Patrick Callaghan - Nico Oud - Johan Håkon Bjørngaard
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Proceedings of the 8th European Congress on

VIOLENCE IN CLINICAL PSYCHIATRY
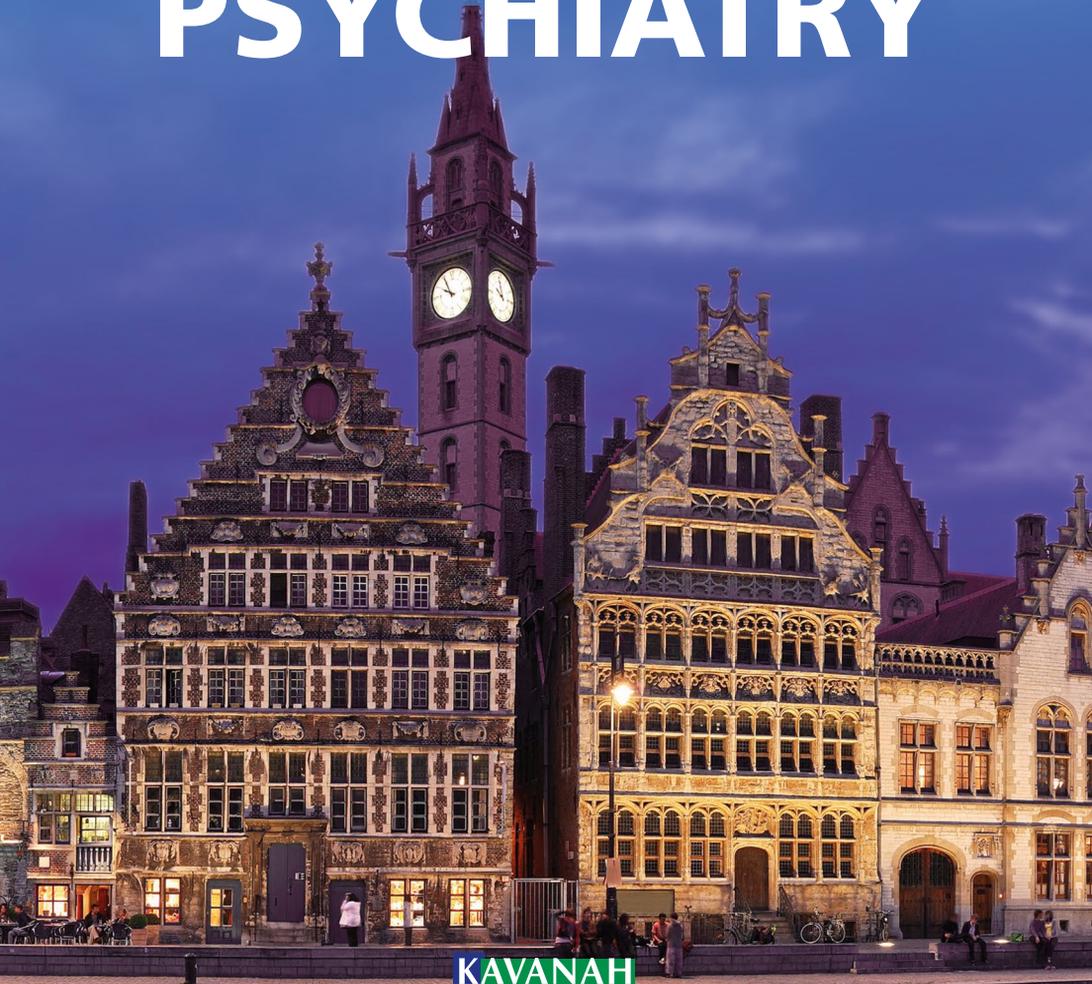
KAVANAH

Violence in Clinical Psychiatry

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Editors

Violence in Clinical Psychiatry

Proceedings of the
8th European Congress on
Violence in Clinical Psychiatry

23 – 26 October 2013
Gent ICC - international convention center
Van Rysselberghedreef 2 bus 1 - Citadelpark
Ghent, Belgium

Preface

Despite progress in the care and treatment of mental health problems, the prevalence of violent incidents – verbal or physical aggression directed at self or others – remains high in many parts of the world.

Violence towards staff is an occupational and public health issue and a serious threat to health services' attempts to deliver quality care. Violence injures patients and staff, loses health services money as staff take time off to recover from injuries, harms the relationship between patients and staff, and damages services' therapeutic nature. Staff are essential resources in providing quality mental health care but when they encounter violence they can suffer prolonged damage to their quality of life, and become suspicious and hostile in their work. Exposure to violence is a pre-disposing factor in the development of Post-Traumatic Stress Disorder in many people. Patients who witness violence on the ward are likely to abscond from fear, and may then be left untreated in the community with potential consequences of harm to themselves and others. Violence is not just a problem for clinical services in psychiatry; it has major social, political, security and judicial implications.

Preventing violence, reducing its incidence and impact, managing its consequences and understanding how and why it manifests itself requires working across different disciplinary perspectives using the most up-to-date techniques and interventions and the best available evidence. Much is already known about violence in clinical psychiatry; much remains to be discovered. It is the latter of these issues upon which the 8th European Congress on Violence in Clinical Psychiatry will focus.

The beautiful canal city of Ghent in Belgium is host to this year's congress which sees a gathering of international academics, clinicians, managers and others with an interest in updating and sharing knowledge on the management of violence.

As the papers in these proceedings show, this year's congress is truly international. People from all corners of the world will deliver papers, symposia and workshops, present posters and debate how 'new and interdisciplinary approaches' might transform the landscape of violence research, education and practice. The concerns the congress addresses will be of interest and significance to people providing, using, developing and commissioning mental health and intellectual disability services, as well as the people who shape policies.

For the first time the congress includes an expanded range of themes showcasing advances in the neurobiological, pharmacological, social, medical, psychological, cognitive and health sciences and their application to specific populations and topics. Presentations also reflect ethical and legal issues in addition to addressing racial, gender and ethnic perspectives.

We are honoured at this year's congress to welcome some of the leading international scholars who are at the forefront of thinking on violence in clinical psychiatry and beyond. Adrian Raine's recently published work examining 'The Anatomy of Violence' sheds new light on how brain structures may underpin an individual's propensity to commit violent acts.

His contribution to the congress will challenge notions about the role of free will and responsibility in the manifestation of violence and has far reaching implications about how societies respond to violent offenders. This is likely to be of particular interest to another of our keynote speakers Kelly McLean, a Registered Nurse who will present what is certain to be a moving account of her recovery from a violent assault while working in a psychiatric emergency room.

Risk assessment is a widely used method of seeking to predict future violence with a view to preventing and minimising the occurrence of violence and managing people whose behaviour is deemed harmful. Henrik Belfrage's work focuses on spousal violence risk assessment. The developer of the Brief Spousal Assault Form, Professor Belfrage examines the possibilities and pitfalls in spousal violence risk assessment and raises the question of which approach might be most useful.

Restraint is a common method of managing violence in mental health settings. However, evidence shows that restraint has led to the death of patients on too many occasions. Joy Duxbury, chair elect of EVIPRG – the European Violence in Psychiatry Research Group – is one of the UK's leading mental health nursing researchers and led a review of restraint-related deaths for the English Department of Health. Joy shares her insights gleaned from this review that will hopefully lead to practice changes that will eradicate these avoidable deaths. The keynotes papers conclude with three speakers from Belgium, this year's host country. Kris Goethals discusses the role of uncontrollable sexual behaviour on violence, while Kurt Audenart examines how brain imaging studies in animals and humans help us understand the use and effect of serotonergic drugs in impulsive and aggressive patients. Christian Decoster from the Belgium Ministry of Health is a key player shaping national policy on violence in health settings. He will share his insights on the measures required to care for interned and other populations.

It seems apt that the 8th European Congress on Violence in Clinical Psychiatry is taking place in the stimulating, idiosyncratic and authentic city of Ghent. We can think of no better setting for a lively three days of making discoveries about violence in clinical psychiatry, and making these discoveries matter to people's health and well being.

Professor Dr. Patrick Callaghan, School of Health Sciences, University of Nottingham, UK
Dr Roger Almvik, Director of Research, St Olav's Hospital, Trondheim, Norway and Chair of the European Violence in Psychiatry Research Group

Supporting Organisations

The Congress organisation committee cordially thanks the following organisations for their support:

- European Violence in Psychiatry Research Group (EViPRG)
- Altrecht Aventurijn
- CONNECTING, partnership for consult & training
- Karolinska Institute
- British Institute for Learning Disabilities (BILD)
- World Psychiatric Association (WPA)
  Section on Art and Psychiatry
  Section on Psychiatry and Intellectual Disability
  Section on Stigma and Mental Illness
- Universitair Ziekenhuis Gent
- Vlaamse Vereniging voor Geestelijke Gezondheid (VVGG)
- Ghent University
- Psychiatrisch Centrum Dr. Guislain
- Universitair Forensisch Centrum (UFC)
- St. Olavs Hospital, Trondheim University Hospital
- Geestelijke Gezondheidszorg Westelijk Noord-Brabant (GGZ WNB)
- The University of Nottingham
- Vlaamse Vereniging voor Psychiatrie
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General scientific remark

Occasionally the congress organization receives queries – especially from
academic institutions – regarding the procedure for the selection of abstracts to be
presented at the congress. Each abstract is submitted for peer review to members
of the International Scientific Committee. Each abstract is anonymously adjudicated
by at least three members of the committee. Abstracts are evaluated according to the
following criteria:
- relevance to the conference theme,
- interest to an international audience,
- scientific and/or professional merit,
- contribution to knowledge, practice, and policies, and
- clarity of the abstract

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

In total we did receive 307 abstracts from 52 different countries worldwide, of which 50
(16%) were rejected, 32 (10%) were withdrawn mainly due to financial reasons or not getting
funding in time, and 54 (18%) were not included in the program and the proceedings due to not
registering after all or not paying the fees in time. Together with the pre-congress workshops,
keynotes and special workshops in total 201 presentations from 28 different countries
worldwide were presented.

Content

Chapter 6 – Advances in psychological therapies

Chapter 7 – Application of new technology

Chapter 10 – New directions in the assessment of risk, prevention & protective factors

Chapter 11 – Other related themes

Chapter 12 – Race, gender & ethnicity perspectives

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Chapter 1 – Pre-Congress Workshops

The black box of aggression unravelled: The application of the Early Recognition Method

Frans Fluttert
The Netherlands

Facilitators

Frans Fluttert is Senior Researcher at FPC Dr. S. Van Mesdag, a forensic psychiatric hospital in Groningen. He finished his Phd on 'Risk Management in Forensic Mental Health Nursing: application of the Early Recognition Method'. He is Ass.Prof. at Molde University College (Norway) and Research Supervisor at Research Centre for Forensic Psychiatry, Oslo University Norway.

Fluttert completed his Phd on 'Risk Management in Forensic Mental Health Nursing: application of the Early Recognition Method'. He lectures at universities in The Netherlands, Germany and Rumania and publishes in international journals. He is involved in several international research projects. In his former professional career he worked as forensic mental health nurse, probation officer and forensic social inquiry reporter for court. Fluttert was Chair of the Nursing Special Interest Group of the IAFHMS, steering group member of EVIPRG and member of the SSTI.

Abstract

Inpatient aggression is a main topic in forensic psychiatric care. The 'Early Recognition Method' [ERM] is a risk management strategy objective to support self-management of patients regarding relapse prevention of aggression. Staff and patient discuss and describe patient's early warning signs of aggression. The focus is on those early warning signs that are very personal based, which are referred to as 'signature risk signs'. The early warning signs are described in the so-called Early Detection Plan [EDP].

A major obstacle in current clinical practice is that there hardly are instruments or tools available to support patients and nurses to collaboratively identify early warning signs of aggression in a structured way. The Forensic Early Signs of Aggression Inventory [FESAI] was developed in order to assist nurses and patient in identifying patient's personalized early warning signs. Using the FESAI the nurse and patient together explore which items of the FESAI represent the patient's early warning signs of aggression, after which nurse and patient elaborate on these early warning signs in the Early Detection Plan.

By means of the ERM 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. Research suggests ERM to contribute to a significant decrease of inpatient violent incidents and a significant decrease of severity of inpatient incidents.

In the workshop the Early Recognition Method will be outlined. The application of the Early Detection Plan and the Forensic Early warning Signs of Aggression Inventory will be demonstrated and trained, by using case descriptions and movie fragments.

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Assessment of protective factors for violence risk: The SAPROF

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Van der Hoeven Kliniek, Utrecht , The Netherlands

Keywords: SAPROF, protective factors, violence risk assessment, dynamic, risk management

Facilitators

Ellen van den Broek is a psychologist and treatment supervisor of the community rehabilitation unit at the Van der Hoeven Kliniek in Utrecht, the Netherlands. She has been involved with the development and implementation of the SAPROF and has extensive experience using risk assessment tools in daily clinical practice.

Michiel de Vries Robbé is a psychologist in the Department of Research at the Van der Hoeven Kliniek in Utrecht, the Netherlands. His near finished PhD research focuses on protective factors for violence risk.

Vivienne de Vogel is a psychologist and head of the Department of Research at the Van der Hoeven Kliniek in Utrecht, the Netherlands. Her research focuses on violence risk assessment, including protective factors and violence (risk assessment) in women.

Introduction

In response to the demand of clinicians in forensic psychiatry for a more positive, changeable and treatment related approach to risk assessment, in recent years research has focused on the development of protective factors for violence risk. Protective factors are characteristics of a patient or offender, their environment or their situation that protect an individual from relapsing into violent behavior (De Vogel, De Ruiter, Bouman, & De Vries Robbé, 2009). In his uncritical acceptance of risk assessment in forensic practice, Rogers (2000) argued that risk-only evaluations are inherently inaccurate and implicitly biased, making it essential for balanced risk assessment to take into account both risk and protective factors. According to Douglas and Skeem (2005), the changeable nature of dynamic factors makes them a promising target for risk reduction in forensic psychiatric treatment. The addition of dynamic protective factors to risk assessment could therefore serve as valuable input for positive risk management by creating a dynamic counterbalance to commonly used risk factors in forensic psychiatry.

Inspired by research findings and reinforced by the desire of clinicians for addition of changeable and positive factors in risk assessment, in 2007 the Structured Assessment of Protective Factors for violence risk (SAPROF; De Vogel, De Ruiter, Bouman, & De Vries Robbé, 2007, 2012) was developed in the Netherlands as a positive supplement to the assessment of risk of future (sexually) violent behavior. The SAPROF is a Structured Professional Judgment (SPJ) checklist containing merely protective factors and intended to be used in combination with a SPJ risk tool, such as the HCR-20 (Webster, Douglas, Eaves, & Hart, 1997) or its successor the HCR-20V3 (Douglas, Hart, Webster, & Belfrage, 2013). The tool was developed based on literature reviews on protective and contextual factors and qualitative research findings within forensic clinical treatment. Since the publication of the English version in 2009, the SAPROF rapidly gained international attention and was translated in over 10 different languages.*

The SAPROF consists of two static and fifteen dynamic protective factors organized within three scales: Internal factors, Motivational factors and External factors. The items are rated on a three-point scale (0-2), reflecting the extent to which they are present as a protective factor for violence risk for a given patient in a specific situation. Additionally, factors can be indicated as particularly important for the individual. Factors that provide much protection at the time of assessment can be marked as key factors, while factors that are seen as potential targets for treatment intervention can be marked as goal factors. In clinical practice, the indication of key factors and goal factors sharpens the view on the importance of specific protective factors for an individual, which can be useful for the development of individualized risk management and treatment intervention strategies. Following the SPJ approach, the SAPROF concludes with a final judgment on the available protection against violence risk (low, low-moderate, moderate, moderate-high or high), which is composed by interpreting and integrating the protective factors that are present. Next, this Final Protection Judgment is combined with the HCR-20 risk factors to come to an integrative Final Risk Judgment on the level of risk for future violent behavior. In De Vries Robbé and De Vogel (2013)

the background and content of the SAPROF is explained further and its protective factors are illustrated in a case example.

The workshop

Like with most SPJ tools, training is recommended before using the SAPROF in clinical practice, in order to ensure a correct understanding of and provide coding practice with the different protective factors. In the workshop participants are introduced to the SAPROF and gain first hand practical experience working with the tool. In addition to an elaboration on the coding instructions and practicing with a case study, the additional value of protective factors for risk assessment and risk management is discussed and research findings with the SAPROF are presented.

Clinical practice

Being mainly dynamic in nature, the SAPROF aims to not only assess protective factors, but to also inform treatment of potential opportunities for positive intervention. In 2007, the SAPROF was implemented into general risk assessment practice for violent and sexually violent offenders in the Van der Hoeven Kliniek, a forensic psychiatric hospital in The Netherlands, to complement traditional risk assessment with the HCR-20 and SVR-20. The dynamic positive approach to risk assessment made the SAPROF easy to implement as it appeared motivating to both clinicians and patients. In clinical practice the dynamic factors of the SAPROF have since proven to be helpful in formulating treatment goals, evaluating treatment progress and stimulating positive risk communication. By doing so, the tool has offered valuable guidance in narrowing the gap between risk assessment and violence prevention and has enabled a more positive approach to the prevention of future violence.

