient to participate, only to make facility staff aware of the possibility of covert feelings of coercion or helplessness in the face of a group of professionals. In addition, the creation and maintenance of a non-punitive environment is essential to create a safe space for staff to share their thoughts and feelings.

Conclusion

These six core strategies, utilized together, are presented for use as part of a comprehensive performance improvement plan to reduce the use of S/R (NETI, 2005). They are focused on prevention and utilize the most current and effective strategies known (NETI, 2005). These core components or strategies have proven successful in a variety of mental health settings serving children and adults, including but not limited to, facilities in Pennsylvania, New York, Massachusetts, Maine, Florida, Tennessee, Oregon, Ohio, New Hampshire, New Jersey, South Carolina, California and South Dakota (NETI, 2005).

In 2003, NASMHPD staff and faculty began using the S/R Prevention Curriculum Six Core Strategies © to train state mental health leadership and facility teams. Early on, eight of these states provided pre- and post-S/R use data and those initial results were encouraging. For instance 5 of 8 hospitals showed reduced hours of restraint; 5 of 7 had fewer restraint events; 5 of 7 showed a reduction in seclusion hours; and 6 of 6 had fewer seclusion events (Conley & Huckshorn, 2004).

The data also showed that S/R hours were reduced by as much as 79%, the proportion of consumers in S/R was reduced by as much as 62%, and the incidents of S/R events in a month

were reduced by as much as 68% (Conley et al, 2004). This was not a formal research project but merely a report of data changes per and post-intervention (NETI, 2005). A current research project in underway in eight states and 49 sites that is building an evidence base for these strategies.

Based on this data and our own experiences with state providers we believe that projects that use "single intervention" approaches are of questionable value (NETI, 2005). A multi-faceted approach to reducing S/R has been substantiated in the literature and appears to be a common thread in successful projects (Visalli et al., 1997; Donat, 2003; Jonikas et at., 2004; Conley et al., 2004; Graham, 2002; Hardenstine, 2001).

Child and adult facilities that have demonstrated successful S/R reduction initiatives have identified common strategies proved effective (NETI, 2005). These include:

- Strong, involved, consistent leadership from CEO or like throughout process
- A change in treatment philosophy to less rule/consequence based to strength based
- A prevention approach adopted rather than one focused on using S/R in "safer" ways
- A thoughtful plan developed and monitored over time
- Workforce development that goes beyond "aggression control" training
- Heightened oversight and immediate leadership response to every event
- Persons in recovery, families or advocates involved as partners
- The use of data in a transparent and motivating manner
- Rigorous analysis after events

In summary, significant lessons learned from these U.S nationally monitored projects have illuminated the necessity of a multifaceted approach to reduction that spans the entire facility and all of the staff and that additional research is needed to study these interventions.

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4. – The community outcomes of forensic patients after prolonged hospitalisation

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The development of safe and ethical services for mentally disordered offenders is a major public health challenge. Those who have been found not guilty of a violent crime (often homicide) on the basis of insanity (also known as 'mental impairment' or lack of criminal responsibility), or who have been deemed unfit to stand trial for such an offence due to mental illness, pose particular challenges due to their political salience. These patients are known in the Australian state of Victoria as 'Forensic Patients'.

Follow up studies of similar patients in other jurisdictions have demonstrated the value, in terms of reduced risk to the public, of carefully monitored community treatment by specialist teams after their discharge from secure hospitals (Lamb, Weinberger, & Gross, 1988; Wiederanders, Bromley, & Choate, 1997; Wilson, Tien, & Eaves, 1995). It is often found that a relatively low threshold for returning patients to secure hospital care minimizes the risk of their reoffending.

Structured 'risk assessment instruments' for assessing violence risk purport to offer significant advantages over unstructured clinical judgement alone when attempting to predict future acts of violence (Douglas, Ogloff, Nicholls, & Grant, 1999; Strand, Belfrage, Fransson, & Levander, 1999). Their potential utility in predicting the community outcomes (in terms of either reoffending or rehospitalisation) of Forensic Patients has implications both for judging appropriate timing of release from hospital, and for suggesting which factors need to be most carefully targeted in rehabilitation programs.

This presentation will:
- Describe the demographic, psychosocial and criminological characteristics of all (n=30) Forensic Patients released from secure care in Victoria between 1991 and 2002.
- Describe the community outcomes of released forensic patients in terms of re-offending and rehospitalisation
- Describe the relationships, if any, between outcomes (reoffending and court-ordered rehospitalisation) in the first 3 years post-release and scores on four risk assessment instruments, rated from case-notes, using information which would have been available at the time of discharge:
  • HCR-20 (Webster, Douglas, Eaves, & Hart, 1997)
  • VRAG (Quinsey, Harris, Rice, & Cormier, 1998)
  • LSI-R (Andrews & Bonta, 1995)
  • PCL-R (Hare, 2003)

The implications of these data for safe, ethical, politically defensible, evidence-based management of high profile, violent mentally disordered offenders will be discussed.

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5. – Is (primary) psychopathy a superfluous construct? – The relationship of factor 1 and factor 2 of the PCL-R with psychological and behavioural variables and risk assessment in a Dutch forensic psychiatric hospital

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'Psychopathy' is not only popular in the movies but also in the scientific forensic psychiatric literature, because of the fact that the diagnosis of psychopathy is a robust predictor of violent recidivism in nearly all forensic samples. The state of the art procedure to measure psychopathy is the scoring of the 20 items of the Psychopathy Checklist-revised (PCL-r), developed bij Hare (1991). There is a large body of research on this topic. Nonetheless the concept of psychopathy and its measuring device the PCL-r are not entirely unproblematic. Or even worse: the concept is theoretically unclear, it is superfluous in predicting recidivism, and it stigmatises patients who get this diagnosis.

Despite the wealth of scientific literature the debate about the nature of the concept of psychopathy is not resolved. In the original formulations of Cleckley (1976) psychopathy is an affective deficit, showing itself in personality characteristics such as pathological egocentrism, emotional poverty, guilt- and shamelessness, unreliability and absence of psycho-neuroticism. The PCL-r of Hare consists of 8 items covering this kind of characteristics, while the other 12 items refer to socially deviant and criminal behavior. These two kinds of items fall apart in factor analyses (with the exception of three items that are not loading). The first factor is described as 'the egoistic, callous and remorseless use of others', the second factor as 'chronic instable and antisocial lifestyle'. Psychopathy as defined by the PCL-r thus consists of these two factors, each about equally contributing to the concept (Hare 1991). Nonetheless most authors follow Cleckley, in considering the affective deficit (F1) as the core of psychopathy, and refer to this as 'primary psychopathy'. That would not be a problem if the two factors were substantially correlated and if they would both comparably correlate with violent recidivism and other important psychological and psychosocial variables.

This is not the case, however. The two factors correlate only moderately to slightly (in Dutch TBS .25 in the research of Hildebrand (2004) and .28 in the data of FPC Oldenkotte). The factors are thus almost orthogonal. Moreover, meta-analyses (Gendreau, Goggin & Smith, Walters 2003) have shown that only the social deviance factor (F2) determines the power of the PCL-r in predicting violent criminality and recidivism. In other words the characteristics that are deemed typical for the psychopathic personality are not associated with later violence, while characteristics that are considered as secondary, and that hardly correlate with typical psychopathy, are. This implies that in risk assessment it is sufficient to determine the score on the social deviance factor. That social deviance in the past predicts social deviance in the future is a well-established fact, by the way (Quincy, Harris, Rice & Cormier, 2006). The score on F1 is superfluous. This, of course, also makes the stigmatising label of psychopathy itself redundant (see also Rassin 2005).

Furthermore studies make clear that the two PCL-r factors are differentially correlated with other variables as well. Table 1 (Lammers 2007) shows that IQ and neurocognitive dysfunctioning of the amygdala is only -positively- correlated with F1, that several kinds of externalising behavior are only associated with F2, and that psychoneuroticism is negatively correlated with F1 and positively with F2.

It seems that the core characteristics of psychopathy if factor 1 do not have much use in forensic psychiatry. Maybe… In the meantime it is very hard for clinicians (and researchers) to say goodbye

to the idea that a person who is callous, shows no remorse or empathy, and who lies and deceits is more dangerous than a person who is honest and sensitive and shows compassion. Besides this, the question arises whether the first factor of the PCL-r is really superfluous. Clinicians often think that a high score on the first PCL-r factor gives an indication about how the patient will behave, for example if he will try to pretend motivation for treatment.

The present study, therefore, is about the validity of the first factor of the PCL-r. Is the score on this factor associated with diagnostic variables and with the behavior of the patient during treatment?

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Table 1: Differential correlations of the two PCL-r factors (adapted from Lammers, 2007)

	Factor 1 (affective interpersonal)	Factor 2 (antisocial and impulsive lifestyle)	
Violent recidivism	Not	positive	Gendreau, Goggin & Smith, 2002; Walters, 2003
Social class/educational level	Not	Positive	Hare 1991; Hare et al. 1990
Neuroticism	Negative	Positive	Hicks & Patrick, 2006
Suicide risc	Not	Positive	Verona, Patrick & Joiner, 2001
Intelligence	Positive	Negative	Salekin, Neumann, Leistico & Zalot, 2004.
Impulsivity	Not	Positive	Fowles & Dindo, 2006
Cluster b personality disorders	Not	Positive	Verona & Vitale, 2006
Externalising disorders in childhood	Not	Positive	Fowles & Dindo, 2006
Alcohol and drugs abuse	Not	Positive	Taylor & Lang, 2006
Plasma Serotonine level	Not	Negative	Dolan & Anderson, 2003
Disfunctioning of the amygdala and dorsal hippocampus	Positive	Not	Laakso et al., 2001

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6. – Predicting future reconviction in offenders with Intellectual Disabilities: The predictive efficacy of VRAG, PCL-SV and the HCR-20

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Accurate prediction of future reconviction, including those for serious crimes, has been shown to be greatly aided by formal risk assessment instruments. However it is unclear as to whether these instruments would also be predictive in a sample of offenders with intellectual disabilities (ID). We followed up 145 ID patients released from medium secure units (MSU) over at least a 2-year period (average=6.5 years) and compared these to an offender control group (N=996) matched in age and gender. Offence histories were obtained from the United Kingdom Home Office Offenders Index. Though the probability of reconviction was lower for those with ID we show that the Violence Risk Appraisal Guide (VRAG), the Psychopathy Checklist Screening Version; (PCL-SV), and the History, Clinical., Risk-Management-20 (HCR-20), were all significant predictors of reconviction, and in many cases their efficacy was greater than in a control sample. For example, the predictive accuracy of the HCR-20 for any offence in the ID group (AUC = 0.82) was significantly greater than for the control group (AUC = 0.65). Similar results were obtained when only violent reconvictions were considered. The results clearly show the utility of these tools in predicting re-offending and violent re-offending in offenders with ID.

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7. – Treating violent sex offenders: the efficacy and frequency of use of alternative approaches

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Violent sex offenders are treated with many different therapeutic methods, but there is disagreement in the literature with respect to the absolute and relative efficacy of these methods (Simon, 2000; Losel and Schmucker, 2005; Saleh and Guidry, 2003; Marshall and Serran, 2000; Hanson, Gordon, Harris, Marques, Murphy, Quinsey and Seto, 2002; Grossman, Martis and Fichtner, 1999). This study is the first to quantify the current thinking of professionals who work with and/or study sex offenders concerning the relative efficacy of various treatment methods.

Sample

Data were obtained through responses to a confidential mail survey to members of the Association for the Treatment of Sexual Abusers (ATSA). ATSA is a non-profit, interdisciplinary organization that fosters research, facilitates the exchange of knowledge, furthers professional education, and advances professional standards and practices in the field of sex offender evaluation and treatment.

ATSA is an international organization of professionals from a variety of fields including psychology, psychiatry, social work, criminal justice, and miscellaneous other fields. It also includes administrators who manage organizations that treat or supervise sex offenders. This diverse group of individuals works with and/or studies all types of sex offenders in many different settings, from private treatment facilities to prisons.

The sampling frame of this study consists of an ATSA membership list with the names and business addresses of 1,040 individuals within the United States. The research instrument was sent to each of the 1,040 members on the list provided by ATSA, of which 540 (52 percent) responded. The response rate was very high for a mail survey. The geographic composition of the sample was similar to that of the ATSA membership list, and respondents from every state in the United States are included in the sample.

Since this study focuses on the therapeutic treatment of sex offenders, only a subset of ATSA members are of particular interest, namely, those who self identify themselves as either a psychologist, a psychiatrist, or a psychotherapist. Altogether, 265 respondents (50.2%) listed one of these occupations, including 149 psychologists (28%), 112 psychotherapists (21%) and 4 psychiatrists (1%). These three groups of respondents are referred to as "therapists" in the remainder of this article.

Method

Many definitions and classifications of sex offenders are delineated in the literature (see Douglass, Burgess, Burgess, and Ressler, 1992; Douglass and Olshaker, 1997). Given the different types of professionals who are the subjects of this survey, this study uses a widely accepted general definition of violent sex offenders. They are defined here as those who have an insatiable predilection for committing additional violence during an act of non-consensual sex. This additional violence goes above and beyond the inherently violent nature of any sex crime, and would include such acts as

battering, torture, and murder. Since the behavior of such offenders is chronic, they conform to the personality type commonly referred to as a "sexual predator." In this study, the terms "violent sex offender" and "sexual predator" are used interchangeably.

The therapeutic treatments for violent sex offenders can be loosely grouped into four main categories, namely 1) Cognitive Therapy, 2) Traditional Psychotherapy, 3) Behavioral Therapy, and 4) Antilibidinal Treatment. Cognitive Therapy involves such methods as skills training, sexual education, violence control, and gender role playing (Marshall and Laws, 2003; Maletzky and Steinhauser, 2002; Aytes, Olsen, Zakrajsek, Murray and Ireson, 2001). Traditional Psychotherapy includes such methods as psychoanalysis, individual psychotherapy and supportive psychotherapy (Wiederholt, 1992; Lothstein, 2001; Buschman and van Beek, 2003). Behavioral Therapy encompasses such methods as classical conditioning, operant conditioning, aversion therapy, and biofeedback (Laws and Marshall, 2003; Maletzky and Steinhauser, 2002; Marshall and Serran, 2000). Antilibidinal Treatments include such methods as castration, estrogen therapy, and various other pharmaceutical treatments (Weinberger, Sreenivasan, Garrick and Osran, 2005; Hill, Briken, Kraus, Strohm, and Berner, 2003; and Studer, Aylwin, and Reddon, 2005).

The surveyed therapists were asked to evaluate these four treatment categories, using a 1 – 5 scale, with 1 meaning "completely ineffective," and 5 meaning "strongly effective." The therapists were then asked to indicate how often they used methods in the four treatment categories, using a 1 – 5 scale, with 1 meaning "never" and 5 meaning "frequently."

Results

Table 1 presents the therapists views concerning the effectiveness of the four types of treatment. Cognitive Therapy was viewed as the most effective treatment, followed in descending order by Traditional Psychotherapy, Behavioral Therapy, and Antilibidinal Treatment. Twenty-eight percent of therapists believed that Cognitive Therapy was "strongly effective," compared to 21% for Traditional Psychotherapy, 10% for Behavioral Therapy, and 5% for Antilibidinal Treatment. The differentials among the four treatment categories become much more pronounced when responses from the two "most effective" answer choices (i.e., 4 – "somewhat effective, and 5 – "strongly effective") are combined. A total of 76% of therapists labeled Cognitive Therapy as at least "somewhat effective," compared to only 54% for Traditional Psychotherapy, 44% for Behavioral Therapy, and 23% for Anti-libidinal Treatment, respectively.

Table 1: Therapists' Views Concerning the Effectiveness of Treatments

Type of Therapy	1 Completely Ineffective	2 Somewhat Ineffective	3 Uncertain	4 Somewhat Effective	5 Strongly Effective	Total
Cognitive Therapy	0.6% 2	5.0% 13	18.5% 49	47.7% 126	28.2% 75	100.0% 265
Traditional Psychotherapy	8.2% 22	15.3% 40	22.2% 59	33.5% 89	20.8% 55	100.0% 265
Behavioral Therapy	3.4% 9	18.6% 49	33.8% 90	34.3% 91	9.9% 26	100.0% 265
Antilibidinal Treatment	10.8% 29	36.5% 97	30.2% 80	17.8% 47	4.7% 12	100.0% 265

Table 2 shows the frequency of the therapists' use of the four types of treatment. As Table 2 indicates, Cognitive Therapy was the most frequently used method of treatment (73%) followed in order by Traditional Psychotherapy (58%), Behavioral Therapy (33%), and Antilibidinal Treatment (2%). The differentials among the four frequency categories become more pronounced when responses from the two "most frequent" answer choices (i.e., 4 – "regularly," and 5 – "frequently") are combined. Almost 93% of therapists used Cognitive Therapy at least regularly, as compared to 75% for Traditional Psychotherapy, 53% for Behavioral Therapy, and 6% for Antilibidinal Treatment.

Table 2: Therapists' Frequency of Use of Treatments

Type of Therapy	1 Never	2 Rarely	3 Sometimes	4 Regularly	5 Frequently	Total
Cognitive Therapy	0.9% 2	1.3% 3	4.9% 13	19.9% 53	73.0% 194	100.0% 265
Traditional Psychotherapy	5.3% 14	8.7% 23	10.7% 28	17.5% 47	57.8% 153	100.0% 265
Behavioral Therapy	9.4% 25	16.4% 43	21.2% 56	20.3% 54	32.7% 87	100.0% 265
Antilibidinal Treatment	56.4% 150	29.2% 77	8.9% 24	4.0% 10	1.5% 4	100.0% 265

Conclusion and Discussion

The purpose of this study was to roughly quantify the current thinking of therapists who work with and/or study sex offenders concerning the effectiveness of various treatment methods. The study findings indicate that there is a pronounced rank order of these methods, with Cognitive Therapy viewed as the most efficacious, followed in order by Traditional Psychotherapy, Behavioral Therapy, and Antilibidinal Treatment. The rank order for frequency of use of the treatment methods follows the identical pattern. This symmetry is not surprising, since therapists would be expected to use treatment methods in direct proportion to the perceived effectiveness of those treatments.

This study has two strengths. The first is the response rate of the ATSA members. A 52% response rate is approximately twice the response rate expected from a mail survey. It is even more difficult to get members of busy professional populations to take their valuable time to participate in studies of this nature. The high response rate is probably attributable to the fact that this is the first time that this group has been surveyed on this subject. It is likely that the respondents welcomed the opportunity to convey their frustrations and concerns regarding treatment methods.

The second strength is that this is not just a study of the attitudes of mental health professionals in general. It is a study of the attitudes of that subset of mental health professionals who work with sexual predators on a regular basis. As such, the study's sample is the best possible one with which to explore these treatment topics.

However, the purpose of this article was not to determine whether the attitudes of ATSA members concerning treatment methods are in line with the "true" efficacy of these methods. Research on treatment efficacy remains controversial and is plagued with methodological problems, and consequently, these issues remain unsettled in the literature (Simon, 2000). However, knowing what the attitudes of ATSA members are concerning treatment does add to empirical knowledge regarding offender rehabilitation, since these therapists are operating on the basis of their beliefs.

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8. – Situational management of institutional violence

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Background

Violence within forensic settings is a significant problem both in terms of its frequency and its consequences. Traditionally, attempts to identify and manage violence risk have centred on identifying variables relevant to the perpetrator. This is both appropriate and necessary however, person-centred variable are only one aspect of the complex and varied processes that might contribute to violence. Situational factors are also relevant and this is particularly likely in institutional settings.

Purpose

This study was carried out with the aim of field-testing and obtaining user-satisfaction data on a set of structured professional judgement guidelines for assessing situational risk factors for violence i.e. PRISM: Promoting Risk Intervention by Situational Management. PRISM includes 20 risk factors corresponding to 5 risk domains i.e., History of Violence, Physical Environment, Organisational Factors, Staff Factors, and Case Management.

Methods

Case study methodology was used to field-test PRISM across 5 Scottish Prisons. Questionnaire methodology was used to obtain user-satisfaction information.

Results

The results indicated that PRISM facilitated comprehensive risk assessments and generated potentially useful risk intervention strategies. User-satisfaction data indicated an acceptable level of consumer satisfaction.

Conclusions

The implications of these results on assessing and managing violence risk in institutional settings will be discussed and priorities for further research in forensic mental health settings will be identified.

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9. – Changes in violence risk factors over time in a sample of forensic psychiatric patients in the Netherlands

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Introduction

In forensic psychiatry, estimating recidivism risk is a crucial task. Risk assessment is essential in making decisions like whether or not to let patients go on a leave or discharge from a forensic psychiatric hospital (Brand & Diks, 2001). In the past, risk assessment tools generally contained a high number of 'static' factors, by which possible changes in the condition of forensic patients as a result of forensic treatment may stay undetected. In the Netherlands a risk assessment instrument was developed in which a relatively high number of so-called 'dynamic' (theoretically changeable) variables were incorporated: the so-called HKT-30 (Taskforce Risk Assessment Forensic Psychiatry, 2002).

The current study focuses on changes in 'violence risk factors' over time as measured with the HKT-30 in a population of forensic psychiatric patients in two high security hospitals in the Netherlands. If the findings of this study indicate these factors to be indeed dynamic (i.e., changeable over time) this measure may be valuable for evaluating individual risk management plans and treatment progress. This seems particularly true, as in an earlier national study (Hildebrand, Hesper, Spreen & Nijman, 2005), it was found that HKT-30 scores were significantly associated with violent recidivism after forensic psychiatric treatment, although the found Area Under the Curve value (AUC) was moderate (i.e. an AUC of 0.72)

Methods

The measure used in this study is the Dutch risk assessment tool HKT-30 (Taskforce Risk Assessment Forensic Psychiatry, 2002), consisting of 11 historical, 13 clinical, and 6 future risk indicators that are scored on a 5-point Likert-scale (range 0-4 of which a score of 4 is supposed to indicate the highest risk). Clinical items are to be scored over the previous year. In the high security forensic hospitals under study (i.e., FPC Oostvaarderskliniek & FPC de Kijvelanden), the HKT-30 is scored periodically for all patients.

As mentioned earlier, previous studies have shown this measure to have moderate to good psychometric properties and predictive validity on violent recidivism (Canton et al, 2004; Hildebrand et al, 2005; Hildebrand et al, 2006; Taskforce Risk Assessment Forensic Psychiatry, 2002). The items of the HKT-30 are presented in table 1.

Assessment took place for 392 male patients under the Dutch Entrustment Act (TBS, see also Van Marle, 2002), with an average age of 37,3 years (SD=9,4) at first assessment and an average IQ of 97,5 (SD=14,6). For these 392 patients at least one HKT-30 assessment had been performed and 127 patients were assessed at least 3 times at an average interval of 15 and 11 months respectively after the first assessment.

Figure 1: HKT-30 - Scales and items

Historical and static factors (H-subscale)
H01   Judicial history
H02   Violation of conditions
H03   Conduct problems before the age of twelve
H04   Victim of violence in youth
H05   History of mental health care
H06   History of employment
H07   Alcohol and drug abuse
H08   Psychotic disorder
H09   Personality disorder
H10   Psychopathy
H11   Sexual deviance
Historical total score   (sum of all H factors)

Clinical and dynamic factors (K-subscale)
K01   Lack of insight
K02   Present psychotic symptoms
K03   Alcohol and drug abuse
K04   Impulsivity
K05   Empathy
K06   Hostility
K07   Social and relational skills
K08   Ability to look after oneself
K09   Acculturation problems
K10   Attitude towards treatment
K11   Responsibility towards crime
K12   Sexual preoccupation
K13   Coping skills
Clinical total score   (sum of all K factors)

Future factors (T-subscale)
T01   Agreement on conditions
T02   Material indicators
T03   Daily activities
T04   Skills
T05   Social support and network
T06   Stressful / destabilising factors
Future total score   (sum of all T factors)

HKT-30 total score   (sum of all HKT-30 factors)

To ascertain whether or not the HKT-30 scores for the group as a whole change over time, an ANOVA was used. As the sample of TBS-patients is a diverse one, the population was also divided in subgroups to see if differences between those could be found. These subgroups consisted of presence or absence of psychotic disorders (31,4%), cluster B personality disorders (59,7%) and/ or substance addiction (69,1%), type of crime committed (murder/manslaughter – 41,8%; rape/ assault – 14,8%; pedosexual crime – 12%; aggravated assault/manhandling – 11,8%; financial crimes such as bribery/blackmail/mugging – 11,7%; arson – 7,9%) and duration of admittance at Time 1 (longer or shorter than 44 months – the national average duration of admittance (Van der Heide et al, 2007). Differences in changes over time on the HKT-30 scores between these subgroups were analysed by means of "Repeated Measures" analyses in SPSS 14.0.

Results[1]

Results on the ANOVA's showed significant decline in clinical, future and overall sum, but not on the historical total score (see figure 2). Significant changes over time have also been detected on several individual items. Between Time 1 and Time 3 six clinical items ('lack of insight', 'empathy', 'social and relational skills', 'attitude towards treatment', 'responsibility towards

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[1] *The results of this study are preliminary. A final article will be submitted once data of a third clinic (FPC Oldenkotte) has been included for analysis.*

crime' and 'coping skills') and all future items declined substantially, meaning that overall patients tend to improve on these factors.

The repeated measures analyses for the different subgroups did not show significant differences for HKT-30 total scores between groups in changes over time. However, total scores for all subgroups did decline over time.

Figure 2: Changes over time in HKT-30 total scores (ANOVA)

Patients with a psychotic disorder did have a significantly higher mean HKT-30 score when compared to patients without psychotic disorders. Patients with addiction disorders and patients with cluster B personality disorders also turned out to have higher overall scores when compared to the remaining patients without these disorders. Decrease in HKT-30 scores over time however, was similar for all groups. The cluster B personality disordered patients had significant higher scores on all three the subscales, whereas the differences between patients with and without addiction disorders can be mainly explained by a difference in the historical total score. As for the type of crime committed, the groups sentenced for aggravated assault/manhandling or financial crimes such as bribery/blackmail/mugging had the highest total score. The groups sentenced for paedosexual crimes, arson or murder/manslaughter scored significantly lower. Patients who had been admitted over 44 months had higher total scores than patients who had been admitter shorter. On the overall total score however, they had the same pattern of decline. The patients who had been admitted for over 44 month had higher scores on the historical scale especially, but lower scores on the future subscale.

Conclusion / Discussion

For the group as a whole the overall HKT-30 scores significantly declined as time progressed. For different subgroups of forensic patients (e.g., psychotic versus non psychotic patients) HKT-30 starting levels appeared to differ, though the overall declines in scores in the subgroups over time were found to be rather similar.

As could be expected, the reductions in overall HKT-30 scores were caused by reductions of the Clinical subscale scores (the K-subscale of the HKT-30) and the Future subscale scores (the T-subscale of the HKT-30), whereas no reductions in Historical subscale scores were found (the H-subscale of the HKT-30). These findings are comparable with results found by Belfrage and Douglas (2002) using the HCR-20 scheme (Webster et al, 1997). With the HKT-30, however, more factors which are potentially changeable over time may be identified in comparison to the HCR-20. For this reason, the HKT-30 risk assessment tool may be a relatively sensitive tool to determine whether the risk of violence in forensic psychiatric patients has decreased. However, it should be noted that up till now no longitudinal studies have been performed that show that declines

in HKT-30 scores are related to decreased recidivism risks later on, although a retrospective study did find HKT-30 scores at discharge to be significantly associated with recidivism rates after release (Hildebrand, Hesper, Spreen & Nijman, 2005). Future longitudinal research should focus on the relationships between (changes in) violent risk factors and recidivism rates for the assessed sample. Although the found reductions in HKT-30 scores are promising, the design of the current study does not allow the conclusion to be drawn that the reductions over time specifically result from the forensic psychiatric treatment that is provided to the current sample. Future studies need to include control groups of patients who did not receive treatment, or who received alternative forms of treatment, in order to gain more insight in the specific effects of the forensic psychiatric treatment under study. Ethical considerations and public safety, however, may make it hard to conduct such studies on a large scale.

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10 – Workshop 1 – Management of aggression – Control, avoidance or contact? A different perspective on the management of aggression and disruptive behaviour in (child) mental health care and (special) school practice

Fleury, H.W. & Van Engelen, Y.M. (Netherlands)

Daily practice

Considering the management of aggression and disruptive behaviour in (child) mental health care institutions and (special) schools, there seems to be a gap between the professional intentions and the daily practice on the shop floor. Often staff is not acting from a particular vision on aggression nor planning interventions based upon a specific view on this behaviour. The problematic behaviour often seems to be considered as an objective, established feature of the client, pupil or parent. Professionals regularly consider the problem behaviour as disturbing and interfering with the primary process in the group. When the professional in the end fails to control the behaviour, sometimes the client is excluded from the situation or the institution and sent to separate services, by which segregation increases.

Several methods are being developed to attack the problem behaviour in general at client level. Most of these methods approach the problem from a social-cognitive point of view and can be applied in group situations. They nearly all focus on learning and reflecting with children/clients on their social skills and moral behaviour and practising their social behaviour in (group) exercises. Next to this therapeutic approaches focus on self control or therapeutic principles according to the learning theory are applied, like positive reinforcement, rewarding, ignoring, etc. to influence problem behaviour. However, in escalating situations, when professionals need to (re)act immediately upon the problem behaviour, these methods provide little hold. The social-cognitive approach is not effective in these situations anymore, because the client lacks self-control and is temporarily not accessible through cognitive interventions. The aroused client needs a different approach that tunes in rather to his emotional state than to his cognitive functioning.

Aggression as the complicated result of many factors is by definition happening within the interaction. The behaviour cannot be disconnected from the situation in which it occurs and therefore cannot be tackled properly without taking the part of the professional into consideration too. The attitude of the professional, the way staff manages escalating situations, is crucial. From a subjective viewpoint the perpetrator can become a victim and the victim can become an aggressor, depending on the attributions both parties make within this process. Aggression is always an interactive datum and needs to be solved within the interaction. In that way aggression can be considered as a meaningful message which professionals should try to understand and cope with in a respectful manner. Therefore aggression needs attention, preferably in a stage the behaviour is not escalating yet. If the professional fails to cope with this properly, the behaviour will manifest itself in less controllable proportions. Interventions are unavoidable by then and many professionals lose control at this point, because they are not educated in how to manage these escalations. In the best case they learned something about prevention. Often the professional lacks self-reflection on this topic because his focus is on the client. Professional codes and ethics are more than often violated, when the client is treated with a less respectful attitude and harm is being caused, mentally and/or physically by the professional who lacks the skills and acts on his own insights or just impulsively, chaotically or incoherently without reflecting. Disproportional

violence is still regularly applied by the professional as a reaction on a threatening situation and professionals still tend to work on their own, without a coherent team system.

However, in fact the professional approach of children/clients with aggressive and disruptive behaviour should match the intended therapeutic and educational goals and perspectives in all situations, also escalating situations as a part of the job.

Educational perspectives

The authoritarian approach in education of the past century was left behind due to the negative results and outcomes. Too much control in combination with too little autonomy led to fear, aggression and a non-assertive, non-responsible attitude of the child. The 'laissez-faire' education of the late sixties and seventies of the last century wasn't evaluated that positive either. Too much autonomy and too little control led again to fear, aggression and a non-responsible, selfish attitude of the child. Nowadays the authoritative approach (Baumrind) as an integration of the best aspects of both former strategies is generally evaluated as best practice in education both in private (family) and in public educational and mental health care institutions. The main aspects of this third way of educating are dialogue, respecting autonomy of children according to age and developmental possibilities, maintaining reasonable rules and structure (authority) in combination with emotional support and warmth. The perspectives and attributions of both parent/tutor and child are integrated in this approach, reason why dialogue is a central aspect. Although scientific research evaluated the authoritative approach as best practice, professionals hardly seem to be able to manage aggressive and disruptive behaviour in accordance to this best practice once there is arousal or a feeling of threat on the shop floor. In general they seem to fall back on the two former styles of educating: they either set out all kinds of strategies to control, either try to avoid the conflict (wanting to prevent) by meeting all the needs of the child and following the child from behind. In both ways the working alliance can be severely damaged. Parallels can be drawn with the classical 'fight/flight' model.

A different approach in staff training

In the training-course 'Management of aggression and social security' for staff employed in mental health care institutions and schools, CONNECTING chooses to work from a broad perspective. Only a comprehensive approach can be helpful in improving the professional practice.

CONNECTING tries to train staff in their attitude to practice according to the well known best practice of education: the authoritative way. Aggression or disruptive behaviour is to be considered as an interactional problem and as a message. In order to improve professional (therapeutic) practice it is important to trying to understand this message. The conceptual dichotomy of 'perpetrator' and 'victim' is left behind and the training focuses on the ways of making contact and staying in contact also during an incident. Not in a frontal, auhoritarian approach of control (nor physically, nor mentally), not overruling (too many staff around), not in a laissez-faire approach (following the client from behind), but in offering structure and limits in combination with emotional support. Staff is trained in improving awareness on these topics and awareness of what they are doing and what the result is. Both parties make their own attributions in this process and this should be a topic of reflection for professionals, leading eventually to reflection-in-action. Physical interventions should be pain-free and just serve as a means to maintain the working alliance with the client.

The focus in the training is, amongst other things, on the impact the problem behaviour has on the professional. The course tries to fit in with the daily reality of the participants and their experience and perception levels. Increasing awareness of the situation and of the meaning of the problem behaviour can be helpful and professionals gain more insight in these aspects by learning about and training on their own contribution to the situation. The training aims at developing professional skills in handling aggression, that leave the working alliance with the client intact. In

the first place restoring safety is required. In order to do this in a proper way staff is being trained to apply painless physical techniques to be used only when necessary and not as a goal but as a means to gain safety and restore the communication and the contact with the client. Staff is being trained in pointing out signals, reflection-in-action and communicative skills under threatening conditions. Self-awareness is in this case an important instrument.

The training is preferably presented to full, multidisciplinary teams/wards in order to guarantee an integral approach and a better coherence with the more comprehensive security management of the institution. Because the training focuses on essential topics and personal difficulties that often lead to emotional reactions of staff, the training has a strong teambuilding effect. Gaining contact with something that affect professionals personally is the first step towards the ability to cope with aggression professionally and with more confidence, without personal fear or on the contrary too much force or 'professional' violence as a reaction. Professionals need to connect with their own primal fears, anxiety, annoyance and irritation before being able to help vulnerable clients in a professional way. Once confidence is gained in the ability to cope with extreme situations, all the earlier steps, like confronting and deescalating can be made more easily and readily. A better timing and coherence of interventions can be achieved as a result of training.

In role-play with professional actors the training course integrates finally all aspects of the training but especially gives participants the opportunity to practice in 'real life' situations. There is no prefabricated scene, the actors react interactively on what's happening. Preferably this takes place with three actors to be able to construct a group-dynamic situation to act in. In real life professionals also have to cope with complex processes within group-situations and need to choose interventions in a split second sometimes on complex activities. Afterwards or during the role play in a time-out, the actors provide in feedback from within their specific role. Not often professionals get the opportunity to hear something so specific about the impact of their behaviour and attitude on the client and this feedback appears to be of great help once the professional is ready for it.

Security in work climate is very important and the training course takes this as a starting point throughout the training but also afterwards in real life situations. Involvement is an important aspect of the training and it's important that feelings of inability and impotence are being recognized. It is crucial that professionals speak out openly about their fears, doubts and annoyance in the context of aggression management and learn to pronounce clearly their expectations towards colleagues and clients, especially in threatening or escalating situations.

Comprehensive approach and social security

Next to training staff in a different, more professional approach that is more in accordance with the therapeutic and educational perspectives and intentions, scientific results show us that a comprehensive organisational approach is required to contain policies and maintain results. Therefore CONNECTING provides in the education of trainers who are taught and trained in a wide range of topics and skills, to be able to serve as a consultant, advisor and agent on social security within the institution, next to the ability to training staff in a one-week-course.

Workshop

In this workshop an introduction into the theoretical background of the training will be presented. The focus will be on the subjective attributions within the interaction and on educational aspects of the professional attitude. Next to this an active introduction will be presented into physical aspects of aggression management.

Speakers

Hans Fleury M.Sc., is director of CONNECTING, also trainer and educator and member of the ENTMA. He has a long-standing experience as a Psychiatric and Community Nurse at different

acute and high security wards in psychiatry and at crisis departments. Besides he is a Gestalt-psychotherapist and has a background in Aikido. Hans was educated 16 years ago as a trainer in Control & Restraint and has been searching since then for developments in the field of the management of Aggression, among which method- and attitude-development and innovation like development and innovation in physical technique that does justice to the perspective of Care, brings the least damage to the working relation and contains contact and communication with the patient.

Yvonne van Engelen M.Sc. is working as an Orthopedagogue (Educationalist), Health Care-Psychologist and Supervisor within the field of Special Education and was working in Child and Youth Mental Health Care in the past. She is, as a freelance co-worker and teacher of CONNECTING involved in the development, training and education of trainers in the Management of Aggression and Social Security, especially with regard to the fields of Childcare, Education and Learning Disabilities. She is also member of the ENTMA.

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11. – Workshop 2 – Crisis Prevention Training – Measuring success in crisis prevention training

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Dr. Randolph M. Boardman currently serves as the Executive Director of Research and Development with the Crisis Prevention Institute (CPI). Prior to joining CPI, he spent 27 years in schools as a special education teacher, a building level administrator, and as an adjunct faculty member at the university level. He also has experience in residential care for adults with developmental delays. Dr. Boardman is responsible for advancing research activity for CPI, as well as aspects of programme development. He is also a Senior Trainer of Life Space Crisis Intervention and a co-author of the CPI advanced training, Enhancing Verbal Skills: Applications of Life Space Crisis InterventionSM.

Keywords
Evidence-Based Practices, Restraint Reduction, De-escalation, Training, Qualitative, Quantitative, Research-Based, Crisis Prevention, Crisis Intervention, Training Process

Introduction/Background

In recent years, there has been a shift toward viewing training effectiveness based on a narrow range of defining criterion. The challenge in attempting to distil information in this way is that this approach can eliminate some of the key constituents that contribute to the successful implementation of training. This workshop will present a perspective, inclusive of a range of measures that exist across the relationship among training provider, commissioning organisation, their staff, and the end service user as a model for a more accurate and balanced measure of key constituents. This approach, rather than the orientation toward singular measurement, can be a practical alternative for evaluating effectiveness, providing that research rigor is properly applied.

Additionally, the presentation will seek to demonstrate that the relationship among proprietary providers, academics, and service commissioners can be productive when focused properly on the best interest of service users.

Main Article

CPI is known worldwide for its innovative and holistic philosophy of ensuring the best Care, Welfare, Safety, and SecuritySM of everyone involved, staff and clients alike, in even the most difficult crisis moments. CPI has been dedicated to providing crisis intervention and violence prevention training since 1980. The Nonviolent Crisis InterventionSM training programme is widely embraced around the world by professional caregivers who are responsible for the management of disruptive and assaultive behaviour.

Much emphasis is placed on programmes and practices to ensure they are "evidence-based." However, an international standard definition for what constitutes an Evidence-Based Programme (EBP) does not exist and debate continues on whether the definition should only include the most empirical research or whether there is value to less rigorous evidence (Center for Substance Abuse Treatment, 2007).

The National Implementation Research Network defines "evidence-based" practice as "skills, techniques, and strategies that can be used by a practitioner. Such practices describe core intervention components that have been shown to reliably produce desirable effects and can be used individually or in combination to form more complex procedures or programs" (Fixsen, Naoom, Blase, Friedman, & Wallace, 2005).

Evidence as a Continuum (From Qualitative to Quantitative)

When inquiries are made for evidence that supports the effectiveness of the Nonviolent Crisis InterventionSM training programme, CPI seeks to provide the most appropriate and relevant information for each. Some questions are best answered through evidence derived from quantitative measures, others may be better answered through more qualitative measures (Sackett & Wennberg, 1997).

To assist Certified Instructors, CPI's Measuring Success: Evidence, Research and the Nonviolent Crisis Intervention® Training Program (2006) introduces the perspective of evidence-based practice through discussion of various layers of evidence used to support efficacy and effectiveness relevant to implementation of CPI training. These layers of evidence range from more qualitative information such as anecdotal evidence, regulatory alignment, and congruence with other literature, to more quantitative data derived from quasi-experimental, scientific, and empirical designs. Collectively, the various layers form a significant body of evidence that the Nonviolent Crisis InterventionSM programme has been utilised and found to be effective in a variety of professional settings.

An informed consumer of research understands the inherent difficulties of accumulating purely quantitative research within the human service professions. Human behaviour is not as quantifiable or as succinctly measured as is, for instance, the effectiveness of a particular pharmaceutical. Successful outcomes may not easily be achieved by a linear or step-by-step approach. The pathway to any positive outcome is based on the continual growth of each individual in care and, in each case, setbacks can occur.

The true test of any effective training or intervention is whether it contributes to a positive outcome (Brendtro, Brokenleg, & Van Bockern, 2005). However, a single intervention is rarely used in isolation to achieve a positive outcome, and often a unique set of interventions will be used for each client, depending upon each individual's needs. This makes scientific correlation studies more difficult as a different regimen of interventions is implemented for each individual, depending upon that individual. Brendtro, Brokenleg, and Van Bockern (2005), further highlight some of these challenges through a quotation from Albert Einstein, "Not everything important can be measured, and not everything that can be measured is important."

Whilst more quantitative evidence will indicate which interventions have been empirically tested and shown to provide a statistically significant effect, more qualitative studies can speak to more humanistic sides of the issue and may discuss more succinctly how the intervention was implemented over a period of time.

Regardless of the source, the evaluation of evidence regarding any training programme or intervention strategy is useful only in as much as it is conducted within a larger "evidence-based decision-making process" (Canadian Nurses Association, 2002). The process should incorporate a "wide range of perspectives including clinical, consumer, administrative, fiscal, organisational, and policy into decisions regarding the identification, selection and successful implementation of evidence-based services" (U.S. Department of Health and Human Services, 2006).

Training Staff for Better Outcomes

Most organisations continually strive to provide the highest level of care and often introduce innovative interventions to provide even better service to those under their care. A mechanism to accomplish such is training in crisis intervention. Absent of proper training, staff will react based on the emotions of the moment. A component of an organisational improvement effort includes training staff in means to de-escalate disruptive and violent behaviour. To assure any successful knowledge transfer into actual practice, any training must be systemic and embedded within the context of a larger, ongoing training process, rather than a one-time event.

In the paper Measuring Success: The Nonviolent Crisis Intervention® Training Program's Congruence with the Literature, CPI (2007) advises its Certified Instructors that initial training should be used to build a foundation and framework for problem solving from which subsequent refresher trainings, practise, reviews, rehearsals, drills, situational applications, and policy implementation will be built.

The UK's Health and Safety Executive (Zarola & Leather, 2006) showed that whilst perceived capability of staff to defuse a disruptive incident increased after training, these effects were short-lived when training was viewed as a one-time event. The authors recommend the training be part of an ongoing training process and developed within an organisation-wide context. Fixsen, Naoom, Blase, Friedman, and Wallace (2005) wrote, "As has been shown in a variety of settings, the 'train-and-hope' approach to implementation does not appear to work" (p. 40).

The American Psychiatric Association, American Psychiatric Nurses Association and National Association of Psychiatric Health Systems (2003) explain how implementation of a training process helps staff build confidence in their abilities to deal with difficult behaviour. "With retraining and sufficient feedback, staff members feel more competent in their techniques and they're less likely to engage in restraint/seclusion because they feel equipped to handle the behaviors clients present" (p. 15). Della (2004) states that training is only effective if knowledge, skills, and behaviours learnt in training are carried through to practice through a well-planned training process.

Restraint Reduction—Not the Only Measure

One measure used in human service organisations to quantify success is a reduction in physical restraint. References to restraint use appear frequently in the literature as the implementation of interventions and training programmes are researched and documented. Whilst a decreasing rate of restraint use certainly serves as an excellent indicator of a successful quality improvement initiative, it is far from the only measure organisations can make to gauge the effects of training or an intervention.

For the purposes of this discussion, the effects of an intervention are best explained on three essential levels:

- Organisational: How an intervention will be implemented on an organisation-wide basis and the broadly-based outcomes that are measured;
- Staff: How the intervention is received and implemented by the staff within the organisation and what measures examine staff issues; and
- Consumer: How the intervention will be delivered to the consumer or to what effect an individual consumer's experiences will change as a result of the intervention.

The various measures are categorised within these three areas and are further divided between measures that already exist in the literature, detailed in Figure 1, and those which are possible avenues of research in the future, depicted in Figure 2.

Examples of how researchers have used these measures include:
(A more complete examination will be presented at the workshop.)

- Staff intention to utilise techniques taught: Calabro and Williams (2002) used a study designed to determine whether mental health care workers showed a significant intention to use the verbal crisis intervention techniques after attending the Nonviolent Crisis InterventionSM training programme. Scores for the respondents showed a strong intention to use the strategies.
- Effective use of techniques: Jambunathan and Bellaire (1996) evaluated staff use of crisis intervention techniques in averting crisis episodes at various behaviour levels using a descriptive correlational research design. Nurses on day and evening shifts completed 146 observations of patient incidents. The results of the study indicate that staff use of the Nonviolent Crisis InterventionSM training programme was effective in resolving crises in 84.2% of the episodes observed and over a wide variety of diagnostic and functional levels.
- Staff self-efficacy: McIntosh (2003) examined attitudes of 90 mental health care staff members from two community mental health centers. Results of this quasi-experimental study showed that staff members who received training in the Nonviolent Crisis InterventionSM training programme had significantly greater confidence and self-efficacy in managing potentially violent clients and a greater awareness of intervention strategies.

Figure 1

	Organisational	Staff	Consumer
What has been measured?			
Restraint Reduction/ Use/Duration	✔	✔	✔
Risks of Physical Restraint	✔	✔	✔
Knowledge Retention		✔	
Skills Retention		✔	
Climate Change	✔	✔	✔
Consumer Satisfaction			✔
Clinical Outcomes Scores			✔
Staff Turnover	✔	✔	
Injuries (Lost Time)	✔	✔	✔
Staff Confidence		✔	
Self-Efficacy		✔	
Intention to Utilise Training		✔	
PRN Medication Use		✔	✔
Effectiveness of Verbal Intervention		✔	✔
Assaults on Staff		✔	✔
Assaults on Others/Consumers			✔

What else can be studied?

Research is a fluid and emerging process, and as many of the questions above begin to be examined, many others surface. The list appearing in Figure 2 is intended to further examine what variables can be measured and is far from complete. It is intended more as a start of the discussion than it is a comprehensive listing.

Figure 2

	Organisational	Staff	Consumer
What else can be measured?			
Fidelity	✔		
Staff Burnout		✔	
Consumer Perspectives/ Attitudes Toward Restraint			✔
Correlative Data	✔	✔	✔
Contraindications			✔
Cost Effectiveness	✔		
Absenteeism		✔	
Others?	✔	✔	✔

Ethical considerations

Ethical concerns must also be considered when pursuing a scientific study in any human services field. Establishing a pure control group could result in the possibility of consumers being denied the highest standard of quality care. Designing a scientific study to find a specific cause–effect correlation in which the independent variable is staff training could place service receivers and providers in the control group at risk of potential injury or death due to lack of the needed training. The potential for such risk—in the name of research—is considered by many professionals and training providers such as CPI, as unacceptable and unethical. CPI remains committed to providing and advancing the best available evidence regarding the effectiveness and validity of the Nonviolent Crisis InterventionSM training programme.

Conclusion/Discussion

This workshop is intended to depict the critical relationship between the different strands of evidence required to more fully evaluate training effectiveness and measure success of crisis prevention strategies. In order for the best interests of service users to remain at the centre of our

focus, it becomes essential that an intelligent dialogue, such as this congress, continues among the academic community, training providers, and service commissioners. An opportunity exists to create the settings, conditions, and momentum to affect change and reduce the use of restraint and seclusion when such triangulation occurs. Such professional collaboration of stakeholders can move forward the collective ultimate goal of restraint-free, patient-centred care facilities.

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12. – Prevention of post-traumatic stress reaction in staff following a patient assault – principles of post-incident care

Richter, D. (Germany)

Background

It is increasingly acknowledged that patient assaults do not only lead to physical damage in mental health staff but also to psychiatric problems, especially to post-traumatic stress reactions. Methods: This presentation reviews the current literature on principles of aftercare following potentially traumatizing events.

Results

Articles from the areas of health care and military forces suggest peer support as a basic organizational principle for post-incident care. While caring for assaulted staff several guidelines need to be considered, e.g., the principles of 'psychological first aid', non-intrusiveness, covering of basic physical and psychological needs.

Discussion

Aftercare for staff after patient assaults must follow two goals which differ in time dimension: adequate immediate reactions from colleagues and a long-term organization of peer support which tries to provide support to the assaulted staff member. A special post-incident care organization for mental health institutions needs to be developed.

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13. – Psychiatric Intensive Care Units (PICUs) in England: characteristics of an effective care pathway

Ken Barrett, Jeri Hawkins, Catherine Davies
Institution: NHS Institute for Innovation and Improvement (UK)

This presentation will present the results of an investigation of best practice in psychiatric intensive care units (PICUs) in England undertaken by the Institute for Innovation and Improvement. The Institute is part of the National Health Service (NHS) for England and Wales and was set up "to improve health outcomes and raise the quality of delivery in the NHS by accelerating the uptake of proven innovation and improvements in healthcare delivery models and processes."

This study posed the following question: What therapeutic and managerial interventions, actions and processes demonstrate a safe, effective, cost efficient pathway that delivers a high quality service to patients undergoing psychiatric intensive care? The overall aim was to identify and disseminate principles of PICU best practice with the aim of reducing variation in practice in England and Wales.

A range of NHS trusts were identified, in collaboration with the UK's PICU Clinical Governance Network and CSIP, the choice reflecting a range of current PICU practice, a mix of urban and rural communities and included NHS and private care organisations. Those trust who were willing to become co-production partners in the study were visited by a team that included a psychiatrist, senior nurse and informatics specialist. Common themes identified during these visits formed the basis of discussion during a co-production day attended by participating trusts and other stakeholders.

The presentation will present the results of these deliberations in the form of a best practice care pathway.

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14. – Preliminary findings of an exploratory study on expressed emotion and aggression in psychiatric nursing

Christoph Abderhalden, Bernd Kozel, Andreas Altorfer, Christa Thomke, Ian Needham, Marie-Louise Kaesermann (Switzerland)

Background

Interactional variables are important but still under-researched causes of violent incidents [3]. Expressed Emotion (EE) in caregiver-patient-dyads [2] could be of utility in investigations regarding interactions influencing the escalation of aggressive situations. However, studies on the possible role of EE in relation to patient aggression in acute settings and its possible role as a provoking or a protective factor are lacking to date.

Objectives

This study endeavored to explore the possible influence of EE in caregiver-patient dyads regarding the development of aggression: The specific research question was: Which characteristics of EE can be identified in caregiver-patient dyads in which aggression did or did not escalate, compared to dyads with challenging but non- aggressive interactions? How do accounts of escalated, non-escalated, and challenging but non aggressive interactions differ?

Methods and Materials

We conducted a retrospective multiple case study with audiotaped descriptions of interactional situations as units of analysis.

We interviewed 16 randomly selected nurses from an urban psychiatric hospital in Switzerland and gathered data on 32 interactional situations from 32 nurse-patient-dyads, comprising 16 difficult to handle non-aggressive situations and 16 initially aggressive incidents subdivided into 8 incidents with and without subsequent escalation.

Data included sociodemographics of the nurses, a verbal description of the situation, and a Five Minute Speech Sample (FMSS) related to the patient involved, which was used to estimate the extent of Expressed Emotion [1]. The FMSS audiotapes and transcripts were independently coded by three raters (AA, CT, MLK) according to the four criteria proposed by Magana [1]: a) initial statement (positive, neutral, negative), b) critical remarks (number), c) quality of relationship (strong positive, weak positive, neutral, weak negative, strong negative), and Emotional Over Involvement EOI (global rating 0 – 5). Two of the three raters are certified raters for Camberwell Family Interview (CFI) data. The overall Kappa coefficients for the interrater agreement in our study were .81, .87, and .90 for EOI, Quality of Relationship, and initial statement respectively. The Intraclass Correlation Coefficient ICC was .98 for critical remarks.

We determined the EE-status for each of the 32 nurse-patient-dyads as follows: We categorized dyads as High EE Critical in the presence of a negative initial statement OR a negative relationship OR if the number of critical remarks exceeded the median number of critical remarks in the whole sample. High EE EOI was assumed as given in the presence of EOI-scores of 3 or more. We treated dyads as General High EE if they were High EE Critical AND High EE EOI.

Furthermore, we compared the verbal descriptions of the situations and the respective FMSS-data with regard to the following criteria:
- Changes in EE-status between non-aggressive and aggressive situations,
- Difference in length of the situational accounts and the FMSS (word count),
- Differentiation between one-to-one or multi-person-interactions,
- Concreteness of descriptions of interactions,
- Pronouns used to indicate the actors in the situations (I vs. we/one).

We employed nonparametric statistics for paired samples to compare data on non-aggressive vs. aggressive situations (McNemar, Wilcoxon), and tests for independent samples to compare escalated with not escalated situations (Chi2, Fishers exact test, Mann Whitney U test).

Results Nurses

The median age of the 16 participating nurses was 50 years and their professional experience in psychiatry ranged from 1 to 35 years. Eight of the subjects were females. All had a diploma in nursing and 12 had undergone specialized basic nursing education in psychiatric nursing. Fourteen had visited a 5-day training in aggression management within the last 4 years.

Situations and EE-status

We found high EE in about one out of four nurse-patient-dyads. However, the proportion of high-EE-dyads did not differ between non-aggressive/aggressive nor between escalated/not escalated aggressive situations (Table 1).

Table 1: EE-Status of nurse-patient dyads according to type of interactional situation

EE-status of nurse-patient dyads	Type of situation					p
	non-aggressive (n=16)	aggressive (all) (n=16)	aggressive not escalated (n=8)	aggressive escalated (n=8)	All (n=32)	
Low EE	13 (81%)	12 (75%)			25 (78%)	
High EE	3 (19%)	4 (25%)			7 (22%)	
Low EE			6 (75%)	6 (75%)		
High EE			2 (25%)	2 (25%)		1,01)

1) Fishers exact test

Ten (63%) of the nurses scored in both the non-aggressive as well as in the aggressive dyads as low EE, one scored high EE in both dyads, and 5 (31%) showed low EE in one and high EE the other dyad (McNemar-Test p = 1,0).

Changes in EE-Status

On a naïve assumption, a change towards higher levels of EE could have been expected parallel to the change of the interview topic from non-aggressive to aggressive situations. However, while there were changes in one or more of the EE-components in 14 of the 16 nurses, many of the changes went towards lower EE. When compared to the non-aggressive situation, the EE-sub-scores in the aggressive situation were lower for critical remarks (6 out 16 nurses) and for the quality of relationship (7 of the 16 nurses) (Table 2).

Table 2: Changes in the EE-status

Changes in EE-components: Aggressive compared to non-aggressive situation		aggressive not escalated	aggressive escalated	aggressive (all)
Initial statement	lower	2 (25%)	2 (25%)	4 (25%)
	higher	1 (13%)	2 (25%)	3 (19%)
	unchanged	5 (63%)	4 (50%)	9 (53%)
Critical remarks	lower	3 (38%)	3 (38%)	6 (38%)
	higher	1 (13%)	1 (13%)	2 (13%)
	unchanged	4 (50%)	4 (50%)0	8 (50%)
Quality of relationship	lower	2 (25%)	5 (63%)	7 (44%)
	higher	1 (13%)	3 (38%)	4 (25%)
	unchanged	5 (63%)	0 (0%)	5 (31%)
EOI	lower	3 (38%)	0 (0%)	3 (19%)
	higher	2 (25%)	1 (13%)	3 (19%)
	unchanged	3 (38%)	7 88%)	10 (63%)

Descriptions of the situations

The material differed with respect to several criteria, depending on the type of interactional situation (Tables 3 and 4). Regarding the word count, the descriptions of the aggressive situations were longer than the descriptions of the non-aggressive situation, whereas the FMSS describing the patient were shorter in 11 out of 16 interviews. The subjects used more impersonal language to describe the aggressive situations compared to the non-aggressive situations, most markedly when they described escalated aggressive situations. Eleven (69%) of the 16 non-aggressive situations were one-to-one interactions, compared with 5 (31%) of the aggressive situations involving multiple staff. All 8 escalated situations involved multiple person interactions, compared to 3 (38%) of the not escalated situations. One of the 16 accounts of non-aggressive situations and 2 of the 8 accounts of not-escalated aggressive situations were unclear regarding concrete interactions, compared to 7 (88%) of the reports on the escalated situations.

Discussion

Our results revealed no association between escalated or not escalated aggressive situations and the EE-status in the respective nurse-patient-dyads. However, descriptions of the situations differed markedly according to the type of situation, and EE-scores changed parallel to the change in the interview topic.

Table 3: Quality of the material related to different types of situations (the numbers are situations)

	Type of situation					p
	non-aggressive (n=16)	aggressive (all) (n=16)	aggressive not escalated (n=8)	aggressive escalated (n=8)	All situations (n=32)	
Lenght of FMSS*	431	372			402	,1071)
			304	440		,7532)
Lenght of description of situation*	511	788			649	,0301)
			800	776		,7532)
1 : 1- Interaction	11 (69%)	5 (31%)				
Multiple persons	5 (31%)	11 (69%)				
1 : 1- Interaction			5 (63%)	0 (0%)		
Multiple persons			3 (38%)	8 (100%)		,0263)
Clear description of interaction	15 (94%)	7 (44%)				
No clear description	1 (6%)	9 (56%)				
Clear description of interaction			6 (75%)	1 (13%)		
No clear description			2 (25%)	7 (88%)		,0413)
Unpersonal language+	2,6	1,6				,2341)
			2,3	,8		,0592)

* mean word count + lower numbers = more impersonal 1) Wilcoxon 2) Mann Whitney 3) Fisher

Table 3: Changes in reporting characteristics of non-aggressive and aggressive situations (numbers are study subjects; n=16)

		aggressive incidents		
		1:1-interaction	multiple persons	p
Non-aggressive incidents	1:1-Interaction	4 (25%)	7 (44%)	
	Multiple persons	1 (6%)	4 (25%)	,0701)
		Clear description	No clear description	
Non-aggressive incidents	Clear description of interaction	7 (50%)	8 (50%)	
	No clear description	0 (0%)	1(6%)	,0081)

1) McNemar

Several arguments may explain these results: The phenomenon of EE was discovered in the context of long standing family relationships and may require a certain "time of exposition" to become

effective. Therefore, EE may not be appropriate to characterize short-term relationships. Given that aggressive situations sometimes involve the participation of numerous staff, the patterns of EE in the helper-patientdyad may be overridden by group effects. Furthermore, the measurement of EE depends on the willingness to self-disclosure. However, this willingness may be overruled by display rules connected to the study topic and are possibly predominant in the organizational and professional setting of this study. This notion is supported by the observed tendency towards lower EE in accounts of aggressive situations, which could be interpreted as a manifestation of an attempt of masking the emotional impact of aggressive situations. This in turn could possibly be related to personality characteristics (suppression/expression) or styles of emotional labour.

Particularly, the characteristics of the accounts of incidents underpin the importance of emotional aspects. Asked for escalating situations the participants tended not to remember 1:1 situations and the respective interactions. Furthermore, their tone of language was markedly impersonal and reserved regarding their emotional involvement and role in the developing situation. This may mirror rules to downplay the staff's own contribution to escalation and may indicate that reflecting one's own contribution to aggressive situations has not yet been incorporated into daily practice.

Conclusion

As preliminary conclusion, the utility of the concept of EE as explaining variable for the course of aggressive incidents remains plausible. However, due to interfering display rules requiring emotional dissonance, it's questionable whether it can be measured adequately using the FMSS in this context. Potentially, other methods of observation or even concepts may be more helpful to capture the obvious role of emotion in aggressive situations. Relational/interactional perspectives on aggression in psychiatry should also consider the short duration of relationships. Furthermore, methods should be developed to explain the mechanisms of situations where multiple staff members interact with individual aggressive patients.

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15. – Workshop 3 – Therapeutic Management of Aggression – Therapeutic management of aggression –staff training program at Stavanger University Hospital

Edouard Laiseau (main presenter), Kim Åke Sviland, Stig Egeland and Tom Runar Pettersen (co-presenters) (Norway)

Keywords:
Aggression, violence, communication, work environment, safety, psychiatry, staff training, skill, e-learning, role play, TMA

Introduction

Work-related violence is the most serious occupational hazards that staff working in the healthcare sector face. The need for a clear and practical strategy to avoid harm to health workers and patients alike is therefore very apparent.

Stavanger University Hospital started training staff in communication skills as well as physical techniques in the early 90's. This training was conducted by third party associates and it was not until 2003 that the hospital decided to take full control, using in-house staff. This was partly a cost issue, but also reflected a desire to refine and adjust the staff training in order to incorporate legal and ethical issues in a broader manner. In doing so, emphasis switched from mastering techniques, to employing sound communication skills as well as trying to use preventive measures and de-escalation methods.

In order to create awareness of these changes, the training itself changed name from "therapeutic management of violence - TMV" to "therapeutic management of aggression – TMA".
It is now mandatory for all staff to attend a three day course in TMA, preferably during their first year of employment. Also, each ward is required to have regular practise in TMA training, so that all staff gets a basic knowledge of the subject.

Findings

Precisely what then, is TMA? One could say that it is a method to assess, prevent and/or handle aggression and violence in a therapeutic environment. It gives the health worker the necessary tools to handle patients in situations that may result in aggression and violence. Nevertheless, it is not a course in self defence or martial arts. One seeks to teach methods and strategies, so that one can avoid reverting to brute strength and blunt force, as was often the case in psychiatry wards in the past.

The purpose of our staff training programme is threefold:
• To lessen the likelihood of physical confrontations between patients and health care workers
• To maintain a high ethical standard and to ensure that patients, even when aggressive and threatening, are treated with respect, dignity and compassion.
• To minimize/prevent the risk of injury – both for patients and staff – due to aggression and violence.

As mentioned above, the initial training consists of a three day course. This course is followed by regular training adapted to individual needs in each ward. The course consists of the following elements:
• Ethical issues
• Legal issues

- Communication skills
- Threat assessment
- De-escalation methods
- Physical techniques

The teaching staff are psychiatric nurses, doctors, psychiatrists and other staff with a sound knowledge and experience of the subjects they teach in. The staff teaching physical techniques must have extensive practical knowledge in dealing with threatening and violent behaviour. A staff member in each ward has a supervisory role in ensuring that regular training is implemented in the daily routines.

For the past year, a project group has been working on an e-learning program enabling all staff to get access to theoretical knowledge of TMA. This consists of a PowerPoint presentation with text and pictures illustrating the breakaway moves as well as control and restraining methods. An instructional film is also being made in order to give an even better presentation of the techniques used. These two tools are not meant to be used on their own, but serve as a help in maintaining and honing skills acquired during the mandatory three day course.

Although great emphasis is placed on the physical part of "aggression management" it is very important not to forget the preventive faze. A substantial part of our three-day course therefore consists of learning about non-verbal communication, other communication skills, placing, as well as ethical and legal issues.

Also, it is of paramount importance to handle violent and aggressive behaviour in such a way that the therapeutic relationship between staff and patient is not destroyed. Doing so, while keeping staff and patient safety in mind as well, can be very demanding. We have found that attending a course in TMA helps build confidence amongst our staff, thus making it easier to avoid physical confrontations. It also helps reducing the level of aggression in patients, as staff is more aware of their body language and other factors which may have an impact in the way they are perceived by patients.In some instances, sadly, it is not possible to avoid a violent incident. When that is the case, it is very important to have adequate routines in place to ensure the proper care of those involved (post-incident care).

Conclusion

Staff safety is of course a top priority. But, so should patient safety be. Even an aggressive or violent patient is entitled to such handling that pain or injury is avoided. All our breakaway moves, control and restraint techniques are therefore designed not to inflict pain and to minimize the risk of injury. Designing those techniques has been a long-term process and we continually evaluate and revise the techniques we use, bearing our objective of ensuring both staff and patient safety in mind.

During the workshop we will give a brief presentation of the way we teach TMA. We will show some of our e-learning tools but will also give a short demonstration of a few techniques. These will be explained in detail and all attendants will have the opportunity to try these, both as caretaker and as patient. This is to experience physically how these techniques actually feel. Since there will be a certain amount of practical training, we advise attendants to dress casually and to use shoes with flat soles.

At the end of the workshop we will summarize our findings, and look at challenges for the future. We believe that our current training model is the best in Norway at present, and look forward to sharing it with fellow health workers in Europe. Hopefully, an exchange of know-how will enable us all to become even better at giving professional care to patients with violent behaviour.

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16. – Workshop 4 – Reducing Seclusion and Restraint in the USA – Successful restraint reduction practices across the United States: actualization of the American Psychiatric Nurses Association's seclusion and restraint standards of care

Marlene Nadler- Moodie (USA)

The American Psychiatric Nurses Association (APNA) provides the leadership for psychiatric nurses throughout the United States as well as including an international chapter. The Seclusion and Restraint Position Statement and Standards of Practice that was published in 2001 have been reviewed, revised and updated in 2007. These standards have been widely disseminated and used throughout the nation over the years since their inception and continue to offer clear direction regarding professional performance in the areas of leadership, staff training, and performance improvement. The standards of care set the course for collaborative work with clients and families; treatment planning; interventions including the initiation, monitoring, assessment and release of patients who, when all else fails, require seclusion or restraint; and standards for documentation.

The actual use of the Standards of Care, to offer evidenced-based best practices throughout the United States can be demonstrated by the successes in culture change in many different facilities where psychiatric patients are cared for and workplace violence potential is a significant consideration.

This workshop will include a thorough review of the American Psychiatric Nurses Association's updated version of the Position Statement and Standards of Practice and Care and evidence of their successful use by sharing practice models from a cross section of different APNA chapter(s) member's descriptions of how they have been and continue to be successfully used. Best practices in the areas of staff training, safely intervening with clients and other "hand's on/how to's" will be presented with an opportunity for discussion. This sharing of stories is a timeless format that offers the learner an array of knowledge from among colleagues within our international community.

The presenter is a current APNA Task Force for Seclusion and Restraint committee member and an elected Board of Directors Member for APNA. In these capacities, the presenter has been gathering successful best practice "stories" from a cross section of chapters and members and compiling them for a compelling session that is practice-oriented.

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17. – Creatinekinase (CK) as predictor of aggressive behaviour

Michael Grube, Robert Liszka, Hildegard Weigand-Tomiuk (Germany)

Key words:
Creatin kinase – aggressive behaviour – general psychiatry – prediction

Introduction:

The isoenzyme CK-MM plays a major role in the synthesis of ATP, the main source of energy in muscles. The enzyme catalyzes the reversible conversion of adenosindiphosphate (ADP) and creatine phosphate into adenosintriphosphate (ATP) and creatine. Other forms of creatine kinase include two additional isoenzymes, CK-MB (cardiac) and CK-BB (brain type), as well as mitochondrial CK. The total level of creatine kinase activity in the body is mainly attributable to the high quantity of CK-MM expressed in muscle mass. The correlation between increased CK-activity and aggressive behaviour has been described in two studies, each of which draws on data from 195 patients (Spitz et al. 1997, Hillbrand et al. 1998). These retrospective studies focus on male schizophrenic patients being treated on forensic-psychiatric wards only, not general psychiatric wards. As Steinert (2006) concluded recently, the findings of these studies are "solitary and not yet sufficiently confirmed". Because it is problematic to generalize results based on such a limited pool of patients, it is necessary to replicate and expand the retrospective studies described above to include a more heterogeneous group of general psychiatry inpatients of both genders.

Objective:

To carry out a prospective study in order to investigate the predictive validity of CK-activity for aggressive behaviour in male and female general psychiatry inpatients with heterogeneous diagnoses

Methods / Examined group:

Blood samples were taken as soon as possible on the referring ward (e.g. central emergency and admission unit) or on the secure psychiatric ward of the Städtische Kliniken-Frankfurt am Main Höchst. The normal blood levels for CK-activity in the Caucasian race are < 142 U/l in females and < 170 U/l in males. The measured CK-activity levels were classified as "pathological" or "non-pathological". In some instances, CK-values were rank-scaled for statistical purposes because the measured data were not normally distributed. Working independently of the doctor who collected the CK data, another doctor then assessed the patient's aggressive actions after admission to a secure ward according to the "Staff-Observation-Aggression-Scale-Revised" (SOAS-R, Nijman et al. 1999, 2005). This doctor also noted aspects of the patient's psychiatric history which could be relevant for future aggressive behaviour such as: history of organic cerebral disease or damage, history of life-time aggression, suicide attempts, self-injurious behaviour, sexual abuse, or maltreatment. Furthermore, information was collected about the ward such as the ratio of voluntarily vs. involuntarily admissions, atmosphere of the ward, and provisions for patient walks outside the secure ward. Using the "Psychopathy Check List: Screening Version" (Hare 2003), the grade of dissocial personality traits was assessed in the sense of Anglo-American definitions of psychopathy. The intensity of mental illness was evaluated with the "Clinical Global Impressions" scale using Item 1 (NIMH 1970). The statistical evaluation was carried out primarily with the help of an ROC curve (Receiver Operating

Characteristic) for plotting false positive and true positive predictions. The area under the curve represents the quality of the prediction (AUC). This differs from a straight diagonal line (the so-called line of no discrimination) that would represent completely random predictors. Nonparametric tests were also employed because of the scales used and the distribution of the values.

Within 3 months, 317 patients with valid CK-values were enrolled. Male patients accounted for 61.5% of the test group; females comprised 38.5%. The average age was 42.72 years (SD: 14.7, r: 18-91). The mean time of guarded inpatient treatment was 11.10 days (SD: 18.58, r: 1-163). The main diagnoses were distributed as follows: intoxications or drug addiction in 40.1% of the patient pool; schizophrenia in 27.8%; personality disorders, neurosis or reactive disorders in 12.6%; dementia or mental disorders of cerebro-organic origin in 5.4%; depression in 5.4%; schizoaffective disorders in 5.4%; and monopolar mania in 0.6%. Applying Item 1 of the Clinical Global Impression Scale, 55.8% of patients were defined as clearly ill persons, 27.8% as moderately ill, 13.9% as severely ill, and 2.5% as slightly ill. Seventy-seven of 317 patients (24.29%) showed aggressive behaviour, including physical and verbal aggression; 22.71% showed verbal aggression only; 8.83% displayed physical aggressive behaviour only. Verbal and physical aggressive behaviour was observed in 7.25% of the patients; 1.5% displayed physical aggressive behaviour without any verbal aggression. Repetitive aggressive behaviour was observed in 5.35% of the patients. The mean severity of aggressive behaviour measured by the SOAS-Score was 9.19 (SD: 5.71, r: 1-23). Fifty-seven out of 77 aggressive actions were observed on the first day of treatment. A fraction of 2/5 of the patients had a history of lifetime aggressive behaviour and an additional 2/5 had a history of attempted suicide. The mean value of dissocial personality traits measured with the help of the psychopathy checklist was 6.57 (SD: 4.4, r: 0-23). The mean CK-value was 272.55 U/I (SD: 673.19; r: 19-10.580). The median level of CK was 126 U/l and the 75% percentile was 253 U/l. The CK-values had no normal distribution (Kolmogorov-Smirnov-Z= 6.321, p= .000). A total of 38.8% of CK-levels were out of normal range.

Results:

We measured the quality of prediction for the occurrence of successive aggressive behaviour by the area under the curve (AUC) of the Receiver Operating Characteristics. Significant predictive factors for future aggressive behaviour include a pathological CK-level (AUC: 70.7%), a history of lifetime aggression (AUC: 69.7%), absence of a history of suicide attempts (AUC: 59.6%), and involuntarily admissions to hospital (AUC: 69.9). The variable "pathological CK-level" has a sensitivity of 70.1% and a specificity of 71.2%. A history of "lifetime aggression" has a sensitivity of 74.0% and a specificity of 65.4%, the variable "involuntarily hospital admission" a sensitivity of 62.3% and a specificity of 77.5%, and the variable "lack of suicide attempts" a sensitivity of 70.1% and a specificity of 49.2%. In addition, the predictive quality of these single variables can be calculated as follows using the odds ratio: pathological CK-level: o.r. = 5.819, p = .000; life time aggression: o.r. = 5.391, p = .000; lack of suicide attempts: o.r. = 2.271, p = .003; involuntarily admission: o.r. = 5.701, p = .000.

The predictive variables described above have a high common variance that can be measured by the calculation of "simple correspondences." A discriminance analysis was conducted using the dependent variable "aggressive behaviour" in order to estimate the predictive quality of each variable in a multivariate model and to ascertain the variance for each individual variable. The standardized canonical coefficients of discriminance progressively decreased between "pathological CK-level" (standardized canonical coefficient: .563), "involuntarily admission" (standardized canonical coefficient: .558), "life time aggression" (standardized canonical coefficient: .434), and "absence of suicide attempts" (standardized canonical coefficient: .217). An analysis of discriminance led to a division into two groups (aggressive vs. non-aggressive behaviour) when all four predictive single variables were integrated into the calculation simultaneously. ROC is useful for appraising the predicative quality of this discriminance analysis model: the AUC showed a correct prediction in 78.2 % of all cases. The sensitivity was 77.9%, and the specificity was 78.3%.

In the group that acted aggressively (N=77), 16 variables were tested to estimate their association with the intensity of aggressive behaviour measured by the SOAS-sum-score. Three single variables showed a significant association with the intensity of aggressive behaviour only: intensity of the mental illness (Spearman rho = .241, p = .035), pathological CK-level (Mann-Whitney U test: Z = -3.047, p = .002), and involuntarily admission (Mann-Whitney U test: Z = -2.283, p = .022). These variables were integrated into an ordinal regression analysis with the dependent variable "intensity of aggressive behaviour". Due to the Wald-characteristic, the variable "involuntarily admission" showed a higher impact on the intensity of aggressive behaviour than the variable "pathological CK-levels". The variable "severity of mental illness" did not reach the defined level of significance.