Research

Although the greatest supplemental value of the SAPROF is its importance for guiding prospective treatment evaluation and planning, confirmation of its psychometric properties is essential. Research has focused especially on the predictive validity of the SAPROF factors for no new incidents of violence during or after treatment (De Vries Robbé & De Vogel, 2012; De Vries Robbé, De Vogel, & De Spa, 2011; De Vries Robbé, De Vogel, & Douglas, 2013). Interrater reliability proved to be good both in retrospective file studies as for clinical codings of the SAPROF. Retrospective studies showed good predictive validities for no violent reconvictions for violent as well as sexual offending. Moreover, the combined use of the HCR-20 (risk) and SAPROF (protection) together showed better violence predictions than the HCR-20 alone. When the changes in protective factors scores during treatment were analyzed, it was found that this change in itself was predictive of no future violence after treatment. This indicates that those patients who improve the most on their protective factors during treatment recidivate the least after treatment, and thus that the SAPROF can be used as a tool to guide clinical intervention and evaluate treatment progress. Next, research has focused on prospective clinical assessments with the SAPROF. It was found that the factors in the SAPROF were able to accurately predict the non-occurrence of violent incidents during treatment. Predictive validities were good for patients with violent offending histories as well as for patients with sexual offending histories, and for patients with Major Metal Illnesses as well as for those with Personality Disorders. Interestingly, different factors appeared to be most protective for violent incidents in the different groups of patients.

Conclusion

At the 8th European Congress on Violence in Clinical Psychiatry a workshop is offered in the SAPROF, a structured risk assessment tool specifically for the assessment of protective factors. Through effectively complementing the dynamic assessment of risk for future violence with protective factors, the addition of the SAPROF cares for a more balanced assessment of violence risk, with the aim to provide a valuable supplemental positive and dynamic approach to preventive risk management in forensic clinical psychiatry.

Acknowledgements

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*German and Italian versions 2010; Spanish, French, Swedish, Norwegian and Portuguese versions 2011; Russian version, Dutch and English 2nd Edition 2012; Danish version 2013; Chinese, Japanese and Youth Version in preparation.

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Violence in the workplace: An endemic but not an inevitable problem of 21ˢᵗ century healthcare delivery

David Jones
United Kingdom

Keywords: Workplace, Health Environments, Violence, Prevention, Strategy, NHS, Mental Health

Facilitator

David Jones is a Consultant Nurse at Nottinghamshire Healthcare Trust. Specialising in the assessment, treatment and management of violence, he has worked extensively with both patient and staff orientated violence reduction initiatives. These have included the development and implementation of violent offender treatment programmes and the delivery of staff training and development strategies that encompass both preventative and reactive elements aimed at minimising the effects of violence. In the last year David has provided leadership in the development of Nottinghamshire Healthcare NHS trusts violence reduction strategy.

Introduction to Workshop

The aim of this workshop is to introduce the concept of violence within the workplace with a particular emphasis on mental health settings. The workshop will provide an overview of the problem of violence in mental health settings in the UK before embarking upon an examination of contemporary approaches to violence prevention from an organisational perspective. Participants will be afforded the opportunity to examine an example of the development and implementation of a violence reduction strategy within Nottinghamshire Healthcare NHS Trust, one of the largest mental health providers in the UK.

Workplace Violence

Workplace violence is considered a global problem which crosses borders, workplace settings and occupational groups. For so long a "forgotten" issue, the subject of violence at work has dramatically gained momentum in recent years and is now a priority concern in both industrialised and developing countries. The problem of workplace violence has attained that of a special interest in recent years, long considered a personal and interpersonal issue; the problem of workplace violence has increasingly become recognised as an organisational and societal concern (Di Martino, 2003). Typical 'workplace' definitions centre on the physical boundaries, e.g. hospitals or units, however, the changing face of the workplace and work patterns through technological advances and new ways of working has increasingly widened the scope of what constitutes workplace environments. Accordingly, Bulatao and VandenBos (1996, p3) have suggested that we should therefore consider "any incident of violence while working or on duty" as workplace violence.

Workplace violence in the United Kingdom (UK) is a major problem. The British Crime Survey which collates the number of threats and physical assaults to workers on an annual basis, estimated that in the year 2010/2011 there were 313000 threats of violence and 341000 reported physical assaults in the UK workplace, an increase of 10% on the previous year. The survey estimated that 43% of all people assaulted or threatened at work were repeat victims, with 24% experiencing three or more incidents of workplace violence per year. The occupations most at risk of workplace violence are those in the protective services (e.g. Police) and those working in health and associated professions (Home Office, 2012).

Violence in Healthcare

Within healthcare settings workplace violence is a significant international problem and an economic burden that adversely impacts upon the quality of care and safety of all involved. According to a number of studies violence in the health sector constitutes almost a quarter of all violence at work (Nordin, 1995; Huckshorn and Le Bel, 2009). In 2007/2008 figures based upon the average cost per incident of workplace violence, indicated that physical violence alone against NHS employees cost the UK tax payer £60.5 million, more recently this figure has grown to around £100 million (NHS Counter Fraud Service, 2007). However, this figure does not take into account staff replacement costs, treatment costs, and compensation

claims, which would all increase this estimate considerably. The focus on financial and asset costs also fails to capture the demoralising impact of workplace violence on the workforce, the increased stress levels for service users and staff alike, and the deleterious effect on the therapeutic milieu and the delivery of therapeutic services.

In mental health care settings violence is considered to be endemic (Richter and Whittington, 2006), with staff injury rates exceeding those of other high-risk industry workers (Love and Hunter, 1996). Although there remains a long standing debate over the relationship between mental illness and violence, 'client initiated violence' is the most frequently recorded category of violence within NHS mental health services (Estryn-Behar et al. 2008). Figures for 2009/2010 showed that there were 38,959 recorded physical assaults within mental health services, representing 69% of the total number of assaults across the NHS as a whole (NHS Security Management Service, 2011). Despite these figures the majority of psychiatric patients are not violent and the small minority that are assaultative account for a disproportionately high number of incidents (Daffern and Howells, 2002). Nevertheless, workplace violence in healthcare settings is problematic and has been recognised as a preventable rather than an inevitable occurrence.

Preventing Violence

In response to the problem of violence, successive governments have put forward a number of initiatives in an attempt to tackle the issues leading to violence and aggression in the NHS. These initiatives commenced in 1999 with the launch of the 'zero tolerance' campaign, which aimed to emphasise the issue of workplace violence as a key priority, sending the clear message that violence against NHS staff was unacceptable and would not be not be tolerated (Health Service Circular 1999/226).

Increasing awareness amongst NHS staff of the importance of reporting incidents of violence and / or abuse through the work of the 'Zero Tolerance' campaign, saw a massive increase in recorded violent incidents from 65,000 in 1998/1999 to 115,000 in 2002/2003 (Health Service Circular (1999). In response to this, in 2003 the Department of Health commissioned the NHS Security Management Service to oversee the management of health and safety issues within the NHS, with a view to reducing its levels of violence. This was supported by a specific mandate from the secretary of state for health, who instructed health bodies to;

"Implement a series of initiatives designed to deliver an environment for those who work in or use the NHS that is properly secure, so that the highest possible standards of clinical care can be made available to patients" (NHS Security Management service, 2003).

Responding effectively to workplace violence is measured by an organisations' ability to implement appropriate measures to prevent or minimise its' occurrence. Contemporary thinking on workplace violence, stresses the need to address the problem in terms of one of a total organisational dimension. The assertion is that a total organisational response to this phenomenon must reflect an organisation that is able to reflect both from a top down and bottom up perspective, continually learning from its current experiences in order to meet existing and future demands.

Within the organisational response is the need for clear leadership and the development, dissemination and implementation of a robust strategy on workplace violence. Any strategy needs to encompass three dimensions, these include; 'primary' approaches taken to prevent violence before it occurs such as risk assessments and staff training in conflict resolution and environmental management; 'secondary' approaches, where measures taken aim to prevent violence when it is perceived to be imminent such as 'de-escalation' and emergency responses, and 'tertiary' responses where action is taken both when violence is occurring and after it has occurred in order to prevent or reduce the potential for physical and psychological harm to the parties involved (e.g. restraint techniques) and also to inform primary and secondary prevention strategies through mandatory post-incident reviews that address the underlying reasons for violence.

Essential to this process is the need to define and understand the concept of violence. Defining violence is not an exact science but a matter of judgement, key to this judgement is the need for an operational definition. Within the literature there are many possible ways to define violence, depending on who is defining it and for what purpose. Consequently violence is often viewed as an extremely diffuse and complex phenomenon, which often negates attempts at implementing effective preventative measures. For this reason the NHS focused on developing a universal definition that would allow all NHS health organisations and staff to be clear about what constitutes physical assault. Focusing their definition of violence within the framework of physical assaults, the NHS described violence as the *'intentional application of force to the person of another without lawful justification, resulting in physical injury or*

discomfort' (Security Management Service, 2003). Whilst it is difficult to provide a comprehensive list of incident types that are covered under this definition, it is widely accepted that behaviours such as pushing, shoving, scratching, poking, the throwing of objects / liquids and spitting, can be included alongside the more obvious forms of physical assault such as punching and kicking.

Criticisms of this definition have typically highlighted the over-emphasis on physical violence, thereby omitting the notion of psychological harm and the deleterious effects that verbal aggression constitutes towards health workers. Ignoring the salience of non-physical aggression also serves to mitigate against the effectiveness of preventative measures, by ignoring important risk factors of physical violence. In reality physical assaults rarely occur in the absence of non-physical aggression and as such non-physical aggression is widely regarded as a salient predictor for physical violence (Stanza, et al 2006).

One possible explanation for the relationship between physical and non- physical violence is that the occurrence and tolerance of non-physical violence in healthcare settings creates or contributes to a culture of disrespect that, in itself, is conducive to the emergence of physical violence. Support for this view comes from studies of behavioural modelling that suggest that mild forms of aggression, if tolerated within any given setting, are predictably followed by more serious forms of violence committed both by observers as well as the original perpetrators (Kelley & Mullen, 2006).

Extending this theory to one of an organisational perspective, leads to the hypothesis that verbal aggression in the form of threats and abuse provides the context for the emergence of physical violence independent of whether or not these escalating forms of violence are perpetrated by the same or different individuals. As such, aggression and abuse represent an equally important intervention target for reduction with regards to preventing violence.

As a concept, violence is typically viewed as an inevitable part of the human condition; 'a fact of life to respond to rather than to prevent' (Butchart 2004). This position has resulted in many health organisations framing the problem of violence as an 'occupational hazard' and a predominantly 'frontline staff problem' (Leadbetter 2004). A consequence of this somewhat pervasive attitude has been a predominant focus on crisis management, rather than an emphasis on strategic service delivery aimed at preventing violence.

In reality violence in a healthcare setting is a multifaceted and complex issue with no single causal factor. Research into this area recognises that its' occurrence is frequently the result of the interplay between a number of contributing risk factors. Accordingly, the development of any preventative strategy will require a clear understanding of the problem and the context in which violence occurs, from a situational, environmental and interpersonal perspective (Wiskow, 2003). To conclude, any effective approach at reducing violence needs to reflect that complex and multi-faceted nature, with regards the interplay between the various components that contribute to the occurrence of violence.

Summary

Violence within healthcare settings is an endemic problem. Violence within mental health environments is particularly prevalent and creates problems with regards to staff and patient safety and the provision of a therapeutic environment where effective treatment can be delivered. Approaches to violence in healthcare settings have shifted from those of a responsive nature, to those of a preventive emphasis and this has been reflected in the adoption of a public health model by many NHS organisations. However, the complex and multifaceted nature of violence means that any organisation developing a strategy aimed at preventing violence, needs to acknowledge and recognise the interaction between the assailant, the potential victims and the context in which the interaction occurs, integrating those factors into whatever approach is adopted.

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Improvement of risk assessment and risk management in violent youth using the SAVRY

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Facilitator

Henny Lodewijks is licensed clinical psychologist and psychotherapist in The Netherlands. He holds a PhD at the Free University Amsterdam, based on the thesis 'Violent risk assessment in adolescents in the Dutch juvenile justice system'.

He was 20 years director and clinical psychologist at a foundation for assessment and counseling for special schools and 15 years treatment director of LSG-Rentray, a foundation for juvenile justice and youth care in the Netherlands. He has been associated as a senior lecturer in a post graduate program for mental health psychologists at Radboud University Nijmegen till 2010. Currently, he is adviser of forensic and youth care institutions.

He published articles on risk assessment and risk management of violence in youth and about treatment practice in youth care in several national and international journals.

Introduction

Violent behavior in juveniles has become a major public health problem in many countries. Violent crime results in many different kinds of losses both to victims and to society in general. A key issue is what measures have to be taken to reduce the risk of a violent offense re-occurring. There is a growing consensus concerning the features of offender treatment which maximize their potential recidivism reducing effect (Hanson, 2005). One of them is the recognition of the importance of structured risk assessment based on historical and dynamic risk factors (also termed criminogenic needs; Andrews & Bonta, 2003).

Historically, the assessment of offender risk and intervention need was largely based on unstructured clinical judgment, which proved to be highly unreliable (Douglas & Kropp, 2002). More recently, however, risk assessments have undergone significant evolution and a number of standardized screening and assessment instruments have been developed specifically to assess risk to public safety and to identify intervention needs among adolescents in the juvenile justice system (e.g., Youth Level of Service/CaseManagement Instrument (YLS/CMI; Hoge & Andrews, 2002), Psychopathy Checklist—Youth Version (PCL: YV; Forth, Kosson, & Hare, 2003), Structured Assessment of Violence Risk in Youth (SAVRY; Borum, Bartel, & Forth, 2006). These instruments are designed specifically to take into account the unique considerations in assessing adolescents (e.g., the instability of some personality traits) while recognizing the dynamic interaction between delinquency risk and protective factors during this period of life. These tools serve three main purposes: (1) help juvenile justice agencies allocate their resources more effectively, (2) provide juvenile justice personnel useful information about the risk and needs levels of each client, and (3) serve as a guide during intervention and management planning.

Several reviews of the growing body of research on these standardized juvenile-justice focused assessment instruments have provided support for the predictive validity of these tools (Fazel, Singh, Doll, & Grann, 2012; Schmidt, Campbell, & Houdling, 2011). In this workshop we will focus on the SAVRY.

Description of the instrument

The SAVRY is a structured professional judgment (SPJ) tool for assessing the risk of violence recidivism in adolescents (between the approximate ages of 12 and 18). For purposes of using the instrument, violence is defined as "an act of physical battery sufficiently severe to cause injury that would require medical attention, a threat with a weapon in hand, or any act of forcible sexual assault." Risk itself is viewed as the product of dynamic and reciprocal interplay between factors that increase, and factors that decrease, the likelihood of violent reoffending in the developing young person over time (Borum & Verhaagen, 2006).

As with most SPJ risk tools, the SAVRY structures professionals' inquiries so that they consider risk factors that are empirically associated with violence, determine the applicability of each risk factor for a particular examinee, and classify each factor's severity and significance. The ultimate determination of a youth's overall level of violence risk is based on the examiner's professional judgment as informed by a systematic appraisal of relevant factors.

The SAVRY protocol is composed of six protective factors and 24 risk factors (see Table 1 for a list of SAVRY items).

Table 1: Items From the Structured Assessment of Violence Risk in Youth (SAVRY)

Historical Risk Factors:
- History of Violence
- History of Non-violent Offending
- Early Initiation of Violence
- Past Supervision/Intervention Failures
- History of Self-Harm or Suicide Attempts
- Exposure to Violence in the Home
- Childhood History of Maltreatment
- Parental/Caregiver Criminality
- Early Caregiver Disruption
- Poor School Achievement

Individual/Clinical Risk Factors:
- Negative Attitudes
- Risk Taking/Impulsivity
- Substance Use Difficulties
- Anger Management Problems
- Lack of Empathy/Remorse
- Attention Deficit/Hyperactivity Difficulties
- Poor Compliance
- Low Interest/Commitment to School

Social/Contextual Risk Factors:
- Peer Delinquency
- Peer Rejection
- Stress and Poor Coping
- Poor Parental Management
- Lack of Personal/Social Support
- Community Disorganization

Protective Factors:
- Prosocial Involvement
- Strong Social Support
- Strong Attachments and Bonds
- Positive Attitude Towards Intervention and Authority
- Strong Commitment to School
- Resilient Personality Traits

Risk factors are rationally divided into three categories; Historical, Individual, and Social/Contextual. The coding form also includes a section for listing "Additional Risk Factors" and "Additional Protective Factors" because the SAVRY is not exhaustive in identifying all potential risk and protective factors for any given individual. In the course of conducting a risk assessment or assessing patterns in past violent episodes, additional factors or situational variables may emerge that are important in understanding a particular juvenile's potential for future violence. In such situations, the evaluator should document and weigh these additional factors in the final risk decisions.

Including protective factors is essential in the risk assessment process and is an important feature of the SAVRY. Protective factors are regarded differently than the simple absence of a risk factor. Indeed, protective factors are conceptualized as variables that reflect involvement with and commitment to conventional society, that control against nonnormative activities, and that refer to activities incompatible with normative transgression.

The SAVRY is coded on the basis of reliable, available information. In most non-emergent circumstances it is helpful to include information from an interview with the examinee and a review of relevant and available records (e.g., police or probation reports, mental health and social service records).

Because the SAVRY does not use cutoff scores evaluators assign a code, but not a numerical score, for each item. Risk items have a three-level coding structure for severity (High, Moderate, or Low). For example, in coding the History of Violence item, a youth would be coded as "Low" if he had committed no prior acts of violence, "Moderate" if he was known to have committed one or two violent acts, and "High" if there were three or more. Protective factors are simply coded as present or absent. The professional who administers the SAVRY must consider the severity, frequency, and recency of each individual item and the applicability of each item to each adolescent's circumstances, and use this information to determine a final summary risk rating (SRR).

The SAVRY is used throughout the world and the instrument and Manual have official translations in the following languages: Swedish , by Niklas Langstrom; Finnish, by Riittakerttu Kaltiala-Heino; Spanish and Catalan, both by Ed Hilterman; German, by Martin Rieger; Norwegian, by Geir Tafjord and Kirsten Rasmussen; Dutch , by Henny Lodewijks.

Results

Borum, Lodewijks, Bartel, and Forth (2010) summarized the interrater reliability of six studies examining SAVRY items and risk ratings. Intraclass correlations (ICCs) ranged from .72 to .95 for summary risk ratings and .81 to .97 for item total scores. More recently, Vincent, Guy, Fusco, & Gershenson (2011) examined the field reliability of SAVRY ratings by juvenile probation officers. The ICC for the summary risk rating of violence was .71 and the four subscales ranged from .67 to .86.

Borum et al. (2010) reviewed 15 empirical studies testing the predictive validity of the SAVRY across different populations and types of reoffending. Area under the curve estimates averaged .74 to .80 across

these studies. In addition, Welsh, Schmidt, McKinnon, Chattha & Meyers (2008) compared the predictive validity of three commonly used risk assessment instruments: YLS/CMI, PCL:YV, and the SAVRY. Across the three instruments, the SAVRY total scores revealed the greatest incremental predictive validity for general and violent offending and displayed the highest AUC values.

Furthermore, the ability of the SAVRY to predict violent reoffending has also been found to be robust across gender (Borum et al., 2010) and race/ethnicity (Vincent, Chapman & Cook, 2011), and in samples of youth placed in short-term detention (Vincent, et al., 2011), residential facilities (Penney et al., 2010; Lodewijks et al., 2008, 2010; Rennie & Dolan, 2010), and youth court-ordered for a mental health assessment (Meyers & Schmidt, 2008; Welsh et al., 2008).

Finally, Lodewijks, de Ruiter & Doreleijers (2010) found the SAVRY Protective scale to be a significant predictor of desistance from violent recidivism. The Protective scale produced a significant increment in the amount of variance explained compared to the Risk Total score alone.

Conclusion and Discussion

First, the most important implication for clinical practice is that the use of SPJ instruments is highly recommended to accurately assess violence risk in juveniles. Compared to unstructured clinical risk assessment, the use of structured risk assessment instruments serves as a sort of check list in systematically collecting, reviewing, weighting, integrating, and combining information needed to code the items. The Dutch Ministry of Justice has also recognized the importance of the use of structured risk assessment. As of July 2006, the Ministry of Justice mandated all juvenile justice institutions admitting juveniles with mandatory treatment orders to perform structured risk assessments on the occasion of supervised or unsupervised leave from the closed facility, transitions from closed to semi-closed facilities, and transitions to conditional or definitive leave. The preferred instrument to be used is the SAVRY. Moreover, the Dutch Ministry of Justice mandates all mental health professionals linked to the juvenile justice facilities to attend a two-day SAVRY training workshop, to guarantee the proper use of the instrument.

A second implication for clinical practice is that risk assessment and risk management should go hand in hand. The objective of risk assessment is not only risk prediction of future violence, but it is particularly designed to identify dynamic risk factors that should be managed to avoid future violence. In this line, some recommendations can be made. The most intensive monitoring and supervision resources should be applied to the highest risk cases. Intensive correctional treatment that adheres to the principles of risk, need and responsivity, yielded lower recidivism in high risk compared to low risk groups. Key criminogenic factors as found in the SAVRY should be targeted for intervention. Programs which focus primarily on these criminogenic factors (e.g., poor parental supervision, poor anger management) showed larger effect sizes in reducing reoffending than those that focus on non criminogenic factors, like self esteem or fear of punishment.

A third implication for clinical practice arises when mental health professionals have to judge the level of risk (high, moderate or low risk). As was found (Lodewijks, 2008), the Risk Total score on the SAVRY is not linearly related to the final risk level. For instance, in the study on institutional violence, a juvenile with a relatively high Risk Total score of 23 was judged to pose a low risk and indeed did not show institutional violent behavior. On the other hand, a juvenile with a relatively low Risk Total score of 16, was judged to be high risk and recidivated violently. This is the reason mental health professionals are advised in the SAVRY manual not to mention numbers in their risk communications, because this could lead to distorted conclusions by the court or the Ministry of Justice. It is recommended to describe the most important (combinations) of risk factors in reports for third parties and to provide management strategies.

A final implication for clinical practice relates to the importance of mapping out protective factors because of their mitigating effects on risk level, resulting in a reduction of violent recidivism. Given the large number of youths in the juvenile justice system and the fact that juvenile recidivism rates remain high, one could reasonably argue that enhancement of protective factors should have a more prominent place in recidivism reduction programs. To prevent or reduce re-offending we advocate transition planning focused on protective factors as an essential component of community reintegration.

The findings of the studies reported in this article call for continued research. Firstly, we suggest that future research with the SAVRY should be clearer about what the index offense was. In most published studies to date, it is unclear whether the index offense was violent or non-violent in nature. Because the SAVRY is intended to predict violent reoffending, it would be very important to include only offenders who committed a violent index offense in the studies.

A few items of the SAVRY need reconsideration and others might be supplemented. In training sessions we found a lot of confusion about item 13 (Stress and Poor coping) and item 18 (Risk taking/Impulsivity). The

reason is that these items combine two criteria, causing interpretation difficulties. It would be preferable to use only one criterion. Moreover, impulsivity is not the same as risk taking. Sometimes risk taking is impulsive, but is could also be calculated. Our interpretation of this item is that it reflects an impulsive lifestyle. On the basis of research some items could be supplemented to make the SAVRY more applicable to adolescent females, like: forced sex in early adolescence (McKnight & Loper, 2002) and religiosity as protective factor (Resnick, Ireland, & Borowsky, 2004).

Finally, the real proof of the importance of dynamic risk and protective factors will be provided by examining them over time. A dynamic association with violent outcome needs to be demonstrated by influencing and changing these factors over time. The basic logic underlying dynamic violence risk and protective factors is that they are prone to change, particularly if they are targeted for violence-reducing treatment strategies. However, the traditional approach when evaluating both violence prediction and forensic treatment is to focus on two points in time, when the prediction was made or the intervention started, and when follow-up data were obtained.

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Chapter 2 – Keynote speeches

Risk Assessment of Spousal Violence: What approach should we use?

Keynote speech

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Keywords: Spousal violence, risk assessment, violence prediction, violence prevention

Introduction

Spousal violence is a major societal problem and one of the most essential tasks in the field of risk assessment and risk management is to improve the accuracy in identifying victims, particularly women, at high risk and, consequently, develop strategies for reducing and managing that risk. The last decades of research has, among other things, resulted in various risk assessment instruments with various, and sometimes even conflicting, approaches. There are today at least over a dozen specialized risk assessment instruments for use in the context of spousal violence. Which one should we use? What approach should we use? What are the pros and cons with various approaches and instruments?
This presentation will provide an overview of various risk instruments for spousal violence and discuss the strengths and the weaknesses of these instruments.

Approaches to Risk Assessment

There are basically three approaches to violence risk assessment: Unstructured professional assessments, Actuarial assessments and Structured Professional Judgment assessments. Although unstructured risk assessments are still commonly used, their validity and reliability have been demonstrated to be inferior to structured approaches, and hence will not be considered further here.
There is a drastic and stark contrast between the SPJ model and the actuarial approach. The actuarial approach view professionals as detrimental to the risk assessment process, and hold that they should be removed from the decision making process altogether. As the authors of the Violence Risk Appraisal Guide, or VRAG, wrote: "What we are advising is not the addition of actuarial methods to existing practice, but rather the complete replacement of existing practice with actuarial methods" (Quinsey et al., 1998, p. 171). The SPJ approach, however, presumes professional expertise—the SPJ model cannot work without it. The latter is intended to provide a lens through which professionals can weigh and evaluate risk-relevant information, and ultimately make sensible decisions. The basis for this approach is very clearly described in the new version of the world's most commonly used risk assessment instrument for violence, the HCR-20, version 3 (Douglas, et al, 2013).

Prediction vs prevention

One major obstacle in the research in this field is undoubtedly that the various approaches described above have very different goals. Actuarial tools are made for prediction, which might be of interest for research work, but for professionals working with real life cases, prediction is most often totally uninteresting and meaningless. For such professionals, "the worst case scenario" is that when they are working with a high risk case, there is recidivism in severe, maybe even fatal, violence. This means that the professional assessed the case as high risk, but couldn't protect the victim. This is, of course, a true nightmare for every professional. But in science (with a predictive approach), this is a success! A correct prediction or, expressed in a more scientific way: a true positive. Thus, the use of actuarial risk instruments very easily creates confusion and misunderstanding about the aim with risk assessments, which most professionals agree should be prevention, not prediction. Besides, to have a predictive approach when working with risk assessments in real life cases would of course be extremely unethical. Professionals are supposed to act out from their risk assessments, not passively stay beside and watch the outcome of their assessments.

How various approaches can lead us to misinterpret the research

For a number of years this author has been involved in research on risk assessment in the context of spousal assault in Sweden. In focus has been various risk instruments and whether these instruments are valid or not. Initially, the results were very disappointing. It seemed like the higher the risk rated by professionals, the less recidivism we came up with in our follow-up studies. From a traditional point of view, using a predictive approach, this was of course a true failure since this indicated that the professionals often were "wrong" in their predictions. However, today we have learned that these results probably must be considered as very good.

In a recent research project in Sweden we decided to test the validity of the B-SAFER (Kropp, Hart & Belfrage, 2005/2010) when used within the Swedish police in terms of recidivism in new spousal assault among a group of 216 men accused of spousal assault. The results showed that the validity was good in terms of a strong correlation between the number of B-SAFER factors and the degree of risk assessed by the police officers. Generally, the more B-SAFER factors that were coded as present, the higher the risk. This was the case both regarding perpetrator risk factors and victim vulnerability factors. Furthermore, the validity was good in the sense that the higher the risks in the summary risk ratings, the more protective actions were initiated by the police (see Belfrage, et al, 2012).

The follow-up of recidivism in new spousal assault in the study group yielded a very high recidivism rate (40%), and a poor predictive power. In fact, the predictive power even tended to be negative in the highest risk group, i.e. the higher the risk, the lower the recidivism rate.

Now, how should we interpret these results? At a first glance, it appeared as if the B-SAFER did not have any effect on how the police assessed and managed risk for IPV. On the contrary, the predictive power was even negative, i.e. the higher the risk as assessed by the police, the less recidivism. Thus, the police seemed to be almost unbelievably incompetent in assessing risk.

However, upon closer inspection, it was determined that the police, who have limited time and resources, operated according to the informal rule that when a B-SAFER summary risk rating indicates a high and acute risk for severe/ fatal violence, they initiate protective actions immediately; all other cases are considered low priority and, thus, do not receive much attention. Now, with this information in hand, the results from this study could be explained in a slightly different light. Overall, similar recidivism rates across all spousal violence risk categories (acute and/or long-term) could probably be explained by the absence of protective actions. And, even more interestingly, in the only risk category where protective actions were taken (the very high-risk group), the recidivism rate was comparatively low. Thus, these important findings indicate that protective actions seem to have an effect, even among high-risk groups (Belfrage & Strand, 2012). Put differently, an adequate interpretation of our results could very well be that the B-SAFER had a good predictive power, but it was masked by the protective police work (discussed further in Belfrage, 2013).

Conclusion

To conclude, we need to expand the focus in our studies on risk assessment instruments to also include risk management and prevention. The predictive validity of risk assessment procedures cannot be judged solely on the basis of their simple bivariate associations with recidivism; risk management must also be considered. Analysis of simple bivariate associations assumes that either there is no risk management or that all risk management is ineffective; both assumptions are untenable (Douglas & Kropp, 2002; Hart, 2001). Results from Swedish research in this area, as discussed above, points to the importance of studying the extent to which protective actions have been taken before drawing conclusions about the predictive validity of various risk instruments. Otherwise, as discussed above, it is clearly very easy to make a logical mistake to interpret poor results as good, and vice versa.

Further, this points at the disadvantages of actuarial methods. Besides having a strict predictive approach, there are other obstacles such as sample dependence; instability of numeric probability estimates across samples; exclusion of potentially important risk factors; low relevance to risk management; degradation of numeric estimates between derivation and cross-validation samples; and under-emphasis on dynamic or changeable risk factors (see also Douglas, et al, 2013). The empirical evidence for these shortcomings is growing, not at least in the context of spousal violence (e.g. Storey & Hart, 2013). Thus: "Maybe, just maybe, we should consider giving up on the predictionist approach to violence risk assessment?" (Hart & Cooke, 2013, p. 99).

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Assaulting behavior: A personal story about the violence no one should experience at work

Keynote speech

Kelly R. McLean
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Summary

This keynote is based on my personal experiences related to the violent assault I suffered at the hands of a patient on an acute inpatient psychiatric unit while working as a registered nurse on August 18, 2010. My injuries include permanent damage to my cervical & lumbar spine, jaw & right eye as well as a traumatic brain injury and some resulting psychological issues stemming from the assault itself. The recovery process has been ongoing both physically and psychologically since the assault. I returned to work for a period of 7 months (after being out for almost four months) and was reassigned to the chemical dependency/detox and rehabilitation unit.

Although the physical violence experienced from the initial assault by the patient was both physically and emotionally devastating, the subsequent maltreatment by some colleagues and certain members of the hospital administration was something quite unexpected and equally disturbing, if not more. I will share my experiences and offer my ideas and thoughts on how workplace violence in healthcare can manifest in different ways and why this issue is worthy of more attention, discussion, education and action.

I currently spend much of my time attending follow up appointments with various doctors and providers. I have been fortunate to do some public and keynote speaking on my personal experience and about workplace violence in healthcare. I continue to try to find ways to draw attention to this issue as I do not believe it receives the attention it deserves.

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Compulsive Care: Measures taken in regard to people who have been interned and others in need of care

Keynote speech

Mr. Christiaan Decoster
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No abstract was submitted.

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Neurobiology of aggressive behaviour: about wild horses and reins

Keynote speech

Prof. Dr. Kurt Audenaert
Universitair Ziekenhuis, Belgium

Kurt Audenaert was trained as a psychiatrist and master in criminological sciences. He was trained as a psychotherapist. His PhD in Medical Sciences was titled "Functional brain imaging in functional psychiatric disorders" and concerned among other molecular imaging of the serotonergic 2A receptor in impulsive behaviour. He actually holds the position of Senior Full Professor at the Gent University and he teaches psychiatry and forensic psychiatry at the Faculties of Medicine and Health Sciences, Faculty of Psychological Sciences and Faculty of Law and Criminological Sciences.

His further research is about molecular imaging (PET, SPET) in impulsive and agressive behaviour in human and large animal studies. He (co-)authored 100+ international publications and is co-editor of the Springer handbook Molecular Imaging in Psychiatry.

His lecture will be focused on human and large animal research on molecular brain imaging studies of the serotonergic system and will give a framework of understanding treatment with serotonergic drugs in impulsive and aggressive patients.

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The Anatomy of Violence: The Biological Roots of Crime

Keynote speech

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Abstract

The very rapid developments taking place in neuroscience are creating an uncomfortable tension between our concepts of responsibility and retribution on the one hand, and understanding and mercy on the other. Neurocriminology is a new field which is increasingly documenting brain impairments not just in adult offenders, but also in antisocial children. This talk outlines implications of this new research not just for current criminological research, but also for our future conceptualization of moral responsibility, free will, treatment, and punishment. If the neural circuitry underlying morality is compromised in offenders, how moral is it of us to punish prisoners as much as we do? Can biological risk factors help better predict future violence? And can we improve the brain to reduce violence?

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A review of theories of restraint-related deaths in the UK

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Introduction

There is considerable controversy surrounding deaths that occur in custody and healthcare. The Independent Advisory Panel (IAP) reported to the Ministry of Justice in the UK that between the 1st January 1999 and the 31st December 2009, there were 6,151 deaths in state custody in all services. Given rising concerns about the extent of the problem there is a need to consider the mechanisms of these deaths and review those that have occurred over the last ten years in order to identify any trends and minimise risk.