Discussion / Conclusion:

The results described above demonstrate that at the beginning of treatment in particular, pathological CK-levels have a high predictive value for aggressive behaviour. Due to the heterogeneous demographic background of the participating patients, the diversity of diagnoses, and the large number of patients, the results of this study are reliable and reproducible for secure wards. The described predictive quality is limited to a maximum of 11 days. Another limitation of the results is that it was not always possible for two separate doctors to independently evaluate the patient's aggressive behaviour and take blood samples. This prospective study concerning the predictive quality of pathological CK-levels thus replicates, underscores, and expands the results of Hillbrand et al.1998 by including both male and female patients who were being treated on secure general psychiatric wards for heterogeneous diagnoses. The results lead to the conclusion that increases in CK-levels in clinical practice should be taken into account in order to predict aggressive behaviour and to take appropriate precautions. The level of pathological CK-activity can give some indication of the intensity of aggressive behaviour to be expected. The next step should be to evaluate the predictive quality of CK-levels in other settings such as outpatient treatment, open psychiatric wards, and day-clinic treatment.

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18. – Blood levels of lipids and serotonin as predictors of self harm and violence in acutely admitted psychiatric patients

Roaldset, J.O., Moger, T.A., Bjørkly, S., Bakken, A, Hervig, T. & Gøtestam, KG, (Norway)

The risk of self-harm or violent behaviour against others in psychiatric patients is a clinical research topic of great current interest. A relationship between low lipid levels and aggressive behaviour against others, and between low serotonin- and lipid levels and suicidal behaviour has been presented in the literature. In our acute psychiatric ward at Ålesund County Hospital we conducted a prospective naturalistic study of risk assessment of aggressive and violent behaviour at admittance and at discharge, followed by prospective measurement of occurred episodes after discharge.

All acute admitted patients during one year (494 persons with 716 admittances) were included in the project. At admittance the Violence Risk Screening-10 (VRS-10; Hartvig et al., 2006), suicidal items and self prediction were recorded, and the patients were asked to give a blood sample to measure lipids and serotonin (289 samples). Incidents of the two types of aggressive behaviour (against others and/or self) were monitored (phase one). At discharge the same measurement procedure was repeated as when patients had been admitted to the ward. Patients will be followed up for one year (measurement of occurred episodes of violence after 3, 6, 9 and 12 months, phase two).

Findings from the analyses of the strength of the relationship between lipids and serotonin as predictors of self-harm and violent behaviour against others during the subsequent hospital stay (phase 1), will be presented.

The project is approved by The Regional Committe for Medical Research Ethics, The Norwegian Social Science Data Services and The Ministry of Health and Care Services.

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19. – Association between aggression and medication changes

L.E. Goedhard, J.J. Stolker, H.L.I. Nijman, ACG Egberts and ER Heerdink (Netherlands)

Background

We recently found that aggression is associated with an increased use of as-needed medication. It is yet unclear whether aggression is also associated with changes in regular medication.

Objectives

To investigate the association between aggression in psychiatric patients and changes in regular medication.

Methods

A 16-months prospective observational study was conducted in three psychiatric wards in which aggressive incidents were registered using the SOAS-R scale.

Aggressive and non-aggressive patients were compared with respect to the event density per 100 personmonths(ED) of psychotropic and somatic medication changes (start, discontinuation, dose-increase, dose-decrease, switch to another drug within the same therapeutic drug class and formula change).

Furthermore, changes in psychotropic medication three days before and following aggression episodes were compared.

Results

A total of 106 out of the 174 included patients exhibited 1107 aggressive incidents. Follow-up time was 1,243 person months. For aggressive patients 653 psychotropic medication changes were observed versus 167 changes for non-aggressive patients (ED: 16.6 and 11.4, respectively; ED ratio : 1.5, 95%CI [1.3-1.8]). For aggressive patients, significantly higher EDs were observed for start of medication and dose-increases (ED 3.9 vs 2.3 and 4.4 vs 2.1, respectively); EDs for other changes were non-significantly increased. ED of somatic medication changes for aggressive patients and non-aggressive patients did not differ significantly (ED:2.5 and 2.0, respectively).

Number of changes three days before and following aggressive episodes did not differ. However, during aggressive episodes, i.e. 16% of total follow-up time, 210 (32%) medication changes occurred.

Conclusions

Increased number of medication changes, especially start and dose-increase, was associated with aggression. Future research should unravel the reasons why regular medication regimens of aggressive patients are frequently subject to change.

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Preferred form of presentation: oral paper presentation

20. – Why do mentally ill individuals act aggressively in specific situations? Towards an integration of the individual model and the situational model

Richter, D. (Germany)

Background

When it comes to explaining violence among mentally ill people, there are currently two models to be found in the research literature, standing side by side. The dominant model is the 'individual model'. This model is centred on personal features of an individual that may contribute to his or her aggressive behaviour (psychopathology, history of aggression, low impulse control etc.). Another, but less dominant model is focussing on the situation and/or interaction, where the actual aggression occurs. This model looks at the situational dynamics, the escalative behaviour of all persons involved or at the environmental features of the location.

Objective

After reviewing several empirical and theoretical aspects of both models, this presentation sets out to develop a theory that aims at integrating both approaches. Based on concepts from developmental psychology, behavioural genetics and sociology of deviant behaviour, it is proposed that mentally ill individuals are likely to evoke harsh reactions from their social environment during their life-course. Reinforced by the actual psychopathology, these reactions are perceived as aversive stimuli during specific situations that in turn may lead to aggressive or violent behaviour.

Discussion

Several methodological and theoretical issues will be discussed, e.g., the topics of violence prediction or the adequacy of theoretical educational models for staff.

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21. – The functions of aggressive acts for high risk personality disordered inpatients

Michael Daffern and Kevin Howells (UK)

Keywords:
Aggression Functions Personality Disorder

Background

In forensic mental health settings, such as those provided by the "Dangerous and Severe Personality Disorder" (DSPD) initiative in the United Kingdom, antisocial expression of underlying needs stemming from personality disorder is likely to take the form of aggression to other patients or staff in the institution. In this case, it becomes necessary to determine what functions such aggression might serve for the aggressive patient. From this theoretical perspective, establishing functions can inform how treatment is then structured – the patient, for example might be helped to develop non-aggressive expression of particular needs.

Such assessment and treatment activity can be related to concepts and methods in behavioural psychology, specifically, functional analysis . Functional analysis is defined by Haynes and O'Brien (1990) as the "identification of important, controllable, causal functional relationships applicable to a specified set of target behaviours for an individual client" (p. 654). This type of analysis seeks to identify the purpose of problem behaviour and determine the factors responsible for the development, expression and maintenance of the behaviour. Assessment of the individual's predisposing characteristics, the antecedent events that are considered important for the initiation of the behaviour, the behaviour itself, and the consequences of the behaviour, which maintain and direct its developmental course (Haynes, 1998) are required. Information obtained from the functional assessment is then used to design an intervention. In practice, the client's functional needs are identified and acknowledged, with the clinician facilitating their expression in a more constructive manner

The focus of the present study was to apply a method used for identifying the functions of aggression to a personality disordered patient population. In addition, the aim was to compare functions across community (the index offence) and inpatient settings (within the hospital). Information about functions would also allow comparison with previous research with mentally disordered offenders. The study was also intended to examine the comparability of assessment of function with the Assessment and Classification of Function methodology (Daffern, Howells & Ogloff, 2007) using file review with an assessment based on interviews with staff and patients. The principle aim was, however, to examine the broad functions of aggression in personality disordered patients so that these needs could be considered in the treatment of aggressive personality disordered patients.

Method

The setting for this project was the Peaks Unit, a high secure Dangerous and Severe Personality Disorder (DSPD) service located within the grounds of Rampton Hospital, England. At the time of this study a total of 45 patients had been admitted to the Peaks Unit.

Measures:

For both studies, the function of aggressive behaviour was determined using the ACF (Daffern et al., 2007). The ACF was revised to include two additional functions: 'sensation seeking' and "sexual gratification' These two additional functions were included because patients admitted to the unit where this study was conducted often scored high in psychopathy and sensation seeking is a prominent characteristic of psychopathic patients (Hare, 1991). Sexual gratification was also included because many Peaks unit patients had a history of sexual offending and because clinical staff often reported that many patients' aggressive behaviour also had sexual functions. The functions assessed in the revised ACF were: Demand avoidance, To force compliance, To express anger, To reduce tension (catharsis), To obtain tangibles, Social distance reduction (attention seeking): To enhance status or social approval, Compliance with instruction, To observe suffering, Sensation seeking, and Sexual gratification. For increased detail on these functions see Daffern et al. (2007) or write to MD (Michael.daffern@forensicare.vic.gov.au) for a copy of the ACF.

Study 1: File Review

The first study involved the assessment of functions in each patient's index offence through file review. Only violent index offences were reviewed. Files were reviewed and the ACF was scored by KH. The second file review study involved the analysis and classification of function of up to five incidents of aggressive behaviour occurring during each patient's stay on the Peaks Unit. Incidents of inpatient aggression were identified by reviewing a database containing dates of aggression as recorded on standard hospital Incident Forms. Once a date for an incident was identified, the patient's file was then reviewed to determine function. File note entries made in the three days prior to the aggressive incident, the day of the incident and three days after the incident were reviewed by MD.

In both file review studies the goal of assessment was to determine whether each of the functions within the ACF was present or absent.

Study 2: Interviews with staff and patients following incidents of aggression

A second study involved the assessment of incidents of aggression occurring within the Peaks Unit between 1st June 2006 and 31st September 2006. The function of these incidents was classified according to the ACF after staff and patients involved in the incident were interviewed by one of the authors. To facilitate this study a nurse who had observed the incident, or another nurse who was aware of details of the aggressive behaviour, and who was familiar with the aggressive patient, was interviewed. In a semi-structured interview the nurse described the incident. The aggressive patient was approached to participate in a similar semi-structured interview provided they were not in seclusion, were able to provide informed consent , and staff believed an approach to participate in the research would not increase the likelihood of further aggression. Following the interview/s with staff and patients MD synthesised the various accounts of the aggressive behaviour and rated the functions.

Results

Anger expression was by far the most common function in all the studies and applied to virtually all incidents. This is consistent with the notion that most incidents are of an angry aggressive rather than an instrumental nature. Tangible instrumental functions (for example, to obtain money) were relatively rare in all settings, though they did occur. It could be argued that "To enhance status or social approval" has instrumental (non-tangible) aspects and this is observed for inpatient aggression for both methods. Enhancing status and social approval are institutional functions based on perceived peer group reinforcement for aggression. Virtually none of the index offences were committed in a peer group context, thus this function is unlikely to be operative.

"To force compliance" was common for the index offence but not for inpatient aggression. This may reflect the high frequency of sexual motives in the index offences, which is consistent with

the high "sexual gratification" function. It is likely that aggression is being used to coerce the victim into behaviours which are sexually arousing to the perpetrator.

"To observe suffering" and "sensation seeking" were more frequent for the index offences than for institutional aggression. This, again, is consistent with a sexual gratification function of a sexual sadistic type .

The high frequency for reducing tension is congruent with the Expression of anger function and also with the general literature on the aetiology of aggression that consistently points to the importance of negative affective states (including anger) as an antecedent for some forms of aggression (Bettencourt et al, 2006; Berkowitz, 1999)

Discussion

The high frequency of anger and tension reduction functions in the present results, rather than instrumental functions, contradicts previous suggestions that personality disorder may be associated with instrumental violence. The latter previous findings, however, relate to psychopathic disorder specifically. Although psychopathy levels are high in the Peaks population (see above), and high PCL-R scores form one criterion for admission, Borderline Personality Disorders and Borderline features are also very common. Negative affect is a core feature of Borderline traits and these may in part account for the negative affect functions found in the present study. An obvious and testable hypothesis for future research is that Psychopathic and Antisocial personality disorders differ from Borderline personality disorder in the functions of aggression.

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22. – Profile of perpetrators with impulsive violence

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Key words
Impulsive violence, reward delay and rapid response impulsive violence, assessment instruments, profile of perpetrators.

Introduction

The basic premise underlying this thesis (Brouwers, 2007) is that many offences are committed impulsively. The offender had no intention of committing the offence yet it still happened. Impulsive violent behaviour (IVB) should be distinguished from instrumental violent behaviour (Weinschenker & Siegel, 2002). In order to clearly define the study objective violent behaviour was chosen, as this has a clear physical component, whereas this is not always the case for aggression, which includes a far broader range of behaviour. Violence, aggression and impulsiveness have been studied in great detail, yet the restriction and amalgamation to IVB yielded, to our surprise, relatively little material.

Many models have been proposed and authors agree that an integrated study of this subject is needed. That is why the biological, cognitive and social psychological perspectives have been integrally included right from the start of the study. The literature about this subject from the cognitive and social psychological perspective is disproportionately smaller than the volume of biological literature.

The clinical and societal relevance of this study: clinically there is a need for an improved distinction and localisation of impulsive violent behaviour, improved predictions of when this will happen and improved treatment to reduce the chance of recidivism in the future, or even to prevent it. The societal relevance is the discussion about shifting the self-determination of perpetrators of impulsive violent offences to incapacity, and persuading offenders to undergo treatment, if needs be in a conditional part of the sentence. For treatment, a disease or disorder is necessary, and IVB does not yet have the status of a separate psychopathological entity. This study intends to, among other things, rectify this last point.

Methods, results

The results of the literature study into the biological, cognitive and psychosocial factors associated with IVB led to a more restricted definition of the subject: impulsive with respect to instrumental violent behaviour. Impulsive violent behaviour can be divided in two entities: the time form based on reward delay impulsivity (TIVB) and the context form based on rapid response impulsivity CIVB).

The TIVB is recognised in the Periodic Explosive Disorder and closely related to the criteria of PES the following criteria for the Impulsive Violent Disorder© based on CIVB are cited:

1. violent behaviour as a response to a provocation (real or imagined);
2. the violent behaviour occurs within a short time span (15-30 minutes) following the provocation;
3. the level of violence is highly extreme compared to the provocation;
4. there is a logical and less violent alternative available;
5. immediately prior to and during the violent behaviour no inner consideration takes place and the consequences and/or context are not taken into account;

6. important information is missed like witnesses or a much stronger opponent;the person exhibits no pattern or regularly applying similar violent behaviour according to the periodic explosive disorder.

The question raised was if men who exhibited this kind of violence were different from the normal population? The literature survey produced a unique set of factors associated with impulsive violence. With respect to the biological factors: in addition to the anatomical locations such as the prefrontal cortex, amygdale and angular gyres, an enhanced primary impulse as a consequence of an elevated dopamine activity in various areas of the brain and the factors facilitating this such as alcohol and cocaine use. Further: reduced secondary sense of meaning as a consequence of high cortisol during aversive stimulation, a reduced serotonin activity which leads to a reduced inhibitive effect, and as facilitating factor a traumatic history. Cognitive factors found to be relevant were a high positive, unstable self-image, impulsiveness, problematic self-control, difficulty with verbal expression, low "self disclosure" and hostility.The psychosocial factors found to be relevant were the influence of an violent group and the presence of a weapon. None of the factors discovered were found to discriminate between having or not having impulsive violent behaviour. It is not even clear to what extent which factor is necessary for IVB to be incited.

The factors themselves are not unique and we find most of them back in the fourth generation risk assessment instruments like the Violence Risk Scale of Stephan Wong and Audrey Gordon (2007). The kind of violence that is used is in our opinion the fourth quality that has to assess besides risk level, criminogenic needs and level of motivation.

Subsequently the items were specified. Initially questionnaires were sought that had previously been used for research into IVB. If these were not available then questionnaires used in research on aggression were sought. Finally, for the remaining items a theoretical argument for an existing instrument (not previously used in research into violence) to measure the item was sought. For example, this was the case for the factor "high positive unstable self image". Where possible, items were also formulated as a single question, for example if alcohol or drugs were used when the violence occurred. The reliability, internal consistency of the questionnaire developed was investigated. As the most commonly used questionnaires have been developed for the American situation, it was necessary to determine the relevance of the translations to the Dutch situation. Impulsive violence has degrees of seriousness and for this study the extremes were chosen. To estimate the criterion validity, two groups were compared for the factors found in the literature and operationalised in the questionnaire. To be sure that the study group were men with an impulsive violent act, men were selected who had committed an impulsive violent offence. The control group were volunteers who had responded by phone following an advertisement and were familiar with the urge to be violent after a provocation but can resist it or were less violent like smashing or kicking a door. It was important that their educational level was the same as that of the control group and that they had not previously been convicted. The study group differed from the control group for almost all factors.

During the calculation of higher order factors, three groups of factors were discovered: the first group contains factors associated with where the situation took place: being under the influence of alcohol or drugs and having a weapon available. The second group concerned reduced verbal intelligence. The third group contained factors that represent a certain tendency towards IVB, namely, impulsiveness, arousabillity, hostility, physical violence and anger.

Conclusion, discussion

1. There are different kinds of violence. Impulsive violent behaviour (IVB) should be distinguished from instrumental violent behaviour although there is considerable overlap and dependent of the population 60-90 percent of violent crimes are committed impulsive (Stanford a. a., 2003, Kockler a. a., 2006).
2. The kind of violence that is used is the fourth quality besides risk level, criminogenic needs and level of motivation.
3. Criteria for Impulsive Violent Disorder are formulated.
4. A new set of factors related to impulsive violence is defined.
5. The profile of the perpetrator with criteria of the impulsive violent disorder distinguished three groups of factors with different levels of importance. First factors associated with the situation: being under the influence of alcohol or drugs and having a weapon available, the second group is concerned with reduced verbal intelligence. The third group contained factors that represent a certain tendency towards IVB, namely, impulsiveness, arousabillity, hostility, physical violence and anger. If men with other forms of violence and or psychiatric disorder have a similar profile should be investigated in future research.

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23. – A brief checklist (VRS-10) for assessing violence risk among patients in acute psychiatric units

P. Hartvig, B.Østberg (Norway)

Violence risk assessment instruments are increasingly being used. Their development and clinical application, however, have mostly been confined to forensic settings. There is a paucity of instruments and studies of violence risk assessment among discharged persons from acute inpatient units. Available instruments are extensive and time consuming for screening or regular use in acute and general psychiatry.

In our research centre a brief screening checklist for violence risk in acute psychiatry with its procedures, has been developed over the last five years. This process started with the compilation of 33 presumably adequate items in a provisional scheme. This scheme was inspired by the HCR-20 (Historical, Clinical and Risk Management Assessment Scheme), and other risk factors found in the literature. One hundred and ten patients from an acute inpatient unit, scored with this provisional scheme at discharge, were monitored for violent episodes throughout the following year. Risk assessments and violence registrations were then compared. Of the 110 patients 29 (26%) had acted violently during the follow-up, with scores of the provisional scheme showing a definite association with post-discharge violence. Receiver operating characteristics (ROC) for the provisional instrument yielded an area under the curve (AUC) of 0.71, ($p<0.01$). Regression analysis indicated that the number of items could be strongly reduced without losing predictive validity.

The aim of the next step was to develop and validate a brief and less time-consuming checklist. This work resulted in a ten-item checklist with the following items: Previous violence, Violent threats, Substance use problems, Major mental illness, Personality disorder, Lack of insight, Suspiciousness, Lack of empathy, Unrealistic planning, Future stress situations. A reliability test showed that the instrument had high interrater reliability (ICC=0.87). During 2006 all admitted and subsequently discharged patients in two acute inpatient units were assessed by the VRS-10 (N=1500 admissions). Violent acts by patients during the inpatient period were recorded and compared to the checklist scores upon admission. Results were promising (AUC = 0.77) By the end of 2007 a one-year comparison between checklist scores upon discharge and subsequent violent acts during a one- year outpatient follow-up will be completed.

Conclusion:

After promising results in a preliminary study, a brief violence risk assessment instrument ("VRS-10", Violence Risk Screening-10) has been developed. Its predictive validity appears to be good. Further clinical trial regarding the predictive validity for discharged patients is currently carried out. Ethical aspects of this research on violence risk assessment, management, communication, and the practical/procedural aspects of the implementation of this brief checklist, will be discussed.

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24. – The efficacy of violence risk assessment instruments in those with personality disorder and mental illness

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Are the factors that predict future violence in mentally disordered offenders independent of their diagnosis? We examined a range of instruments designed to predict future violence in three all male samples. The first sample had a diagnosis of mental illness (MI, mainly schizophrenia and affective disorders; N=668), the second a diagnosis of Personality Disorder (PD; N=98) and the third had co-morbid MI and PD (N=75). We followed the patients' criminal histories after discharge from medium secure units over at least a 2-year period (average=6.5 years). Reconviction rates for violent offences in the MI group were under ½ that of the PD group, with the co-morbid group lying in between. Our risk assessment instruments (VRAG, PCL-SV, and HCR-20), all showed significant predictive power (defined by ROCs) in the MI group and the co-morbid group. The AUCs for the PD group were well below that of the other groups and none differed significantly from chance. The results suggest that those with PD are far more violent than those without PD. However, the risk assessment tools currently in use do not appear to be able to differentiate which of these offenders with PD are the most likely to be violent.

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25. – Risk factors considered by nurses when assessing subjectively the risk for violence among patients in psychiatric admission wards

Christoph Abderhalden & Caroline Gurtner (Switzerland)

Background

Accurate risk assessment plays a crucial role in the prevention of violence in psychiatric settings. One of the clinical methods to assess the short-term risk for violence is the subjective assessment of risk. Employing Likert-type scales or Visual Analogue Scales emphasizes the staff's ability to judge the risk by integrating all available information into a formal subjective risk prediction statement. Investigators applying this approach found promising proportions of correct predictions [1-6]. In acute settings, this method has several advantages over more sophisticated actuarial methods: To include the experience of the staff currently dealing with the patient allows the consideration of fluctuating situational, environmental and interactional risk factors, and does not depend on data that may not be readily available in acutely admitted patients. However, one of the problems related to the subjective risk assessment is the lack of information on the factors considered by the staff members [1]. Based on these findings, we initiated a study to explore the thoughts of psychiatric nurses when subjectively assessing the risk for violence among acute psychiatric inpatients. We intended to get insights into the actual clinical practice and to use the implicit clinical knowledge of nurses in order to identify risk factors that might be of importance in the improvement of short-term risk assessment.

Methods and Materials

The study took place in three psychiatric acute wards in German speaking Switzerland. On the study wards, nurses routinely apply a modified version of the Broeset Violence Checklist (BVC-CH) [1]. This instrument includes a slide-ruler-style Visual Analog Scale to assess subjectively the overall risk for a physical assault within the next few hours. Risk is expressed in a scale ranging from 0 (no risk) to 6 (very high risk).

One of the authors (C.G.) interviewed a convenience sample of psychiatric nurses immediately after they had assessed a patient's short term risk for violence. The interviews took place on the wards and were audiotaped. The interviews started with a few questions on the respective patient (gender, age, duration of stay, if the nurse knew the patient before and if the risk assessment was perceived as diffult). The main question then was "You made an assessment on the risk for violence, which observations, past experiences, thought and feelings had an influence on your estimation of the risk? Please tell us everything that occurs to you".

We analysed the transcripts of the interviews employing qualitative content analysis techniques. In a first step, we extracted text segments (meaning units, items) containing different single aspects considered. In a second step, we clustered these items into descriptive categories. In this paper, we report some descriptive results concerning the aspects considered in the course oft he risk assessment process.

Results

Sample

The sample consisted of interviews with 31 nurses on the risk-assessment of 60 patients. The mean age of the nurses was 38 years, and sixty-five percent of them were female (n=20). The mean clinical experience in psychiatry was 7 years. Nineteen had an education in psychiatric nursing and 12 in general nursing.

Content analysis: Overview

We extracted 278 items in total. The median number of items mentioned per interview was 4 and ranged from 1 to 12. We identified 13 descriptive main categories (Table 1). Three of these categories were further divided into subcategories.

Table 1: Main descriptive categories (numbers are frequencies of items)

Main category	n	%	% cumulated
Actual behaviour	79	28,4	28,4
Patient's history	76	27,3	55,8
Own feelings/experiences	43	15,5	71,2
Interaction/ communication	28	10,1	81,3
Therapeutic interventions	13	4,7	86,0
Physical appearance	10	3,6	89,6
Psychopathology	8	2,9	92,4
Type/direction of aggression	6	2,2	94,6
Lack of information	6	2,2	96,8
Personal risk assessment experience	4	1,4	98,2
Circumstances of admission	2	,7	98,9
Reactions of fellow patients	2	,7	99,6
Ward environment	1	,4	100,0
Total	278	100,0	

The most frequently used categories were actual behaviour, patients history, own feelings/ experiences, interaction/ communication. These categories accounted for 81% of the items mentioned. Less frequently found categories were psychopathology, circumstances of admission, therapeutic interventions, reactions of fellow patients, type/direction of aggression, physical appearance, lack of information, personal risk assessment experience, and ward environment.

Content analysis: Most frequently used categories

Patient's history. Nurses often relied on previous experiences with the patient. This information was equally used as argument for or against the presence of risk. Own experiences was more frequently mentioned than actuarial information or informations obtained from colleagues. Historical information was mainly used to interpret actual behaviour ("He appears tense, but he has never actually attacked someone in the past", and vice versa).

Actual behaviour: Actual behavior was a crucial factor to assess an increased or decreased risk. The most frequently cited behaviours could be placed on three continua: calm vs. tense/restless;

cooperative vs. non-cooperative; predictable/stable/consistent vs. unpredictable/fluctuating/inconsistent. Other relevant behaviors were the ability of the patient to regulate nearness-distance or the capability to comply with mutual agreements or ward rules. In many cases, positive and negative aspects were weighted against another ("He is confused, but he still manages to balance near and distance").

Interaction/Communication: The perception of communication and interaction processes plays an important role. Communication barriers were associated with higher risk estimations. However, these barriers could be related to language problems as well as to the patients or the nurses ("I cannot reach him"). In contrast, an open flew of communication was seen as resource for prevention and lowered the risk.

Own feelings/Experiences: In many situations, a gut feeling was the decisive factor. This was sometimes evoked by reminiscences of similar situations. Usually, uncertain feelings with regard to the level of risk led to higher risk estimation.

Discussion

The aim of this study was to identify factors considered by nurses when they subjectively assess the risk for violence among psychiatric inpatients. The results indicate that the nurses in our study considered a great variety of factors possibly influencing the risk for violence. Some of these factors are well known from the literature (e.g. history of violence). However, others are rarely researched and/or integrated into risk assessment instruments. Behavior on the ward (e.g. degree of cooperation; stability/predictability) and communication/interactional aspect could be potentially useful concepts and might deserve more attention in clinical practice and research.

However, the rare use of other factors like environmental aspects indicates unused potentials of an open subjective risk assessment.

It was remarkable that nurses tend to balance risk increasing and risk decreasing factors in order to decide on the level of risk. Further exploration of these decision making processes could contribute to the development of more sophisticated instruments for risk assessment that would encompass more than just lists of factors known to increase the risk.

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26. – Therapeutic Management of Violence (TMV) – A multichannel approach to prevention and management of violence

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Keywords
Staff Training; Violence; Prevention; Management; Aggression; Therapeutic

Introduction

Although rules and regulations within the health system in Norway and most other countries state that staff has not only the right, but also a duty to restrain behaviour which is potentially dangerous to oneself or others, alternatives to the use of force should be the option of choice. Health staff is thus required to take care of a person who is acting aggressively in an emergency situation, in a humane and least restrictive way.

Methods to reduce and prevent restraint are legally, ethically and professionally required at all levels. To meet these demands, the program Therapeutic Management of Violence (TMV®) has been developed by Lovestad School. It is a nation-wide multi-channel, practical approach to the prevention and management of violence, experienced as a best-practice method over 30 years. The method is based on multimodal interventions, and includes behavioural components, emotion-targeted components as well as cognitive components.

This paper presents the background of TMV, and illustrates its best evidence based practice with examples on the use of TMV. Further, the paper elaborates on how the principles of the method may be practiced on individual and institutional level after getting a detailed training under skilled instruction.

Last, an example from a supporting software tool, TMV-SAK, is used to illustrate the effect of TMV. This software has been used in several institutions and hospitals in Norway over the last years, and clearly documents how TMV has helped staff to gain greater confidence and skills in preventing and handling difficult situations, as well as supporting and speeding up the effect of cognitive treatment programs on aggression and violence.

The nature of violence

In this paper, we use a wide definition of violence: "All psychical and physical molestation". By nature, violence reflects a desire for change or alteration – the function of violence is to make this alteration. Violence is also a way of communicating. Simply put, "violence is the weapon of the weak" – under severe stress a person with poor communication abilities may find it easy to resort to the use of violence. Hence, training in communication skills is the single most important factor in preventing violence. This is valid both for staff and clients

Communication in this context includes the body language and your placing and angle in relation to a potentially violent person. According to our experience on this subject over the last 30 years, consciousness regarding strategic placing in critical situations is the most powerful change in staff behaviour, and is the single most important factor to reduce the statistics of injury caused by violence in institutions.

TMV – the "Bridge over troubled water"

Therapeutic Management of Violence (TMV®) is a multi-channel approach to the prevention and management of violence, developed by Lovestad School. TMV is an alternative to more primitive martial arts based self-defence programs for conflict handling, and offers untraditional and unique solutions that supports and speeds up the effect of cognitive treatment programs on aggression and violence, such as anger management and aggression replacement training.

Our ambition has been to build a bridge between what happens before violence an incident occurs, what happens after it has occurred, and how to prevent it to happen. The handling and management of the acute situation when verbal or physical violence occurs has traditionally not been linked to recognized methods for prevention and treatment of violence. TMV provide this link, by introducing principles for communication that works equally well in treatment of patients as in handling a patient who is acting aggressively in an emergency situation.

The five main building blocks of TMV are:

• Understanding of violence
• Prevention of violence
• Management and handling of violence
• Follow-up after violence/incident
• Treatment of violence

The program increases the understanding and awareness of how aggressive behaviour may escalate, and thereby how one may act pro-actively in such situations. TMV also includes psychological as well as physical techniques for the staff. Through these techniques one learns how to minimize the use of physical power, giving several alternatives to restraint, and thereby providing a more acceptable ethical solution to the problem.

The method stress the importance of paying respect to the patient one is trying to help, as well as creating an attitude towards protection of persons who lack the ability to draw their own limits.

The guidelines of this unique method, which also includes untraditional physical techniques for minimizing the use of physical power, was initially developed for management of violence in society at large, e.g. at home and in the streets. It was later developed to also support therapeutic management of violence in psychiatric institutions. During the last decade, there has been a trend in Norway away from the traditional psychiatric institutions, towards care and control in more open and decentralised institutions. This has brought TMV back to many of the initial focus areas, i.e. handling and management of violence in social settings still applying the same fundamental principles for communication.

Benefits of TMV and where and how it may be applied

TMV has been developed as a practical method with training courses on pro-active prevention and solving of conflicts and aggressive behaviour among clients in institutions. The principal aim of the program is to help and protect the client, at the same time meeting the staff's need for psychological as well as physical security. Staff feeling tense and insecure can easily appear as a threat to the patient and thereby provoke aggressive behaviour. Hence, a sense of physical and psychological security is seen as necessary in order to develop a good atmosphere in the relationship between patients and staff.

The techniques of management must in it self be shaped for improving relations and making the client more secure and less anxious. It is of vital importance to have comprehensive knowledge about the psychological processes physical interventions may trigger. Otherwise these interventions may have effects opposite of those desired. This is especially important in connection with maltreated clients.

Based on a special model of the body zones, developed and designed at the Lovestad School, the methods of physical techniques for body handling in TMV are well-founded psychological,

pedagogical, ethical and legally. All involved in the therapeutic environment need to know that this is a secure place to be. Causing pain, on the other hand, increase aggression. Then the "therapeutic handling" may easily be experienced as "muscle psychiatry", see illustrations below of techniques to avoid:

Figures: "muscle psychiatry" in practise…

Psychologically there is little care in holding a client in a way that prevents natural defence mechanisms. It is especially bad to expose maltreated clients. Techniques where the arms of the client are hold to the sides may well be provoking fear and anxiety and will then in reality be anti-therapeutic! Legal protection is a requirement for all parties involved, also for the client - meeting violence from a client with violence from the staff is not an acceptable solution, either legally, professionally or ethically. TMV offers an alternative to such methods.

TMV has been used with good results within the health sector, in units for violent/aggressive psychiatric patients, and institutions for mentally retarded, autism, dementia, ADHD, drug care. Also, the method has been applied with noticeable effect within schools, social security offices, service institutions and companies. The method has even been used with good effect towards refugees suffering from war trauma and mental overload. TMV has been shaped from a service user perspective, as well as for maltreated clients with serious behaviour problems. It is lately used at governmental level in Norway as the basis for new treatment programs for violent youths.

How to make TMV work

Implementing TMV in an efficient way assumes that is wise to handle the clients in the same way in peaceful situations as in emergency situations. Hence, one may practise TMV principles in every-day situations, on a daily basis, and thereby prepare oneself how to act in threatening or even critical situations.

Training in TMV is a practical way of conducting quality assurance of the way we communicate. The non-verbal management of violence includes specially developed physical techniques for the staff, based on the principles of a "firm and caring hand", where one learns how to minimize the use of physical power:

Figure: Training in the use of a "Firm and caring hand" and minimal use of physical power

Based on our assumption mentioned earlier, that violence is a way of communicating; one of the fundamental principles of TMV is to transform aggressive behaviour into positive behaviour by using paradoxical techniques. This is supported by a curve we have dubbed "SBC tension curve" (SBC =SAK in Norwegian, thereof the term TMV-SAK introduced elsewhere in the paper). The figure illustrates how a violent incident may escalate – where an external stimulus may trigger the patient's tension level changing from normal (low-tension to tense), and further to high-tension, and finally ends up in the client acting out when the tension level reaches overwrought level.

Figure: SBC tension curve, where S=Situation and Signals, B=Behaviour, C=Consequence

We use the curve to train how to analyse what happens before, during and after violent incidents. It serves as a useful aid in providing training in observing, interpreting and predicting signals, situations and contexts where clients may act aggressively or violent. This in turn, increases the understanding and awareness of how aggressive behaviour may escalate, and thereby how one may act pro-actively to avoid such situations.

The figure also illustrates how TMV Case Management techniques may be used to as alternatives to violence, both pedagogically and therapeutically:
• Relaxation of tensions
• Distraction
• Alternatives to violence: Think, Talk, Treat (TTT)

Further, TMV Case Management recommends the following techniques:
1. Consciousnesses regarding strategic placing yourself in relation to the client, also taking into account the client's body zone/ comfort zone.
2. Make sure you obtain eye contact, and activate the client's natural language comprehension ability (activate the Werncike area of the brain).
3. Act as a waiter – activate the client's own ability to speak (activate Broca area of the brain).

The same principles may be applied whether the client is drugged, psychotic, confused or determined. It is recommended that the principles of the method is practiced on individual and institutional level after getting a detailed training under skilled instruction. To secure functional training in the mental, verbal and non-verbal techniques, a follow-up program is organized with resource persons (ombudsman). A more extensive education for training of trainers in TMV is also offered.

Effects of staff training in TMV

The software program TMV-SAK has been used in several institutions and hospitals in Norway over the last years to document the effect of staff training in general, and training in TMV in particular. The general trend is that it shows significant effect on the staff in changing their behaviour and attitudes towards the clients, thereby creating a calmer and more secure atmosphere.

The reports gathered from these institutions documents how TMV has helped staff to gain greater confidence and skills in preventing and handling difficult situations, as well as supporting and

speeding up the effect of cognitive treatment programs on aggression and violence. TMV thus proves to be at help to a more non-violent behaviour among clients.

The case below is collected from an institution where an extremely violent patient suffering from frontal lobe dementia caused daily injuries to the staff over a long period. The registration of incidents and injuries took place over a period of 12 months before training in TMV was conducted, and thereafter over a period of 12 months after the training in TMV took place.

The first comparison shows a reduction of sick leave from a total of 353 days distributed on several staff before the training, down to a total of only 10 days, and for one staff only, after the training! Add to this fact that these10 days of sick leave was attributed to one staff that returned from previous sick leave, without getting trained in TMV before entering into new duty…

The second comparison shows that not only did the sick leave go drastically down after training in TMV was conducted, but also did the type of incidents change into less serious type of incidents after the training:

Conclusions and final remarks

Realizing that violence reflects a desire for change or alteration, and that violence is a way of communicating, TMV stress that training in communication skills is the single most important factor in preventing violence.

New rules and regulations within the health system in Norway and most other countries calls for methods to reduce and prevent restraint, and that they are legally, ethically and professionally acceptable. Experiences from more than 30 years of development of TMV, and teaching TMV to hospital staff humane ways of dealing with violence, has showed that TMV really works – it does offer health staff a practical, humane and least restrictive way to take care of a person who is acting

aggressively in an emergency situation, and it does offer a therapeutic management of violence. Over the last 8 years, the software TMV-SAK has been used to document this experience.

On a last remark, we see a future potential for further improvements of the positive effects of TMV by combining it with other programs for treatment of clients, since treatment is not the main focus area of TMV.

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27. – Evaluation of a 3-day training course in aggression management on nursing students

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Keywords
Aggression, violence, nursing student, nursing education, aggression management

Introduction and background

Aggression perpetrated by patients or relatives is neither confined to a certain country nor to psychiatric settings (O'Connell et al. 2000; Wells & Bowers 2002; Winstanley & Whittington 2002; 2004). As the British Crime Survey (Upson 2004), the North Eastern Health Board (NEHB 2004) and research in other countries (Needham et al. 2005) state the nursing profession has one of the highest assault risks. There is also evidence of high rates of assaults towards students and those who are younger and less experienced (Beech & Leather 2006; Rippon 2000; Wells & Bowers 2002). Beech & Leather (2006) pointed out that although education in handling aggression has been a demand of the English National Board for Nursing since 1993 there are still no appropriate curriculum contents in pre-registration training programmes.

To achieve the aims of a training programme the delivered topics and methods should be mixed and adjusted appropriately to the target group and target setting (Beech & Leather 2006). But up to now little was known about students' particular issues on the theme. Therefore this research was conducted to identify what nursing students perceive as problems, resources, necessities, needs, and wishes regarding the handling patient aggression. The following problems of beginners became evident: Nursing students should acquire knowledge about aggression and must have awareness of the contributing problems, develop more self-confidence in dealing with aggressive patients, must have assertiveness and empathy in communication and the ability to cope in an appropriate manner (Nau et al. 2007).

Based on these findings and based on current theories of conflict management and de-escalation a training course was adjusted to the needs of students.

This study set out to test the acceptance of the training programme by its target group and to gain information about necessary improvements. A further aim was to assess the impact of the training course on student's confidence in coping with patient aggression. The underlying hypothesis was that the novel training programme will be able to enhance the confidence in dealing with aggression whilst concurrently being accepted by the students. Thus the following research questions were addressed: How strong is the impact on the students' confidence in coping with patient aggression? What are the students' opinions on the contents, methods, and underlying learning outcomes of the course?

Methods

Participants
Sixty-eight students in their 28th and 32nd month of the three years nursing education attended the three-day-training unit in four different groups. Each group was composed of fifteen to nineteen students.

Intervention
The same course model trained each group. One half of the training included practical trainings like physical techniques and role-play with actor-patients and the other half was devoted to information and discussion. Two teachers (male and female)conducted each training during three successive days with 8 lessons a day and 45 minutes per lesson with flexible breaks.

Instruments
To achieve the aims of the study five instruments were used.

Confidence in Coping with Patient Aggression Scale
The confidence in coping with patient aggression was considered to be a key-factor of the supporting effect of the course. The confidence in coping with patient aggression scale conceptualized by Thackrey (1987) was administered three times: Before the intervention as a baseline measure, immediately after the termination of the training course as a post test, and two weeks after the students had started their practical training phase on the wards and/or in health care institutions. The scale scores from 1 to 5 with high scores denoting greater perceived confidence. The scale was evaluated by computing the mean of the items.

Questions about perceived changes in nursing practice
At the third measurement point (2 weeks into their practical placement) the students were posed with open-ended questions regarding possible changes in their nursing practice which are attributable to the training course. The written texts were analyzed by qualitative content analysis as described by Mayring (2002).

Evaluation of topics and methods
Immediately after finishing the training a questionnaire designed with open questions to explore students' opinions about successful or inappropriate methods and contents of the training was administered. The answers of the open questions were evaluated by analyzing the content frequencies and values (Lamnek 1995) independently by two raters.

The appraisal of the appropriateness of learning outcomes
The training was established according to learning outcomes which had been derived from the results of previous interviews (Nau et al. 2007). After completing the course, the students were considered to be able to rate the usefulness of the underlying learning outcomes with respect to their own concerns and with regards to their achieved knowledge about aggression in healthcare settings. The results of this scale employing a five-point Likert format were evaluated by computing means and standard deviations.

Questionnaire about demographic data and frequency of perceived aggression
A demographic questionnaire on the age, gender and on the frequency of experienced verbal and physical aggression was distributed to the students prior to commencement of the training programme.

Results

Questionnaire about demographic data and frequency of perceived aggression
Of the 61 participating students 8 were male. The students were aged between 19 and 46. Spontaneous answers concerning episodes of perceived aggression or violence ranged from 0 to 40. During the training many students remarked that they did not perceive some sorts of aggression as such prior to the training but at post-training they would apply the term violence.

Confidence in Coping with Patient Aggression Scale
The nursing students demonstrated an enhancement of their self-reported confidence that persisted into their practical placements. The mean of the total score changed from 2.5 in the pretest to 3.6 after the training and 3.7 after two weeks in the practical placement. The change in every item between t1 (before the intervention) and t2 (after the intervention) is significant (Wilcoxon p<001). The increase in confidence stayed stabile between t2 and t3, except for the items 6 and 7 there. The perceived ability to handle physical aggression decreased 4 to 8 weeks after the training (p<0.048), although still significant higher then at t1. The perceived safety around an aggressive patient increased between t2 and t3 (p<0.033) (Table 1)

Evaluation of topics and methods
Teaching breakaway and escape techniques and "guidelines for course of action" are the most important content and correspond to the results of the learning outcome rating. The theoretical and practical training were emphasized as the most important methods.

Appraisal of learning outcomes
The rating revealed valuable information on the students' opinions of what is worthy to strive for and what is perceived as less important. In general no learning outcome was rejected. The narrow standard deviations (0,38 – 0,85) show that students appraise the learning outcomes in a similar way although some students do not agree with the relevance of each item.

Questions about perceived changes
Thirty-two respondents (54%) said that they perceived changes and added written descriptions how they experienced change in encounters with patients and relatives. The results were clustered in three change effects: "Understanding", "knowing what to do", and "self-confidence". Twenty-three students (39%) said that they perceive no change in their way of dealing with patients.

Discussion

This investigation provides evidence that the programme has a significant positive effect on self-confidence which is considered to be antecedent of a successful performance (Bandura 1977, 1993). Interestingly, the baseline mean of confidence of the students in this study corresponds to the results of similar investigations (Needham et al. 2004 ; Thackrey 1987; Zeller et al. 2006) and thus clearly illustrates that there is consistency over different groups of nurses having undergone no training in violence management. Given the students' responses on topics, methods and learning outcomes we can infer that the pedagogical design of the training suits them and that some self reported change in actual nursing practice occurs. However, the format of the investigation did not observe any kind of performance change in clinical practice and thus the self reported enhancements must be treated with caution.

Conclusion

Giving nursing students the opportunity to acquire knowledge about aggression and related topics and to develop and train verbal and physical skills leads to highly significant enhanced self-

confidence in managing aggression. Student training on management aggression should be seen as a valuable first step in enhancing aggression-related requirements in the nursing profession and providing a solid basis for advanced vocational trainings. Further research should investigate the impact of such training courses on the performance in healthcare settings.

Table 1: Results of Confidence in Coping with Aggression Scale

		t1	t2	t3	Signif.* t1-t2	Signif.* t1-t3	Signif.* t2-t3
		mean	mean	mean			
1.	How comfortable are you in working with an aggressive patient?	2.21	3.31	3.25			.537
2.	How good is your present level of training for handling psychological aggression?	2.4	3.83	3.84			.959
3.	How able are you to intervene physically with an aggressive patient?	2.78	3.86	3.72			.129
4.	How self-assured do you feel in the presence of an aggressive patient?	2.6	3.4	3.64			.108
5.	How able are you to intervene psychologically with an aggressive patient?	2.59	3.56	3.78	.000	.000	.088
6.	How good is your present level of training for handling physical aggression?	2.21	3.98	3.77			.048
7.	How safe do you feel around an aggressive patient?	2.19	3.07	3.4			.033
8.	How effective are the techniques that you know for dealing with aggression	2.54	3.75	3.77			.748
9.	How able are you to meet the needs of an aggressive patient?	2.75	3.65	3.79			.369
10.	How able are you to protect yourself physically from an aggressive patient?	2.87	3.95	3.93			.703
		2.51	3.64	3.69			

*Wilcoxon; alpha 0.05

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28. – Management of violence training program in Castle Peak Hospital, Hong Kong

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For many years, violence to staff in psychiatric hospitals was probably seen as 'part of the job', an unpleasant experience but an unavoidable occupational hazard. Now it is possible that both staff and their employers are beginning to consider violence by patients as unacceptable behaviour because of the serious consequences for all those involved and the requirement of legislation of Occupational Safety & Health. Health care providers can only satisfy their main duty of care by first ensuring their own safety (Wykes 1994). Safety Training is to equip personnel with knowledge to work safely and without risk to health (COPSM 2002). Previously, staff working in Castle Peak Hospital only received theoretical input and did not have systematic practical training in management of violence. Therefore, a psychiatric nurse was sponsored to England to attend a training course: 'Training the Trainer---Control & Restraint Skill' in January 2000. After the training, a three-level training program is designed for clinical staff of Castle Peak Hospital to enhance the management of violent situations at work. In the late 2004, part of the training has been extending to other 2 general hospitals within the cluster.

Each level progressively builds up knowledge and skill on prevention and management of violence. Level I is a half-day theoretical input seminar which includes Definition of Violence, Normal Response, Model of Violence, Assault Cycle, Warning Signs of imminent danger, De-escalation Techniques, Management of Violent situations, Ethical & Legal Issues and Post-incident Debrief.

Level II is a half-day Breakaway Techniques workshop including a range of skills that enable the caregivers to maintain their personal safety when faced with a violent aggressor. The caregivers can escape from the violent situation and ask for assistant (Glynis 1997). The skills include variations of Wrist grab, Hair pull, Clothing grab, Strangle-holds, Bear hugs, and etc.

Level III is a 4-day workshop on control & restraint techniques (teamwork). Another three-day Workshop on Control & Restraint (Teamwork) is planned for Health Care Assistants. This workshop includes a set of physical intervention skills which may be used to control an individual whose behaviour may be injurious to himself/herself or to others, and with whom non-physical intervention skills have failed (Glynis 1997). The participants should step up the level of training if their working condition required.

On the other hand, Control & Restraint Techniques Training Team (The Team) was established in April 2001 with 13 psychiatric nurses as members. The Team provides training to staff of the hospital, Non-government organisations, Universities and other rehabilitation institutions with good and positive feedback. Also, the team produced a Breakaway Techniques Manual with Video Compact Disc in February 2002 and revised in January 2004 for the refresher training program.

In 2002, research was conducted on 'An evaluation of an education program on management of violence for qualified nurses in Castle Peak Hospital by Research Committee (Nursing) Castle Peak Hospital' (Ng et al, 2002) with the following findings:

1. Overall attitude towards the use of Control & Restraint is positive even without training;
2. Significant positive attitude change after Control &Restraint workshop;
3. Both the Breakaway and Control & Restraint workshops can increase the subjects' confidence;
4. Significant increase in knowledge after both workshops.

The conclusions are:

1. All the three parts of the training program are highly recommended;
2. If resources are so limited, priority should be arranged to the half day seminar and breakaway techniques first;
3. Be more aware of the detrimental effects related to violence – the training would help.

At the end of 2006, over 98% clinical staff of Castle Peak Hospital completed Level I & II training; about 60% clinical staff have completed Level III training. For level I seminar, over 98% participants claiming that the course content was informative & useful in daily work. For Level II workshop, 98% participants expressed 'increased confidence in management of violence'. For Level III workshop, 97% participants expressed that 'The programme was informative and useful' from returned questionnaires. They also expressed that they had insufficient time to practise the skills in both workshops.

The workplace violence injury on duty rate and sick leave days decreased 16% and 26% from 2003 to 2005 respectively. However, there was a slight increase in reported verbal abuse and physical assault incidents in 2006 because staff are encouraged to report workplace violence incidents through the new reporting system introdcued in late 2005.

Further, a Psychiatric Emergency Training Resource Centre with training venue was established in Block S, Castle Peak Hospital since August, 2006 to improve & enhance the efficiency & effectiveness of the training. The training program was revised in 2007 based on the feedback of participants and trend analysis of staff injury on duty. The level II workshop was extended to one day to enrich the contents & increase practicing time.

In conclusion, staff are equipped with a set of safe and effective techniques ensuring the safety of patient & staff during the management of violent situations, therefore quality of care is improved. Through press and other media propagation, public is more understandable how the violence is managed in psychiatric hospital, safety of patient & staff are both concerned, therefore hospital image is also improved.

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29. – Withdrawal of antipsychotic medications in aggressive mentally retarded adults

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Keywords
Mental retardation, antipsychotic medications, relapse, aggression, self- injurious behavior.

Introduction:

A significant number of mentally retarded individuals exhibit aggressive behaviors, including aggression toward others, such as biting, hitting, and throwing objects, aggression toward self, including self-biting, eye gouging, and head banging, and disruption/destruction. Such behaviors can result in serious injury. A mainstay of treatment for these behaviors is the use of antipsychotic medications (1). To this end, first generation antipsychotic agents such as chlorpromazine, thiothixine, haloperidol and thioridazine and second generation agents such as olanzapine, risperidone and quietapine have proven to be effective anti-aggression agents.

However, over time, medical and judicial influences have led to relatively restrictive recommendations and guidelines regarding the use of antipsychotic and other psychotropic drugs in the mentally retarded. These policies have as their aim the minimizing of tardive dyskinesia and other such side effects. Periodic psychotropic medication dosage reductions are now an accepted part of the procedures occurring in institutions for the mentally retarded (2).Weaning off antipsychotic medications or determining the lowest effective dose are practiced widely in mentally retarded patients receiving psychotropic drugs. Indeed, a significant number of aggressive mentally retarded individuals can be weaned from their antipsychotic medications once the aggression has been alleviated (3,4,5). However, a number of aggressive individuals relapse during an antipsychotic drug withdrawal attempt, 40% in a recent study by the authors (3).

In the current study, we attempted to determine whether an increase in aggression (i.e. a relapse) following an attempt to withdraw a first generation antipsychotic medication predicted subsequent antipsychotic drug withdrawal associated relapses, i.e. if a first relapse predicted further relapses.

Methods:

This study is a retrospective 10 to 15 year intensive evaluation designed to determine whether or not mentally retarded individuals who had one antipsychotic withdrawal induced relapse would have multiple relapses when subsequent withdrawals from antipsychotic medications occurred.

The subject group consisted of 57 residents of the Murdoch Center, a 583-bed North Carolina intermediate care facility for the mentally retarded, located in Butner, North Carolina. The majority of subjects were severely or profoundly mentally retarded, with an average age of 51.5 years (range 30-78). There were 37 males and 20 females. Thirty-seven were Caucasians and 20 were African Americans. The subjects studied had been prescribed first generation antipsychotic medications (haloperidol, thioridazine, chlorpromazine, perphenazine, thiothixine), given between 1980 and 1990, given alone or in combination with other psychotropic medications. All 57 subjects had experienced at lease one episode of an intensification of self-injurious behavior, aggression, and or destruction/disruptive behavior following or during withdrawal from their antipsychotic medications. These symptoms were reversible by reinstitution of or increasing the dose of either a first or second generation antipsychotic medication. Cases in which relapses occurred were

accumulated between 1990 and 2000 and followed for relapse between 1990 and 2005.
The study methodology consisted of a review of quarterly (or more frequent as needed) Neurobehavioral Review Conference (NBR) reports generated from 1990 until the end of 2005. These conferences were conducted on all Murdoch Center residents requiring psychotropic medications for behavioral purposes.

All NBR reports were analyzed, noting the initial date of symptom intensification (i.e. relapse) following an antipsychotic drug withdrawal attempt (3) and any subsequent relapses following first or second generation antipsychotic drug withdrawal attempts that occurred between the time of the first relapse and 2005. Relapse was defined as the occurrence of intensified aggression, self-injurious behavior, or destructive/disruptive behavior, or a combination of the above behaviors, occurring within 3 months of the lowering or terminating of antipsychotic drug administration. This phenomenon was reversible by an increase in or reinstitution of antipsychotic drug dosage. Initially, first generation antipsychotic drugs were used to treat aggression. Subsequently, second generation drugs or a combination of first and second generation drugs were more frequently used.

The mean doses of first and second generation antipsychotic medications administered in 2005 were also recorded.

Results:

By 2005, most of the 57 individuals who had experienced an initial antipsychotic drug withdrawal induced relapse had undergone subsequent withdrawal attempts where they were again taken off antipsychotic medications. By 2005, 14 (24.6%) had experienced two relapses (the initial relapse and one additional relapse), 19 (33.3%) had three relapses, 10 (17.5%) had four, and 4 (7.0%) had five relapses. Ten individuals (17.5%) were kept on first generation antipsychotic agents or were directly transitioned to a second generation antipsychotic agent without subsequent withdrawal attempts, due to the intensity of the first relapse and fear of future relapses. There was an average of 2.75 relapses per individual between 1990 and 2005. The mean year of the first (initial) relapse was 1993.

Of those who had relapsed by the end of the study in 2005, 13 (22.8%) were at that time receiving a first generation antipsychotic medication as monotherapy. Fourteen (24.6%) were receiving a first generation antipsychotic medication and a second generation antipsychotic agent. Twenty-six (45.6%) were receiving a second generation antipsychotic agent as monotherapy (usually olanzapine or risperidone) in place of a first generation antipsychotic agent. Four (7.0%) had become antipsychotic drug free.

At the end of the study in 2005, the average doses of first generation antipsychotic drugs being used at that time were thioridazine 126mg/day, thiothixine 3.5mg/day, haloperidol 6.7mg/day and chlorpromazine 125mg/day. The average doses of second generation antipsychotic medications given with or without a first generation antipsychotic drug were risperidone 3.9mg/day, olanzapine 12.8mg/day and quietapine 175mg/day.

With respect to outcome, by the end of 2005, 45 of the subjects were considered to be doing well, 11 were doing equivocally (with no mention made of changing medications) and one subject was doing poorly with a change in medication suggested.

Discussion:

Our results indicate that for individuals who have experienced intensification of aggressive symptoms during an antipsychotic medication withdrawal attempt, most will have subsequent relapse or relapses when further attempts at antipsychotic medication withdrawal occur. For such individuals, there was often a cycle of aggression during each withdrawal attempt, with some of these destructive episodes causing significant harm to self or to others. In essence, the individuals relapsed each time the antipsychotic drug dosage was withdrawn or lowered, until the treatment team decided to treat using a long term maintenance or preventative strategy.

Our results suggest that in most cases where an attempt was made to substitute second generation

antipsychotic agents for first generation ones, the switch was effective. This observation is consistent with a number of studies showing that second generation antipsychotic agents have efficacy in controlling maladaptive behaviors. Second generation antipsychotic medications have a lower incidence of extrapyramidal symptoms and tardive dyskinesia, but most also have other side effects such as weight gain, type II diabetes and hyperlipidemia (1).

However, in a significant number of cases there was a need to continue first generation antipsychotic drugs either alone or in combination with second generation antipsychotic drugs. In these cases the second generation antipsychotic medications did not successfully substitute for first generation antipsychotic drugs.

The knowledge that a specific mentally retarded individual relapses when antipsychotic medications are tapered or stopped should be an indication to strongly consider continuing antipsychotic treatment indefinitely in order to stop the cycle of repeated behavioral deterioration. Certainly, reductions in dosage should not occur if there is a significant potential cost to the patients or staff. Since we have no data for periods longer than 15 years, we would not argue that such antipsychotic drug treatment should be continued indefinitely. However we do believe that maintenance treatment should be considered for a number of years in patients with a history of severe or multiple relapses, with the caveat that if such an individual has been stable for many years and is doing well, at some point one might contemplate a very gradual withdrawal attempt.

Our data thus suggest that guidelines should be reconsidered to incorporate just how unlikely it is that antipsychotic drug free status can be obtained in previously relapsing individuals. Adherence to guidelines should not make it difficult to maintain good clinical practice. Careful scrutiny of previous records for medication withdrawal attempts are indicated to break the cycle of relapse and aggression.

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30. – Double depot for severe psychotic aggression

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Keywords
Double depot, Polypharmacy, Secure hospitals, Detained, Clozapine, Risperidone, injections, Neuroleptic Malignant Syndrome, Extra pyramidal, Atypical.

Introduction/Background

The treatment of psychosis for the last 50 years has been predominantly with neuroleptic medication. Initially the mainstay was a phenothiazine anti-psychotic drug like chlorpromazine. The drawbacks with this regime were soon recognised as non-compliance and subsequently after around ten years these and similar compounds were converted into long acting depot injections. In the 1980's it became apparent that extra-pyramidal side effects (EPS) were a major problem with these drugs, particularly as there was a cohort of patients that developed non-reversible tardive dyskinesia. Around this time the development of a novel anti-psychotic agent clozapine was progressing on the continent of Europe. This preparation had little in the way of extra-pyramidal side effects. It was also more clinically effective than the older drugs but it had the drawback of life-threatening reductions in the white blood cells. In 1990 this drug became more widely available after a multi-centre US trial (Kane et al.) showed its superior efficacy in treatment resistant patients and led the way to mandatory white cell monitoring.

There followed several other compounds with low EPS profiles, the atypical neuroleptics, and two of them, namely olanzapine and risperidone, became the most popular with clinicians. As a result of these atypical neuroleptics the use of the older (typical drugs) reduced and the use of depot injections also reduced. The effect of the depot injections was to increase compliance in patients and because all the atypical agents were oral initially, the spectre of non-compliance once again re-emerged. Those psychiatrists in forensic care saw an increase in the admissions of patients with long-term non-compliance on atypical neuroleptics.

Often, the restoration of a depot preparation was enough to restore stability to their mental state but in some cases this was not enough and was accompanied by a refusal to take clozapine because of the blood tests and the fact that it was an oral preparation. In some of these cases the insight was poor and subsequently they did not see the need for any medication.

In the secure (locked) hospitals in the UK the most violent patients are detained under conditions of low, medium or high security. The idea is to find a care pathway to move the patient down the scale from more secure to the least and from there back to an ordinary psychiatric unit and hopefully back to the community. There are a variety of factors that need to be considered by the multi-disciplinary teams before this can be achieved but the main one is that of risk. As well as a suitable support network the patient has to be stabilised on a medication the regime that is transferable to the different settings.

In many of these severely affected patients the medication regime consists of polypharmacy possible due to the clinicians' desperation to find a formula that suits the patient. Many international bodies including the UK Royal College of Psychiatrists have roundly condemned Polypharmacy. In the USA there has recently been talk of rational polypharmacy but still many severely ill patients are on two different neuroleptics. Often either both are oral or at least one is a depot preparation and sometimes there is a mixture of typical and atypical drugs. What is rare is that two depots are used together.

This clearly means more injections but with a patient that has no insight and refuses all medication and remains a serious risk to himself and others then it is a more humane alternative than prolonged seclusion. There are few of these patients, but they are costly in terms of staff time and finance and there is a need for effective, safe alternatives.

The main paper

This is a naturalistic retrospective study of a cohort of seven patients detained under conditions of medium security who were given double depot medication The compounds chosen in six of these patients were Risperidone Consta a novel atypical depot along with a typical depot usually zuclopenthixol decanoate. The Consta was given every 2 weeks and the other depot was given weekly so that on alternative weeks there were two injections.

Initially there were protests from the nurses who refused to give this treatment for reasons of a legal nature. It should be noted that they had no problems with giving more that two different oral neuroleptics or indeed one depot with one or more oral preparations. There was no ruling to be found that prevented the use of double depots and the UK system of a mandatory independent second opinion doctor for all medications given against the patient's will, backed the use of this regime. The movement of some nurses to a different setting proved to be an amicable solution.

It should be noted that this cohort of patients was the most treatment resistant and/or those with the most violent tendencies. The patients were all male aged between 25-45 years and all detained in medium secure facilities. This means it was a locked unit with facilities for seclusion and with protocols and procedures to prevent escape but in this case without a perimeter wall. Patients in this setting tend to be those with or without convictions but all have a history of severe violence or arson or sexual offences. After a 12-month period none of the patients remained on double depot.

3 patients were stabilised on one depot plus another oral neuroleptic agent.

3 patients were just on one depot preparation.

1 patient was on clozapine.

6 were still in medium secure and one had been moved to high secure facilities.

6 were still violent.

2 had previously tried clozapine.

6 patients had refused clozapine.

2 patients were of Afro-Caribbean race, one was of mixed race and 4 were white Caucasians.

2 patients having been tried on double depot and stopped clozapine were being put back on double depot.

Conclusion/Discussion

The regime of double depot was always going to be controversial. It is difficult to understand why this is the case. Is it that the two injections were felt to be too invasive? Was it about risk to the patient? Was this the risk of EPS or local damage to the injection site? It must be acknowledged that this was always for a very small cohort of the most violent intractable patients and the risk of patients continuing untreated or partially treated in this state must be taken into account.

Even if the patient agrees to take clozapine as a result of this procedure, and if he then improves, then this must be seen as a positive move. Polypharmacy is widespread in the disturbed wards. Whether this is 'rational' or a treatment of desperation by the clinician is a matter for judgement. Whether polypharmacy is any different from double depot I would argue that polypharmacy may be slightly less 'rational'.

More work is needed clinically as this is only a retrospective pilot study but as new depots emerge with different receptor profiles then it may be that combination therapy becomes the norm, not just for psychosis but for other intractable psychiatric conditions like personality disorder.

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Apart from various international guidelines from the USA and UK there is no literature on this.

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31. – The pharmacological management of agitated patients in emergency psychiatric hospitals in Rio de Janeiro – Brazil: the results of two pragmatic randomized clinical trials

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Background

In Brazil the combination of haloperidol plus promethazine is frequently used (>80%) for agitated and violent patients.

Objective

TREC (Rapid Tranquillisation Clinical Trial [Portuguese]) was designed to determine the relative value of this combination.

Design, Setting, and Patients

Two randomised, pragmatic, open trials in three psychiatric emergency rooms in Rio de Janeiro, Brazil. Patients requiring urgent IM sedation because of agitation and/or dangerous behavior

Interventions

TREC-Rio-1 (ISRCTN44153243) haloperidol 5-10mg IM plus promethazine up to 50mg IM compared with midazolam (up to 15mg).
TREC-Rio-2 (ISRCTN83261243) haloperidol 5-10mg IM plus promethazine up to 50mg IM compared with haloperidol 5-10mg IM. Doses were at discretion of prescribing clinician.

Outcome Measures

Primary outcome, chosen by the staff of the emergency rooms: proportion of patients tranquil or asleep by 20 minutes. Secondary outcomes: tranquil or asleep by 40, 60 and 120 minutes, physically restrained or given additional medication within 2 hours, severe adverse events, another episode of agitation/aggression, additional visit from the doctor during the subsequent 24 hours, overall antipsychotic load in the first 24 hours and still in hospital after 2 weeks.

Results

TREC-Rio-1- 151 patients were randomised to midazolam, and 150 to the haloperidol-promethazine mix. Primary outcome available for 298 (99%), 73% of whom were thought to have a psychotic illness. Patients allocated midazolam were more likely to be tranquil or asleep by 20 minutes compared with those receiving haloperidol-promethazine IM (RR 1.32 95%CI 1.16 to 1.49, NNT 5 95%CI 3-8). By 40 minutes, midazolam still had a statistically and clinically significant 13% relative advantage but after 1 hour, about 90% of both groups were tranquil or asleep. One important adverse event occurred in each group: a patient given midazolam had transient respiratory depression, and one given haloperidol-promethazine had a grande mal seizure.

TREC-Rio-2 - 160 patients were randomised to haloperidol-promethazine and 156 to haloperidol alone. The Data Monotoring Comittee advised that the study should be stopped after they saw the results of the interim analysis. Primary outcome data available for 311 (98.4%), 77% of whom were thought to have a psychotic illness. Patients allocated haloperidol-promethazine were more likely to be tranquil or asleep by 20 minutes compared with those receiving haloperidol IM alone (RR 1.30 95% CI 1.10-1.55, NNT 6 95% CI 4-16). There were no differences after 20 minutes. There were, however, ten cases of acute dystonia, all in the haloperidol alone group.

Conclusions

Haloperidol-promethazine is a better option than haloperidol alone in terms of speed of onset of action and safety. Compared to midazolam, both treatments were effective. Midazolam was more rapidly sedating than haloperidol-promethazine, reducing the time people are exposed to aggression. Adverse effects and resources to deal with them should be considered in the choice of the treatment. There are now enough data to change guidelines and haloperidol alone should no longer be recomended. Trials evaluating new generation of antipsychotics should use haloperidol plus promethazine as a comparator.

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32. – Behaviour problems in childhood and adolescence in schizophrenic offenders: an exploratory study

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Introduction

Patients that develop a schizophrenic disorder and commit criminal offences in adulthood already show prodromal signs in childhood and adolescence. It turns out that poor results at school, problems with attentiveness, a higher birth weight, and a greater head circumference are associated with a risk of violent behaviour in adulthood (Cannon et al., 2002). This is confirmed by earlier studies (Schanda et al., 1992; Heads & Taylor, 1997). On the basis of data from the Dunedin study, Arsenault et al. (2000) concluded that psychotic symptoms during childhood are an important risk factor for violence in patients with a schizophreniform disorder. Physical aggression during childhood was also a risk factor, but to a smaller degree (Arsenault et al., 2003). Conviction for a violent offence in late adolescence also shows a significant association with a future diagnosis of schizophrenia (Gosden et al., 2005). Antisocial behaviour is seen in many schizophrenic patients with a criminal record. A usable classification of schizophrenic offenders into early and late starters was investigated by Tengström et al. (2001). In two retrospective studies, a clustering was suggested on the basis of behaviour problems measured with the CBCL (Neumann et al. (1995), Rossi et al. (2000)). Finally, a Scottish study used the results of the CBCL to predict later schizophrenia (Miller et al., 2002). The problem scales that predicted later schizophrenia were 'withdrawn' and 'delinquent and aggressive behaviour', but these predicted less accurately than the isolated psychotic characteristics immediately prior to the onset of schizophrenia. No studies on a forensic population could be found. The key question here is: what were the behaviour problems in childhood among schizophrenic offenders without a personality disorder, non-delinquent schizophrenics, schizophrenic offenders with a personality disorder, and non-psychotic offenders with a personality disorder?

Methods

Four groups of patients (total n=147) were created. Three of the four groups consisted of TBS-detainees with a psychosis and/or a personality disorder. The Dutch TBS system (indefinite detention under the Entrustment Act) is intended for mentally ill offenders that have committed a serious violent offence, for example, (attempted) murder and (attempted) manslaughter. Group A (n=35) consists of psychotic TBS-detainees without a personality disorder. Group B (n=32) consists of non-delinquent psychotic patients in general psychiatry without a personality disorder. These patients are between the ages of 20 and 50 and were recruited from a long-stay ward (minimum duration of admission 2 years, and the last admission was involuntary). Group C (n=35) consists of psychotic TBS-detainees with a personality disorder, and group D (n=35), finally, consists of non-psychotic TBS-detainees with a personality disorder.
The forensic patients were recruited from 3 Dutch forensic hospitals. The control group B consisted of psychotic patients from a general psychiatric hospital, and they were selected on the basis of the fact that their last admission was involuntary. Existing data were used to compare the four groups.

The anamnestic, diagnostic and psychological test data were retrieved retrospectively from reports to the court and intake reports. In the case of the control group B, the medical files were examined, with special attention to the prior history. In order to identify the precursors of delinquent behaviour, in addition to a list of sociodemographic, (familial) psychiatric and criminological variables that was compiled on the basis of a study of the current literature in this field, we used the Child Behaviour Checklist (CBCL) for 4 to 18 years of age (Achenbach, 1991). The Dutch translation is reliable and valid (Verhulst et al., 1996). In this study, the CBCL 4-18 was scored on the basis of data in the patients' records. These records contained reports of conversations with the parents or important educators of the patient regarding the patient's younger years. Good to excellent ICCs were found (scores between .720 and .977). The data were analysed using the SPSS version 14.0 Statistical analysis (chi-square tests or Fisher's exact test for categorical variables and a t-test for continuous variables). A hierarchic cluster analysis was used to divide the total group of patients into two clusters.

Results

Using a repeated-measures MANOVA, we investigated whether the four groups differ with regard to the problem scales of the CBCL. There was a significant difference between the four groups on the problem scale 'delinquent behaviour'; $F(3.92)=5.041$, $p=.003$. There was a significant difference between the psychotic TBS-detainees with a personality disorder and psychotic patients in general psychiatry in the age ranges 7 to 12 years ($F(1.43)=4.034$, $p=.051$) and 13 to 18 years ($F(1.42)=8.070$, $p=.007$). Significant differences between psychotic TBS-detainees with and without a personality disorder were not found on this problem scale. On the problem scale 'aggressive behaviour', the difference between the four groups was only marginally significant; $F(3.91)=2.435$, $p=.070$. For this reason, no further analysis was done. There were again remarkably significant differences between the four groups on the problem scale 'attention problems'; $F(3.92)=6.177$, $p=.001$.

In order to determine whether there is a relationship between patient group and cluster, a chi-square test was done with the cluster (1 or 2) as the dependent variable and the patient group (A/B/C/D) as between-subject factor. There was a marginally significant difference between the clusters with regard to the distribution of the patient groups; $\chi2 (3)=6.568$, $p=.087$. Cluster 1 (N=69) contained 85.7% of the psychotic TBS-detainees without a personality disorder and 87.5% of the psychotic patients in general psychiatry. Cluster 2 (N=26) contained 30.8% of the psychotic TBS-detainees with a personality disorder and 40.6% of the TBS-detainees with a personality disorder only.

Significantly higher scores were seen on the problem scales 'delinquent behaviour' ($F(1.93)=35.401$, $p=<.001$) and 'aggressive behaviour' ($F(1.93)=173.189$, $p=<.001$) in cluster 2. This was true for all age ranges. It is again striking that there is a highly significant difference between the clusters on the problem scale 'attention problems', the score being significantly higher in cluster 2 for all age ranges.

The score for internalising behaviour is not significantly higher in cluster 1. This applies to all three of the problem scales 'withdrawn', 'somatic complaints' and 'anxious/depressed'.

Using a repeated-measures MANOVA, we determined the problem scales on which the early and late starters scored differently. The TBS-detainees with only a personality disorder were also included in this analysis. Early starters scored significantly higher on the problem scale 'delinquent behaviour'; $F(1.78)=9.948$, $p=.002$. Significantly higher scores for early starters were also found in the age ranges 7 to 12 years and 13 to 18 years; $F(1.81)=11.117$; $p=.001$ and $F(1.81)=7.062$, $p=.009$, respectively. The early starters also scored significantly higher on the problem scale 'aggressive behaviour'; $F(1.77)=5.419$, $p=.023$. On this scale, the early starters scored significantly higher in the age ranges 7 to 12 years and 13 to 18 years; $F(1.77)=5.416$, $p=.023$ and $F(1.78)=5.613$, $p=.020$, respectively. Early starters thus display more externalising behaviour than late starters.

Discussion

Psychotic TBS-detainees with a personality disorder score significantly higher on the CBCL problem scale 'delinquent behaviour' and marginally significantly higher on the problem scale 'aggressive

behaviour' than do psychotic patients in general psychiatry. These findings are in agreement with the international literature (Hodgins et al., 2005). Higher scores for delinquent and aggressive behaviour on the CBCL seem to be predictors of a serious psychiatric disorder, such as a psychotic disorder with a comorbid personality disorder or a severe personality disorder (groups C and D in this study).

TBS-detainees with a (comorbid) personality disorder have higher scores for externalising behaviour. This is in agreement with the findings of Gosden et al. (2005), among others. Psychotic TBS-detainees with a personality disorder display more externalising behaviour than psychotic TBS-detainees without a co-morbid personality disorder. It is possible that the comorbid group is externalising on the basis of the comorbidity with a personality disorder. There is no difference between the groups as far as internalising behaviour is concerned. Early starters display more externalising behaviour than late starters. This is in agreement with what Moffitt and Caspi (2001) wrote about life-course persistent antisocial pathways. Tengström et al. (2001) also found an early-onset Conduct Disorder in early starters. What we found in a population of TBS-detainees is thus in agreement with the international literature.

In conclusion, we can state that prospective research will be necessary to test the above findings in a larger patient population. In any case, problem children with a great deal of externalising behaviour should be followed clinically within the mental health service because they run a severe risk of becoming patients with serious psychiatric disorders.

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33. – A study of forensic psychiatric screening reports and their relationship to full psychiatric reports

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Introduction

The primary task of forensic psychiatric and psychological experts is to assist the courts in questions concerning the defendant's accountability at the time of the crime, and eventually to give an assessment as to the likelihood of re-offence by the defendant.

Some countries (Norway and Sweden), have implemented a system in which a forensic psychiatric screening report can be requested by the prosecution authorities to evaluate the need for a full forensic psychiatric report (full report). In Norway a forensic expert does this report based on the police documents and an interview with the defendant. The screening report concludes with one of three alternative recommendations in regard to instigation of a full report: recommended, not recommended or left undecided. The prosecution authorities are free to follow or discard the recommendations in the screening report. The screening report by itself is normally not a document valid for the court.

The report shall present a forensic expert evaluation of two matters. 1) To clarify if the defendant had a mental state relevant for § 44 of the Norwegian Criminal Act, i.e. psychosis, high grade of amnesia/unconsciousness, or severe mental retardation at the time of the crime. Note that the circumstances of the crime do not count, and Norway thereby is one of the very few countries that follow the 'biological principle' – only the mental state is decisive concerning accountability.
2) The screening report shall conclude as to a recommendation concerning the need for a full report.

Aims of the study

1) Are screening reports considered relevant for the prosecution authorities?
2) To what extent are their recommendations followed?
3) What is the concordance of the conclusions of the screening reports and the full reports concerning the major issues in § 44?