In order to examine this issue further we were commissioned by the MOJ to review the nature and extent of restraint related deaths in care and custody settings in the UK in the last 10 years; highlight risks to certain vulnerable populations; and to explore the implications for practise.

Methods

A literature review was conducted. UK sources were the primary focus for accessing research on restraint-related deaths using the hierarchy of evidence levels 1- 6. However, anticipating that there would be scant or unreliable evidence, the strategy included international published papers and professional text. Studies were included in the review if they met the following inclusion criteria:

- Medical sciences (physiology, biochemistry, anatomy) as well as the clinical aspects (cardiology etc) relating to restraint related deaths with particular reference to positional asphyxia.
- Studies were published between 1st January 1992 and 1st June 2010 as the primary seminal work was published in 1992 (3)

Search terms used were positional asphyxia; restraint AND death; sudden death AND custody; excited delirium OR acute behavioural disturbance; physiological AND restraint AND death; prone position AND adverse effects.

Databases searched included BNI, EMBASE, HMIC, MEDLINE, PsycINFO, CINAHL and PubMed. There were 21 relevant international studies identified and 7 UK studies.

Additionally specific cases were identified through NEXIS; a full-text database of news and business intelligence drawn from over 29,000 sources, INQUEST; A charity that provides a free advice service to bereaved people on contentious deaths and their investigation with a particular focus on deaths in custody and a previous reported upon survey (1). Comparisons were made with available statistics and the evidence base to date.

Results

A number of conditions and vulnerabilities were evident in the cases scrutinised for this research. There were 38 UK restraint-related deaths identified (from 1st January 1999 to 31st December 2009). Of these, 7 were individuals detained under the Mental Health Act and 4 were informal patients in mental health care settings. From the literature a range of medical theories on restraint related deaths were identified. For the purpose of this paper, a review of the literature on theories is outlined.

Theories of sudden death in restraint

The small amount of national and international research published since 1992 on restraint-related deaths must have the caveat; until further sound and relevant research is carried out, guidelines on safe restraint for those who have to intervene in the last resort, are based on limited information.

The following theories of potential causation, however, are most evident in the research reviewed.

1   Positional asphyxia

When an individual is restrained or contained in a prone position, three things happen that compromise the body's ability to breathe:

- There is possible occlusion of the respiratory orifices (1)
- There is a compression by weights or restriction to movement of the ribs limiting their ability to expand the chest cavity and breathe (2);
- The abdominal organs may be pushed up, restricting movement of the diaphragm and further limiting the available space for the lungs to expand (3).

Simply restraining an individual in a prone position may be seen as restricting their ability to breathe, so lessening the supply of oxygen to meet the body's demands causing positional asphyxia. Restriction of the neck, chest wall or diaphragm can also occur when the head is forced downwards towards the knees.

Parkes (4) postulated that breathing can be reduced by 15% in a face down position and by 23% if the person is bent in a face down position. Paterson (5) states that the prone position is actually a range of procedures incurring possible risks.

NICE guidelines (6) on the management of violence state that the evidence base surrounding the dangers of positional restraint is weak and it is not possible to give a specific time frame for keeping someone restrained. The Metropolitan Police Service Review on restraint (7) concluded that it was neither safe nor practicable to set a time limit for the restraint of a person in the prone position.

2   Excited delirium and acute behavioural disturbance

Excited delirium has been described as an agitated, aggressive, paranoid behavioural disturbance where the individual also has great strength and numbness to pain (8). It is a form of acute behavioural disturbance.

In a review of excited delirium deaths during custody, victims were predominantly male, (97%), had an average weight of 220 lbs. and a mean body temperature of 104ºF (9). Mash (10) found that victims were young (mean age 34.2), males, with a high body mass. Mean body temperature was 40.7 ºC, and seizures were observed in 13% of cases. Many of the deaths occurred one hour after initial police contact, cardiac arrest occurred shortly after use of restraints. Although the majority of reported drug associated fatal excited delirium cases have involved the use of cocaine, other stimulant agents, including LSD, phencyclidine (PCP) and methamphetamine, have been implicated in excited delirium deaths.

The pathology of this condition may include genetic susceptibility and chronic stimulant-induced abnormalities of dopamine transporter pathways, along with elevation of heat shock proteins in fatal cases (11). However, the exact incidence of excited delirium (ED) is impossible to determine as there is no current standardised case definition to identify this state (11). It is currently not a recognised medical or psychiatric diagnosis according to either the Diagnostic and Statistical Manual of Mental Disorders (DSM-IVTR) of the American Psychiatric Association or the International Classification of Diseases (ICD-9) of the World Health Organization (12).

3   Pre-existing conditions

A number of pre-existing conditions are known to contribute to restraint related death.

- For example, people with serious mental illness have much higher mortality rates particularly when suffering from conditions such as respiratory, cardiovascular and infectious diseases (12). The risk of sudden deaths due to cardiac arrhythmias related to antipsychotic drugs is thought to increase in people with cardiac disease, those taking multiple QT-acting drugs, and those taking antipsychotics at high dose for long periods (13). Violence in prison as a result of untreated or deteriorating mental health, and/or substance misuse, may increase the likelihood of being restrained.

- In one UK study volunteers with stable chronic obstructive pulmonary diseases (14) were randomly allocated to five positions. The response to the prone position with or without wrist restraint appeared highly individual, with some individuals tolerating the prone position with no measurable clinical effects and others suffering a clinical worsening of symptoms. The reasons for this individual variation remained unclear. The small number of subjects in this study and the difficulty in applying it to mental health or custodial settings decrease its validity and relevance.

- Exercise-related collapse in individuals with sickle cell anaemia is a rare but serious complication. Local hypoxia causes intravascular sickling, in turn causing vascular occlusion and organ and tissue damage. This can result in rhabdomyolysis (the breakdown of muscle fibres resulting in the release of

muscle fibre contents into the bloodstream), myocardial ischemia, arrhythmias and sudden death (15). Incidence of restraint-related deaths of individuals with sickle cell anaemia is extremely rare.

- Post ictal aggression in epilepsy can occur when physical restraint is applied to a delirious or confused patient. In particular, this can lead to a vicious circle of attempts to restrain and resulting resistive violence with fatal results (16). Sudden unexpected deaths in epilepsy (SUDEP) may be caused by respiratory events, including airway obstruction. In addition, cardiac arrhythmia, during both the ictal and interictal periods, leading to arrest and acute cardiac failure, play an important role (17). The additional factor of extreme exercise as in struggling in restraint is therefore still unknown.

- In diabetes low blood sugar may precipitate sudden mood swings that could appear as sudden anger or crying, sweating, nervousness, rapid heartbeat, confusion, and seizures. Aggressive behaviour may appear similar to acute behavioural disturbance (18).

4 Stress-related cardiomyopathy

Otahbachi (19) found that the pathogenesis of excited delirium deaths was multifactorial and included positional asphyxia, hyperthermia, drug toxicity, and/or catecholamine-induced fatal arrhythmias. These deaths were secondary to stress cardiomyopathy. Sudden death in adults, particularly young adults who are asymptomatic, may occur from the onset of ventricular tachycardia (a type of rapid heart rate) or other dangerous arrhythmias. In restraint-related deaths, extreme physiological stress and sudden exercise, e.g. violence and struggling, in an individual with genetic predisposing factors, may result in fatal hypertrophic cardiomyopathy. An abnormally enlarged heart has been reported as one of the predisposing factors that can lead to restraint-related death (20). It has been linked to chronic stimulant drug abuse (21). In O'Halloran's study (22) of 21 cases of restraint-related deaths, on autopsy, 15 had heart disease including an enlarged heart.

5 Catecholamine hyperstimulation

Recent research (23) indicates that physical struggle is a much greater contributor to catecholamine surge and metabolic acidosis than other causes of exertion or stimuli. Michalewicz (24) saw catecholamine hyperstimulation as one of the risk factors of restraint-related deaths. DiMaio (25) found that during high intensity exercise, e.g., a struggle, there is release of catecholamines.

6 Acidosis

Hick (26) found in five cases of sudden death that there may have been exacerbation of exercise-induced lactic acidosis by sympathetic-induced vasoconstriction, enhanced by the actions of cocaine in at least some cases. Alshayeb (27) also noted that people exercising intensely, who are aggressive and then restrained, and have taken cocaine, may develop lactic acidosis and subsequently suffer cardiac arrest. In this process, cocaine toxicity prevents the reuptake of noradrenaline, serotonin, and dopamine at presynaptic nerve terminals and increases the release of calcium from the cerebral vascular smooth muscle cells, resulting in accumulation of neurotransmitters at postsynaptic sites and generalised vasoconstriction (28). This will lead to increasingly impaired tissue perfusion resulting in impaired cardiac contractility, cardiac arrhythmias, and cardiac arrest.

7 Alcohol abuse

Sudden death of an individual with a history of alcohol abuse, and under the influence of alcohol, may occur during a struggle. Alcohol is a recognised cause of atrial and ventricular arrhythmias. A prolonged QT interval, a problem associated with sudden death, as well as increased levels of norepinephrine may be present in prolonged alcohol abuse.

These predispositions to arrhythmias can be exaggerated by catecholamines released during a violent struggle. In a study (29) of 30 cases of positional asphyxia, chronic alcoholism or acute alcohol intoxication was found in 75% of cases with average post-mortem blood alcohol concentrations of 0.24%. When alcohol is taken in conjunction with cocaine the risk of violence is increased; there is also a new compound produced, cocaethylene, which lasts longer in the body and has even more powerful toxic effects (30).

8 Neuroleptic medication

Paterson (31) found that administration of neuroleptics increased the risk of death during restraint by weakening the individual's ability to swallow or expel leading to an increased risk of the inhalation of vomit.

Neuroleptic malignant syndrome (NMS) is a rare but potentially lethal side-effect of atypical antipsychotics. Between 20 and 30 percent of service users who develop severe NMS may die. Risk factors include the use of high-potency typical antipsychotics, being young and male, and with an organic brain syndrome (32),

agitation and recent use of restraint (33). Serotonin syndrome (SS) can be misdiagnosed as NMS. It may be associated with an acute behavioural disturbance. It is an usually results from an increased dose of a single serotonergic agonist drug, polypharmacy of serotonic agents, or a drug interaction of a monoamine oxidase inhibitor (MAOI) with a serotonin reuptake inhibitor (SRI). SS can be fatal (34). Physical restraint for agitation in SS is contraindicated as this may contribute to mortality by enforcing isometric muscle contractions (36).

Discussion

From this review and in light of the current situation in the UK, there is a gap in the reporting of restraint-related deaths, and concerns as to the determination of direct cause and effect. It should be assumed that everyone is at a potential risk rather than try to profile individuals only medically at risk. This is a class of death not fully understood and one, which is clearly the result of complex factors and situations.
The more valid studies are those with large numbers of retrospective case histories and autopsies. These, however, are mostly published in literature from the USA. The frequency and acceptance of excited delirium syndrome as a cause of death in restraint incidents in this body of literature make inferences and associations with UK deaths in custody more problematic. There are also difficulties around identifying and studying excited delirium syndrome because of the lack of well-defined, consistent epidemiological case definition and overlap with other established diseases. In deaths in custody, there will always be the additional difficulty of separating any potential contribution of control measures from the underlying pathology. For example, was death due to the police control method, or to positional asphyxia, or from excited delirium syndrome/acute behavioural disturbance or from the interplay of all these factors? Further research is needed such as determining if training and placement of police officers in mental health settings enabled a greater understanding and impacted on the way they responded to people in mental distress. Also, a consistent case definition should be developed and applied in a large epidemiologic study or from a national or international database of all suspected cases, including those who survive.

Focussing on biophysiological causation alone ignores the narrative of each individual death and the complex factors leading up to the death including contextual, attitudinal and cultural factors. There are no unconditionally safe restraint positions. How risky a restraint position is may be quite individualised, depending on characteristics of the person held, the length of time, the forcefulness of the hold and a range of other factors such as biophysiological mechanisms. Early warning predictors and markers for those with a pre-existing condition that could lead to collapse during restraint should be more closely noted by staff, albeit within the context of the setting in which people are cared for.

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Does hypersexuality exist?

Keynote speech

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Introduction

Hypersexuality can be defined as an uncontrollable sexual behaviour that causes clinically significant distress or impairment in social, occupational, or other important areas of functioning. In the past it has been variously described as 'compulsive sexual behaviour' (Black, 2000; 1998; Coleman, 1992), 'non-paraphilic compulsive sexual behaviour, 'paraphilia-related disorder' (Kafka & Hennen, 1999; Kafka & Prentky, 1992) or 'sexual addiction' (Carnes, 1992; 1991). However, it was originally described by von Krafft-Ebing's book 'Psychopathia Sexualis'(1998). This book was a sort of catalogue of sexual perversions, explained by case studies. It was meant to be a forensic reference work for medical doctors and lawyers. In the first edition of 1886, von Krafft-Ebing divided sexual deviations into four categories: paradoxia (sexual desire in childhood or in eldery, anesthesia (insufficient desire), paraesthesia (desire with wrong purpose or object, e.g. fetishism, masochism), and hyperesthesia (excessive desire). Hypersexuality mostly refers to non-paraphilic sexual behaviour (Krueger &Kaplan, 2001), but a combination of paraphilic and non-paraphilic sexual behaviour can occur (Kafka & Prentky, 1992). In research on risk assessment and recidivism there is evidence that an excessive interest in sexual activities – beside a deviant sexual preference – is a strong predictor of sexual reoffending (Hanson & Morton-Bourgon, 2004).

Excessive sexual desire in psychiatric classification systems

Excessive sexual desire, or hypersexuality, is not included in systems such as the Diagnostic and Statistical Manual of Mental Disorders (DSM) (Kafka, 1997). The hypersexual disorder as a proposed diagnosis for the DSM-5 was described by the same author (Kafka, 2010). However, this disorder was rejected. Frances (2013) was very happy with this decision. Excessive sexual behaviour is often unwise, but rarely refers to a mental disorder. He agreed with Kessler et al (2003) that it is a severe mistake to medicalize sexual misconduct in order to decrease his own responsibility, and to offer him an excuse for his hedonistic behaviour. In the fourth edition (inclusively the fourth-totally revised one) (APA, 1994; 2000) only the hypoactive sexual disorder is mentioned. Surprisingly some disorders with an excessive urge in other fields were included, such as eating (bulimia nervosa) or substance abuse (abuse and dependence). The DSM-III (APA, 1980) described nymphomania (in women) and the Don Juan syndrome (in men), listed under the subcategory 'other sexual disorders'. However, in the DSM-III-R (APA, 1987) nymphomania and the Don Juan syndrome disappeared, but the term non-paraphilic sex addiction appeared. In the DSM-IV the non-paraphilic sex addiction disappeared again (ten Hag, 2007).

Proposed classification criteria

Stein et al (2000) already proposed that hypersexuality should be included in the DSM. The proposed criteria were:
1. The existence of recurrent, intense, sexually arousing fantasies, sexual urges, or behaviours that persist over a period of at least 6 months and do not fall under the definition of paraphilia.
2. The fantasies, sexual urges, or behaviours cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
3. The symptoms are not better accounted for by another Axis I disorder (e.g., manic episode, delusional disorder, erotomanic subtype).
4. The symptoms are not due to the direct physiologic effects of a substance (e.g., a drug of abuse or a medication) or a general medical condition.

A decade later, Kafka elaborated the first criterion, and advised to specify the kind of hypersexual behaviour. Here you can find his proposed diagnostic criteria (Kafka, 2010):
    A. Over a period of at least 6 months, recurrent and intense sexual fantasies, sexual urges, or sexual behaviours in association with 3 or more of the following 5 criteria:
    A1. Time consumed by sexual fantasies, urges or behaviours repetitively interferes with other important (non-sexual) goals, activities and obligations.

A2. Repetitively engaging in sexual fantasies, urges or behaviours in response to dysphoric mood states (e.g., anxiety, depression, boredom, irritability).

A3. Repetitively engaging in sexual fantasies, urges or behaviours in response to stressful life events.

A4. Repetitive but unsuccessful efforts to control or significantly reduce these sexual fantasies, urges or behaviours.

A5. Repetitively engaging in sexual behaviours while disregarding the risk for physical or emotional harm to self or others.

B. There is clinically significant personal distress or impairment in social, occupational or other important areas of functioning associated with the frequency and intensity of these sexual fantasies, urges or behaviours.

C. These sexual fantasies, urges or behaviours are not due to the direct physiological effect of an exogenous substance (e.g., a drug of abuse or a medication).

Specify if: masturbation, pornography, sexual behaviour with consenting adults, cybersex, telephone sex, strip clubs, others.