Methods

Material
The material of this study consisted of all, 419, screening reports issued at the Office for Forensic Psychiatry, Oslo Police District, from January 2002 to May 2005. Additionally, all the 91 (22%) full reports issued concerning defendants with a screening report were collected from the files of the Norwegian Forensic Board.

Rating form
All reports were scored according to a form that consisted of 50 variables. Information rated from the screening reports was demographic data on the defendant, type of charged crime and the

ICD-10 diagnosis. The recommendations of the screening reports were noted. The presence of psychosis, unconsciousness, or severe mental retardation was considered. The concordance of the conclusions concerning psychosis, unconsciousness or severe mental retardation of the screening and full report was calculated.

Information on how the recommendations in the screening reports were used by the principals was collected from the Norwegian Criminal Register, independent of the rating form.

Statistics
Categorical data were analysed with chi-square statistics and continuous data with independent sample t-tests. The associations between relevant independent variables and the initiation of full reports (dependent variable) were examined with logistic regression analyses. The strengths of the associations were expressed as odds ratios (ORs) with 95% confidence intervals (95%CI). A significance level of $P < 0.05$ was chosen, and all tests were two-tailed.

Results

Characteristics of persons who got only screening reports
The severity of the alleged crime was the variable in the reports that made a significant difference between persons who got only a screening report and no full report. The defendants for whom the prosecution authorities or defence requested a full report had been charged with more severe crimes than those who did not have such a request. In addition those who also had full reports were younger (p=0.006), and their civil status was more frequently non-paired (p=0.01).

Variables associated with request of a full report
In univariable regression analyses age, positive recommendation (with open recommendation as reference) and the severity of crime were significantly associated with request of a full report. However, only positive recommendation and severity of crime were significantly associated with full report in the multivariable analysis.

How did the prosecutors deal with the recommendations in the screening reports?
Among the 118 reports with a positive recommendation for a full report, 50% lead to instigation of a full report by the prosecution authorities. Of the 59 reports in which the positive recommendation was not followed, 20 of the cases were dismissed due to doubt regarding the defendant's accountability and 32 of the cases were not closed with a final decision at the time of our study. If the recommendation in the screening report was negative, this advice was followed in 98% of the cases. In the 181 cases with "open" recommendation, 16% were followed by a full report.

The relation between the conclusions of the screening and major reports concerning criteria for non culpability
The total agreement between conclusions of screening and full reports concerning psychosis was 46% and kappa 0.25. There was a high agreement (24 cases) among the reports with negative conclusions, i.e. no psychosis. However, 10 of the positive psychosis conclusions in the screening reports were negative in the major reports.

We also calculated kappa statistics for the concordance of the screening and full reports regarding ICD-10 diagnoses which could imply psychosis (i.e. F00-09, F10-19, F20-29 and F30-39). Kappa values for F00-09 could not be calculated due to low numbers, for F10-19 kappa was 0.54, F20-29 0.47, and for F30-39 0.13.

Concerning unconsciousness the agreement between screening and full reports was 78%, and. regarding severe mental retardation was 94%.

Discussion

We found that the recommendations given in the screening reports made a significant difference for the prosecutors' further decision in the relevant cases. Negative recommendations was close to always followed, while only half of the positive and 16% of the 'open recommendations' lead to a full report. The severity of the crime was a strong predictor of full report, but so was also positive recommendation (with open recommendation as reference). The agreement between screening and full reports regarding psychosis was low, but high regarding both unconsciousness and severe mental retardation, although these states were rare.

Concerning our findings there are no other studies published to which they can be compared. Nevertheless our study raises several questions regarding the use of screening reports in the forensic psychiatric practices. Firstly, the fact that the prosecution authorities dismissed a lot of recommended cases may be questioned. It is open to debate that important legal decisions with considerable consequences for the defendants are taken based on reports that are provisional. This practice could also give the experts who issue screening reports a feeling of futility since positive recommendations frequently are put aside.

Secondly, the validity of the screening reports could be questioned since the agreement with the full reports regarding psychosis was quite low. A more general concern regarding identification of psychosis in forensic psychiatric practices emerges; when the agreement of the two independent experts i.e. those conducting screening reports vs. full reports in this study is, seemingly, low. The main tool for the forensic expert is the clinical interview (Grøndahl 2005). It could be argued that the clinical interview is not a sufficient tool alone to reach acceptable reliability among experts.

Thirdly, the seriousness of the criminal act was the main characteristic that triggered the prosecuting authorities to initiate a full report. In this regard Norway seems to follow a European tradition, where the character of the offence is the major reason to conduct a full report (Soothill et al. 1983). A serious criminal act may, if the defendant is found guilty, trigger a harsh sentence. It seems, therefore, logical to initiate a full report in serious criminal cases in order to thoroughly examine the defendant's accountability, thereby protecting the security of justice.

Fourth, 181 of the screening reports had an open recommendation. This type of conclusion may not be very helpful for the principals, and it could be argued that the practice here should be changed.

To conclude; the findings of this study indicate uncertainty about the purpose of screening reports in the Norwegian penal system. The intention of the screening reports is to clarify the prosecutors' doubt about a defendant's accountability and clarify the need for a full report. However, the system seems primarily to fulfil that function when the conclusion is no need for a full report. Whether the arrangement with screening reports is cost effective is not known since there is no general criminal statistics covering the use of screening reports. The findings of this study should encourage more studies of the reliability between experts doing forensic examinations. This would hopefully increase both the quality and scientific base in the forensic psychiatric and psychological field.

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34. – Incident profiling on patients characteristics in a forensic setting

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Inpatient violence, START Outcome Scale, self-reports, diagnosis, violence risk assessments

Introduction

Inpatient violence is a prevalent but not well understood phenomenon. It not only threatens the safety of patients and staff members (Nijman et al, 1999) but also has a major impact on treatment and risk management strategies (Doyle & Dolan, 2006; Ogloff & Daffern, 2006). According to Mulvey (2005) prevalence of inpatient violence is a major predictor of community violence. A thorough and systematic evaluation of inpatient violence, in relation to patient characteristics can contribute to a better understanding of (violent) incidents. As a consequence, more specified prevention methods are possible. Several studies have shown important variables in the prediction of future inpatient violence varying from self-report to violence risk assessment. For example, Novaco and colleagues (1994, 1998) have found that self reported aggressive behaviour seems to be a better predictor of future inpatient violence than the amount of prior violent acts. Several authors have also argued for the incremental value of disorders in the prediction of aggressive behaviours, for example psychotic symptoms seem to increase inpatient violence (Soyka, Morhart-Klute, & Schoech, 2004; Stafford & Cornell, 2003; Tengström, et al., 2006). Moreover, these findings suggest that the type of the disorder, roughly divided into schizophrenia, personality disorder and sexual disorder needs to be considered in predicting aggressive incidents (Joyal, Dubreucq, Gendron, & Millaud, 2007; Krakowski & Czobor, 1997; Soyka, Morhart-Klute, & Schoech, 2004; Stafford & Cornell, 2003; Tengströmet al., 2006). This classification also has practical implications, since most forensic institutions reserve distinguished treatment settings, based on these classifications. Furthermore, violence risk assessments based on the HCR-20 and the PCL-R, have shown to go beyond unstructured clinical judgment and self-reports in predicting future aggressive behaviour (Belfrage, Fransson, & Strand, 2000; Douglas & Webster, 1999; Grevatt, Thomas-Peter, & Hughes, 2004; Hildebrand, 2004; Nicholls, Ogloff, & Douglas, 2004; de Vogel & de Ruiter, 2005).

In this study, violent incidents in 'de Rooyse Wissel", a Dutch forensic hospital are analyzed and related to the patients' characteristics. In particular, we have the opportunity to test the predictive value of the different characteristics simultaneously. Much is known of the predictive value of self-report of aggressive behaviours, diagnostic characteristics, and risk assessment. However, it is interesting to see if the different characteristics improve the predictive value or if one predictor outperforms the others. Also, on a more practical level, specific aggression profiles for different disorder types - psychotic, personality disordered and sexual disorder are provided.

Hypothesis

It is assumed that violence risk assessment procedures will be the best predictors for inpatients violence, since research indicates its important predictive value on future aggressive behaviour (Belfrage, Fransson, & Strand, 2000; Douglas & Webster, 1999; Grevatt, Thomas-Peter, & Hughes, 2004; Hildebrand, 2004; Nicholls, Ogloff, & Douglas, 2004). Mainly, because violence risk assessment procedures account for a broad spectrum of risk variables and are believed to be less susceptible for impression management by patients, such as 'faking good', than unstructured clinical judgment and patients self-reports (Cima et al., 2003; Haywood, Grossman, & Hardy, 1993; Lewak & Hogan, 2001; Walters, 1988). Additionally, long-term treatment in a forensic institution leads to moderation of self-report scores (Kenny, Calsyn, Klinkenberg, Winter, & Trusty, 2004).

Therefore, the following hypotheses were tested;
"Risk assessments (based on the HCR-20 and PCL-R score) will provide the best predictive validity in explaining aggressive inpatients incidents, beyond clinical diagnosis and self-reports of aggression."
"Different clusters of patient profiles based on a combination of risk assessment, diagnostic characteristics and self-report of aggression are distinguishable."

Methods

Self-report measures
BDHI; The Buss-Durkee Hostility Inventory exists of 40 true-false items reflecting two subscales measuring overt aggression (reflecting the predisposition of verbal or physical aggression) and covert aggression (reflecting the emotional, cognitive state; BDHI; Buss & Durkee, 1957; Lange, Pahlich, Sarucco, Smits, Dehghani, & Hanewald, 1995).
NOVACO; The NOVACO Anger Scale is a 25-items questionnaire which determines the patients aggression in a 4-option likert scale (1= not at all enraged; 2= a little enraged; 3= rather enraged; 4= very enraged) (NAS; Novaco, 1994, Dutch version, Meesters, Muris, Bosma, Schouten, & Beuving, 1996).

Psychopathology
DSM-IV-TR; Patients diagnoses based on the Diagnostic and Statistical manual of Mental disorders (4th TR ed. APA, 2002) were extracted from treatment reports. Violence risk assessment procedures.
HCR-20; The Historical Clinical Risk management–20 is a 20-item (0= does not apply; 1= applies to a certain extend; 2= does definitely apply) structured guideline that inventorises violence risk ranged in three risk categories; low, moderate or high (Webster, Douglas, Eaves & Hart, 1997).
PCL-R; The Psychopathy Checklist-Revised (PCL-R; Hare, 1991; 2003) is a 20-item assessment for psychopathy (0= does not apply; 1= applies to a certain extend; 2= does definitely apply). The PCL-R utilizes a 4-factor (Hare, 2003) model separating an arrogant and deceitful interpersonal lifestyle (factor 1), deficient affective experience (factor 2), an impulsive and irresponsible behavioural lifestyle (factor 3) and antisocial facets (factor 4).

Outcome measures of inpatient violence
START Outcome Scale; The Short-Term Assessment of Risk and Treatability provides a structured framework categorizing violent incidents within 11 categories on a 4-level severity range (Nicholls, Brink, Desmarais, Webster, & Martin, 2006).

Procedure

All incidents occurred between March 2000 and June 2007 in a Forensic Psychiatric Centre (FPC) 'de Rooyse Wissel' and have been retrospectively scored with the START Outcome Scale (n=3.373 incidents caused by n=150 patients). Data of the incidents is paired to self-reports of aggressive behaviour on admission (Novaco; n=113l; BDHI; n=139), along with diagnostic characteristics (DSM-IV-TR; n=227) in order to present patients profiles during treatment. Moreover, violence risk assessments (HCR-20; n=220; PCL-R; n=162) are compared to the profiles in order to determine their predictive validity.

Results

Self-reports of aggressive behaviour and diagnostic characteristics revealed a small effect for overall inpatient aggression; both accounted for only 18% of the prediction at best (Field, 2005). Risk assessments by the HCR-20 or PCL-R performed marginally better, but still only showed a small effect in explaining inpatient aggression, accounting for a maximum of 20%.
　To test the incremental value of the different characteristics; a hierarchical stepwise linear

regression analysis is performed with self-reports, diagnostic characteristics and risk assessment collectively for predicting inpatient aggression. Stepwise linear regression on the total numbers of violent incidents, as well as individual categories of aggression (verbal aggression, substance use and unauthorized leaves) shows risk assessment by the PCL-R as main predictor (see Table 1). Further, hierarchical linear regression was set out with the PCL-R as best predictor entered first in the model and the other supplemented predictors afterwards, to determine their incremental value (see Table 1). Analysis revealed the antisocial factor of the PCL-R as best predictor for total incidents (β=.038), but no significant incremental value for neither self-report nor diagnostic characteristics.

Analysis of the individual categories of aggression confirms the PCL-R as best predictor. The antisocial factor of the PCL-R proves to be the only significant predictor for unauthorised leaves, while the lifestyle factor of the PCL-R is the only significant predictor in substance use (see Table 1). Verbal aggression is best predicted by a model of risk assessment (PCL-R), self report (BDHI) and clinical characteristics (psychotic symptoms). These findings show that self report and clinical characteristics provide incremental value only in predicting verbal aggression. Independent T-tests with group (psychotic, personality disordered, and sexual distorted) as the independent variable and type of aggression as the dependent variable reveal discriminate patterns displayed in the different treatment settings.

Patients with psychotic symptoms showed more aggression overall. In line with this finding, they tend to show more verbal and physical aggression towards others. In contrast they had fewer unauthorised leaves and used fewer substances. Surprisingly, linear regression analysis reveals that neither self-reports of aggressive behaviour, diagnostic characteristics nor risk assessment account for these differences, but the amounts of time spend in the clinic. Patients with a personality disorder used more substances and had fewer unauthorized leaves than the rest. Analysis reveals that a combination of the BDHI indirect aggression scale and the lifestyle factor of the PCL-R predict substance use (R^2= .42; F = 8.100; p =0.000). Remarkably, unauthorized leaves are only explained by the amount of time spent in the clinic.

Patients with a sexual distortion exhibit the least incidents overall. Moreover, they had few unauthorised leaves and had no incidents regarding substance use. Again, analysis revealed that these differences were dependent on the time spent in the clinic.

Conclusion

Self-reports of aggressive behaviour and diagnostic characteristics revealed a small effect in predicting inpatient aggression (Field, 2005). Although PCL-R factors most strongly related to recidivism in previous research (factor 3 and 4; Hildebrand, 2004), proved most valuable in predicting inpatient aggression, results request reservation. Focusing on the critical data predicting inpatient aggression enlightens the fact that past aggressive behaviour is the best indication for future inpatient violence.

Ultimately, prediction models individualized on specific treatment settings do reveal that most differences between treatment settings (psychotic, personality disordered and sexual distorted) do not depend on patient characteristics, but are due to the amount of time spend in the clinic. Logical, patients that spend more time in the clinic also committed more incidents. Patients with psychotic symptoms not only show more aggression, but also remain longer within the clinic.

Clearly, evidence found that patients with a personality disorder do display far more substance use then the rest of the patients, which proves to be predictable by self-reports of aggression (BDHI) and the lifestyle factor of the PCL-R.

The results indicate that prevention methods regarding aggression should be focussed on patients scoring high on the lifestyle and antisocial factor of the PCL-R. Further, special interest is needed for patients with a personality disorder concerning substance use.

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35. – Workshop 5 – Reducing Seclusion and Restraint – An institutional model for reducing restraints and seclusions

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Abstract

This workshop combines the results from two formal studies and makes practice application recommendations on how to effectively implement a crisis management system to reduce the use of restraints and seclusions. The first study's objective was to identify the criteria that an organization needs to meet in order to implement and maintain and effective crisis management system that reduces the need for restraint and seclusion. The second study's objective was to examine and describe 45 child and adolescent fatalities related to restraint in residential (institutional) placements in the United States from 1993-2003 in order to identify basic, immediate and root causes that lead to these events. The workshop discussion will focus on the key domains identified that should be addressed by an organization to fully implement a crisis management system that will reduce the use of restraints and seclusions.

Residential care professionals require specialized knowledge and skills to prevent and manage aggressive and acting out behavior on the part of children and young people in their care. Often a child's aggression is visible through crisis episodes that leave both the child and the care worker in turmoil. Without proper training and supervisory support, staff can react to a child's aggression with counter-aggression; or worse, staff can respond with abusive behavior toward the child. This workshop will present the process and impact of implementing a consistent crisis intervention methodology known as Therapeutic Crisis Intervention (TCI) in a residential care organization. Impact was measured by monitoring critical incidents, staff knowledge, confidence and skill levels, and the consistency of staff intervention pre and post implementation. The implementation of TCI was successful in substantially reducing critical incidents, significantly reducing documented physical restraint episodes, and increasing staff knowledge, confidence and consistency in crisis intervention facility-wide.

In addition, information from a descriptive study examining 45 child and adolescent fatalities related to restraints institutional placements in the US from 1993-2003. In the 23 cases in this study where information is available, none of the child behaviors or conditions that prompted the restraint would meet the standard of danger to self or others: the commonly accepted criteria for the use of a restraint in any circumstance.

The workshop will begin with a presentation outlining how to use a systems approach to implementing a crisis prevention/management system. The presentation will include an overview of the five domains for effective management (leadership/administrative support, clinical oversight, supervision, training, and critical incident monitoring and feedback) and a sample of how an agency might do a self-assessment. Participants will be given the opportunity to assess their organizations level of implementation of any crisis prevention and management system against established and researched criteria. There will also be a question and answer period to address specific issues and concerns.

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36. – Workshop 6 – Emergency Response Belt – Safely restrain and transport violent persons

Boatman, P. (UK) & Fleury, H.W. (Netherlands)

The Emergency Response Belt (ERB) is a patented "tough cloth" protective, restraining and transport device designed and developed by Thomas J. Archambault, a nationally recognised 'use of force' instructor and expert in the USA. It is constructed of a tough fabric, with an attached powerful Velcro® system. It has been in continuous use in prisons, health care institutions and the police service in the US since 1989 without ever being the subject of litigation.

With "handles on the body" concept, the ERB, when properly positioned on the upper torso, prevents the subject from assaulting personnel with punches. The ERB can also be positioned on the legs at the knees and also at the waist allowing complete and total safe restraint of violent subjects. The ERB has proven to greatly reduce the potential of positional asphyxia.

With the ERB in position the subject can be walked under complete control, or with three devices in place, safely carried to transport. It has been proven that a subject sufficiently restrained is less likely to violently struggle, thereby greatly reducing the likelihood of injuries to him/herself as well as personnel.

The ERB has been subject of detailed operational evaluation and medical reviews prior to its adaptation in the UK. It has now also been introduced into health care settings in the UK and has proven invaluable in reducing risk of injury to health care staff and those they are caring for.

ERB-Europe is a company that was set up specifically to assist in the supply and distribution of the Emergency Response Belt throughout Europe and to help ensure that interested parties get the proper training, as no belts are sold without evidence of training. For this matter ERB-Europe is closely collaborating with CONNECTING, a partnership for consultancy and training in the Netherlands.

Participants will be informed about what the ERB is, and what its restraining capabilities and transport potential is. Further participants will be informed about the background, philosophy, history and use of the ERB in the USA and the UK, and plans for further distribution throughout Europe. Followed by an interactive demonstration of the use of the ERB in practice.

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37. – Mental health inpatient services: making safety our priority

M.K McGeorge, L. Shinkwin, G. Hinchcliffe (UK)

When we become unwell and require hospitalisation, we expect that we will receive treatment and care that will speed our recovery. Recent societal and policy changes in England and Wales have meant that many of our mental health wards are becoming increasingly dangerous places to spend time and our patients are often challenged to 'recover' their mental well-being in these very challenging environments.

The subject of the prevention and management of violence in hospital settings has come under increasing levels of scrutiny over the last ten years. The publication in 1998 and 2005 of two evidence-based guidelines on the subject means that we now have an authoritative knowledge base on the factors that precipitate violent incidents. Armed with this, our services are seemingly well equipped to effect strategies that will minimise risk and maximise safety. The journey of evidence into practice, however, can be slow and hazardous: many staff teams are 'change weary' and feel unable to take on new challenges; health service managers face numerous competing demands and the voice of front-line workers can be all-to-easy to ignore.

In 2006, the Royal College of Psychiatrists Centre for Quality Improvement was funded by the Healthcare Commission to run a national audit programme that would support in-patient mental health services to examine their practices in relation to the prevention and management of violence. The audit worked with 80% of providers in England and Wales, with a focus on both acute and older people's services, across a total of some 220 wards. The data collection period ran between October 2006 and March 2007 and the methods used were challenging and comprehensive: staff, services users and visitors were surveyed about their experiences; ward safety was scrutinised by multi-professional teams; aspects of clinical practice were subjected to team review and audit. The emphasis throughout the programme was on service improvement and through regional workshops at the end of the programme, local teams were supported to share good practice and develop action plans for their wards.

The dataset generated by the audit is both extensive and compelling (the survey element alone generated over 5500 individual returns). The presentation will draw upon qualitative and quantitative data from the audit to illustrate the size and nature of the challenges facing our services – from the differing perspectives of staff, service users and visitors. It will also describe some of the strategies that local teams have developed to tackle the problems identified through the audit processes.

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38. – Understanding and support vs. power and control in a psychiatric intensive care unit

J. A. Noone & M. Moreau (Canada)

The psychiatric intensive care unit (PICU) in Riverview Hospital, British Columbia, Canada admits patients from the psychiatric units of acute care hospitals in British Columbia, which has a population of 4.1 million. Riverview Hospital houses a total of 250 patients: 190 adult and 60 geriatric patients. Riverview was once on the outskirts of civilization. Although communities have now grown up around it, it is still somewhat isolated, in part due to its location on a large expanse of treed land. The PICU is located on the fourth floor (i.e., no garden access) of a stately, old, and somewhat decrepit building. In addition to the eight beds for external admissions, the unit has seven beds for patients transferred from other units in the Adult Program.

Patients who are admitted to the PICU have been referred, in general, due to aggressive behaviour that cannot be managed in the secondary health care system. Most patients have been in seclusion, often for several days. Many arrive in four-point restraints. Riverview is seen by the public, by health care providers, and by mental health clients as a place to which patients are sent when all interventions have failed. Treatment providers in the secondary system, which is taxed by many conflicting demands, often feel not only frustrated, but also fearful of patients whose aggression does not respond rapidly to psychiatric medication and coercive measures.

The task of Riverview's PICU is to rekindle hope, to understand the patient as a person, and to view aggressive behaviour as a product of alienation, confusion, and frustration. The therapeutic approach to aggression is expressed by the admission protocol, by staff training in the prevention and treatment of aggressive behaviour, and by the use of a staff rating scale (the SOAS-R) to review aggressive incidents.

When patients are admitted to the PICU, they are oriented to the unit, placed on 15-minute checks by the nursing staff and informed that they will be given their clothes as soon as possible. Patients are encouraged by the expectation that their stay will be a short one and by the realization that staff endorse their desire to regain control of their lives.

All staff of the PICU (both nursing and multidisciplinary staff) are required to complete an annual two-day Code White workshop on the understanding, prevention, de-escalation, and treatment of aggressive behaviour. The goal of this training is that staff learn how to develop and maintain a therapeutic relationship with the patient by using interventions that are respectful and professional and do not rely on pain compliance or higher levels of physical control. Practice sessions in the physical techniques are held on a weekly basis.

Data from the SOAS-R are used to examine the type of patient aggression, (e.g., verbal threats, strikes, punches, kicks), the provocation of aggression, and the nature of the staff response (e.g., verbal intervention, hands on, time out, seclusion). The effective functioning of the PICU is evidenced by the low seclusion rate and the short length of stay on the unit.

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39. – Violence, Self-Harm and Vulnerability: Development of a national mental health framework for best practice in the management of risk in England

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Abstract

Risk management is a core activity in mental health care but approaches toward it vary considerably across service providers. This paper will describe the development of a national framework to guide best practice by practitioners and organisations in England and Wales when managing the risk of violence, self-harm and vulnerability. The framework consists of a set of sixteen principles of best practice combined with structured information on a suite of risk management tools. The aim was to provide guidance applicable to all mental health care settings from community based care, including crisis intervention, assertive outreach and early intervention services, to high secure care. A philosophy emphasising positive risk management and collaboration between service providers and users was adopted but the full meaning of these terms is highly contested in mental health care. A process of national and international expert consultation and systematic review of evidence was used to develop the framework. Consulted experts included service users, carers and ward based staff. The presentation will include discussion of some of the key principles and reflection on the process for developing such national policy documents.

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40. – The beliefs of mental health nurses regarding the causes and management of aggression and violence by psychiatric inpatients: a comparison between nurses from Switzerland and the United Kingdom

J Duxbury, S Hahn & D Pulsford (UK)

Keywords

Attitudes, Beliefs, Acute In-patient, Aggression, Nurses, Switzerland, United Kingdom, Violence

Introduction

Incidents of patient aggression and violence are common occurrences in acute psychiatric in-patient facilities both in the UK and across Europe. It has been suggested that one factor that influences the way that mental health nurses respond to aggression is the beliefs and attitudes that they hold about its nature. Studies have been carried out in a range of European countries to survey mental health nurses regarding aspects of these beliefs and attitudes, but very few have attempted to make comparisons between countries using a standardised instrument. This paper reports on one such comparison, exploring the beliefs held by mental health nurses in Switzerland and the United Kingdom as to the causes and most appropriate management techniques for aggression and violence in their respective acute in-patient settings.

The study

Aims

1. To compare the beliefs of mental health nurses from Switzerland and the United Kingdom regarding the causes and management of aggression and violence among psychiatric in-patients.

Design

A retrospective study was conducted to compare the existing data of two previous studies, one conducted in Switzerland and the other in the United Kingdom, that both used the Management of Violence and Aggression Attitude Scale (MAVAS) (Duxbury & Whittington, 2005; Hahn et al, 2006). The items within the MAVAS guide respondents to give their views as to the causes of patient aggression underpinned by three broad theoretical models: the Internal, External and Situational/Interactional models. MAVAS also asks respondents to give their views about common aggression management strategies, including interpersonal and physical or "controlling" means of management.

Participants

Switzerland: 75 nurses working on six acute psychiatric wards in three psychiatric hospitals in the German-speaking part of Switzerland. 45 were female and 30 male. The mean age of the whole sample was 36.24, and mean length of experience in psychiatric nursing was 7.35 years.
United Kingdom: 75 nurses from three wards (acute in-patient; high dependency and psychiatric intensive care) within one psychiatric unit. 58 were female and 17 male. The mean age of the whole sample was 32, and mean length of experience in psychiatric nursing was 5.25 years.

Data Collection

All participants completed the MAVAS, which contains 27 statements about causes of aggression and violence, and approaches to their management. Participants gave their views on each statement on a visual analogue scale, by marking a 100-millimeter straight line, the ends of which represent extremes of possible response. A low score indicates agreement with the statement.

Data Analysis

Analysis was carried out on a question-by-question basis. The mean responses of the Swiss and UK nurses to each question were calculated and compared using independent two-tailed t-tests.

Findings

Beliefs regarding the Causes of Patient Aggression

Table 1 sets out participants' responses to the MAVAS statements that relate to the three underpinning models of causation.

Internal Model: Both the Swiss and the UK nurses gave responses that were in accordance with views supporting the internal model of causation of aggression and violence. There were no significant differences between the groups on three statements related to this model. The remaining two statements produced statistically significant differences in responses that suggested that the Swiss nurses embraced the internal model to a greater extent than those in the UK. Swiss nurses were less likely to disagree that "It is difficult to prevent patients from becoming aggressive", suggesting some degree of personal control by patients. Swiss nurses were more likely to disagree that "Aggressive patients will calm down if left alone".

External Model

There were statistically significant differences in responses to two out of the three statements pertaining to this model. UK nurses agreed with the statement that "Patients are aggressive because of the environment they are in", while Swiss nurses disagreed. UK nurses were more likely to agree with the statement "If the physical environment were different, patients would be less aggressive".

Situational/Interactional Model

Both groups broadly agreed with three of the statements related to this model, indicating support for the impact of interpersonal and situational influences. The Swiss nurses disagreed with the statement "Other people make patients aggressive or violent",, while the UK nurses as a group were less certain (mean score 50.87). Both groups disagreed with the statement "Patients commonly become aggressive because staff do not listen to them", although the UK nurses leaned more towards agreeing with this view. These findings suggest slightly stronger views about the impact of this model among the UK nurses.

Beliefs regarding the Management of Patient Aggression

Table 2 sets out the mean responses between groups pertaining to the management of aggression and violence in psychiatric in-patient facilities. Both groups agreed that a range of approaches were used in their clinical area to manage aggression and violence, and also that aggression could be handled more effectively on their respective wards.

Use of Medication

Both groups agreed that medication was a valuable approach to the management of aggression, yet also recognised that prescribed medication could lead to aggression. Despite this Swiss nurses felt that medication could be used more frequently. UK nurses in contrast disagreed that this should be the case.

Use of Seclusion

Both groups disagreed with the statement that seclusion was used more than necessary and that the practice of secluding patients should be discontinued, although Swiss nurses were stronger in their level of disagreement. Similarly Swiss nurses agreed that seclusion is one of the most effective approaches to aggression management, while UK nurses disagreed.

Use of restraint

Both groups disagreed with the statement that physical restraint is used more than necessary. UK nurses agreed that patients are restrained for their own safety, while Swiss nurses disagreed.

Use of non-physical methods of aggression management

There was support in principle for non-physical approaches to management. Both groups agreed that expressions of anger do not always require staff intervention; that non-physical methods could be used more frequently, and that the use of de-escalation is effective. Both groups also agreed that negotiation could be used more effectively, Swiss nurses more convincingly than their UK counterparts.

Discussion

There were no significant differences between the Swiss and UK nurses' responses to 16 out of 27 of the MAVAS statements, representing nearly 60% concordance of views. There was some support for each of the three causative models of aggression and violence, indicating that both groups recognised the multi-factorial nature of causation. There was also general support for "controlling" means of managing aggression (medication, restraint and seclusion), though both groups felt that non-physical methods could be used to a greater extent. Both groups agreed that patient aggression could be handled more effectively on their wards. There are clearly common issues and views held by nurses in these different European countries.

At the same time, a number of significant differences were noted. With regard to the causation of aggression, the Swiss nurses were somewhat more inclined to support the internal model than the UK nurses, while the latter more strongly embraced the external model. The UK sample was also more inclined to support the situational/interactional model, though both groups appeared somewhat ambivalent towards this model.

The UK nurses' greater espousal of the external model of causation may be seen in the context of recent critical reports about the physical and social environments of acute in-patient units in this country (e.g. MIND, 2004; Sainsbury Centre for Mental Health, 2004). Their focus on external factors is likely to reflect dissatisfaction with the environments in which they work, though it is unclear whether they are criticising the physical or social aspects of those environments.

Significant differences between the groups regarding the management of aggression were consistently in the direction of the Swiss nurses being more in favour of physical or controlling methods. At the same time, Swiss nurses agreed more strongly that negotiation could be used more effectively, suggesting that they would appreciate greater use of non-controlling strategies.

The Swiss nurses in this study, therefore, may be regarded as displaying a more "traditional" view of patient aggression to their UK counterparts, in that the significant differences between the groups were in the direction of Swiss nurses' greater espousal of the internal model of causation as opposed to the external and situational/interactional models, while also being more in favour of physical or controlling means of aggression management.

These findings may be seen in the context of high rates of aggression reported in Swiss acute in-patient units (Needham et al, 2004). It may be that frequent aggressive incidents lead to nurses regarding those incidents as emanating from factors within patients, and responding with controlling management strategies. It is also possible that overuse of controlling strategies may itself lead to ward environments characterised by confrontation, with aggressive incidents being easily triggered. The latter point raises the question of the role of training in modifying

staff attitudes and approaches to the management of aggression and violence, though the recent literature has been equivocal (Needham et al, 2004; Bowers et al, 2006 a & b; Hahn et al, 2006).

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Table 1: Comparison of responses to MAVAS statements related to beliefs regarding the causes of aggression and violence

	Country	N	Mean	Sig	Comment
Internal Causative Factors					
4. It is difficult to prevent patients from becoming aggressive	S UK	75 75	56.31 61.76	*	Disagree: UK>S
5. Patients are aggressive because they are ill	S UK	75 75	48.25 44.68	NS	Agree
7. There are types of patient who are aggressive	S UK	75 75	33.35 37.26	NS	Agree
9. Patients who are aggressive should try to control their feelings	S UK	74 75	44.70 46.84	NS	Agree
14. Aggressive patients will calm down if left alone	S UK	75 75	70.68 61.48	*	Disagree: S>UK
External Causative Factors					
1. Patients are aggressive because of the environment they are in	S UK	75 75	56.08 46.41	*	S Disagree UK Agree
16. Restrictive environments can contribute towards aggression	S UK	75 75	32.44 32.72	NS	Agree
27. If the physical environment were different, patients would be less aggressive	S UK	75 75	44.16 37.06	*	Agree: UK>S
Situational/Interactional Causative Factors					
2. Other people make patients aggressive or violent	S UK	75 75	59.93 50.87	*	S Disagree UK Unsure

	Country	N	Mean	Sig	Comment
3. Patients commonly become aggressive because staff do not listen to them	S UK	75 75	68.31 58.17	*	Disagree: S>UK
6. Poor communication between staff and patients leads to patient aggression	S UK	75 75	43.03 41.85	NS	Agree
20. Improved one to one relationships between staff and patients can reduce the incidence of aggression	S UK	75 75	26.53 27.02	NS	Agree
23. It is largely situations that can contribute towards the expression of aggression by patients	S UK	75 75	40.40 38.95	NS	Agree

NB: Low scores indicate agreement with a statement; high scores indicate disagreement with that statement

Table 2: Comparison of responses to MAVAS statements related to beliefs regarding the management of aggression and violence

	Country	N	Mean	Sig	Comment
Management: General					
8. Different approaches are used on the ward to manage aggression	S UK	75 75	31.05 30.21	NS	Agree
21. Patient aggression could be handled more effectively on this ward	S UK	75 75	47.13 43.96	NS	Agree
Management: Use of Medication					
13. Medication is a valuable approach for treating aggressive and violent behaviour	S UK	74 75	33.93 36.67	NS	Agree
22. Prescribed medication can sometimes lead to aggression	S UK	75 75	38.63 42.12	NS	Agree
25. Prescribed medication should be used more frequently for aggressive patients	S UK	75 75	43.37 52.26	*	S Agree UK Disagree
Management: Use of Seclusion					
10. When a patient is violent seclusion is one of the most effective approaches	S UK	74 75	41.16 55.96	*	S Agree UK Disagree
12. The practice of secluding violent patients should be discontinued	S UK	75 75	78.12 68.79	*	Disagree: S>UK
24. Seclusion is sometimes used more than necessary	S UK	75 75	66.05 63.23	NS	Disagree
Management: Restraint					
11. Patients who are violent are restrained for their own safety	S UK	75 75	54.79 42.94	*	S Disagree UK Agree
18. Physical restraint is sometimes used more than necessary	S UK	75 75	62.33 60.17	NS	Disagree
Management: Non-physical Methods					

	Country	N	Mean	Sig	Comment
15. Negotiation could be used more effectively when managing aggression and violence	S UK	75 75	28.31 37.09	*	Agree: S>UK
17. Expressions of anger do not always require staff intervention	S UK	75 75	35.11 37.06	NS	Agree
19. Alternatives to the use of containment and sedation to manage physical violence could be used more frequently	S UK	75 75	40.88 42.63	NS	Agree
26. The use of de-escalation is successful in preventing violence	S UK	75 75	27.91 29.88	NS	Agree

NB: Low scores indicate agreement with a statement; high scores indicate disagreement with that statement

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41. – Medical students' perception of patient aggression

A Hannah, J MacKay, C Gale (New Zealand)

Background

Patient-initiated assaults (Coverdale et al, 2005), being shouted at and physically threatened (Sheehan et al. 1990), are serious risks for medical students. What does not appear to have been researched is whether certain styles of communication are correlated with increased patient violence. Over half the registrars in one study reported being threatened verbally, or physically intimidated by patients, with one third indicating they had been physically assaulted (Coverdale et al, 2001). Descriptions of patient-initiated assaults on medical students have included being pushed, slapped and grabbed (Waddel et al, 2005). Recent research has found that 68% of medical students throughout New Zealand had experienced one adverse event at medical school (Wilkinson et al, 2006).

Research has also focussed on the effects that the patient-initiated assaults have on medical students. Wilkinson et al (2006) found that while many students could move on from the event easily, one fifth required several days, and 5% said they would never forget the experience. Some students who had been attacked stated they felt depressed and angry. Students said they did not see any reason in laying a complaint about abuse due to fear of further consequences the complaint may have on themselves, and also that reporting it would not actually change anything (Elnicki et al, 2002).

Objectives

The aim of this study was to examine Medical students' perception of patient aggression and correlate the data with aspects of students' perceived communication style. This was a pilot study.

Method

208 medical students in their three clinical years of training were sent the questionnaire along with a covering letter and a pre-paid return envelope. The survey was mailed out three times. Anonymity of participants was maintained.

Results

A 39% (83) response rate was obtained. Some of the results indicate 31% of medical students were subjected to verbal anger, 5% verbal threat, 5% humiliation, 7% physical aggression, 7% sexual harassment. A factor analysis indicated some styles of communication were associated with aggressive events. Gender effects were found.

Conclusions

Medical student abuse by patients is correlated with students' perception of their communication style. This pilot study may be adapted to survey other health professionals and raise awareness for the need of self-evaluation of whether professionals' communication style is actually patient centered or is it that they only believe that it is. Teaching in interpersonal skills, and making professionals aware of how their communication style affects patients, appears essential in reducing patient aggressive events.

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42. – An exploration of Irish mental health nurses' experiences in the management of aggressive and disturbed patients

Angela Cocoman, Anne Scott, Anne Matthews (Ireland), Professor Maritta Välimäki (Finland)

Keywords
Qualitative understanding. Thoughts & Feelings. Support. Education Distressed & disturbed patients.

Introduction / background

This exploration of Irish mental health nurses' experiences in the management of aggressive and disturbed patients is part of a larger EU funded project called ePsychNurse.Net. The outcome of this project is to ensure high quality, ethically appropriate and therapeutically effective interventions to enable nurses to manage distressed and disturbed patients in psychiatric hospitals and inpatients units in six European countries. As part of an educational needs analysis, focus groups were conducted in six European countries to explore nurse's perceptions.

Psychiatric nurses share many of the stressors of other nurses but the nature of psychiatric nursing necessitates intense interpersonal involvement with patients and carers (Edwards et al 2000). Caring for patients with mental health difficulties is an interpersonal process that involves strong feelings and emotions. Akerjordet & Severinsson (2004) suggest it is important to develop psychiatric nurses' hidden resources such as their feelings, their beliefs , their perception abilities (or perceptions and abilities??) , their emotional skills of self-awareness, reflection and intuition, as their compassionate values and attitudes are major assets in the health service. The long term management of distressed and disturbed patients in acute inpatient settings (Jenkins & Elliott 2004) often results in sick leave, burnout and poor recruitment and retention rates. Dealing with physically threatening, difficult or demanding patients was found to be the most stressful part of the job, with over many staff showing signs of high burnout in terms of emotional exhaustion (Jenkins & Elliott 2004).

The main paper / article

There has been little research to date on nurses' subjective experiences of managing distressed and disturbed patients and their thoughts and feelings about these experiences and their beliefs about the education and support needed to sustain those experiences and feelings. Therefore, the four focus groups that were conducted in a psychiatric hospital in Dublin, Ireland, with 23 psychiatric nurses adds to the growing body of knowledge. The principal elements identified in the analysis of the Irish focus group interviews, was that it was something nurses can't always prepare for in advance, mostly because there are a lot of decisions to be made very quickly. Nurses who participated in these focus groups describe the physical and emotional experience as they describe feeling under pressure, feeling fear, being hyped up, and often feeling sore and tired. Also they found it hard to switch off after an incident and many admitted that it was the worst part of the job therefore adequate training and support is essential.

Conclusion / Discussion

The management of distressed and disturbed patients in the acute inpatient setting often involves the use of restraint and seclusion which have a physical and psychological impact for both patients and staff. The themes that were revealed from the Irish psychiatric nurse in this study were that it is a highly emotional experience; however the role experience plays is important in coping. Also highlighted is the need for adequate staff training in the control and management of aggression and violence, and a recognition of the importance of post incident care in using some form of critical incident stress debriefing.

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43. – Seminar 1 – Reduction of seclusion and restraint – Assessing organizational readiness to reduce restraints

David Colton PhD, (USA)

Mental health providers tend to be client/patient focused and may not be cognizant of the influence that organizational factors play in the quality and delivery of treatment. This presentation describes how organizationa development can lead to cultural change within mental health settings and the influence this has on efforts to reduce use of seclusion and restraint. Based on a study of children's treatment programs, more than a process of initiating specific activities, programs that successfully reduce use of seclusion and restraints undergo a process that transforms th organization's underlying culture - shared belief systems and values that are ingrained and therefore difficult to modify.

44. – Seminar 1 – Reduction of seclusion and restraint – Why don't some organizations learn?

Brodie Paterson,Ph.D., M.Ed, BA (hon) RMN, RNLD, RNT, Lecturer, Department of Nursing and Midwifery University of Stirling, Stirling, FK9 4LA

Current management theory stresses the need for organizations to be learning entities by means of continual reflection on their philosophy, strategy and operations in order to improve their performance. There are now multiple examples of organizations adopting this approach to successfully reduce violence towards staff together with the use of coercive interventions such as restraint and seclusion. Such good practice is though far from universal and it seems appropriate therefore to explore why many organizations do not adopt it. In practice a number of barriers can be observed. Some organizations operate according to a frame which constructs certain phenomena such as violence perpetrated by people with mental health problems as a form of natural phenomena akin to the weather (and thus not amenable to human intervention or control) and constrained in their world view by this frame see coercive interventions such as restraint and seclusion as inevitable. If though a problem is deemed irresolvable learning and reflection are not appropriate and punitive, fatalistic or sadistic, coping strategies may be adopted both by organizations and individuals.

Seminar 2 – Training in the management of aggression and violence

Kevin McKenna Dundalk Institute of Technology & Health Service Executive Ireland & Gail Miller Associate Director Violence Reduction West London & Broadmoor Mental Health Services Trust.(England)

This seminar will present a critical evaluation of the key issues related to the provision of staff training as one component of a comprehensive organizational strategy in the management of work related aggression and violence within clinical care settings.

The seminar will consist of nine sequentially structured presentations and conclude with an interactive forum debate with a geographically diverse panel of international subject experts.

Presentations will explore key themes related to the structure, process, and effectiveness of training provision from clinical, organizational and governmental perspectives. As such this seminar will be of interest to clinicians of all disciplines in addition to leadership and management personnel.

While presenters include both internationally acknowledged subject specific researchers and clinicians, a central focus will be on:
- the application of research findings to clinical practice
- the contemporary debates surrounding each theme
- emerging evidence and future directions.

The open panel forum will explore a number of key issues by briefly sharing international perspectives followed by a facilitated interactive panel discussion.

By the conclusion of the seminar delegates will have had the opportunity to critically appraise contemporary practices and research and to develop an informed understanding of the contribution which staff training can make to the attainment of clinical and organizational excellence in the management of work related aggression and violence.

45. – Seminar 2 – Training in the management of aggression and violence – Gail Miller (UK): Organisational Ownership and Cultural Change

Rick Tucker, NHS Security Management Service United Kingdom & Gail Miller, Associate Director violence reduction west London and Broadmoor Mental Health Services Trust. (England)

Traditionally, prevention and management of violence training and practice has been based on reaction to events once they have occurred. This meant that staff were trained, at best, in physical intervention skills at the expense of non-physical skills and, at worst, received no training at all.

The introduction to health services of Control and Restraint Training (C&R), which had originated in the prison service, brought about some consistency in approach, but still failed to adequately equip staff with the knowledge and skills to intervene safely in non-physical ways.

Recent research (Royal College of Psychiatrists/Healthcare Commission, Audit of Violence 2005) in the UK shows that the main causes for violence in mental health and learning disability services are environmental and cultural, not clinical. However, the vast majority of assaults against staff in the English NHS (70%) occur in mental health and learning disability services, which must lead to the question 'why?' being asked.

The provision of C&R training for staff became the only response to the levels of violence on clinical areas and did not achieve a reduction in violent incidents; in fact this one-dimensional approach may have eroded traditional clinical skills which are more appropriate for preventing violence.

There is now a need for mental health and learning disability services to take a more holistic approach to the problem, seeking out and eradicating, where possible, the causes of violence, whether they be environmental, cultural or educational. Training is but one aspect of what has to be a more generalised and strategic approach.

46. – Seminar 2 – Training in the management of aggression and violence – Training 'who' to do 'what'?: Reappraising the role function and purpose of training in the management of aggression and violence within clinical settings

Kevin McKenna Lecturer Dundalk Institute of Technology & Project officer Program on Work-related Aggression and Violence Health Service Executive (Ireland)

Traditional attempts to understand aggression and violence within clinical settings as being a function of either patient pathology, or staff inability to manage such occurrences typically resulted in organisational responses which either focused on 'managing' the patient or 'training' the staff.

Subsequently training focussed predominantly on tertiary interventions employed to 'safely manage' occurrences of aggression and violence. While a number of factors have significantly contributed to the perpetuation of this approach, clinical and research attention has focused on how interventions be employed 'more safely' rather than efforts exploring whether these interventions should be employed 'at all'.

More enlightened understanding of the problem of aggression and violence from both contextual and organisational perspectives has now increasingly recognised the limitations of such approaches. With this recognition there is also a growing realisation that achieving meaningful improvement at clinical and organisational levels will require that educational responses encompass personnel at all levels of the organisation and that these are refocused from a tertiary to a preventive frame of reference.

For the potential contribution of staff training efforts to be fully actualised it is necessary for the predominance of 'training' responses in tertiary interventions to be replaced with 'educational' responses in which clearly articulated aims, objectives and learning outcomes are developed from a critical analysis of the educational goals from the perspectives of 'participant', 'content' and 'provider'.

This presentation will discuss strategies through which organisations can attempt this shift from 'training' to 'educational' responses and the contribution this reappraisal can make as part of broader strategic efforts toward achieving both clinical and organisational excellence.

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47. – Workshop 7 – Sibling violence and aggression – Assessment & clinical intervention with children, families and adults

John Caffaro, PH.D. Professor, California School of Professional Psychology, Los Angeles. Assistant Clinical Professor of Psychiatry, University of California, San Diego School of Medicine, Child Psychiatry Residency Training Program (USA)

Introduction

- Society's awareness of sibling violence, and its response, lags behind other child abuse issues and concerns
- Sibling violence is generally underreported by parents, teachers, mental health professionals, and the community
- Treatment for sibling assault requires multidisciplinary cooperation and usually, the coordination of services among several provider systems.

Sibling Relationships Across the Lifespan

- Our siblings often constitute our ongoing sense of family.
- The sibling bond can be obscured by adulthood.
- In most families, sibling ties begin in childhood with parents writing the script.

Early childhood
- Parent's role is especially important in shaping sibling relations in early childhood
- By age four, 2nd-born children spend more time talking and playing with an older sibling than with parents (Dunn, 1993).

Adolescence
- Siblings generally become less important during adolescence as peers take on more important role for children.
- This is especially true regarding social relationships, however, siblings still exert a significant influence on identity formation during this time.

Adulthood
- Less than 3% of adult siblings ever completely cutoff their relationship with a sibling in adulthood (Cicirelli, 1982)
- Sister-sister bond is usually closest (Pulakos, 1989)
- Later, men often benefit from a close relationship with a sister in terms of decreased anxiety and depression and increased life satisfaction (Cicirelli, 1990).

Some Developmental Observations

- Siblings perceive same events in families differently and tend to recall events in ways that stress their own identity in contrast to sibling and reinforce frozen roles (Caffaro & Conn-Caffaro, 1998).
  · Get each sibling's perception of events.

· Each child actually inhabits his or her own unique niche in the ecology of the family; it is within these sibling microenvironments that formative aspects of development occur.

· Two children growing up in same home might have very different experiences in that home (2/3 of mothers acknowledge feeling more affection for one child over another [Dunn & Plomin, 1990]

- Best parents can hope for is feeling of "overall fairness" with different children in same home.
- Sibling deidentification may also play a part in differential treatment.
- Siblings have separate relationships which change when others intrude.

· There is no tradition in child/family therapy for interviewing the sibling dyad--but the research suggests there should be.

· Assessment should include observing siblings individually, dyadically, and with parents.

· Most studies of sibling violence rely on parental report. Large risk of parents underreporting the incidence of sibling violence.

- Discovery that children brought up in same family are no more similar that they would be if they had been brought up on different planets shows how poorly we understand personality development.

· What we know is that childhood is a jungle… and the first problem that children face is how to hold their own among siblings and peers.

The Sibling Domain

- Sibling rivalry and fighting are usually considered a normal part of family life. In fact, the words "sibling" and "rivalry" are practically synonymous in our society.
- Freud conceived of family as a kind of "domestic boxing ring" over scarce commodity of parental--particularly, maternal—love. His theory provides little allowance for mixed feelings.

Culture and the Sibling Domain

- Preponderance of Western-bred research makes the primacy of sibling rivalry appear normal and universal.
- In Vietnam, terms of address for lovers and spouses are anh ("big brother") and em ("little sister"). There is a tightly woven sibling bond firmly rooted in survival and the self organized more closely around the "we" than the "I". Sibling interdependence begins early.
- Greater affluence of Western cultures permits siblings to be more independent of one another.

Sibling Rivalry v. Violence

- Sibling Rivalry is a normal and mostly harmless part of growing up characterized by sibling interaction which leads to healthy competition without anyone getting hurt.

· Evidence that this sort of rivalry teaches children how to share, compromise, and win without humiliating other as well as lose without self debasement. In such cases, siblings rotate roles of winner/loser with more balance.

- Sibling violence has been minimized and described as rivalry for long time even when it leads to injury. No consensus on definition in the literature.
- Sibling Violence is a repeated pattern of physical aggression with intent to inflict harm and motivated by need for power and control.
- Experts generally agree that the most violent members of the American family are the children yet sibling violence is rarely systematically studied. There have been only 2 major national studies.

Reasons why sibling violence is thought to be less harmful:
- Presumption that child offenders not as strong, and victims therefore, not as damaged by threats
- The notion that child-on-child violence developmentally is normal and therefore victims feel less stigmatized and violated
- It leads to belief that children are developmentally more resilient when child perpetrators involved
- Finally, presumptions of mutual responsibility in terms like scuffle, fights, squabbles often used to describe sibling conflict

Critique of Presumptions:
- Lack of socialization often make child offenders more, not less dangerous.
- Remember, sex crimes are believed to be more injurious the earlier they are experienced
- Children may have much more intense and on-going contact with assailants--siblings--than would most adult victims

Results of a recent national study:
- 35% of national survey of 2,030 children interviewed had been "hit or attacked" by sibling in past year
- 14% repeatedly attacked by a sibling
- Children ages 2-9 who were repeatedly attacked were twice as likely as others their age to show severe symptoms of trauma, anxiety, and depression, including sleeplessness, suicidal ideation, and fear of the dark
- Sibling victimizations most common for 6-9 year olds. Experience associated with most symptoms was chronic sibling violence against younger children (5 or more episodes in year)

Sibling Abuse Trauma

- Data from 73 adult survivors of sibling incest or assault
- 36% (N=26) were sibling assault survivors
- 45% (N=12) brother-brother assault
- 30% (N=8) brother-sister assault

Addressed 3 key features with our inclusion criteria:
a. Role rigidity- resulting in solidification of victim/offender status.
b. Self perception of victim
c. Psychological maltreatment

Research criteria for inclusion in study:
- Individuals, who as children perceived themselves as "picked on" by one sibling in particular – psychological maltreatment
- Individuals who would characterize their childhood sibling interactions as violent and abusive – self perception
- Siblings who perceived a higher level of conflict with a childhood sibling in the home than with other peers –- role rigidity

Selected Research Results
- Psychological maltreatment is a core element of sibling violence
- Many of the sibling violence survivors in our study suffered from multiple traumatization
- "Teasing" may include ridiculing, insulting, threatening, terrorizing and belittling
  · Destroying a sibling's personal property
  · Rejecting, degrading and exploiting a sibling

- Persistent sibling conflict is one of most common family complaints
- National surveys suggest sibling aggression is many times more common than spousal and parent/child abuse combined (Gelles & Straus, 1988)
- Sibling violence, particularly for child in offender role may also be more important than other family interactions in terms of socializing towards violent behavior May be more predictive of later violence than parent-child abuse (Gully et al., 1981).
- Increasing evidence that sibling victimization has serious short-and long-term effects. One area of close study is emotional cutoff

Emotional cutoff: a denial of the intensity of unresolved emotional attachment to family member (Bowen, 1978).
- Family of origin cutoffs implicated in lower adaptability to stress, greater anxiety and higher levels of depression.
- Administered the Family Relationship Questionnaire (FRQ) to 73 participants. (67% female, ages: 18-54, u=38 yrs). Ethnicity: 77% white, 10% Latino, 13% African American.
- Examined the relationship between FRQ items and sibling violence:
  · 34% of our sibling violence participants were practicing an "emotional cutoff" pattern with at least one adult sibling
  · Likely to repeat problematic cutoff pattern in marriages
  · More depressed and more likely to initiate divorce
  · Lower adaptability to stress and higher levels of anxiety

Additional Long-range Consequences
- Problems in development of social skills that help to initiate, maintain and enhance peer interactions.
- Evidence to suggest that sibling abuse victims are less competent in social interactions with peers.
- Lack of acknowledgment in family leads many to feel frustration, hopelessness about establishing a normal relationship with offender and mistrust and betrayal of parents.
- At risk for repeating dysfunctional patterns and roles in relationships with peers, spouses, and others.
- Increased anxiety, depression, and possible development of PTSD-like symptoms
- Consonant with lower self esteem and greater anxiety and depression

Consequences for the untreated offender:
- Links between sibling assault and subsequent dating violence in males
  · Simonelli et al., (2002) report link between sibling abuse and subsequent dating violence in males
  · MENTION FLORIDA (2004) STUDY HERE

Family Risk Factors

- Parental unavailability
- Attachment difficulties where parents may be physically available but emotionally absent
- Father's role may be particularly salient in forecasting quality of sibling relationship

- Low levels paternal acceptance and involvement linked to higher levels of sibling conflict
  · Peripheral fathers are over-represented in families experiencing sibling assault and lower levels of paternal acceptance and involvement have pervasive negative effects on children.
  · Siblings who characterize father as warm and treated siblings equally had lower levels of sibling conflict (Stocker & McHale, 1992).
  · Interventions should include father whenever possible. Father's role with male children has

been related to empathy development.
- Research (Koestler, 1990) demonstrates that the amount of time a father spends with his children is one of strongest predictors of empathy in adulthood.
- Specifically, a father who is able to display tender emotions is an important ingredient for the development of empathy in male children

- Ineffective parenting
  · Ideally, parents learn to create a balance between over-involvement in sibling affairs and a lack of protective, competent parenting
- Sibling relationships characterized by power imbalances, role rigidity, and unclear boundaries
  · Situations where one child repeatedly is violating another's physical, and psychological space
- Consistent disregard for sibling's personal and psychological space usually indicates more serious problems
- Differential treatment of siblings

Guidelines for Intervention

- Create flexible, but distinct bridges between family-based and individually oriented approaches
- Understand and recognize how different cultural expectations influence the developmental course of relationships between parents, children, and extended family
- Cultural, Gender Implications

African American siblings
- Emphasis on pseudo-parent sibling role important.
- Depathologize through normalization.
- Only pathological when sibling is parenting parent. (parental child role)
  · Oldest male most vulnerable to assuming pseudo-parent sibling role

Mexican American siblings
- Oldest female child most vulnerable
- Strong sibling interdependent family ties through lifespan, independent of birth order and family size

- Sibling abuse family configurations can be useful in making sense of patterns and guiding treatment
- Unlike many offenders in parent-child maltreatment, sibling offenders often remain in the home after disclosure

Implications for practitioners

- More needs to be done about collecting data and assessing for sibling violence
- Child-on-child violence (under 12 yrs) not currently counted in National Crime Victimization Survey (NCVS)
  · On the one hand, child-on-child violence not criminal (CA law states "mutual affray")
  · On the other, children experience violence more frequently than most adults therefore it is of public policy interest
  · Possible solution: include experiences of younger children in data gathering, but report experiences of all juveniles (younger and older) together in separate reports re juvenile victimization.
- Continued development of Sibling Abuse Interview (SAI)

- Evidence (Finkelhor, et al., 2006) suggests sibling abuse will not be disclosed unless it is mentioned specifically by researcher or practitioner

Implications for Society

- Sibling violence needs to be taken more seriously
- Set clearer standards against such violence and earlier intervention to prevent recurrences
- Parents encouraged to establish no hitting policies among children
- More parent education regarding sibling violence is necessary
- Underreporting by families is a significant concern despite high incidence rates in literature
- Linked to violence toward peers and adults

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48. – Protective factors for violence risk: clinical experiences and first results with a new instrument for risk prevention: the Structured Assessment of PROtective Factors for violence risk (SAPROF)

Michiel de Vries Robbé, MSc, Vivienne de Vogel, PhD, & Eva de Spa, MSc (Netherlands)

Keywords
Risk assessment, protective factors, SAPROF, HCR-20, violence, risk management

Introduction / background

The knowledge on risk factors and risk assessment for (sexual) violent behavior has grown rapidly in the last decades. However, most of the risk assessment instruments for adults stress risk factors and disregard entirely the other side of the equation: protective factors. A balanced evaluation of risk assessment should take into account both risk and protective factors (Rogers, 2000). The identification of possible protective factors is important because the ultimate aim of risk assessment is to minimize violence risk. Protective factors are defined as factors that serve to modify the effects of risk factors and reduce the likelihood of violent recidivism (De Vogel, De Ruiter, Bouman, & De Vries Robbé, in press).

Considering the rather scarce empirical knowledge on protective factors and the mental health professionals' need for practical guidelines in this area, we decided to develop a guideline to assess protective factors. Important goals of standardized assessment of protective factors are: to complete the violence risk assessment resulting in a more balanced, and possibly more accurate risk assessment; to provide guidelines for risk management; and the positive and motivating effect on patients and treatment staff. The guideline we initially developed is called the Structured Assessment of PROtective Factors (SAPROF) Research Version and is designed according to the method of Structured Professional Judgment (SPJ; see Douglas, Cox, & Webster, 1999; Webster, Douglas, Eaves, & Hart, 1997). The SAPROF Research Version is based on available empirical knowledge on factors that reduce recidivism and experiences of raters – both researchers and clinicians - in the Van der Hoeven Kliniek, a Dutch forensic psychiatric hospital (see De Vogel & De Ruiter, 2006). In 2006, we conducted a pilot study with the SAPROF Research Version in two Dutch forensic clinical settings (Van der Hoeven Kliniek and Pompe Kliniek) and one ambulatory setting (De Waag). In this pilot study, 20 raters coded the SAPROF Research Version for 40 patients and critically reviewed the item descriptions and coding procedure. All raters were positive about the use of the guideline, especially with respect to the positive approach towards the patient and the suggestions the guideline provides for treatment. They also had several suggestions for improvement of the guideline. Based on the comments of the raters and a literature update, we adapted the SAPROF Research Version resulting in the SAPROF Version 1 (De Vogel et al., in press).

The SAPROF Version 1 contains 3 subscales: 1) Internal factors (5 items); 2) Motivational factors (7 items); and 3) External factors (5 items), and is specifically intended for use in clinical practice. Most of the items (15) are dynamic and provide concrete guidelines for treatment. The SAPROF should always be used in conjunction with SPJ risk assessment guidelines such as the Historical, Clinical, Risk Management-20 (HCR-20; Webster et al., 1997) and should be repeated regularly, for instance, when the context of the patient changes. The design and coding procedure

of the SAPROF is highly comparable to those of SPJ guidelines such as the HCR-20. The items have to be coded on a three point scale: '0' the item does not apply according to the available information, '1' the item probably or partially applies, and '2' the item definitely applies. The Final Protection Judgment has to be defined as little, moderate, or much and is valid for a specific time period, for instance, during a specific treatment phase or for a given context (e.g., inpatient versus outpatient). The SAPROF is a SPJ guideline and thus, the Final Protection Judgment does not depend on the simple summation of item scores. The surplus value of the SPJ method is in systematically collecting, reviewing, combining, weighing, and integrating information, and discussion with colleagues - preferably from different disciplines - to reach a final judgment upon (sexual) violence risk. Finally, the SAPROF results have to be integrated with the results of a structured risk assessment guideline such as the HCR-20, resulting in an Integrative Final Risk Judgment (low, moderate or high).

The main paper

In this paper, the SAPROF is introduced and the importance of the use of this structured professional guideline for treatment in forensic settings is discussed. As the SAPROF focuses on the preventive effect of protective factors, we will present some background on the potentials of the guideline as a tool that can be used in developing positive risk communication, learning objectives and program development. Experiences of forensic psychiatric hospital staff with the instrument will be discussed. Furthermore, results will be presented of a retrospective study into the interrater reliability and predictive validity of the SAPROF, the changeability of protective factors during treatment and the additional value of the SAPROF to the currently used risk assessment with the HCR-20.

Method

The SAPROF and HCR-20 were coded for 41 male patients and 25 female patients admitted to the Van der Hoeven Kliniek, a Dutch forensic psychiatric hospital. For 15 of the 41 male cases, the SAPROF was coded by three independent researchers, for all female cases, the SAPROF was coded by two independent researchers. The interrater reliability of the SAPROF as well as its predictive validity for violent recidivism after treatment were examined.

Results

The overall interrater reliability of the SAPROF was good (ICC single measure for total score = .92 for males and .84 for females, both $p < .001$). Furthermore, predictive validity was good for men for the short-term; the SAPROF total score demonstrated to be a significant negative predictor of violence (Area Under the Curve (AUC) at one year follow up = .17 and at two year follow up = .23, both $p < .01$). However, at 5 year follow up, the AUC value (.39) was no longer significantly different from level of chance (.50). The HCR-20 total score was a significant predictor of violent recidivism for the male patients (one year follow up AUC = .80, $p < .01$). When the SAPROF total score was substracted from the HCR-20 total score, this resulted in a higher - although not significantly – predictive validity (one year follow up AUC = .84, $p < .01$). For the female patients, both the HCR-20 and the SAPROF total score were no significant predictors of violent recidivism (see also De Vogel & De Ruiter, 2005). In a small number of cases (N = 8 males), the SAPROF was coded retrospectively both at the beginning of treatment and upon discharge. The mean score on the SAPROF at the beginning of treatment was significantly different from the mean score upon discharge (6.7 (SD = 2.6) versus 14.5 (SD = 5.5), $p < .01$).

Conclusion

The present study demonstrated evidence for the SAPROF as a reliable tool for the assessment of protective factors. The guideline can be reliably coded for both male and female forensic psychiatric patients and demonstrated to be a strong negative predictor of violence upon one or two year follow up in male patients. Furthermore, we believe that this guideline has additional value for risk assessment in clinical practice, since it provides a more balanced picture of risk for violence and specifically focuses on prevention. Thus, it is more motivating for both treatment staff and forensic patients than when there is sole focus on risk factors. Of course the present study was a first, rather small, retrospective study, so future (prospective) research in multiple settings is needed to further establish the value of the SAPROF for clinical practice.

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49. – Structured crisis monitoring versus clinical judgement in psychiatric wards

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Introduction;

Many experts in acute mental health care report that clinical decision-making at moments of high of violence is mainly driven by experienced-based expertise (van Strien & Daneels,1996, Alaszewski, 2004, Lendemeijer, 2000). However most of the de-escalation interventions are mainly contextual or traditional orientated and are seldom research for their effects or potential threats to individual health issues. One of the most common pitfalls in acute mental health care is emergency mental healthcare; applying drastic intervention based on poorly checked risk-information or taking to much risk in patients with an unknown high risk profile (Aleszewski, 2003, Hermann, 2002, Naish, 2002, Whitfield & Shelley, 1991). On the other hand, structured risk assessments tools could never replace the value of clinical judgement. (Achilles et al, 1999). Instruments such as the crisis monitor (van de Sande et al, 2005) are designed to support experienced crisisinterventors in emergency decision-making.

Approximately 30 to 50% of the violent incidents in Dutch acute psychiatric admission wards seem to result in seclusion interventions (Nijman et al, 2005). A history of violence can strongly predict the risk of violence in the future. However this information is less helpful in predicting when and how the patient will be violent.

There are many risk taxation instruments available (Rush et al, 2005) have evaluated 230 APA validated instruments. Most of them are characterized as time consuming clinical interviews, selfratingscales and very few observation scales are available to use in acute mental healthcare settings.

Risk managent related definition of the World Health Organization (WHO)

Risk taxation (www.who.org)	Risk management (www.who.org)
The scientific analysis of known and potential threats of health related danger to individuals. This process should contain the following steps: (1) identification of danger (2) determination of the level of dangerousness (3) taxation of the exposure of danger (4) characterization of the level of risk. The emphasis of this approach is strongly oriented on the quantitative estimating of potential risks.	The process of judging the alternatives in health-policy to accept calculated risk and to reduce severe consequences and to select de/escalation procedures to reduce fatal consequences.

A set of observation instrument could support clinical decision-making in patients who are highly agitated, confused and non-compliance to psychiatric treatment. For this reason van de Sande et al, 2006) developed the Crisis Monitor Model for nurses at acute psychiatric emergency wards. This model enables nurses to rate their observations of incidents and to monitor high risk symptoms. Their findings could be discussed in multidisciplinary treatment planning meetings for fine-tuning de-escalation and recovering strategies

Building block for crisis monitoring and risk management in acute mental healthcare settings;

Integral risk management by using the crisis monitoring model consist of the following aspects

1) Structured and daily identification of current risk factors
2) Registration of current incidents and learning from individual escalation patterns
3) Judgement of the compound and severity of symptoms in their social context
4) Guarantee of transparency of clinical decision-making in case of high risk of violence
5) Structured monitoring of patients at risk
6) Providing tailor-made de-escalation interventions in critical periods

Sample

Approximately 700 inpatients in closed psychiatric admission wards were included in a quasi-experimental research over a period of nine months in 2007. The aim of this research project was to measure the effect of using a model of structured crisis monitoring by nurses on the amount of seclusion hours and severity of aggressive incidents compared to the usual clinical judgement practice. The population characteristics are; mainly involuntarily acutely admitted adult psychiatric patients from the urban area of Rotterdam, severe psychotic or manic episodes, behavioural problems and frequent substance misuse. This research project is financed by the Dutch Mental Health Board. Ethical issues are screened by the regional medical ethical commission. Due to the fact that these extremely vulnerable patients will not be intrusively approached by the use of observational screenings lists no objections were posed to start the process of gathering data. In addition to this research project a new type of specified registration on coercive interventions will be launched in the Netherlands. The selected units in collaboration with six other mental health trusts will be on the lead of a establishment of a national case registers on coercive interventions. The premilary results of this quassi- experimental research project will be presented at this conference Also the process of training nurses in working with sort term structured risk assessment instruments will be discussed.

Method

All admitted patients in 4 comparable admission units will be included. A two months period of baseline measurement (SDAS, SOAS-R, Self Harm Scale) at all units started in March 2007. In May 2007 by drawing of lots a control (2 units) and experimental group (2 units) will be determined. Nurses of the experimental units are trained in using a model of structured crisis monitoring; the experimental group will remain assessing short-term risks by clinical judgment. The findings of structured crisis monitoring on every patient will be discussed in the weekly multi-disciplinary staff meeting. A similar procedure is used by the control group based on clinical jugdement. The crisis monitor model consist of a set of observation scales; 1) Staff Observation Aggression Scale (Nijman et al, 1999), Selfharm Scale (Nijman et al, 2004), Broset Violence Checklist (Almvik, 2000), Danger Scale (Mulder & van Baars, 2004), Social Dysfunctioning and Aggression Scale (Wisted et al, 1990), Kennedy-Axis V (Kennedy,2000). These instruments can be used in clinical and community psychiatry, however raters should have frequent face to face contacts such as in Assertive Community Treatment Teams. After a period of six months the outcome of seclusion hours and the amount and severity aggressive and self-harm incidents will be are compared by multivariate regression analysis.

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50. – Implementation of a risk checklist for general psychiatry

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Keywords
violence risk assessement, general psychiatry, checklist, mentally ill, HCR-20, community

Introduction

There is some evidence that individuals with a severe mental illness have a higher risk of commiting a violent crime compared with the general population group (Böker and Häfner 1973, Angermeyer and Schulze 1998, Fazel and Grann 2006). This observation does not apply to any psychiatric patient since the prevalence of community violence varies according to the individual diagnosis (Steadman et al. 1998). In the public view however the risk of becomming a victim of a crime committed by a mentally ill person is believed higher than the actual risk (Pescosolido et al. 1999). Especially after a violent incident the public calls for stricter laws and a more effective observation of those patients (Appelbaum 2006).

Violent incidents caused by mentally ill people in Bremen in the year 2002 led to an unavoidable public and medial discussion about how effective and safe our local psychiatric system is. Psychiatric treatment in Bremen is provided by 2 hospitals and 5 treatment centers. Each treatment center , placed in one of the 5 sectors of the city, delivers help especially for those people living in the respective area and tries to guarantee an enduring personal attendance.

The public discussion about how dangerous mentally ill people really are is often emotionally charged rather than evidence-based. To explore if our local system worked efficient enough and assured adequate protection, the responsible authorities commissioned an investigation. According to this survey (Olivia et al. 2006), the work done in the treatment centres was of good quality and provided adequate security. Nevertheless, the authors recommended to install a system in which the results of the work especially with our potentially dangerous patients could be more precicesely examined and evaluated.

Despite the fact that the risk of becoming a victim of a crime comitted by a mentally ill person is comparably small, the goal should be to eventually minimize the risk of our patients to endanger others or hurt themselves. To meet the proposals of our local authorities we developed a risk checklist based on the Historical, Clinical and Risk Management Assessment Scheme (HCR-20) (Webster et al. 1997) which fits needs for general psychiatry. Assessing the risk of violence of the patients discharged from a general psychiatric hospital is necessary to offer special treatment strategies that might help reducing aggression against others in the community and lowering the number of patients sent to forensic wards (Swanson et al. 2000).

Methods

We included all in-patients that have been sent to our hospital by involuntary commitment or recieved this status during their stay from October 1st till December 31st 2006. All of these patients were examined with our risk checklist by their main therapist shortly before their discharge acknowledging the whole period of their stay. Our checklist consists of 18 items including 4 questions concerning the case history (aggressive behaviour, addiction, personality disorder, etc.), 8 questions for psychopathology (impulsive behaviour, delusional phenomena etc.) and 5 for social background/context (socioeconomic status, possession of weapons, non-compliance, etc.). The score consits of 5 gradings (unrateable, 0 = missing, 1 = lightly, 2 = medium, 3 = heavy)

which add up for each of the 3 sections (case history, psychopathology and social background). At the end of our checklist there is a concluding question leading to a decision if severe future aggression is being expected (yes/no). A patient was rated positive if there was a high score in at least on of the three sections (case history ≥ 6 points, psychopathology ≥ 10 points, social background ≥ 10 points) or if the question about future aggression was answered with yes. During the ongoing 1 year follow-up we plan to validate our checklist, trying to investigate (1) if our including characteristic (involuntary treatment) was useful and (2) if the chosen items and the way of evaluating them was sufficient.

Results

Between 1.10.- 31.12.06 we recieved 1023 cases of patients to be treated on our psychiatric wards. 198 (= 19%) of these were sent to us by involuntary commitment (PsychKG / BGB) or recieved this status during their stay. In 65 (= 29%) cases the concluding question was answered with "yes" meaning that severe violent acts were expected to be commited in the future. 45 (= 23 %) cases scored high in case history, 42 (= 21 %) in psychopathology and 27 (= 14 %) in social background. We counted 83 cases in which at least one of the 4 sections were positive (= 42 %). Of these 83 the main diagnosis of 35 cases was schizophrenia, 19 had an addiction and 16 a personal disorder.

Discussion

Our risk checklist was easily introduced to the general psychiatric wards and quickly accepted by the therapists. Eventualy every of the 198 cases was scored and could be evaluated.

During the last quarter of the year 2006 19% of our patients were treated involuntarily to a certain point of their stay and were therefore included to our study. Of these patients 29 % were expected by their therapist to behave aggressively in the future. It is difficult to interpret our results at this point of the investigation since we will still need to validate our checklist during the ongoing year. Out of the fear of every single therapist not wanting to underestimate the potential danger of certain patients it is possible that there is an overestimation in our risk checklist arising.

Not having access to police-data we plan to examine the hospital data of the patients, counting every aggressive behaviour leading to a new involuntary admittance or otherwise documented aggressive behaviour in the records of the identified patients in 2007. We need to take every single one of the 1023 cases also into account, in order to estimate if our including criterion of involuntary commitment was efficient or not. It is also necessary to evaluate the cases that were wrongly rated as negative or as positive trying to prevent patients from being misjudged.

Considering different approaches to risk assessment and the problems involved with this topic (Doyle and Dolan 2006), it will still be essential to inform the public about the actual risks and to explain that absolute safety cannot be guaranteed.

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51. – Seclusion and restraint and other coercive measures in Flanders – Highlights of the research-efforts over a period of 25 years in Flanders

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Starting from 1985 onwards, seclusion policies have been subject of research activities at the university hospital in Ghent. At the same time a first written code of practice for the seclusion procedure was developed. It included the following instructions: type of patients, reason for seclusion, and that seclusion could not be used as a punitive measure.

In 1986, a first retrospective study on the use of seclusion was carried out (Thomas, 1992). The results suggested the existence of -a large number of informal regulations for the use of seclusion. More important the prevalence of seclusion in Flanders was underestimated substantially: it was estimated 5%, which turned out to be over 20%.

In order to gain insight in the use of seclusion and to compare these results with the situation in other hospitals, an exploratory, prospective study was conducted in six psychiatric hospitals, consisting of 21 units (Thomas&Jannes, 1990 & 1991). The monitoring included the following ten characteristics: incidence, phase, point of time, duration of seclusion, frequency, the use of mechanical restraints, the use of additional pharmacological therapy, number of staff involved, reason for seclusion, and psychiatric diagnosis.

The results of this monitoring project provided additional evidence of a lack of uniform regulations and procedures regarding the use of seclusion. It appeared that the seclusion procedure was largely based on local habits and traditions. In the same time the regional government said by a ministerial circular letter in 1990 that specific monitoring and a code of practice should be obligatory for all psychiatric in-patient proceedings. In 1993-1995 the ministery of health of Flanders ordered a study with three main goals: to design an uniform registration form, to study the different 'codes of practice', and to elaborate on minimal archtectional conditions for a 'save and humane' seclusion room (Thomas, 1995). In 1999, the first prospective study of 1987-1989 was replicated. Still 4 psychiatric hospitals and 13 units were available to provide the ten characteristics. They were regrouped in: 3 admission-units, 3 addiction -units, 3 adolescents -units, 2 depression -units and 2 unit for mentally handicapted with compulsion-disorders. After ten years we found spectacular changes in the use of seclusion, duration,incidence,mechanical restraints, pharmacological therapy and number of staff involved.In the lecture, these changes and potential reasons for them will be addressed.

In the declaration of the 'patient-rights' in 2002 in Flanders a large number of rights were installed: Right of free choice of caregivers, right on information, right of informed consent, right on privacy, and the right on filling complaint….Despite all these rights the existence of coercive measures is still not clearly defined. Even in Europe there are no uniform and clear definitions of seclusion and restraint. It is absolutely necesarry that we start working with uniform definitions otherwise we'll never can understand an compare seclusion frequencies among each other.

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52. – The use of seclusion in the Netherlands compared to countries in and outside Europe

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Keywords

Seclusion incidence, Published seclusion rates; International comparisons; Methodological issues

Introduction

In the Netherlands seclusion of psychiatric patients is a frequently applied intervention aimed at protection, control and containment of potentially dangerous, aggressive behaviour. Seclusion is locking up a patient alone in a specially designed seclusion room either with or without his/ her consent. Seclusion is a controversial intervention. Its use is discussed. Some Dutch authors conclude that seclusion is a widely accepted often used intervention in the Netherlands, and more often used than in many European countries. However, these authors did not support their conclusions with underlying quantitative data.

The main goal of this study is to describe the seclusion events in all the Dutch general psychiatric hospitals and compare these data with published rates of other countries in and outside Europe. The following question was addressed: Is seclusion more often used in Dutch psychiatric hospitals than in psychiatric hospitals in other European countries?

The present study is a part of a collaborative effort of twelve middle sized and large (250 – 900 beds) psychiatric hospitals aimed at a reduction of the use of seclusion. One of the goals of this collaborative effort was to estimate the number of applied seclusions in all the Dutch psychiatric hospitals, by comparing data gathered within the Dutch Health Care Inspectorate (IGZ) with data gathered at ward level within the twelve hospitals. The IGZ database is based on the Dutch law (Special Admissions act for Psychiatric Hospitals (BOPZ)) (GIGV, 1994) who covers involuntary admissions and emergency measures or involuntary treatments.

Literature

For the purpose of this study, only articles were selected dealing with surveys into seclusion use over several psychiatric hospitals in which number of seclusion events, or seclusion ratios in a circumscriptive time-span are presented. Of these , four articles (Way & Banks, 1990, Betemps et al, 1992, Crenshaw & Francis, 1995, Ray & Rappaport, 1995) originated from the USA, one from Australia/New Zealand (Cannon, et al, 2001) and five from Europe (Thompson, 1987, Kaltiala-Heino, et al, 2000, Demeestere, et al, 1995, Martin, et al, 2005, Martin, et al, 2007, Janssen, et al, 2005) The reviewed studies show various study methods and time frames. Some articles gave some essential information how they counted seclusions. Some authors counted each discrete seclusion which started when the patient is locked up and ended when the patient leave the seclusion room. Other authors counted seclusion records in which a number of seclusions take place, interspersed with periods in which the patient stays on the ward. The methods used differ over many of the reviewed articles. Some authors used questionnaires or self-reports by mail or post. Other authors extracted their data from hospitals or governmental organizations. The used time frame differs from one month to one year. A number of authors make no differences between restraint and seclusion, they presented rates on the number seclusions included. Critical information such as number of beds, the daily census and number of admissions is lacking in the majority of the articles.

Some authors expressed their seclusion rates in the mean number of seclusions per 1000 inpatient days. One authors presented the number of seclusions calculated by the number of admissions. Other authors presented the absolute seclusion rates. The inconsistent ways to express the seclusion rates, lacking some essential data together with heterogeneity in used methods and time span makes it impossible to weigh the importance of each study and calculate an overall mean of seclusions per 1000 admissions of inpatients days. Within the number of seclusion events no one of the authors makes clear of the patient the total time or a part of e.g. the nighttime or some hours at daytime spends in seclusion. Moreover, the authors did not make clear what was meant by seclusion.

Material and methods

The data were obtained out of the database of the (IGZ) and administrative databases of the twelve collaborating Dutch hospitals. The IGZ provided over the year 2002 data of each seclusion record such as date of the initiation of the seclusion, the regulatory context of the seclusion, the date of release the seclusion, registration number of the patient, sex of the patient and the name of the collaborating hospital, data of the other hospitals were anonymous. The patient-administrations-offices of the 12 collaborating hospitals provided the same data as the IGZ did completed with the regulatory context of the seclusion record (with patients consent or emergency measure or involuntary treatment. The Dutch business organization of all Dutch psychiatric hospitals (GGZ-Nederland) provided information such as totally number of admitted patients in 2002 and the mean number of occupied beds in all the psychiatric hospitals. These figures were made specific for the 12 collaborating hospitals.

The data were entered in the Statistical Package for Social Science (SPSS 14.0.). The differences between the twelve collaborating hospitals and other (anonymous) hospitals on the mean number of seclusion events per patient were tested by t-test. Frequencies were calculated only for the twelve collaborating hospitals in the IGZ database and compared with the frequencies calculated out of databases with the 12 hospital's data. At least, an extrapolation of the comparison between the IGZ data and the data of the collaborating hospitals was made to estimate the total number of seclusions in the Netherlands. To compare these outcomes with the outcomes of the reviewed literature the results are presented per year in number of seclusions per 1000 admissions as well as number of seclusion per 1000 inpatients days.

Results

In 2002 according to the IGZ database 3232 patients were secluded in the Netherlands and were subject to 5166 seclusion records. Most of the patients were secluded only once. The mean duration of the seclusion episodes was 18 days. Of these registered seclusion records 35% occurred in the twelve collaborating hospitals, within 1138 patients again revealing a mean of 1.65 seclusions per patient. No differences were found between the anonymous hospitals and collaborating hospitals in the IGZ database with respect to seclusion use per patient.

In the twelve collaborating hospitals 2165 patients are secluded one or more times, an average of 2.9 seclusions per patient. Of these seclusions 61% occurred with patients consent, 26% occurred within an emergency measure and 13% as a part of involuntary treatment. The mean duration of the stay in seclusion is 16 days, 52 percent of the seclusion episodes did not extend beyond 5 days. When the extrapolation is extended to the Dutch psychiatric hospitals as a whole, including seclusion with consent, for 2002 it may be calculated that 17,500 seclusions (95% CI 16,300-19,200) occurred involving 6000 patients. For 2002, a mean of 3.5 seclusions per 1000 inpatient days and 338 seclusions per 1000 admissions was calculated, this means that one out of three or four patients experience seclusion during their admission.

Discussion / Conclusion

This study provides some insight into the Dutch seclusion rates as a whole. However, with the data of this study only a rough estimation of the seclusion use in the Netherlands could be made. The results show that Dutch inpatients have a real chance to be secluded or witness seclusion of other patients. Our data, however confirm the impression that seclusion is a widely accepted (too) often used intervention in the Netherlands in comparison to several European countries. The international studies we reviewed show widely disparate rates of seclusion in the various countries. Because of the inconsistent and often quite differently applied materials and used methods as well as the variation in chosen presentations of data a sound comparison between the countries is impaired to a large extent. Moreover in the Dutch seclusion rates and the rates found in the literature minimal attention is paid to time the patient spend in seclusion. Information is lacking of the patient the full time of the days or a part of it's spent in seclusion. A vital step toward monitoring and comparing restraint and seclusion use within hospitals, regions or over countries is a sound registration and expression of seclusion rates. In the current study the absolute number of seclusions, the number of patients, and the number of daily admitted patients was presented as well as the ratios by 1000 inpatient days or admissions, in line with Bowers (2000) recommendations this being a valid and accurate way to express seclusion rates.

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53. – Monitoring seclusion and restraint use: the introduction of a new registration form in the Netherlands

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Keywords
seclusion, restraint, registration.

Introduction

The use of seclusion and restraint is controversial in dealing with patients' behaviour. Seclusion and restraint are a widely accepted and too often used intervention in the Netherlands. Especially seclusion is applied more often used than in many European countries One in the three of the admitted patients have the chance to be confronted with various fully restrictive measures such as seclusion, isolation, fixation or enforced medication (Janssen, et al, submitted). In the Netherlands these restrictive measures are the focus of much interest, both in governmental policy, as well as at the level of hospital management. In the opinion of many Dutch psychiatrists, nurses and policy makers view fully restrictive measures as secluding or isolating patients as old fashioned and unethical. In line with this opinion, Dutch Government funded a nationwide effort to reduce seclusion use with 10%. Within these alternative interventions should be developed. Earlier research into seclusion and restraint use show that the used registration method in the Netherland is inadequate for monitoring and reviewing (Janssen, et al, 2005, Janssen et al, submitted). It is not sensitive for changes in the seclusion rates and its validity is unclear. Moreover, the registration system leaves no opportunity to count alternative interventions and thereby provides no data on possible explanations of change in restraint measures.

The mean goal of this study is to describe experiences with a new way of day-to-day registration of all restrictive measure in applied in a number of Dutch psychiatric hospitals. The following question was addressed: Is the new registration system adequate for monitoring and reviewing the daily practice concerning the use of all restrictive measures.

Literature

In literature some attention is paid to registration and data collection in reviewing the use of restrictive measures. The majority of authors have the opinion that data collecting, monitoring and reviewing data are essential factor is in reducing the use of seclusion and restraint. More than once inadequate monitoring and the lack of systematic data collection is noted (D'Orio et al 2004, Currier 2002, Crenshaw and Francis, 1995, Janssen et al 2005). For hospitals interested in changing their policies and practice in the use of seclusion and restraint, the data of seclusion and restraint use provide initial parameters for planning those modifications (Crenshaw and Francis 1995, Donat 2003). The authors recommend that hospitals collect data on the number of patients, the number of discrete incidents and the number of hours of seclusion and restraint. Hospitals that already collect these data can use results to compare their performance with that of similar institutions (Crenshaw and Francis 1995). Martin et al (2005) and Martin et al (2007) described the registration of seclusion and restraint in a region in Germany describe data collection in several hospitals in two countries making comparisons between the hospitals and countries. This report gives an example of how data can be calculated en feed the wards as to how they apply restrictions and how reduction may be realized.

Method and materials

Five Dutch hospitals took the initiative to develop a new registration form called Argus. In this form, not the legal framework, but the nurses action is the subject and organizing principle of the form as well as the dataset. The nurses on the ward filled the registration forms in after applying a restrictive measure. They noted each discrete restrictive measure the time it started and ended on the registration form. A distinction was made between full (such as seclusion, isolation and fixation) and partial restrictive measures. The partially restrictive measures are physical holding, hand in hand accompaniment or continue supervision are seen as preventive alternatives or substitutions for the fully restrictive measures. They may be used to calm the patient down. Alternatively, they may also be used to shorten the fully restrictive measures in the mobilisation process. The use of (forced) medication and feeding are registered alongside these restrictive measures.

This registration system Argus was tested in four Dutch hospitals. The nursing staff was trained in recording the interventions. The definition of the interventions was developed together with participating nursing staff. During 6 months the restrictive measures were registered both in this new system as well as in the contemporary systems. Data were tracked with respect to the number of discrete events, hours and day of application. We tested Reliability by comparing Argus to existing systems and nursing reports. The outcomes were communicated to the staff every trimester.

Results

The two hospitals gathered data over a 6-months period. In participating departments of the first hospital 132 beds were occupied, receiving 492 admitted patients. In the second hospital 196 beds were occupied, receiving 450 admitted patients.

The 1419 registration forms in the first hospital show a mean duration of 17 hours (s.d. = 7 hours) a day over all restrictive measures per patient at baseline. Seventy-five patients experienced a seclusion, isolation or fixation. A mean of 17,4 register forms per patient was found indicating the mean number of days a 'measure record' would take. The 2053 forms in the second hospital show a mean duration of 17 hours (s.d. = 7 hours) a day over all restrictive measures per patient at baseline. The next data were observed with respect to several measures:

- In the first hospital 54 patients were secluded with a mean duration of 10 hours (s.d. = 5 hours) a day over 8,1 days. On average patients underwent 1,18 discrete seclusions a day. The mean duration of each seclusion is 8:45 hours a day. In the second hospital 50 patients were secluded with a mean duration of 14 hours (s.d. = 5 hours) a day over 10,3 days. On average patients underwent 1,4 discrete seclusions a day, the mean duration of each discrete seclusion was 12:00 hours a day. So, in the second hospital seclusion took more time over more days in lesser patients.
- In the observed period in the first hospital 43 patient were isolated with a mean of 13 hours a day over 17,4 days . These patients were isolated with a mean of 1,63 discrete isolations a day. The mean length of each isolation is 8 hours. In the second hospital 21 patients were isolated with a mean of 12 hours a day over 39 days and a mean of 1,14 discrete isolations a day, with a mean length of 10 hours. Again the second hospital showed significantly longer isolation programs. Looking at the level of the patient, the data showed four severely chronic mentally ill were responsible for the differences.
- 23 patients were fixated in the first hospital with an average of 13 hours a day over 11,6 days. The mean number discrete fixations is 1,87 per day with a length of 7 hours. In the second hospital 12 patients were fixated with an average of 9,6 hours over 22 days.
- Within the partial restrictive measures in the first hospital 54 patients were confronted with these measures with a mean 11 hours a day over 11 days in sequence. In the second hospital these measures were registered in 35 patients, with a mean of 12 hours a day over 15 days. The most reported restrictions were hand in hand accompaniment and continuous supervision.

Second, reliability of the registration was tested by means of matching data with the contemporary registration system, showing an increase of 50% when comparing day-to-day registration with the contemporary registration system. Interventions such as forced feeling and the use of fixation were too few detected in the contemporary system, even though registration is mandatory. Also, contemporary registration system did not compel registration of partial restrictive measures. The data of registration system were also matched with the daily nursing reports over same period. The use of seclusion matched in 82% of the found cases (kappa = 0,64), isolation matched in 78% of found cases (kappa = 0,49) and fixation matched 38% of the cases (kappa = 0,19).

Conclusion

The new system showed a more complete picture of which interventions on what time of the day were used per patient. The data from this new registration system were more reliable then previous systems, however attention must paid to use of fixation and the partial restrictive measures. In the registration of fixation some misinterpretations are made. Sometimes were fixation not registered because it was a protective measure to protect the patient to falls. In the new registration system these restrictive measure must be noted on the Argus registration form. With the data out of the new registration system it is possible to monitor and evaluate the nursing interventions to decrease the use of the full restrictive measure, especially seclusion. For the nurses on the ward, policy makers have figures about the length of stay in seclusion and the number of discrete seclusions important parameters for discussing their activities.

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54. – Workshop 8 – Violent offender treatment program: developing evidence based practice for working with violent mentally disordered offenders – theory, integration & practice

(1) Integrated model of violence: underpinning theory and development,
(2) Integrated model of violence: turning theory into practice, &
(3) Integrated model of violence: issues, considerations & further developments

Dr Louise Braham & Mr David Jones. Rampton Hospital, Nottinghamshire NHS Trust. (UK)

Background

Most mentally disordered offenders (MDO)s present with histories of difficulties relating to a primary mental disorder and antisocial behaviour. Typically, MDOs present with multiple problems, including severe affect regulation, cognitive deficits, poor social skills and, in many instances, a long history of substance misuse and a lifestyle reflective of criminal behaviour. MDOs may be difficult to treat and manage, with low levels of motivation to engage in treatment and often, poor outcomes.

The prevalence of violence within MDO populations is significantly higher than other types of offending. There are however, few treatment programmes to tackle this and even fewer (if any) with a solid evidence base and The need for psychologically based treatments designed to address such violent offending is paramount and has been repeatedly identified anecdotally, governmentally, and within the academic literature. Research on the treatment of violent offenders indicates the need for high intensity multi-modal treatment packages reflecting a cognitive-behavioural and psychological basis (McGuire, 1995). Furthermore, developments in aggression research indicate that social cognition and problem-solving, social learning theory, emotional intelligence and developmental aspects of aggression may also be important aspects of treatment for this population, as well as consideration of emotional regulation and individual cognitions.

Whilst agreement amongst clinicians about what constitutes appropriate treatment for MDOs is often elusive (Muller-Isberner & Hodgins, 2000), they typically present two categories of treatment need that include needs emanating from the specific diagnostic criteria associated with their mental disorder (mental illness and/or PD) as well as needs that have been identified as criminogenic i.e. those that promote or are associated with criminal behaviour (Andrews & Bonta, 1998; Taylor, 2003).

The Programme

The Violent Offender Treatment Programme for individual's with mental illness (VOTP) is part of a treatment pathway designed to assist mentally disordered offenders attend to &/or modify anti-social and violent behaviours. Delivered over a one-year period on a twice weekly basis within a group setting, the VOTP utilises a variety of cognitive behavioural (& other) strategies that focus on specific criminogenic factors associated with violent offending as well as recognising the impact of mental illness and or personality disorders on behaviour. The programme accounts for theoretical and therapeutic content as well as responsivity and other delivery issues. The programme is structured and manualised; multi modal and delivered in approximately 280 hours of group therapy plus a range

of weekly individual work and support. Staff training is an essential component of the programme. The initial phase centres on insight development and enhancing readiness for change in relation to personalised patterns of violence, problem ownership and goal setting. A specific focus of the programme targets the thinking patterns of violent offenders in terms of their appraisals, attitudes, and beliefs about situations, others people and themselves with regards to the particular cognitive distortions (Neutralisations) that they employ to trigger and maintain their violent lifestyle. Subsequent modules focus on the development of intra and interpersonal skills in the form of coping strategies, crisis resolution skills and conflict management techniques. This incorporates a specific focus on techniques such as self-monitoring, emotion regulation, perspective taking, social problem solving and assertiveness. Although the impact of mental illness and substance misuse on violent behaviour is covered in a specific module, these themes are emphasised throughout the programme. In the final components of the programme a relapse prevention ethos is utilised to develop an idiosyncratic action plan to assist participants to manage their own level of risk with regards to violence and other forms of offending. A particular tenet of this phase is the focus on high risk situations, thoughts, emotions and behaviours and the need for counter strategies (skills) to negate these risk factors thus minimising the likelihood of recidivism. The relapse prevention module represents a culmination of all the components of the VOTP covered to that point and serves to measure participant's level of understanding with regards to the programmes treatment targets.

Paper 1- Integrated Model of Violence: Underpinning theory and development

In the development of programmes to address criminogenic behaviours, there is an emerging literature to identify the need for a sound theoretical model to be developed to underpin a fully manualised and flexible treatment programme. The following paper will present a newly developed integrated model of violence that has underpinned the development and delivery of the VOTP. Presenters will discuss the different components of this model and how they link to existing theoretical models of violent behaviour.

The paper will focus on the model broken down into 3 main areas.

a) Developmental issues and immediate antecedents.
b) The activating event, interpretation and cognitive and emotional components.
c) Maintaining and reinforcing factors.

Case vignettes will be utilised throughout this paper to illustrate how the academic model works in clinical practice.

Paper 2- Integrated Model of Violence: Turning theory into practice

The Violent Offender Treatment Programme is a manualised treatment package, designed and developed to map onto the integrated model of violence as outlined in paper 1. This paper will consider the programme as a whole as well as each module of the programme, considering the evidence for its inclusion & how it relates to the different components of the integrated theoretical model. The paper will also provide discussion around the practicalities of delivering such a programme within services and the impact that the programme has had outside of the individual group members. Furthermore the paper will consider adaptations (flexibility / responsivity) that are necessary to increase the treatment programme's relevance to patients detained within high secure settings.

Paper 3- Integrated Model of Violence: Issues, considerations and further developments

This paper will provide an overview of the patient population the VOTP is intended for across different levels of security; and will provide an overview of the change demonstrated in a pilot

study examining the effectiveness of the VOTP within a high security hospital. Psychometric assessment data and anecdotal findings will be discussed, alongside feedback from group participants and clinical teams with regards to the efficacy of this programme. This paper will also seek to explore the problems and pitfalls uncovered during the preparation, establishment and delivery of the VOTP as well as the difficulties involved in evaluating outcomes with violent offenders. Furthermore, the paper will outline the strategies the VOTP have used to overcome or address such difficulties when trying to establish and deliver a treatment programme of this nature. Lastly future developments for the programme will be discussed.

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55. – The effect of NK1 receptor blockade on territorial aggression and in a model of violent aggression in rats

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Background. NK1 receptor blockers were recently proposed for the treatment of anxiety and depression. However, disparate data suggest that substance P and their NK1 receptors are also involved in the control of aggressiveness. Objectives. The aim of the study was to study the involvement of NK1 receptors in the control of normal and abnormal aggression in rats. Methods. We investigated the involvement of NK1 receptor-bearing neurons in the control of aggressive behavior by immunocytochemistry. We also studied the effects of NK1 receptor blockers in two models: the resident/intruder test, and a recently developed model of hypoarousal-driven abnormal aggression (Haller et al., Eur J Pharmacol 526: 89-100; 2005). Results. By double labeling neurons for the NK1 receptor and the c-Fos protein (a marker of neuronal activation) we showed that agonistic encounters activate a large number of NK1 receptor-positive cells in areas crucial for the control of aggressive behavior, e.g. the medial amygdala and the hypothalamic attack area. In behavioral studies, the NK1 antagonist L-703, 606 had a specific effect on biting attack counts but not other behaviors in resident/intruder conflicts. Surprisingly, mild forms of attacks were not affected, but hard bites and clinch fights were significantly reduced. This suggests that NK1 receptors play a role in controlling violent, but not milder forms of attack. In the model of abnormal aggression, the frequency of hard bites/clinch fights was also reduced. In addition, attacks on vulnerable body parts of opponents (the main symptom of violence in this model) were decreased to the levels seen in controls. Conclusions. NK1 receptor blockade decreased violent forms of attack in both territorial aggression and a model of violent aggressive behavior. We showed earlier that there are multiple similarities between antisocial personality disorder-related aggressiveness and the aggressiveness of rats submitted to our model. Taken conjointly, our data suggest that NK1 blockers may constitute a novel approach to the treatment of violent aggressiveness, and may especially be useful in antisocial personality disorder.

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56. – No abstract available

Unfortunately there was no text available at the copy deadline for this book of proceedings.

57. – Rapid tranquillization of acutely agitated patients: intramuscular olanzapine vs haloperidol + promethazine – pragmatic randomized control trial

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Objectives

To compare two commonly used interventions in controlling agitation or violence in an emergency psychiatric setting [pragmatic design, non-pharmaceutical sponsored].

Methods

We randomized 300 consecutive people with psychotic or mood disorders to IM olanzapine (10 mg) or IM haloperidol (10 mg) + promethazine (50 mg). Randomization used computerized blocks and allocation to intervention was blind till the point of intervention. The principal outcomes were blinded assessments of proportions sedated or tranquillized at 15 minutes and 4 hours post-intervention; un-blinded secondary outcomes were rates of tranquillization and sedation, clinical global improvement, need for additional medication, use of restraints, numbers absconding, need for additional medical attention and side effects of interventions. Analysis was by intention to treat. This trial was part of TREC studies (TREC = Tranquilização Rápida-Ensaio Clínico, translation: Rapid Tranquillization - Clinical Trial) which were undertaken in response to clinical need for good evidence.

Results

Both interventions were equally effective in producing tranquillization at 15 minutes and at 4 hours (over 87% and 96% in each group, respectively), though greater numbers given the Haloperidol + Promethazine combination were asleep at this time (RR 0.79, 95% CI 0.67-0.93; NNT 7 95% CI 4-18) and throughout the four hour follow-up. The combination resulted in greater proportions clinically improved, less need for doctors to be recalled and less additional medication than olanzapine. Neither intervention resulted in significant adverse effects.

Conclusions

Both interventions are effective in controlling violent behavior. The haloperidol-promethazine combination is superior to olanzapine if sedation or prolonged tranquillization is preferred.

Keywords
Rapid Tranquillization, Intramuscular Olanzapine, Intramuscular Haloperidol & Promethazine

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58. – The findings of the intervention study: "early recognition of violence" in forensic care

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Keywords
Risk management, violence, prevention, intervention, research

Introduction

In forensic care nursing staff are often confronted with inpatient violence that causes a huge impact on nurses and patients (Jansen 2005, Bowers et al. 2006). The cause of inpatient violence is explained by multi factor models in which patients', staff' and environmental variables are interacting (Fluttert et al. 2007, Hiday 1997, Kettles 2004, Nijman 1999). However the key-variable in managing inpatient violence is the interaction between staff and patients (Duxbury et al. 2005, Meehan 2006) and staff's skills to recognize preliminary signs of aggression (Fluttert 2007, Nijman 1999, Webster 2004). In forensic care nursing staff plays an important role in the management and de-escalation of inpatient violence (Doyle, 1998; Doyle & Dolan 2002; Mc Kenna, 2002; Morrison et al., 2002; Rask & Brunt 2006, Webster et al., 2004). There is an urge for evidence based risk management methods for nursing staff; however these methods are seldom available (Bjørkly, 2004; Morrison et al., 2002).

This article addresses the study of the application of the 'Early recognition method' in forensic care. This risk management method aims to support self management of patients regarding relapse prevention of violent behaviour. Staff and patient discuss and describe patient' early signs of violence. The focus is on those early signs of violence that are very personal based which are referred to as 'signature risk signs' (Fluttert et al 2007, Webster 2004). Patients monitor their behaviour aiming to recognise their early signs. If so, action may be taken to prevent a serious violence and to help the patient to regain equilibrium.

An 'early recognition package' was developed. This package covered an intervention protocol and training for staff. The protocol provides a clear structured description of the intervention and is a skilful tool for the nursing staff. The intervention is a weekly prolonging collaborating activity between staff and patient.

The study period lasted from January 1st 2003 until June 30th 2005. The purpose of the research was to study the effect of applying the 'early recognition method' to forensic patients who were admitted by court order at a forensic psychiatric hospital. The research question was twofold: firstly which patients comply to and benefit from the intervention and secondly what is the effect of the application for patients, nurses and the interaction between them? The research hypothesis was that the 'early recognition method' results in less severe inpatient violence and a decrease of seclusion. Outcome for research was 'patient' incidents that resulted in seclusion'.

Method

The study lasted 30 months. A quasi-experimental design with 'delayed implementation' of the intervention was performed (Table 1: Research design). All 16 wards of the hospital were matched and assigned to three study groups, aiming to spread patients' characteristics. The intervention was applied to the study groups with interval of 6 months.

	Group I 6 wards	Group II 5 wards	Group III 5 wards	All
T 0	Base line measurements Care as usual			S
T 1	Training program applying intervention	Care as usual	Care as usual	O A
T2	Continuing intervention	Training program applying intervention	Care as usual	S
T3	Continue intervention	Continue intervention	Training program applying intervention	-
T4	Continue intervention	Continue intervention	Continue intervention	R

Table 1 Research design

We tested the degree of homogeneity of the matched study groups using T-tests and Chi-square tests. The data of the baseline measures were compared to the main features regarding ethnicity, diagnoses and PCL-R, offence and ward culture between the three study groups

The population under study were of all the patients who stayed in study period on the 16 wards of the forensic psychiatric hospital in the Netherlands. All staff members, who started the intervention in the same study group, were trained within the same week. When a patient was transferred from an 'intervention ward' to a ward with care as usual, the new staff mentor was trained in order to prolong the intervention. The whole procedure was similar for all 16 wards.

Main outcome of research was incident behaviour, rated on the SOAS-R (Nijman 1999). During the study all incidents with seclusions were scored on the SOAS-R in examining three different sources of hospital records in which incidents and seclusions are described. Reliability of incident registration and rating was a pivotal issue in relation to the outcome of this study: two checks of reliability were performed. Firstly inter rater reliability: 20 descriptions of incidents were ad random selected and blind rated by another researcher of a similar hospital. Comparing both ratings resulted in agreement > 0.8 on Pearsons r. Secondly we studied if this retrospective scoring would result in equal rating when the same incidents were scored prospective immediately after an incident took place. For that purpose nursing staff of all wards scored during 4 months the SOAS-R within one day after an incident happened. After this the same incidents were also retrospective rated on the SOAS-R. These incidents were compared which resulted in correlation > 0.9 between the two ratings.

We determined for every patient which month the exposure started. Effects of the intervention were calculated between the phases that patients were exposed compared to the phases that patients were treated as care as usual. At every patient the frequency of seclusions and total scores on the SOAS-R were examined to the indices 'seclusions/patient/month' (frequency) and 'SOAS-R-score* seclusions/patient/month' (severity). The indices before and after the exposure were compared using the paired T-test. This means patients were their own control. Additional the effect size was analysed with 'Chronbach d' for paired samples (Seskin, 2004).

Results

Of the more then 224 eligible patients, 25% were excluded because they were transferred outside the hospital or persistently refused (11%) any activities regarding the intervention. An exploratory analyses of the main characteristics of the refusing patients revealed that they particularly scored high on psychopathy seldom were schizophrenic patients. Regarding the comparability of the three study groups it appeared that only on the diagnosis 'schizophrenia' there was a slightly, but significant, difference between study groups.

The features of all 168 compliant patients were assessed. Almost 40% of the patients had other than two Dutch parents, mostly of North African origin. Assessed on DSM-IV about half of the patients were diagnosed schizophrenia and half personality disorder, among others 23% co morbidity of both. Regarding the index offence a quarter of the patients were convicted for manslaughter, half of the population for severe violence and the rest for offences such as sexual misuse, rape and arson.

The effect of the intervention was calculated by the length of exposure. The average incident levels per month, before and after exposure, were compared for every patient by means of a paired t-test. The first preliminary results show that the intervention resulted in a significant (p < 0.001) decrease of seclusions. The severity of incidents, rated on the SOAS-R, appeared significant (p<0.003). In Figure 1 the effects are illustrated for the different study groups in the research.

Figure 1: Results study groups

We studied the effects in four subgroups: patients with schizophrenia, patients with APD (anti-social personality disorder), patients with substance misuse and patients convicted for sexual offences. The results suggest a significant decrease in the number of incidents in patients with schizophrenia, APD- patients and in patients with substance misuse. The severity of incidents was significantly lower in patients with schizophrenia and APD-patients. Patients who were convicted for a sexual offence did not significantly benefit at all from the intervention. The effect size in regard of frequency of seclusions, as well as for severity of incidents, appeared to be low for all exposed patients and low for the sub population patients with schizophrenia but medium for patients with APD and patients with substance misuse.

Conclusion

The preliminary main findings of this study suggest that the application of the 'early recognition method' resulted in a significant reduction in seclusions and a decrease of severity of inpatient violence for included patients.

Of the eligible population of 189 patients only 21 patients persistently refused the intervention. The drop out rate is relatively small, compared to another Dutch study with 36% drop out, and similar population and also cognitive based interventions (Hornsveld & Nijman 2005).

This study had some methodologicay limitations. Patients were exposed to all kind of influences and to a treatment programme that probably influenced the effect of the intervention under research. These influences were not controlled for; randomly assigning patients to intervention or 'care-as-usual conditions' was not possible. In study group 1 patients with schizophrenia were over represented. Because study group 1 firstly started applying the intervention, this theoretically implicates that these patients contribute longer to the overall effect which is a limitation comparing subgroups.

The preliminary promising results have to be interpreted within the context of an innovation: the 'early recognition method'. An innovation that offered staff an evidence-based method and encourages staff and patients to collaborate in relapse prevention of violence and in gaining insight in the early signs of deterioration.

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59. – Positive clinical interventions for psychiatric patients presenting with extreme levels of violence and aggression

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Keywords
Seclusion, violence, aggression, cognitive, physical, neurodynamic.

Abstract

Within the UK Mental Health Act of 1983 seclusion is defined as the supervised confinement of a patient in a room, which may be locked to protect others from significant harm. Its sole aim is to contain severely disturbed behaviour that is likely to cause harm to others. Unfortunately within the UK psychiatric system a small number of patients, due to extreme difficulties in managing violence and aggression, become long-term seclusion patients. This group of patient's has highly limited access to therapeutic resources. This paper describes the theoretical background to the development of a range of interventions with this patient group, with emphasis placed on increased physical activity, low demand social interaction, pro-social behaviour modelling, neuro-cognitive stimulation, and insight focused therapy. One of the successful programs developed with this group has been the Ashworth Hospital 'Gym-Seclusion' Project. Ashworth Hospital is a high secure psychiatric hospital with a catchment area covering North West England and Wales. Using methods derived from an integrated model of: developmental psychology, cognitive neurodynamics, and practical methods of management of violence and aggression, twelve long-term 'seclusion' patients have taken part in excess of one hundred and forty activity sessions, as yet without incidence of aggressive or violent behaviour. Prior to this intervention these patients had been regarded as presenting the highest levels of risk of violent behaviour. It would appear that there are very few patients whose level of aggression is such that engagement in well-considered, positive, activity based sessions are not possible. Outcome measures, technical developments, and future directions for such projects are discussed.

Introduction

"Seclusion is the supervised confinement of a patient in a room, which may be locked to protect others from significant harm. Its sole aim is to contain severely disturbed behaviour which is likely to cause harm to others" (Department of Health an Welsh Office, 1999). A very small number of patients within the English 'Special Hospital' (high secure psychiatric) system become long-term seclusion patients. Behavioural characteristics leading to long-term seclusion appear to include: persistent aggressive behaviour, a capacity for causing serious harm to others, an ability to resist 'restraint', and difficulty in identification of clear antecedents to violent behaviour. Clinical characteristics may include: treatment resistant psychotic illness, persistent disinhibition, empathy deficits, difficulties in emotional self-regulation, and an impaired range of social skills. In addition to patients cared for within long-term seclusion are a group of patients managed in long-term 'geographical' or social restriction; such patient's share many of the behavioural and clinical characteristics of long-term seclusion patients but may through structural or managerial opportunity have access to a wider spatial environment.

Within the English Special Hospitals – Ashworth, Broadmoor and Rampton a range of specialist clinical interventions have been developed to facilitate the 're-association' of seclusion and

geographically restricted patients. However in a very small number of cases, patients presenting with extreme levels of violence and aggression may have very limited opportunity for access to therapeutic resources and wider social interaction, other than through some form of physical barrier.

It is well recognised that long-term seclusion or geographical restriction alone is highly unlikely to have any therapeutic value (Sailas & Wahlbeck, 2005). It is likely the patient will have highly reduced levels of physical and social activity. Links between obesity and the prescription of antipsychotic medication have been described in some detail (Wirshing, 2004), which when combined with this reduced level of physical activity may have significant impact on patient health.

In order to address the challenges presented by this group of patients a model of working has been developed. Treatment priorities were identified as including: increasing the quantity and range of physical activity, engaging the patient in low-demand social interaction, development of opportunities to model pro-social behaviour, and ultimately engaging in insight focused therapy. These priorities were considered to be mutually compatible in a cognitive / neurological sense in that: engagement in new physical activity is likely to lead to stimulation of the motor and motor-planning areas of the cerebral cortex (Tanji, 1994); that these areas are located in the frontal lobe of the cerebral cortex, as are the areas associated with social functioning and inhibition (Blair & Cipolotti, 2000; Schore, 1996), and negative symptoms of psychosis (Andreasen, Nasrallah, Dunn et. al. 1986; Steen, Mull, McClure, Hamer & Lieberman, 2006); and that the cerebral cortex is both modular and highly distributed leading generalised to patterns of stimulation (Brown, Britain, Elvevag & Mitchell,1994), which may be highly significant to personality functioning (Grigsby & Stevens, 2000). It was also considered that engagement in physical activities would allow graduated reintroduction to social interaction, and repeated opportunities for pro-social modelling. In general a small but developing literature appears to suggest that exercise based interventions can form a valuable adjunct to existing therapies for patients with psychosis (Ellis, Crone, Davey & Grogan, 2007).

Method

Detailed demographic and clinical data on the patient group has not been included. The patient group described in this project clearly had limited ability to offer their consent to a formal research paper.

All participants were male and had extensive histories of violent and aggressive behaviour within both the community and psychiatric settings. All patients were regarded as experiencing, or having experienced, a psychotic spectrum disorder. One patient was not receiving anti-psychotic medication; however this was on the basis of his negative physiological response to previously prescribed anti-psychotics, rather than the absence of symptoms of psychotic illness.

Rates of personality disorder in the patient group appeared high, although their clinical presentation made formal psychological assessment difficult. Antisocial, Narcissistic and Schizoid personality features were notable, although the presence in many cases of chronic psychotic illness suggested specific personality disorder diagnosis should be approached with caution.

The overall level of intellectual functioning of the patient group varied widely from a 'borderline' level of cognitive functioning to a number of patients with an above average level of ability. Several patients demonstrated characteristics indicating 'frontal' / 'dysexecutive' features.

Following formalisation of the project thirteen referrals have been received. Twelve patients chose to participate in sessions. One patient declined the offer sessions. All were patients in long-term (greater than two weeks) seclusion or on long-term (greater than two weeks) 'geographical' restriction. Time period spent in seclusion varied from approximately two weeks to in excess of three years.

Prior to participation in sessions patients received: an assessment of risk; a review of cognitive / neuropsychological functioning; and a physiological screening.

A minimum of four staff were used to facilitate the sessions. A maximum of fourteen staff were used for sessions (five gym staff, one psychologist, one C&R co-ordinator, six ward based nursing

staff and one medical 'first responder'). Efforts were made to ensure staff teams included both male and female staff. All sessions were structured to adapt to the clinical need and presentation of the individual patient. Techniques included:

- 'Parallel Activity' – a frequently used technique in the majority of sessions was engagement with the patient in parallel activity, with staff taking part in the same activities as the patient.
- 'Low level social demand' – in the initial stages of engagement the social demands of the sessions were deliberately minimised.
- 'Pro-social modelling' – staff participation in activities allowed the modelling of appropriate social behaviour for the patient within the session.
- 'High intensity sessions' – where patients had previously demonstrated high levels of distractibility and a tendency to drift into antisocial behaviour or fantasy, sessions were maintained at a high level of intensity.
- 'Shared conformity to social boundaries' – with patients who had demonstrated a history of social boundary violation and high levels of 'Hare Psychopathy' participating staff would apply the same limits to their behaviour as the patient.
- 'A participation model' – staff were encouraged to dress appropriately to take part in sessions and where possible to engage with the patient in activities. The tendency of some non-involved staff to spectate on sessions was actively discouraged.

In no cases was it considered necessary or appropriate to use physical restraint in order to manage the patient. Where patients expressed a wish to terminate a session early, or to miss a session completely, this view was respected and the session ended.

Results

To date since the formal onset of the project in April 2006 twelve patients have been able to take part in 170 sessions, 148 of which took place in the hospital gymnasium or using outdoor facilities; the remaining 22 sessions being ward based. All sessions progressed without incident of aggressive or hostile behaviour.

1 Total Sessions   2 Gym/Outdoor Sessions   3 Incidents

During the time period of the project two of the twelve patients progressed to the point that they no longer needed seclusion.

Discussion

The current described project appears to illustrate that there are very few patients whose level of aggressive behaviour is such that engagement in well-planned, structured sessions with trained staff is not possible. It was not possible to find a patient wishing to take part in the project at Ashworth Hospital that could not be offered some form of physical activity.

The project remains in an early stage of development but appears to have succeeded in some of its goals. All patients were able to participate in a wider range of physical activity. All patients

had opportunity to engage with clinical staff without an intermediate physical barrier and many opportunities to model pro-social behaviour were created.

From a health economics perspective this model of working could be considered expensive given the increased demands on staff activity, however there would seem to be a range of anecdotal evidence that many cost savings were made in terms of: reduced rates of use of control and restraint teams to deliver medication to the patients, increased compliance with staff, and some reductions in rates of aggressive behaviour beyond the sessions. The enthusiasm of staff to participate in positive interventions with this client group, when supported with appropriate planning and training, also served to minimise the additional costs of the project. The overall viability of the project from a health economics stance has yet to be established, but the current position appears relatively positive.

Areas for further research may be developed in terms of examining: the physiological benefits of participation in the project; any associated mental health and interpersonal gains; and the longer-term outcomes of patients engaging in the project.

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60. – Managing aggression – a self-evident task for mental health nurses?

Jonker E.J., Goossens P.J.J., Steenhuis I.H.M., Geerling B., Heemskerk L.C., Fluttert, F.A.J. & Oud, N.E. (Netherlands)

Introduction

Although a lot of research has been carried out on aggression in health care settings, it is still a frequently discussed problem. In Dutch mental health care settings, an increased incidence of patient aggression can be observed (Peerdeman, 2006). Nurses are, in comparison to other professions in health care settings, more often involved in patient aggression and violence, in view of the nature of their contact with patients (Lanza 1985, Rippon 2000, Whittington & Higgins 2002). Therefore this study focuses on nurses' attitude.

International studies on patient aggression in clinical psychiatry also address cultural differences in managing aggression. Remarkable to mention in Dutch studies is that a rather high proportion of aggressive incidents are followed by seclusion of the patient (Janssen et al., 2005). In 1995, Jansen et al. conducted a cross-cultural study on differences in mental health nurses' attitudes to patient aggression, measured with the ATAS. Attitudes differ; for example Norwegian nurses are horrified by seclusion (Bowers, 1999; Jansen et al, 2006).

The aim of this study is to make an inventory of the current situation regarding nurses' perceptions of the prevalence of aggression, their attitudes towards patients' aggression and determinants of using coercive interventions. What are nurses' perceptions of the prevalence of aggression? With which types of aggression do nurses think they are confronted most in their daily practice? Which attitude do nurses have towards aggression? Which perceived behaviour control do nurses have towards managing aggression? Do nurses receive social support from their colleagues in situations when nurses are confronted with patient aggression? Do nurses have the intention to use less coercive interventions toward their patients?

Materials and Methods

A quantitative, cross-sectional research design, using questionnaires was used. This study distinguishes itself from previous studies, in the use of a combination of existing instruments, the ATAS, the POPAS and questions based on the Theory of Planned Behaviour (TPB) (Ajzen, 1991).

Questionnaires

To measure nurses' attitude towards aggression, the ATAS is used. Its development is described in earlier studies (Jansen et al., 1997; Jansen et al., 2005; Jansen et al., 2006). The ATAS is found to be a valid instrument with a Cronbach's Alpha for all 18 Items of 0.70. Five types of attitude were measured; 1) offensive attitude, 2) communicative attitude, 3) destructive attitude 4) protective attitude, 5) intrusive attitude.

To measure nurses' perceptions of the prevalence of aggression, The Perceptions Of the Prevalence of Aggression Scale (POPAS), developed by Oud in 2001 is used. On this 16-item questionnaire, nurses can rate which types of aggression they have experienced and witnessed during the last 12 months (Nijman et al., 2005, Oud, 2001).

A shortened version of the POPAS was used in this present study. After combining these twelve types of aggressive behaviour remained:

1   non-threatening verbal aggression,
2   threatening verbal aggression,
3   humiliating aggressive behaviour,
4   provocative aggressive behaviour,
5   passive aggressive behaviour,
6   splitting aggressive behaviour,
7   threatening physical aggression,
8   destructive aggressive behaviour,
9   physical violence,
10 violence against self,
11 suicide attempts,
12 sexual intimidation/harassment.

The internal consistence of the POPAS appears to be good, with a Cronbach's Alpha of 0.80.
    For each type of aggression, determinants to reduce the use of coercive interventions are measured, including attitude, social support and perceived behaviour control.

Sample size
A quota sample of 113 nurses from six, closed and semi-closed, inpatient wards was surveyed. All 113 nurses received a questionnaire and within a period of four weeks a response of 75.2% (N=85) was reached.

Data analysis
A descriptive analysis was conducted to describe general characteristics of the population as well as scores on the ATAS, POPAS and determinants of using less coercive interventions.
With One Sample T-Tests, the mean scores of the ATAS were compared with the mean scores of the ATAS from an earlier study (Jansen et al, 2006).
    Independent T-Tests were used to test for differences on the main variables (confrontation with aggression, attitude, social support, perceived behaviour control and intention) between different groups based on age, gender, education, years of work experience.
    Finally, a stepwise regression-analysis was conducted, with age, gender, education and years of work experience as independent variables in the first step; and psycho-social determinants as independent variables entered in the second step: attitude (importance), perceived behaviour control, subjective norm (social support) and intention to use less coercive interventions.

Results

Demographic background
The sample consisted out of 58 females (68%). The majority followed a bachelor education. The mean number of years working experience was 12.96 ± 11.0. Forty respondents are working full-time (47%). Seventy-four graduate nurses (87.1%) followed the existing managing aggression training; Control and Restraint Course (CRC).

What are nurses' perceptions of the prevalence of aggression?
The mean score on "experienced confrontation with aggression" measured on a 5 point scale was, 2.46 ± .76 and the reported estimated number of confrontations with aggression was 181.5 ± 220.56 times a year. The majority of the nurses reported "never/rarely" being confronted with aggression.

With which types of aggression do nurses think they are confronted most in their daily practice?
In 60 percent of all reported confrontations with aggression, nurses reported non-threatening verbal aggression, followed by passive aggressive behaviour. Predictors for being more confronted with aggression were being older and having more years of work experience.

Which attitude do nurses have towards managing aggression?
The mean scores on different attitudes towards aggression, measured with the ATAS, were compared to the mean scores of a study conducted by Jansen in 1995 (Jansen et al., 2006). Significant differences were found on all subscales. Measured on a 5 point scale, respondent's mean score on destructive attitude was 3.67 ± .85 and on offensive attitude 3.65 ± .70. Lower scores were given on protective attitude and on communicative attitude.

What self-efficacy do nurses have towards managing aggression?
Measured on a 5 point scale nurses scored 3.99 ± .58 on perceived behaviour control. In-service educated or middle educated nurses scored significantly higher on the perceived behaviour control they have towards managing aggression than their higher educated colleagues. Also nurses with more work experience (above 12 years) scored significantly higher, 4.19 ± .43 than there less experienced colleagues.

Do nurses receive social support from their colleagues in situations when nurses are confronted with patient aggression?
The overall mean score on receiving social support was 4.39 ± .50. This item was measured on a 5 point scale.

Do nurses have the intention to use less coercive interventions toward their patients?
The mean scores on the intention to use less coercive interventions (e.g. seclusion) toward the patient was 2.81 ± .83 and 2.96 ± .81 on the importance to reduce the use of these interventions. Male nurses seem to have a significantly higher intention to use less coercive interventions in comparison to their female colleague's. A higher score on the importance to use less coercive interventions seems to be a predictor for the intention to use less coercive interventions.

Discussion

Although nurses seem to be confronted with aggression regularly they experienced it as never/ rarely being confronted with aggression. This perception of nurses could be caused by their daily confrontation with aggression. It seems to be part of their daily practice. Nurses reported that they are mostly confronted with non-threatening verbal aggression and least with sexual intimidation and physical aggression. These results show similarity to the results of previous study conducted by Oud, in 2001.

Patient aggression is mainly seen as a destructive and offensive attitude. Nurses hardly see aggression as a protective and communicative attitude of patients. These results differ to the results of a previous study in the Netherlands (Jansen et al., 2006). In their study, nurses had the highest score on aggression as a protective attitude. An explanation for this difference could be that Jansen et al. conducted their study in 1995/1996 and since than nurses' attitudes changed. The reasons for this shift go beyond the scope of this study.

Overall, nurses seem to be able to manage most adequately with non-threatening verbal aggression and least with suicide attempts and physical aggression. It seems that older, well-educated nurses with more work experience and perceived behaviour control in managing aggression have a higher intention to use less coercive interventions. The mean score on the intention and the importance to use less coercive interventions can be interpreted as a low score. An explanation could be the involvement of three wards where coercive interventions are hardly used.

In order to reduce the use of coercive interventions, it is recommended to target interventions that provide a change to nurses' intention towards the use of coercive interventions. If nurses are aware of the fact that they are daily confronted with aggression and aware of the use of coercive interventions, nurses' intention towards the use of these interventions might change.

Interventions could focus on communication skills, risk taxation and risk management interventions to early recognize and prevent the occurrence of aggression.

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61. – Seminar 1 – Reduction of seclusion and restraint – Six cores strategies to reduce the use of seclusion & restraint

Kevin Ann Huckshorn RN, MSN, CAP; Director, Office of Technical Assistance; National Association of State Mental Health Program Directors (USA)

A focus on recovery and trauma informed care has and recent changes in United States' laws and regulations regarding the use of S/R have created an impetus for service providers to reduce and even eliminate the use of these potentially dangerous interventions. However, health care providers have largely been left to their own devices in reducing the use of S/R and in many cases have primarily focused on how to use S/R interventions more safely. Best practices are those aimed at the prevention of conflict and violence and effective and replicable strategies have been identified but are not yet widely used on the local level. This session will provide and overview of the Six Core Strategies to Reduce the Use of S/R © in inpatient mental health facilities that serve children and adults.

62. – Seminar 1 – Reduction of seclusion and restraint – Practice implications

Wanda Mohr (USA)

Unfortunately there was no text available at the copy deadline for this book of proceedings.

63. – Seminar 1 – Reduction of seclusion and restraint – Organizational diagnostics

David Leadbetter, M.Sc, BA (Hons) CQSW, Director CALM training Services, Elmbank Mill, Menstrie, Clackmannanshire, Scotland (UK)

An overly narrow focus on the individual to the neglect of the organisational dimensions of violence prevention has recently been suggested to be one of the reasons why many services continue failing to realise the ideals of the public health approach. However, given that the role of the organisation has been stressed it can be argued that diagnosing whether and to what extent an organisation has conceptualised the problem of violence has been theoretically underdeveloped. Understanding how organisations typically respond to the problem of violence and why is though a necessary precursor in terms of knowledge for those involved in violence prevention who want to hasten the evolution of their organisations construction of violence.

64. – Seminar 2 – Training in the management of aggression and violence – Effectiveness of training interventions in the management of violence in healthcare: a systematic review

D. Richter (LWL-Hospital Muenster, Muenster, Germany), I. Needham (University of Applied Sciences St. Gallen, St. Gallen, Switzerland)

Many psychiatric institutions provide training programs for their staff in order to prevent or to cope with assaults by aggressive patients. Little is known about the effectiveness of such programs. A systematic review of all published and 'grey' research studies on the evaluation of aggression management training programs in health care has been conducted. The studies have been reviewed for their results concerning following issues: Incidents, work absenteeism, injuries, coercive measures, knowledge, confidence, and skills. Results: We identified 48 studies that have been published from 1976 to 2005. Most studies have been done in psychiatry/mental health, few have been conducted in other fields (e.g., intellectual disabilities, emergency care). Content of the evaluated trainings were mainly combinations of psychological de-escalation with physical techniques. Pure de-escalation interventions or physical technique-interventions were less often evaluated. Up do date only one randomised controlled trial has been done, most studies have case-control-designs and before-and-after-designs. Independent of setting and design, most studies on knowledge and confidence show that trained staff gains in knowledge about violence and in confidence about dealing with difficult situations. Less clear is the outcome on incidents, injuries etc. Several studies find less incidents and their consequences, but several studies find no differences or even increasing numbers between control conditions or before and after trainings. The finding that trained staff knows more about aggression and is more confident about handling difficult situations is a worth in its own. The background of the conflicting findings on the number of incidents etc. remains obscure. One reason might be the sensitization and vigilance to aggressive incidents that is happening while staff is trained. Although the results about the number of incidents reveal no clear tendency, it is concluded that training programs for staff in health care should be provided.

65. – Seminar 2 – Training in the management of aggression and violence – The safety of physical interventions: a literature review

Dr. Andrew McDonnell

There are a variety of approaches to providing staff training in the use of physical interventions. A systematic literature review has not yet been conducted.

To review all published data based staff training research which contained physical interventions and to make recommendations based on the findings. Electronic literature searches were conducted were conducted using Web of Science ©, Cochrane Database of Systematic Reviews © , Medline © , Social Science Citation Index © and Psychlit © and from websites of leading international training organizations.

Forty-seven studies were identified of which 12 were quasi-experimental and experimental studies. Twenty-six studies were conducted in adult psychiatric services and 10 in learning disabilities services.

Courses varied widely in their content and methods of teaching. There was evidence of effectiveness, including decreases in client incidents, reductions in restraint use, increased use of appropriate restraint, increases in staff confidence and decreases in staff fear in some studies. Other studies found no effects of training and a few found harmful effects, such as increases in physical interventions and assault rates following training.

Future research should (a) simplify course content and use empirical methods to determine course content; (b) use multiple reliable and valid outcome measures and adequate experimental designs; (c) make greater use of behavioural skills training, including modeling, rehearsal and feedback in live situations; and (d) evaluate follow-up and staff support mechanisms after initial training.

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66. – Seminar 2 – Training in the management of aggression and violence – Developing a framework to evaluate the safety of physical interventions

Dr. Brodie Paterson Lecturer, Department of Nursing and Midwifery University of Stirling, Stirling, FK9 4LA

An increased awareness of the potential for serious injury and death during the use of physical interventions has led to calls for such interventions to be evaluated before their use is approved.

Unfortunately the widespread prevalence of lax regulatory regimes fail to routinely monitor the use of such interventions in practice, a notably diverse range of interventions and a research base in its infancy mean that the quality of evidence available to inform such an evaluation is problematic.

Any evaluation must also take into account not only the potential for adverse consequences associated with applications of procedures as they may be described in the relevant training manual but also from misapplications whether these are due to incompetence or malice.

This leaves service providers in a potential dilemma but a pragmatic approach drawing upon both current evidence informed opinion and reasoned speculation allows an evaluation to be conducted which is valid in the context of the field at this time.

67. – Workshop 9 – Prediction of aggression – Prediction of aggression of patients while on crisis duty

E.J.M. Penterman / K. Berkhout (Netherlands)

Keywords: Aggression, crisis intervention, risk factors

Introduction

The prediction of violent behaviour of psychiatric patients is not easy. Being on duty in a crisis team of the Mental Health Service can be a highly emotional and stressful experience. Pressed for time and providing a 24-hour service, team members often have to make major decisions without consulting and the agreement of all the parties concerned. The East Brabant Mental Health team felt they needed to find out more about the threatening behaviour encountered by the crisis team and to identify the risk factors.

In the literature there are different forms of investigations written down. With differing success the prediction of aggression on short or longer term was possible. For instance, the Broset Violence Checklist is one of the few instruments suited for short-time prediction of violence of psychiatric inpatients in routine care. The Psychopathy- Checklist-Revised (PCL-R) is also used in the forensic field.

Purpose

The testing of Checklist Risk Crisis intervention (CRC) used in the 24-hour service. A specific instrument that tries to predict aggressive behaviour before a team member sees the patients.

Method

For the purpose of prediction of violent behaviour team members kept a daily record of the CRC.. They filled in the Checklist Risk Crisis intervention (CRC) before the contact with the patient on basis of the information of the applier. Most of the time patients were referred through a GP, general practitioner.

All the incidents that occurred were registered and discussed and analyzed with the help of the Staff Observation Aggression Scale- Revised.

Results

In this workshop we will discuss the results of the research from the period July 2003 -July 2005. The results do give a very positive view; 90 % prediction of later aggressive behaviour seems to be possible.

Conclusions

About 14 % of the crisis contacts involved aggression. A striking feature of these incidents was that they occurred relatively often at certain times; at the end of the morning or very late at night/ in the early hours of morning. Using the CRC can help to take adequate measures, like going to see the patient together with another co-worker or even call the police for assistance. The use of

the SOAS-R is based on incidents while the use of the CRC is required before every contact with the patient and therefore will become routine.

The weekly meeting at which the incidents can be fully discussed is an opportunity to pass on to all staff members the knowledge and skills needed to deal with aggression.

We will also show a video in which workers from the Mental Health Service are interviewed about their experiences with threat and violence in the working field and the consequences for them personally.

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68. – Workshop 10 – Predicting Adolescent Violence (SAVRY) – Predicting violence among adolescents: predictive accuracy and clinical utility of the SAVRY – Structured Assessment of Violence Risk Among Youth

Anders Tengström, Ph.D. FORUM & Therese Åström, Ph.D-student. FORUM – Research Centre for Adolescent Psychosocial Health, Karolinska Institute, Stockholm (Sweden)

Violence conducted by adolescents is a societal problem of great magnitude. In order to prevent violence, the violence risk must be assessed as accurately as possible. SAVRY – Structured Assessment of Violence Risk among Youths is a relative new checklist developed to assess violence risk as well as the magnitude of violence among adolescents. In contrast to many other risk assessment instruments particular those based on an actuarial approach, SAVRY with its included dynamic risk- and protective factors can guide clinicians on treatment decisions and intervention strategies.

This workshop study comprises 180 randomly selected adolescents, 81 boys and 99 girls (mean age 17 years), who were referred to a substance use treatment center. Referral is in most cases due to substance use problems but could also be indicated by psychiatric or social problems. The study is a prospective study with a two six months follow-up periods. All adolescents were assessed regarding violence risk using SAVRY at baseline. Self-reported violence during the last year preceding the base-line assessment was obtained. A new SAVRY-assessment was conducted at each follow-up along with self-reported violent behavior. The prospective accuracy for SAVRY to predict violent behavior during the two follow-up periods was good, where about two-thirds of those predicted to be violent actually conducted a violent act. Only about ten percent of those assessed with low risk reported a violent act during follow-up. The study concluded that SAVRY is a feasible instrument to use for predicting violence in a population of non-criminally identified adolescents. More comprehensive results will be presented during the workshop.

The later part of the workshop will discuss the practical and clinical implications of using SAVRY in the daily routines of the authorities dealing with violence among adolescents. Specific issues will be addressed regarding how to create interventions for the different risk factors included in the SAVRY. Further, examples will be given on the experiences of implementing the use of SAVRY in organizations dealing with adolescent's criminal behavior.

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69. – Structuring multidisciplinary judgements of risk: developing an evidence base in applied practice

T E Hogue & C Allen (UK)

Research into the assessment and management of violent risk has typically concentrated on the general identification and prediction of future violence; most often within a community settings where the offender may act out future violent crimes. During recent years substantial literatures have developed regarding the prediction, and to some extent management, of the risk of future violent or sexually violent acts. There has however been much less of a focus on, the multidisciplinary application of the risk assessment and management process within secure settings. This paper describes the implementation and evaluation of a system designed to help structure multi-disciplinary risk decision making. Within a high secure hospital setting clinical teams need to make judgements about an individual's potential for future violence related behaviour and how to manage this risk. This paper focuses on the predictive validity of the Structured Clinical Judgement: Risk (SCJ Risk) assessment scheme which is designed to assess the risk of; violence to others, violence to self, vulnerability to others, institutional disruption and problematic institutional management. To ensure a consistent approach to judgements of violence risk, over forty clinical teams have been trained to implement the same multidisciplinary risk assessment process. The structure and core components of the system are based around the HCR-20. A computerised system is used to assist teams in recording and monitoring levels of risk and related management plans. This paper describes the SCJ: system and the development of an evidence base related to the clinical use of the system. Ratings from the SCJ Risk are used to predict subsequent intra-institutional violence and other factors relevant to an institutional setting as part on an ongoing evaluation programme. The relationship between the assessment and management of risk within a high secure forensic setting is also discussed.

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70. – Risk for being restrained among girls in residential settings

J. J. Haugaard and B.D. Leidy (USA)

Background

Reduction of physical restraints is an important issue in residential treatment facilities because of the potential for injury to staff and residents and their impact on the treatment environment. In addition, systematic reviews of restraints across the facility's population prepare staff to be alert to critical incidents that can escalate into crises. This study explores restraints across the population of a northeastern United States residential treatment facility for adolescent girls to see what trends, if any, emerge that would strengthen prevention efforts and lead to a reduction in restraints.

Study Objectives and Design

This study drew together and reviewed data about physical restraints that occurred in a residential-care facility for girls from 1999 to 2002. Goals were to explore relationships between restraints and the characteristics of the adolescents and the setting to provide information about the girls and their environment that led to an increased number of restraints.

All restraints at the facility were recorded during the study period, along with characteristics of the girls involved and the time, location, and duration of the restraint. A series of analyses were used to explore associations between child, situational, and facility characteristics and the frequency and timing of restraints. Bivariate analyses included crosstabulations for dichotomous and categorical data, and means tests, t-tests, and correlations for continuous data. Multivariate analyses included negative binomial regression, multiple regression and ordinal logistic regression.

Findings

During the study period there were 415 consecutively admitted adolescent girls. One hundred and fifty five of them were restrained a total of 1059 times. Age was the best predictor of number of restraints: Younger adolescents were restrained more often than older adolescents. Other child-characteristic predictors were diagnosis, length of stay, and stage of placement. Children who arrived at the facility with a mental health diagnosis were restrained significantly more often than children without a diagnosis. The longer adolescents were in care, the more restraints they experienced. There was an interaction between age and length of stay: older adolescents who were restrained frequently had shorter lengths of stay while younger adolescents who were restrained frequently stayed in care for long periods. Analysis by stage of placement showed an overall decline in the frequency of restraints throughout the placement, although restraints spiked at the end of placement for many adolescents.

Setting characteristics were also important. Most restraints occurred in the late afternoon and evening, with a high concentration between 7:00 and 9:00 PM. Restraints were at their highest on Mondays and gradually decreased through the course of the week and were at their lowest on Fridays. Restraints tended to occur in clusters. Three-quarters of the restraints occurred on less than one-fifth of the days in the study period, and a quarter of the restraints occurred on just 3% of the days.

Discussion

Age was the strongest predictor of the number of restraints an adolescent experienced with younger adolescents being restrained more often than older adolescents. The reasons for this remain unclear, although the adolescents' size, their level of maturity, their relative inability to express anger or other emotions verbally (compared with older adolescents), or their need for physical contact may have influenced the numbe rof restraints. It may be more expedient in some situations to restrain an adolescent who is small and verbally inaccessible. As a result, facilities need to be vigilant that staff and program needs are not the reason an adolescent is restrained.

Length of stay, diagnosis, and stage of placement were also important predictors of frequency of restraint, although the roles these variables play were less straightforward. The longer adolescents were in care, the more restraints they experienced, and younger adolescents tended to stay in care longer. So it would seem that age explains why adolescents who are in care longer experience more restraints. However length of stay and age are independent of each other in that older adolescents who needed to be restrained frequently did not stay in placement very long while younger adolescents experienced lengthy stays even if they were restrained frequently.

Diagnosis frequently showed up as important, even in multivariate analyses. Diagnoses were divided into two categories, internalizing disorders and externalizing disorders, to determine if there were differences in the frequency of restraints between these two groups. While there were small, non-significant difference between adolescents with internalizing disorders and those with externalizing disorders, there were large, significant differences between adolescents who had a diagnosis and those who did not. Adolescents with a diagnosis of any type were more likely to be restrained and were restrained more often than those who did not have a mental health diagnosis. It may be that adolescents who arrived at the facility with a mental health diagnosis had more severe problems and had been in the system longer than adolescents who arrived without a diagnosis, which may have influenced their likelihood of being restrained. Residential child care staff, especially clinical personnel, should be alert to the potential for restraints among young female adolescents who present with mental health diagnoses at intake.

Restraint by stage of placement was also considered important. The overall pattern was one of decline in the frequency of restraints throughout an adolescent's placement, although there were spikes in the middle and at the end of placement. The pattern found was confirmed by anecdotal evidence from the field as well as by recent literature (Delaney & Fogg, 2005).

Restraints tended to occur more frequently in the late afternoon and evening or during the least structured part of the day when adolescents were in their cottages or living areas. Probably the best speculation for why this pattern was noted is the amount of free time during this period of the day when children are not as directed in their activities and they are free to interact with each other potentially leading to conflict with other residents and staff. This is also a traditional family time especially for younger adolescents when the reality of their placement in a non-family setting may be more obvious giving rise to negative feelings about their situation.

Restraints tended to occur more frequently on Mondays and gradually diminish during the course of the week. Children at this facility were permitted to go home on weekends for family visits when transportation could be arranged and when the home environment was suitable for a visit. There was speculation that children used tobacco and other substances when home and might be experiencing withdrawal symptoms upon their return. This pattern could also have been the result of children dealing with family issues and separation issues immediately after returning from their home or simply difficulty readjusting to the return to the normal weekly routine.

Finally another important finding of the study was the way in which restraints tended to cluster. Three-quarters of the restraints during the study period occurred on less than one-fifth of the days in the study period, and a quarter of the restraints occurred on just 3%, or 42 of the days. The manner in which the occurrence of restraints tended to cluster suggested a chain reaction of sorts where one restraint had the potential to spark others.

Physically restraining an adolescent who is in a treatment or correctional facility is considered a critical incident in residential treatment that demands a multilevel response by an agency or facility. The research literature questions their usefulness in curbing aggression and contributing to overall safety. Together with governmental initiatives to reduce the frequency and intensity of restraints, there are demands that facilities routinely collect and analyze data on restraints for characteristics and patterns that will lead to systematic prevention and management strategies. The characteristics of adolescent females being restrained and the patterns evident in the data reported in this study point to necessary program improvement at intake to identify adolescents at risk for restraint, modification of staffing and programmatic patterns during critical times, and organizational strategies that might defuse restraint clustering. The study verifies that if the facility concentrates on a handful of high restraint girls, they can significantly reduce the frequency and intensity of restraints in the facility.

Residential treatment agencies also collect data on other characteristics of the population they serve, their work force, and other aspects of their program that assess child outcomes. Unfortunately these data are typically kept in disparate, often incompatible formats that make systematic analysis difficult if not impossible for both researcher and practitioner. There were other child and staffing variables we would like to have considered but we lacked both the resources and the capacity to extract other data and combine it with existing restraint data. Other variables important to address in future research would be the impact of restraint frequency on discharge decisions, future placements, and eventual child outcomes. We view the recognition and examination of patterns of physical restraint that adolescent girls experience in residential care as a first step.

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71. – Aggressive behaviour in an adolescent forensic unit: the perceptions of adolescents and staff

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Keywords
perception, aggression, staff, patient, forensic

Background

Patient aggressive behaviour is a professional challenge for staff members working in mental health care. Particularly in forensic psychiatric settings staff experience high frequency of aggressive behaviour due to violent and non-compliant patient population. High levels of aggressive acts compromise the safety of the unit and endanger the therapeutic milieu of the ward (ICN 2000).

The perception of what constitutes an aggressive act varies in health care settings. For example Finnema's et al. (1994) study of nurses' perception of patient aggressive behaviour it was not possible to formulate general definition of aggression because nurses description of aggressive behaviour varied considerably, whereas in O'Connells et al. (2000) study nurses stated that aggressive behaviour included verbal abuse, physical abuse and/or intimidation. In Rippon's (2000) definition aggressive behaviour was characterised over three dimensions: 1) intention to harm another person or oneself, 2) forms of aggressive behaviour (i.e. physical, verbal, active, passive, direct, indirect), and 3) association of anger and aggressive behaviour.

Aggressive behaviour in inpatient settings is an outcome of several factors (Nijman et al. 1999, Meehan et al. 2006). According to Nijman et al. (1999) patient, ward and environmental factors explain patient aggressive behaviour during inpatient care. In Meehan et al. (2006) study, patients identified a combination of patient, staff and environmental factors contributing to violence. The cause of aggressive behaviour centred around five major themes: the environment, empty days, staff interactions, medication issues, and patient centred factors. Similarly, in Duxbury & Whittingtons (2005) study about staff and patient perceptions about causes of aggression and it's management, complex reasons were identified to contribute patient aggressive behaviour. However, there were differences between the views of staff and patients: patients mentioned environmental factors and particularly poor staff-patient interaction contributing aggressive behaviour, whereas staff members mentioned internal factors, like mental illness, causing aggression.

The perceptions of staff, and patients of aggression has been neglected research area in mental health care. Of particular interest for practice development is to compare staff' and adolescents' perceptions of aggressive behaviour. Recognizing differences in staff and adolescent views of aggression increases staff's understanding of aggressive situations. This new understanding helps staff to intervene proactively and implement more individually focused interventions, which may increase safety in the unit.

Aim of the study

The aim of this study was to explore 1) how adolescent and staff conceptualize aggressive behaviour and 2) what explanations they give for aggressive behaviour in an adolescent forensic unit.

Methods

Participants and setting

Convenience sample of 18 staff members and 6 adolescents from an adolescent forensic unit in Finland participated in this study. The adolescent forensic unit offers specialized psychiatric treatment services for minors with severely delinquent background and violent and non -compliant behaviour, aiming to minimize the risk of aggressive behaviour and to ensure secure treatment (Salize & Dressing 2006).

Data collection

The data collection took place using personal thematic interviews covering adolescent aggression and treatment practices for aggression. The interview themes were developed on the basis of the research literature and they were similar in staff and adolescent interviews. The themes focused on the following areas: definition of aggressive behaviour, reasons for aggression, emotional responses to aggressive acts, description of aggression management protocols and practices, and evaluation of aggression management practices in the unit. The present study focuses on findings related to the first two themes. The findings presented here are preliminary because of ongoing data collection.

Data analysis

The interviews were analysed using qualitative content analysis (Graneheim & Lundman 2004, Polit & Beck 2004). The analysis progressed from surface level and concrete meaning units to more abstract categories (Graneheim & Lundman 2004). First, the tape-recorded interviews were transcribed verbatim and the transcriptions were read through in order to get familiar with the data. Second, the data was transferred and stored in the ATLAS-ti 5.0 computer analysis programme that was used for data management and organization (Muhr 2005). Participant's descriptions of aggressive behaviour and the reasons for it constituted the unit of analysis. Third, the text was reread in detail and meaning units were identified and condensed in order to make the text shorter but to retain its core messages (condensed meaning unit). Fourth, the condensed meaning units were abstracted and labelled with codes. Lastly, the various codes were compared with reference to differences and similarities and sorted into categories to produce a categorization frame. (Graneheim & Lundman 2004.)

Findings

Definition of aggressive behaviour

Staff members perceived aggressive behaviour as having three dimensions: physical, verbal and non-verbal. Physical aggressive behaviour included aggressive behaviour damaging property, violent behaviour towards individuals, violent behaviour with use of weapon and self- harm behaviour. Verbal aggressive behaviour included verbal resistance, verbal hostility and verbal abuse. Non- verbal aggression was recognized as changes in body posture and facial expressions, and changes in distance between two persons.

Staff recognized different levels of aggressive behaviour. Minor aggressive incidents were not directed towards somebody and these situations could be resolved quickly, whereas in major aggressive incidents there was intention to harm the victim or to display self-harm and the situation ended up with staff applying restrictive measures to control aggressive behaviour.

Adolescents recognized similar dimensions and levels of aggressive behaviour than staff members. One of the adolescents mentioned self- harm behaviour having also positive aspects for the young person, whereas staff perceived self-harm only negative and most serious act of aggression.

Factors contributing to aggressive behaviour

Both staff and adolescents identified several factors contributing aggressive behaviour. Staff mentioned frequently negative childhood experiences, like maltreatment and violent family situation, as being the basis of adolescent aggressive behaviour. Mental illness and cognitive deficiencies, like poor coping and self-control strategies, were also mentioned. Factors related to unit care approach (unit rules and day structure) were perceived triggering aggressive behaviour. Only a few staff members mentioned interaction between staff and adolescents contributing to aggressive behaviour, but they recognized interaction in peer group causing aggressive incidents.

Adolescents did not mention factors related to their childhood history and only one of them mentioned problems with mental health causing aggression. On contrary to the staff, they recognized factors related to staff-patient interaction contributing aggressive behaviour. Adolescents perceived disagreements between staff and young people and feelings of not being treated equally causing irritations. Interaction in peer group, like disagreements between two young persons, was also mentioned as precursors to aggression.

Adolescents mentioned factors related to unit care approach causing aggressive behaviour. They felt that day structure and numerous rules restricted their normal daily activities causing boredom and frustration. Adolescents mentioned lack of meaningful activities triggering aggressive behaviour, and they also pointed out that just being committed to the unit was annoying them.

Discussion

Participants perceived aggressive behaviour similarly. The perception of aggressive behaviour in this study is in line with Rippon's (2000) definition of aggression. However, adolescents' and staffs' perceptions differed in one point: self-harm behaviour was perceived as having positive aspects by adolescents. This difference in perceptions has to be acknowledged by staff so they can adequately respond to self-harm incident and deal it therapeutically with the adolescent.

Participants recognized several factors contributing aggressive behaviour. This is in line with Nijman et al. (1999) model of aggressive behaviour that considers several factors causing aggression. However, in this study, there were differences how staff and adolescent thought. Staff perceived internal factors contributing aggressive behaviour, whereas adolescents mentioned mainly factors outside oneself causing aggression. Similar findings has been reported in Duxbury & Whittingtons (2005) and Duxburys (2002) studies, where nurses perceived patient-centered factors causing aggressive behaviour, but patients believed that aggressive behaviour stemmed from environmental factors.

In this study, majority of staff did not mention interaction causing aggressive behaviour, but adolescents mentioned poor interaction triggering aggressive acts. In the literature, interactional variables are increasingly recognised to contribute to aggressive behaviour (Ilkiw-Lavalle & Greyner 2003, Duxbury & Whittington 2005) and negative staff interaction, in particular, is identified to contribute to non-therapeutic relationships (Duxbury 2002). It is indeed alarming if staff is not able to recognize it's own role in interaction because this may hamper creating a therapeutic relationship with adolescents.

Conclusions

It appears from these findings that there is some differences in perception of aggressive behaviour between staff and adolescents. Particularly the different view on staff interaction as an antecedent to aggressive behaviour is problematic. Offering ongoing education may help staff recognizing the problem and give possibility to develop professionally.