Compulsive, impulsive and addictive models

Stein (2008) argued that each of the compulsive, impulsive, and addictive approaches seems to offer only a partial view of these conditions. Obsessive-compulsive disorder is perhaps the paradigmatic compulsive disorder, impulsive personality disorders are perhaps the paradigmatic impulsive condition, and substance dependence is the paradigmatic addictive disorder. The key components of such conditions include affective dysregulation (A), behavioural addiction (B), and cognitive dyscontrol (C). First of all, affective dysregulation may play a role in hypersexual disorder, because symptoms may be triggered or exacerbated during times of increased stress, many patients have co-morbid mood and anxiety disorders, and selective serotonin reuptake inhibitors (SSRIs) can decrease symptoms of hypersexual disorder (Stein et al, 1992; Kafka, 2000). Next, patients with hypersexual behaviour may be preoccupied with their sexual desires, may demonstrate an escalating pattern of acting on such desires, and may exhibit dysphoria when they attempt to cut back on their behaviour. Dopamine probably plays a role here, since pro-dopaminergic drugs may increase sexual behaviour. Giugliano (2009) used the label 'out-of-control sexual behaviour' for sexual addiction. Finally, cognitive dyscontrol may play a role in hypersexual behaviour. There is evidence that executive functions are impaired in patients with paraphilias.

Commonalities with paraphilias

According to Kafka (2010), hypersexual disorder shares many common characteristics of paraphilias. First, hypersexual disorder is predominantly male disorder (ratio man versus woman 5:1), just like paraphilias (20:1). Second, both disorders report the onset of intensified or unconventional sexual arousal during adolescence (e.g. Black et al, 1997). Third, several studies have reported that patients with paraphilias or hypersexual disorder commonly self-report the presence of multiple rather than a single paraphilic or hypersexual behaviour over the course of a lifetime. Fourth, in both disorders, sexually arousing fantasies, urges, and behaviours can be time consuming or associated with sexual preoccupation. Fifth, analogous to paraphilias, hypersexual disorder can be either ego-syntonic or ego-dystonic, and more likely to occur during periods of stress (Black et al, 1997). Sixth, males with paraphilias as well as hypersexual disorder are equally likely to self-report periods of persistently heightened sexual behaviours. And finally, in both disorders patients may withdraw from sexual encouters with a partner in preference to engage in more sexually arousing, unconventional sexual activities.

Risk assessment in hypersexuality

Assessing risks in hypersexuality is a tough business. Hypersexuality, sexual preoccupation, sexual obsession, and sexual addiction are all terms that refer to an excessive sexual urge, meaning that a person is too busy with sex. However it is not clear how 'too much' can be qualified. In Kafka & Hennen (1999) the label 'paraphilia-related disorder' is used, implicating that there is no deviant preference, but an excessive amount of sexuality. The 'Total Sexual Outlet' (TSO) is used as a measure for the amount of organisms. A TSO score of seven or more is indicative for a hypersexual period. The higher the TSO score or the longer the hypersexual periods, the more likely there is hypersexuality in a person. Moreover, the more deviant preferences, the greater the chance on hypersexuality, and vice versa, the greater the hypersexuality, the greater the chance on deviant preferences. This means that hypersexuality is an important risk factor for sexual recidivism.

Risk assessment instruments that consider hypersexuality or sexual preoccupation as an item, describe in their manual that there should be 'much' and 'obsessive' sex, but the real meaning of these adjectives remains unclear. In this regard it is interesting to mention the STABLE-2007 (Hanson et al, 2007).

Contrary to other instruments that measure static risk factors, such as the SVR-20 (Boer et al, 1997) or the STATIC-99 (Hanson & Thornton, 1999), the STABLE-2007 includes dynamic risk factors in sex offenders. These dynamic risk factors are: important social influences, possibility to get stable relationships, identification with children, hostility towards women, social rejection/loneliness, interest in welfare of others, impulsive behaviour, problem solving skills, negative emotions, sexual preoccupation, sexual coping, deviant sexual interests, and collaboration with practitioners/supervisors. In this instrument, hypersexuality/sexual preoccupation is disconnected from sexual coping. Sexual coping refers to the process in which sex (mostly masturbation) is used as the method for regulating stress, meaning that a person has the tendency to seek the positive feeling of an orgasm as a response to stress. It is not yet clear whether or not sexual coping can contribute to an increase of sexual recidivism, but pathways through sexualizing and masturbation fantasies are conceivable.

Comorbidity in hypersexuality

Several authors investigated Axis I and II comorbidities (Kafka, 2010). For example, in systematically evaluated Axis I psychiatric disorders in 'sexual compulsive' males and females (Black et al, 1997; Raymond et al, 2003) or males with paraphilia-related disorders (Kafka & Hennen, 2002; Kafka & Prentky, 1994, 1998) the great majority of patients with these disorders had multiple lifetime comorbid mood, anxiety, psychoactive substance abuse, and/or other impulsive disorders. Patients with pathological gambling also had an increased incidence of compulsive sexual disorder. Grant et al (2005) reported that 9.4% of pathological gamblers had a lifetime history of this disorder. In a sample of Raymond et al (2003), 46% of the sample (n=24, 22 males, 2 females) met criteria for at least one personality disorder according to the DSM-III-R, the most common being cluster C personality disorders (39%) followed by cluster B personality disorders (23%). Black et al (1997) found that in 44% of a sample of 28 males and 8 females the most common Axis II diagnosis was a cluster B (29%) and a cluster C (24%) personality disorder. In both studies antisocial personality disorder and borderline personality disorder had a low prevalence, although they are specially associated with impulsivity.

Clinical cases: is hypersexuality related to (sexual) aggression?

In this lecture clinical vignettes and data from a Belgian sex offender population at the University Forensic Centre (Antwerp University Hospital) will be presented. And finally, the importance of this topic for caregivers in general and forensic psychiatry will be discussed.

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Chapter 3 – Special Workshops

Corporate Culture Change: Developing Cooperative Relationships in a Coercive World

Bob Bowen
University of Rochester School of Medicine and Dentistry in Rochester, New York, USA

Human services are provided in the context of staff to staff relationships. The relational violence that is part of so many systems and the subject of so much study continues to be a major focus of conferences, workshops, and articles.

This interactive workshop will present a model to measure the presence of coercion in a culture, and how to develop and maintain a workplace culture that moves away from coercion. In our employment laws, personnel policies, and regulatory framework coercive interventions are pervasive and powerful forces. Working within this coercive framework the presenter will offer a model which invites and supports cooperative relationships.

Supporting People with Complex Behavioural Profiles: Integrating Neurosensory, Psychological, and Behavioural Methodologies to Support People, Not Just Their Behaviours

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Complex behavioural profiles are indicative of complex etiologies, and almost always include a history of trauma. This workshop will integrate knowledge of how human neurosensory and neuropsychological systems develop and mature, and how this process is altered by trauma. A framework will be presented to empower human service professionals to support the process of healing people from their deep woundedness through a holistic, team centred approach.

The model will integrate neurosensory research, behavioural methodologies, and psychological models to chart a path towards wholeness and wellness for people whose needs heretofore have posed barriers to success.

Presenter

Bob Bowen is an administrator, researcher, presenter and author with over 30 years of experience in human services. He has presented at numerous conferences in Europe, Australia, Hong Kong and North America as an invited speaker, and puts his theoretical framework into practice through individual and organisational consultation as well as teaching workshops in the prevention of workplace violence. Bob is the CEO of The Mandt System, Inc., and has a research appointment as an Adjunct Assistant Professor of Psychiatry at the University of Rochester School of Medicine and Dentistry in Rochester, New York, USA.

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Chapter 4 – Advances in epidemiology, nature and cross-cultural aspects

Violence Against Women in Nigeria: Prevalence and Help-Seeking Behaviour

Paper

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Keywords: Intimate partner violence, Women, Prevalence, Help-seeking behaviour, Nigeria

Introduction/ Background

Globally, a common manifestation of gender-based inequality is violence against women, often occurring in the form of Intimate Partner Violence (IPV (Kim et al., 2007). IPV affects a large number of women around the world, and research pertaining to developing countries suggests that the magnitude of life-time experience of such violence ranges from 15% - 80% (Garcia-Moreno et al., 2005; EPRC, 2009). In addition to its pervasive nature, IPV threatens the physical, sexual, reproductive, emotional, mental and social well-being of individuals and families (WHO 2010). It is also a risk factor for a host of adverse health outcomes (e.g., dangerous life-style choices such as substance abuse) (Garcia-Moreno et al., 2005; WHO 2010). Moreover, IPV inflicts a huge financial burden on the victims, their families and the larger society within which they live (Duvvury et al., 2012).

This form of violence has been reasonably explored in developed countries, and studies indicate that women rely on both formal (e.g., shelter, police, healthcare, and judicial services) and informal help (e.g., family, friends, and broader community support) to cope with the grave burden of IPV (Ellsberg et al., 2001; Barrett & St. Pierre, 2011). To tackle the IPV issues, governments of such developed countries have established standard policies to prevent it and, in the case of its occurrence, help provide support for women who unfortunately fall prey to violence. On the other hand, in developing countries (especially in Africa) where research has shown that the level of IPV could be as high as 80% (EPRC, 2009), policies against IPV are weak and in most cases non-existent (NPC and ICF Macro, 2008). This leaves one wondering who victims of IPV turn to for help and how they cope with the affliction.

The purpose of this research is to study the magnitude of IPV in an African developing country (Nigeria), and also explore the help-seeking behaviour of abused women by documenting the strategies and services used by them in response to the violence experienced.

Methods

Study Design

The study was a cross-sectional population-based household survey conducted in Kwara State – Nigeria, involving 719 Nigerian women (aged 18 years and above, currently or previously in cohabiting or non-cohabiting relationships). A multistage sampling procedure that involved three stages of randomly selecting wards, then smaller clusters of people (enumeration areas) and, finally, households, were used to select eligible women (one per household). A detailed questionnaire administered by trained healthcare professionals was used to capture the required data. In order to estimate the prevalence of IPV and explore the help-seeking behaviour of the victimised women, a statistical software package (IBM SPSS Statistics 20) was used to analyse the data collected.

The study site – Kwara State – is a middle-belt state that serves as a gateway between the northern and southern parts of Nigeria, with a population that is diverse in terms of demographics (e.g., ethnicity and socio-economic groups), making it a preferred site for the study. The research was conducted in both rural and urban locations in the State, and strict adherence to the ethical guidelines designed by the WHO for Research on Domestic Violence Against Women (2001) was observed throughout the study. Approval for the study was obtained from the Ministry of Women Affairs in Kwara State.

Questionnaire
The preparation of the questionnaire drew on the experience of recent work by the WHO – Multi-country study on domestic violence against women (Garcia-Moreno et al., 2005) and ICRW – Study on the cost of domestic violence (ICRW, 2009). It was designed to capture from each eligible woman: her demographics and those of her partner, her attitude towards gender roles, her partnership and general community characteristics. The questionnaire also solicited information pertaining to the woman's experiences of life-time IPV (victimisation by an intimate partner during her lifetime) and current IPV (victimisation during the 12 months preceding the survey). The forms of IPV covered include the acts of physical, sexual, and emotional (psychological) abuse by current and previous partners in both cohabiting and non-cohabiting relationships. As previously used by Garcia-Moreno and colleagues (2005), behavioural-specific questions related to the earlier mentioned forms of IPV were employed to measure the exposure of the women to violence. This approach has been shown to encourage greater disclosure and ultimately more accurate results.

In addition to the specific questions covering both life-time and current IPV experiences, the questionnaire was structured to capture in detail at least one recent incident (a separate episode) of IPV from women who reported current IPV experiences (and up to three incidents, in cases where women have been recently victimised more than once and could give detailed account of their experiences). These extra data collected include health consequences of violence, whether the women sought help after victimisation and the sources of such help, whether they incurred any expenses and how the cost (payments) were met.

Data Analysis
To estimate the prevalence, the number of women reporting victimisation was divided by the number of women in the sample multiplied by a hundred. This was computed automatically with the aid of the SPSS statistical software package. Estimates were computed for life-time and current IPV prevalence of any form of IPV (i.e., physical, psychological and/ or sexual violence), as well as for each of the specific forms of IPV covered in the study. In analysing the help-seeking behaviour of abused women, descriptive statistics (counts and percentages) were also used to explore service usage in relation to the incidents reported by current IPV victims in the study.

Results

Prevalence
Characteristics of women and prevalence of IPV are given in Table 1. In this presentation of results, any statement of life-time or current prevalence of IPV implies the prevalence of any form of life-time or current violence, unless otherwise stated to mean just a specific form of violence in particular (e.g., physical abuse).

The results show that the life-time and current prevalence of IPV are 25.5% and 16.7% respectively, with psychological abuse being the dominant form of IPV; this is followed closely by physical aggression (24.3% and 18.6% of women suffered from these forms of abuse over a life-time, respectively). The results also show that there is not much difference in the prevalence of IPV between the Urban and Rural areas. As regards age, women within the age category of 50 – 59 years show higher exposure to IPV (having a life-time prevalence of about 34.0%). When compared with women having higher educational attainment, those with lower or no attainment at all show greater prevalence of IPV (those with primary or no attainment at all having life-time prevalence of 48.9% and 43.0%, respectively). They also show similarly higher levels for current prevalence (42.2% and 35.5%). Women who are not literate in the study show a higher level of IPV prevalence – life-time (43.0%) and current (36.0%). In terms of employment, women who are working were more prone to IPV when compared with those who are not (life-time prevalence of any form of IPV amongst those in employment is about 26.0%, and current prevalence is 18.0%).

Table 1. Prevalence of Physical, Psychological, Sexual and Any form of violence (Physical, Psychological and/ or Sexual) by demographic characteristics of the women.

Variable	Physical violence		Psychological violence		Sexual violence		Any form of violence		Total no. of women
	Life-time (%)	Current (%)	Life-time (%)	Current (%)	Life-time (%)	Current (%)	Life-time (%)	Current (%)	(n)
Area									
Rural	18.8	13.9	23.4	16.8	10.7	5.5	24.6	16.8	346
Urban	18.5	11.5	25.2	16.4	12.1	6.7	26.3	16.6	373
Woman's educational attainment									
None	40.5	33.1	43.0	35.5	18.2	14.0	43.0	35.5	121
Primary	35.6	28.9	48.9	42.2	20.0	15.6	48.9	42.2	45
Secondary	16.4	10.2	22.3	14.8	12.1	5.9	23.0	14.8	256
Higher	9.1	4.0	14.8	6.4	6.7	1.7	16.8	6.7	297
Woman's age									
18 – 29	15.3	8.4	24.5	11.2	12.0	4.0	27.3	11.6	249
30 – 39	21.5	18.1	23.0	20.4	11.3	8.3	23.0	20.4	265
40 – 49	18.0	10.0	24.0	18.0	9.3	5.3	24.7	18.0	150
50 – 59	28.6	17.1	34.3	22.9	17.1	5.7	34.3	22.9	35
60 and above	10.0	5.0	25.0	10.0	10.0	10.0	25.0	10.0	20
Woman literate									
No	40.8	33.6	43.2	36.0	18.4	14.4	43.2	36.0	125
Yes	14.0	8.2	20.4	12.5	9.9	4.4	21.7	12.6	594
Woman in employment									
No	12.6	7.4	21.1	12.6	12.0	3.4	24.0	12.6	175
Yes	20.6	14.3	25.4	17.8	11.2	7.0	25.9	18.0	544
Total	18.6	12.7	24.3	16.6	11.4	6.1	25.5	16.7	719

Help-seeking Behaviour

Table 2 shows the help-seeking behaviour of women who reported current IPV in the study. It covers 185 incidents reported in detail by those women.

The results show that help-seeking in response to an IPV incident is a common practice amongst abused women in the study (with 68.0% reporting that they sought at least one form of help). There is also an indication that the women incurred financial costs in the process of seeking help, with great chunks of those costs borne mainly by the abused women and their native family members (costs in 63.2%, and 26.5% of incidents were paid for by these groups, respectively). This implies that family members provide financial support in about 40.0% of incidents involving some form of costs, and women pay some money from their own pockets in about 94.0% of such incidents. Most of the women used formal services (59.5%), while a similarly high number of women sought informal help as well (53.0%). Health/ medical services rank highest amongst the formal services used, with every woman that reported a contact with formal services in relation to IPV incident reporting contact with the health services. The other three formal services considered were poorly utilised (police, 5.4%; judicial service, 0.5%; shelter, 0%). In terms of the informal services, usage of traditional healers was the highest (33.0%), with a fair number of women also seeking help from local community leaders (29.2%). Besides, the results show that abused women do not often leave the abusive environment (home) after incidents of IPV – only 14.0% of women reporting they left home in the 12 months prior to the study. Nonetheless, when women do choose to leave home, they mostly turn to family members for help (92.3%).

Table 2. Help-seeking behaviour of women and monetary implications

Variables	Options	Incidents of IPV	
		Number	Percentage (%)
Woman sought help	No	60	32.0
	Yes	125	68.0
Formal services*	No	75	40.5
	Yes	110	59.5
Informal Services#	No	87	47.0
	Yes	98	53.0
Health/ Medical care	No	75	40.5
	Yes	110	59.5
Police	No	175	94.6
	Yes	10	5.4
Judicial service	No	184	99.5
	Yes	1	0.5
Traditional Healer	No	124	67.0
	Yes	61	33.0
Local/ community authority	No	131	70.8
	Yes	54	29.2
Left Home after IPV incident	No	159	86.0
	Yes, stayed with family	24	13.0
	Yes, stayed with friends	2	1.0
	Yes, stayed at shelter	0	0
Monetary cost involved	No	60	32.4
	Yes, partly or wholly borne by woman	117	63.2
	Yes, partly or wholly borne by natal family	49	26.5
	Yes, partly or wholly borne by partner	26	14.1

Formal services include: police, shelter, health and judicial services.
#Informal services include: traditional healers, support from community leaders, family and friends.