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72. – Workshop 11 – Prediction and Prevention of Violence – Presentation of an interactive model that predicts and prevents violent and aggressive inpatient behaviour

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Keywords
Interaction, self-control, coping style, Violent behaviour crisis development model prevention

Introduction

There are different ways of approaching violent and aggressive inpatient behaviour.
The model presented here, focusses on interaction between patients and health care workers.
By understanding this interaction and taking appropriate intervention, the prevention of aggressive behaviour increases.

The model is built on four experiences.
1. Aggression is the result of a person's loss of self-control.
2. This loss of self-control mostly takes places in the interaction with other people.
3. The connection between loss of self-control and interaction is a person's individual coping style.
4. In clinical psychiatry the main interaction takes place between the patient and the health care worker. At the first place the health care worker is able to understand this interaction and can take the appropriate intervention.

Background

Within the Forensic Psychiatric Hospital in Eindhoven this model is developed and after that used for the last 12 years by al forensic patients. In this period there was a significant decrease of aggression. The health care workers got special training and coaching in understanding the interaction and coping styles within the patient and in making an aggression prevention plan together with the patient.
This year the decision was made by the direction of the psychiatric hospital to implement this model in the hospital as a hole. The aim is to decrease the use of seclusion.
The model was published in the professional Dutch Mental Health Care magazine "PsychoPraxis" (no. 4, August 2005)

The main paper / article

Method:
The aggression prevention plan looks at the way a person exhibits self-control, and makes use of an interactive model. This makes it possible to assess fear and tension building between the patient and health care worker. By understanding this interaction and taking the appropriate action, the ability to prevent aggressive behaviour is increased. The aggression prevention plans can be applied to patients with a psychotic disorder or a personality disorder.

Crisis development can be seen in different stages. At the first place there is balanced behaviour, then there is a stage called fear of losing control, after that there is a stage called, losing control,

which ultimately can lead to violent behaviour.

For every stage of losing control there is a corresponding recommended intervention that the health care worker should initiate. The model can also be used to explain a patient's behaviour to the patient himself, enabling him to stop escalation before things get out of hand.

Table 1 – Stages of Crisis and Corresponding Recommended Interventions

Phase	Description of Stage of Crisis	Recommended Intervention
0	Balanced behaviour	Follow normal routine
1	Fear of losing control	Be supportive, communicative
2	Losing control	Take control, with respect relationship
3	Violent behaviour	Physically intervene, proportional
4	Tension release	Allow cool-off time before evaluating

There is in fact a stage 5 that can be called relation restore; often after a crisis with violent behaviour the (working) relation between the healthcare worker and the patient is disturbed. It takes time and there is a need for good talking before this relation is again on the same level than before the crisis development.

Prevention of Aggressive Behaviour

In adapting this model to aggression prevention plans, we became aware that the crucial stage of the process for preventing aggressive behaviour involved recognizing the transition from phase one to two, and taking the correct action. Health care workers are often good communicators who prefer to use talking as their method of intervention. However, continuing to be supportive and discussing the issue over and over when the crisis develops to the stage of losing control is not effective and it increases the risk of violence. The challenge at that stage is to take control, by intervening directly but still attached and with respect for the relationship. This enables the patient to gain self-control when possible.

The crisis development model can be applied to the patient, but can also be applied to the health care worker. Experience taught us that for psychotic patients, the aggression prevention plan must focus on the behaviour and the loss of control of the patient himself. This is how existing prevention plans work. However, for patients with a personality disorder the aggression prevention plan must focus on the behaviour and the loss of control of both the patient and the health care worker. In these cases, we often see that either the patient or the health care worker or both lose control during the crisis period.

By understanding a patients coping style the health care worker is able to understand the corresponding patient- and interaction-signals to every stage of the crisis development. Also by understanding the coping style the health care worker is able, in every stage, to take the appropriate intervention. In an aggression prevention plan both the signals and the intervention are described. The aggression prevention plan will make the interaction between the patient and the heath care worker more predictable, and therefore increases the feeling of self-control in the patient. The aggression prevention plan can also be used to explain the interaction to the patient himself, and enabling him to stop escalation before things get out of hand. In this way, the aggression prevention plan becomes a social contract between the patient and the health care worker.

The most important aggression signals are dependent on the individual coping style of the patient. The individual's aggression coping style is built up of several of the following coping mechanisms:

Ineffective coping:
A common lack of skills is in dealing with stress and strong emotions. When the patient can no longer cope with the problems, he is likely to lash out. The ensuing aggression is mostly focussed on things, not on people.

Not coping within the family:
Within families there are often very complicated patterns of interaction, with high expectations from relationships. Seemingly minor occurrences can cause very emotional responses. A simple telephone call or visit from a family member may cause an upheaval. The resulting aggression is mostly focussed on things, or is directed verbally to people in general.

Increased need for control:
The patient deals with his fears by trying to control the other person, without considering that person's needs or feelings. It can manifest itself as inappropriate behaviour and lead on to person-focused aggression. The aggressor attacks the person who refuses to accept his need to keep control.

Project and identify:
When a person is not able to cope with his own feelings of anger or fear, he rejects these feelings and projects them on to another person. The perpetrator will deny doing this. The other person feels wrongly accused and reacts by feeling powerless, indignant or angry. This may in turn anger the perpetrator, who reacts more defensively, which can lead to a cycle of deteriorating interaction, and ultimately to person-focused aggression.

Changeable sense perception:
Sense perception can be affected by exhaustion and stress. As a result, sense perception can be seriously impaired (resulting in such impairments as tunnel vision, an autistic fixation on dots and lines, epileptic twilight state, psychotic hallucinations etc.)
This mostly results in aggressive behaviour towards the patient himself or his surroundings; very rarely is it directed towards other people, and certainly not directly.

Disturbed thinking:
In this coping strategy a person's perception is impaired. The person involved acts strangely, acting on his warped perception. The response is not that of a 'normal' person. It can eventually lead to aggression directed towards a person.

Defensive coping:
With defensive coping, the patient's fears and feelings of insignificance are overridden. The person develops an inflated self-image that is not easily corrected. The person comes into conflict with others who do not concur with this self-image. In an attempt to cope, this person comes more and more into conflict and the possibility of aggression increases. The aggression is often directed toward the person who threatens the inflated self-image of the offender. Quite often the ensuing aggression is unheralded and unexpected.

By detecting which coping mechanisms the patient in interaction with the health care worker exhibits the development of an effective aggression prevention plan.

Case study

I will give an example of an aggressive incident followed by a quick scan on the life of the patient and the way this patient behaves in the hospital and the reaction of the Staff. After that I will analyze together with the audience, which coping mechanisms we can detect. From there, we will search for the appropriate interventions. My aim is to finish the workshop with a review on the aggression prevention plan.

Conclusion

In my presentation/workshop I have tried to show you how we work to predict and prevent aggressive behaviour. Our experience has taught us that aggression often starts within relationships and that these relationships are for the health care worker the most important tools to use when it comes to prevention. This is also why it is very important to have an interactive model that explains the mechanisms underlying possible escalation.

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73. – Frequency and severity changes of violent behaviour in psychiatric inpatients

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Background

Inpatient aggression is a prevalent behavior on psychiatric wards; it causes a serious threat to the safety and well-being of psychiatric patients and their caregivers and is in fact a major determinant of the need for institutionalization[1,2,3,4]. The measurement and prevention of violence should have a high priority in psychiatric hospitals. Standardized definitions of violence, prospective designs and considerable follow up periods are urged in order to fulfill this aims accurately[5]. The researchers had proposed that an objective, multivariable instrument is a necessary first step toward studying aggression in psychiatric facilities[6,7].

Objective of study: The purpose of the study is to explore frequency and severity variations and predictors of violent behavior in different psychiatric hospital wards throughout one-year period.

Methods

A one-year follow up study was made in a sample of 113 chronic and subacute patients. Initially, clinical and sociodemographics variables were assessed using clinical flies and collateral informants. The outcome variable was recorded with a Spanish translation of the Modified Overt Aggression Scale and the data were analyzed by means of a panel design.

Results: In those patients who completed the 12 months follow-up, 38% presented at least one violent behaviour in any MOAS categories. Verbal aggression was the most frequent and self-aggressions the least frequent. Those patients less severely affected in their global functioning were those who showed more violent behaviours in all MOAS categories. Although mean frequency of violent behaviour did not vary during the year, severity of aggressions increased substantively in one group probably due to environmental variables. Different variables were associated with violence by group and period of the follow-up. Some of them were predictors of aggressive behaviour and they could be important targets of risk management and prevention strategies.

Keywords
violence, predictors, civil psychiatric patients.

Note
This is a work in progress; more results will be available for the Congress.

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74. – The clinical evaluation of aggressive mental health inpatients in Greece

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Introduction

Violence, according to the National Institute for Occupational Safety and Health (NIOSH), is every physical attack, threatening behaviour or verbal aggression, during the work or any other activity. The expression of violence during the nursing care of a mental health patient is the result of many factors that affect the patient's behaviour. Frequently a patient acts violently because of:
1. The nature of his/her disorder
2. The restraint (unintentional nursing)
3. Fear for the unknown environment
4. The way of their commitment to the hospital.

Violence, like every human behaviour, is not continuous or steady and is affected by many other factors.

Objectives

Purpose of this review is to summarize the findings concerning (with special mention of the interventions used in Greek mental health settings):
1. The method of approaching a violent mental health patient
2. The restraining of a violent patient
3. The drug treatment of an aggressive patient
4. The therapeutic approach of the violent and aggressive patient.

Results

The cooperation of many mental health professionals, can result in a successful control of the patient's violence. The treatment plans must concern:
1. Improvement of the mental condition
2. Improvement of self care, self respect and social interactions
3. The decrease of aggressive behaviour
4. Encouragement for social communication and
5. The assessment of the risk involved for every intervention.

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75. – Ward safety perceived by nurse managers in Great Britain, Germany and Switzerland

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Background

Little is known about how safe nurses feel on psychiatric wards across different European countries.

Aim

To evaluate how ward safety is perceived by ward managers in Great Britain, Germany and Switzerland. We also obtained data on the management of aggression, staffing levels, staff training, alarm devices, treatment and management of aggression and the existence and perceived efficacy of standards (protocols, guidelines).

Methods

We replicated a Swiss study in Germany and Britain, which asked ward managers on adult psychiatric wards to fill in a questionnaire giving details about staffing levels (qualified staff only), staff per bed ratios, perceived problems of violence, training, standards and type of restraint used.

Results

The British sample had by far the highest staffing levels per psychiatric bed, followed by Switzerland and Germany. The British ward managers by far perceived violence and aggression least as a problem on their wards, followed by Germany and then Switzerland. British ward managers are most satisfied with risk management and current practice dealing with violence. German managers were most likely to use fixation and most likely to have specific documentation for coercive measures. Swiss wards were most likely to use non-specific bedrooms for seclusion and carry alarm devices. British wards were far more likely to have protocols and training for the treatment and management of violence, followed by Switzerland and Germany.

Conclusions

British ward managers by far perceived violence and aggression to be a small problem on their wards compared to Swiss and German ward managers. This was associated with higher staffing levels, the existence of clear protocols and regular training.

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76. – Repetitive aggression in mental health care: characteristics of repeat assaulters and changes over time in staff and patient behaviour

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Background

This project sought to examine the significance of repetitive aggression as a component of the overall problem of aggression in secure and other secondary mental health care settings. In particular, the hypothesis that high-frequency repeat assaulters would have a distinctive demographic profile was examined.

Method

A dataset of 20,025 incidents and 4,909 patients was constructed by amalgamating three existing datasets drawn from high secure, medium secure and low secure (i.e. local general service) settings in a single trust. Using a cross-sectional survey design, patients were categorised according to the frequency of involvement (never, low-frequency and high-frequency) in risk-related incidents overall and aggressive incidents specifically and associations with demographic characteristics were examined. In addition, using a longitudinal design, incident sequences were examined for changes over time in terms of incident type and C&R use.

Results

The distribution of involvement in incidents followed a 'reverse J' shaped curve common in criminological research and 1% of patients were involved in approximately 50% of incidents. Rates of involvement varied significantly across the three settings. High frequency assaulters had distinctive profiles based on age and gender in high-secure settings and based on age, gender and ethnicity in low-secure settings. There was evidence that the first incident logged for a patient differed from subsequent incidents in terms of incident type and that C&R use by staff decreased as the number of incidents involving a particular patient increased.

Conclusion

It is desirable that high frequency assaulters should be identified in high, medium and low secure settings and focused upon in terms of interventions and that practitioners should be alerted changes in their own behaviour and that of patients as exposure to particular patients develops over time.

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77. – A study of violence in acute care of a psychiatric hospital

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Keywords
Violence, aggression, Psychiatry, Psychiatric illness, attitude.

Introduction:

Violence in psychiatric patients poses a major challenge not only for the clinicians but also for the carers and the society at large. Perceived dangerousness is an important factor contributing to discrimination of the mentally ill in the society (Link et al, 1987).

Epidemiological studies conducted in the previous decade have confirmed that violence occurs far more frequently among the psychotic patients than merely expected by chance (Swanson et al, 1990; Hodgins et al, 1992). Reports from hospital-based studies revealed that 20% of patients in Psychiatric emergency came with a history of violence (Tardiff & Sweillam, 1980) and more than 50% of the outpatients showed hostility and aggression (Bartels et al, 1991). A large number of studies have reported varying rates of violence among the psychiatric patients before hospitalization, for example, 10% (Bartholomew, 1965); 9.8% in men & 5.9% in women (Tardiff, 1984); 22.3% (McNiel et al, 1988); 21% (Binder & McNiel, 1988); 9.21% (Humphreys et al, 1992); 13.6% in men & 14.7% in women (Tardiff et al, 1997).

Few studies have been conducted on violence in Psychiatric patients in hospital settings in India. Kumar et al (1999) studied 53 consecutive drug free patients attending OPD and used the Social dysfunction and aggression scale (SDAS-9) (Wistedt et al, 1990) and the Brief psychiatric rating scale (BPRS) to study the relationship between aggression and psychopathology. There was no difference in aggression scores in different diagnostic categories although manics were significantly more likely to be restrained. Akhtar & Jagawat (1993) studied 2785 patients attending OPD of a psychiatric hospital. 70 patients were brought to the hospital restrained and no difference was found in the level of aggression and the extent of voluntary participation between restrained and unrestrained subjects. Studies done in India are not only few in number, but also, lack in systematic assessment and description of the phenomenology of violent behavior. The present study was thus planned and conducted to address some of the above issues in the acute care of a psychiatric hospital.

Objectives:

1. To study violent behavior in severe mental illness
2. To study the attitudes of family care givers towards the violent behaviour of the patient.
3. To study patients' own attitudes towards their violent behaviour.

Methods:

Institute of Human Behavior and Allied Sciences (IHBAS) is a neuro-psychiatric institute that caters to a large population of northern India. It has an inpatient facility with 200 psychiatry beds and on an average about 500 patients visit the outpatient department everyday. There is a round the clock emergency and a 10 bedded short observation facility (up to 72 hours) for acute care. About 30-40 patients per day are managed in the emergency.

The study was conducted during the period from 15th January to 15th March 2007. An attempt was made to screen a series of consecutive patients who visited the emergency and were advised

care in the short observation facility. A verbal informed consent was taken from each subject and family members before recruiting them for the study. 117 patients were approached; of which 39 refused to participate in the assessment and another 16 patients did not cooperate through the course of the interview. Finally the assessment could be completed with sixty-two subjects and their family members. All assessments were done by a qualified Psychiatrist (KM) within 36 hours of registration with emergency services. Information was collected by interviewing the patient and their family members and also from the hospital medical records. A semi-structured proforma developed for the study was used for socio-demographic, clinical and phenomenological factors related to violence. Psychiatric diagnoses were made using Mini International Neuropsychiatric Inventory (MINI version 5.0.0) (Sheehan et al, 1998). Overt Aggression Scale-Modified (OAS-M) (Coccaro et al, 1991) was used to assess severity of current violence. Attitudes towards violence in mentally ill patients were assessed among family members using a list of five statements on two point responses. Patients' attitudes towards their own violence were also assessed in a similar way. Data were analyzed using appropriate statistical tests.

Results:

Socio-demographic profile of the subjects is shown in Table 1. Mean age of subjects was 35.95 ± 13.11 years and 37 subjects were 31 years and above. Only eighteen subjects were females, 23 subjects were unemployed and only 12 subjects were illiterate. 54 persons were married and 40 had vegetarian food habit while 46 belonged to urban areas.

47 (75.8%) patients manifested violent behavior in the last three months whereas a lifetime history of violent episode could be elicited from the caregivers in 57 (91.9%) patients. Characteristics of recent violent episode are shown in table 2. In 28 (59.57%) cases the victims were female. 34% had attacked the spouse or partner and in 34% cases targets were children. In 63.83% the victims were other family members. In 4 (8.51%) cases the victims suffered moderate to severe physical injuries and in 13 (27.66%) cases the physical injuries in the victims were minor. 87% of patients did not use any weapon during violent acts. In 43 (91.49%) cases the violent behavior manifested within the family settings.

Diagnostic breakup of the 62 subjects as well as the mean and SD of OAS-M score for each diagnostic category has been shown in Table 3. ANOVA was used to compare the mean OAS-M score among various diagnostic groups. Statistically significant differences were found (p=.019) with maximum mean OAS-M score in subjects suffering from BPAD (mania) (48.16±29.85). Post hoc analysis further revealed a significantly higher score of aggression among the group of Bipolar Affective disorder (mania) than all other diagnostic groups excepting that of Unspecified Psychosis.

The putative risk factors as assessed with OAS-M score are shown in Table 4. Mean OAS-M score was significantly higher in subjects with current substance abuse / dependence than in those without (p=0.019). Similarly those with history of recent trauma had a significantly higher score than those without (p=0.025). However, only a trend of significance was seen in the subjects with non-vegetarian food habits and those with psychotic symptoms compared to their counterparts.

Table 5 shows the attitudes of family members towards violence. 41.94% caregivers believed that "violence is only a symptom of mental illness". 22.58% believed that "violence is deliberately shown by mentally ill persons to manipulate others". Chi-Square analysis revealed that these misperceptions were equally seen across rural and urban settings. Table 6 shows subjects' attitude towards their own violence. 94% of the subjects had externalized the cause of recent violence. Only 3.2 % of the subjects understood that violent episode was due to his / her own illness / change in behavior. Post violence remorse was absent in 50% of subjects.

Discussion

The present study has revealed that 75.8% of the patients manifested violent behavior in the last one month whereas a lifetime history of violent episode could be elicited from the caregivers in 91.9% patients. Violence score was significantly higher among the subjects with BPAD (Mania), subjects with current substance abuse and those with recent history of physical trauma. Target of violence was mostly family members and weapons were sparingly used; so most of the victims suffered no or mild physical injury. Gross misperception about violence in psychiatric patients was present in 41.9% of the care givers. Externalization of the cause of violence was perceived by 77.4% of subjects.

Majority of our patients were young adults, unemployed or unskilled / semiskilled workers, married, with preferences for vegetarian food, living in nuclear families in urban settings and were educated up to middle school. These findings are consistent with most of the previous international studies (Tardiff, 1997; Taylor, 1998; Swartz, 1998) as well as few studies done in our country (Akhtar, 1993; Kumar, 1999) However one study reported higher educational level and lower frequency of married subjects among their study subjects than subjects described in other studies (Swartz, 1998).

Majority of our subjects were suffering from severe mental illness (Schizophrenia or BPAD). ANOVA revealed significantly higher aggression score among the subjects with BPAD mania. Similar findings were seen in previous Indian studies (Akhtar, 1993; Kumar,1999) and few western studies (Carlson & Goodwin, 1973; Binder & McNiel, 1988; Lion et al, 1981) However most of the studies reported a significant association of violence with psychosis especially Schizophrenia. (Shader, 1977; Tardiff & Sweillam, 1980; Craig, 1982; Brennan, 2000; Link, 1992; Arango, 1999; Arseneault, 2000). This may be because of the fact that subjects suffering from schizophrenia present to the emergency settings in different clinical states like acute agitation, negative symptoms, catatonia, and noncompliance, whereas subjects with BPAD (Mania) most commonly present to emergency with acute agitation.

Of the risk factors analyzed in our study current substance abuse and history of recent physical trauma showed statistical significance while food preference (non vegetarian) and presence of psychotic symptoms had only a trend of significance. Psychotic symptoms and substance abuse have been described as risk factors in a number of studies (Scott, 1998; Soyka, 1993; Lindquest, 1989; Kjelsberg & Dahl, 1988; Swanson et al, 1990). However recent history of trauma has been suggested in few studies (Neller, 2006). No study, to our knowledge, has addressed food preferences as risk factors of violence. Studies with bigger sample size are necessary to further examine this issue.

Many of the violent episodes were directed against children, elderly and women, which is a matter of concern. However no or minimal injuries were suffered by the victims in majority of the episodes of aggression. This could be likely because weapons were sparingly used by our subjects. Majority of violent episodes took place inside subject's own house. This obviously indicated significant level of domestic violence among psychiatric patients.

While assessing attitudes of the family members towards violence in mentally ill persons it was found that gross misperceptions were present in at least 42% of the caregivers which may have contributed to high expressed emotion and overall stigma against psychiatric illness.

Most patients had externalized the reason for their own violence; only 2 subjects had the understanding that his illness / change in behavior were the cause of his violence. Post violence remorse was present in 40.3% of the subjects. Whether the presence of remorse predicts less occurrence of violence may be addressed in longitudinal studies.

Although our study had certain limitations like small sample size and cross-sectional design, phenomenology of violence has been described and attitudes of caregivers and severely ill psychiatric patients were assessed.

Table 1. Socio-demographic characteristics of the subjects

Variable	N=62	%
Gender		
Male	44	70.97
Female	18	29.03
Age		
>20	5	8.06
21-30	20 Mean ± SD=35.59 ±13.11	32.26
31-40	18	29.03
>40	19	30.65
Religion		
Hindu	49	79.03
Muslim	11	17.74
Others	2	3.23
Occupation		
Unemployed	23	37.10
Employed		
Unskilled/semiskilled	26	41.94
Skilled	12	19.35
Professional	1	1.61
Education:		
Illiterate	12 Education in Years	19.35
Primary education	13 Mean ± SD = 6.16±4.71	20.97
Middle school	19	30.65
10th Standard	14	22.58
Graduation and above	4	6.45
Marital status		
Married	54	87.10
Unmarried	8	12.90
Food preferences		
Vegetarian	40	64.52
Non-vegetarian	22	35.48
Family Type		
Nuclear	40	64.52
Extended	14	22.58
Joint	7	11.29
Residence		
Rural	16	25.81
urban	46	74.19

Table 2. Characteristics of most recent violence episode

Characteristic of violent episode	Men (N=32) N %	Women (N=15) N %	Total (N=47) N %
Target			
Spouse or partner	10 31.25	6 40.00	16 34.04
Children	10 31.25	6 40.00	16 34.04
Other family members (family members other than spouse and children)	23 71.88	7 46.67	30 63.83
Others (non family members)			
	8 25.00	2 13.33	10 21.28
Physical Injury to the victim			
None	18 56.25	12 80.00	30 63.83
mild	10 31.25	3 20.00	13 27.66
Moderate to severe	4 12.50	0 0	4 8.51
Use of a weapon			
Yes	5 15.63	2 13.33	7 14.89
No	27 84.38	13 86.67	40 85.11
Location			
Private residence	30 93.75	13 86.67	43 91.49
Street	6 18.75	2 13.33	8 17.02
Public place	0 0	0 0	0 0
Office	0 0	0 0	0 0

Table 3. Overt Aggression Scale-Modified Score in different diagnostic categories

Diagnostic category	Number of subject	Mean score on OAS-M	
Schizophrenia	15	27.73±18.19	ANOVA df= 61 f=2.962 p=0.019 (significant; p≤0.05)
ATPD	2	15.00±4.24	
BPAD (Mania)	19	48.16±29.85	
Depression (bipolar & Unipolar)	10	12.50±17.81	
Unspecified Psychosis	8	34.25±28.29	
Others (OCD, Alcohol Dependence, substance induced Psychosis, Deferred)	8	31.50±32.34	

Table 4: Putative Risk factors for Violence

Variable		Violence score (OAS-M) Mean ± SD	Statistical test (t test)
Gender	Male (N=44)	33.41 ± 31.03	t= 0.426; df=60
	Female (N=18)	30.11 ±16.37	p=.672
Age	Young adult (21-40) (N=38)	36.05 ± 31.98	t= 1.305; df=60
	Rest (N=24)	26.75 ±17.42	p=0.197
Education	Illiterate + up to Primary education (N=25)	33.24 ±19.58	t= 0.184; df=60
	More than primary education (N=37)	31.92 ± 32.00	p=0.855
Marital status	Married (N=54)	34.22 ± 28.18	t= 1.326; df=60
	Unmarried (N=8)	20.50 ± 19.68	p=.0.190
Employment Status	Employed (N=39)	36.08± 32.17	t= 1.178; df=59
	Unemployed (N=22)	27.50 ± 14.88	p=0.244
Food Preferences	Vegetarian (N=40)	27.73 ± 24.88	t= -1.862; df=60
	Non vegetarian (N=22)	41.05 ± 30.43	p=0.068
Residence	Urban (N=46)	30.67 ± 24.32	t= -0.861; df=60
	Rural (N=16)	37.56 ± 35.51	p=0.392
Psychotic symptoms	Present (N=50)	35.60 ± 27.53	t= 1.878; df=60
	Absent (N=12)	19.33 ± 24.13	p=0.065
Substance abuse (current)	Present (N=22)	43.36 ± 28.88	t= 2.407; df=60
	Absent (N=40)	26.45 ± 25.08	p=0.019 *
Medical comorbidity	Present (N=6)	24.67 ± 24.62	t= -0.727; df=60
	Absent (N=56)	33.29 ± 27.85	p=0.470
History of Physical Trauma	Present (N=8)	52.63 ± 36.42	t= 2.301; df=60
	Absent (N=54)	29.46 ± 24.98	p=0.025 *

* = significant; p≤0.05

Table 5. Attitude of family members towards violence

Statement	No. of family member who has agreed with the statement	%
Violence is only a symptom of mental illness	26	41.94
Violence is deliberately shown by mentally ill people to manipulate others	14	22.58
Violence in mentally persons completely resolve with treatment of mental illness	16	25.81
Violence in mentally ill person continues even after successful treatment	3	4.84

Misconception Vs Locality

	LOCALITY		Total	
	urban	rural		
Agree	17	9	26	
Disagree	29	7	36	
				Chi-square=1.815 df=1 p=0.178
Total	46	16	62	

Table 6. Patients' attitude towards violence

Attitude	No. of subjects	%
Reason for violence		
Circumstances	18	29.0
Other persons behaviour	30	48.4
Change in his own		
behaviour / his illness	2	3.2
Drug use	4	6.5
Others	2	3.2
Post Violence Remorse: (within 1 week of violent episode)		
No remorse	31	50
Remorse present	25	40.3
He is not sure	6	9.7

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78. – Violence against nurses in Thailand: prevalence and consequences

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Keyword
Violence, Nurses, Thailand, anti-violence measures

Violence in health care sectors refers to any situation where health are workers are abused, threatened, or assaulted in work circumstances, involving challenges to their safety, well-being, or health (Cembrowicz, Ritter & Wright, 2001). This definition encompasses relatively minor actions (such as verbal abuse, intimidation, harassment, and threat), racial discrimination, sexual assaults, and physical attacks. Violence tends to be destructive and have profound effects on nurses' physical, psychological, and behavioral dimensions. Physical attacks inflict pain, bruises, lacerations, wounds, muscle sprains, bone fractures/dislocations (Sitthilutrakul, 2003) and various physical symptoms (e.g., palpitations and restlessness) (Mezey, 2001). Psychological problems entail posttraumatic stress disorder and depression. Behavioral changes encompass substance abuse, absenteeism, loss of interest at work, social withdrawal and, relationship failure (Mezey, 2001).

Limited studies concerning violence against nurses have been conducted in Thailand, thus impeding comprehensive understandings of such phenomena. The current research aimed at: a) examining the prevalence of violent acts against nurses in Thailand, and b) investigating the effects of violence on nurses' psychological health

Method

Study Design and Sample
This study was a part of a national research initiated and funded by The Nurse Association of Thailand. A cross-sectional survey was used. Target populations of this study were nurses who work for health care facilities throughout Thailand. The convenience sampling design was utilized. The questionnaire package was mailed to nurse administrators of 1,626 health care facilities across the country. The package contained a cover letter, questionnaires, consent forms, and a prepaid self-addressed envelope. The cover letter explained the purpose of the study, requested the nurses' participation, and asked the administrators to distribute nurse questionnaires to their subordinates. Afterwards, they were also asked to collect all questionnaires and mail them back to the researcher by using the provided envelopes.

Instruments
Data were collected by means of a self-reported questionnaire, containing questions related to personal information, institution information, the Thai-version Workplace violence in the health sector questionnaire (WHVQ, Martino 2002), and open-ended questions.

The WVHQ was originally developed by International Council of Nurses (ICN) in English and translated into Thai by the researchers with ICN permission. The WVHQ was designed to assess 2 major dimensions of violence, including physical and psychological violence (verbal abuse, bullying/mobbing, sexual harassment, and racial harassment).

Each aspect of the WVHQ entails 3 sets of questions whose response categories vary depending upon the questions. The first set contains 15 questions assessing the nature of each

incident occurred in the past 12 months, its negative effects, and victims' actions. The second set contains 2 questions: "have you ever witnessed violence against other persons in the past 12 months?" and "how would you rate the severity of such violence?" The third set of questions also contains 2 questions asking "have you ever reported violent incidents that you experience in your workplace?" and "If yes, have you ever been advised how to write an incident report?" Finally, the open-ended questions allowed nurse respondents to identify three precipitating factors for violence and to suggest three effective measures to prevent violent actions.

Data Analysis
Data were analyzed by using the SPSS 13.0 software. Descriptive statistics was conducted to describe sample characteristics and variables of interest. Data from open-ended questions were analyzed by content analysis.

Results

Sample Characteristics
In this study, 4,954 out of 8,418 (58.85%) nurses completed the questionnaires. Of these respondents, 4,333 (87.5%) were registered nurses, 235 (4.7%) were technical nurses, 350 (7.1%) were other types of nurse, and 36 (0.7%) did not answer. Most nurses worked for provincial hospitals (500 inpatient beds) (n=1,346; 27.2%), followed by regional hospitals (> 500 beds) (n=1,144; 23.1%), community hospitals (n=1,056; 21.4%) and private hospitals (n=357; 7.2%). The majority of nurse respondents were between 25-35 years old (n=3,622; 73.1%), female (n=4,820; 97.3%), and married or cohabiting with partners (n=2,665; 53.8%). Most nurses held a Bachelor degree in nursing (n=3,946; 79.7%), followed by nursing diploma (n=176; 3.6%), Bachelor degree in other disciplines (n=164; 3.3%), Master's degree in Nursing (n=162; 3.3%), and Master's degree in other disciplines (n=161; 3.2 %). It is noted that the nursing diploma required 2 years of education, the Bachelor degree consists of 4 years, and the Master's degree entails 2 years of advanced education.

Prevalence of Violence against Nurses in Thailand
Results indicated that violence against nurses exists to some extent in Thailand. As displayed in Figure 1, 225 of 4,954 nurses (4.5%) faced physical violence and 1,248 of 4,954 nurses (25.2%) encountered at least one type of psychological violence in the last year. Of the latter, 1,144 (91.6% of 1,248) respondents experienced verbal abuse, 246 (19.7% of 1,248) encountered bullying/mobbing, 97 (7.7% of 1,248) faced sexual harassment, and 38 (3.0% of 1,248) reported racial harassment. Table 1 shows that patients and patients' relatives were main perpetrators for physical violence, verbal abuse, sexual harassment, and racial harassment. Superiors and colleagues were prime perpetrators for sexual harassment. Furthermore, most violent acts took place in health care facilities.

Figure 1 Prevalence of different types of violence against nurses in Thailand
Note: Respondents could choose more than one type of violence

Table 1: Perpetrators of different types of violence

Psychological violence					
	Physical violence (n=225)	Verbal Abuse (n=1,144)	Bullying/ Mobbing (n=246)	Sexual Harassment (n=97)	Racial Harassment (n=38)
Perpetrators					
Patients	189 (84%)	316 (27.6%)	22 (8.9%)	39 (40.2%)	7 (18.4%)
Patients' relative	9 (4%)	341 (29.8%)	33 (13.4%)	20 (20.6%)	6 (15.8%)
Colleagues	4 (1.8%)	232 (20.3%)	96 (39%)	10 (10.3%)	4 (10.5%)
Superiors	3 (1.3%)	101 (8.8%)	49 (19.9%)	4 (4.1%)	5 (13.2%)
Others	11 (4.9%)	79 (6.9%)	29 (11.8%)	16 (16.5%)	12 (31.6%)
Missing data	9 (4%)	75 (6.6%)	17 (6.9%)	8 (8.2%)	4 (10.5%)

Note: Respondents could choose more than one type of violence

Psychological Symptoms

Current findings suggested that victims of violence exhibited symptoms of post-traumatic stress disorder (PTSD), including recurrent flashback/nightmares, avoidant symptoms, hyper-vigilance, and overly fatigue (Figure 2). Victims of physical violence (n=157; 69.8% of 225) and sexual harassment (n=71; 73.2% of 97) mostly manifested hyper-vigilance. Victims of verbal abuse

(n=874; 76.4% of 1144) and racial harassment (n=25; 65.8% of 38) mostly exhibited avoidance whereas those of bullying/mobbing (n=201; 81.7% of 246) experienced overly fatigue.

When compared across groups of violence (Figure 2), it is evidenced that the victims of verbal abuse displayed the highest percentage on experiencing recurrent flashback/nightmares (67.7%). Furthermore, nurses who encountered bullying/mobbing showed the highest percentage on avoidance (79.3%), hyper-vigilance (78%), and overly fatigue (81.7%).

Discussion

The current study aimed at examining the prevalence and consequence of violence against nurses in Thailand. Research findings indicated that the prevalence for physical and psychological violence was 4.5% and 25.2% respectively. Verbal abuse appeared to happen most frequently (23.1%). Furthermore, violence acts provoked symptoms like PTSD, including flashback, hyper-vigilance, avoidance, and overly fatigue. When compared to previous studies conducted in Australia, Lebanon, Portuguese, South Africa, and other countries, findings revealed a wide prevalence rate of 26.3-73.5%; Verbal abuse are in the range of 27.5-58% (Deeb, 2003; Ferrinho et al., 2003; Maghew & Chappel 2003; Steinman 2003). Despite such variation, it is evident that violence against nurse is not a local problem; it is actually a global one.

Evidence from this study and other international investigations collectively convey a strong message to the world that violence in health sectors actually exists. Immediate actions from administrators and policy makers are required in order to establish violent-free environments for nurses. In Thailand, some nurses started to take this issue seriously. There are some efforts to develop training programs for nurses across regions. For other countries that already comprehend the nature of violence, they are also encouraged to develop effective anti-violence strategies. National and international efforts should be made in a timely fashion. ICN/WHO guidelines on violence (Steinman 2003) may be adapted and implemented according to sociocultural contexts.

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79. – Seminar 1 – Reduction of seclusion and restraint – Reducing reactive aggression by reducing coping demands: principles supporting why it works within child & adolescent treatment environments

Kathleen Delaney, PhD, RN, APRN (USA)

The neurobiology of stress responses and neuronal kindling in the face of excessive stress provide the logic for a milieu structure that aims to help children maintain control by reducing coping demands. Reducing coping demands is accomplished several ways. First, by keeping expectations in line with a child's ability to reason, sequence and process information. To do this, environmental expectations must be adjusted in line with the staff's assessment of the child's cognitive function. They must also be reasonable and appropriate to the child's level of control and also be within a child's reach to achieve. A milieu that is predictable, that develops a pattern to the day and to interactions with staff also reduces stress; especially for children whose deficits in regulation arise from difficulty encoding social information or who have problems with response flexibility. Children with emotional problems frequently have poor emotion regulation skills and when they experience strong negative affects they diffuse them via behaviours such as tantrums, venting and aggression. In addition they often do not seek out support in their environment when overwhelmed. They need adults who are attuned to their affect shifts and step in to bolster faltering functioning. Thus a milieu aimed at stress reduction must be populated with generous adults who are able to attune to a child's changing affect levels. One way to reduce coping demands is to support a child's autonomy by choice, minimal coercion, and rationales for disciplinary rule. A milieu that encourages autonomy via choice supports coping and reduces stress. This presentation will elaborate on these approaches, how they are used to construct a stress-reducing milieu and the theory supporting their mechanisms of action. Clinical examples will be provided as well as the data on the use of emergency measures on the unit where the model is implemented.

80. – Seminar 1 – Reduction of seclusion and restraint – Issues of power & control that lead to human service-perpetrated violence

Marc Tumeinski (USA)

Power and control issues can lead to violence perpetrated by human services on those who consume them. Understanding how such issues unless understood can lead to violence is therefore necessary in order that prevention can be realised. Social devaluation is a reality for many of the people who use human services and its implications are significant for both staff and services users. The impact of powerlessness may be particularly significant. The challenge for services is therefore to recognise the reality of unconsciousness in the human service dynamics of power, control and violence and to find ways of achieving and maintaining a more valid stance.

81. – Seminar 1 – Reduction of seclusion and restraint – Containment and physical restraint

Laura Steckley. Scottish Institute of Residential Child Care, Glasgow (UK)

Containment has been referred to the primary task in residential child care, and the term is used in varying ways. In some cases, containment simply refers to a literal sense of physical care and limits on behaviour. It is the extreme end of this interpretation, the physical containment of potentially harmful behaviour, that has generally been applied to physical restraint. Emotional containment, however, refers to a much broader notion of helping young people, over time, to manage their 'uncontainable' emotions through therapeutic relationships and the use of lifespace. This paper will explore the concept of containment, using it as a way to understand the experiences of physical restraint of staff and young people in residential child care, and offer implications for practice.

82. – Seminar 2 – Training in the management of aggression and violence – Toward integration: organisational approaches to training

David Leabetter Director CALM Training services, Menstrie Business Centre, Elmbank Mill, Menstrie Clackmannanshire, Scotland (UK)

In the recent past training for direct care staff in aspects of secondary and tertiary intervention has dominated responses to the problem of aggression and violence because violence has been framed as one affecting individual patients and individual staff.

More recently this paradigm has been challenged by an emerging literature that stresses the potentially vital role played by the organisation in violence prevention.

The current challenge faced by managers, practicioners and trainers is however how to develop reponses that ensure training is used as part of a whole organisation approach within a public health perspective.

This requires training providers in particular to recognise the need for multi level systemic interventions addressing audiences, themes and issues potentially unfamiliar to them and to convince service providers of the value of this approach.

83. – Seminar 2 – Training in the management of aggression and violence – Non physical management of aggression and violence: a training problem?

Gail Miller. Associate Director Violence Reduction West London and Broadmoor Mental Health Services Trust. England (UK)

Commentators have suggested that an over emphasis on the physical management of violence in training has led in some care settings in the UK to the emergence of a culture of violence in which staff were trained in how to respond to violence but not in how to stop it happening.

Such concerns have resulted in increasing attention being paid to the non physical management of violence as a training issue. However who should be trained in what remains a live question for many services.

Three key groups in needs of training have traditionally been identified, direct care staff, managers and the trainers themselves but more recently it has been suggested there is a fourth group which comprises service users.

How organisations respond to this training agenda poses a number of challenges which this presentation will discuss with reference to examples and recent research.

84. – Seminar 2 – Training in the management of aggression and violence – The future: clinical governmental and organisational perspectives

Kevin McKenna Lecturer Dundalk Institute of Technology & Project officer Program on Work-related Aggression and Violence Health Service Executive Ireland (Ireland)

A national syllabus, supported by governmental directions, in non-physical skills, Promoting Safer and Therapeutic Services (PSTS) was launched in 2005 and within two years approximately 90% of mental health and learning disability services in England have assimilated it into their training programmes.

The Government are also likely to publish national standards for physical interventions in 2008 and introduce a national scheme for the registration, accreditation and regulation of all management of violence trainers and training. This will lead to the whole spectrum of non-physical and physical skills being subject to national standards and the regulation of the industry that delivers it.

There is potential for these developments to spread to all sectors of health and social care, as well as having an impact on other types of service industry (e.g. transport, retail, leisure). It may well be influential in terms of the development of similar programmes in Europe and further a field.

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85. – Workshop 12 – Prevention, Intervention & Evaluation – Violence Policy – Preventing, intervening and evaluating in-patient violence incidence – Is it really working?

Lene Berring, Chief Developer, RN, BA, MScN; Juno Calmer, Chief Psychologist, RN; Fergus Clancy, RN; Morten Ekstrøm, Specialist in Psychiatry, Ph.D.; Bent Slot, Psychologist (Denmark)

Summary

This paper describes a project implemented at a psychiatric hospital in the northern part of Copenhagen. The scope of the project is implementing strategies for prevention, intervention and evaluation of violent or potentially violent in-patient incidences. In 2005 a new non-violence policy was developed and initiated with the following cornerstones - 1) developing and implementing a staff training program, 2) appointing "risk instructors" who are responsible for maintaining staff competences in this field, 3) implementing risk-assessment, 4) implementing deescalating techniques and 5) establishing procedures for evaluation of violent incidences.

Introduction

Aggression and violence at inpatient psychiatric units is a significant problem among the staff. The constant risk of violence often affects the nurse-patient relationship negatively and creates stress in the individual staff members and in the psychiatric environment in general. Some nurses describe how they constantly are imagining "the worst case scenario" (1).

Research shows an association between the level of education among psychiatric staff and the number and severity of incidents with patient violence (2, 3, 4, 5). In order to reduce violence, to create a safe environment, to prevent burned out symptoms among staff and thereby to retain staff, the hospital has developed and implemented a non-violence policy. This policy includes staff education, risk assessment, strategies of de-escalation and intervention as well as procedures for evaluation.

The policy has among others resulted in local guidelines describing the staff member responsibilities, the expectations of staff articulated in a competence development measurement and procedures for staff education articulated in a staff training programme.

The policy has also resulted in local guidelines related to the care planning, describing how to risk-assess and how to use de-escalation techniques. Generally the guidelines are based on pro activity, which means action before the episode escalates into aggression and violence. This includes different types of de-escalation- "talking down", milieu therapy, establishing the level of observation, determine degrees of seclusion, administration of medication and determining the use of coercive procedures.

When a situation is escalating we have procedures for how to engage inter-disciplinary to avoid danger, how to restraint the patient in the most safe and respectful way and how to evaluate the violent incidents.

When implementing a non-violence policy it is necessary to have a thorough knowledge of the local psychiatric culture. The nursing culture in Denmark is based on interdependency, evidence-based nursing isn't very common and the health system is based on low hierarchy. Authoritative behaviour is less acceptable, which means that all interventions have to be discussed. Nobody wants to tell anybody what to do and nobody wants to do what they are told. This attitude can cause problems especially in stressful situations with potentially violent patients. When you have to cooperate in stressful situations, somebody has to take charge and take on a "leading" or "coordinating" role. We call it "the case coordinator".

Implementing the project

The project was implemented at a psychiatric university hospital situated outside Copenhagen, the Psychiatric Centre Gentofte. The hospital serves 150.000 citizens and has a capacity of 95 in-patients. The hospital includes two closed wards where acting out or violent patients are admitted. Staff members (app. 300) include physicians, psychologists, RNs, psychiatric nurses, occupational therapists, physiotherapists, social workers and office staff. Before implementing the non-violence policy it was discussed and accepted at all levels in the organisation. In order to form the educational level, it has been necessary to integrate the staff training in the everyday practice that is done by special trained instructors chosen among the staff. The purpose of the risk instructors is to do the every day training. The teaching method is role-plays and rehearsals in the daily practice, everybody has to do the training at least 16 times a year. Besides the every day training we have developed a staff training programme.

Staff training program
The staff training programme focusses on staff competences according to risk assessment, de-escalating techniques, defusing and debriefing. The programme has a very practical focus and involves the following areas:
- Information regarding a safe environment (1½ hour)
- Staff training in the everyday practice (at least 16 times a year)
- Basic deescalating techniques, risk assessment legal aspects and the law of psychiatry (2 days)
- Basic physical contact skills/ interventions (5 days)
- Communication strategies (2 days)
- Advanced physical contact skills/ interventions (3 days)
- The role of the "case coordinator" (1 day)

Competence development measurement
To identify the staff competencies, a Competence Development Measurement (CDM) has been developed, which in 5 stages describes the staff competencies. The CDM is the basis for the implementation process. During the implementation period staff competency levels will be assessed three times through self-evaluation. The CDM is inspired by Patricia Benner's theory (6), where stage one classifies the novice and stages five classifies the expert. We presume that "the case coordinator" is at least at stage three, which characterises the competent staff member who is able to take charge, stay calm and act properly and professionally in a threatening or violent situation. The staff responsible for implementing the non-violence strategy is at least at stage four (the proficient nurse). At this stage you will be able to relate theory and practice and to be an identification model for colleagues.

Before potential violence
When staff at psychiatric wards is confronted with potentially violent patients, it is important that they maintain composure and assume authority. Staff should listen to the patient, maintain a suitable distance, remove objects that could be used as weapons and inform colleagues. In order to prepare staff better so that unexpected situations occur less frequently it is important to use a simple system known and used by everyone in order to foresee potentially violent episodes.

Risk assessment
For risk assesing we use the Brøset Violence Checklist (BVC)(7,8,9,) systematically in order to assess the risk of violent behaviour among the patients. Violence is defined as any physical or psychological contact or action, which the individual experiences as offensive or hostile towards his or her physical or mental well being. BVC is a short-term violence prediction instrument developed in Norway from the empirical work of Linaker and Busch-Iversen. Due to their research over a 5-year period they found six behaviours in the patients that most frequently were associated

to subsequent violent incidences namely confusion, irritability, boisterousness, physical threats, verbal threats and attacking objects. Each of these six behaviours is in BVC are scored for their presence (=1) or absence (=0) which means that a patient can score a minimum of 0 points when they are relaxed and cooperative and a maximum of 6 points when they are at a high risk of violent behaviour. Scores of 2-3 suggest that the risk of violence is moderate and preventive measures should be taken while scores of 3-6 indicate that risk of violence is increasingly high and preventive measures must be taken immediately.

When screening patients admitted to our Psychiatric Emergency Ward we ask ourselves three questions – (1) Is there a previous history of violent or threatening behaviour? (2) Are there current signs of possible or potentially violent behaviour? (3) Does the patient need to be admitted to a closed ward? If the answer to any of these three questions is YES, the following steps are implemented – (A) patient assessment according to the BVC scoring system is initiated (B) a contract of cooperation is formulated together with the patient addressing the issue of preventing violent behaviour (C) identification of possible trigger factors in the patient, that is factors which provoke aggressive or violent behaviour.

When BVC scoring is initiated, it has to be done a minimum of once a day but often once or twice in each shift if the situation is very unstable. Only when the patient scores zero three days in a row, BVC is no longer used. Systematic use of BVC begins again if it later becomes clear that the patient is showing signs of potentially violent behaviour. Risk assessment is documented using a BVC-rating chart.

De-escalation
De-escalation involves the following areas: cooperation, risk assessment, "talking down", observation levels, protection, medication and restraining. In de-escalation some basic rules are followed.
- The general attitude and contact with the patient must be emphasised. The patient's state of mind must be taken into consideration. The staff must be aware of the more delusional the patient is, the more careful you have to be in your interventions to make sure that the patient understands your actions.
- The focus of the de-escalation process is to control the situation and not the patient. Staffs have to assess the risks that are associated with the chosen de-escalation method and regard the intervention in a realistic manner. Staff have to adapt to the patients wishes in a emphatic way if they are realistic and calming. It demands a lot of the staff and it is a challenge to be flexible if you feel insecure and under pressure.

Most important is verbal and non-verbal communication and we are focusing on the staff behaviour and reactions in an appreciative way.

During the incident
Physical contact skills/ intervention and deescalting techniques are used, guided by the case coordinator.

After the violent incident
To avoid anxiety and burned out symptoms, and to maintain and develop staff competencies we are after the incidents using the following techniques -
1) brief evaluation, 2) defusing and 3) debriefing.
The "brief evaluation" is lead by the "case coordinator" and subsequently a person at competence level 3. All the staff who have been involved gathers immediately afterwards and talks the episode through. The purpose of this brief evaluation is to give every one the possibility to verbalize the incident in few words e.g.: " How did I manage my role in the incident?" "Did we all corporate in a good way?" "What have we learned from this process and do I feel okay?" If one of the participants feel the need for a more thorough talk they all agree to meet later the same day for more reflection and consideration.

The "defusing" gathers all the involved staff once again and the defusing procedure is used. Often the case coordinator is the leader of the defusing. Commonly when there is a need for defusing, the violent incident has been a shocking and overwhelming incident for some of the staff. The incident has created a feeling of loss of control. The purpose of the defusing is to verbalize the incident, get a coherent description, try to re-establish feeling of control and analyse if any staff needs further follow up; a formal debriefing. (10)

The "debriefing" typically takes place one or two days after the episode. In this situation a psychologist is the group leader, and a formal procedure is followed. All psychologists at the centre are trained in this discipline.

Hopefully this reflection process will develop staff competencies and develop an environment where we are aware of an appreciative culture and that defusing gives a dynamic view.

Results and discussion

The BVC risk assessment initiated in 2007 and therefore at the present stage is not yet evaluated. However an evaluation will take place in September 2007 and the conclusions will be presented at the conference.

The staff education programme is being tested during the implementation period, by accessing the staff member's level of competence (self evaluation schemes). The preliminary results suggest that staff members (n 300) with very little or no education tend to overestimate their level of competence. We noticed that the staffs self-evaluations differed from the first rating to the second rating, six months later (in sep. we will do the third rating, 6 months). The staff s competences lowered, we interpreted this as increased knowledge of own capacity. Studies have shown that younger and less experienced staff faces greater risk of being assaulted. One reason for this could be unrealistic confidence in personal skills, which our self-evaluations also indicate (2).

The immediate staff responses are: "we are getting to know each other, which are positive in acute situation" (related to the every day practice), "this is making me happy when I'm working (related to role-plays), "the management is caring for the staff" (related to the training program.

In defusing as a method we have noticed some difficulties in motivating staff for defusing in practice. Everybody agrees that it is very important to develop ones competence individually and as a team. But in daily practice we have noticed some difficulties when the staff has to initiate the meeting. The result is very few meetings held, instead the staff ask for debriefing.

The workshop

At the workshop we will briefly (max. 15 min.) present the non-violence policy developed and implemented at our centre. Some results will also be presented. The rest of the workshop will be based on role plays illustrating threatening or violent incidences and evaluation situations where the workshop participants are invited to reflect and discuss prevention, intervention and evaluation of violent incidents on psychiatric wards. We will do joint risk assessment, techniques of de-escalation will be illustrated, development of staff competency through defusing will be demonstrated as will a debriefing session. The workshop will be very interactive and hopefully inspiring and creative. We will highlight the difficulties of incorporating a high level of security in a dynamic therapeutic environment.

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86. – The use of police officers within mental health institutions: a case study from Ohio – USA

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Introduction

Approaches to ensure safety and security within mental health care institutions vary, and are often a reflection of current and/or local issues. The most striking aspect of institutional security in Ohio is the possession of a designated police force. A small-scale study on role perception within one such designated police force was carried out in order to explore issues relating to security in a major mental health institution.

Since a police presence within a mental health organization was unfamiliar to the author he sought to find out about this role for two reasons: i) to satisfy his own professional curiosity to determine what sort of impact the police had within the organization and ii) to be able to describe the roles of the SPF officers to students undertaking clinical experiences in the units for eight week periods.

A series of formal and informal interviews were carried out with different ranks of the special police force within the Behavioral Healthcare Organization (BHO) over a three-month period. Data from the interviews were collected in note form and written up as 'field notes' (Clandinin and Connelly 1998).

Special police officers reported that their role did have some unique elements, and in particular commented upon the importance of being seen to be impartial within the intuition. Clients often view the officers as being a neutral presence in the institution; someone who will act with fairness and impartiality and respect the rights of the client.

The perceived need for a police presence

The potential use of police officers is usually associated with the threat of violence towards staff, for example, Loughran (2007) noted that there is a need for police presence on United Kingdom (UK) wards if greater security is to be achieved. Parish (2006) notes that far too often staff in mental health hospitals have to request police help with non-compliance issues, such as the administration of medication to potentially violent patients.

Examination of the role of the police working with patients/clients who are brought into care would suggest that police officers are good at "identifying patients in need of psychiatric care," (Strauss et al 2005). Various schemes have been put in place to establish strategies between health care providers and the police in dealing with people with mental disorders (O'Conner 2004; Nursing Standard 2004). A range of training initiatives for police officers (usually working in Crisis Intervention Teams) have been established and found to be beneficial (Teller at al 2006; Journal of Psychosocial Nursing 2001; Norris and Cooke 2000).

There are two themes that emerge from the literature on the use of police officers in health care. The first theme is that police officers should be readily available to protect hospital staff, particularly from assault; the second theme is that police officers, usually working in the community, should be able to identify potential mental health clients who are in crisis and be sensitive to their needs.

The BHO special police

The police officers working within the institution are members of a special police force, known as BHO Police. The Ohio Department of Mental Health (ODMH) establishes the minimum duties and responsibilities of the BHO police to enforce the laws of the state of Ohio. A "Police Officer" in the BHO means any special police officer, as defined in section 5119.14 of the Revised Code, (Ohio Government 2007) who has had special training and authority, including the power to arrest. At the time of the study there were 7 officers working in the BHO, supervised by a Lieutenant. A Chief of Police has responsibility for the BHO police at this and a sister BHO campus, located in a nearby city. Most BHO police officers transfer from mainstream law enforcement. They are part of the security services within the BHO, but unlike other police officers they do not carry firearms. They undergo special training at the BHO site on therapeutic intervention with clients, with an emphasis being placed on verbal intervention. They retain the usual duties of a police officer with regard to serving warrants, arrest, etc, and are required to intervene in any cases of assault. They also provide "consumer [client] escorts as deemed necessary" (Ohio Government 5122-7-04; 2007).

The officers work across three shifts (with a two hour overlap between shifts), working 10 hours per day for 4 days followed by 3 days off-duty. One officer on each shift is a 'Visitation Host' who: greets people at the reception desk; informs them of the rules of the institution; can refuse admission (for example if a visitor smells of alcohol); can search visitors if necessary. Having received the same basic training as other police officers the BHO officers are certified through the Ohio Police Officer Council. Candidates are expected to have had previous police training and have to undergo a background check to ensure that they do not have any felony convictions.

The requirements of the BHO police include protecting "consumers, visitors, staff, grounds and buildings" whilst being "sensitive to the needs of consumers" and participating "whenever possible in assisting consumers in their recovery" (Ohio Government; 2007).

Police offices working in the BHO

There were 59 incidents reported by the special police in the BHO in September 2006 and 38 incidents in October 2006. An incident is defined by the Incident Reporting Administrative Rule (5122-3-13) as:

Any occurrence which is not consistent with the routine care of a client; the routine services provided by the hospital; or the routine standard of care for the hospital. Incidents include accidents, unusual occurrences, or situations which might result injury to a person or damage to property or equipment. Incidents may involve clients, employees, visitors, and other persons. (Ohio Government 5122-3-13;2007).

All incidents are reported (ultimately to the Chief Executive Officer of the BHO) to determine if a full police report is required and whether criminal charges are involved.

Restraint of clients is viewed as a clinical issue and is out-with the remit of the special police. Any client who feels that they have been wrongfully restrained can report this to the special police, as they would with any other complaint they had. If it is determined that restraint was wrongful then a full police report would be made and criminal charges could be brought to bear.

An important part of the role of officers is the taking of statements for police reports in order that the officer can ascertain why an incident occurred. One officer described this documentation process as the role of a "historian." Officers reported that accurate documentation was sometimes difficult when working with witnesses who had mental health problems, especially if the patients feel pressurized into finding a reason for an incident occurring. Officers also reported difficulty when investigating damage by clients to property. The BHO Police must decide if there is a clinical basis to the behavior or whether it is a deliberate act to achieve specific ends (for example to try to "beat the system to get back into jail").

Officers reported that when they do respond to an emergency situation, often the presence of the police uniform is enough to diffuse the situation. Not because the clients feel threatened by

the uniform, but because they feel that a source of mediation is available and "the rules will be applied." The author observed that when called to an incident the officers remained detached from the action, mostly acting as a neutral observer of the incident (they would speak to clients to warn them of their behavior, or assist staff, if deemed necessary).

The officers felt that the clients had a great deal of respect for them. They explained that when they are called to an incident in a unit a client often wants to be the first to make contact with the office in order to give their version of the incident. The clients know that the officers are there to respect their rights and uphold the law. Officers noted that over time, either in the forensic units, or with returning clients in the admission units, it is possible to build up relationships of mutual respect with the clients

Summary and Conclusions

The two themes identified in the literature are evident, but perhaps presented differently, in the BHO special police investigated. The police officers are readily available to protect hospital staff. This is, however, only one part of their protective role as stipulated by the Ohio Government. They also view themselves as being charged with protecting the clients (or anyone else on the BHO campus). Through interviews with the officers and observations in the units the author would confirm that the clients view the special police as an agency to protect their rights and uphold a position of neutrality between the clients and institution staff.

The theme of sensitivity to client needs was also apparent within the BHO special police. Being stationed within a health care facility, and having had special training, the officers demonstrated a professional approach to clients whilst remaining insightful to their needs. Therefore they do not view their primary role, as perhaps anticipated in some other countries, as merely the protection of the staff.

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87. – Handling patient violence in in-patient settings: implications for nursing management

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Keywords
Violence; Aggressive behavior; Representation, Skills, qualitative research

Background

Aggressive and violent behaviors are a major concern in in-patient psychiatric care. Numerous studies on this topic have shown the necessity of increasing prevention measures, developing communication skills and implementing strategies to defuse violence. However, violence in in-psychiatric care settings seems to increase and to be underestimated by those who are facing it. Moreover, there few studies have been published on the nursing perception of this phenomenon and on related knowledge.

Therefore, two independent qualitative exploratory studies were conducted in the French speaking part of Switzerland in 2005. They were carried out for the nursing profession, by the nursing profession.

Aims

1. To present the different methods used to meet corresponding objectives
   a. To investigate the nurses' perceptions of violence of patients suffering from psychiatric disorders.
   b. The implementation of individual (theoretical knowledge, experiential knowledge, emotions, and attitudes) and institutional (team management, warning systems) resources.
2. To present the results of the two studies
3. To question the formation of the management of violence during the basis education program, in the University of Applied Sciences, training of the nursing profession.

Methods

Institution	Psychiatric Center of the Nord Vaudois (CPNVD)	University Department of Adult Psychiatry (DP-CHUV)
Objects of the research	Real life experiences of the care staff of the violence from patients hospitalized in a psychiatry department Real life experiences of the resources allotted	Representations of the care staff: - of the violence from patients suffering from mental problems - of the practices used
Context of the study	CPNVD/ University of Applied Sciences La Source (Lausanne) collaboration	Study developed in the context of a Master training in Paris (University of Paris XII). DP-CHUV/FORESO collaboration

Institution	Psychiatric Center of the Nord Vaudois (CPNVD)	University Department of Adult Psychiatry (DP-CHUV)
Sample	12 nurses were questioned about a violent incident, encountered in their psychiatric care role.	6 nurses having been the subject of an aggression from a patient being looked after in a psychiatric department
Method	Qualitative method Semi-direct support . account of the aggression suffered Analysis of the support by conceptualizing categories (Maillé and Mucchielli 2003)	Qualitative method Open semi-managed support Approach by the victimization approach (Madeleine Monceau) Analysis of the data according to the context proposed by Abric on the representations of the practice

Results

Psychiatric Center of the Nord Vaudois (CPNVD)	University Department of Adult Psychiatry (DP-CHUV)
Dynamics of the phenomenon of violence as experienced by the care staff	The emotions felt in the situation (fear, anger, surprise, culpability, feeling of impotence)
Five categories: To explain the act of violence To live in tension To define and to tolerate different types of violence To feel emotions, and feelings and to manage them To mobilize resources in a violent situation	Different representations of the care role in the confrontation with the violent patients (role of therapist, evaluation, protection, contention, even coercive, informal (gendarmes, teaches, parents)
Individual resources mobilized Relational strategies and techniques The knowledge of the patient The observation and the decoding of the behaviors at risk Intuition The knowledge and self control	Individual resources: The care team To unwind & relax To laugh
Institutional resources The care team and the doctors The medical treatment The safety measures The other patients The police	Institutional resources The care team The intensive care rooms The medical treatment Safety measures (aggression beep, emergency interventions, private security – the Securitas – the police) The post-applicable institutional resources (debriefing, supervision, post incident review conference). The law (filing a complaint)

Discussion

The results of these two studies using different methodological approaches converge on four points:

1. They confirm the frequency, the recurrence, and the seriousness of phenomenon of professional violence experienced, particularly the emotional impact on nurses and the consequences on private and professional life. If care staffs work with a risk of violence's population, violence is a phenomenon with which they are confronted regularly. The primary emotions (fear,

surprise, anger, sadness) are very present without being named spontaneously. The first reflex is to explain the act of violence ("He had hallucinations", "He was very distressed). When solicited to express their feelings and emotions faced with this violence, the comments of the nurses however change. Although the nurses reject any "free violence", differences in apprehension on this phenomenon between them appeared in connection with the mental illness responsibilities in the aggressive interaction.

2. Significant individual and collective resources in violent situations are mobilized but not acknowledged. On the level of the individual resources, the strategies of communication are privileged, just as the knowledge of the patient. The observation, the intuition, the knowledge and the self-control are also quoted as having a very positive influence on the patient and the rise of his/her aggressiveness. With respect to the institutional resources, the care staff questioned named as the first institutional resource the care team (support from more experienced care personnel, sharing of different views, solidarity in moments of difficulty …). Several other methods are quoted to manage the violence: intensive care room, medical treatment, locking of the ward, safety measures (beep alarm system, calling for male reinforcements, calling for security staff), contact with the police and the law. The importance of coercive measures in the exercise of caring, underlines the question of the control and the negative impact of certain environmental factors such as the use of constraint. It reinforces the feeling, sometimes paradoxical, with patients that the nurses sometimes act contrary to the wishes of the patient. Thus, they ask questions about their role limits of and ethical interrogations when they don't have the possibilities of maintaining the framework envisaged by the patient.

3. The institutional management of violence risk is present but remains criticized. Nurses evoke the shortage of staff, which needs to be reinforced in the care teams. The question of the type of care staff is posed (e.g. Skill mixed staff), sometimes requiring the employment of more men.

4. Experiential knowledge and the quality of teaching about violence should be a priority in the basic nursing curriculum. Empirical knowledge remains an important element in the knowledge of violent problems, supported by the knowledge of the most experienced staff. Training on violence in the institutions care remains an essential training element for nurses but necessitates re-actualization of knowledge still today insufficient. Nursing staffs report a lack of preparation for the confrontation of violent situations in hospital context during the basic training.

Conclusion

The results of two independently studies conducted on in-patient's violence in psychiatric settings give rise to suggestions for nursing management. Difficulties experienced, and critical raised by nurses in clinical settings, should be heard and attended to by nursing managers. Healthcare professionals should receive more support in their complex and sometimes dangerous tasks. Nursing management should be more attentive to deviations in the nursing role at the times when "security" and "zero tolerance" are proclaimed and prioritized. Finally, nursing managers should reflect about education and promote the sharing of experiential knowledge about violence amongst nursing professionals.

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88. – Violence reduction strategies: a multidisciplinary collaborative effort to manage violence behaviour

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Keywords
Causes of violence, strategies to manage violence, milieu therapy, psychiatric hospital

Introduction/Background

Violent incidents are well-documented rising phenomena in mental health care settings. In 2004, the assault workgroup in a state psychiatric hospital in Singapore conducted a clinical practice improvement project to study patterns and incidents of assaults. The findings from this study showed that 43% of assaults occurred in the acute admitting wards and 57% of assaults occurred in long stay wards. In addition, such assaults occurred among 61% of both experienced and inexperienced mental health care staff. There was also a higher chance of assaults among young, inexperienced, mental healthcare staff.

Main Paper

The aim of this paper is to identify causes for violence and strategies to reduce incidences of violence.

Causes for Violence

The common causes for patient-to-patient violence are disagreement over issues, disputes over food/money/cigarette and past history of aggression and mental illness. With regards to patient-to-staff violence, disagreement over issues, unmet needs (e.g. outing/ phone calls/ food/ medication), altered behavioral patterns and mental illness were the main causes identified.

In terms of the number of assaults among nurses, healthcare assistants and health attendants, it can be seen in Table 1, that the number of assaults have decreased over the years. However, the institution would like to further reduce the number of incidents.

Grade	Number of Assaults in 2005	Number of Assaults in 2006	Number of Assaults in 2007
Nurses	58	45	48
Healthcare Assistant	17	9	5
Health Attendant	18	16	6
Total	93	70	59

Table 1: Comparison of assault on nurses, health attendants and health care assistants from 2005-2007

Identification of violent patients

The first step taken by the institution was to identify the following patients who have a higher risk of violence:

1. High-risk patients

Using the Electronic-Hospital Occurrence Report (e-HOR) system, the institution identified a list of high-risk patients, who were likely to be violent. Such a list enabled staff to be more vigilant. Other identifiers included letting these patients don orange colored T-shirts and placing green magnetic buttons against their names on the ward census board. Identified high-risk patients were also referred to psychiatrists for frequent regular reviews, intensive drug therapy and behavioral modification.

2. High-risk staff

Using the e-HOR, the institution also identified staff who have been assaulted at least twice or more within a month. It was found that young, female foreign, inexperienced staff who had difficulty communicating in Mandarin were likely to be assaulted.

3. High-risk Wards

After identifying high-risk patients and staff, the institution also identified high-risk wards, which included wards that had three or more violent incidents within a month.

4. High-risk situations

From the e-HOR data, the institution identified various situations and circumstances, which heralded violent behaviour. Aggression and violent incidents occurred during meals, bathing and medication time, over-crowding, interpersonal conflict over smoking, demand for the use of phones and outing.

Violence Reduction Strategies

In view of the identified causes, the following violence reduction strategies were introduced within the institution:

1. Milieu therapy including use of mural paintings

Milieu Therapy (MT) was introduced in November 2005 as a model of care for selected inpatient wards in the hospital. The institution envisages that through careful structuring of the social and physical environment, every interaction and activity thus becomes therapeutic for the patient.

The two acute wards on each floor level, which traditionally were managed as independent units, were merged into one entity under the management of a single team. One remained as the acute admitting ward to accept newly admitted disturbed patients and the other, converted into the therapeutic ward to support stabilized patients for MT. The MT wards were redesigned to incorporate a home-like living environment. Patient care activities, once conducted on an ad-hoc and needs basis, were planned under a multidisciplinary team effort, with each member of the team taking a specific time slot of the day to run targeted patient-focused educational and therapeutic activities. On a hospital-wide level, staff organized interesting mind-engaging daily patient social activities.

2. Fixed-on chairs in high-risk wards

From the e-HOR data in 2006, there were 14 violent incidents in which patients in the acute admitting wards used chairs in the dinning areas to hit or threw at their victims, resulting in serious head injuries. In view of these, chairs in the dining areas in these high-risk wards were fixed onto the floor.

3. Assault reduction training program, manual and posters

In an attempt to reduce the number of assaults, an assault reduction-training program was designed and conducted by the multidisciplinary team to train nurses on violence reduction techniques. Upon completion of the program, these nursing leaders imparted their knowledge to nurses in their respective wards. The program equipped healthcare staff with knowledge and skills on the management of violence and aggression. Various violence reduction techniques such as recognition of early warning signs of aggressive behaviors, de-escalation techniques, the assault cycle, and techniques of therapeutic communication were taught through active group discussion and role play in the program. In addition, assault reduction training manuals and posters were also issued to all departments to reinforce learning.

4. Disturbed, Aggressive and Violent (DAV) ward

A Disturbed, Aggressive and Violent (DAV) ward was set up to provide specific treatment care to patients who have recurrent aggressive or offensive behaviors, despite the provision of intensive psychopharmacological and behavioral interventions. Only patients with the following characteristics were considered for transfer to this ward:

- Patients who displayed aggressive behavior for at least three times over the past six months.
- Patients who were unmanageable in their current wards.

These patients would stay in the DAV ward for at least six months before they could be deemed fit for transfer back to their previous wards. This arrangement has also ensured the safety and well being of patients and staff in the high-risk wards.

Additional Strategies

Foreign and non-mandarin speaking staff were scheduled to attend "In-house Basic Conversational Mandarin" courses to improve their conversational skills with mandarin speaking patients and to help them gain a better understanding of their patients' needs.

In addition, soothing music, soft lighting and wall murals were used to create a calm and soothing environment for patients in non-milieu therapy wards. Besides these, staff were also encouraged to report all assault incidents occurred in the wards for quality improvement and learning purposes.

Results

The introduction of these strategies has improved the patients' physical, psychosocial and emotional environments. Together with consistent reinforcement of positive behaviour by the multidisciplinary team through psycho-education and active patient participation, patients were less agitated and more ready to participate in their treatment. The number of patient-staff assault incidents has reduced significantly from 93 cases in 2005 to 70 cases in 2006 and 59 cases in 2007 (refer to table 1).

In addition, as seen in Table 2, the incidences of violence in the MT wards have also decreased drastically from 64 cases in 2005 to 40 cases in 2006 and 14 cases in 2007.

Milieu Therapy Wards	Before implementation	After implementation	
	2005	2006	2007 (Jan – Jun)
Ward A	26	12	4
Ward B	17	10	5
Ward C	6	7	1
Ward D	15	11	4
Total	64	40	14

Table 2: Comparison of assaults before and after implementation of Milieu Therapy wards

In terms of patients' overall satisfaction about their hospital stay in these MT wards have also improved. Table 3 illustrates an upswing of patient satisfaction ratings using the Client Satisfaction Questionnaire 18B (CSQ-18B) (Attkisson & Zwick, 1982).

Year	Patients' Average Overall Satisfaction with Hospital Stay
2006 (Mar – Dec)	81.3%
2007 (Jan- Jun)	86%

Table 3: CSQ18B survey results on patients' average overall satisfaction with their hospital stay from 2006 - 2007

The CSQ-18B survey conducted in 2006 till date also showed positive outcomes in areas such as service standards, staff knowledge, environment, programme, patient rights and recommendation (refer to table 4).

Year	Service Standards	Staff Knowledge	Environment	Programme	Patient Rights	Recommendation
2006 (Mar – Dec)	80.2%	80.6%	76%	80.7%	85.4%	84.4%
2007 (Jan- Jun)	85.5%	85.6%	84.6%	85.6%	88.3%	87.2%

Table 4: CSQ18B survey results on patients' average overall satisfaction with their hospital stay from 2006 - 2007

However, as seen in Table 5, there is a slight increase in the number of reported assault incidents from 282 cases in 2005 to 297 cases in 2006. This increased might be due to an increased awareness of the e-HOR. Hence, more staff reported violent incidents at the institution.

Year	Nos. of Assaults
2005	282
2006	297
2007 (Jan- Jun)	142

Table 5: Comparison of patient-to-patients assaults from 2005 - 2007

Conclusion

Assault reduction is an ongoing process of learning and understanding the patterns of violence in patients with mental illnesses. Implementation of violence reduction strategies with multidisciplinary collaboration has to be well integrated to be able to reduce assaults and violence thus ensuring a safe environment for both the patients and healthcare staff.

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89. – The engagement model and the use of comfort rooms as a means to reduce aggression, seclusion and restrictive measures – results of a baseline study

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Keywords
restraint measures, seclusion, aggression.

The use of seclusion in psychiatry is a controversial issue in the Netherlands, especially for the last 10 years. In 1994, the Special Admissions act for Psychiatric Hospitals replaced the madness act of 1884. Restrictions in legislation have lead to an increase in seclusion and many other restrictive measures, as an effect of deleting the 'best will' criterion from the law. In 2005 Dutch authorities allocated funding for psychiatric hospitals to reduce seclusion use.
In a three-year prospective follow up study the effect of a therapeutic model on aggressive incidents and the use of seclusion and restrictive measures will be investigated. This model incorporates the engagement model and comfort rooms (Murphy & Bennington-Davis, 2005) as a means to reduce aggression, seclusion and restrictive measures. In this model, getting acquainted with experienced traumas in the patients' history is seen as a way to prevent arousal and in effect reduce chance on acting out and aggressive behaviour.

The first year constitutes a baseline. The baseline was done to assess the relation between possible determinants of restrictive measures such as age, sex, mental state, degree of aggression, personnel compilation and bed occupation with outcome as measured in a reduction of restrictive measures. In this year nurse training was focussed on assessment and raising consciousness with respect to reducing seclusion and using alternative restrictive measures. These primarily partially restrictive measures may be seen as preventive alternatives or substitutions for seclusion, being used to calm the patient before becoming dangerous, but also used to shorten the seclusion. In this year the comfort rooms but also the engagement model is yet to be implemented at a hospital level. This report provides a first analysis of the baseline data. We were interested in the next questions:
1. Which restrictive measures are applied?
2. How many patients are subject to these restrictive measures
3. How many aggression incidents occur?
4. To which extent are aggression incidents followed by restrictive measures?
5. Are background data related aggression incidents?
6. Are background data related restrictive measures?

Method

The nursing staff was trained in applying and recording the next fully restrictive measures: (1) seclusion according to protocol (2) confinement in a closed room and (3) fixation. Also a number of partially restirctive measures was recorded, such as: (1) holding, (2) complete visual contact, (3) staying in direct contact, or (4) providing intensive care. Many of these partially restrictive measures were applied directly after seclusion as part of the de-seclusion process. Often aggressive incidents preceded restrictive measures. Concurrently, two assessment instruments were applied to monitor aggression and application of restrictive measures: the staff observation and aggression scale (SOAS-r, Palmstierna & Wistedt, 1987) and the Argus daily register of restrictive measures (Janssen et. al, 2007), a simple instrument to monitor nurses restrictive interventions day to day basis.

Analysis

First, frequencies were calculated. Then the background data were compared by means of cross tabulation with the occurrence of aggression or restrictive measures. Finally, the background data were related to aggression and fully restrictive measures by means of linear regression.

Results

The study was conducted on 16 hospital wards covering 196 beds. In the six-month measurement period 756 admissions occurred in 492 different patients.

In this period 77 patients(16%) underwent some form of restrictive measure. 50 patients (10%) were secluded over a total of 516 days. 21 patients (5%) experienced confinement in their own or a specifically designed room over a total of 820 days. 12 patients (2%) experienced fixation over 262 days. Alternative measures were registered in 35 patients (7%) over 549 days. Both confinement and fixation often occurred in programs, spread over some time, with a mean duration of 40 for confinement and 21 days for fixation. Seclusion occurred in most of the instances (83% of the patients) for fewer than 2 days, while for four patients 178 scelusion days occurred, from 12 up to 63 days. The alternative measures were applied for fewer than 2 hours but were registered in 8 out of the 16 departments. A reliability check of the registration, however, showed the registration of the fully restrictive measures as seclusion, and confinement to be reasonably reliable (% agreement of 83% and 79%, a κ of 0.64 and 0,58), while the registration of fixation and alternative measures was much less (% agreement of 42% and 28%, a κ of 0.11 and 0,08).

In the same period 215 aggression incidents were registered. These 215 incidents occurred in 77 patients. The incidents concerned 147 verbally and 136 physically aggressive incidents. Again a few patients (n=8) were responsible for a large number of incidents (n=64), and especially the more severe incidents. In 40 cases the aggressive incident resulted in physical pain. In 54 cases the incident led to seclusion, accounting for approximately half of all aggression incidents. Of the other 53 aggression incidents, in 42 occasions force was used to expel the patient from a room, in 29 occasions confinement to their own room was agreed on. In the remaining 11 cases medication was applied as a measure. Apart from holding other alternative measures were not applied following an aggression incident. In total, of the 215 incidents, 83 lead to some restrictive measure.

Aggression occurred more often in men than in women (20% v.s. 10%, chi-q=7,6, p<0.0000). In contrast restrictive measures showed no level of agreement with any of the background data. No significant relation between aggression incident and application of restrictive measures apart from seclusion could be detected. Also, diagnosis proved to have no relation with seclusion, a finding in line with data previously gathered in this hospital, but contrary to other studies on seclusion reduction (Noorthoorn et al, 2007).

Regression analysis showed aggression incidents are related to predictors as male sex (β=0,27, p<0.001), time after admission (β=0,23, p<0.02) and admission duration (β=0,18, p<0.03). Seclusion was predicted by the diagnosis borderline (β=0,12, p<0.01), confinement by borderline (β=0,17, p<0.02) and female sex (β=0, 11, p<0.04). Fixation occurred in too few occasions to be related to determinants sensibly.

Aggression shows a powerful relationship with seclusion, especially when the aggression proved to be violent. Of the 50 patients secluded, 43 were involved in more than one aggression incident. Patients involved in aggressive incidents had 6 times more chance to be associated with restrictive measures than patients with no aggressions (OR 6,3,. P<0,000). This finding is in line with many other studies in the past (e.g. Nijman, 1997).

Discussion and conclusion

The baseline measurements show some interesting observations. Seclusion and alternative measures occurred folowing incidents and are applied in general for not many days in sequence. Fixation and confinement occurred predominantly as a part of long-term programmes. In a small number of patients seclusion occurs in a large number of days, from 12 up to 63 sequential days. Agression occurred in a comparible number of patients, again a majority of the incidents boil down to a very small number of patients. The baseline data show a concentrated group of patients should be focus of attention for preventive measures. In the presentation these results will be placed against the background of the main aim of the study, to reduce aggressive incidents and restictive measures by means of a change in attitude and ward culture.

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90. – A randomized clinical trial of schema focused therapy in forensic PD patients

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Introduction

Personality disorders (PD) are very common in forensic populations; prevalence is especially high for cluster B and paranoid PDs (Arseneault, Moffitt, Caspi, Taylor & Silva, 2000; Stadtland, Kleindienst, Kroner, Eidt & Nedopil, 2005). In Dutch TBS clinics[III] two thirds to 90% of the patient population has a DSM-IV personality disorder (de Ruiter, & Greeven, 2000; Hildebrand & de Ruiter, 2004; Timmerman & Emmelkamp, 2001). Personality disorders are often linked with a poor outcome to all different kinds of therapy (Hemphill, Hare, & Wong, 1998; Hiscoke, Langstrom, Ottosson, & Grann, 2003; Jamieson & Taylor, 2004). Recent research shows only limited effect of standard cognitive and behavioural approaches in forensic PD patients (Reid & Gacono, 2000; Timmerman & Emmelkamp, 2005). For example, in a recent British study, forensic patients with personality disorders were seven times more likely to have a subsequent serious offence after release from a high security hospital, compared to patients with other psychiatric problems (e.g., schizophrenia) (Jamieson & Taylor, 2004).

New developments in treatments for personality disorders hold promise for the treatment of forensic patients. Young (1999) designed a new treatment model he referred to as schema-focused therapy [SFT] as a potential treatment for personality disorders that are difficult to treat. SFT is an integrative form of psychotherapy combining cognitive, behavioral, psychodynamic object relations, and humanistic/existential approaches (Young, 1999; Young & Flanagan, 2000; Young, Klosko & Weishaar, 2003). Schemas and early maladaptive schemas [EMS] are the key elements. EMS's encompass themes about oneself and one's personal relationships and can, when triggered, evoke powerful emotions, such as sadness, fear, and anger. Patients with severe PDs often switch rapidly between these emotional states. The original SFT model was developed as a treatment for patients with a personality disorder seen in psychiatric ambulatory treatment facilities. Over time, Young found that standard SFT techniques emphasizing EMS's and coping responses were of limited effectiveness in treating severe personality disorders (Bernstein, Arntz & de Vos, 2007; Young et al., 2003). Young's solution was to develop a more manageable and effective alternative for treating these shifting emotional states: the Schema Mode model (Young, et al., 2003). Schema Modes are defined as the emotional state or "part of the person" that dominates a person's thoughts, feelings, and behaviour at a given moment in time (Young et al., 2003).

Most forensic hospitals offer cognitive-behavioural treatment, but very few outcome studies have been conducted evaluating the treatment outcome for forensic patients with severe PDs by using a longitudinal design (de Ruiter & Trestman, 2007). Thus effect studies into improvement of treatment for forensic patients with personality disorders should be a priority. Recently in a multi centre randomized clinical trial (RCT) that was completed in the Netherlands, patients with

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III   *Ter beschikking stelling (TBS) can be translated as 'disposal to be treated on behalf of the state'. This means that mentally disorded offenders are sentenced by court of law to involuntary treatment at a forensic psychiatric hospital. The TBS order's primary aim is to protect society from offenders with unacceptably high risks of recidivism, directly through admission to a secure forensic psychiatric setting, and indirectly through the treatment provided there (De Vogel, de Ruiter, van Beek & Mead, 2004; Hildebrand, 2002; Hildebrand & de Ruiter, 2004; Hornsfeld, 2004; Ullrich, Borkenau, & Marneros, 2001).*

Borderline PD who were given SFT showed substantial improvements in their symptoms and functioning over a three-year course of treatment, as well as over the one year follow-up (Giesen-Bloo et al., 2006). These results suggest that SFT is an effective treatment for Borderline PD. This raised our question if it may also be effective in treating this disorder and other PDs in forensic patients. It was in this spirit that we undertook the project of adapting and testing the efficacy of SFT methods in forensic patients with personality disorders.

For the past two years, we have been working with treatment professionals in the Netherlands to adapt and integrate SFT in their work with forensic patients. We discovered that ambulatory personality disorder cases overlap only partially with forensic personality disorder patients; in the latter group, issues such as violence, deception/manipulation, remorselessness, and addiction are far more salient. Based on our experience and collaboration, we have developed a forensic adaptation of SFT that includes the addition of four "forensic modes" that appear to be common in forensic patients. The 4 new modes are Angry Protector Mode, Predator Mode, Conning and Manipulative Mode, and Over-Controller Mode (Obsessive and Paranoid subtypes) (see table 1).

Table 1 Forensic Modes

Angry Protector Mode	a state in which a patient uses anger to protect himself from perceived threat or danger, creating a "wall of anger" to keep the threat at a safe distance
Predator Mode	a state in which a patient focuses on eliminating a threat, rival, obstacle, or enemy in a cold, ruthless, and calculating manner
Conning and Manipulative Mode	a state in which a patient cons, lies, or manipulates in a manner designed to achieve a specific goal, which either involves victimizing others or escaping punishment. The patient may assume a false identity, give misleading information, or behave in a seductive, manipulative, or theatrical manner, to achieve his ends.
Over-Controller Mode	a state involves a narrowing of attention along with obsessive rumination in an attempt to protect oneself from a perceived threat.
Obsessive subtype	In the Obsessive subtype, the patient attempts to control a source of danger through the use of order, repetition, or ritual.
Paranoid subtype	In the Paranoid subtype, the patient attempts to seek out and therefore control a source of danger or humiliation, usually by locating and uncovering a hidden (perceived) threat.

In our study, we will test the efficacy of SFT in forensic patients with 4 severe personality disorders – Antisocial (ASPD), Narcissistic (NPD), Borderline (BPD), and Paranoid (PPD) -- in ameliorating personality disorder symptoms and reducing risk of criminal and violence recidivism.

Methods

The study design involves one hundred male patients with above mentioned disorders and will be recruited from several TBS clinics in the Netherlands. Inclusion criteria are; detention at a TBS institution and main diagnoses of ASPD, BPD, NPD and PPD. General exclusion criteria are current psychotic symptoms, schizophrenia or bipolar disorder, current drug or alcohol dependence, low intelligence (i.e., IQ < 80), serious neurological impairment, autistic spectrum disorder and paedophilia (fixed type). These disorders were excluded because they generally need primary treatment.

Patients will be randomly assigned to receive either SFT or Treatment as Usual (TAU). Randomization was performed after the adaptive biased urn procedure and was done by an independent researcher (Schouten, 1995). TAU is defined as the customary treatment at that

facility, which is typically a form of cognitive-behavioural, psychodynamic, or humanistic psychotherapy. Patients receiving SFT will be given psychotherapy session twice a week, which is the recommended "dose" of SFT for patients with severe personality disorders (Giesen-Bloo, et al, 2007; Young et al., 2003). Patients receiving TAU will receive psychotherapy once a week, because this is the customary practice at TBS institutions. Patients in both groups will be given 3 years of psychotherapy.

The participants will be assessed at the beginning of treatment and every 6 months for the duration of the study. To circumvent the problem of patients' tendency to "fake good" we will establish our assessments primarily on observations of patients' behaviour provided by knowledgeable staff members, rather than on patients' own self-reports.

The primary outcome measures in this study are the severity of personality disorder symptoms and risk of recidivism and violence (measured with the HCR-20 and START). Our main outcome instrument is the Schedule for Non-adaptive and Adaptive Personality ([SNAP], Clark, 1993). We adapted (in agreement with the authors) this version for forensic purposes and created a patient and informant version; only the items referring to the main four personality disorders selected in this trial were taken into account.

We hypothesize the patients receiving SFT will show reduced levels of personality disorder symptoms and reduced risk of violence and recidivism, compared with patients

Results

In the first six months of 2007 we recruited N = 27.

Conclusion/Discussion

SFT may provide a more effective alternative treatment for forensic patients with personality disorders. This approach may provide a conceptual framework and set of interventions for managing the fluctuating emotional states of personality disorder patients. In some instances, these temporal sequences of unfolding schema modes may help to explicate the events leading up to and culminating in the commission of crimes (Bernstein, Arntz & de Vos, 2007).

The proposed additions and adaptations to the SFT conceptual model may help to contribute to the development of more evidence based forensic treatment. If SFT, proves to be an effective treatment, it would have important implications for treatment of forensic patients in the Netherlands and internationally. Successful treatment of this population would reduce the risk of violent and criminal recidivism.

In a future follow-up study, we will determine the actual recidivism rates of the patients enrolled in our current study, after some of them are released to the community.

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91. – Prevention of aggressive incidents on acute psychiatric wards

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Objective

This study assessed the effectiveness of a programme based on Animal Assisted Activities (dog) in the prevention of aggressive behaviours of adult patients at moderate or high risk of violence, who were hospitalized in two psychiatric wards of a Universitary Hospital, Portugal.

Methodology

Quasi-experimental study. Sample: 52 patients, 26 in the experimental group and 26 in the control group, with homologous socio-demographic and clinical characteristics. Eligibility criteria: age: 18-65 years old; moderate or high risk of violence; internment forecast over 3 weeks; ineligibility criteria: phobia and/or allergy to dogs. The programme included 6 visits by a dog, 2 sessions per week, 15 minutes each; each session involved two selected patients, The handle and a nurse specialised in P.M.H. (Psychiatric and Mental Health). Assessment during: aggressive behaviour (Staff Observation Aggression Scale-Revised: SOAS-R; Nijman, 1999). Statistics tests used in data analysis: non-parametric tests: Chi-squared, Fisher, Mann-Whitney U.

Results

The experimental group displayed less aggressive behaviour which was less severe and had fewer consequences for the people involved and required less control by means of medication.

Conclusions

The programme was effective in the prevention of aggressive behaviour in the psychiatric context, producing a safer and more humane therapeutic atmosphere with less use of medication.

Introduction

The phenomenon of violence in the psychiatric context is a reality. It is understood to be an incident in which professionals are physically threatened and attacked in their workplace, implicitly or explicitly involving changes in their safety, well-being or health[1]. It is most frequent in short term psychiatric units [2], [3]. Around 10% of psychiatric patients develop aggressive behaviour towards professionals[4]. This is most often observed amongst younger patients[5], those who are seriously ill[6] or confused, those who do not accept medication[7], those with a criminal history, those who are socially mal-adjusted or

are substance abusers[8] and those who are dysfunctional in their experience and expression of anger[9]. Different models of intervention have been implemented with a view to preventing and controlling this phenomenon, for example, psycho-pharmacological and psychosocial interventions which sometimes involve using restrictive measures. However, prevention also involves recourse to prophylactic measures as well as the control of environmental and communicational stress according Nijman3 which may be reduced by means of activities suited to the patients' capacities and necessities including Animal Assisted Activities (AAA).

These activities were conceived to provide well being and quality of life to the beneficiaries[10] (Delta Society[IV]) by providing stimuli of pleasure and joy[11]; they are undertaken by a specifically trained volunteer/animal team who operate in different contexts. In psychiatric contexts they have the potential to influence change in the behaviour of hospitalised patients: emotional levels and social skills[12,13].

A study undertaken in a psychiatric unit for patients suffering from dementia[14] identified differences in the effects produced by visit from a dog, namely a reduction in the incidences of violence and improvement in social skills.

A programme based on AAA, more particularly on the visit of a dog to patients hospitalised in a psychiatric context with violence risk factors[V], may contribute to a change in aggressive incidents, providing a safer therapeutic environment. Given the importance and relevance of the subject and since, to our knowledge, no studies of this nature have been carried out in Portugal, a study designated "Animal Assisted Activities (dog) in the prevention of violence in short term psychiatric units" was undertaken; this was based on the hypothesis that it would reveal changes in the behaviour of selected patients, namely in aggressive behaviour.

Methodology

A quasi-experimental study was undertaken involving two groups (Experimental group and control group).

Sample

The participants were patients hospitalised in two short term psychiatric units, one for men and the other for women, belonging to a Teaching Hospital, selected according to the following eligibility criteria: aged between 18 and 65 years old, moderate or high risk of violence (according to the assessment obtained from the Aggression and Violence Assessment Scale [15]), internment forecast over 3 weeks and non-eligibility criteria: phobia and/or allergy to dogs, unwilling to participate, having been included in the study during an earlier phase.

Of the 52 people selected the first two cases assessed were assigned on a weekly basis to the experimental group and the second to the control group (26 people in each group). Thus, in the experimental group, the procedures were undertaken in 13 pairs.

Both groups compare in terms of socio-demographic and clinical characteristics (Table 1).

Instruments

The Aggression and Violence Assessment Scale was conceived to assess the risk of violence which a person with psychiatric problems may present during their hospitalisation 20. It takes the following factors into consideration: history of violence, history of recent aggression, history of aggression in family of origin, situation in terms of substance abuse, distrust/hostility, impulsiveness, arousal and orientation. Each factor includes items which are assessed on a scale with three levels: level 0 – of no concern, level 1 – moderate risk and level 2 – high risk.

Staff Observation Aggression Scale - Revised: SOAS-R3. This is an instrument which permits the systematised register of aggressive incidents and their characterisation. It contains five components: aggression triggers, means used by the patient to commit aggression, target of aggression, consequences for the victim and intervention used to control the aggression. The

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IV   One of the biggest organisations responsible for the certification of animals involved in therapeutic programmes.
V   Static and dynamic (Scott & Resnicck, 2002)

incidents are then classified according to Heinze[16] as "mild" (1-7 points), "moderate" (8-15 points) and "serious" (16-22 points). These records are completed by the professionals who witnessed the incidents immediately after bringing the situation under control.

Procedures

The Animal Assisted Activities (dog) programme included group activities with two hospitalised patients based on a visit from a dog with a view to promoting contact with the animal and interaction with its partner. The sessions included the dog trainer and a nurse specialised in Psychiatric and Mental Health (the researcher). Each group was visited by the dog twice a week resulting in six sessions over three weeks. Each session lasted 15 minutes. Some objects were used in the sessions: balls, dolls, brush and clicker[VI].

Bearing in mind the structural and functional conditions in each unit selected and given the recommendations made in the international regulations[17] especially with regard to ensuring the safety and comfort of those involved, the required resources were selected for the implementation of the programme; each unit provided access to similar conditions: room, equipment, lighting, temperature, sound.

The team (volunteer/dog) were certified to carry out AAA in a health context by the Associação Portuguesa para a Intervenção com Animais de Ajuda Social called Ânimas with its head office in Porto. The chosen dog had the following characteristics amongst others: Labrador Retriever, female, four years old, yellow, calm, tolerant and playful. Special mention goes to the following characteristics of the volunteer: availability, trained and professional experience as a trainer.

Before signing the consent form to participate in the study the selected patients were informed about the programme and involved in the assessment planning. They were also introduced to their partner and to the team (volunteer/dog) before beginning.

Data was collected before, during and after the programme was implemented. Initial assessments were undertaken from Friday through to Sunday and final assessments were undertaken on Wednesday and Thursday in accordance with the schedule established previously during interview with the patients and based on the sources of information necessary for their undertaking.

In order to complete the Staff Observation Aggression Scale – Revised Nijman 3 some information regarding recording and codification was supplied to the nurses (potential witnesses).

After the selected instruments were implemented the data obtained was analysed using the statistical software SPSS 11.5. Tests which permitted comparison between groups were used: T- student for independent samples, Chi-Squared, Fisher and Mann-Whitney.

Results

Aggressive behaviour. Of the 52 patients selected, 17 displayed aggressive behaviour (6 from the experimental group and 11 from the control group) (Table 2). An analysis of the characteristics of the behaviour displayed (Table 3) reveals the following results:

Frequency.

The patients from the experimental group (6; 100.00%) did not repeat aggressive behaviour whereas most of the cases in the control group did (54.50%), reflecting a statistically significant difference between the groups (p=0.043) in terms of the patients who did not benefit from the programme repeating aggressive behaviour more often during hospitalisation.

Nature

No statistically significant differences were observed in the different components with the exception of the consequences for the victim in which the consequences were less in the experimental group (16.70%) than in the control group (72.70%); this was particularly true for the consequences to the people involved in which significant differences were revealed between the groups (p=0.050)

VI   An instrument used by the trainer to ensure good behaviour from the dog during the sessions.

and also for the measures used for aggression control, especially pharmacological measures which were less used in the experimental group (16.70%) than with the patients from the control group (72.70%), revealing differences in the threshold of significance (p=0.050).

Severity.
The results obtained show that of the 6 subjects from the experimental group who displayed aggressive behaviour, 4 were recorded as mildly serious, 3 as moderately serious and none as very serious (p=0.028). Using the Mann-Whitney test, significant differences were also revealed on the SOAS-R scale (p=0.015).

Discussions

The results revealed some differences between the two groups especially in terms of the frequency, nature and severity of aggressive behaviour. More specifically, in terms of frequency, it is possible to state that the subjects in the experimental group created less incidents that those in the control group, reflecting statistically significant differences between them with patients who did not benefit from the AAA (dog) programme repeating aggressive behaviour more often during hospitalisation. The importance of this programme is therefore highlighted since its objective was to prevent aggressive behaviour. These results are in keeping with some studies carried out in this area given that they have revealed their efficacy in preventing violent incidents particularly in psychiatric contexts 18, 19; they reinforce the usefulness of the AAA which were conceived in the same context with a view to creating and helping to develop self control in the individual[18].

In terms of the nature of the aggressive behaviour, it may be stated that the results obtained were similar in the two groups in almost all the components except the component related to the consequences for the victims; it was verified that the aggressive behaviour displayed by the subjects in the experimental group produced less consequences for the people involved and required less control through medication; both these aspects revealed statistically significant differences.

Various studies have been undertaken to evaluate the efficacy of intervention programmes of differing natures with the same objective. For example, Hamilton[19] (1992) considers that there are very efficient sedative and tranquilising medications removing the need to recourse to physical restraint and helping the patient develop self control. On the other hand, Nijman et al. [20] undertook a quasi experimental study with a view to evaluating the efficacy of a programme based on verbal strategies[VII] in the prevention of aggressive incidents in three closed wards. Aggressive incidents before and after the intervention were monitored during 3 months using the same Staff Observation Aggression Scale-R. Before using the programme it was noted that the incidents recorded were serious. The programme was implemented during one month and in the following period a decrease in the frequency and severity of aggressive incidents was recorded.

The study carried out by Needham & Abderhalden[21] in Germany and Switzerland with a view to evaluating the efficacy of a training programme for nurses also produced results which promoted a reduction in aggressive incidents and also a decrease in the use of restrictive measures to control them.

In terms of the severity of the incidents, it was noted that the average seriousness of the aggressive behaviour displayed by the experimental group was inferior to that of the control group revealing statistically significant differences.

In terms of reinforcing the efficacy of the programme under assessment it seems relevant to stress that the results found may suggest that AAA (dog) in these kinds of contexts are efficacious in changing aggressive behaviour. In effect, violent incidents have constituted a considerable challenge for Psychiatric and Mental Health professionals on account of the associated risks and the problems that arise in their management. Apart from the physical and psychological consequences there are also financial implications[22].

Nevertheless, the interpretation of the results takes some limitations into consideration. Amongst the study's limitations special mention goes to its methodological design on account of

VII By Kalogjera and collaborators (1989)

the complexity of the variables studied and their measurement, the choice of field of research, the number of participants and the data analysis and processing.

With regard to the variables studied and their measurement, the limitations are related to the need to use strategies for clinical and psychological information gathering; the implementation of these strategies required the participation of professionals, as was the case in the observation and recording of aggressive behaviour. These were naturally influenced by the subjective area of the variable and by personal disposition towards filling in the forms.

The limitations related to the conception of the programme are related, on the one hand, to the constitution of pairs for both the groups implying the existence of failed couples on account of one of the members wishing to withdraw and, on the other, to the functionality/availability of the team (volunteer/dog).

Conclusions

In terms of the efficacy of the AAA (dog) programme in the psychiatric context, special mention goes to the results obtained in the prevention of aggressive behaviour especially in terms of decreased frequency and the nature of the behaviour (less consequences and less use of control medication). The results obtained by the experimental group which benefited from the programme also stand out with regard to the diminishment in the state of anger. The promotion of a safer, more humane and less costly therapeutic atmosphere should also be highlighted.

New avenues may emerge for further studies geared towards the evaluation of the efficacy of this kind of programme in psychiatric contexts following a similar methodological design at least in terms of the use of instruments that permit the comparison of results.

Table 1: Comparison of Group Characteristics

Socio-demographic characteristics		Experimental group (n=26)		Control group (n=26)		Comparative Tests
		Mean	sd	Mean	sd	
Age (years)		35.92	13.18	34.54	9.84	$t=.429$; $p(50)=.670$
		n	%	n	%	
Sex	Male.	12	46.20	12	46.20	$\chi(1)^2 =.000$; p=1.000
	Female.	14	53.80	14	53.80	
Civil Status	Married+de facto union	3	11.60	9	34.60	a) $\chi(2)^2 =4.558$; p=.102
	Single	18	69.20	15	57.70	
	Widowed+separ-ated+divorced	5	19.20	2	7.70	
Education	Basic	13	50.00	14	53.80	$\chi(2)^2 =1.141$; p=.565
	Secondary	6	23.10	8	30.80	
	Higher	7	26.90	4	15.40	
Occupation	Specialised, managerial jobs…	5	19.23	5	19.20	$\chi(2)^2 =.111$; p=.946
	Non-specialised jobs	7	26.92	6	23.10	
	Unskilled, unemployed, retired	14	53.85	15	57.70	

Clinical characteristics		Experimental group (n=26)		Control group (n=26)		Comparative Tests
		n	%	n	%	
Means of admission	Consult.+transf.	3	11.54	3	11.54	a) $\chi(2)^2$ =.168; p=.919
	Emergency	20	76.92	19	73.08	
	Legal	3	11.54	4	15.38	
Prior hospitalis-ation	Yes	20	76.92	20	76.92	$\chi(2)^2$ =.000; p=1.000
	No	6	23.08	6	23.08	
Risk of violence	Moderate	23	88.46	26	100.00	b) Fisher p= .235
	High	3	11.54	0	0.00	
(First) Medical diagnosis	Psychotic disturb.	14	53.84	12	46.16	a) $\chi(2)^2$ =.821; p=.663
	Emot. disturb.	10	38.46	10	38.46	
	Other disturb.	2	7.70	4	15.38	

a) Some expected frequencies fall below 5;
b) The Fisher test was used as the Cochran conditions for the implementation of the χ^2 test did not exist.

Table 2: Comparison of the groups in terms of the number of individuals who displayed aggressive behaviour

Aggressive behaviour	Experimental group (n=26)		Control group (n=26)		Differences between the groups
	n°	%	n°	%	
Yes	6	23.10	11	42.30	χ^2 (gl=1) = 2.185
No	20	76.90	15	57.70	p = .139

Table 3: Comparison of the groups in terms of aggressive behaviour characteristics

Aggressive behaviour characteristics		Experimental group (n=6)		Control group (n=11)		Comparative Tests a)
		n°	%	n°	%	
No. of displays of aggressive behaviour						
	1	6	100.00	5	45.50	Fisher p=.043
	> 1	0	0.00	6	54.50	
Description: Types of provocation						
Other patients	Observed	1	16.70	2	18.20	Fisher p=1.000
	Not observed	5	83.30	9	81.80	

Aggressive behaviour characteristics		Experimental group (n=6)		Control group (n=11)		Comparative Tests a)
		n°	%	n°	%	
Help in satisfying basic needs						
	Observed	0	.00	1	9.10	Fisher p=1.000
	Not observed	6	100.00	10	90.90	
Refusal of patients' requests by professionals						
	Observed	1	16.70	6	54.50	Fisher p=.304
	Not observed	5	83.30	5	45.50	
Ordering the patient to take the medication						
	Observed	1	16.70			Fisher p=.333
	Not observed	5	83.30			
Description: Means used by the patient to commit aggressive act						
Verbal	Observed	5	83.30	11	100.00	Fisher p=.353
	Not observed	1	16.70	0	.00	
Parts of the body+common objects						
	Observed	2	33.30	8	72.70	Fisher p=.353
	Not observed	4	66.70	3	27.30	
Description: Target of the aggression						
Nurses	Observed	5	83.30	10	90.90	Fisher p=1.000
	Not observed	1	16.70	1	9.10	
Others (patients+other professionals+family members)						
	Observed	1	16.70	7	63.60	Fisher p=.131
	Not observed	5	83.30	4	66.70	
Description: Consequences for the victim						
Objects	Observed	1	16.70	0	.00	Fisher p=.353
	Not observed	5	83.30	11	100.00	
People	Observed	1	16.70	8	72.70	Fisher p=.050
	Not observed	5	83.30	3	27.30	
Description: Means used to control aggression						
Non-restrictive measures						
	Observed	5	83.30	6	54.50	Fisher p=.333
	Not observed	1	16.70	5	45.50	

Aggressive behaviour characteristics		Experimental group (n=6)		Control group (n=11)		Comparative Tests a)
		nº	%	nº	%	
Restrictive measures	Observed	2	33.30	8	72.70	Fisher p=.162
	Not observed	4	66.70	3	27.30	
Administration of medication						
	Observed	1	16.70	8	72.70	Fisher p=.050
	Not observed	5	83.30	3	27.30	
Severity: Classification (Heinze, 2000)						
	Mild	4	66.70	1	9.10	b) Fisher p=.028
	Moderate	2	33.30	6	54.50	
	Serious	0	.00	4	36.40	
		Mean	sd	Mean	sd	
SOAS-R (Nijman, 1999)		6.33	5.35	14.18	4.95	c) Mann-Whitney U=9.000 p=.015

a) The Fisher test was used as the Cochran conditions for the implementation of the $\chi 2$ test did not exist; b) calculation based on the fusion of the levels of moderate and serious severity; c) significant for $\chi <. 05$

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92. – Workshop 13 – Legislation and practice of coercive measures during in-patient treatment in 15 European countries: Results of a case vignette study

**(part 1) in-patient scenarios &
(part 2) outpatient scenarios and
(part 3) summary**

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Background and aims

Patients who exhibit violent behaviour or refuse medication during in-patient treatment are a challenge for clinical management. The management of those clinical situations is different in European countries with respect to legislation and clinical routine. Little is known about the discrepancies between legal predispositions and day-to-day practice.

Methods

We selected three case vignettes, which were considered as most typical and relevant by a vote among members of the European Violence in Psychiatry Research Group (EViPRG). Case 1 represents a voluntary in-patient who assaults a staff member, case 2 an involuntary patient who does not behave violently but refuses medication. Case 3 represents a community patient who stopped medication, refuses to see services and has become aggressive towards his carer. In all three case vignettes the respective patients were presented as suffering from schizophrenia or mania. From each of the 15 European countries, at least two experts were interviewed with a questionnaire about the typical clinical management and its legal requirements in these cases. Consensus among the country experts was reached after further discussion, if necessary.

Results

Considerable differences were found with respect to involvement of jurisdiction and police, requirements for a transfer to forensic psychiatry, and use of coercive measures. Application of involuntary medication is allowed across all countries. Use of intravenous medication is rare. Physical restraint, seclusion, and mechanical restraint each are common in some countries and forbidden or definitely not used in others. Mechanical restraint is not allowed across the British Isles. Net beds are only allowed across German speaking countries (D,A,CH,LUX). Most countries have some kind of community provision and in practice allow various options to access help for relatives.

Conclusions

Different traditions and a dearth of data may contribute to the enormous variety of practice and legislation across Europe. A variety of interpretations of national legal provisions seem to exist even within the same country. More evidence from sound studies is required regarding safety, outcomes and ethical aspects of coercive treatment. This may increase understanding and offer alternatives to patients.

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93. – Self-Efficacy in self- management programs to prevent aggression in children with a psychiatric disorder

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Keywords
children, anger, aggression, self-efficacy, self-management, prevention

Introduction

An unpublished literature review on self-management of aggression in children and adolescents with a psychiatric disorder indicated that interventions aiming at aggression prevention have a limited long-term effect. Many of these interventions contain aspects of social cognitive theory in which self-efficacy plays a central role. According to Bandura (1997), self-efficacy refers to the belief in one's capabilities to organize and execute actions to achieve desired goals. Self-efficacy can be used as a predictor for success, which increases motivation and further enhances one's self-efficacy.

Lorig and Holman (2003) indicate that self-efficacy plays an important role in the effectivity of self-management programs for patients with a chronic disease. Psychiatric disorders are mostly of a chronic nature, and interventions that teach children how to manage their anger in order to prevent aggression can be regarded as interventions improving self-management capabilities. We therefore hypothesize that adapting these interventions to the individual child based on the child's self-efficacy, increases success experiences and motivation to self-manage anger, which improves the long-term effect of these interventions.

An instrument to measure self-efficacy for anger management of these children was not available. The objective of the study presented in this paper is to develop an instrument that measures self-efficacy for anger management capabilities of psychiatrically disordered children, 8 - 12 years old, who are treated for aggression. The following research questions had to be answered: (1) which skills do these children learn during anger management interventions, and (2) which situations and factors affect the application of these skills in these children's everyday life?

Method

A methodological research design was used to explore the concept of self-efficacy with respect to anger management. The design incorporated development steps as suggested by Maibach and Murphy (1995).

Therapists who carry out anger/aggression intervention programs for children and adolescents in 60 mental health care institutions throughout The Netherlands were asked to fill out questionnaires about the intervention program they used. From these questionnaires relevant anger management skills were identified. In addition, therapists were interviewed to collect detailed information about situations and factors that affect children's abilities to manage anger. The interviews (n=7) were audiotaped and transcribed.

Content analysis of the questionnaires and transcriptions of the interviews was performed in winMAX pro 98 through coding of text fragments. Based on this analysis, items were generated for the new self-efficacy instrument.

Two 'normal' children who were not treated for aggression reviewed an initial concept of the instrument for comprehensibility. The resulting instrument was pre-tested for comprehensibility by children from the target population (n=10), who were selected by the therapists that also took part in the interviews. Comprehension was determined by the therapists based on clinical experience with the child and whether the child needed an explanation before answering the question that corresponded to the instrument items.

Results

Apart from institutions that indicated that they did not have a special anger management program for children (n=12), more than half of the institutions (n=29) returned the questionnaire. From the questionnaires the following skills relating to anger management were identified:

- recognizing potential aggression triggering situations;
- relating events, thoughts and emotions to one another;
- estimating someone's intentions;
- recognizing your own contribution;
- coming up with alternative behaviors;
- predicting the consequences of your behavior;
- determining whether your behavior is fitting;
- thinking stepwise;
- recognizing physical signals;
- naming physical signals;
- recognizing counter-productive thoughts;
- holding yourself back;
- asking for help;
- moving away from a situation;
- expressing anger in an acceptable manner;
- maintaining self-control;
- judging your behavior afterwards.

These skills could be divided into the following 4 categories: (1) prevent getting into situations in which anger may arise, (2) recognizing your own anger, (3) managing your anger appropriately, and (4) reflecting on situations in which anger arose or could have arisen.

During the interviews these skills were presented to the therapists for confirmation. Situations that the therapists mentioned most as a trigger for aggression are: not getting what you want, being or feeling challenged, being told to do something, and being teased, bullied or called names. According to the therapists, factors that affected the children's abilities to effectively manage their anger were, amongst others: fear, fatigue, a feeling of unfairness, and a feeling of insecurity or unclear expectations.

Based on these data a 25-items self-efficacy measuring instrument was developed containing questions through which the level and strength of self-efficacy can be assessed. These questions relate to situations in which the child is not angry yet, is angry, and had been angry. The scale is called Self-Efficacy Scale for Anger Management Evaluation (SESAME) and is in Dutch. Some translated item examples are:

- How well do you recognize situations that could make you angry?
- How well do you recognize that you are angry?
- How well can you tell someone why you were angry and what you did when you were angry?

Most items have short vignettes that describe challenging situations followed by a question. Some examples are:

While you are playing a girl bumps into you.
How well can you determine if she has bad intentions?

You are angry because someone is calling you names.
How well can you walk away without doing something nasty?

You are angry because someone is disturbing you.
How well can you tell the child that it is disturbing without doing something nasty?

The strength dimension of self-efficacy is measured on a 5-points semantic scale supported by pictorials. A thumbs-up picture is used that increases in size, as suggested by Van der Bijl and Shortridge-Baggett (2001). The bigger the thumb, the higher the self-efficacy. The scale ranges from "Maybe I cannot do that" through "I'm not very good at that", "I'm slightly good at that", "I'm quite good at that' to "I'm very good at that".

All of the children who took part in the pre-test were boys. Two were 8 years old, one was 9, six were 10 years old, and one was 11. No major issues were identified concerning clarity and readability of the items. Half of the children used all options of the strength scale at least once, including the lower strength option "Maybe I cannot do that".

Discussion

From the returned questionnaires it was clear that they described interventions for both children and adolescents. However, no major differences were found between skills that are taught to children and skills taught to adolescents. Most skills were of a cognitive nature, and not all of those skills were included in the instrument. For example, being able to determine whether your behavior is fitting for a given situation is necessary to predict the consequences of that behavior. Knowing what is fitting or not constitutes knowledge. Because self-efficacy concerns organization and execution of actions, and not constraints like the availability of knowledge, such skills were not included in the instrument. This applies to 'determining whether your behavior is fitting', 'relating events, thoughts and emotions to one another', and 'naming physical signals'.

Although the response to the questionnaires was high, it is possible that institutions that did not respond teach the children other skills than those included in the instrument. Personal contact with the therapists via e-mail and telephone, however, gave no reason to suggest that they actually do teach different skills.

A limitation of this study is that therapists, rather than the children themselves, were interviewed to gather information about situations and factors that affect the children's ability to apply the anger management skills in everyday life. To increase the likelihood that the children do recognize the instrument items, only those situations and factors were used that were mentioned most, i.e. mentioned by more than half of the interviewees.

Although the sample of children in the pre-test was small, the results were encouraging. Before the instrument is clinically used, however, extensive testing for validity and reliability is required.

Once validity and reliability have been established, its contribution to the long-term effect of anger management interventions can be studied longitudinally.

After validation, the self-efficacy instrument developed in this study may be useful for therapists who are involved in anger management programs for psychiatrically disordered children treated for aggression. Clinical application of the instrument is best started individually for each child. This provides the opportunity for the child to acquaint itself through a guided instruction example, and for the therapist to explain items that may not be entirely clear to the child. Based on the measured self-efficacy the anger management program can be tailored to the child's weakest skills.

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94. – The role of cognitive distortions on the effect of Aggressive Replacement Training (ART) on adolescents; mediator or moderator? – Preliminary findings

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Keywords: adolescents; aggression; behavioral problems; cognitions; training

Background

Social Information Processing Theory (SIP) [1] presents a model which explains how early socialization experiences result in a pattern of information processing associated with aggressive behavior in adolescence and adulthood. Different forms for learning experiences (e.g., observational learning, operant conditioning, respondent conditioning) are seen as causal factors in the development of cognitive distortions and maladaptive behavior.

Following cognitive dissonance theory [2, 3], after certain forms for maladaptive behavior have been established, to avoid cognitive dissonance between maladaptive behavior and own attitudes and cognitions, new cognitive distortions may emerge. Hence, a self-supporting system of behavior and attitudes / cognitions may have become apparent.

Figure 1: Model on the development and maintenance of maladaptive behavior based on cognitive behavioral theory

Also in the development and maintenance of aggression and delinquency, antisocial / procriminal attitudes and cognitive-emotional states are seen as significant factors [4]). According to Gibbs [5]), moral judgment of antisocial adolescents is developmentally delayed. Gibbs and Potter describe four different kinds of cognitive distortions [6]: (1) Self-Centered, (2) Blaming Others, (3) Minimizing/Mislabeling and (4) Assuming the Worst. Based on this model of cognitive

distortions, Barriga and Gibbs developed the How I Think (HIT) questionnaire [7], which is designed to measure these four kinds of cognitive distortions.

Following this cognitive behavioral model on the development of maladaptive behavior, one of the pathways to more well adapted behavior is to systematically focus on the adolescent's attitudes and cognitions. Therefore, most multimodal programs aimed at youth with maladaptive behavior also include modules to help the adolescents resolve cognitive distortions.

Figure 2: Model in which improvement of social skills and anger control and resolvement of cognitive distortions mediate the effect of trainings programs for youths with behavioral problems.

In Adolescents, Aggression Replacement Training (ART) is one of the best-known multi-modal programmes aimed at aggressive and antisocial youths [8]. The program consists of three separate modules: social skills training, anger management, and moral reasoning. In the ART morale reasoning module the participants' cognitive distortions are challenged and the development of mature moral reasoning is stimulated. The pathway to more adequate behavior is, at least in part, thought to go through the development of cognitive distortions into more mature moral reasoning. Thus, improvement of cognitive distortions is theorized to mediate the effect of Aggression Replacement Training on maladaptive behavior. Hence, the idea that cognitive distortions lead to and maintain antisocial behavior is one of the central arguments in some of the best-known multi-modal programs aimed at aggressive and antisocial youths. However, some researchers criticize the causal role of cognitive distortions in the development of antisocial behavior [9], reasoning, between others, that there is little or no support for the argument that excuses precede and lead to offending. Others claim that it is the personality disorder of psychopathy that makes individuals more likely to learn antisocial strategies to reach goals and that there is a genetic contribution to this disorder [10]. Blair argues that individuals with this personality disorder are less likely to learn to avoid actions that will harm others. Antisocial cognitions (including a high degree of cognitive distortions) are seen as core parts of the psychopathic personality disorder. Also children and adolescents might show these in part genetically determined psychopathic tendencies. Following this rationale, to improve the maladaptive behavior of adolescents with a high degree of cognitive distortions will be more challenging than for their peers with less cognitive distortions. In other words, following the psychopathy paradigma, the higher the degree of cognitive distortions we find in adolescents, the less we can expect their maladaptive behavior to change as a result of a trainings program like ART. The most positive effect of ART can be expected on the behavior of youngsters with few cognitive distortions. So, following the psychopathy paradigma, cognitive distortions might moderate, not mediate the effect of ART on the maladaptive behavior of its participants.

Figure 3: Model in which cognitive distortions moderate the effect of a trainings program

In this study, two hypotheses on the role of cognitive distortions on the effect of Aggression Replacement Training on social skills of adolescents and behavioural disturbances were tested: 1. In line with with cognitive behavioral theory, cognitive distortions mediate the effect of ART on social skills and behavioural disturbances (figure 2); 2. In compliance with the psychopathy paradigma, cognitive distortions moderate the effect of Aggression Replacement Training on social skills and behavioural disturbances in adolescents (figure 3). Following hypothesis 1, the effect-pathway of ART on social skills and behavioural disturbances is partly through the change of the adolescents' cognitive schemes. Following hypothesis 1, changes in social skills and behavioral disturbances as a result of ART will only occur simultaneously with a decrease in cognitive distortions. Hypothesis 1 is supported if (a) main effects of ART on cognitive distortions and social skills / behavioral disturbances at post-test are found and (b) changes in cognitive distortions and changes in social skills / behavioral disturbances are interrelated.

Hypothesis 2 is supported if: (a) A significant interactional effect between the ART-condition and degree of cognitive distortions on the improvement of social skills and decrease of behavioural disturbances at post-test is found: In other words, the lower the level of cognitive distortions in the participants, the more we can expect their maladaptive behavior to change as an effect of ART. (b) Since, following the psychopathy paradigma, cognitive distortions are seen as part of a rigid personality disorder, a main effect of ART on cognitive distortions is not anticipated.

Method

Two studies were performed. The first study utilized a quasi-experimental design, which involved the collection of information relevant to two groups of adolescents. The Experimental Group comprised 65 children and adolescents who were exposed to 24 hours of Aggression Replacement Training in groups with five to eight participants. They received a standard ART intervention with at least four sessions from each component of skills training, anger management training and moral reasoning training. The duration of the intervention period was ten weeks. On average, the interventions had eleven sessions of social skills training, eight sessions of anger control training, and five sessions of moral reasoning. The ART trainers were 23 students (fourteen females, nine males, mean age=38 years) participating in a 60-credit further education course in training of social competence. All ART-trainers had three years of college education as teachers or authorized social educators, and all were employed full-time at local schools and institutions. Prior to the ART intervention, all students had theoretical and practical training in ART and related topics corresponding to 30 credits of education. Control group comprised 48 individuals and received the standard child social and educational services as defined and delivered by the actual school/institution. All youngsters completed the How I Think (HIT) questionnaire and the Social Skills Rating System (SSRS) at pre-test and post-test. The HIT self-report questionnaire measures cognitive distortions in adolescents. The SSRS measures social skills and behavioural disturbances in the following domains: Cooperation, Assertion, Self-Control, Responsibility, Externalizing, Internalizing and Hyperactivity. All participants completed HIT and SSRS simultaneously at pre-test and post-test. For the individuals receiving ART, the post-test was performed shortly after finishing the Aggression Replacement Training. Additionally, teachers and parents of all participants in the study completed respectively a parent-version and a teacher-version of the

SSRS at pre- and post-test.

The second study comprised a group of 40 adolescents, following a randomized multiple baseline design. Before randomization, all participants, their parents and their teachers completed the set of instruments (pre-test measurement). After randomization, group 1 (n=18) followed a 10-weeks Aggression Replacement Training sequence. Then, a new measurement was performed (post-test 1). Consequently, group 1 had a four weeks waiting period and then performed post-test measurement 2.

In contrast with group 1, group 2 had, after randomization, a four-week waiting period, then filled out pre-test 2. Consequently, they followed the same 10-weeks Aggression Replacement Training sequence, followed by a post-test measurement. ART-trainers in study 2 had the same qualifications as in study 1.

Figure 4: design study 2:

Results

Study 1
Significant effects of ART on the adolescents' social skills and behavioral disturbances were found, but, compared with the control condition, no significant effect of ART on the adolescents' cognitive distortions were found. Further, we found an interactional effect of the ART-condition and level of cognitive distortions at pre-test on the effect-size of ART.

Study 2
To date (july, 27th 2007), results of study 2 are not yet available. Moderating and / or mediating effects of cognitive distortion on ART will be presented orally at the 5-th European Congress on Violence in Clinical Psychiatry.

Conclusion / discussion

The results from study 1 did not support hypothesis 1. The findings partially support hypothesis 2. These finding might indicate that cognitive distortions seem to moderate, not mediate, the

effect of ART on social skills and behavioural disturbances in adolescents. Possible alternative explications of the results of this study and implications of our findings on the understanding of the relation between cognitive disturbances and behavioural disturbances in adolescents will be discussed.

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95. – Compassion fatigue and burn out syndrome in professional helpers working with traumatised clients

V. Petrovic (Serbia)

The objectives of the investigation

The main objective was to investigate the effects of exposure to the traumatic stories of the clients to group of volunteers and professional helpers.

Specific interest was to explore the compassion fatigue and burn out syndrome in helpers in regard to: job motivation, coping stress strategies, exposure to traumatic events and social support in job environment.

Experimental method used

The investigation included three groups of helpers:

The first one, experimental group, 34 helpers volunteers of non governmental organization "Srce", educated in giving emotional support in prevention of suicide, in SOS service.

The second one, control group, 32 helpers in Social welfare center – psychologists, social workers, pedagogues and lowers, working with dysfunctional families and couples in the process of divorcing, abused children, adolescents, and old people.

The third one, control group, 15 potential volunteers selected and educated in emotional support for clients, on two months provisional work, under supervision.

Total number of helpers included N = 81 of the above mentioned.

Aims of the investigation were to answer to the following questions:
1. Do these three groups differ regarding the type of traumatic events that they are exposed in their job?
2. Do these three groups differ in intensity of compassion fatigue, burn out syndrome and emphatic gratification?
3. Which one of the independent variables (symptoms, coping stress strategies, motivation in job, and colleague's social support in working environment) are significant correlates of the burn out syndrome in this three groups of helpers?

These three groups were filling in the next psychological instruments:
1. General list of socio demographic information
2. List of traumatic events (Cornille &Meyers, 1999, Simic, 2002)
3. Compassion fatigue test (Stamm, B.H., & Figley, C.R., 1996)
4. Burn out syndrome questionnaire (Wolf, B., Kapor Stanulovic, N, 2001)
5. Coping stress strategies in work environment questionnaire (Somer, T., 2001)
6. Social support questionnaire (Somer, T., 2001)

Essential results (including data and statistics)

Results say that there is a significant difrerence in compassion fatigue, emphatic gratification and burn out syndrome in examined groups. The diference has been found in the level of work motivation, too.

We found the next predictors of compassion fatigue: symptoms and signs of burn out syndrome, work motivation and coping mechanism focused on emotions.

We also found the next predictors of burn out syndrome: exposure to the traumatic stories and traumatic events in job, symptoms and signs of burn out, job motivation and level of social support in job surrounding.

Conclusions

The important result is that, among this three groups, Social welfare center's professional helpers are under the highest risk for compassion fatigue and burn out syndrome. „Very fresh" volunteers have the lowest risk for explored issues. Preventive strategies are esential in a professional helper's work and life.

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96. – The use of coercion in Norwegian adult psychiatry

T. Hatling, P. B. Pedersen and J. H. Bjørngaard (Norway)

Internationally there has been a long debate regarding the use, and potential misuse, of coercive measures in psychiatry. While few countries have been able to document the total volume of coercive measures used, substantial institutional and national differences in use have been reported.

Methods

This study presents results from surveys including all Norwegian psychiatric hospitals, psychiatric wards in general hospitals and other adult psychiatric inpatient institutions regarding their use of mechanical restraints, forced (short time) medication and isolation in 2001, 2003 and 2005.

Results

Mechanical restraints was used by most psychiatric hospitals and -wards, by a minority of other institutions, and most frequently in acute wards and high security wards. There has been an increase in number of times, number of patients and number of hours between 2001 and 2005, ranging from 40-50%. In 2005, it was used 5130 times towards 1118 patients for a total of 40440 hours. At hospital level we find large, consistent differences between institutions, both regarding number of times, patients and hours for all three years.

Forced (short time) medication was used by most psychiatric hospitals and -wards, and by a few other inpatient institutions. It was most frequently used in acute wards and high security wards. Number of times it was used was stable between 2001 and 2005, while we observe an 39% increase in number of patients. In 2005 it was used 2238 times towards 824 patients. Between hospitals and –wards there were an even gradient from those who rarely use it to those who use it towards the highest number of patients.

Isolation was used by a minority of psychiatric hospitals and –wards, and only three of these institutions had any significant use related to number of beds filled. Number of times it was used was reduced by 78% between 2001 and 2005, and number of hours with 39%. In 2005 it was used 184 times towards 33 patients for a total of 184 hours.

The paper will also present results regarding use of coercive measures and gender, the distribution of use between patients, and analyze whether patient flow, severity of illness, staff ratio or skills contribute in explaining the large institutional differences.

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97. – Gender related aspects of coercive interventions in a German psychiatric hospital

Steinert T, Borbé R, Eisele F. (Germany)

Background and aims

Coercive interventions are applied to cope with behaviour that cannot be managed otherwise. Such behaviour is different among different genders. We examined whether there are gender differences in the frequency and in the indications of coercive interventions. Methods: We use a well-established database, in which coercive interventions are recorded routinely regarding type of intervention, type of preceding challenging behaviour and duration. Aggressive incidents are recorded by means of the SOAS-R, sociodemographic and illness-related patient characteristics by use of the German BADO (base documentation). The sample represents all hospital admissions of the first six months in 2007. Correlations of self-directed and other-directed violent behaviour with the use of coercive interventions are calculated for both genders in each diagnostic group (ICD-10 F0-F9), separated for seclusion and mechanical restraint. Mean SOAS-R values of males and females exposed to seclusion and restraint are compared as well as further patient characteristics.

Results

Data will be available in July 2007. Results will be presented and discussed.

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98. – Observations in acute psychiatric units in Landspitali University Hospital in Reykjavik

J. Snorrason (Iceland)

Introduction:

Observations of different kinds are used in psychiatric hospitals in Iceland as in other countries. The most common reasons for observations are violence, agitation and self-destruction.
The personnel working in acute psychiatric units often view observations as a safety measure and not as a treatment form in itself.

Limited research has been done on which treatment forms or what kind of care are the most successful or the best to reduce or minimize situations that lead to observations in psychiatric units.

The purpose of this research was to investigate the number of patients on observations in psychiatric units in Landspitali-University Hospital Reykjavik during a 3 months period during the last three months of the year 2004; the reasons and length of observations being used during the hospitalization, the reasons for the observations´ discontinuation and who made those decisions, the patients´ diagnosis and previous admissions of these patients to psychiatric hospitals.

Two questionnaires were used for this particular research, one for the patients and another for the personnel. The two questionnaires allowed the patients and the personnel to express their own views regarding the use of observations.

Method

The researchers made daily recordings in the four acute psychiatric units during a three months research period. Information collected were age, sex, diagnosis, number of days from admission, types and reasons for observations and the reasons for changes made during hospitalization whether it was a change in the types of observations or its discontinuation.

All patients answered a questionnaire composed of 12 questions to investigate their opinions and views towards the observations being used.

Also, five nurses, five nurses´ aids and five staff members on each unit were questioned about their views on observations. Their age, sex and the years they had worked were recorded.

Results

Observations weres used in 157 cases or one third of the total number of admissions during the research period on the four acute psychiatric units of Landspitali-University Hospital in Reykjavik. Regular intermittent observation was used for the majority of patients (82.59%), "one to one" observation was used for one fourth (25.16%) of the patients and constant observation was used for the least number of patients (11%).

Observations were most often decided by the doctor on call (82,59%) but the discontinuation of observations was most often done by patients´ psychiatrist (43,47%).

The mean length of observation was 5,7 days (sd 13.7). Almost three fourths of the patients (73%) had previously been admitted to psychiatric hospitals. Most of the observations were used in the first week of admission (87%).

The most common diagnoses according to the ICD-10 classification system were mood disorders (37%), substance abuse (20%), schizophrenia (15%), neurotic disorders (8%), personality disorders (4%) and other behavioural and emotional disorders (4%).

The patients´ views regarding the purpose of observation depended on which type of observation was used. The majority of all patients put safety in first place but only fifth of them found the communication of the personnel useful.

The personal, however, found caring, respect and communication to be the most useful aspects of observation and it was not in coherence with the type of observation being used.

The majority of patients saw lack of freedom as the most difficult part of being on observation. One third of the patients on constant observation and one-to-one observation did not find it at all difficult to be observed.

The personal however found the work load and responsibility as the most difficult aspects while observing patients on any kind of observation,

Conclusions:

The nature, size and practice of observation seem to be similar in Iceland as in other countries. It is necessary to define different observations, the nomenclature, the application and the documentation in the Department of Psychiatry in Landspitali-University Hospital.

Other issues such as hospital rules and regulations on who decides and/or discontinues observations, and its lengths need to be addressed and decided upon.

Clinical supervision and continuing education is important to support personnel in order to increase the knowledge of the personnel in nursing patients on observations.

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99. – Seminar 1 – Reduction of seclusion and restraint – Does over training lead to over use of physical interventions?

Andrew McDonnell, Studio III Training Systems, United Kingdom, (UK)

Staff training in the managing of violent and aggressive behaviours is an area which to date is still poorly understood and researched. Trainers in physical interventions often make assumptions about the outcomes that their respective training systems deliver. Most notably there appears to be an implicit assumption that training in physical interventions will in essence reduce their usage especially if training also contains methods of de-escalation. What evidence exists that this is actually the case in reality? This paper will argue that increased regulation may actually be counterproductive as it will greatly increase the numbers of staff who will receive such training and increase the usage of physical interventions in care environments. Examples will be used from our current knowledge base. It is argued that greater emphasis needs to be placed on training in de-escalation only and compare it with training that contains physical interventions to fully test this assumption.

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100. – Seminar 1 – Reduction of seclusion and restraint – "Tell me what to do!" How to change from old habits to new

The impact of naturalistic education on direct care staff members' perceptions of aggression in Child & Youth Mental Health

Lorelei Faulkner, RN, BSN, CPMHN(C), MSN(c) and Ross E. Gibson, BA, MEd(c), British Columbia Mental Health and Addiction Services: Child and Adolescent Mental Health Program, Vancouver, BC (Canada)

The research presented examines the impact of education in relation to a project being implemented at a tertiary pediatric mental health centre, aimed at changing perceptions and approaches of direct care staff in working with children and youth. The focus of the project involves creating a culture of safety for clients and staff utilizing concepts from trauma informed care; milieu therapy and shared governance. The education strategies implemented to attain this culture include in-house education/discussion; reference to international literature and speakers; advanced crisis intervention training; community communication and collaboration and staff to staff coaching/debriefing.

Staff perceptions of aggressive behaviour were measured prior to any educational interventions; six-months post implementation of the education process and at eighteen-months. Questionnaire results reveal the views of employees in various inpatient and outpatient programs both before and after several educational experiences designed to improve understanding and broaden perspectives of participants. Participants were given training in a trauma-informed model of care delivery and information about the risks and ethical considerations inherent in the use of seclusion and restraint; alternate verbal de-escalation strategies. Changes in staff's perceptions about restraint and seclusion, corollary reduction in the use of these measures, and the implications of perceptual change as a component of restraint and seclusion reduction programs are discussed.

101. – Seminar 1 – Reduction of seclusion and restraint – Developing and implementing the promotion of a safe and therapeutic services program

Gail Miller. BA (CBT) RMN, Associate Director Violence Reduction West London and Broadmoor Mental Health Services Trust. England (UK)

From "What if…." To "Why…." For many years healthcare services have responded to the problem of aggression and violence by asking what shall we do if it happens. On reflection the questions that should have been asked is why is it happening and what can we do to prevent it. In October 2005 the first mandatory national training syllabus anywhere in the world in the prevention and management of aggression in mental health services , called Promoting Safer and Therapeutic Services (PSTS), (Paterson and Miller 2005) was launched in England. Previous interventions have largely been typified by an excessive focus on reactive measures, methods of de-escalation, strategies to calm the already distressed person down by means of positive communication, or responding to an actual or potential act of violence by means of physical control. Implicit to such training has been the location of responsibility for the violent act with the patient or in the interactions with staff immediately preceding the incident. The PSTS syllabus seeks explicitly to reframe how the problem of violence in services is understood in order to support the adoption of structured, holistic organisationally led approaches to violence reduction in services which will reduce not only violence towards staff but the need for coercive interventions such as restraint and seclusion The authors will provide an overview of the English policy agenda, discuss the evidence base used to inform the syllabus development, identify key components of the training and examine how the initiative will be evaluated.

Seminar 2 – Training in the management of aggression and violence

Kevin McKenna (Ireland) will lead an international open panel / forum discussion: From issues and perspectives to the future

Possible panel members: Lovestad, E. (Norway), Nau, J. (Germany), Tam, J. (Hong Kong), Laiseau, E. (Norway), Nadler-Moodie, M. (USA), Engelen van, Y.M. (Netherlands), Noone, J.A. & Moreau, M. (Canada), Kemp, S.(USA), David Leadbetter (UK), Dirk Richter (Germany)

102. – Workshop 14 – Forensic Psychiatric Care – Forensic psychiatric care in a general mental health institute

David Koppers[VIII] Frank Don, Erik Sikkens & R. Schroevers (Netherlands)

Keywords
forensic psychiatry, general mental health clinic, Dutch criminal law

Introduction

Recently the Netherlands were faced with several seriously violent crimes. In all of these cases the offenders involved had psychiatric problems. They relapsed while being treated or having finished compulsory treatment. These relapses received a lot of media attention and caused the Dutch government to reconsider its current forensic psychiatric care within the criminal law system. The government recommended that in the future General Mental Health Clinics should be more closely involved in treating psychiatric law-offenders. This workshop proposes an innovative implementation of this recommendation for General Mental Health care.

Governmental developments in forensic psychiatry

The Netherlands provide a unique forensic care system for law-offenders with psychiatric disorders. This forensic psychiatric care is part of the Dutch criminal law system. It consists of compulsory intensive nursery care (TBS) aimed at relapse prevention. The TBS program is enforced when there is a relationship between the offence and the psychiatric disorder of the offender and the offender can therefore be not or only partly held accountable for his or her offence. The recent violent incidents have led the dutch government to reevaluate this TBS system A committee was formed to conduct a parliamentary inquiry. It concluded that the system is adequate but needs additional support from the General Dutch mental health system.

The associated Dutch mental health clinics (GGZ Nederland) and the government are now considering how these recommendations can be implemented through specific programs in the current Dutch mental health care.

Forensic psychiatric care within general mental health care

JellinekMentrum, an Amsterdam based Mental Health Clinic started a pilot-project to embed forensic psychiatric care in general mental health care. The aim of the pilot-project is to investigate which organisational model of forensic psychiatric care is best en whether it's economically viable.

The project contains a so-called integrated model of forensic mental health, which consists of forensic mental health specialists working within regular mental health teams. These specialists both offer regular and forensic mental health care. They also serve as consultants for colleages not specialized in forensic care. The advantage of forensic care within in a general mental clinic compared to specialized forensic psychiatric care is that it has access to an array of psychiatric treatment programs in different settings, ranging from out-patient cognitive behavior therapy for panic disorder to clinical psychiatric treatment for schizofrenia.

This program is also applicable to other General Mental Health Clinics.

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Workshop program

This workshop will address this subject in more detail. It consists of three successive presentations of 20 mins each followed by discussion. The first presentation is about the current Dutch forensic care and its developments in the Dutch criminal law system.

The second presentation describes how forensic care can be organised in a general mental health clinic, like JellinekMentrum.

The third presentation discusses the treatment programs for (ex-) forensic patients offered by JellinekMentrum, and their possibilities and restrictions. It also includes a short interactive demonstration of a group intervention program for batterers.

After these presentations participants are invited to ask questions and discuss the topic of implementing forensic psychiatric care within a general mental health clinic.

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103. – Keeping the unit safe

M.E. Johnson & K.R. Delaney (USA)

Background

To date, the predominant focus for the prevention of aggression and violence on inpatient psychiatric units has been the use of de-escalation techniques. Although these interventions are useful and appropriate, they are based upon an assumption that escalation begins and unfolds in a predictable trajectory. This paper will describe the findings from a grounded theory study that grapples with the complexity involved in keeping the unit safe, a central concern for nursing staff.

Purpose

The purpose of the study was to develop a midrange theory of violence prevention on inpatient psychiatric units.

Design

Methods consistent with grounded theory were used for data collection and analysis: 12 patients and 16 staff members were interviewed; all staff and patients were observed for over 400 hours; data collection and analysis occurred simultaneously; and data were analyzed using constant comparative methods.

Findings

Data analysis revealed four contextual dimensions to keeping the unit safe: ideology, space, time and people. This paper will discuss how these four dimensions contribute to or detract from keeping the unit safe. Data analysis revealed six essential skills for prevention of violence: being there, being aware, caring, connecting, balancing and deciding how to respond. This paper will describe these essential skills. Data analysis also revealed three types of escalating situations--suddenly erupting situations, smoldering situations and bubbling-up situations--and three phases of escalation--noticing the beginning, reaching the point and beyond the point. This paper will describe these types of situations and phases and will discuss how knowledge of escalation can contribute to violence prevention.

Conclusion

Keeping the unit safe is a central concern to nursing staff. However, keeping the unit safe and preventing injury to patients and staff is a complex phenomenon that requires highly skilled staff and knowledge of the complexity of keeping the unit safe. This paper will close with recommendations for practice and future research.

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104. – Identification and management of domestic abuse in accident and emergency departments

L A Lynch & J E Kenkre (UK)

Introduction

The most common form of physical, mental or emotional abuse of women in the United Kingdom (UK) is domestic related. Abuse accounts for one quarter of all violent crimes in the UK (Home Office 1997) and is the cause of two female deaths in England and Wales every week (Simmons & Dodd 2003). The Confidential Enquiry into Maternal Deaths (1997–1999, 2000-2002) showed that domestic violence is associated with maternal death, alcohol, drug abuse, suicide, miscarriage, foetal injury and death (RCOG 2001,2004). Research over the last three decades has shown that domestic abuse may commence or escalate during pregnancy (Gelles 1975; Stark, Flitcraft et.al. 1979; Bowker 1983; Hillard 1985; Surgeon General 1986; Bohn 1990) although some women report a decrease (Hilberman and Munson 1978).

The impact of domestic violence occurs in different settings within health care one of which is the Accident & Emergency Department. Even though the response by staff may be inadequate at times, violence against women can account for 22–35% of visits to Accident & Emergency Units (Adam 2002). Eighty percent of women in a violent relationship have sought help for their injuries or other related issues from the health service at least once and this may be after a prolonged history of abuse.

However, it was not known to what extent the problem was affecting a South Wales Community so the aim of the study was to investigate all people who attended an Accident and Emergency Department at the District General Hospital as a result of an assault.

Methods

A semi-structured questionnaire was developed to elicit information from people who attended an Accident & Emergency Department (A&E) as a result of an assault. All people attending the A&E department from the beginning of October 2003 to the end of September 2005 were asked to participate.

Demographic information on those assaulted, the time and place of assault, the type of assault and by whom and if the person wished to be referred to other agencies.

All assault victims were given an information sheet explaining the research being conducted prior to written informed consent to participate in the study being obtained. Consent was gained prior to giving the questionnaire. If consent was denied for participation in the research study but the person wished to be referred to other agencies consent was taken for referral.

The research study excluded patients unable to speak English but interpreters/ language line arrangements were made for these patients.

Ethical approval was gained from the Central Office Research Ethics Committee and from the Associated NHS Trust Research and Development Committee.

Results

From the beginning of October 2003 until the end of September 2005 there were 917 questionnaires completed on assaults to patients who had attended the A&E department, 548 (59.7%) male and

369 (40.2%) female. Of these 227 (24.8%) were as a result of domestic violence, 47 (20.7%) male and 180 (79.3%) female. 11 (6.1%) of the 180 females who were assaulted in a domestic incident were pregnant. One-hundred and ten (48.5%) of those that had been attacked due to a domestic incident had been attacked by the same person before, and 59 (26%) had attended the same A&E department before. However, only 50 (7.2%) of those who had suffered common assault had been attacked by the same person previously and 71 (10.3%) and had attended the same A&E department. In 16 cases there was no statement on the assault.

Of the 227 people who attended A&E following domestic incident 92 (40.5%) had been assaulted by their partner and 53 (23.3%) by their ex partner. But 77 (33.9%) were assaulted by a member of their family. However, of those that were involved in common assault: 310 (46%) were assaulted by a stranger; 296 (44%) by an acquaintance or friend; and 16 (2.4%) by a 'bouncer' and only 3 by a member of their family. Those who were assaulted due to a domestic incident 174 (76.7%) were attacked by a male, 36 (15.9%) were attacked by a female and 17 (7.5%) were attacked by both male and females. Of the 227 who had suffered domestic abuse 57 (25%) wished to be referred to other agencies. In fact, 154 (67.8) of the incidents of domestic violence were reported to the police whereas the police were only informed on 344 (51%) incidents of common assault.

The majority of those attacked due to a domestic incident were assault by one person 196 (86.3%) of cases. This is different to those attending A&E as a result of a common assault where 356 (52.8%) were assaulted one person. Although in both groups this rose to 6 people involved in the assault but this happened more frequently in common assault 47 (7%) occasions (Table 1). Of the 227 domestic assaults there were 90 incidents where children were at home. There were 50 (56%) assaults that took place with the children present. However, only 38 (5.6%) of instances of common assault was a child present.

Table 1: Number of attackers involved in reported incidents of domestic violence and common assault

Number of attackers	Domestic Violence	Common Assault
One	196 (86.3%)	356 (52.8%)
Two	21 (9.3%)	128 (19%)
Three	1 (0.04%)	55 (8.2%)
Four	4 (1.8%)	43 (6.4%)
Five	1 (0.04%)	28 (4.2%)
Six	1 (0.04%)	47 (7%)

The use of a body part as a means of violent behaviour was similar in both groups 174 (78.4%) in those in a domestic incident and 528 (78.3%) for common assault (Table 2). However, the place where the incidents occurred varied the main place for domestic violence (45.8%) was in the home whereas for common assault this was in the street (46.9%)

Table 2: Method of Assault

Assaulted By	Domestic Violence n = 227	Common Assault n=674
Body part	178 (78.4%)	528 (78.3%)
Knife	8 (3.5%)	6 (0.9%)
Blunt instrument	16 (7%)	42 (6.2%)
Bottle/Glass	1	29 (4.3%)
Kicked	12 (5.3%)	34 (5%)
Attempted strangulation	2	1

Discussion

As in 2002 (Adam), the findings from this research showed that domestic violence accounted for 24.8% of all assaults thus supporting earlier research by Adam. In Wales, the South Wales Police and Cardiff Women's Safety Unit have worked together with women experiencing domestic abuse in identifying their individual level of risk (Goodwin 2003). In Wales, a South Wales Multi Agency Risk Assessment Conference (MARAC) has been developed and regular interdisciplinary meetings take place for women identified as very high risk or who are living in potentially dangerous situations (Robinson 2004). This system follows a series of risk assessments and highlights exactly how much danger a woman may be facing. The police are now taking a more active constructive role in addressing domestic violence, 154 (67.8) of the incidents of domestic violence were reported to the police.

It is acknowledged that health care professionals have a pivotal role in the identification and management of domestic abuse in the community. Over ten years ago Kingston and Pentale (1993) found that many survivors described how desperately they wanted health professionals to ask them about domestic abuse; this is supported here. On 154 (67.8) of the incidents of domestic violence the police were informed whereas the police informed on 344 (51%) incidents of common assault. On asking if those whose has experienced domestic violence wanted to be referred to other agencies 57 (25.1%) wished this to happen compared to only 14 (2.1%) of those who had suffered a common assault wished to be referred.

Alarmingly this research has highlighted that 22% of children were present when the assault occurred. This has to raise child protection issues; research sponsored by the National Children's Home (1994) in the UK found that in 25% of cases the male partner had also been violent to the children. Further research (Hughes, 1992) found that in 90% of incidents involving domestic abuse the children were in the same or the next room when the abuse took place. Where children are involved, their needs and welfare are paramount. Therefore disclosure to social services will override any confidentiality request that the mother may make as a child protection issue, yet it needs to be made clear that even if she refuses consent, health professionals must still disclose this information to social services at the earliest opportunity (DoH 1998).

However screening must be supported by appropriate interventions based on evidence. Ramsay, Richardson et al (2002) found in their systematic review that there is insufficient evidence regarding the outcomes of subsequent interventions for the women who choose to disclose, a finding confirmed by NICE (2003). This is therefore an identified area of further research.

Conclusion

Domestic abuse has a huge physical and psychological impact on the families affected by violence, including victim/survivor, perpetrator and children within the situation.

As health professionals we have a duty of care towards our clients/patients, yet domestic abuse has remained largely unasked, and unreported, with many clients going home with the perpetrator of the violence.

There is consequently an urgent need for mandatory training and collaboration between primary and secondary health, liaising with local agencies to support clients experiencing domestic abuse.

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105. – Implementation of the 'early recognition method' in forensic care

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Forensic nurses in forensic psychiatric hospitals encounter violent and aggressive inpatient behaviour every day. The 'Early Recognition Method (ERM)' has been shown to reduce and prevent aggressive behaviour of patients. The method emphasizes the patients' self-management skills in order to prevent (repeatedly) occurring violent behaviour. In applying this method, forensic nurses teach patients to monitor their behaviour, to recognize early warning signs of deteriorating behaviour and to carry out actions in order to prevent further deterioration and

In the Forensic Psychiatric clinic, the Oostvaarderskliniek, in the Netherlands, the method has been introduced since 2005. Forensic nurses have been trained to apply the method with patients and, for research purpose, to monitor and evaluate the implementation.

In this presentation we will focus on the training course and the training program as applied in the Oostvaarderskliniek. We will also address the problems we encountered during the implementation of the method in the Oostvaarderskliniek and what we have learned during this process.

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106. – Effectiveness of assertive community treatment for patients mandated for involuntary outpatient treatment

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Keywords

Assertive community treatment, involuntary outpatient commitment, Kendra's Law, proximal outcomes, distal outcomes, dangerousness

Background

Patients with severe mental illness often referred for involuntary admission to a psychiatric hospital because of dangerousness to others may now be referred for involuntary outpatient treatment (Swartz & Monahan, 2001). When New York State passed Assisted Outpatient Treatment (AOT) law, known as Kendra's Law, this provided for involuntary outpatient commitment, communities used existing programs such as Assertive Community Treatment (ACT) to provide the mandated treatment (Swanson, et al., 1997). ACT for voluntary patients is associated with reduced hospital readmissions, use of emergency services, legal problems, and homelessness and improvement of clinical symptoms and global functioning (Scott & Dixon, 1995; Lehman, et al., 1999). There is less evidence that ACT improves social functioning and employment (Mueser, Bond, Drake & Resnick, 1998). Little information exists about the effectiveness of ACT for patients who have been court-ordered to receive treatment (Phillips, et al., 2001). This study examines the effectiveness of ACT for patients referred for involuntary outpatient treatment.

Patients with severe mental illness often have impaired functioning, inability to tolerate stress, limited social skills and compromised judgment (National Institute of Mental Health, 1991) that result in unmet needs (Perese, 1997; Arvidsson, 2003); poor health (Massaro, 1992); poverty; homelessness and victimization (Steinwachs, Kaspser & Skinner, 1992); increased police contact, arrests and incarcerations (Schellenberg, Wasylenki, Webster & Goering, 1992); unemployment (Anthony & Blanch, 1987; Mueser, Drake & Bond, 1997); lack of social support (Cohen & Farkas, 1986; Estroff, Zimmer, Lachicotte & Benoit, 1994; Shankar & Collyer, 2002) and diminished quality of life, (Mueser, Drake & Bond, 1997). Lehman (1996, 1999) recommends that measurement of treatment effectiveness consider the intervention's ability to bring about change for these multiple problems and that proximal and distal outcomes be measured.

Research questions

1. Was there improvement of proximal outcomes –basic needs, psychiatric symptoms, psychological distress, stress, and dangerousness to self and to others---after six months of ACT?
2. Was there improvement of distal outcomes –health, functioning, social support, life satisfaction, employment, homelessness, police contacts, arrests/incarcerations and use of psychiatric and non-psychiatric emergency rooms and hospitals-- after one year of ACT? 3. How satisfied were the patients with treatment?
4. Was there a relationship between patients' status—voluntary or referred for involuntary outpatient treatment-- on admission to ACT and outcomes and on satisfaction with treatment?

Method and results

The setting was an ACT program administered by a not-for-profit Behavioral Health Services Organization in Buffalo, New York, a small, formerly industrialized city in the western area of New York State. With institutional and agency approval, all 71 patients in the ACT program were invited to participate. Fifty-six (79%) agreed and signed consent forms. There was no significant difference in age, race, marital status, living situation, employment, dangerousness, arrests/incarcerations, hospital readmissions, and functioning between patients who agreed to participate and those who refused. Women were more likely to refuse, as were patients with higher levels of educational achievement and patients with lower rates of alcohol and substance abuse.