Discussion and conclusion

The findings of this study indicate a relatively high level of IPV (about 1 out of every 4 women has experienced IPV at least once in her life-time), consistent with the pervasiveness reported by other research (EPRC, 2009; WHO, 2010). The study found that psychological abuse was the highest form of IPV experienced by women (life-time and current prevalence of 24.3% and 16.6%, respectively), lending further credence to observations of prior studies (NPC and ICF Macro, 2008; Okenwa et al., 2009). This high level of IPV victimisation indicates how imperative it is for the government and other relevant stakeholders to act swiftly in providing support for abused women and, most importantly, develop policies to prevent the occurrence of violence.

The findings regarding help-seeking behaviour show that women often seek help in response to IPV and that they are not passive victims of abuse (68.0% sought help after IPV incidents), corroborating the findings of studies such as those of Barrett and St. Pierre (2011). In terms of preference of support, formal services were mostly used (59.5%); although this is only slightly higher than the usage of informal services (53.0%). Considering this, the Nigerian government should enhance services provided by the formal sector for abused women, whilst at the same time support the informal sources (e.g., by promoting the responsibility of families and friends to support abused women, or by considering informal care givers, like traditional healers, as relevant stakeholders in the design of policies to tackle IPV issues). Despite the high usage of formal services in general, the results indicate low utilisation of some particular formal services – police (5.4%), judicial service (0.5%), and shelter (0%). This poor usage may be due to

inaccessibility of such services or, perhaps, lack of trust in service providers – as research in other countries (with similar patriarchal structures as Nigeria) have shown how law enforcement agents trivialise IPV, letting perpetrators off scot-free (Hassan II University, 2009). Besides, lack of awareness regarding the existence of services may also be a barrier to usage.

Finally, the fight against IPV in Nigeria would greatly benefit from the overhaul and reform of the judicial system and police service to provide better access and support for abused women, as well as to ensure that they have equal rights in all ramifications of social life. These steps could also serve as a preventative measure or deterrent against IPV perpetration, as they would help create a climate of non-tolerance of violence. In addition, considering the high utilisation of healthcare services amongst abused women, adoption of a screening protocol that is sensitive in detecting IPV – as suggested by John and colleagues (2011) – would assist in identifying abused women and afford a chance of supporting them (e.g., through a referral to other relevant agencies or provision of other specialised supports).

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Assessment of the Risk Factors Affecting Intimate Partner Violence in Nigeria

Paper

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Introduction - Background

Violence against women is pervasive in virtually all societies in the world, and comes with grave consequences. A common type of such violence is Intimate Partner Violence (IPV) which occurs in intimate relationships (e.g., marital and dating) in the form of physical aggression, sexual coercion and psychological abuse, as well as controlling behaviours. IPV has been reported to affect about one in every three women (Heise and Garcia-Moreno, 2002), and it is associated with a range of adverse health outcomes including infectious diseases like HIV/AIDS and dangerous life-style choices such as substance abuse (Garcia-Moreno et al., 2005; WHO, 2010). Besides, it places great financial burden on the victims, their families and societies at large (ICRW, 2009; Duvvury et al., 2012).

Studies have explored some of the likely factors responsible for IPV occurrence and the results show that individual demographic factors (e.g., age and education), nature of relationship and general community characteristics are associated with the risk of violence (Koenig et al., 2006; Ackerson et al., 2008; Abramsky et al., 2011). Additional studies, mostly in developed countries, are emerging in this realm of violence, shedding further light on the issues of IPV. Despite these remarkable contributions from the developed world, there has been barely little progress in terms of exploring these issues in developing countries, especially in Africa. Although the governments in most of these developing countries are signatories to international conventions protecting the rights of women, they are yet to have specific legislation addressing IPV (NPC and ICF Macro, 2008). Therefore, comprehensive research is urgently needed in developing countries to look into these problems and generate information that can be used to support programmes for the reduction and prevention of violence.

The purpose of this paper is to study factors (individual- and relationship-level characteristics) that are likely to help predict the occurrence of IPV in a developing country – Nigeria. More importantly, it explores whether the identified sets of factors are different from, or consistent with, those known from other studies conducted in both developed and developing countries, as this would help in discerning the variants of established programmes and policies that could be imported from such different countries to tackle issues of violence.

Methods

Study Design
To study the predictors (likely risk factors) of IPV in Nigeria, a cross-sectional population-based household survey involving 719 Nigerian women (aged 18 years and above, currently or previously in cohabiting or non-cohabiting relationships) was conducted in Kwara State - Nigeria. A multistage sampling procedure that involved three stages of randomly selecting wards, then smaller clusters of people (enumeration areas) and, finally, households, was used to select one eligible woman per household in the study. A detailed questionnaire administered by trained healthcare professionals was used to capture the required data. A statistical software (IBM SPSS Statistics 20) was subsequently used to analyse the data collected.
The study site – Kwara State – was selected as it has a population that is diverse in terms of demographics, making it a suitable site for this type of study. The research was conducted in both rural and urban locations in the State, and strict adherence to the ethical guidelines designed by the WHO for Research on Domestic Violence Against Women (2001) was observed throughout the study. Approval for the study was obtained from the Ministry of Women Affairs in Kwara State.

Questionnaire

The questionnaire is composed of structured questions with closed responses that solicit information about the respondent's and her partner's demographic characteristics, her community, her general state of health, her reproductive health, her attitude towards gender roles, her partner's controlling behaviour, her experiences of partner violence and the consequences of such violence. The design of the questionnaire drew on the experience of recent studies on IPV (Garcia-Moreno et al., 2005; ICRW, 2009), and behavioural-specific questions related to physical, sexual, and psychological forms of IPV were used to measure the exposure of the women to violence, as this approach of conceptualising IPV encourages greater disclosure and more accurate results (Garcia-Moreno et al., 2005).

Analysis of Data

Bivariate logistic regression analysis was first performed to study the crude association between each of the independent variables and occurrence of IPV (Simple logistic regression). The independent variables explored include: woman's characteristics (age, literacy, educational attainment, employment, partnership status, categorical number of children, rural-urban residence, and frequency of communication with her family), partner's characteristics (age, literacy, educational attainment, employment, general history of physical aggression, affairs with other women, alcohol use, history of drug use - substance taken for its narcotic effects, and controlling behaviours), as well as relationship characteristics (age difference, employment and educational disparity, payment of dowry/bride price, discord, and choice of partner). Potential variables for multivariable analysis were selected from the simple logistic regression results using a significance criterion of $p<0.05$. Drawing on the experience of relevant literature, in addition to the selected variables, other independent variables were also selected for inclusion in the multivariable analysis based on prior knowledge of them being major contributors towards IPV.

Sequential logistic regression was used in the multivariable analysis to find the best fitting, most parsimonious and biologically reasonable models to describe the association between the sets of individual- and relationship-level variables and occurrence of IPV. As the name implies, the analysis was executed in stages. The first stage included all the variables that were statistically significant in the simple logistic regression analysis followed, in subsequent stages, by each of the other variables considered to have relevant importance. To decide which variables to include in the final best fitting models, the extent to which each variable associates with IPV or attenuates the association of other variables in the models was examined via Wald test ($p<0.05$), with the direction as well as degree of association expressed in the form of adjusted odds ratio and 95% confidence interval. Statistical significance of the final models was further assessed using omnibus chi-square test as well as Hosmer and Lemeshow test, with $p<0.05$ and $p>0.05$ respectively indicating good fit.

Results

Individual-level model

Table 1 shows the details of variables in the final parsimonious model fitted at the individual level [$c2 (25, N=719) = 235.76$, $p<0.001$; Hosmer and Lemeshow: $p=0.679$]. Variables including women's age group, women's educational attainment, partner's educational attainment, partner's controlling behaviour, and partner's use of drugs all having significant (main effect) in predicting IPV occurrence in the fitted model ($p<0.05$).

Women within the age group of 30–49 years compared with those in the youngest age group (18–29) were 2.3 times less likely to experience IPV ($p=0.011$). Considering women's educational attainment, lower or no attainments expose women to IPV victimisation ($p<0.001$), with women having primary or no attainments about 7 times more likely to experience IPV than those having higher attainments. As opposed to the case of women, male partner's higher educational attainments actually increased the occurrence of violence ($p=0.04$). Compared with partners having tertiary attainments, those with primary or no attainments indicated a lower perpetration of IPV – about 2.5 times less likely to commit violence ($p=0.023$). Regarding a partner's controlling behaviour, the result shows that greater controlling behaviour is directly proportional to a higher likelihood of perpetrating IPV ($p<0.001$). Indeed, partners exhibiting 4 or more controlling behaviours have a 26.8-fold increase in likelihood of perpetrating IPV compared to those without any controlling behaviour. Results on partner's history of drug use show that, in comparison with male partners who have never used drugs, those who indulge in daily usage or 1 to 4 times a month were 16.8 to 46.5 times more likely to be perpetrators of IPV ($p<0.001$).

Table 1. Adjusted odds ratios*, 95% confidence interval and p-value of the best fitting logistic regression model for the individual-level variables

Variable	OR (95% CI)		p-value
Woman's age group			0.036
18–29	1		
30–49	0.43	(0.22–0.83)	0.011
50 and above	0.57	(0.19–1.68)	0.308
Partner's age group			0.652
18–29	1		
30–49	1.40	(0.66–2.98)	0.382
50 and above	1.27	(0.47–3.45)	0.638
Woman literate			0.133
Yes	1		
No	0.48	(0.19–1.25)	0.133
Woman's educational attainment			0.000
Higher	1		
Secondary	1.43	(0.84–2.44)	0.193
None or Primary	6.98	(2.84–17.19)	0.000
Partner's educational attainment			0.040
Higher	1		
Secondary	1.03	(0.58–1.84)	0.913
None or Primary	0.41	(0.19–0.88)	0.023
Partner's general history of physical aggression			0.053
No	1		
Yes	1.94	(1.13–3.33)	0.017
Woman unaware	0.98	(0.40–2.42)	0.969
Partner engaged in affairs with other women			0.056
No	1		
Yes	1.19	(0.60–2.37)	0.612
May have	2.58	(1.28–5.22)	0.008
Woman unaware	1.51	(0.87–2.61)	0.143
Partner's history of drugs use			0.000
Never	1		
1–4 times	46.54	(4.88–443.94)	0.001
Everyday	16.82	(4.81–58.79)	0.000
Woman unaware	4.38	(2.17–8.85)	0.000
Partner's controlling behaviour			0.000
None	1		
One	5.80	(1.63–20.63)	0.007
2 or 3	8.98	(2.88–27.97)	0.000
4 or more	26.80	(8.58–83.77)	0.000
Categorical number of children			0.086
5 or more	1		
3–4	0.43	(0.23–0.82)	0.011
1–2	0.54	(0.25–1.16)	0.115
None	0.60	(0.25–1.45)	0.258
Woman's frequency of communication with family			0.104
Corresponds at least once a week	1		
Corresponds at least once a month	1.50	(0.91–2.46)	0.110
Corresponds like once a year or hardly ever	1.76	(0.94–3.33)	0.080

*Odds ratio adjusted for all the variables in the table
OR = Odds ratio, CI = Confidence Interval

Relationship-level model

In Table 2, the model fitted separately for relationship level variables [c2 (11, N=719) = 190.36, p<0.001; Hosmer and Lemeshow: p=0.651] shows that partnership age and educational differences, partnership discord, and choice of spouse all contribute significantly to the model (p<0.05).

In terms of partnership age difference, women with partners who are 10 or more years older than themselves showed significant reduction in IPV occurrence, when compared with couples of equal age (p=0.032). The age difference conferred a 3.6-fold reduction in the likelihood of experiencing IPV. Men having better education than their partners were found to perpetrate IPV 2.1 times more than those having the same level of education as their partners (p=0.002). In comparison with women who reported no partnership discord, those who reported rare or frequent occurrence of discord were found to have a 5- and 38-fold increase in the experience of IPV, respectively (p<0.001). Regarding choice of spouse, cases where women had no say in selecting their partners showed a 5.2-fold increase in IPV experience, when compared with partnerships involving couples choosing one another of their own accord (p<0.001).

Table 2. Adjusted odds ratios*, 95% confidence interval and p-value of the best fitting logistic regression model for the relationship-level variables

Variable	OR (95% CI)		p-value
Partnership age difference			0.002
Woman is same age as partner	1		
Woman is older	0.47	(0.06–3.47)	0.458
Woman is 1–4 years younger	0.84	(0.28–2.55)	0.755
Woman is 5–9 years younger	0.50	(0.16–1.55)	0.230
Woman is 10 or more years younger	0.28	(0.09–0.89)	0.032
Partnership educational difference			0.002
Same level	1		
Partner better educated	2.07	(1.35–3.17)	0.001
Woman better educated	0.85	(0.37–1.99)	0.713
Partnership discord			0.000
Never	1		
Rarely	5.00	(1.94–12.88)	0.001
Often/ sometimes	38.03	(14.26–101.40)	0.000
Choice of spouse or partner			0.002
Both chose	1		
Respondent chose	0.75	(0.16–3.44)	0.712
Others chose with woman's consent	0.65	(0.29–1.43)	0.281
Others chose without woman's consent	5.21	(2.11–12.88)	0.000

*Odds ratio adjusted for all the variables in the table
OR = Odds ratio, CI = Confidence Interval

Discussion and conclusion

Overall, the analysis performed in fitting the most parsimonious model for individual-level variables indicates that women's age, women's and partner's educational attainments, partner's history of drug use, and partner's controlling behaviour all associate significantly with IPV. In the case of relationship-level variables, factors such as partnership age and educational differences, partnership discord, and choice of partner were statistically significant. Some of these factors have also been reported by other studies to strongly associate with IPV occurrence in a similar fashion, while others have shown different results.

For example, in terms of educational attainment, low level of attainment has been consistently reported in association with male perpetration and female victimisation of IPV (Koenig et al., 2006; Abramsky et al., 2011). In line with these findings, women with lower educational attainment in this study were found to experience significantly higher occurrence of IPV. On the opposite side, results pertaining to male partner educational attainment in this study refute those of the earlier studies stated, as higher educational attainment was found to increase IPV perpetration. Besides, some studies have shown that women with

a higher level of education relative to their partners are more prone to IPV experience (Xu et al., 2005; Ackerson et al., 2008). However, the results in this study indicate that women with lower educational attainment than their male partners are more prone to such violence.

Finally, having considered the similarities of the results in this study with those from other locations, it could be concluded that situations elsewhere do not necessarily mirror what is happening in Nigeria. As a result, adopting a one-size-fits-all approach to intervention (i.e., direct usage of policies/intervention developed for other countries or settings) would not always succeed and therefore there is a need for more exploration of in-country IPV issues, as well as for the design of appropriate interventions tailored to capture the somewhat unique Nigerian experience.

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Focus on India (90 minute workshop)

Workshop

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The Mysore Declaration

In February 2013, the First Symposium on Coercion was organised by Professors Raveesh and Lepping as a collaboration between the recently formed Indian Forensic Mental Health Association (IForMHA) and the European Violence in Psychiatry Research Group (EViPRG). IForMHA was formally launched at the Symposium. It is affiliated with the Indian Psychiatric Society, and it is the first association of its kind in South Asia. Alongside the launch of IForMHA, senior Indian and European contributors composed and signed a declaration on the minimisation of coercion in mental health practice, known as the Mysore Declaration. The core declaration states:

'There is an urgent need for the recognition and implementation of the rights of persons with mental illness, following principles with regard to equality, security, liberty, health, integrity and dignity of all people, with a mental illness or not. All parties responsible for the care and treatment of mental illness should work towards the elimination of all forms of discrimination, stigmatization, and violence, cruel, inhuman or degrading treatment. We affirm that coercion or violence against persons with mental illness constitutes a violation of the human rights and fundamental freedoms, and impairs or nullifies their enjoyment of those rights and freedoms. We will strive to uphold the human rights of persons with mental illness. We will work towards the prevention of violation, promotion and protection of their rights.'
The Declaration proceeds to define coercion, and urge Indian health care providers to benchmark coercive measures, compare results and develop strategies to reduce coercion in medical settings.

Forensic services in India

The application of legal knowledge to the psychiatry and of psychiatric knowledge to legal issues is the sub-specialty of psychiatry known as forensic psychiatry. In India, forensic psychiatry is still an emerging area in its infancy. The legal issues pertaining to the mental health care in India appeared only after British Rule with minimal changes occurring post independence. There is an increasing awareness regarding Mental Health in India. Along with this comes an increasing involvement of psychiatry with the law which forces our attention on the relationship between the Psychiatry and Law. Also, the information technology has sensitised civil rights movements, consumer council and rights in democracy resulting in increased litigation. Currently, there is poor training of psychiatry postgraduates to the idea of an interface between law and psychiatry. It is much neglected, ignored, misinterpreted and misunderstood. To meet the standards of the developed world and International covenants there is a pressing need by psychiatric community in the region to understand the existing legislation and initiate change through various agencies and regulatory bodies. This paper attempts to elucidate the interface of law and psychiatry in India, the legal provisions as are available in relation to psychiatric patients, their implications, benefits and drawbacks.