This 12-month study was conducted to compare the effectiveness of ACT for voluntary and involuntary patients by examining changes in proximal and distal outcomes for both groups. Record review, face-to-face interviews with the patients and staff observations was used to obtain data about proximal and distal outcomes. ACT staff completed scales for severity of psychiatric symptoms and level of functioning based on their observations. At 12 months, patients completed a questionnaire that measured their satisfaction with the program.

The ACT program provides 24-hour, 7 day a week services by a multidisciplinary team--a psychiatrist, a nurse, case managers, substance abuse and vocational specialists and peer counselors. It collaborates with housing, transportation, social services, and vocational rehabilitation programs and has an agreement with a primary care clinician to provide medical care. Priority for admission to ACT is given to patients with severe mental illness who are non-responsive to treatment, homeless, recently incarcerated, at risk of danger to themselves or others, frequent users of psychiatric emergency services and with repeated hospital admissions. Patients are admitted voluntarily, often upon discharge from the hospital; or, involuntarily under AOT.

The Buffalo Client Assessment Inventory (BCAI) that was developed by the authors and used to obtain data includes structured questions and research instruments; e.g., 10 brief self-report instruments and 3 observation-based instruments. Psychiatric diagnosis was the diagnosis entered in the patient's record by the ACT team psychiatrist on enrollment in ACT and was based on longitudinal data, an extensive psychiatric evaluation and data available from collateral sources. Data relating to readmissions to a psychiatric hospital, police contact, arrests, and incarcerations during the year preceding admission to ACT were obtained from the record. Legal status was obtained from the record and is represented by AOT status, Group I patients, and voluntary status, Group II patients. Among proximal outcomes, basic needs (food, clothing, transportation, medical care, dental care, housing and finances) were measured using the Meeting Basic Needs scale, a subscale of The Colorado Client Assessment Record (Ellis, Wilson & Foster, 1984) that was modified to include medical and dental needs. Psychiatric symptoms were measured with the Brief Psychiatric Rating Scale (BPRS) (Overall & Gorham, 1962); psychological distress with the Six-Item Indexes of Psychological Distress (Rosen, Drescher, Moos, Finney & Murphy, 2000); stress with the Modified Stress Ladder (Duffy et al., 1992) and dangerousness with the Violent Behavior Scale (Neale & Rosenheck, 2000) that elicits patients' history of dangerous behaviors toward self and toward others. Distal outcomes—overall perception of health, social support and life satisfaction--were measured respectively with the Self-rated Health Scale (Stewart, Hays & Ware, 1992) and the Self-reported Health scale (Idler & Angel, 1990), the Social Support Index (SSI) (Bell, et al., 1982) and the General Life Satisfaction Scale (GLSS) (Lehman, 1988). Functioning was measured with the Role Functioning Scale (RFS) (Goodman, Sewell, Cooley & Leavitt, 1993) and the Global Assessment of Functioning (GAF) (DSM-IV, 1994). Satisfaction with treatment was measured with the Client Evaluation of Services (CSQ-8) (Nguyen, Attkisson & Stegner, 1983).

Analysis of data

A repeated measures analytical approach was used to answer our research questions. Descriptive statistics were used to present demographic characteristics. Chi-square analysis was used to examine demographic characteristics between patients referred by AOT and voluntary patients. Paired t-tests were used to compare the effectiveness of the intervention between prior year or baseline and 6 months for proximal outcomes and to compare the effectiveness of the intervention between prior year or baseline and 12 months for distal outcomes. To manage missing data, existing time one data was used to create a regression equation. Based on the parameters estimated by these regression equations, we substituted the missing values. Chi-square and independent t-tests were also used to compare outcomes of Group I and Group II. Statistical significance level was set at $p < 0.05$ and a 1-tailed test was used.

The majority of the patients were male (77%) and African-American (59%). Twenty-four (44%) had not completed high school. Most frequent diagnosis was schizophrenia. More than half (57%) had a recorded diagnosis of substance abuse; 91% had been hospitalized at least once in the prior year; and 31% of 41 participants with available data had exhibited dangerousness to others. Nineteen (34%) lived in unstable situations (emergency housing, shelters or "staying with friends") and nineteen (34%) had been homeless at least once during the prior year. Thirty-seven (66%) had been referred by AOT and nineteen (34%) were voluntary admissions. The groups did not differ on admission in rates of hospitalizations, homelessness, dangerousness and arrest/incarcerations. Group I had more young and old patients. Group I patients reported less social support. Six month proximal outcomes-- psychiatric symptoms, distress, stress and dangerousness to self-- improved. There was a trend toward improvement of unmet needs. Dangerousness to others did not improve. In responding to questions of whether they talked about hurting or striking someone or threatened to do so, patients often indicated that those actions were required to protect themselves in the community. Among distal outcomes, health, life satisfaction, psychiatric and medical emergency room visits, medical hospitalizations, homelessness and police contacts/arrests improved. Social support, psychiatric hospitalizations, incarcerations and employment did not. There was improvement of one measure of functioning, the GAF that includes psychiatric symptoms, but no improvement in functioning as measured by the RFS that does not include psychiatric symptoms.

Conclusion

There was no difference in the effectiveness of ACT for voluntary patients or patients referred for involuntary outpatient treatment. There was a marked decrease in medical emergency room visits, medical hospital admissions and psychiatric emergency room visits with the rates cut nearly in half that may have been due to improvement of the proximal outcomes--psychiatric symptoms, distress, stress and dangerousness to self. Lack of improvement of the proximal outcome, dangerousness to others, appears to be reflected in lack of improvement of distal outcomes of incarcerations and hospitalizations. Similar to the findings of Swanson et al, (2002), dangerousness to others occurred more often among patients with comorbid substance disorders and repeated hospitalizations and police contact. Victimization was more frequent among patients exhibiting dangerousness to others.

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107. – Differences between seclusion and mechanical restraint in restrictions to human rights - a randomised controlled trial

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Objective

To assess the restriction to human rights caused by seclsion and mechanical restraint. Seclusion and restraint are considered as effective and safe interventions but there is a lack of evidence from well-designed studies on compulsory measures in psychiatry.

Method

We conducted a comprehensive cohort study comparing seclusion and mechanical restraint among in-patients with severe mental illnesses. We determined the restriction of human rights from the patients' point of view as main outcome variable, measured by a scale developed for this purpose, Human DIgnity during COercive Procedures, DICOP-Score.

Results

102 out of 233 patients exposed to coercive measures within 24 months could be included, 26 could be randomised (12 seclusion, 14 restraint). There were no significant differences between the two interventions referring to DICOP-score and duration of the intervention. The burdens most frequently reported during after seclusion were "I felt lonely", "I felt my dignity was taken away" and "I couldn't understand why the measure was carried out". Most mentioned stressors in mechanical restraint were "Restriction of ability to move", "Fear to be lonely" and "Being dependent on the help of others". Watching pictures of several alternatives in the interview, including physical restraint and net bed (not available in Germany), most patients preferred seclusion, independent of which intervention was conducted.

Conclusions

Randomized controlled trials on coercive interventions in psychiatry are feasible. Both from ethical and safety aspects the results do not yield evidence to prefer or forbid one of the interventions. Clinical decisions should take into account patients' preferences.

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108. – Aggressive behaviour by people with dementia: issues and answers?

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Keywords
Aggressive Behaviour, Aggression, Alzheimer's disease, Dementia, Residential Care, Violence

Introduction

There are today around 700,000 people in the UK with a dementing illness (Alzheimer's Society, 2005), three times as many as have schizophrenia (SANE, 2005). Dementia care is still however a relatively neglected area of mental health practice. This is despite the challenges that professional carers face in managing some of the consequences of dementing illnesses. One such challenge is aggression perpetuated by people with dementia against those who care for them. This paper will discuss the literature related to aggression by people with dementia in residential care settings.

The context of aggressive behaviour among people with dementia

Aggressive behaviour by people with dementia is categorised among the "behavioural and psychological symptoms of dementia". Other examples are wandering, agitation, shouting, hoarding, sexual disinhibition, eating disorders, inappropriate toileting, repetitive questioning, self-injurious behaviour and apathy (Turner, 2005). Ascertaining the incidence and severity of aggressive behaviour is not straightforward. Recent UK national surveys of aggression in health care settings have not highlighted people with dementia as a separate group (Department of Health, 2002). There is also considerable evidence that care staff under-report incidents of aggressive behaviour perpetuated against them (Gates et al, 1999; Healthcare Commission, 2004). It has also been observed that two apparently similar care facilities can experience very different rates of aggressive behaviour (Gates et al, 2003). The overall impression is of a high incidence of usually low-impact aggressive behaviour among people with dementia. Aggressive behaviour is more common among people with dementia than among older people who do not have dementia (Chou et al, 1996, Wystanski, 2000), and aggression against family members is a major reason for the person entering residential care (Gilley et al, 2004).

Causes of aggressive behaviour in people with dementia

Aggressive behaviour in people with dementia has several possible causative factors. Firstly, the person may have a history of aggressive behaviour prior to contracting a dementing illness. However, research to date has not found a clear link between pre-morbid personality and such behaviour in people with dementia (Kolanowski & Garr, 1999; Low et al 2002). Whilst dementing illnesses can cause personality change, this may actually serve to reduce a person's tendency to behave aggressively. Secondly, aggressive behaviour may occur as a consequence of the illness process. Traditional perspectives on dementia have tended to regard behavioural and psychological symptoms as random expressions of neurological damage (Kitwood, 1997). Thirdly, aggressive behaviour may occur for psycho-social reasons. Some see aggressive behaviour as resulting from factors in the environment of care (Stokes, 2000), or as a consequence of operant conditioning (Ballard et al, 2001). Another formulation of aggressive behaviour derives from the person-centred approach of Kitwood (1997). Stokes (2000) regards aggressive behaviour as "poorly communicated need". This view sees aggressive behaviour as having meaning for the person, often underpinned

by the need to remove a perceived threat. Research indicates that aggressive behaviour happens most often when the person is receiving intimate care (Keene et al, 1999), suggesting that the person misinterprets such care for a personal violation by the professional carer. Studies involving observation of interactions between professionals and people with dementia during intimate care suggest that the approach adopted by the carer is a factor in whether the person with dementia responds aggressively.

Reactions of professional carers to aggressive behaviour

The reactive and seemingly non-intentional nature of aggressive behaviour by people with dementia, coupled with the likelihood that such aggression is only rarely physically injurious to the victim, has led to the view that it is a relatively trivial phenomenon that should be accepted by professional carers as "part of the job" (Gates et al, 1999). This perspective is not however always shared by those professional carers who are victims of aggressive behaviour, and who experience considerable stress, negative feelings and burnout as a result (Gates et al, 1999; Oser, 2000; Rodney 2000; Evers et al, 2002; Astrom et al, 2004). The negative reactions of professional carers to assault may also lead to the perpetuation of aggressive behaviour in those for whom they care. The finding mentioned above that apparently similar care settings can experience widely differing incidences of aggressive incidents may reflect different ways that staff interact with residents, and respond to aggression (Gates et al, 2003).

Conceptual approaches to the management of aggressive behaviour

A number of conceptual approaches to the management of aggressive behaviour by people with dementia can be identified. These approaches can be used in conjunction with each other, but they tend to derive from different philosophical bases, leading to the question of which approach should be preferred in any situation.

The Pharmacological/Physical Approach: This approach derives from the "standard paradigm" of dementia care (Kitwood, 1997), that views aggressive behaviour as the more or less random consequence of neurological damage, and considers that the best response to such behaviour is to minimise its occurrence and effects by using tranquilising drugs and/or physical restraints. Some studies have found evidence for the effectiveness of pharmacological interventions in reducing aggressive behaviour (Raskind, 1999; Mintzer, 2001; Brodaty & Low, 2003; Lawlor, 2004), while other studies have found limited positive effects of neuroleptic drugs (Schneider et al, 1990; Lee et al, 2004; Sink et al, 2005). Side effects are a major concern when using these drugs with people with dementia, as they have been linked with quickened cognitive decline (McShane et al, 1997), and increased risk of adverse cerebro-vascular events (Committee on Safety of Medicines, 2004). While psycho-active drugs may reduce aggression by dispelling psychiatric symptoms such as delusional thinking or depression, in many cases drugs are used principally for their sedative properties.

Physical restraint of people with dementia may be achieved by holding the person's arms and body during personal care activities; through the use of mechanical devices such as restraining chairs or cot sides, or by employing control and restraint techniques to prevent the individual from attacking another person. The area of physical restraint as a means of managing aggression in people with dementia is grey and sometimes unclear, with little literature to guide practitioners in the use of such strategies, and the possibility of them being used in an abusive way.

The Environment Management Approach: This approach derives from two related assumptions. Firstly, that people with dementia are particularly sensitive to stress-provoking factors within their physical environment, and may react to these factors with challenging behaviour such as aggression. Secondly, that providing an environment that takes account of the cognitive disabilities of dementia allows some behaviours, for example wandering, to be reframed as non-challenging, with a consequent reduction of aggression from individuals prevented from walking around their

living space. A literature has developed regarding the optimum living environment for people with dementia who may be prone to challenging behaviours (Marshall, 2000; Stokes, 2000), embracing fundamental principles such as homely furnishings and decoration; colour and lighting that aids perception; minimisation of stress-provoking background noise; space for people to not feel overwhelmed by others, and safe and stimulating areas for the person to walk about in. There are however many care areas for people with dementia that are not built to the specifications recommended in the literature, and converting some environments would be highly costly.

The Behaviour Modification Approach: This model holds that learning theory principles can be adopted to extinguish aggressive behaviour. Wells and Wells (1997) suggest that analysis of the antecedents and consequences of aggressive behaviour can lead to staff devising interventions that will deny positive reinforcement to such behaviour, and if these interventions are implemented consistently, that behaviour will be reduced or eliminated. Other authors dispute that behaviour modification is feasible or appropriate for people with dementia and also hold that the underlying philosophy of behaviour modification is inimical to person-centred values of respect and understanding of the emotional world of the person (Stokes, 2000). Behaviour modification consequently remains the most controversial, and least used strategy for managing aggressive behaviour in people with dementia.

The Person-centred Approach: This approach focuses on attempting to understand the poorly communicated need being expressed by the aggressive person, and finding individualised ways of meeting that need (Stokes, 2000). Such strategies may embrace individualized care plans for assisting residents to complete activities of daily living without provoking aggressive responses. Another focus is the use of individual or group activities to relieve boredom, dispel energy and engender a sense of well-being in participants. The evidence for the effectiveness of person-centred care principles is compromised by practical problems with implementing such principles in residential care settings. Changes in care regimes as a result of training have proved difficult to sustain (Moniz-Cook et al, 1998; Lintern et al, 2000), often due to high staff turnover.

Conclusions

There are therefore potential practical and sometimes ethical problems with each approach. The pharmacological/physical approach used alone can deny the personhood of the individual, and can leave the person prone to damaging side effects, and even the risk of abuse. The environmental management approach may be prohibitively expensive to implement in some care settings. The behaviour modification approach again compromises personhood, and the person-centred approach, while ethically sound and supported by current policy, may be hard to implement and sustain. While the person-centred approach has much to commend it on ethical grounds, as it implies high quality nursing care, it is difficult on the basis of current research evidence to make a clear recommendation as to whether it or another approach should be adopted as best practice, and practitioners may be best advised to adopt a multi-factorial strategy to both understanding and intervening with aggressive behaviour, basing their approach on the particular circumstances of each individual (Turner, 2005).

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109 – Workshop 15 – Neurobiological Aspects – Neurobiological aspects of aggression: an update and clinical implications

A.M. van der Loo, M. Loomans, G. Goriounov & F. Timmermans (Netherlands)

1. Models of aggression and neurobiology

Adriano van der Loo, Rob van Ojen, Berend Olivier, Frank Koerselman, Speaker: Adriano van der Loo

Research on determinants of aggressive behaviour has long focussed on environmental variables only. More recently compelling evidence for neurological, endocrinological, and other biological determinants has been found. Integrative models for classification of different types of aggression has been proposed to be crucial. Research has previously been seriously flawed by divergence of these models between studies. Animal research using strict classifications of types of aggression has indeed presented noteworthy results on neurophysiological mechanisms, that may in part be translated to humans.(1)

Moyer (1968) describes aggression as "a behaviour that causes (or leads to) harm, damage or destruction of another organism." This behavioural definition excludes related affective responses such as "fear", "threat" or "hostility". Modern research on pathological aggression converges towards a model that discriminates between three major determinants: 1. dysfunction of aggression-inhibiting regions of the brain such as traumatic brain lesions, epilepsy, and Alzheimer disease; 2. hypo arousal associated with prolonged low plasma glucocorticoids, which diminish emotional inhibition of aggression such as conduct disorder and antisocial personality disorder; and 3. hyperarousal associated with irritability and outbursts such as depression, intermittent explosive disorder, and chronic fatigue. These three determinants may be associated with increased levels of specific types of aggressiveness: Hypoarousal may be associated with increased instrumental aggression, whereas hyperarousal and brain dysfunction may be associated with increased impulsiveness. Another classification of aggressive behaviour, discriminating offensive, defensive and predatory aggression, may partially overlap this model: Offensive behaviour is characterized by initiation of aggression and harmful intent. Offensive aggression may be predominantly instrumental and may be increased in hypoarousal. In contrast, defensive aggressive behaviour is purely a respons to threat. Defensive aggression may be predominantly impulsive and may be increased in hyperarousal. Predatory aggression may be primarily driven by appetite mechanisms. Predatory aggression may be either instrumental or impulsive and may be increased in brain dysfunction.

Decreased serotonin and increased testosterone levels have been shown to be most strongly associated with offensive (instrumental) aggression. Impulsive (defensive) aggression, however, has also been shown to be associated with low CSF 5-HIAA concentrations. These seemingly contradictory results may corroborate findings in animal research that suggest that a specific subset of the serotonin-system, such as the postsynaptic 5-HT1B receptor, may be important. Further research is needed to elucidate the role of specific serotonin receptors in the regulation of one or more subtypes of aggression, and possible associations with pathology in humans.

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2. Physiological aspects of aggression

By M.Loomans, Speaker: M. Loomans

Aggression is a complex phenomenon in which multiple causes involving biologic, psychological, and social aspects interplay. Moreover, different forms of violent behaviour may each result from different biopsychosocial pathways. Various psycho-physiological parameters are involved in the regulation and expression of aggression and violence in the antisocial spectrum. Understanding possible links between autonomic physiology, for example the finding of psycho physiologic underarousal (e.g., reduced resting heart rate and skin conducting levels, increased slow-wave EEG) may advance our understanding of this highly costly behaviour. Reduced resting heart rate and skin conducting levels are seen with adult offenders as well as juvenile delinquents. Recent research shows that there is similar autonomic response in boys with conduct disorder and their fathers. Autonomic measures may be less prone to bias and measure-related error than self-reports of psychological functioning. They may also be more sensitive indexes of the brain processes that are ultimately thought to be responsible for the behaviour. Violence associated with anger and emotional aggression (which is often more impulsive, less controlled, and reactive to some perceived provocation) may have different in psychophysiological aspects. The relationship of psycho physiologic underarousal to antisocial behaviour, therefore, may be specific to some forms of antisocial behaviour and perhaps to some less severe forms of violent behaviour.

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3 Hormones and aggression

By S. Goriounov, speaker: S. Goriounov

There is no evidence, that any hormone of aggression exists, but according to scientific research testosterone may be related to some forms of aggression. Testosterone levels will also be associated with different behavioural profiles among men, associated with life history strategies involving emphasis on either mating or parental effort. In aggressive personality disorders research has shown elevated testosterone level. A one-to-one relation between increased levels of testosterone

and aggression has been, nevertheless, difficult to reveal. Two metabolites of testosterone, estradiol and 5alpha-dihydrotestosterone (DHT), have been studied much less in human aggressive behavior. Estradiol might reduce androgenic effects and have a counterbalancing influence on aggression. Testosterone can exert its effects in one of two ways: either on androgen receptors after conversion to 5-alpha-dihydrotestosterone or on estrogen receptors after aromatization to estradiol. It can act via genomic mechanisms to induce production of proteins or via non-genomic mechanisms to modulate neural activity. Testosterone receptors are mainly in some hypothalamic neurons, where it is aromatized into estrogens, which determine the increase in aggressiveness. Seasonal and circadian fluctuations in male testosterone production might be responsible for some of the inconclusive testosterone-aggression results. A relation between testosterone levels and diencephalic serotonin has also been shown: the lack of serotonin increases aggressive behaviours both in animals and man. Cortisol has yielded conflicting results as a mediator in aggressive behaviour. Both higher and lower levels have been reported. Findings obtained with models suggest that hyperarousal-driven aggressiveness has at its roots an excessive acute glucocorticoid stress response (and probably an exaggerated response of other stress-related systems), whereas chronic hypoarousal-associated aggressiveness is due to glucocorticoid deficits that affect brain function on the long term.

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4. Alcohol and Aggression

By F. Timmermans, speaker: F. Timmermans

It has been demonstrated that consumption of alcohol can promote aggression, but the underlying mechanism and the differential effects are not fully understood. In naturalistic studies, alcohol has been identified as a clinically important risk factor for the occurrence of aggressive and criminal behaviour in subgroup of the population. Also experimental laboratory-based studies have demonstrated that alcohol consumption can facilitate aggressive behaviour. Studies on the pharmacological pathway, cognitive mediators and the individual differences in the reaction to alcohol have yielded interesting findings and hypothesises. It is clear that the relation between alcohol and aggression depends on multiple factors or causes. For the clinician, it could be of significance to be able to identify these risk factors or the risk groups. Typologies of alcoholism in the past have described a subtype, in which alcohol dependence has a genetic predisposition and is associated with impulsive-aggressive, antisocial behaviour (with or without alcohol). Animal and human studies have elucidated a variation in the serotonergic system that seems to influence circuits of self regulation and control, resulting in behaviour corresponding with subtypes of alcoholism. There is growing evidence for an important role of the serotonin (5HT) transporter gene. Gene polymorphisms in the 5HT-transporter system are shown to be related to the occurrence of aggression and the tendency to drink large amounts of alcohol. Recent literature on this topic focuses on gene to gene interactions and environmental influence on gene expression. Future research on serotonergic function, drinking habits and aggression might result in diagnostical and therapeutical options for alcohol related problems and impulsive, aggressive behaviour.

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110. – Workshop 16 – Dialectical Behaviour Therapy

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Anti-social personality disorder is, next to borderline, a disorder in which therapists experience difficulties in creating a therapeutic alliance. The character of the problems, and the fact that the problem behaviour is often seen as not connected to the disorder, does not motivate therapists to create a working alliance. DBT is based on the assumption that the attitude of therapists needs to be changed into a transparent, understanding and compassionate one, in order to make treatment effective. In a forensic psychiatric setting like Oldenkotte, normally a very judgmental attitude towards patients is found. In order to make forensic treatment possible, and effective, this attitude needs to be changed.

In recent years a treatment program was developed, and research has been started. The workshop will demonstrate the program and give the opportunity to experience some of the beneficial effects of this training. Even without implementing DBT as a treatment program, changing the attitude of the workers has an effect on the level of violence from and towards the patients.

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111. – Keynote 4 – Clozapine: anti-aggressive effect and compulsory treatment

P.F.J. Schulte and the ClozapinePlusCollaborationGroup (Netherlands)

Keywords
clozapine, aggression, compulsory treatment, schizophrenia

Introduction

Clozapine is the well-established gold standard in treatment of treatment-resistant and partially responsive schizophrenia and schizoaffective disorder . Recent effectiveness trials with real-world patients have shown better results with clozapine in comparison to other atypical antipsychotics. Earlier naturalistic evidence of a special anti-suicidal effect of clozapine was proven in a randomised-controlled trial in schizophrenic and schizoaffective patients with high suicidality . Interestingly, in humans suicidal behaviour and automutilation is associated with aggression and both seem associated with low serotonergic function .

Naturalistic investigations show a striking reduction of aggression in psychotic patients who are treated with clozapine because of treatment intolerance or refractoriness for conventional antipsychotics. Mallya et al. found in 107 psychotic patients treated with clozapine a significant decrease of episodes of restraint by 92% and seclusion by 83% . The duration of restraint and seclusion was reduced by 66% and 77% respectively. Another report by retrospective chart review on five psychotic inpatients residing on a specialized unit for the severely aggressive indicated that the overall frequency of assaults, self-abuse, and the use of seclusion, mechanical restraint, and chemical restraint was reduced although psychotic symptoms were not greatly affected by the drug . Buckley et al. compared the symptomatic response on the Brief Psychiatric Rating Scale (BPRS) between hostile schizophrenic patients and patients without aggression. While dramatic improvements were evident in aggression, both groups were indistinguishable with respect to BPRS response. This report indicates that the highly aggressive patients may improve substantially from clozapine . Rabinowitz et al. reported incidents of aggression and restraint of 75 schizophrenic inpatients with serious physically and verbally aggressive behaviour for 3 months before clozapine treatment and for 6 months on clozapine treatment . Patients showed significantly fewer incidents of physical aggression per month on clozapine and a similar decline in verbal aggression and necessity of restraints. Spivak et al. treated fourteen neuroleptic-resistant chronic schizophrenic patients with clozapine and prospectively evaluated for aggressiveness and impulsiveness for 18 weeks. Clozapine treatment induced a significant and marked decrease in impulsiveness (32% on the Impulsivity Scale) and aggressiveness (98% on the Overt Aggression Scale (OAS) . Frankle et al. reported on 165 psychotic patients with positive criminal histories, 65 of whom were treated with clozapine . Receiving clozapine during specific periods of time was significantly associated with a 68,9% lower arrest rate.

Clozapine's anti-aggressive effect may be independent from diagnosis and even psychosis: several case reports and series have been published on anti-aggressive effects of clozapine in patients with severe mental retardation. In these patients a diagnosis of psychosis is impossible. Vyncke looked at 40 patients with idiocy or imbecility and behaviour disorders which were not controlled by high doses of psychotropic drugs. Clozapine significantly decreased agitation, motor unrest, irritability and aggressiveness . A second publication describes the case of a low-grade imbecile who was unable to speak or understand much language, "behaving like a wild animal", totally unmanageable, persistently restless and violent. With clozapine he became calm and made his bed and dress. During hospitalisation for femur fracture clozapine was stopped. Again he became

unmanageable until re-institution of clozapine . Two cases with moderate mental retardation and autism showed with clozapine moderate or major improvement of property destruction, self-abuse (both cases) and assaultiveness (one case, the other not showing assaultiveness before) . Finally, Cohen & Underwood (1994) reported on four cases with moderate to profound mental retardation without schizophrenia. All cases had had numerous failed trials with conventional antipsychotics and other anti-aggressive medications. Three cases were diagnosed with seizure disorder also and were maintained on valproic acid during clozapine treatment. All patients showed marked decrease of assaultiveness and self-injurious behaviour.

Unfortunately lack of insight leading to rejection of antipsychotic medication is a frequent phenomenon amongst psychotic patients, especially under the most seriously affected. A literature search revealed only two publications on compulsory restart of clozapine after refusal.

This keynote lecture presents results from two randomised controlled trials on reduction of aggression and results of a naturalistic trial of compulsory treatment with clozapine of a cohort of severely ill psychotic inpatients.

Clozapine and aggression: randomised controlled trials

Volavka et al. (2002) randomised 157 partially treatment resistant patients with chronic schizophrenia or schizoaffective disorder and persistent positive symptoms and vocational or social dysfunction during the two preceding years in a first 8 week phase to fixed doses of haloperidol 20mg, risperidone 8 mg, clozapine 500mg or olanzapine 20mg . All patients received anticholinergics. In a second 6 week phase dosage was flexible. Now olanzapine was allowed to increase up to 40mg. The trial was not primarily designed to investigate anti-aggressive effects. The post-hoc results showed nevertheless significantly better effect for clozapine than for risperidone or haloperidol and numerically better effect than olanzapine on hostility . This effect was independent from paranoid ideation, formal thought disorder, hallucinations, sedation, akathisia, anxiety, depression or agitation. Once an adequate therapeutic dose of clozapine was reached (after 3 weeks of treatment), percentages of patients with at least one aggressive event were 17,5% with clozapine, 23,1% with olanzapine, 24,4% with risperidone and 45,9% with haloperidol (all sign. better than haloperidol) . Only clozapine proved to be superior to haloperidol in reducing the number and severity of aggressive incidents. Patients exhibiting persistent aggressive behaviour showed less improvement of psychotic symptoms than the other patients. There was an interaction between aggressiveness, medication type, and antipsychotic response: risperidone and olanzapine showed better antipsychotic efficacy in patients exhibiting less aggressive behaviour; the opposite was true for clozapine.

On the basis of these results the National Institute of Mental Health funded a trial to investigate clozapine's anti-aggressive effect in 116 schizophrenic or schizoaffective patients of state-hospitals with a clearly confirmed episode of physical assault directed at another person during their hospitalization and some persistence of aggression, as evidenced by the presence of some other aggressive event, whether physical or verbal or against property . These patients were not necessarily treatment intolerant or resistant to other antipsychotics. Substance use disorder was not stated to be an exclusion criterion. They were randomised to haloperidol 10-30mg, olanzapine 10-35mg or clozapine 200-800mg. All patients were receiving anticholinergics. Positive and Negative Syndrome Scale (PANSS) and Modified Overt Aggression Scale (MOAS) were used for measurement of psychopathology and aggression. For each subject, the overall total MOAS score was also computed. The total score for each type of incident (physical aggression, verbal aggression, and aggression against property) represents the number of incidents over time as well as their severity. Clozapine was superior to both olanzapine and haloperidol in reducing the number and severity of physical assaults as assessed by the MOAS physical aggression score and in reducing overall aggression as measured by the MOAS total score. Olanzapine was superior to haloperidol in reducing the number and severity of aggressive incidents on these 2 MOAS measures. There were no significant differences among the 3 medication groups in improvement

of psychiatric symptoms as measured by the PANSS total score and the 3 PANSS subscales. Thus the Krakowski trial proved not only clozapine's superior effect on aggression but also the independency of this feature from a special antipsychotic effect.

Compulsory treatment with clozapine

Because of the superior effect of clozapine on treatment refractory psychosis, aggression and suicidality the Dutch ClozapinePlusCollaborationGroup has investigated the effectiveness, tolerability and safety of compulsory treatment with clozapine (CTC) in a cohort of 17 severely ill psychotic patients (14 (82%) with schizophrenia and 3 (18%) with schizoaffective disorder) without earlier treatment with clozapine . The severity of illness in this population is highlighted by the reasons that led to CTC: treatment-resistance combined with serious suffering, suicidality, automutilation, assaultiveness, self-neglect, anorexia, or risk of permanent hospitalisation. If a psychiatrist had been unable to convince a patient of the necessity of treatment with clozapine and had subsequently given the patient the choice of taking clozapine orally or otherwise being given an injection with clozapine, we defined this patient's treatment as compulsory, even if in the end the patient had decided to swallow the medication. The primary measure of effectiveness was the change from baseline (T0) until the end of the acute-treatment phase (T1) and last observation (T2) with Clinical Global Impression-Severity (CGI-S) and Clinical Global Impression-Improvement (CGI-I). Response was defined as a CGI-I of 1 (very much improved) or 2 (much improved). The point taken as the end of the acute-treatment phase with clozapine was determined by the treating psychiatrist's clinical judgement, since this duration may vary widely inter-individually. The point of last observation was the last available evaluation of the patient whether on or off clozapine. Moreover, we wanted to evaluate whether a putative detrimental effect of coercion at T1 would last until T2. As a secondary measure, the amount of custodial restriction at T0 and T2 was noted. We constructed a scale from the most restrictive to the least restrictive environment, ranging from restraint/separation, closed ward, open ward with 24-hour nursing staff or 16-hour nursing staff, sheltered accommodation, nursing staff on request, to private accommodation. Tolerability of clozapine injections was evaluated by Clinical Global Impression Scale-Tolerance (CGI-T, a rating scale from 1 (excellent) to 5 (discontinuation necessary). Every adverse event was to be registered if the treating psychiatrist considered the relation with intramuscular clozapine as "very probable" according to the following definition: an adverse event which is mentioned as a possible side effect in the clozapine product information and which cannot be explained by other reasons such as concomitant medication or concomitant diseases. Safety was evaluated by registration of all serious adverse events during treatment with clozapine injections, irrespective of causation. At the beginning of the treatment period all patients were hospitalized in closed wards, seven patients in seclusion rooms.

The most serious form of coercion, physical constraint, was necessary in only three patients (18%). Five patients (29%) collaborated after intimidation by heavy nursing presence. In all other patients the firmly stated choice of taking clozapine orally or otherwise being given an injection with clozapine was sufficient. In 7 patients (41%) no injection was necessary, and 10 patients (59%) were given at least one injection. Duration of injection treatment was one to four days for four patients (40%), seven to eleven days for three patients (30%), and one to three months for three patients (30%). The maximum daily dosage of IM clozapine, given in one or two injections, was 12.5 to 25mg for four patients, and 50mg, 150mg, 200mg, 225mg, 300mg and 500mg for six patients respectively. Reasons for termination of clozapine were side-effects in two patients (leucopenia with IM clozapine and impaired liver function tests with oral clozapine in one patient each), and continuous injection treatment of 90 days without perspective of a switch to oral treatment in one. One patient's treatment had to be discontinued because of further psychic and somatic deterioration and swelling at the injection site. Another patient recovered to such an extent that he could convince the commission for complaints that compulsory treatment should be stopped. He was in a relapse at T2 but was treated successfully with a second course

of CTC later on. The last patient convinced the locum to return to compulsory treatment with haloperidoldecanoate and stopped his hunger strike.

The course of CGI-S scores shows a favourable time effect of CTC. Mean CGI-S decreased significantly from 6.4 before initiation of clozapine to 4.6 at the end of the acute-treatment phase (T1, mean (s.d.) 7.8 (6.8) weeks after baseline) and 4.5 at last observation (T2, mean 15.7 (17.3) months after baseline) (Friedman's non-parametric test: Chi-Square 21.06; df 2; p<.0001). This interpretation is substantiated by mean CGI-I: 2.5 (moderately improved) between T0 and T1 and 2.3 (much improved) between T0 and T2. The slight improvement between T2 and T1 as shown by CGI-S is reflected by a mean CGI-I of 3.4 between these points in time. Eight of 17 patients with CTC (47%) were considered to be responders (CGI-I of 1 (very much improved) or 2 (much improved) at the end of the acute-treatment phase. At last observation as many as ten of the 11 patients still on clozapine (59% of the total cohort) were classified as much improved or very much improved, although the patients on clozapine were followed up (T2) for a mean of 15.2 months. At T2 eight patients were taking clozapine voluntarily (mean CGI-I: 1.9), while three still needed some coercion (mean CGI-I: 1.3). The remaining six patients had returned to other antipsychotics than clozapine; half of them were taking their medication voluntarily (mean CGI-I: 3.0), the other half compulsorily (mean CGI-I: 3.7). The degree of custodial restriction at T2 showed improvement in 11 patients (65%) and no change in six (35%). No patient needed more custodial restriction at T2 in comparison to T0.

Seven patients (70%) tolerated the injection treatment very well or showed only minor side effects (CGI-T of 1 or 2). Sialarrhoea was reported in two patients, and somnolence and speech disorder in one patient. Two patients with a dosage of 150mg and 225mg respectively developed local swelling and one patient backflow of clozapine solution at the injection site. Transient leucopenia was seen in one patient and led to cessation of CTC (CGI-T of 5). No serious adverse events were observed.

The results of this naturalistic long-term study show that in a clozapine naive cohort of 17 patients with serious chronic psychotic disorders a compulsory trial with clozapine turned out to be feasible, effective, safe and well tolerated.

Conclusion

Clozapine shows superior efficacy in treatment resistant schizophrenic and schizoaffective patients. It has specific anti-suicidal and anti-aggressive properties. In case a patient with a strong indication for clozapine rejects this treatment a compulsory trial may be considered.

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Benzodiazepines versus antipsychotics were compared in three studies (Foster et al., 1997; Dorevitch et al., 1999; Alexander et al., 2004). In one study lorazepam was comparable to haloperidol (Foster et al., 1997). In two studies a benzodiazepine, flunitrazepam or lorazepam, was as effective as haloperidol (Dorevitch et al., 1999; Alexander et al., 2004).

Figure 1: Drugs joined by arrows have been compared to each other (in one or more studies); numbers along the arrows indicate the total number of study participants in each treatment arm of the RCT(s). Dosages per administration are indicated under the drug-name. For references, we refer to Goedhard et al. (2007a).

Antipsychotics

Haloperidol, a high-potency antipsychotic, is the most frequently evaluated drug in RCTs. One of the first placebo-controlled trials in acute aggression reported efficacy of haloperidol in dosages of two and five mg over placebo and chlorpromazine (Reschke, 1974). Furthermore, a number of other typical and atypical antipsychotics have been studied. In general, only small differences in efficacy between the drugs were found. The observed differences in efficacy and adverse effects between the different typical and atypical antipsychotics predominantly rest on differences in pharmacokinetic properties of the different drugs. In addition, it was found that in the case of mild aggressive behaviour, oral administration can be a good alternative to parenteral tranquillization (Currier et al., 2004; Dubin et al., 1985).

Benzodiazepines

The short-acting lorazepam is the most extensively studied benzodiazepine in aggression. It has been compared to haloperidol, placebo and olanzapine and to combination therapy of haloperidol and promethazine. No significant differences between haloperidol and lorazepam were observed in the trials. However, combination therapy of haloperidol and lorazepam was superior over monotherapy of haloperidol or lorazepam in that the onset of action was more rapid (Battaglia et al., 1997; Bieniek et al., 1998). Furthermore, more sedation was reached with combination therapy compared to monotherapy.

Maintenance pharmacotherapy of aggression

For maintenance therapy, i.e. pharmacotherapy for patients in which aggression is an ongoing problem, long-term sedation might be considered an undesired effect. Therefore, also drugs with other anti-aggressive properties are used. Ideally such drugs act on neurotransmitter pathways specifically implicated in the modulation of aggression. We recently reviewed 31 RCTs aimed at maintenance pharmacotherapy of aggression. For a detailed review as for study references, we refer to Goedhard et al. (2006). A broad spectrum of psychotropic drugs was studied and evidence was evaluated (Table 1). Most studies were conducted in a schizophrenic population and in borderline personality disordered patients.

Table 1: Review of RCTs studying maintenance pharmacotherapy of aggression (Goedhard et al., 2006). For references, we refer to Goedhard et al. (2006).

Drug	Evidence				Acceptable Generalizability
	N	k	SS	Efficacy	
Classical antipsychotics vs placebo	308	3	2/3	Weak evidence of efficacy	1/2
Atypical antipsychotics vs placebo and/or haloperidol	2122	7	3/7	Weak evidence of efficacy compared to placebo and haloperidol	5/7
Beta-adrenergic blockers vs placebo	169	5	2/5	Weak evidence of efficacy	4/5
Anticonvulsants vs placebo	450	6	3/6	Weak evidence of efficacy	2/6
Antidepressants vs placebo	1024	10	6/10	Weak evidence of efficacy	6/10

N = Total number of participants of the RCTs; k = Number of studies; SS = Number of studies in which a statistically significant effect was found.

Antipsychotic agents

This anti-aggressive effect of antipsychotics might be due to the treatment of the acute illness, as other studies have shown that patients with unstable mental illness are at increased risk of displaying aggressive behaviour (McNiel et al., 1988). However, theoretically, antipsychotic agents might also be effective in reducing aggressive behavior independently from the effect on psychosis, as both typical and atypical antipsychotics act on dopaminergic mechanisms and the atypical antipsychotics additionally on the serotonergic receptors. From the RCTs we retrieved, it was found that haloperidol was superior over placebo in reducing hostility. Furthermore, atypical antipsychotics were superior to typical antipsychotics in reducing aggressive behaviour. One study showed that clozapine was significantly superior over haloperidol, risperidone and olanzapine in a schizophrenic population resistant to previous neuroleptic treatment (Citrome et al., 2001). The anti-aggressive mechanism of clozapine in this study appeared unrelated to the overall psychopathological improvement.

Antidepressants

Neurobiological studies have indicated the importance of serotonin in the modulation of aggressive behaviour (Olivier, 2004). Consequently, in the last decade, serotonergic antidepressants have been investigated for their anti-aggressive properties. It can be concluded that there is some

evidence that serotonergic antidepressants are effective in reducing aggressive behaviour in several psychiatric diseases. However, in some studies the follow-up period was probably too short to evaluate efficacy sufficiently.

Beta-adrenergic blockers

The mechanism by which beta-adrenergic blocking drugs might reduce aggression is not fully understood, as both beta-adrenergic blockers passing the blood-brain-barrier and beta-adrenergic blockers hardly passing the blood-brain-barrier were found effective. Overall it may be concluded that beta-adrenergic blockers can be useful in reducing aggressive behaviour in schizophrenic patients. However, it is unclear whether these benefits outweigh the observed adverse events like syncope and bronchospasm, which were observed in the RCTs evaluated.

Anticonvulsants

Anticonvulsants are frequently used in the management of aggressive behaviour (Citrome, 1995). A possible rationale for this is the association of aggression and EEG abnormalities or seizures (Monroe, 1989; Stone et al., 1986). Furthermore some anticonvulsants, including valproate and topiramate, have GABA-ergic properties. We found that anticonvulsants can be effective in reducing aggressive behaviour in cluster B personality-disordered outpatients. In some studies however, the sample-size was small or the population consisted of patients with an acute exacerbation of mental illness, a population in which it is difficult to investigate the effect of maintenance therapy.

Practice based evidence

In clinical practice a broad spectrum of psychotropic drugs is used for the treatment and management of aggression. Clinicians 'struggle' with prescribing drugs for patients with aggression for many reasons (Stolker, 2002). Aggression is not a psychiatric diagnosis. It is difficult to study heterogeneous phenomena associated with many biological, psychological and social factors. Especially the population of highly aggressive patients, involuntarily hospitalized on closed wards and forensic settings for whom medication may be used as a last resort, is a very complex population with multiple psychiatric and somatic disorders. In addition to monotherapy and polypharmacy in fixed dose regiments, as needed medication is frequently used for these patients (Craig and Bracken, 1995; Craven et al., 1987; McLaren et al., 1990). As recruitment procedures for RCTS frequently depend on voluntary participation (Edlund et al., 1985), these highly aggressive patients are likely to be excluded from participation in RCTs In addition, psychiatric patients with co-morbid disorders are frequently excluded from RCTs (Heerdink et al., 2004). For example, patients with substance abuse, which is associated with aggression, were frequently excluded from the RCTs we analyzed (Steadman et al., 2000). Concomitant use of psychotropics was also frequently used as an exclusion criterion. Therefore, it is likely that the scarce evidence for the treatment of aggression that is available is not based on patients we struggle most with in clinical practice.

Observational studies to study aggression

Observational studies can play an important role in filling the gap between evidence based on RCTs and clinical practice. Descriptive and exploratory observational studies may help to analyse the gap. For example, we conducted a study on three wards for long-term treatment of patients with externalising problem behaviour and compared the use of as-needed medication in aggressive and non-aggressive psychiatric patients. Furthermore, we explored patterns of administration of as-needed medication around aggressive incidents. For a detailed description of this study, we refer to Goedhard et al. (2007b). It was found that an increased use of both psychotropic and somatic as-needed medication is associated with aggressive behaviour. Aggressive patients had an increased

use of both psychotropic and somatic as-needed medication (incidence density ratio, 2.5; 95 % confidence interval, 2.2 – 2.7 and incidence density ratio, 2.1; 95 % confidence interval, 1.8 – 2.4, respectively). It was also found that 15% of psychotropic as needed medication was administered in a time-window of 48 hours around an incident. This medication is more frequently administered shortly after an aggressive incident than shortly before. Probably medication after an incident is mainly administered to regain control and / or prevent further escalation. For the other as-needed medications administrations it is possible that aggressive patients are keen on as-needed medication, which they might obtain by showing demanding behaviour. However, on the basis of this study it also might be possible that aggressive behaviour in the past leads to the administration of as-needed medication in the future, with the aim of preventing the occurrence of other aggressive incidents.

Observational study designs should not only be used to explore the gap between evidence from RCTs and clinical practice, but also to study the effectiveness and safety of drugs used to treat aggressive patients (Heerdink et al., 2004; Stolker, 2002). We conducted a study to the association of antipsychotics and seclusion (Stolker et al., 2005). The median time from admission to seclusion among psychotic patients who used antipsychotics during the first week was 7 days. In patients not using antipsychotics this was 2.5 days. Antipsychotic use was significantly associated with a later application of seclusion with an adjusted (gender, age, GAF score) hazard ratio of 0.6 (95% confidence interval: 0.3-1.0). Among patients with psychotic disorders, 15.3% who used antipsychotics prior to seclusion during the first week of hospitalization were secluded compared to 20.5% of the psychotic patients not using antipsychotics during the first week. This corresponds to a relative risk of 0.7 (95% confidence interval: 0.5-1.2). In patients with psychotic disorders, seclusion relatively often preceded the prescription of antipsychotics with a relative risk of 2.0 (95% confidence interval: 1.2-3.4). It was concluded that the use of antipsychotics is associated with a later application of seclusion, probably a delay. Because antipsychotics leads to a reduction of agitation and aggression both in psychotic and non-psychotic patients, it is likely that use of antipsychotics also leads to a lower risk of seclusion. In a substantial proportion of our patients antipsychotic treatment was initiated shortly after starting seclusion. We think that earlier (involuntary) use of antipsychotics might have prevented patients from being secluded.

Conclusion

Evidence on effectiveness of pharmacotherapy in aggressive psychiatric patients is scarce and, if available, of disputed quality. Nevertheless, medication is a mainstay in both acute and maintenance treatment of aggressive symptoms in psychiatric practice. More and better clinical trials are needed to provide a more solid evidence base for the application of medication in these patients. However, since large trials in complex patient groups will face major practical, ethical and financial challenges, it is unlikely these will be performed. Meanwhile, well-designed observational studies may offer insight in the effects of pharmacotherapy on aggression, resulting in practice-based evidence that may bridge the gap between pharmacological theory and the needs of daily psychiatric practice.

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113. – Keynote 6 – Violence Research: Pharmacological and Fundamental Aspects

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Keywords
serotonin, aggression, 5-HT1B receptor, 5-HT transporter, 5-HT1A receptor

Introduction/background:

Fundamental research into neurochemical bases of violence is extremely difficult to perform in humans and animal modelling of such violent or pathological aggressive behaviour may contribute to better understanding of the complexity of the underlying neural systems and possible therapeutic strategies. Most commonly used animal models of aggression employ situations that evoke normal species-specific agonistic behaviours (offense, defense, submission and flight). Such normal aggression is ritualized, follows specific rules and is biologically adaptive. Pathological aggression and escalated aggression occur under certain conditions, including genetic predispositions, social provocations, frustrating experiences and direct brain manipulations. Pathological aggression may occur in certain genetically modified mice, e.g. the serotonin1B (5-HT1B) receptor knockout and the neuronal nitric oxide synthase (nNOS)-knockout mouse. Systematic investigation of brain mechanisms changed in such genetically mutated animals may help in unravelling potential neuronal networks and neurochemical pathways involved in aggression. Although several neurochemical systems are involved in the modulation of (pathological) aggression, the serotonergic system seems particularly important and is the focus of this paper. The 5-HT system is a complex, elaborate neuronal network present in all areas of the brain and spinal cord. Serotonergic cell bodies in the midbrain project densely to brain structures implicated in the modulation of aggression. Serotonin is involved in many functions, including mood, anxiety, sleep, feeding, sex and aggression. The serotonergic system employs 14 different receptor types and one transporter molecule, the target of an important class of antidepressants, the SSRIs. The firing activity of serotonergic neurons is fine-tuned by feedback mechanisms.

The general dogma that serotonergic activity is inversely related to aggression, is clearly too simple seen the complex make-up of the serotonergic system and in particular the 5-HT1B receptor plays a prominent role in the modulation of aggression. This receptor is present pre-synaptically as inhibitory autoreceptor on serotoninergic neurons and as inhibitory postsynaptic heteroreceptor on various non-serotonergic neurons. Activation of postsynaptic 5-HT1B receptors selectively suppresses attack behaviour and appears a key player in the serotonergic involvement in aggression. Early clinical studies with selective anti-aggressive drugs (serenics) pointed to some clinically relevant anti-aggressive effects but those drugs failed to reach the market.

Some triptans presently used to treat migraine, possess agonistic activity for the 5-HT1B receptor and, therefore, should exert clinically relevant anti-aggressive activity. Whether such drugs are helpful in treating human pathological aggression and violence is still speculative.

Aggression, serenics and 5-HT1B receptor agonists

In the 1970s attempts were made to develop specific drugs to treat pathological aggression. This led to the development of eltoprazine, a highly potent and selective anti-aggressive (serenic) drug (Olivier et al., 1994). Serenics exerted high binding to 5-HT1A and 5-HT1B receptors and are (partial) agonists at 5-HT1A and 5-HT1B receptors (Olivier et al., 1994).

Although 5-HT1A receptors may play a role, extensive pharmacology indicated that in particular 5-HT1B receptors play a modulatory role in offensive aggression. Further on, local injection studies in the brain strongly suggested that post-synaptically located 5-HT1B receptors (heteroreceptors) mediate this specific anti-aggressive effect (Olivier et al., 1994).

Is serotonin inhibitory in aggression?

The big dogma in the relationship between serotonin and aggression is that 5-HT inhibits aggression, mainly derived from studies in which brain serotonin levels were decreased by neurotoxic agents depleting serotonin from serotonergic cells. Such an inverse relationship between 5-HT and aggression has been found in animals and humans, although in humans measurements on 5-HT activity were based on CSF levels of the main metabolite of serotonin, 5-hydoxyindoleacetic acid (5-HIAA). Notwithstanding severe criticisms on this parameter, for many years it was the only measure in humans reflecting (indirectly) the functional status of the 5-HT system. In animals, 5-HT and 5-HIAA are measured directly in the brain and it could be assumed that the inverse relationship between functional serotonergic activity and aggression should easily be established. However, several contradictory results have been found and even reports of a positive relationship between 5-HT and aggression occur. In humans aggression is associated with suicidal behaviour and both seem associated with low serotonergic function, although it is possible that both phenomena are independently regulated (Mann, 2003). A causal relation between 5-HT activity and aggression or impulsivity cannot be derived from static measurements of 5-HT or 5-HIAA measurements in brain tissue or CSF-fluid. A functional role of serotonergic neurons in the initiation, execution and stopping of aggression (Coccaro, 1989; Miczek et al., 2002) still has to be established although some progress has been made using in vivo microdialysis techniques in freely moving (aggressive) animals. This technique however, still lacks sufficient resolution because sample time (minutes) is still of a different magnitude than the actual behavior (seconds). Moreover, the serotonergic system is not made up of one homogeneous mass of cells but is a very differentiated and complex system.

A recent approach to unravelling the role of the 5-HT system in aggression studies differences between highly aggressive and low-aggressive rats. De Boer et al.(2003) argued, based on the assumption that individual levels of aggression of a rat (offensive aggression) is part of an individual coping strategy of the animal and thus an important indicator of a trait-like behavioural and physiological response pattern. In contrast to the existing theory of inversed relationship between 5-HT activity and aggression, a positive correlation was found between the level of trait-like aggression (high or low) and basal CSF concentrations of 5-HT and 5-HIAA (Van der Vegt et al., 2003). Moreover, frontal cortex levels of 5-HT and 5-HIAA measured by in vivo microdialysis did not differ between endophenotypes. Apparently, normal offensive aggression is positively related to serotonergic neuronal activity, whereas an inverse relationship probably exists between 5-HT activity and impulse-like violent aggression (Coccaro, 1989). Thus a general pattern emerges where trait and state aggression are probably differentially regulated by the 5-HT system (and other systems) although much more research is needed to substantiate this hypothesis.

Is the serotonergic system in highly aggressive animals different from those of normal and low aggressive animals? De Boer et al. (1999) describe that WAY-100,635, a silent 5-HT1A receptor antagonist (with regard to intrinsic effects on aggression) has differential effects on low (increase in aggression) versus high aggressive rats (decrease in aggression), indicating differential basal tones of the serotonergic systems. In contrast, studies of 5-HT1B receptor agonists have always found anti-aggressive effects, independent of the basal aggression level of the animals (Mos et al., 1992; Miczek et al., 2002; Olivier and Mos, 1986), again additional support for a direct postsynaptically mediated 5-HT1B receptor agonism underlying the specific anti-aggressive effects.

5-HT1B receptor knockout mice show enhanced aggressive behaviour (Saudou et al., 1994). More recent studies (Bouwknecht et al., 2001; Pattij et al., 2003; 2004) have implicated the 5-HT1B receptor in impulsivity regulation, rather than offensive aggression per sé (Lesch and Merschdorf, 2000). Olivier et al. (1995) suggest that the specific anti-aggressive effects of 5-

HT1B receptor agonists are postsynaptically modulated. Such postsynaptic 5-HT1B receptors are located as heteroreceptors on non-serotonergic neurons (including dopaminergic, cholinergic, and GABAA-ergic neurons). When activated by 5-HT, they inhibit ongoing behaviour, including aggression. Thus, 5-HT1B receptor agonists inhibit those 'aggression or impulsivity' modulating neurons and removing postsynaptic 5-HT1B receptors (via null mutation of the 5-HT1B receptor gene) removes this 'brake', thereby facilitating various behaviours related to impulsivity, hyperactivity and aggression (Olivier and Young, 2002).

Human evidence

Our hypothesis that the 5-HT1B (hetero) receptor plays a vital role in modulation of consummatory aspects of offensive aggression, also implies that altered function of this receptor in humans may contribute to (pathological) changes in aggressive behavior under various circumstances. The human 5-HT1B receptor (HTR1B) is located at chromosome 6q14.1 and does not have introns. Many mutation scans have identified a number of polymorphisms in the coding sequence and surrounding 5'- and 3'-untranslated regions (UCR) and more than 20 association studies have been published with varying results (Sanders et al., 2002). A missense mutation G861C, a silent SNP, has often been used for the association studies and some interesting associations have been found using this polymorphism, including antisocial alcoholism (Lappalainen et al., 1998), history of suicide attempts (New et al., 2001) and obsessive compulsive disorder (Mundo et al., 2000). It has been found that subjects homozygous for G861C show an enhanced binding to the HTR1B; thereby indicating functional changes (Huang et al., 1999). Other likely candidates that influence the functional activity of the 5-HT1B receptor genes are functional SNPs in the regulatory (promoter) regions of the HTR1B. Some functional SNPs have been found (Duan et al., 2003) and they seem to be in linkage disequilibrium with the G861C marker: the latter has been associated with several psychiatric disorders, including pervasive aggressive children (Davidge et al., 2004), and antisocial behavior in alcoholics (Hasegawa et al., 2002; Soyka et al., 2004). Suicidal behavior and suicide, often considered inward-directed aggression were however, never associated with G861C polymorphism (Nishiguchi et al., 2001; Rujescu et al., 2003; Stefulj et al., 2004).

It is not at all clear however what the importance of these various polymorphisms in the promoter or coding regions of the HT1B is: in our theory a decrease in function would induce enhanced aggression. Moreover, because the polymorphisms are present in the pre- and postsynaptic 5-HT1B receptors, the functional consequences could be extremely complex.

Another candidate gene, indirectly influencing the activity at 5-HT1B (hetero) receptors is the 5-HT transporter (5-HTT). Lowered serotonin levels at the 5-HT1B heteroreceptor might lead to diminished activation of it and consequently to less inhibition of the postsynaptic neurons, leading to enhanced aggression. A functional polymorphism of the 5-HTT gene has been described, a 44-base pair insertion/deletion in the upstream regulatory promoter region (5-HTTLPR): two alleles are present: 'long' (L) and 'short' (S) ones (Heils et al., 1995). Moreover, a variable number of tandem repeats polymorphism (VNTR) in the second intron has been found (Ogilvie et al., 1996). The VNTR polymorphism consists of nine, 10 or 12 copies of a 16-17 base pair repeat element that may influence transcription of the 5-HTT gene (MacKenzie and Quinn, 1999). There are no studies into the relationship between the 5-HTT VNTR and aggression. This in contrast to the bi-allelic functional polymorphism in the promoter region, that affects 5-HTT-gene expression since the S promoter is less active than the L promoter, and SS genotypes express 50% of the 5-HTT-protein level of LL genotypes (Collier et al., 1996). The 5-HTTLPR polymorphism has been studied extensively in relation to personality and psychiatric disorders, and a number of studies have indicated that genotype of the 5-HTTLPR allele is associated with various anxiety- and depression related personality traits (Van Gestel and van Broeckhoven, 2003; Schinka et al., 2004). Several studies have found associations between aggression and violence and the S-alleles of the 5-HTTLPR, e.g., in extremely violent crime in Chinese males (Liao et al., 2004), in forensic psychiatric violent Caucasian males (Retz et al., 2004), in suicidal behavior (Anguelova

et al., 2003; Arango et al., 2000; Bellivier et al., 2000; Caspi et al., 2003), in aggressive children (Davidge et al., 2004), and in impulsivity (Lee et al., 1999).

Because such studies are based on associations and not on direct causality the results have to be considered extremely careful. Nevertheless, the data seem in line with our hypothesis that lower 5-HT activity somehow can be associated with enhanced aggression and violence.

No specific drugs are available for treatment of aggression or violence in humans, in particular acting via 5-HT1B receptors. Although some anti-migraine triptans (notably zolmitriptan and sumatriptan) can be applied in patients, no well-designed and controlled studies with these compounds have been performed in the realm of potential anti-aggressive activity. It would be highly interesting to see whether such compounds indeed might reduce aggression, as suggested by animal studies (De Almeida et al., 2001). Selective serotonin re-uptake inhibitors (SSRIs) seem to exert some anti-aggressive effects but most studies are performed in psychiatric patients where aggression was co-morbid, e.g., in depression or anxiety disorders (Walsh et al., 2001). Again, SSRIs have never been tested on their primary anti-aggressive potential in patients with aggression or violence as primary indication. Animal studies suggest that SSRIs might have some, but limited anti-aggressive action, in aggressive or violent patients.

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114. – Keynote 7 – The use of physical restraint within the context of the ethical standards of psychiatric professionals

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Keywords
physical restraint, ethical standards, risk

Introduction

This paper focuses on physical restraint procedures and examines how, and if, the use of restraints is consistent with professional ethical practice given the myriad of risks inherent in their implementation. Violence, coercion, and the use of seclusion and physical restraint continues to be one of greatest, high profile concerns within the field of psychiatric and mental health service systems for over the past 10 years. This topic has resulted in countless articles, conferences, position papers, and federal regulatory changes. Nevertheless, physical restraint deaths continue to happen in mental health settings in the United States on a regular basis.

By now it should be apparent to those of us in the psychiatric professions that restraints and seclusion are not benign procedures and the reasons that people die proximal to their use has been documented exhaustively. There has also been much written about the adverse emotional effects of restraint and seclusion (Gallop, McCay, Guha, & Kahn, 1999; Mohr, Petti, & Mohr, 2003). To date in the United States there is no precise way to measure the number or extent of the injuries to children and injuries also to staff as a result of the use of restraint use. Nunno and his colleagues (2006) recorded the deaths of 45 children from restraints in a 10 year period from 1993-2003. Most recently, the Child Welfare League of America (CWLA) estimated that between 8 and 10 children in the U.S. die each year due to restraints, while numerous others suffer injuries. How many adults die as a result is not known as such data is collected inconsistently and carelessly. Moreover the largest regulatory agency, the Center for Medicare and Medicaid Services does not maintain comprehensive and reliable information about reported restraint and seclusion-related deaths (Levinson, 2006). As caregivers who have chosen to work for the well being of people with mental illnesses, we can all agree that even one of these deaths is unacceptable.

Psychiatrists and psychiatric nurses have called for more staff training in de-escalation techniques and they have issued numerous position papers and guidelines asserting that restraints and seclusion are interventions of last resort. There is little to disagree with in any of these well-meaning pronouncements. However, the position papers and statements fail to convey the complexity of the factors involved in patient aggression, its management, alternatives to, and death and injury proximal to the use of physical or mechanical restraints. Nor do they address the key elements that should be foundational with respect to the consideration of any intervention that we include in our therapeutic armament. Such interventions should be informed by a solid knowledge enterprise that deals with questions of: 1) What do we know? 2) How much do we know? and 3) How well do we know it?

Three areas beg for attention in our knowing enterprise with respect to the above questions: education, research and practice. In the area of education, our professions have failed to educate our students and residents adequately with respect to the multi-factoral reasons for aggression and violence, how to de-escalate potentially violent situations, what risks are inherent in their use, and how to apply restraints safely. However, the professions of nursing, social work, and psychology are beginning to include subject matter about the lethality and other adverse effects of restraints.

But there is only so much that these professions can do as psychiatry remains at the top of the treatment hierarchy and psychiatric physicians are frequently referred to as the "Captain of the Ship". But, as recently as 2004, Kaplan and Sadock's Comprehensive Textbook of Psychiatry, perhaps the definitive psychiatric textbook in the United States, and perhaps internationally, failed to provide a single sentence on the necessity of personnel training or on the danger of restraint use, either to patients or staff (Slaby, Dubin, Baron, 2004). This is a serious omission given that it is physicians who are ultimately responsible for patient treatment and who are the individuals who write the orders allowing staff members to use restraints. It is even more serious as in the U.S. the restraint issue has been a very important topic of discussion over the past 10 years, leading to significant federal regulation and legislation.

In the area of practice, health care professionals have been remiss in failing to identify patients who, because of potential risk factors, might be at high risk of death and injury. In the research arena, the situation is even more dismal. Research is urgently needed to address risk factors associated with death proximal to physical restraint of patients. Studies should be conducted on independent, interactive, and cumulative effects of these risk factors on death and injury rates.

Multidisciplinary research is also needed in determining what programming actually constitute a best practices approach with respect to primary and secondary prevention of violence, and which constitute the safest approaches in the unavoidable event that a restraint becomes necessary. In sum, our knowing enterprise needs serious focus before our positions on the use of this coercive measure as a tool in our psychiatric armament can be fully realized. None of this has happened and restraint deaths continue to occur across a variety of institutional settings in the U.S.

All mental health professionals are aware that most chronic mental illnesses are conditions without cures, but our goal for patients is to provide them with tools necessary for their return to productive and meaningful lives. This is no easy task and sometimes coercive measures are necessary in order for patients deemed dangerous to themselves or others to receive the help that they need. Legally, in the U.S. we have a number of commitment laws at our disposal in such instances, and this is not necessarily an inappropriate situation. When patients are placed in institutions we also are permitted to subject them to the coercive measures of seclusion and restraint which are meant to control violence and provide for patient safety. However, legal legitimacy of the use of such measures requires moral validity. Because a procedure is considered legal and not outside of the standard of care, it is not necessarily morally justified.

Mental health services are provided by a myriad of different helping professionals, both within and outside of institutional settings. These professionals include psychiatrists, psychologists, nurses, and social workers. Each of these professions has a code of ethics. These codes are public statements that set clear expectations to guide practice and speak to the core values of the profession. The codes are more similar than dissimilar, and they are broadly based on the principles of beneficence, non-malefiscence, autonomy, and justice (Parsons, 2001). The codes derived from the aforementioned set of principles are meant to be applied to the individual exercise of professional judgment.

Professionals who work with psychiatric patients in any capacity are expected to adhere to a their ethical codes which are meant to guide practice that is in the best therapeutic interest of their clients or patients. However, given that employing the procedure of physical restraint, that has been shown to be dangerous to patients and staff, and which has not been subjected to research scrutiny in the same way that any other intervention that we employ in psychiatry is lacking in moral validity. It violates each of the broad principles underpinning the ethical practice of the helping professions and does not constitute ethical practice.

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115. – Keynote 8 – Do patients with Asperger's Syndrome have an increased risk of violence? – Some preliminary findings from a literature review

Stål Bjørkly (Norway)

Keywords
Asperger's syndrome, violence, review

Some clinical features associated with Asperger's Syndrome

Despite some differences in diagnostic criteria, sustained impairments in social interaction and restricted repetitive patterns of behaviour are common criteria for a diagnosis of Asperger's syndrome (AS) to the DSM and ICD system. Individuals with AS display a wide spectrum of behavioural responses and it is not unlikely that a substantial proportion of their conduct problems is triggered by actual and/or perceived failure in social interactions. In contrast to autism, onset criteria state that there should be no clinically significant delay in language acquisition, cognitive and self-help skills. Although individuals with AS generally do not suffer from speech abnormalities, some communication deviances are often present: a constricted range of, and often inappropriate, intonation patterns, unusual rate of speech, tangential and circumstantial speech, and incessantly talking about a subject disregarding whether other persons are interested or not. Even though individuals with AS find themselves socially isolated they are not usually withdrawn in the presence of other people. They may want friendships but their wishes are thwarted by eccentric, awkward approaches, and insensitivity to other persons' feelings, intensions, and analogue communication. Typically, they may be able to cognitively describe other people's emotions and intentions, but they are unable to act on this information in an intuitive and spontaneous way. Their dependence on rule-governed behaviour creates a picture of social rigidity and immaturity that is so typical of these persons. Acquisition of motor skills is typically delayed and they often appear visibly awkward with bouncy gait patterns, poor coordination, and odd posture.

Asperger's Syndrome and violence

In a review of the literature Fombonne and Tidmarsh (2003) found but one epidemiologic study that investigated only AS and six studies that provided specific estimates for the prevalence of AS together with estimates for other subtypes of pervasive developmental disorders. The prevalence rates reported in these studies ranged from 0.3 to 48.4 per 10,000. The authors conclude that the reviewed studies were flawed by methodological problems and further research is needed to obtain more valid estimates. Given the low prevalence of AS, it is not clear how commonly violent behaviour occurs. Attempts to assess the violence rate have been hampered by problems pertaining to reliable and valid diagnosis of Asperger's Syndrome and accurate recording of violence. The divergent estimates obtained reflect that the exact prevalence of violence in persons with AS is far from settled. Moreover, it is unclear whether the studies referred to above actually can be taken as evidence of a true and specific association between AS and violence.

Even if such a prevalence association is found we still need to find out more about possible features of AS that also make some individuals with the syndrome prone to violent behaviour toward others. Several case studies document some unusual examples of violence committed by an occasional AS patient (e.g. Everall, & Lecouteur, 1990; Holander, Dolgoff-Kaspar, Cartwright,

Rawitt, & Novotny, 2001; Milton, Duggan, Latham, Egan, & Tantam, 2002). However, some of these studies used very wide definitions of violence including agitation, non-violent anger, damage to property, and the like. Furthermore, there is a paucity of articles that have compiled case studies to do a systematic search for common elements of dynamics of violence specific to this disorder. This implies that our current knowledge is lacking of any particular characteristics of dynamics of violence specific to these persons: What would motivate violent behaviour? Are there any certain triggers or precipitants of violence? What type of violent behaviour is to be expected? Who would the victims of violence be?

In sum, although findings from some studies indicate the existence of a possible AS-violence link a systematic review of the literature appears to be well founded. The main objectives of the review are (1) to examine the empirical basis for the existence of a relationship between Asperger's Syndrome and violence risk, and (2) to determine whether certain characteristics of Asperger's Syndrome may have a higher violence-triggering potential.

Method

Data collection

Two searches were conducted on the possible relationship between Asperger's Syndrome and violence in the anglophonic literature. Studies were obtained through electronic data searches on CINAHL (1982 to medio February 2007), Cochrane Reviews (1992 to medio February 2007), Medline (1966 to medio February 2007), ProQuest (1992 to medio February 2007), PsycInfo (1967 to medio February 2007), og ScienceDirect (1995 to medio February 2007). The search terms for the first search were Review of and Asperger's syndrome and risk assessment or risk management and violence risk or violence or violent behaviour or aggression or aggressive behaviour and psychiatric patients or psychotic patients or psychosis or forensic patients or personality disorders. Apart for not including 'review of', the search terms for the second search were identical to the first search. Hand searches were conducted in the reference lists of all relevant papers for additional studies.

Assessment criteria

Inclusion criteria for study type. Studies were considered for inclusion if they provided qualitative or quantitative data on the relationship between AS and violence and had been published as full papers or research notes in peer-reviewed journals.

Inclusion criteria for diagnosis Only studies describing patients who met the ICD-10 criteria for AS and DSM-IV criteria for Asperger's disorder, except the one related to completely normal development in the first three years of life, were included.

Inclusion criteria for violence

Violence is defined as intentional attempts at, threats of, or actual and intended infliction of bodily injury or harm on another person.

The basis in the definition of violent behaviour as a criterion variable is taken from the MacArthur Violence Risk Assessment Study (Monahan & Appelbaum, 2000):
- physical assaults leading to physical injury in another person
- the use of a dangerous object/weapon against another person
- threats about using a weapon against another person
- the use of physical force in connection with sexual offences

The review also includes physical and verbal threats which clearly express an imminent physical assault.

Results

Is there an empirical basis for the existence of a relationship between Asperger's Syndrome and violence risk?
Only five studies accentuated the link between AS and violence as an explicit research aim in the title, the abstract, and the introduction.

Design and Sample
Six of the studies were carried out in forensic settings and five were from general psychiatry facilities. Eight case studies (N=14 patients with AS and violence) and three prevalence studies (N=8) were found. The patients were all male, and mean age for the 17 patients for whom this information was presented was 27.9 years (Range=16-44 years).

Do certain characteristics of Asperger's Syndrome have a higher violence-triggering potential?
A total of 29 violent incidents were found and analyzed pertaining to motives, triggers, types, and victims of violence.

Motives of violence. Ten of the violent acts were motivated by communicative and social misinterpretations of other persons' intentions. Sensory hypersensitivity was the second largest source of violent behaviour. In eight of the incidents no motive was presented.

Triggers of violence Visual appearance was reported as a final trigger in six out of the 21 episodes with information of immediate precipitants of violence. Another category of triggers pertains to "not getting the right response or being approached in a wrong manner by others". Ordinairy, non-provocative physical nearness and limit-setting were also presented as possible precipitants of violence in some case studies.

Type of violence Twenty-three of the 29 violent acts were physical assaults, including four homicides, one attempted rape, and one case of spree arson. Six physical threats were reported, two of which were threats with a knife in hand. Although some angry violent incidents were reported, the violence was generally characterized by an emotionally detached nature. However, this detached type of violence appears to be qualitatively different from the callous instrumental violence found in psychopaths.

Victims of violenc. Fourteen females and 12 males were targets of violence. In three cases the sex of the victim was not specified. The violence was mainly directed against strangers (N=17), but occurred in close relationships as well (N=10). Parents were the targets on seven occasions.

Discussion

The main findings of this review were: (1) there appears to be no empirical evidence for the presence of a link between Asperger's syndrome and violence. However, (2) the paucity of studies of this relationship preclude from claiming that there is not an increased risk of violence in persons with AS. (3) preliminary results indicate that specific characteristics of dynamics of violence may distinguish patients with AS from other violent persons with mental disorder.

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116. – Keynote 9 – The violent offender – What do we know? – What can we do?

Clive R. Hollin (UK)

University of Leicester

As citizens we should be under no illusions about the amount of violence that is always around us locally, nationally, and internationally. Indeed, the extent of violence in contemporary society was recognised in a recent World Health Organisation (WHO) report that referred to violence as a "global public health problem" (Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002). The WHO report describes four forms of violence, which are "physical violence", "sexual violence", "psychological violence", and "deprivation and neglect". The WHO report classifies these various forms of violence as "self-directed", "interpersonal", or "collective" in nature. As citizens and as professionals we understand that violence can assume many forms, and we also see that it causes widespread distress and harm (Godsi, 2004). Given this it is appropriate to ask ourselves two questions about violence: What do we know? What can we do?

The WHO report offers an understanding of violence that is too wide ranging –- encompassing acts such as self-harm and suicide, physical and sexual assault, and collective acts such as genocide and violence perpetrated by gangs to be covered – to be covered in a single paper. In WHO terms, the focus here is on interpersonal violence, specifically interpersonal violence where physical harm is the outcome. Acts of interpersonal violence may take many forms, ranging from criminal behaviours specifically forbidden by law, such as murder and assault, to "low level" acts such as bullying, and verbal and physical intimidation (Goldstein, 2002).

Interpersonal Violence: What Do We Know?

What do we know about interpersonal violence? First, we know that violence can occur at any time in any place, including the home, the workplace, and in public places. Second, we know that interpersonal violence may have significant costs to the victim: alongside pain and physical damage there may be psychological effects, such as anxiety and depression, and social effects, as with school refusal or long-term absence from work. Third, it is clear that interpersonal violence has substantial financial costs as seen for example in insurance costs, health care costs, and the costs inherent in maintaining a criminal justice system.

So, how can we explain violence, a form of behaviour that is widespread and causes such levels of harm? The complexity of an explanation can be seen in the behavioural model of violent conduct developed by Nietzel, Hasemann, and Lynam (1999). This model is based on four sequential stages across the life span.

Distal Antecedents	Early Indicators	Developmental Processes	Maintenance Variables
Biological Factors	Conduct Disorder	School Failure	Peers
(Eg Brain Dysfunction)	Poor Parenting	Cognitive Style	Opportunities
Psychological Factors	Early Aggression	*(Eg Hostile Attributions)*	Social Deprivation
(Eg Impulsiveness)		Substance Abuse	
Environmental Factors			
(Eg SES)			

Figure 1.: Possible developmental sequence in the aetiology of violent behaviour (after Nietzel et al., 1999).

At the first stage, there are distal antecedents or predispositions to violence, which may be biological (e.g., genetic transmission and ANS lability), psychological (e.g., impulsivity and deficient problem solving), or environmental (e.g., the social fabric of the neighbourhood). As the child develops we move to the second stage of early indicators of violence: these early warnings include features of childhood such as conduct disorder and parenting style. As the child matures into adolescence at the third stage there are developmental processes that intensify the violent behaviour: these processes include school failure, association with delinquent peers, and substance abuse. At the final stage, as the adolescent moves into adulthood, maintenance variables, such as continued reinforcement for violence, intrinsic rewards such as feelings of power, and association with criminal peers, serve to maintain the violent conduct. It is, however, likely that there will be variations in these patterns for male and female populations (Moffitt et al., 2001).

With regard to the role of psychological factors, a continuing line of research has highlighted the role of processes such as a hostile attribution bias, style of problem solving, personal beliefs and values that favour the use of violence, and the impact of emotional, particularly angry, arousal (Hollin, 2004). These psychological factors should, of course, been seen in the context of lifestyle issues such as substance misuse, educational failure, and a delinquent peer group (Hollin & Palmer, 2004).