Prevalence of patient and visitor violence (PVV) in medical settings in India and North Wales

A survey was conducted by asking the staff to fill the questionnaire based on SOVES (Survey Of Violence Experienced by Staff). For the survey, two high risk wards were identified in three general hospitals covering all of North Wales. The ward staff were asked to comment on the nature of violence (between verbal abuse, threats and physical assault) and the frequency of the violence they were subject to, in the last four weeks. In India staff from the Mysore Memorial Hospital were questioned in the same way. The hospital has no separate psychiatric wards. Thus, psychiatric patients are treated on medical wards.

Method of analysis

As the data was predominantly nominal with some continuous data such as age and length of work experience, Pearson Chi-square was considered appropriate analysis. Fisher's exact and linear values were used in the interpretation where necessary. T-tests and regression where used as appropriate. SPSS was used for all analyses

Results

In North Wales a total of 158 staff responded to the questionnaire. 75 were qualified nurses, 38 were Health Care Support Workers (HCSW). 111 of 158 staff work full time (70.25%). 131 of 158 staff (82.9%) reported being subjected to verbal abuse in the past 4 weeks. 79 of 158 staff (50%) reported being threatened in the past 4 weeks. 99 of 158 staff (62.6%) reported being physically assaulted in the 4 weeks prior to filling the questionnaire. 55 staff members (55.5% of assaults) sustained injury from the assault and 3 needed medical assessment and/or treatment.

Reported abuse by role: Nurses and HCSW were the two groups more likely to receive verbal abuse. HCSW were significantly more likely (not statistically significant) to encounter violence and possibly more than one kind of abuse. Nurses and HCSW faced multiple abuse more often than other professions. The high likelihood could be due to the length of face to face contact to the patient and the nature of the job, which requires attending to the discomfort of an already confused / distressed patient. The incidence of any violence from patients as a source is more common than relatives. "Other" sources of abuse included colleagues and were relatively rare. Experience in the job did not protect from PVV, although staff with fewer years service were more likely to experience verbal abuse.

In India 203 staff members completed the questionnaire. 153 (75%)were female. 128 (62%) of them were nurses, 10 (5%) were HCSW. 144 (71%) worked full time, 157 (77%) were hospital based. 74 (36%) had been subjected to verbal abuse in the past 4 weeks, 31 (15%) had been threatened. 5 (2%) had been physically assaulted but 93 did not answer this question. Indian nurses were much less likely to identify the source of the violence with over 75% not answering this question. Of those who answered the 40 identified patients, 41 cited relatives and 14 cited co-workers as the source of the violence for verbal abuse. For threats patients were more commonly the source than relatives, followed by co-workers.

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Mental illness and violence: a comparison between formely and never violence patients living in residential facilities

Paper

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1. Background

Since the 80s many studies have attempted to investigate the relationship between mental disorders and violence, investigating whether disease severity, comorbidity, the condition of hospitalization and other factors such as age, sex, co-existence of organic disease, number of hospitalization in a mental hospital might be predictors of future violent acts. To date, several variables, which appear to be related to an increased risk of committing violent acts in psychiatric populations, have been identified. An history of violent behaviour, a diagnosis of schizophrenia, especially early onset, the severity of psychiatric symptoms, substances abuse, and the number of previous psychiatric admissions are risk factors for aggressive behaviour in psychiatric patients (McNiel & Binder, 1994; Arango et al., 1999; Steinert et al., 1999).

With regard to the specific Italian situation, the largest study has been realized in the framework of the nationwide project called 'PROGRES-Acute' (Preti et al., 2009), which surveyed a large sample of hospitalized patients (N=1,324) in 113 General Hospital Psychiatric Units (GHPUs) and 32 private RFs (Biancosino et al., 2009). The results of this study showed that in a small albeit significant percentage of psychiatric patients violent behaviour is associated with a severe mental disorder, and it occurs particularly in patients with acute disorders requiring hospitalization; thanks to hospital treatment, the dimension of aggression-violence decreases significantly; there are some specific psychopathological dimensions which differentiate psychiatric inpatients who acted and/or act violently from never violent inpatients, the latter representing the majority of patients who require hospital treatment.

With regard to the population with mental disorders admitted to Forensic Mental Hospitals (FMHs), the most important Italian study is the MoDiOPG, a naturalist prospective cohort study. This study showed that the FMHs population is highly complex, with social and health needs, difficult to meet through current care pathways.

Data from this study, and especially the new Italian law on the treatment of patients with mental disorders, authors of violent acts (Law 17, February 2012, n. 9), emphasize the need of a careful investigation of care pathways (Fioritti et al., 2001; 2006). In fact, this law states that all patients currently hospitalized in the 6 Italian FMHs should be discharged and transferred to other RFs, non-judicial but medical.

Therefore, further study is necessary to shed light on the dimension of aggressive behaviour and on the risk of violence in the specific context of the Italian mental health care, in order to identify the most appropriate strategies for prevention and treatment of patients with severe mental disorders which act violently.

The present study is part of a prospective observational cohort study involving St John of God Order's 23 medium-long term RFs in Northern Italy (de Girolamo et al., 2013), aimed at describing the sociodemographic, clinical, and treatment-related characteristics of RFs patients during an index period, and at identifying discharge-associated predictors and characteristics at 1-year follow-up.

1.1 Aims of the study
Specifics aims of the present study are to investigate the sociodemographic, clinical, and treatment-related characteristics of a sample of male patients living in RFs with an history of violent behaviour (so called 'violent' patients); to compare the characteristics of violent patients with residents never violent; to analyse the association between aggressive behaviours (e.g., verbal, physical and sexual) committed in two years of observation and to belong to the two groups (violent vs never violent).

2. Methods

All male patients staying in these medium-long term RFs in September 2010, with a primary psychiatric diagnosis and age of < 65 years were recruited. Exclusion criteria were age 65 years or older, and primary diagnosis of organic mental disorder (i.e. dementia or mental retardation).

The sample was divided into two groups: 'never violent' patients and 'violent' patients. The violent group included:

1. patients who were at least once in their lifetime in FMHs for violent crimes;
2. patients who were at least once in their lifetime arrested for violent crimes;
3. patients with a life history of violent acts against persons (including sexual violence).

For each inpatient was filled out a 'Patient Schedule' composed of BPRS, HONOS, FPS, PHI, SLOF. Socio-demographic and clinical data were also collected.

The Brief Psychiatric Rating Scale (BPRS) was used to assess psychopathology (Ventura et al., 1997). The Health of Nation Outcome Scale (HoNOS) (Wing et al., 1998) and the Personal and Social Performance (PSP) scale, a modified version of the DSM-IV Social and Occupational Functioning Assessment Scale (SOFAS), were used to assess psychopathology and social functioning (Morosini et al., 2000). The Specific Levels of Functioning (SLOF), recently considered the 'gold standard' in this field (Harvey et al., 2011), was administered to assess psychosocial functioning and disability. Cognitive functioning was assessed with the Repeatable Battery for the Assessment of Neuropsychological Status (RBANS) (Gold et al., 1999).

Furthermore, a specific module to assess aggressive behaviours lifetime and in the 2-year observation period was used. Aggressive behaviours assessed were: shouting, threatening, pushing others, slapping, punching, inappropriate sexual behaviour, sexual harassment, using weapons. These behaviours were grouped into the following three categories: verbal, physical and sexual aggressive behaviours.

3. Results

3.1 Characteristics of the sample

A total of 268 male patients were assessed at baseline: 81 violent and 187 never violent patients. The mean age of violent patients was 46.5 years (SD= 9.5; median 47), compared to 47.7 (SD= 10.2; median 49) of never violent patients; oveall 45.7% of violent patients were between 18 and 45 years of age, as compared to 38.5 % of the never violent group.

The majority of patients had a schizophrenia spectrum diagnosis (70.5% in violent group, as compared to 83% in the never violent patients). Violent patients were more likely to have a diagnosis of personality disorder (29.5% vs 17%), and this difference was statistically significant (X^2=4.825, p=.028).

The mean RF stay duration was 3.1 years (SD=3.5; median 1.9) in the violent group, as compared to 4.0 years (SD=6.5; median 2.1) among the never violent patients; the difference was not statistically significant.

Regarding lifetime compulsory admission, 18 (21.5%) violent patients had none, 40 (50%) patients had 1-3, 22 (27.5%) had more than 4. In the never violent group they were rispectively 105 (57.1%), 50 (27.2%), 32 (15.8%), and the differences between the two group were statistically significant (p<.001).

The mean illness duration was 21.6 years (SD=11.1; median 22) in the violent group, as compared to 22.1 years (SD=12.0; median 20) in the never violent patients.

Concerning the ability to cooperate in the previous year, 47 (58%) patients of the violent group were actively cooperative with the treatment, compared to 104 (55.9%) of the never violent group.

Furthermore, treating clinicians predicted that a higher percentage of never violent patients (N=161, 87.0%) was to remain in the current or in another RFs in the following year, as compared to 60 (74.1%) in the violent group, and this difference was statistically significant (p=.010). Coherently, after one year, 9 (11.8%) patients of the violent group were discharged, as compared to 26 (14.2%) of the never violent patients.

3.2 Assessment scores

At entry, the mean total BPRS score was 59.7 for violent patients and 59.6 for never violent patients: these scores indicate a moderate level of symptoms.

Concerning the specific items of BPRS, there were statistically significant differences between the two groups in hostility (p=.050), grandiosity (p=.046), suspiciousness (p=.040), motor slowing (p=.018), and conceptual disorganization (p=.039).

The HONOS mean total score was also only in a moderate range, with 19.5 for violent patients and 20.0 for never violent patients.

The PSP score showed a significant level of psychosocial impairment. However, violent patient had a higher score, indicating a better functioning, as compared to never violent group (44.2 vs 37.9, p=.001). About the SLOF, there were statistically significant differences between the two groups in two areas: 'activities' (p=.047) and 'work skills' (p=.007): also, in this case, violent patients had a higher score, indicating a better functioning. Lastly, the mean total RBANS (neuropsychological status) score was 71.9 for violent patients and 69.9 for never violent group, indicating the presence of a mild cognitive impairment for both groups, without statistically significant differences.

3.3 Differences of aggressive behaviours between the two groups

Table 1 shows the difference in the frequency of aggressive behaviours during the observation period (two years) between violent and never violent patients. There were significant differences between the two groups in the number of aggressive behaviours: the number of aggressive behaviours observed among the violent patients was significantly higher than among never violent patients in all categories of aggressive behaviours assessed: verbal, physical and sexual.

Table 1

	'Violent' patients (N=81) %	Never violent patients (N=187) %	Test	p value
Verbal aggression				
Yes	40	21.9	$X^2 =9.21$	.002
No	60	78.1		
Physical aggression				
Yes	30	15.5	$X^2 =7.39$	.007
No	70	84.5		
Sexual aggression				
Yes	17.3	3.2	$X^2 =16.21$	.000
No	82.7	96.8		

4. Conclusion

People with severe mental disorders and a history of violent offending are usually seen as a difficult-to-manage population. They are characterized by a high risk of crime recidivism, poor compliance with community programs and aftercare, and homelessness (Teplin, 1990; Coid, 1991; Dolan & Doyle, 2000; Jamieson & Taylor, 2002). Nevertheless, reintegrating even seriously mentally ill violent offenders into the community may be an achievable outcome, provided that sufficient care resources are allocated to this aim.

In our study, violent patients were younger, with a prevalence of personality disorders. These data are in line with the current literature, which shows that younger patients have a greater chance of displaying violent behaviour (Walker & Caplan, 1993).

Furthermore in our study, the number of aggressive behaviours observed among violent patients was significantly higher than among never violent patients. The presence of a history of serious violent behaviours against people in the past (violent group) was significantly associated with a higher number of verbal, physical and sexual aggressive behaviours.

Consequently, it's very important to study the characteristics of these patients, in order to organize RFs hosting violent patients as effectively and safely as possible. In fact, very little is known to which extent, and in which way, RFs meet the everyday needs of patients with an history of antisocial behaviour. Whereas most investigations aimed at evaluating risk of reoffending in this group of patients (Hodgins &

Müller-Isberner, 2004), only very few studies to date have examined these patients' adjustment after their release from RFs to the community (Heilbrun et al., 1994).

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Violence against schizophrenic women: a review

Poster

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Abstract

Tragic and high profile killings by people with mental illness have been used to suggest that the community care model for mental health services has failed. It is also generally thought that schizophrenia predisposes subjects to homicidal behavior.

Although expert opinion has asserted that there is an increased risk of violence in individuals with schizophrenia and other psychoses, there is substantial heterogeneity between studies reporting risk of violence, and uncertainty over the causes of this heterogeneity.

Research indicates that women with serious mental illness like schizophrenia are vulnerable to physical, mental and sexual abuse, resulting in adverse health outcomes such as posttraumatic stress disorder (PTSD).

We will review literature concerning all kind of violence among inpatient and outpatient schizophrenic women.

Educational Goals

- Epidemiological data
- Ethical perspectives

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Chapter 5 – Advances in neurobiological approaches and pharmacological therapies

Variation in the DRD2 gene affects impulsivity in intertemporal choice

Poster

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Abstract

Objectives
Impulsivity is a core deficit in biopsychosocial disruptions such as addiction, antisocial personality disorder, and depression. Impulsivity in intertemporal choice has been operationalized as 'delay discounting,' referring to the preference for a sooner, smaller reward in neuroeconomics. It is reportedly associated with the dopaminergic systems. Dopamine receptor D2 (DRD2) is the D2 subtype of the dopamine receptor of the G-protein coupled receptor family. The aim of this study was to explore the effect of single nucleotide polymorphisms (SNPs) in DRD2 gene on delay discounting.

Methods
The participants consisted of 91 healthy Japanese people (66 males and 25 females with a mean age (SD) of 40.9 (6.9) years). Each participant completed the Kirby's monetary choice questionnaire (MCQ) for delayed gain and donated a whole blood sample. Two SNPs (C957T (rs6277) and TaqI A (rs1800497)) in DRD2 were genotyped by using the DigiTag2 assay. SNP linear regression analyses with 100,000 permutations were conducted for the hyperbolic time-discount rate (k).

Results
The SNP C957T showed a significant association; participants with more minor alleles (T) were more impulsive in intertemporal choice for delayed gain (multiplicity-corrected P = 0.041).

Conclusion
The variation in the DRD2 gene is associated with impulsive decision-making. By utilizing neuroeconomic theory, future psychiatric studies could investigate the role of the DRD2 gene in impulsive problem behavior observed in addiction, antisocial personality disorder, and depression (suicide). This is the first study to demonstrate an association between DRD2 and impulsivity in intertemporal choice with a multiplicity-corrected significance.

Educational Goals

This study will contribute to investigate the role of the DRD2 gene in impulsive problem behavior observed in addiction, antisocial personality disorder, and depression (suicide) by utilizing neuroeconomic theory.

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Neuropsychological Features and Psychosocial Backgrounds among Schizophrenia Patients with a History of Serious Violence in Japan

Paper

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Background

Findings are inconsistent regarding the relationship between violence related to schizophrenia and cognitive functioning, particularly executive functioning. One reason for this is the difference in the definition of violent acts and diversity among patients' violent backgrounds.

Aims

This study examined whether there are differences in patients' backgrounds and cognitive functioning between violent and non-violent patients with schizophrenia, and differences among violent patients based on variability in violent backgrounds.

Methods

The treatment group comprised male patients with schizophrenia hospitalised under the Medical Treatment and Supervision Act (MTSA) for committing murder, attempted murder, or causing serious injury to others (hereafter 'relevant action') while in a state of insanity or diminished responsibility (MTSA group). The comparison group comprised hospitalised male patients with schizophrenia with no history of violence and age-matched to the MTSA group (control group). A variety of participant characteristics were obtained. Psychopathology was assessed using the Positive and Negative Syndrome Scale (PANSS). The Brief Assessment of Cognition in Schizophrenia Japanese-language version (BACS-J) was used as a neuropsychological assessment. Furthermore, the MTSA group was divided into two groups and compared in terms of the presence of a history of substance use, relationship with the victim, severity of violence, strength of their relationship with psychosis according to the 'CODING GUIDE FOR VIOLENT INCIDENTS', and existence of any significant violent behaviour apart from the relevant action according to the 'DRAWING A CRIMINAL PROFILE'.

Results

Thirty cases of the MTSA group and twenty-four cases of the control group participated. The MTSA group had a longer non-treatment period than the control group (p = .005) and had significantly better BACS-J executive functioning than the control group (p = .004). Moreover, within the MTSA group, 18 cases with violent behaviour in addition to the relevant action had a shorter educational history (p = .05) and scored higher on the positive scale of the PANSS (p = .047) than the 12 cases with no remarkable violent behaviour other than the relevant action. The 20 cases whose victims were non-family members showed significantly better executive functioning than the 10 cases whose victims were family members (p = .004).