The model proposed by Nietzel et al. shows the importance of understanding the complex interactions between social and environmental forces, and psychological functioning. Importantly, the model is dynamic that it seeks to incorporate progression and change over the life-span.

Mental Disorder and Violence

The literature on violence in mentally disordered populations shows a similar range of life-span factors in the aetiology of violence conduct. The early antecedents, which may precede the onset of both the violent behaviour and the mental disorder, include child abuse, conduct disorder, and family disruption (Blumenthal & Lavender, 2000). Similarly, the developmental processes include drug and alcohol misuse and educational difficulties (Hodgins & Janson, 2002). The factors that maintain violence in mentally disordered populations have been studied in three ways. First, there are studies which reveal that the maintaining factors in inpatient populations are likely to include intrinsic rewards for violent acts, perhaps linked to psychopathology; and extrinsic rewards associated with peer group, interactions with staff, and coping with a stressful environment (Nijman, 1999). Second, there are studies with community-based mentally disordered populations that suggest similar intrinsic rewards for violent acts, again possibly linked to psychopathology; and extrinsic rewards linked to peer group, family, and social and economic disadvantage (Teplin,

1984). There is a great deal of discussion as to the specific elements of mental disorder that may be linked with violence, including the role of command hallucinations, perception of threat, paranoia, persecutory delusions, and some aspects of personality disorder.

Finally, there are studies of the predictors of violent recidivism in mentally disordered populations. A meta-analysis of these studies suggested that the predictors of violent recidivism in mentally disordered populations – criminal history, employment problems, poor living arrangements, family problems, and substance use -- are remarkably similar to the predictors for non disordered populations (Bonta, Law, & Hanson, 1998).

It is clear that any explanation of violence will demands a theory that integrates a myriad of factors. While acknowledging the influence of the mental disorder, there is arguably a marked overlap between mainstream and mentally disordered violent populations.

Interpersonal Violence: What Can We Do?

One approach to reducing violence lies in attempting to change those aspects of the individual's functioning, in terms of both cognitive and behavioural change, that are related to their violent conduct. In this regard, behaviour change programmes are currently a popular means by which to deliver treatment (Polaschek, 2006). Aggression Replacement Training (ART; Goldstein, Glick, & Gibbs, 1998) provides an excellent example of a treatment programme specifically designed for violent client groups.

The ART programme consists of three component: these three components, delivered sequentially, are Skillstreaming, Anger Control Training, and Moral Reasoning Training. Skillstreaming involves the teaching of skills to displace destructive, violent behaviours with constructive, prosocial behaviour. The skills element of ART uses a step-by-step approach to developing skills to manage potentially problematic social situations. In keeping with the principles of skills training, the skills are modelled by group leaders and then, with appropriate feedback, practised by clients.

Anger Management within ART uses the standard anger management techniques of enhancing self-awareness of internal angry cues, teaching coping strategies, skills training and development, self-instructional training, and increasing social problem solving ability. Moral Reasoning Training is concerned with personal and social values and seeks to enhance the client's moral reasoning skills and widen their social perspective taking. Changes in moral reasoning are achieved through self-instructional training and guided peer group social decision making meetings.

ART has been adapted for use with forensic psychiatric populations (Hornsveld, 2004) and a similar, although perhaps more extensive, programme has been developed at Rampton Hospital in the UK (Jones & Hollin, 2004).

Conclusion

The continually growing research base provides an increasingly strong empirical base from which to develop services. The completeness of the research base might be strengthened further with an attempt to connect further what we know about collective, criminal, and "low level" violence. Such a bold conceptual step would, of course, also seek to understand better the link between mental disorder and violence. It is crucial that we continue to connect clinical and forensic research to treatment and, equally importantly, rigorously research the effectiveness of treatment.

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117. – Keynote (10) – Searching for new strategies to reduce inpatient violence

Prof. Henk Nijman (Professor Forensic Psychology, Nijmegen University) (Netherlands):

Unfortunately there was no text available at the copy deadline for this book of proceedings.

Poster 1. – Sudden Unexplained Death Study of Psychiatric In-Patients Aged Under 45 years

S. McDonnell, N. Swinson, N. Kapur, K. Windfuhr and L. Appleby (UK) Centre for Suicide Prevention, University of Manchester, (UK)

Background

The occurrence of sudden and unexplained death (SUD) among people with mental illness has been a source of public and professional controversy for over three decades. However, little is known about the characteristics and antecedents of SUD in the psychiatric patient population, particularly young in-patients.

Aims

The current study examined the SUD phenomenon amongst psychiatric inpatients aged under 45 years using qualitative research methods. The aim of the study was to identify and describe the events leading to their deaths, in particular, issues related to control and restraint prior to death.

Method

All patients under 45 years of age who died on a mental health ward in England and Wales from March 1999-December 2001 were identified. Detailed information was collated from up to four clinical and non-clinical sources for fourteen psychiatric in-patients.

Results

Themes identified as possible risk factors for SUD among patients aged under 45 years, are as follows: restraint; rapid tranquilisation; antipsychotics; continuity of care; physical illness; observation; staff related issues and physical environment. Whilst many themes are relevant to all cases in the study, findings suggest there are specific themes related to cases of SUD where restraint had occurred shortly prior to death. The antecedents for those patients who were restrained prior to death may differ from those patients who were not restrained.

Conclusions

This study identified the characteristics and antecedents of young psychiatric in-patients who died suddenly and unexpectedly. The use of qualitative research methods has resulted in rich and detailed information on the antecedents of SUD. Further research is needed to elucidate the characteristics and antecedents of SUD in the young in-patient population generally, and in different sub-groups of patients specifically (e.g. restrained vs. non-restrained).

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Poster 2. – Study of psychodynamic factors of suicide in Persia

Ghaffarinejad, A., Associate Professor of Psychiatry, Kerman University of Medical Sciences & Toofani, K., MD (Iran)

Introduction

Suicide is one of the major causes of death in many parts of the world. Many people who commit suicide are of working age, and their loss causes economic damage. One of the factors that features rarely in literature is evaluation of suicide from psychodynamic point of view. Psychodynamic factors that are well known are, guilt, rebirth, loss of love object, retaliatory abandonment and revenge. This research was conducted in Kerman/Iran. We evaluated factors such as those stated above in individuals who attempted suicide and were rescued.

Materials and Method

In this descriptive study, 80 individuals admitted in two general hospitals of Kerman/Iran were selected randomly. They were interviewed when they became stable and wanted to cooperate. They were interviewed and a psychodynamic formulation was recorded for each of them. They were also requested to report any dreams they remembered in the previous three months. Suicidility was evaluated with the California risk questionnaire. We assessed it's reliability and validity with a local population.

Results

The mean age of individuals was 25.51 years. Thirty six were female and 44 were male. Single individuals were 61.3% of sample size. We found that psychodynamic factors for suicide existed in 67 (83.7%) of individuals. The most prevalent of psychodynamic factors was retaliatory abandonment (65%) and the least prevalent factor was revenge (3.8%). The relationship between psychodynamic risk factor for suicide and demographic factors was evaluated.

Discussion: We conclude that psychodynamic factors are important contributing factors in suicide. We suggest that many physicians in emergency room as well as psychiatrists do not pay sufficient attention to these factors. We thought that one reason for this is difficulty in psychodynamic evaluation, which requires special training. We suggest every patient who attempts suicide be recommended to a specialist for dynamic evaluation as well as other risk factors for suicide.

Poster 3. – Violence risk estimates and gender

Gammelgård, M., Eronen, M. & Kaltiala-Heino, R. (Finland)

The Structured Assessment of Violence Risk in Youth (SAVRY) is a professional judgement tool for estimating the risk of severe violent behaviour in adolescence. The method comprises 24 items associated with elevated risk of violence among youth, and six protective items. Most of the risk factors apply broadly to all young people regardless of gender, age or ethnic background. However, it has been suggested that, for example, academic failure and a lack of parental/social support might be stronger indicators of future violence in girls than in boys. In this study, which is a part of the validation of the Finnish SAVRY-version, we aim to identify and evaluate the impact of possible gender differences in a sample of institutionalized youth.

Subjects

The total sample comprised 158 adolescents (106 boys and 52 girls) treated in a forensic psychiatric setting (n=47) and in three correctional schools (=110). Mean age of the sample was 15.0 (SD 1.6; range 11-18).

Method

The study involved retrospective chart reviews of patient files and child welfare records. Violence risk was estimated with the SAVRY (Bartel, Borum & Forth, 2002).

Results

A majority (86%) of the youth were rated as having a modest to high summary risk rating. When weighing the impact of the different risk items girls scored higher than boys on items measuring self injuring behaviour ($p < .001$) and problems related to substance abuse ($p < .05$). Boys on the other hand scored higher on such items as early start of violent behaviour ($p < .05$), poor school adjustment ($p < .05$) and ADHD type of problems ($p < .01$). However, when considering the impact of gender on the Summary risk rating, the different subscales or the total risk scores of the SAVRY there were no statistically significant differences were found.

Conclusion

Findings support the assumption that the SAVRY is a valid tool for assessing the risk of violent behaviours in youth regardless of gender. Even though there are some gender differences in specific items, the SAVRY estimate should be considered as a sum of its sub-items. We can therefore feel comfortable assuming that it is a valid tool for assessing violence risk in both boy and girl samples.

Poster 4. Successful seclusion and restraint reduction techniques on inpatient psychiatric units

Bannerman, Reginald E., RN, MSN, MBA, Manager Inpatient Adolescent Psychiatry and Garten, Kathryn RN, MSN, APRN, BC Manager Inpatient Child Psychiatry, (USA)

Keywords
Aggression, Time out, Seclusion Room, Restraints, and Safety.

Definition

Any purposeful action which includes but is not limited to an attempt to injure self, others and/or destruction of property

Causes

Due to acting out and uncontrolled behaviors children and adolescents have the potential to be secluded or restrained to minimize any form of injury to self and/or others.
Inpatient Psychiatric Units: The Inpatient Child and Adolescent Psychiatry Unit consist of 12 and 14 beds respectively with two distinct multidisciplinary treatment teams. The units are highly structured, with privileges tied to progress in treatment. The unit offers individualized psychiatric assessments, diagnosis, evaluation and crisis intervention for patients with history or the potential for aggressive and/or violent behavior with the objective of providing intensive Individualized Treatment Plans (ITP).

Intervention

Interventions are based on milieu management techniques such as time outs and aggressive patient management. The Time-Out record is used to help the staff monitor time-out usage and gauge when a patient is escalating to possible seclusion or restraint use. The Aggression Patient Management Screening tool helps staff determine potential for aggressive behaviors at the time of admission and the implementation of interventions to prevent the potential for seclusion or restraints.

Results

A substantial decline in the use of seclusion and restraints on the both the Child and Adolescent Psych Unit by over 70%. Overall the Inpatient Child Unit has seen the most decline over the years. Future consideration, on both units is a seclusion free environment backed by evidenced-based practice and publishing.

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Poster 5. – In the eye of the beholder: how female caregivers in nursing homes perceive violence

Isaksson, U., Åstrom, S. & Graneheim, U.H. (Sweden)

Violence towards caregivers is recognized as an increasing problem in various types of health care and community residential settings. Previous studies have focused on prevalence and types of violence and injuries in various settings and among various professionals. There are, however, few studies that examine how caregivers perceive violence. This study desribes how female caregivers in nursing home perceive violence.

Forty-one female caregivers at nursing homes were asked to reflect on the following vignette: As a female caregiver is helping a male resident in the lavatory, he suddenly screams loudly, shakes his fist, calls her derogatory names, and scratches and pinches her until a colleague comes to help her. The reflections were analyzed by qualitative content analysis.

The main finding is that violence is in the eye of the beholder. The caregivers' perceptions of violence are highly subjective; each caregiver seems to have her own interpretation of what violence means and the degree of tolerance various among the caregivers. The caregivers perceive violence as challenging, intentional, excusable, ordinarily, and contextual. Since the perceptions are highly personal, there is a great variance within each category.

Violence is challenging and lies in the caregivers' way of relating to being physically hurt, insulted, abused, and offended and in the fact that the caregivers feel threatened and uncertain about their own safety.

Violence is intentional. It is deliberate and has a purpose if the caregivers deem the resident as cognitively clear and lucid. When the caregiver considers the resident as confused, a violent act is no longer considered as violence.

Violence is excusable in spite the fact that it can be quite serious. The caregivers describe why the violence may be excused: the residents are old, have a brain damage, and are cognitively impaired. The caregivers also blame themselves for the emergence of violence.

Violence is ordinary and a part of the caregivers' work. It is something that happens so often they no longer consider it as violence. Being cursed at, even on a daily basis, is not seen as violence, more as impoliteness.

Violence is contextual. Whether an action is considered as violent or not depends on where it takes place. Exposure to violence at work can be accepted while similar actions outside work are considered as violence. The caregivers express that they find it difficult seeing violent actions, by old residents in a nursing home, as violence.

Since violence is in the eye of the beholder, there is a risk for under-reporting as well as over-reporting the occurrence of violent incidents. To avoid this, it is important to use well-developed and operationalized definition of violence for research purposes. Furthermore, our findings indicate the need for individually structured and adjusted support for caregivers. To explore the complexity of violence, further research is needed that considers how caregivers and residents experience violence in a nursing home context.

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Poster 6. – Violence on the schizophrenic disorder

Garriga Guitart, D. (Spain)

Introduction

The relationship between Mental Health and Violence is one of the most discussed issues in recent times. The main idea is that the mental patients are more predisposed to do violent acts than the general population. Among the studies on this issue, some of them conclude that this is true, that mental diseases, and more specific the Schizophrenic Disorder, can be one of the main factors for a violent behaviour. However there are other studies that deny the fact that there exists a significant relationship between violent behaviour and schizophrenic patients.

The purpose of this study is to observe if there is a relationship between violence and squizophrenic patients, or if the number of violent crimes perpetrated by this kind of patients is just comparable with the ones committed by the general population. It also intends to summarize the related factors and if they are associated with the violent behaviour of this kind of patient an effective therapeutic treatment to prevent this kind of behaviour can be proposed.

Hipothesis

The number of violent crimes perpetrated by convicts with schizophrenic disorder is larger than the average figure for the rest of the convicted population.
The number of violent crimes is related to additional factors more than those that derive from the schizophrenic disorder.

Method and materials

We have done a descriptive and comparative study between the general convicts that are in prison because of violent behaviour in Catalonia, and the ones imprisoned because of violent behaviour that have been diagnosed with schizophrenic disorder in the Psychiatric Jail Hospital of Catalonia ("UHPP-C"). This study is based on data from the last 2 years (January 2004- December 2006). We have also investigated the existence of additional factors and their relationship in psychiatric convicts.

Results

Based on data from the Justice Department of the Catalonian Government, the percentage of violent behaviour of the general convicts is 19%: 7% murder and homicide crimes, 6% sexual crimes, 4% assault and battery and 2% home violence. On the other hand the results of the convicts with schizophrenic disorder are 44%: 22% murder and homicide crimes, 13% sexual crimes, 6% assault and battery, and 3% home violence. By sex: 95.3% men and 4.7% women. By age: 13% from 18 to 25 years, 21% from 26 to 35, 45% from 36 to 45 and 21% more than 45. According to the participation: 7.9% group acts and 92,1% individual acts.

The factors that are related with convicts with schizophrenic disorder that were appearing with a percentage greater than the sample are the following: 76% excessive alcohol, 68% low level of school attendance, 84,2% no accomplishing the treatment, 55,2% disorganised family and 89,4% with a minimum of 2 previous admissions because of unbalance.

Conclusions

- The relationship between violent behaviour and the diagnostic of schizophrenia is two times bigger than that existing on general convicts.
- The main characteristics of the violent convict with an schizophrenic disorder in Catalonia are: men between 36-45 years old and with individual violent acts.
- The violence of schizophrenic patients is related mainly to excessive alcohol consumption, low level of school attendance, not accomplishing the treatment, disorganised family and several previous admissions because of psychiatric imbalance.
- An effective treatment to reduce these factors would be the best preventive element against the violent behaviour in schizophrenic disorder.

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Poster 7. – Nursing care management of clients with aggressive behaviour

Burkertová, H. & Treslová, M. (Czech Republic)

Psychiatry nursing is specific in many ways, among others, also because the nurse is in contact with clients who don't have a rational opinion about their diseases, don't cooperate and very often refuse help from healthcare personnel (Petr, 2006).

The factors, which play a role in the increase of aggressive behavior of a client will be analyzed in the presentation. Authors will also concentrate on the aspect of early detection of potential aggression. The main topic of the presentation is the management of nursing care of restless, agitated and/or aggressive clients and description of use of standard constraint instruments in selected healthcare institutions in the Czech Republic (psychiatrical hospitals).

The aim for the care of clients with aggressive behavior is to guarantee their safety as well as the safety of other clients and of the healthcare personnel, to restore comfort for the client and regain his/her involvement with his/her treatment regime. Very important is a safe environment, also regarding to the awareness of the client himself. Among the principals of standard process of care of the client who displays aggressive behavior, is:

- to remain calm, monitoring verbal and nonverbal manifestations of the client,
- not to disturb his/her private zone / space,
- not to touch the client, in case he/she would perceive it as an aggression stimuli,
- to enable the client to verbalize his/her own anger,
- to help him/her to identify the cause of anxiety,
- to help the client to recognize factors that promoted the loss of control,
- to propose alternative solutions,
- to enforce a team attitude-acceptance of the client
- to let other clients express their feelings,
- to engage the client into company of others, after he/she is calmed down,
- to manage an inadequate behavior

The use of restrain instruments is possible only if that is necessary in order to ensure safety of the client, to protect other clients, personnel and property, and in case of a need to solve a crisis situation. Also in the situation when the client threatens him/herself or their surroundings and when it is not possible to find an eliminable cause of that kind of behavior such as pain, discomfort, drug side-effects, stress, relationship problem with other clients or with healthcare personnel, or physical illness.

Nurses use the most reasonable (comfortable) and suitable restrain instruments and only for the shortest possible period of time. It is on the basis of doctor's prescription and promoted by nurse's documentation. Restrictive instruments are: restriction in bed, therapeutic isolation, net beds, safety jacket, manual fixation, parenteral administration of psychopharmacy without clients' consent. The use of restrictive instruments in Czech Republic is defined in Methodological provision of Ministry of Health of Czech Republic, in Public Notice of Ministry of Health No.1/2005. More specific information and principals of the framework of requirements is given by the Public Notice and should be resolved as internal regulations of each institution.

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Poster 8. – Constellation of five rare psychiatric syndromes in a single case

Alireza Ghaffarinejad MD,associate professor of psychiatry,behashti hospital of Kerman medical university (Iran)

Objective

Lycanthropy, Cotard's syndrome, Dorian Gray's syndrome, Fregoli syndrome and subjective double are five rare psychiatric syndromes. There was no reports of co-occurrence of these five rare syndromes in a single patient.

Method

A single case was reported

Results

We had impression of bipolar mood disorder (mixed type) for this Patient. He believed that he is a wolf and master of jungle and had ability of snake to transform himself into any animal. He thought, he remains young and preserve his internal organ in a watermelon for future. He also had delusion of subjective double . Presenting symptom was aggressive behavior.

Conclusion

For the first time occurrence of these syndromes in a single case is reported. We suggested two fundamental basis for his illness, misinterpretation and immortality. We concluded using descriptive approach is not sufficient to understand such patients completely.

Keywords
Lycanthropy, Cotard's syndrome, Fregoli syndrome , Subjective double, Dorian gray

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Poster 9. – Intensive care room concept implementation: opportunities and questions

Camus, D., Faust, J.M. & Chappuis, V. -Psychiatric Department, CHUV (Switzerland)

Background

Despite progress in psychiatric treatments, seclusion remains a practice widely used to achieve therapeutic benefits but it is also strongly disputed by patients, relatives and sometimes by the professionals themselves. Generally used in the treatment for violent, aggressive or inappropriate behaviours, it remains nevertheless a source of disagreements, even of feeling of discomfort, at various levels (clinical, legal, ethic and safety).

To adapt the new legislative aspects introduced in Canton de Vaud (Switzerland) in 2002, the University Department of Adult Psychiatry (DUPA) in Lausanne has redefined its practices with the development of the concept of the Intensive Care Room (ICR), the development of the an individual treatment care plan with the patients and the development of a specific protocol.

Aims

It objectives were:
1) to examine how ICR were used, for whom and with what results
2) to evaluate the impact of establishment of the new practices.

Method

In 2004-2005, a prospective a "Case-Control" study was carried out in the department of adult psychiatry.

During a one-year period, various data were obtained for the two groups (patients treated with ICR or patient treated without ICR), at different times during the hospitalisation (admission and discharge to hospital for the both groups, getting in and getting out of ICR exclusively for the patients of ICR group).

Data applied 1) patients characteristics, 2) clinical assessment, 3) contractualisation process 4) patients point of view of the on ICR treatment, 5) professionals (doctors and nurses who were involved in the clinical process with the patients) point of view 6) organisational data.

Results

Two-hundred and fourteen patients participated in the study and 128 ICR situations were investigated.

The results confirm various points published in the literature: The profile of the patients in ICR is different from those patients of the group control. Therapeutic goals correspond to those developed in the literature. The favourable symptoms of the patients show the benefit and utility of this practice. The results suggest also that practice of ICR is slightly different between different sections of the department.

Nevertheless, several questions arise on difficulties still encountered with this new concept on various, but well know, aspects such as 1) clinical, 2) organisational, 3) ethical and 4) legal.

Conclusion

Research on the containment and risk management in psychiatric settings must continue. The implementation of this new practice and the special procedures may benefit with the creation of a multidisciplinary training on the concept of ICR. This training would make it possible to better define this concept and to limit once more its negative effects.

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Poster 10. – Violence in older adults with Alzheimer's disease: rates and risk factors in community based caregiver / patient dyads

VandeWeerd, C. & Paveza, G.J. (USA)

Purpose

Physical violence as a form of elder mistreatment is a serious issue affecting the lives of thousands of older adults each year. While researchers have begun to pay attention to sub-sets of persons who may be at risk for varying kinds of mistreatment, little research has focused specifically on the risk for persons with dementia of the Alzheimer's type (AD). As this population grows, identifying factors that put these persons at risk for mistreatment will become paramount. While several interventions and preventions have been suggested, before methods of best practice can be adopted to serve this vulnerable population, risk profiles must be further developed. This study examined violence as a form of physical mistreatment in a sample of community dwelling older adults with Alzheimer's Disease (AD) using the Risk & Vulnerability model as a means for identifying factors associated with increased risk in caregiver/patient dyads.

Design and Methods

Subjects were recruited in the State of Florida through their association with one of five state funded memory disorder clinics or with one of three local chapters of the Alzheimer's Association. In all, 254 caregivers and 76 older adults met the study inclusion criteria and completed both an in-home interview and a mailed questionnaire between the years of 1998 and 2003. Physical violence was measured using the violence sub-scale of the Conflict Tactics Scale, and logistic regression analysis was used to examine factors associated with increased risk.

Results

Use or violence was self reported by 17.2% of caregivers, and was reported as a technique used against them by 26.1% of older adults with AD. Logistic regression analysis suggests that factors associated with increased risk for physical violence by caregivers included alcohol problems (p=.041), providing care to elders with high levels of functional impairment (p=.034), and providing care to elders with greater numbers of dementia symptoms (p=.019) or to elders who used violence against them (p=.010).
Implications of these findings will be discussed in terms of policy and practice.

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Poster 11. – Caregivers' reflections on their interactions with people with intellectual disabilities

Antonsson, H.A., Åstrom, S. & Graneheim, U.H. (Sweden)

In a recent published Swedish study 40 %of caregivers in group-homes for person with intellectual disabilities reported exposure to violence from residents. People with intellectual disabilities and their caregivers often have difficulties interacting. At the same time as they have difficulties understanding the caregivers' communication it is often difficult for the caregiver to interpret and understand the residents´ signals. Depending on the persons physical and mental handicap along with communication obstacles situations arise where caregivers have to take stand in the residents place or have a struggle with meeting the resident's needs and challenging behaviour. Aggressiveness, reluctance, self-destructive behaviour and screaming are frequently occurring behaviours among a large number of persons with intellectual disabilities.

The aim of this study was to describe caregivers´ reflections on their interactions with people with intellectual disabilities. In a previous study the interaction between sixteen caregivers and eleven residents with intellectual disabilities were video recorded. In this study stimulated recall interviews about the interaction were carried out with all the caregivers who had been involved in the video recordings. The text was analysed using qualitative content analysis.

The caregivers reflected on successful interaction and unsuccessful interaction. Successful interaction includes understanding cues, satisfying needs and managing challenging behaviours. Successful interaction promotes security, confidence and satisfaction among the residents. Unsuccessful interactions are concerns in failing to understand cues, failing to satisfy needs and failing to manage challenging behaviours. Unsuccessful interaction may cause irritation, aggression and violence.

The cargivers reflexion on the interaction with people with intellectual disabilities indicates that caregivers trys to fulfil their duties and that they experience both success and failure in the interaction and that unsuccessful interaction could cause violence from the persons with intellectual disabilities. One implication from the results is that caregivers working with persons with intellectual disabilities are in great need for support and supervision in their daily work and that further research is needed to find strategies bridging the difficulties in the interaction between the caregivers and persons with intellectual disabilities.

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Poster 12. – The European Violence in Psychiatry Research Group (EVIPRG)

R. Whittington[1] et al. (UK)

1)*University of Liverpool, UK*

The European Violence in Psychiatry Research Group (EViPRG) is an active network of mental health researchers, educators and practitioners with over 40 members in 15 European countries. The group aims to enhance the understanding, prevention and management of violence in psychiatric settings by conducting research and disseminating good practice. New applicants for membership are always welcome. This poster will summarise the aims of the group, how it is organised, some recent projects and activities run by the group and how to apply to join the group.

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Poster 13. – Factors associated with effective interventions for violence involving people with a mental disorder and / or offending behaviour: a systematic review

R. Whittington[1], M. Leitner[2], W. Barr1, J. McGuire[1] & S. Jones[1] (UK)

1)University of Liverpool, UK; 2)InfoTech UK Research

Background

This poster will summarise some key findings from a large systematic review of research into risk assessment and interventions for violence by people with a mental disorder and/or offending behaviour.

Methods

The review represented a deliberate departure from the current tradition of focussing reviews on a very tightly defined section of the literature since the aim was to provide a picture of the literature which was broad enough to inform future improvements in research, policy and clinical practice. The population of interest consisted of offenders with and without a mental disorder plus non-offenders with a mental disorder. The review entailed a search of 31 electronic databases since their inception, a hand search of 42 specialist journals in the period 1990-2003 and a survey of established researchers in the field. Grey literature was actively sought and 26% of the final set of studies (including 162 PhD theses) were not published in journals. More than 41,000 relevant citations were identified but the majority were polemical or opinion pieces. 550 of the 1212 eligible studies (45%) were concerned with interventions for violence and predictors of effectiveness were examined in this subset of studies. An effective study was defined as one in which a statistically significant positive difference in the treatment group was reported on at least one outcome measure and no weighting for sample size was applied in this preliminary analysis.

Results

There was a significant association (p<.02) between type of intervention and effectiveness with psychological interventions (n=142 studies, 50% successful) and pharmacological interventions (n=276 studies, 49% successful) more likely to be effective than structural and organisational-level interventions (n=111 studies, 33% successful). 112 studies of psychological interventions where n>1 were selected for closer scrutiny, including 27 RCTs. The majority (77%) of these studies used behavioural, cognitive or allied therapies while the remainder (23%) used psychodynamic, group-experiential, or other forms of therapy. Univariate analysis indicated that treatment effectiveness was associated with design quality (p<.01) in that the mean quality rating of effective studies was higher than that for ineffective studies. There was no association between effectiveness and the sample profile in terms of patient factors (gender, age, ethnicity, diagnosis, offence type) or other factors (setting, country, date of publication).

Next steps; A weighted multivariate analysis of factors associated with effective interventions incorporating these and other variables is currently underway.

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Poster 14. – All Wales Care Pathway: Routine enquiry into domestic abuse

Lynch MBE, L.A. & Kenkre, J. (UK)

The issue of domestic abuse is very much at the forefront of the political health agenda in Wales. For women seeking assistance, health services may be their only point of contact and chance to disclose. Given that women will experience thirty-five episodes of violence before seeking help, women may not readily volunteer information unless asked directly.

Government statements and professional publications have suggested that where abuse is suspected, it is the health professional's duty to question the woman involved, explicitly but carefully.

In order to meet the challenges that lay ahead, the Welsh Assembly Government have financially supported the development of an evidence based care pathway that will form the basis of enquiry. Clinical care pathways are becoming increasingly popular within health care as they provide a structured framework for both existing practice and development, are 'patient' or woman centred and clinically driven. They are used as a tool for systematic action to ensure continuous improvements in care by being evidence based.

An all Wales midwives and health visitors networking group was set up in 2004 to explore routine enquiry into domestic abuse in the antenatal period. This led to the development of an all Wales care pathway, ten minimum standards of care and accompanying training pack.

Project developments

- All women in Wales will be asked routinely about domestic abuse at least once in the antenatal period.
- The care pathway to be used to aid midwives and health visitors in asking the question and signposting women who have disclosed domestic abuse to the appropriate support agencies
- The training pack developed for midwives and health visitors in Wales, is used to train health professionals in domestic abuse, routine enquiry, and using the care pathway documentation

Practice application

- Members of the All Wales Networking Group are training midwives and health visitors locally for domestic abuse and routine enquiry.
- Routine enquiry into domestic abuse will be carried out with all pregnant women in Wales, at least once in the antenatal period.
- If a midwife is unable to see a woman on her own antenatally, then she will 'flag' this as a priority to her health visitor colleagues so that the question can be asked postnatally
- The ten minimum standards are to be adhered to so that all areas of care have been addressed
- Where domestic abuse has been disclosed, the midwife or health visitor follows the care pathway process in order to highlight the woman's level of risk and can make appropriate referrals onwards to support systems.
- Training of midwives and health visitors is to be ongoing and mandatory. Universities of health visitor and midwifery education have been included in the development of the training pack and are involved in pre and post registration training for domestic abuse.

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Poster 15. – Prevention and management of violence in Belgian psychiatric institutions: do current practices respect international guidelines?

Lardennois, M., Duquesne, P., Gillain N., Vanbelle S., Leduc, D. & Bardiau, F. (Belgium)

Background

A vast literature is dedicated to violence in psychiatric institutions and international guidelines exist to cope with this problem. Due to the lack of relevant information in Belgium, the Ministry of the Interior and the Ministry of Public Health jointly conducted in 2004 a study to assess the prevalence of violence in psychiatric institutions and in psychiatric units of general hospitals. This study demonstrated the higher prevalence of violence in psychiatry but also emphasized the lack of prevention, management and recording incidents involving violence. A study on this topic was commissioned by the Ministry of Public Health in January 2007, including a 5-month survey.

Aims

Make an inventory of prevention and management of violence procedures used in Belgian psychiatric units and institutions with the purpose of establishing recommendations to hospitals and to healthcare authorities. What tools should be used to discern patients at risk and to prevent violence? What is the current level of implementation of international guidelines in Belgium? What are the difficulties and obstacles in actual settings?

Methods

A 5-month survey will be conducted from April through August 2007 in all psychiatric hospitals and psychiatric units (137 hospitals with 19000 psychiatric beds) based on questionnaires about the recommendations, their implementation and the difficulties encountered in practice. Data will be analyzed by means of appropriate statistical methods. Site visits will be made to understand or verify local evidences.

Results

The results of this large scale study will be presented in detail.

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Poster 16. – Differences between seclusion and mechanical restraint in restrictions to human rights – a randomised controlled trial

Bergk, J. & Steinert, T. (Germany)

Objective

To assess the restriction to human rights caused by seclsion and mechanical restraint. Seclusion and restraint are considered as effective and safe interventions but there is a lack of evidence from well-designed studies on compulsory measures in psychiatry.

Method

We conducted a comprehensive cohort study comparing seclusion and mechanical restraint among in-patients with severe mental illnesses. We determined the restriction of human rights from the patients' point of view as main outcome variable, measured by a scale developed for this purpose, Human DIgnity during COercive Procedures, DICOP-Score.

Results

102 out of 233 patients exposed to coercive measures within 24 months could be included, 26 could be randomised (12 seclusion, 14 restraint). There were no significant differences between the two interventions referring to DICOP-score and duration of the intervention. The burdens most frequently reported during after seclusion were "I felt lonely", "I felt my dignity was taken away" and "I couldn't understand why the measure was carried out". Most mentioned stressors in mechanical restraint were "Restriction of ability to move", "Fear to be lonely" and "Being dependent on the help of others". Watching pictures of several alternatives in the interview, including physical restraint and net bed (not available in Germany), most patients preferred seclusion, independent of which intervention was conducted.

Conclusions

Randomized controlled trials on coercive interventions in psychiatry are feasible. Both from ethical and safety aspects the results do not yield evidence to prefer or forbid one of the interventions. Clinical decisions should take into account patients' preferences.

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Poster 17. – Blood levels of lipids and serotonin as predictors of self harm and violence in acutely admitted psychiatric patients

Roaldset, J.O., Moger, T.A., Bjørkly, S., Bakken, A, Hervig, T. & Gøtestam, K.G. (Norway)

The risk of self-harm or violent behaviour against others in psychiatric patients is a clinical research topic of great current interest. A relationship between low lipid levels and aggressive behaviour against others, and between low serotonin- and lipid levels and suicidal behaviour has been presented in the literature. In our acute psychiatric ward at Ålesund County Hospital we conducted a prospective naturalistic study of risk assessment of aggressive and violent behaviour at admittance and at discharge, followed by prospective measurement of occurred episodes after discharge.

All acute admitted patients during one year (494 persons with 716 admittances) were included in the project. At admittance the Violence Risk Screening-10 (VRS-10; Hartvig et al., 2006), suicidal items and self prediction were recorded, and the patients were asked to give a blood sample to measure lipids and serotonin (289 samples). Incidents of the two types of aggressive behaviour (against others and/or self) were monitored (phase one). At discharge the same measurement procedure was repeated as when patients had been admitted to the ward. Patients will be followed up for one year (measurement of occurred episodes of violence after 3, 6, 9 and 12 months, phase two).

Findings from the analyses of the strength of the relationship between lipids and serotonin as predictors of self-harm and violent behaviour against others during the subsequent hospital stay (phase 1), will be presented.

The project is approved by The Regional Committe for Medical Research Ethics, The Norwegian Social Science Data Services and The Ministry of Health and Care Services.

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Poster 18. – Measuring quality in forensic psychiatry – implementation of a local quality register

Turtell, I.[1], Sturidsson, K.[2] & Gershater, S.[2] (Sweden)

1)Main Author: Turtell, Inger MSc Forensic Psychiatric Centre, SE- Säter Sweden. 2)Secondary Author(s): Knut Sturidsson, MSc, C. Psychologist, Karolinska Institutet, Stockholm, Sweden. Steven Gershater. Data Manager,Dalarna County Data Management Group, Sweden.

Learning Objectives

A local quality register was established during 2005 at one of the larger forensic psychiatric clinics in Sweden.

This provides:
-unique opportunities to evaluate routine clinical care
-data from the register shows detailed information on various parameters such as diagnoses, medication, body mass index, index crimes, current services and interventions, social situation, social network, and clinical factors.

Background

In order to evaluate medical care, data concerning different aspects of the care provided has to be collected. In Sweden this is a routine procedure in most branches of somatic medicine but to a lesser extent in psychiatric care. A local quality register was established during 2005 at one of the larger forensic psychiatric clinics in Sweden. This provides unique opportunities to evaluate routine clinical care.

Methods

Basic patient characteristics, process indicators and outcome variables are continuously recorded for all inpatients at the clinic. The information is updated once a year or if the patient status is changed (discharge, leave etc). Various professionals such as psychiatrists, psychologists, nurses, occupational therapists and social workers collect information concerning the patients and the care provided. Also, the patients evaluate his or her own perception of health, quality of life and risk for violent crimes.

Results

Data from the register shows detailed information on various parameters such as diagnoses, medication, body mass index, index crimes, current services and interventions, social situation, social network, and clinical factors such as mood symptoms, anxiety symptoms and psychotic symptoms.

Conclusion

The local quality register has improved the overview of the patients and the care provided, and also informed hospital management on necessary actions for improvements regarding the care. Examples of findings from the quality register are that the administration of certain anti psychotic medication is associated with a higher BMI. Also, perhaps a bit surprisingly, 70 percent of the patients rate their quality of life and health as high.

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Poster 19. – Use of physical restraints in group-homes for persons with intellectual disabilities: prevalence and characteristics of residents

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1)Department of Nursing, Umeå University and
2)Department of Community Medicine and Rehabilitation, Geriatric Medicine, Umeå university.

Objectives

The aim of this study was to investigate the prevalence of physical restraints in group-homes for people with intellectual disabilities in Sweden and to identify resident characteristics relating to the use of physical restraints. The literature review shows very few Swedish studies regarding frequencies, reasons for and characteristics of situations where physical restraint is used in the care for people with intellectual disabilities. However, an international comparison has shown that restraints in different types of care are more commonly used in Scandinavia than in other parts of Europe.

Methods

This study had a cross-sectional design and was carried out in October 2003. The study comprised 556 persons with intellectual disabilities aged 16-90 years, of which 46% were women. The sample included residents living in 118 group-homes. All residents were assessed by means of the Multi-Dimensional Dementia Assessment Scale. The scale measures motor function, vision, hearing, speech, behavioral symptoms, psychiatric symptoms and the physical and psychological workload of the staff. Questions concerning physical restraint were added to the survey. In the present study, a physical restraint is defined as a mechanical device inhibiting free physical movement, including chair belts, wheelchair tables, chair with fixed tray table, and locked room doors.

Results

Ninety-nine of the 556 residents studied (17,8 %) had been subjected to the use of physical restraints during the previous week. The most commonly used type of physical restraint was chair belts (73,7%). Twenty-one percent of the residents had more than one type of restraint during the week. Physical restraints were found to relate most strongly to age, walking ability, ADL, spasticity and speech. Other variables relating to the use of physical restraints were cognitive function and behavioral symptoms such as, violence towards staff, restless, yelling, and shouting.

Conclusion

This study has shown that physical restraints are used frequently in group-homes for people with intellectual disabilities despite the fact that in Sweden, there is no legal authority for restraint for people with intellectual disabilities living in special accommodation. Further, that physical and cognitive impairment as well as behavioral symptoms relate closely to the use of physical restraints.

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Poster 20. – Evaluation period for psychiatric patients suffering from severe aggressive behaviour and psychotic symptoms in HUCS, Finland

Laura Männynsalo, RN, MNSc (student), Hanna Putkonen, MD, PhD, Chief Psychiatrist., Hanna Kristola, RN, Erja Tikka, RN, Nurse Manager, , Outi Lehto, MD, Senior Ward Physician, Helsinki University Central Hospital ,Department of Psychiatry (Finland)

Keywords:
Aggressive psychiatric patient, evaluation, nursing care, development.

The unit for forensic psychiatric and difficult-to-treat patients in the Helsinki University Central Hospital treats and evaluates psychotic patients suffering from severe aggressive behavior. The evaluation period patients mainly come from the Helsinki city area and are admitted to the care from Helsinki city's primary psychiatric care due to unmanageable aggressive behavior. The unit has three wards, two of which admit patients for the evaluation period. Ward 7 has 16 beds and ward 10 has 12. The evaluation period lasts for two months.

The purpose of the evaluation period is to assess the patient (thorough history, diagnosis), her/his need for care and her/his violence risk and to prevent further aggressive behavior and psychotic symptoms. The evaluation is a multi-professional task: a forensic psychiatrist, two primary nurses, a social worker, an occupational therapists and a physiotherapist all take part as part of the process. A central task is to prepare a well-defined individual treatment plan for each patient. A special purpose of the evaluation period is to clarify the course action in treatment to improve the efficacy of the care in the future unit of treatment and how to address the risk of violence.

In the nursing care, special attention is paid to the content and development of the primary nurse-patient-relationship, and a special goal is to create a functional co-operation with the patient. The primary-nurse-patient-relationship is based on the unit's common values that are: the respect of human dignity and individuality, responsibility, safety, and primary nursing. The multi-professional team evaluates the risk factors of the aggressive patient with the help of HCR-20 -violence risk assessment instrument. The results of the HCR-20 evaluation are taken into consideration when planning future care. The authors started developing the evaluation period by reviewing literature on evidence-based-treatments for aggressive psychiatric patients to develop psychiatric nursing care in our unit. The Broset-Violence-Checklist (Almvik, R et al.) is currently being considered for use the evaluation period.

In conclusion, the development of the evaluation period has made the content of assessment and care more comprehensive, evidence-based, and up-to-date, and it has clarified the nursing process as a whole. Also the information and guidance given to the patient has increased, and information on risk factors for aggressive behavior is now better documented.

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Poster 21. – Using a prone / supine survey and literature review to forward the conversation regarding all restraints

Holden, J., Johnson, T., Nunno, M. & Leidy, B. (USA)

The concern for safer physical restraints continues to permeate discussions for child and youth residential care facilities worldwide. One of the most controversial conversations appears to be centered in prone physical restraints versus supine physical restraints. In New York State, the Office of Mental Health (OMH) teaches the use of supine restraints and has banned the use of prone physical restraints in its licensed youth residential centers. The Office of Child and Family Services (OCFS) allow use of prone restraints in its licensed youth residential centers. Many youth residential centers are licensed by both agencies, which has resulted in confusion and contradictions in training and program implementation.

Safety of both youth and staff during physical restraints is paramount for any conversation regarding restraints but even more challenging when using floor restraints. There has been relatively limited research comparing the use of restraints particularly the prone and the supine physical restraints. This quantitative study and literature review is designed to assess basic differences in physical and emotional risk, safety, efficiency, and training associated with using supine and prone, in addition to all physical restraints.

A perception survey using a Likert scale was conducted with one agency in New York State that uses both the OCFS approved prone restraint and the OMH approved supine restraint with staff that had experience using both techniques (n-54). The study included the mean and paired sample correlations as well as an analysis of the variables (ANOVA). The literature review represented 78 total articles, 48 were included in the study while 30 were excluded for reasons of non-relevance. The research was conducted using MasterFile Premier, Academic Search Premier, ERIC, and PsycINFO databases.

Conclusions were difficult to draw based on the information collected and analyzed. From the perception survey, the respondents indicated a preference for the prone restraint. The data from the participant perception surveys suggested the staff agreed that the prone restraint was safer, less risky, and easier to use, easier to learn and evoked less aggression and counter-aggression than the supine restraint. The literature review was less conclusive. There does seem to be agreement however, that all restraints present considerable risk to the youth, are intrusive to the youth, have a negative effect on the treatment environment, and have a profound effect on those youth who have experienced trauma in their lives. Additionally, other factors such as pre-existing physical/medical conditions may affect risk more than the type of restraint that is used.

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Poster 22. – Experiences of patients and mental health workers in the case of seclusion in the psychiatric emergency room of a general hospital

Voskes, Y. RN. & Teijeiro, R. MD (Netherlands)

Background and objectives

As a result of the recent debate, in the Netherlands, about force and coercion in psychiatry, a set of criteria for quality was developed. Bye and bye, occasional attempts to implement these criteria have occurred in General Psychiatric Hospitals. These quality criteria for force and coercion have not yet been applied in the psychiatry units of general hospitals, even though it is conceivable that here, too, the quality of force and coercion could be improved. This research was carried out with the objective to gain a better understanding of seclusion experiences of patients, for the benefit of mental health workers; and to help improving the quality of care with seclusion, as well as decreasing the number of separations.

Methodology

All patients who had been in seclusion within a period of six moths, and all mental health workers involved in this, took part in this study. Semi-structured in-depth interviews were carried out to gather information about the experiences of both patients and mental health workers. For the latter, a focus group meeting was organised. A specific case history is presented in focus groups, inviting interactive reactions, exchange of ideas and experiences, and suggestions for negotiation.

Results and conclusions

Seclusion is a negative experience for the majority of patients. Seclusion is felt as a punishment. Patients also believe that the measure of seclusion often is not in proportion to the danger to be averted. A less intrusive measure would have sufficed. Factors that influence the experience of seclusion are the reason for seclusion, its duration, and contact and communication with mental health workers. The majority indicate that there is too little communication with the patient. De reason for seclusion often is not explained nor structurally evaluated with patients. The experiences of mental health workers differed widely. There was no consensus on the reason and duration of seclusion. Averting danger constitutes a reason to seclude for all mental health workers, but most health workers maintain that seclusion can also be utilised to as an area free from external stimuli. In addition, mental health workers indicate that separation can and may be implemented as a form of therapeutic intervention. There is agreement about the importance of evaluating seclusion both within the team of mental health workers as with the patient proper. This is an important factor in improving the quality of care in seclusion and decreasing the number of seclusions.

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Poster 23. – The story of the failed attempt at closing the seclusion rooms in a general psychiatric hospital

Teijeiro, R., Westerkamp, D. & Kok, H (Netherlands)

Background

With agitated and aggressive (psychiatric) patients, seclusion is the most commonly applied strategy in the Netherlands. For legal reasons, drug treatment is not possible in most cases. Restraint is often applied in general hospitals but little in psychiatric hospitals. Seclusion and isolation are contested measures with both patients and mental health workers, but are accepted in society at large.

Objectives

The new management of a general psychiatric hospital challenged its staff to close the 22 existing seclusion rooms within a year and to put an end to this form of "treatment." A special budget was made available to train and motivate personnel. The entire staff was offered the opportunity to experience the "Italian model" in Rome as an instrument for changing the culture of treatment in the hospital.

Methods

The internal architecture of the wards was adapted to the new model. Patients can dispose of individual rooms and there are clearly ordered common rooms. The programmes of treatment were changed in the wards, geared to working within a medical psychiatric model using behavioural therapeutic interventions.

The culture of change features
- A shift in thinking and acting
- More negotiation
- Detailing agreements
- Providing room and trust
- Evaluation and readjustment on a daily basis
- Shared responsibility
- More unrest and "madness" on the ward

Leadership is implemented on the basis of
- Daily presence
- Daily deliberations
- Clear guidance
- Propagation of vision and internal hospital culture
- Formulating policy

Teams are formed on the basis of
- Experience of staff
- Quality of staff
- Sufficient staff for each shift
- Male/female proportion
- Training, education

Results

Within two years the number of seclusion rooms was reduced to 2. Former seclusion rooms were dismantled and / or transformed to offices. There was a decrease in the number and duration of seclusion. Systems for administering medication were developed within the frames of legal possibilities. Seclusion was only implemented if accompanied by medication within these frames. There was a radical decrease in aggression incidents.

Consequences

The consequences were twofold. On the one hand, patient and family satisfaction increased, as did the quality of care. The phenomenon of "revolving door" patients disappeared altogether. On the other, the period of admission grew shorter; production, in financial terms, dropped. The growth of policlinical / extramural production, carried out by the same team in order to support patients after discharge and prevent recidivism, was not sufficient for compensating for the financial shortages in the clinic. The Board of governors decided to dismiss management. Key figures in the team left the hospitals for positions elsewhere. Seven years after the experiment was initiated, seclusion rooms were re-established.

Conslusions

The quality of care is not just a financial matter. Without a broad social and political debate and endorsement it is not possible to implement substantial changes. There is a cost to quality in care.

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Poster 24. – "Do not leave a serious sick patient alone" - randomised clinical trials on reducing seclusion

Georgieva, I. (Netherlands)

The Dutch tradition in using seclusion as a method of restrain, has been criticized a lot the last years, because of the higher usage and duration of seclusion, compared with other European countries. The psychiatric hospital GGZ Westelijk Noord-Brabant in cooperation with Erasmus MC Rotterdam developed two interventions to reduce the number and the average duration of seclusions. The first intervention addresses the question of whether the use of relapse prevention plans in nursing practices will reduce the usage and the average duration of seclusions with at least 30% in comparison with the control "care-as-usual"condition. The relapse prevention plan focuses on early recognition and early intervention directed to prevent psychological decompensation by psychiatric patients. The objective of this study will be investigated through randomized controlled trial (RCT) with a follow-up of 3 months.

The second intervention has the same goal, but it is focused on the use of chemical restraint in the treatment of acute agitation or violence in the emergency department. To investigate this objective patients will be at random divided between two units of the emergency department. At unit 1 involuntary medication will be used as a method of restraint, while the participants at unit 2 will receive care-as-usual. Besides the number and the average duration of seclusions, the sort and the number of the aggression accidents will be registered respectively with "Social Dysfunction and Aggression Scale" (SDAS-11) and with "Social Observation and Aggression Scale" (SOAS).

Data on the attitude of the staff toward seclusion, methods of restraint and aggression are collected as well.

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Poster 25. – Team satisfaction after assessment and prediction of violence risk of psychiatric inpatients and de-escalation training, consequences on treatment approach and violent incidents

Pfersmann, V., Kloesch, G., Schmid-Siegel, B., Bayer, F. & Haushofer, M. (Austria)

AB

Violent incidents are a common risk for staff working at psychiatric wards. At the admission ward of the psychiatric department of a regional hospital in Vienna, Austria, about 1/3 of the admitted patients present a risk of self- harm or harm other persons in relation to their psychiatric illness.

Aim

The aim of this study was 1. to investigate the consequences of the implementation of a deescalation-training in the staff 2: to better predict the risk of violence of patients at admission and during treatment, 3. to optimise the therapeutic strategies, medical and nursing interventions, 4. to reduce the number of violent incidents and coercitive measures, 5 to optimise staff security and work place satisfaction.

Hypothesis

On setting the focus on the assessment and prediction of violent behaviour of the patients and focussing on methods of deescalation of risk situations and optimising therapeutic interventions, the necessity and the form of coercitive treatment methods and of violent acting out should be reduced and lead to a better work place quality and security of staff. The patients should be more satisfied with the treatment.

Methods

Within an observation period of six months all admitted patients were diagnosed by psychiatrist following ICD- 10 Criteria, psypathology was assessed with BPRS (Brief psychiatric rating scale) and CGI (Clinical Global Impression) scale. The patients evaluated their satisfaction with the treatment and the staff. At the beginning and the end of the study the staff of the admission ward assessed their work place satisfaction and intensity of burn-out with the MBI (Maslach Burnout Inventory) and SBB.

The risk of violence of the patients was assessed with the SOAS- R scale (Staff Observation of Aggression) twice a day during the first three days after admission and BVC-CH (Broset violence Checklist) and during further hospitalisation after a violent incident.
Therapeutic interventions such as therapeutic speech, talk down, medication and the necessity of coercitive measures were documented.

Results

The impact of the implementation of the deescalation-training on the staff, work place satisfaction, prediction of violent incidents and therapeutic approaches will be presented.

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Poster 26. – Community mental health case managers' perspective of violence among women diagnosed with schizophrenia

Rice, E. (USA)

Violence is a major problem for mental health providers as well as consumers of mental health care. In the last decade there has been an increased focus on the high rates of violence in the lives of women diagnosed with severe mental illness. Research has demonstrated that violence, particularly physical and sexual abuse; frequently coexist for women with a history of severe mental health problems. A history of violence has been correlated with a variety of negative social, physical, and psychological outcomes for women diagnosed with severe mental illness. Mental health case managers often care for this population of women in the community. These providers hear women's stories of violence but generally report feeling ill equipped to adequately provide support to extricate or treat women who have experienced violence.

This presentation will present research that was conducted with case managers with an aim to gain a better understanding of their experiences working with this vulnerable population of women. The methodology chosen for this qualitative research was interpretive phenomenology. Eleven community health case managers were interviewed for this study and these interviews were transcribed and analyzed by a team of experienced phenomenological researchers. Three general themes were developed and include; Knowing and Avoiding, Accepting and Forsaking, and Being Supportive and Overwhelmed. Case managers described being aware of the negative effects of violence on women but for a variety of reasons avoided addressing them. They saw themselves as advocates for women, but were frustrated with their evolving roles and felt overwhelmed and alienated from women's problems with violence.

This presentation will discuss each of these themes and also suggest practice, education, policy and research implications of this research. The issue of violence for both providers of mental health care as well as consumers is complex, and there is a need for an increased examination of the many facets of how violence is negatively impacting psychiatric and mental health practices.

Specific Objectives

This presentation will:
1. Further our knowledge of the prevalence of violence that is directed at women diagnosed with schizophrenia.
2. Provide a nuanced perspective of how case managers who work in the community understand the violence that is directed at their clientele.
3. Examine the many layers of care that case managers provide in the community and gain a better understanding of how the addition of violence changes how case managers cope with working with this vulnerable population.
4. Provide suggestions for needed changes in mental health practice, education, and policies to better equip case managers to direct proper service provision for women diagnosed with severe mental illness.

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Poster 27. – Olazepine (zalasta) and lorazepam (loram) treatment of agitation and positive phenomenology in patients with schizophrenia

S.Arsova Hadzi-Angelkovska, V.Calovska Samardziska, Gj.Hadzi-Angelkovski, V.Vujovik, V.Gerazova, E.Miceva Velickovska (Macedonia)

Aim of the study

The aim was to follow the efficacy of Olazepine in agitated patients with schizophrenic disorder in two levels: reduction of agitation and positive persistent hallucinatory-delusive phenomenon.

Material and methods

In the research we included 18 patients diagnosed by the ICD 10 with Dg. F 20. They were from both sexes, randomly chosen, aged 20-50 treated in-patients in the Psychiatric clinic, Skopje. The patients were with intensive treatment with atypical antipsychotic (Olanzepine) and anxiolitic (Lorazepam) therapy. During the research we included the following psychometric instruments: PANSS scale and BPRS scale to evaluate reduction of agitation and positive hallucinatory-delusive symptoms. The patients were evaluated in the beginning of the treatment and after 7 days, 15 days and 1 month treatment with Olazepine (Zalasta tablets) in dosages of 10-20 mg. per day and Lorazepam (Loram tablets) in dosages of 15-20 mg. per day.

Results

Expected effects on the part of Olazepine and Lorazepam in agitated patients with schizophrenia to reduce psychomotoric agitation and hallucinatory-delusive symotoms were achived.

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Poster 28. – 1-Year follow-up of a randomised controlled trial comparing seclusion and mechanical restraint in people with serious mental illness

Bergk, J. & Steinert, T. (Germany)

Objective

Seclusion and mechanical restraint are widely used for people with serious mental disorders. In most countries one intervention is preferred while the other is considered as inhuman or not sufficiently safe, but identical arguments refer to different preferences. There is a lack of evidence from well-designed studies on compulsory measures in psychiatry.

Methods

We conducted a cohort study with optional randomisation comparing seclusion and mechanical restraint among in-patients with acute psychotic disorders. We determined an ethical aspect as main outcome variable: the restriction of human rights from the patients' point of view, measured by a scale developed for this purpose, Human DIgnity during COercive Procedures, DICOP-Score. In addition we screened for posttraumatic stress disorder (PTSD). After one year a follow up was conducted by telephone interviews. We reassessed the actual incidence rate of PTSD after coercive measures with the Impact of Event Scale.

Results

102 out of 233 patients exposed to coercive measures within 24 months could be included, 26 could be randomised (12 seclusion, 14 restraint). 60 patients could be contacted for follow up interviews. Further results will be presented.

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Poster 29. – Hospitality against separation on closed wards

Hoeken van, D., Gigch van, B. & Hummel van, E. (Netherlands)

The Parnassia Group is a large mental health institute based in The Hague, the Netherlands, with about 1000 beds. There are 9 closed wards with a total of 270 beds and 19 isolation cells. Per year 1720 patients are admitted to the closed wards, including 870 admissions by court order. 70% of the admitted patients are of non-Dutch origin.

Objectives:

Parnassia is currently running a project aimed at reducing isolation/separation and aggressive incidents by 30% in three years. The ultimate aim is to end all separations by 2012. Based on the experience of previous projects aimed at improving the quality of care, a current project aims to achieve the reduction of isolation and aggressive incidents by improvements in hospitality in those units that are at risk. These concern the closed admission wards for patients who have a combination of severe mental illness and behavioural problems, failing impulse control and often lack of insight into their illness. The treatment programme for psychotic disorders has the majority of closed wards and isolation units, and most incidents of aggression, forced treatments and admissions by court order.

Methods:

Improvement in hospitality entails:
- Implementation of the concept of hospitality management
- Introduction of hosts who receive new patients and those who accompany them at admission, and who take care of everyday matters
- Introduction of fixed cleaning personnel
- Introduction of a behavioural code for patients
- Involvement of family in the treatment
- Equipment/furnishing of buildings aimed at preventing and managing behavioural problems
- Improvement of recognizability of employees

The improvements are guided and monitored by a quarterly evaluation among patients, staff and relatives of the patients, starting spring 2007.

Results:

In our oral presentation we will describe the aims and methods of the implementation project in more detail, and we will present some results from the first two quarterly evaluations.

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Poster 30. – Psychopathology and violent behaviour

Douzenis, A.[1] & Lykouras, L.[2] (Greece)

1) Ass. Professor in Forensic Psychiatry, Second Psychiatry Department, Athens University Medical School, Atticon Hospital.
2) Professor in Psychiatry, Second Psychiatry Department, Athens University medical School, Atticon Hospital

Introduction

Aggressive and violent behaviour has always been considered, in popular belief, a major characteristic of mental illness. This wrong assumption has contributed greatly to the stigmatization of mentally ill individuals. However, violence and aggression apart from beeing human behaviours are symproms of many psychiatric disorders.

Aim

This presentation reviews the psychiatric diagnoses that include violence or aggression as one of the prerequisite symptoms for the diagnosis in DSM and ICD classification systems. These nosological entities include schizophrenia, bipolar disorders, mental retardation, acute confusional states and dementia as well as certain personality disorders. The present descriptive psychopathology of violent behaviour is discussed.

Results

Detailed psychopathological descriptions of violence and aggressive behaviour will further the classification and definition of this destructive and damaging behaviour and increase our understanding of the association between the symptom and the psychiatric disorder.

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Poster 31. – Translation, cultural adaptation and validation of the Portugese version of the ATAS (Attitudes Toward Aggression Scale)

Rosa, A.G.S., Marque, I. & Barreto, J. (Portugal).

Health care workers, especially psychiatric nurses continue to be victims of assaults from their clients. One of the factors known to be associated with the management of patient aggression is the attitude of staff members toward the aggressive behaviour of patients.

Objectives

The aim of this study was to translate, adapt and validate an instrument to assess the attitude of nurses toward aggressive behaviour in psychiatric care.

Research question

To what extent does the construct validity and the reliability of the 18–item scale for the measurement of attitudes toward impatient aggression in psychiatry vary from the original version and the other accomplished studies?

Methods

Factor analysis and simultaneous component analysis were performed with data from a convenience sample of 110 psychiatric nurses. The sample was recruited in four psychiatric hospitals in Coimbra.

Results

Data are still being analysed by the author of the study.

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Poster 32. – Coersive measures in Wales (UK)

Lepping, P. (UK)

Aim

To give an overview of coercive measures in the UK and present data relating to coercive measures in the Wrexham Maelor Hospital in Wales.

Method

Audit data presentation and overview

Results

Coercion in the UK is primarily done by control and restraint procedures, which may lead to the application of medication (chemical restraint). Mechanical restraint is not used at all in adult psychiatry. Overall incidences of coercive measures are less frequent and less long than in equivalent German hospitals.

Conclusion

It is possible to run adult psychiatric wards without long-term mechanical restraint.

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Poster 33. – Forms of aggressive behaviour in forensic inpatients

Urheim, R., Hoff, H., Jakobsen, D. & Mykletun, A. (Norway)

Background

There is evidence for the distinction between affective and instrumental forms of aggressive behaviour (Baron 77, Berkowitz 93). A further differentiation in irritable, defensive and predatory aggression has been suggested (Nussbaum, 1999). There is, however, sparse research on diversity and heterogeneity of aggression among psychiatric patients. Thus, there is limited evidence for distinctions of aggressive behaviour beyond the dichotomy (affective versus instrumental). The present investigation proceeds from a previous study examining the interrater reliability of a classification including irritable, defensive, and predatory aggression (Urheim & al 2005). The interrater reliability was satisfactory. However, all raters were therapists who all knew the patients and the instrument well. The aim of the present study is to evaluate the validity of the classification system including irritable, defensive, and predatory aggression.

Methods

For the present study, we developed a 13-item questionnaire with items characterizing perceived intentions of the aggressors. The form was completed by ward staff immediately after each aggressive episode in the context of routinely reports of aggressive behaviour (SOAS). Information was collected between January and November 2006, and included 251 aggressive episodes among 11 patients handled/observed by 50 ward staff members. Principal component analysis with varimax rotation was employed to analyse the factor structure of the aggressive behaviour.

Result

Three factors with eigenvalues >= 1 emerged with good correspondence with the a-priori defined constructs. Rotated eigenvalues were 3.3, 2.4 and 2.1 for predatory, irritable and defensive aggression, respectively. This factor structure explained 60% of the variance in the data. The homogeneity of the factors was also good, in particular for defensive aggression, whose items loaded only weakly on the two other factors.

Discussion

Classification of aggressive behaviour into irritable, defensive, and predatory aggression seems to have empirical support, and might have predictive value. Understanding of heterogeneity of patient aggression based upon these categories is likely to be relevant for risk assessment and treatment. Commonly used assessment procedures do not include this categorization of aggressive behaviour. We speculate whether routinely description and categorization of aggressive episodes would be of clinical relevance in forensic psychiatric contexts.

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Poster 34. – Situational factors influencing aggressive episodes in a security ward

Urheim, R., Jakobsen, D., Nome, S., Rypdal, K. & Palmsteirna, T. (Norway)

From the opening of a ten bed security ward in 1989 until 2006, more than 6000 aggressive episodes, performed by 70 patients, have been assessed by SOAS. There have been changes in aggression patterns and substantial decrease in aggression rate. Basic patient characteristics, in addition to some situational factors, as staffing resources, personnel characteristics and educational background, have been stable. Increased number and turnover of patients seem not to have influenced aggression rate.

Various situational factors, which may have influenced rate and pattern, will be described. Intervention procedures have been implemented, milieu rules have changed, as well as organizational structure. Some changes have happened after external or non-planned influences to the ward, such as new laws, departure of key personnel etc. Ward culture and norms have gradually changed. Looking backwards, it seems reasonable to discriminate between distinct periods in the history of the ward. Differences in organization, risk management regime, intervention style and treatment programs, and patient autonomy can be traced, and are candidates for possible causal factors.

The first five years period was characterized by a rather conservative and cautious regime and relatively modest activity program with small demands upon patients. The next six year started with new leadership, introduction of additional treatment procedures, more extensive activity programs, staffing and material resources related to this and increased demands upon patients. The last five years started with new health laws stressing patient rights and autonomy, change in activity personnel and decreased demands upon patients, combined with more individualized programs and opportunities for the patients.

Description of changes in rate and pattern of patient aggression will be presented, followed by hypotheses of causal connections, discussing possible causal factors as:
- Changes in demands and strain put upon patients
- Patient rights and autonomy have got a more central place
- Dialogues related to risk situations have replaced strict regimes, increasing understanding and knowledge of individual vulnerabilities and risk factors
- Norms for judgement and decision making by ward staff in risk situations have changed, being less rule governed and allowing greater opportunity of flexible solutions and individual problem solving.

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Poster 35. – Measures to deal with aggressive episodes: 16 years review with SOAS-R in a security ward

Rypdal, K., Nome, S., Urheim, R. & Palmstierna, T. (Norway)

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This poster will build upon findings and central hypotheses described in the poster "SITUATIONAL FACTORS INFLUENCING AGGRESSIVE EPISODES IN A SECURITY WARD" by Urheim & al

Changes in rate and pattern in use of measures to stop aggression will be presented. Coercive measures are reduced, especially in the less severe episodes. Further changes in use of measures and relations between measures and provocation/result items will also be described.

Followed by hypotheses of causal connections, discussing possible causal factors as:

- Central hypotheses described in the above mentioned poster.
- Norms for use of measures to stop aggression affects rate of aggressive episodes and results for victims.
- Use of less coercive measures may inflate the result items of aggressive episodes and thereby reduce physical consequences for victim.
- Use of less coercive measures may inflate the rate of aggressive episodes and thereby reduce the rate of aggressive episodes.

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Poster 36. – Development of a novel psychotherapy service in Holloway prison for women prisoners who self harm

Regan, J., Bartlett, A., Malley, M. & Browne, M. (UK)

Holloway prison is a women's prison in London which houses 450 women at any one time. Self harm is a particular form of violence identified as a problem within prisons, especially amongst women, and resulting in considerable staff distress and institutional difficulty. A recent review described 80 prisoners in Holloway self harming in one day. Self harming prisoners are often moved between prisons because they pose management problems. Many women who self harm also have borderline personality disorder (BPD). In 2006 Holloway healthcare began designing a novel psychotherapy intervention to address these issues.

A literature review identified two evidence based therapies for BPD: mentalisation based therapy (Bateman and Fonagy) and dialectical behaviour therapy (DBT- Linehan) our service will use elements of each. However neither therapeutic model fits the prison perfectly, so a scoping exercise was carried out involving 15 prisoners and 20 members of staff to "tailor make" the service to the institution. We identified enthusiasm among both groups for our service. However the exercise led to important structural changes. Prisoners disliked the name "therapy" preferring a pragmatic group based training we called "life skills ". Their rapid movement through the custodial system prevents prolonged therapy. Instead we propose modular therapy of several 6 week courses, which can be completed in a flexible way. Each module focuses on a specific area of difficulty ie: emotion regulation, expressing distress, managing anger, interpersonal relationships and self esteem. Group work will aim to improve emotional literacy and the ability to "mentalise" the responses of others.

Prisoners described intense anxiety regarding their release. We therefore devised a unique "beyond prison" component to the programme. Prisoners will begin individual therapy just prior to release, continuing for up to one year after release, with financial support to return to the prison weekly.

Women with 3 full threshold BPD traits, including self harm, will be accepted to the service. They will attend groups twice a week for 6 weeks: 75% attendance will be expected. The total course of therapy will be 48 weeks long. One to one work begins when group therapy finishes or immediately prior to release, whichever is sooner. Outcomes will be assessed over the course of therapy including rates of self harm, use of close observation within the prison and subjective ratings of mood instability. Drop-outs and a non treated control group will also be followed. The initial phase of the service will be a pilot and will begin accepting clients in Autumn 2007.

Prison officers described anxiety in managing self harm: a second component of the service will be education to prison staff in understanding and responding to self harm. The third component of the service will be expert consultation and liaison to external prisons in managing BPD and self harm, to reduce disruptive transfers of disturbed prisoners.

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Poster 37. – The examination of interactions between nurses and patients in terms of predisposition to violence: a preliminary study

Bilgin, H., Özcan, N., Küçük, L. & Ulusman, Ö. (Turkey)

Introduction

It has been accepted that effective communication is key determinant of patient safety, compliance and recovery. Faulkner (1998) states that effective communication with other people is the heart of total patient care. For this reason, communication and communication skills have an important role in nursing education and practice (Chant et.al. 2002).

It is reported that the relationship between nurses and patients has a huge importance in the literature of psychiatric nursing care (Morrison&Burnard 1991). Verbal interactions between nurses and patients and also the support given by nurses in the relationship are described as the milestones of care (Rask&Brunt 2006).

Violent behaviour has been regarded as serious problem for psychiatric nurses and other health care staff. The underlying processes of violence involve many factors. It has been reported that some nurse behaviours (rigidity, authoritarianism, frustration and anger) lead to predisposition and expansion of anger and aggression on patients and some applications which are used due to psychiatric treatment and care occasionally might be perceived as aversive by patients and might be predictors of aggression in psychiatric settings (Ryan&Bowers2005).

Spesific objective of the study

The objective of this study is to examine spesific interactions between patients and nurses and to evaluate the possibility of moderating aggressive aspects of nurses' interaction styles.

Method

The study occurred over a one-month period, on Wednesdays to Thursdays , between the hours of 09.00 and 15.00, from December 2006 to January 2007 in two adult male inpatient units of a psychiatric training hospital. Data on nurses' interactions with patients were obtained via non-participant observation. The average number of nurses on duty in day shift was 4-5, the number of observations was 35 during selected observation periods.

In the data analysis, the behaviour patterns which are seen frequently and repeated were classified as basic and discrete categories.

Results

Within the units, nurses are mostly in nursing office or desk, many interactions occurred in these settings; nurses' interactions amongst themselves are higher than with patients; the physical contact with patients were reduced during the observation periods.
- Out of 35 observed interactions, 24 (68.5%) were negative, 11 (31.4) were positive.
- Analysis of interactions according to verbal and nonverbal language
- For verbal language; the behavioral patterns are reported below:
    · Rejection 62.5% (15)
    · Frustration 45.8% (11)
    · Hostility 37.5% (9)
    · Criticize 12.5% (3)

In the context of positive interactions, the patterns of supported/encouraged, reality oriented, respectful predominated.

Non-verbal interaction which were particularly negative involved remaining distant, not building eye contact, having angry gazes, and not touching.

Discussion

These findings are preliminary and they are based on observations of interactions between nurses and patients. When examining behavioral patterns, they are not the only cause of aggression, but findings support the view that nurses' interaction styles might cause aggressive behaviours in patients and the need to deal with them for prevention and management of aggression.

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Poster 38. – Violence towards health care staff in Turkey: a systematic review

Ozcan, N. & Bilgin, H. (Turkey)

Background

In last decades, the incidents of aggression and violence towards health care staff has increased in Turkey like in other countries (Bilgin 2006, Ayranci et.al 2006). The importance of the topic and the need to investigate this issue are seldom reported

Objective

The aim of this systematic review was to describe the dimensions, nature and outcomes of violence towards health care staff in Turkey.

Methods

A systematic review of literature from 1999 to 2007 was conducted using PubMed, Medline, CINAHL, PsychINFO and national universities' databases.
Articles from national and international journals in Turkish and English were included to this review.

Results

The literature showed that this is an important topic and a problem for nurses in Turkey (Ozcan 1994). Since 1997, the interest of this subject has increased in research and publications. Twenty published studies were included. Most of these studies are descriptive and were produced in general settings and ERs. The samples of most studies consisted of nurses. The highest level of violence occurred to nurses although they studied most amongst all members of health care team. Only one study was carried out in psychiatric clinics (Bilgin 2006). This is noteworthy when compared to other literature. Two studies examined the existence and effect of violence on student nurses (Lash et.al.2006). One of them was a phenomenological study. The sort of violence, the effects and outcomes of violence on staff and staff' attitudes have been studied. Thus, it is proposed that the frequency of verbal and physical aggression are high and there are some psychological and physical outcomes for staff.

Conclusion

From the results of this systematic review, it is clear there is a huge threat to work safety of staff in health care settings in Turkey, similar to other countries. These studies might be classified as epidemiological studies about violence against health care staff. It is recommended that this review should be taken into account as evidence for practice and might be reflected in programmes of violence prevention for both staff and patients.

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Poster 39. – Secluded patients' experiences – case reports

Keski-Valkama, A. Eronen, M. & Kaltiala-Heino, R.K. (Finland)

Background

Seclusion is a prevailing coercive measure in psychiatric treatment, but clinical, ethical, and legal debate has increased the awareness of its controversial nature. However, studies focused on the experiences of the secluded patients themselves are sparse.

Aims

This poster presents different kinds of representative cases derived from an extensive research project concerning the secluded patients` experiences in forensic and general psychiatric hospitals.

Method

The secluded patients were interviewed using a semi-structured interview developed for the purpose of this project. The background data were collected from the charts of each patient. Conclusion: Clinical implications are discussed.

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Poster 40. – Use of seclusion and restraint, and its relationship to the patient's gender - a retrospective multi-center study from three Departments' of Acute Emergency Psychiatry

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Abstract

Use of seclusion and restraint, and its relationship to the patient's gender
A retrospective multi-center study from three Departments' of Acute Emergency Psychiatry in Norway

Background:

Previous studies show inconsistent findings about gender association with seclusion and restraint. A study from an acute emergency department (Knutzen 2002) showed that the number of women secluded and restrained were lower than for the men. But among repeatedly secluded and restrained patients the women were in majority and they also had more episodes with seclusion and restraint. Method: In an ongoing multi-center study conducted in three acute emergency psychiatry institutions with total responsibility for representative catchments areas we retrospectively examine data from seclusion and restraint protocols and data about all the patients admitted over a two-year period. We note how many patients have had episodes with seclusion and restraint. We also note duration/ time/ date of each episode and the reason given for using seclusion and restraint and the relationship by gender. Each patient is only counted once in this period, controlling for readmission. Results: Preliminary findings from one of the departments replicate findings in the study from the 1994-99 (Knutzen 2002) that the total number men secluded and restrained were higher than for women, but among repeatedly secluded and restrained patients the women were in majority. At the congress we will present results from two of the departments. Conclusion: Our data indicates that the use of seclusion and restraints varies by gender and the need to study not only the rate of seclusion and restraint, but also the episodes of seclusion and restraint by gender.

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Poster 41. – Psychiatric intensive care units (PICUs) in England: characteristics of an effective care pathway

Barrett, K., Hawkins, J. & Davies, C. (UK)

Institution
NHS Institute for innovation and improvement (UK)

This poster will present the results of an investigation of best practice in psychiatric intensive care units (PICUs) in England undertaken by the Institute for Innovation and Improvement. The Institute is part of the National Health Service (NHS) for England and Wales and was set up "to improve health outcomes and raise the quality of delivery in the NHS by accelerating the uptake of proven innovation and improvements in healthcare delivery models and processes."

This study posed the following question: What therapeutic and managerial interventions, actions and processes demonstrate a safe, effective, cost efficient pathway that delivers a high quality service to patients undergoing psychiatric intensive care? The overall aim was to identify and disseminate principles of PICU best practice with the aim of reducing variation in practice in England and Wales.

A range of NHS trusts were identified, in collaboration with the UK's PICU Clinical Governance Network and CSIP, the choice reflecting a range of current PICU practice, a mix of urban and rural communities and included NHS and private care organisations. Those trust who were willing to become co-production partners in the study were visited by a team that included a psychiatrist, senior nurse and informatics specialist. Common themes identified during these visits formed the basis of discussion during a co-production day attended by participating trusts and other stakeholders.

The poster will present the results of these deliberations in the form of a best practice care pathway.

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