Conclusions

The violent background that accompanies schizophrenia is diverse, although some patients might share characteristic neuropsychological profiles and psychosocial backgrounds. Future research should extend the number of cases examined.

Educational Goals

To better understand the patients with schizophrenia who have caused serious cases and hospitalised under the Medical Treatment and Supervision Act (MTSA), which is relatively new legislation for offenders with mental disorders in Japan.

To understand the neuropsychological profiles and psychosocial backgrounds among patients with schizophrenia who had a history of seriously violent behavior.

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Do we need guidelines in rapid tranquilisation? A survey of prescribing preferences in Belgian psychiatrists and emergency doctors

Paper

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Running title: surveying prescribing patterns in acute agitation

Introduction

Agitated behaviour during an hospital admission is a frequently encountered problem, both in psychiatric and general hospitals as well as in their emergency services. It is estimated that yearly 1.7 million hospital admissions accur due to agitation [1,2]. About 10% of patients admitted to the emergency department are at risk of developing agitation symptoms during medical evaluation [3]. Agitation is seen in conjunction with different psychiatric disorders, such as schizophrenia and bipolar disorders but also in non-psychiatric medical conditions [4,5,6].

Although motor restlessness, increased responsiveness to external or internal stimuli, irritability, inappropriate and usually purposeless verbal and motor activity are reported as the major hallmarks of the syndrome, there is no consensus regarding the symptoms (and their definitions) that constitute agitation or how this syndrome is associated with other co-morbidities. Little is known about its course over time and what level of agitation leads to pharmacological treatment [7,8]. This lack of clarity for several issues in diagnosis and treatment all hamper the development of generalisable guidelines for the clinician [9]. As a result, although good clinical trials have been conducted to investigate the effectiveness and the safety of several drugs that are being prescribed foragitated behaviour [10,11,12], opinion is divided as to whether the reported results have better internal validity or better ecological validity [13,14,15]. In addition to this diagnostic and therapeutic lack of consensus in trials patiënt selection, randomization and the use of well validated rating scales to monitor effect and safety is also of great concern. Consequently, prescribing preferences may not always be based on evidence-based guidelines , although the use of psychopharmacological drugs is widely spread [1,2,9,15].

In order to map prescribing habits of physicians in their approach to acute agitation, a series of studies – surveying physicians' preferences - was conducted between 1999 and 2004 [10,12, 16-20]. Although they all differ in methodological design and are all country or service-specific, a few trends can be found in these reports. Firstly, antipsychotics (olanzapine, promethazine, haloperidol and droperidol) and benzodiazepines (diazepam, lorazepam) are the main drugs of choice. Secondly, there is no real preference for peroral or intramuscular administration. Thirdly , there is a reported trend in favour of using combinations of drugs (e.g. haloperidol/promethazine or haloperidol/lorazepam).

The present study had two objectives. We first aimed to describe the current prescribing preferences of psychiatrists and emergency doctors in the Flemish speaking region of Belgium (i.e. Flanders) and second we evaluated the extent to which prescribing preferences were in accordance with published treatment guidelines.

Methods

A cross-sectional online survey was conducted between the 1st of July 2012 and the 31st of September 2012 in 39 psychiatric hospitals, 11 psychiatric wards of a general hospital and 61 emergency departments. Two hundred and eighty-one psychiatrists and 267 emergency doctors received an invitiation to respond to the survey. The hospitals were located in the northern part of the country (Flanders) and were representative of Belgian practice. Participating psychiatrists and emergency physicians were asked to give 1) demographic and professional information, describe 2) their prescribing habits in the treatment of acute agitation (irrespective of the underlying DSM-IV diagnosis), 3) their use of evidence based guidelines and 4) the type of monitoring (effectiveness, safety) they provide for their patients. Agitation was defined in the

survey as a clinical condition with acute onset of psychomotor and emotional excitement. The following parameters were collected: Age, gender, type of doctor (psychiatrist, emergency doctor), type of hospital (psychiatric hospital, psychiatric ward in a general hospital, emergency department), number of patients with agitation admitted in one month, use of diagnostic rating scales, preference of drug prescribed, use of drugs in combinations, effect of seclusion and or restraint on prescription preference, use of guidelines and modalities of monitoring of efficacy and patient safety.

The following aspects of the responses were evaluated: [1] preferred medication classes and specific drugs (alone or in combination) and if preferences changed in the case the patiënt needed seclusion and/or restraint, [2] differences in prescribing habits depending on the medical specialty of the prescribing doctor. Descriptive statistics were applied for basic demographic data and prescription preferences. Comparisons between groups for categorical data were calculated by means of a likelihood ratio, because sample sizes are relatively small. IBM SPSS version 20.0 was used for all analyses.

Results

Response rate and respondents characteristics
One hundred and tenpsychiatrists and emergency doctors responded to the online survey, yielding a response rate of 20 %. From the 110 respondents, 70 (63.6%) weremale and 40 (36.4%) werefemale. Psychiatrists accounted for 65.5 % of the answers, emergency doctors for 34.5 %. The age groups are listed in Table 1 with the majority of respondents aged between 30 and 45 years. Doctors worked in different settings; 43 (39.1%) in a psychiatric hospital, 25 (22.7 %) in a psychiatric ward of a general hospital and 42(38.2 %) in an emergency service. A maximum caseload of 10 patients per month was reported by 71 (64.5%) participants, 39 (35.5%) had a monthly caseload of more than 10 agitated patients.

Table 1.: Age distribution of respondents

	Frequency	Percent
25-30 jaar	5	4,5
30-35 jaar	22	20,0
35-40 jaar	28	25,5
40-45 jaar	13	11,8
45-50 jaar	11	10,0
50-55 jaar	7	6,4
55-60 jaar	16	14,5
60-65 jaar	7	6,4
ouder dan 65 jaar	1	,9
Total	110	100,0

Preferences in medication prescriptions

1. General preferences for a medication class in acute agitation
Respondents were asked to point out which medication class theyfavoured in the treatment of acute agitation. The highest ranking medication class was antipsychotics (58.2 %), followed by Benzodiazepines (53.6 %), mood stabilizers (36.4 %) antidepressants (37.3 %) and antihistames (43.6 %) .
Rankings for all medication classes are shown in Fig. 1.

Figure 1. Ranking of medication classes

AP= antipsychotics, BZD = benzodiazepines, AD = antidepressants, MS = mood stabilizers, AH = antihistaminics, MISSING= left blank

2. Prescribing preferences in non-secluded patients

All participants were asked to rank their drug preferences when considering all patients in need of treatment for agitation. (Fig. 2). Olanzapine (21,8%), lorazepam (20,9%) and clothiapine (19,1%) were the three highest ranked drugs followed by lorazepam (20.9%), olanzapine (17.3%) and droperidol (11.8%), Clothiapine (12.7%), lorazepam (10.9%) and olanzapine (10.9%) were reported most. Although zuclopenthixol preference was less common, (2.7%), the long acting formula of this drug is reported more frequently (1.8%; 2.7%; 8.2%).

Of the participants, 20.9 % reported using only one drug whilst a combination of drugs was used by 10.9 % of participants. This combination of drugs was prescribed by 65.5 % of participants.

Figure 2. Distribution of medication choices in non-secluded patients

3. Prescribing preferences in secluded patients

We also asked whether prescription preferences changed when patients were in need of seclusion as a non-pharmacological approach to agitation. This was reported in 60.9 % of the participants (37.3 % of participants reported they did not change their prescription preferences). Ranking for choice preferences in secluded patients are shown in Fig. 3. Clothiapine (16.4%), droperidol (11.8%) and olanzapine (10.9%) were the three highest ranked drugs followed by lorazepam(15.5%), clothiapine (9.1%) and diazepam (8.2%), Haloperidol (7.3%), clothiapine (6.4%) and lorazepam (6.4%) were reported most. Again, zuclopenthixol was not commonly preferred(1.8%). However, the long acting formula of this drug is reported more frequently than in the non secluded group of patients (4.5%; 3.6%; 7.3%).

Of the participants, 8.2 % reported to use only one drug (monotherapy) whilst a combination of drugs is used by 17.3 %. Again, among 36.4 % of participants these drugs wereprescribed in a step-up regime.

Figure 3: Distribution of medication choices in secluded patients
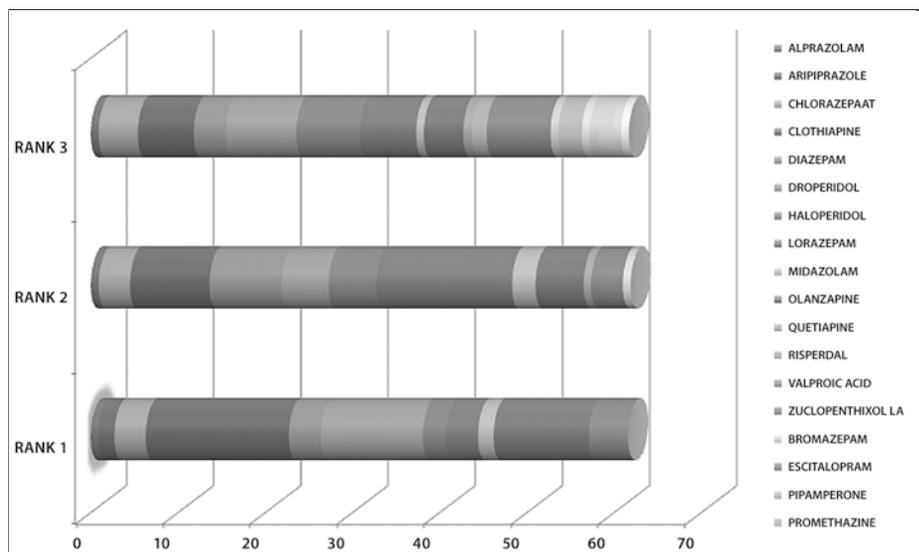
Between group differences

1. Differences in medication preferences

In non-secluded patients, likelihood ratios for significant associations with medication rankings were calculated for; gender (22.050,df=14,p=0.078; 18.120,df=17,p=0.381; 27.420,df=21,p=0.157), age (106.588,df=112,p=0.627; 87.161,df=136,p=0.995; 142.050,df=168,p=0,928) and caseload (21.653,df=14,p=0.086; 24.840,df=17,p=0.098; 34.424,df=21,p=0.053) No significant correlations were found. Only the type of hospital (53.177,df=28,p=0.003;55,842,df=34,p=0.01; 65.345,df=42,p=0.012) and type of specialist (32.568,df=14,p=0.003; 45.243,df=17,p<0,001; 47.403,df=21,p=0.001) yielded significant results.

In secluded patients, likelihood ratios for significant associations with medication rankings were also calculated for; gender (4.316,df=11,p=0.960; 9.291,df=12,p=0.617;21.278,df=19,p=0,322), age (61.547,df=88,p=0.989;84.273,df=96,p=0.789; 107.983,df=152,p=0.997) and caseload (12.012,df=11,p=0.363;11. 682,df=12,p=0.472;22.379,df=19,p=0,266) again without significance. Again, type of hospital (34.996,df=22,p=0.039; 42.343,df=24,p=0.012;56,460,df=38,p=0.027) and type of doctor, psychiatrist or emergency doctor (27.522,df=11,p=0.004;32,741,df=12,p<0.001;32.958,df=19,p=0.024) produced significant likelihood ratios.

2. Differences in medication classes

Gender (1.601,df=1,p=0.201), age (11.034,df=8,p=0,200) and caseload (0.597,df=1,p=0.440) did not produce significant associations with choice of medication class. We did find significant associations for type of hospital (22.536,df=2,p<0,001) and type of doctor, psychiatrist or emergency doctor (16.886,df=1,p<0.001).

Use of guidelines and monitoring for efficacy and safety
Guidelines are not frequently used. Only 26.4 % reports the use of guidelines. This can be an individual set of recommendations (16.4%), a recommendation issued by a national professional society (4.5 %) or a published guideline (5.5 %).
The majority of respondents (94.5%) used only clinical evaluations to monitor the effect of the rapid tranquilisation.

Discussion

Agitation is a frequently encountered clinical condition by psychiatrists and emergency doctors since two third of respondents have a maximum of 10 cases per month in treatment. To our knowledge, there are no reports on the prevalence of acute agitation in other countries with which to compare .
In the total sample, antipsychotics are ranked first choice and benzodiazepines second choice when all respondents in the survey are considered. In non-secluded patients, preference is given to olanzapine and lorazepam. In secluded patients, who arguably demonstrate higher degrees of agitation compared to non-secluded patients, clothiapine and droperidol are prescribed most often. This seems in line with a recent consensus statement of the psychopharmacology workgroup of the American Association for Emergency Psychiatry [21] where antipsychotics – and in particular olanzapine or risperidone – are recommended as first-line management of acute agitation. However, this report does not differentiate patients according to their level of agitation, as is the case in our study. On the basis of a non-systematic review of the literature, Bak et al. [22] also advocate olanzapine and lorazepam, although the authors recommend to use lorazepam only in non-psychotic agitation. In addition, in a review of the literature from the period 1960-2000 Battaglia et al. [23] , found that most evidence for a safe and effective treatment of acute agitation was Haloperidol, Olanzapine and Lorazepam. This recommendation is also supported in the UK National Institute for Health and Care Excellence [NICE]guidelines on acute agitation [24].
It is surprising that our respondents are not in favour of zuclopenthixol as drug of choice for agitated patients. In contrast with this, the long acting form of zuclopenthixol is well-favoured, especially in secluded patients. This is not in line with earlier mentioned recent recommendations found in the literature [21,22].
Combinations of drugs are most frequently used in secluded patients. Given the lower proportion of respondents that use step-up regimens in secluded patients, it can be concluded that in this group a combination of drugs is the most prevalent procedure, which is in line with what is found in other studies [10,12, 16-20].
An interesting finding is that in non-secluded and secluded patients, a significant difference is found for the type of hospital when medication preferences (and ipso facto medication class) is considered. For secluded patients, this result is also significant when type of respondent is taken into consideration. To our knowledge, this distinction is never made in earlier prevalence studies although it seems relevant to do so. Psychiatrists and emergency doctors have different education and – in Belgium – are approached with prescribing information by different pharmaceutical companies. It can be arguedthat this practice has an effect on which drug is prescribed, certainly in the context of our finding that most respondents never use any published guidelines, nor in selecting a drug or monitoring effect.
An explanation for our finding of the sparse use of monitoring - at least for assessment of efficacy of a treatment - is given in a recent systematic review by Zeller and colleagues who reported a similar observation [25]. The authors hypothesize that, although agitation is a common behavioural emergency, there is a lack of easy-to-administer treatments that could improve treatment quality or predict treatment effects. Although Flanders' practice is close to what is advised in the literature, there remains a lack of research evaluating the clinical efficacy of antipsychotics and benzodiazepines for acute agitation. Both medication classes seem to be effective but, in the presence of limited available data from well designed pharmaceutical trials, recommendations are still largely based on either consensus statements or observational data. Moreover, it is of great concern that there is a substantial lack of assessment tools that measure the effect of treatment – preferably directly in the moment and not post hoc through an evaluation by a caregiver.

Conclusion

Our results show that real prescription practice in Flanders (Belgium) in acute agitation is more or less following published recommendations. Prescription habits differ however accordingly to medical specialty, probably because most of the information on prescribing reaches the doctor via pharmaceutical companies andbecause of the sparse use of guidelines. However, it cannot be expected that doctors use a standardised guideline as there is still a lack of primary studies and assessment techniques for efficacy in this clinical field.

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Chapter 6 – Advances in psychological therapies

Engaging and managing angry young men: a six-session intervention

Workshop

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Overview

Personality disorders are longstanding maladaptive patterns of perceiving and relating to people and stressful situations. Antisocial personality disorder (ASPD), one of the commonest personality disorders, is characterized by a gross disparity between behaviour and the prevailing social norms and a pervasive pattern of disregard for, and violation of, the rights of others that begins in childhood or early adolescence and continues into adulthood (National Institute of Health and Care Excellence [NICE], 2010). It is strongly associated with interpersonal and social impairment, offending behaviours and increased risks of mental and physical health problems, particularly alcohol and other drug misuse. Many more individuals do not possess the full disorder and are said to have antisocial traits (such as irresponsibility, deceitfulness, recklessness, impulsivity, irritability and aggression), while an even greater proportion only exhibit such traits when exposed to stress.

The nexus between genetics and environment in the aetiology of the disorder is inconclusive, though it is clear that both ASPD and borderline personality disorder (BPD) are common outcomes of childhood trauma (Sansone & Sansone 2006; Sousa et al 2011), and that 'resilience' may explain inter-individual differences in those exposed to the same trauma (Pereda et al 2011). People with both disorders "frequently grow up in fractured families where parental conflict is the norm and where parenting is often harsh and inconsistent" (NICE, 2010), leading to acting out at school, truancy and other delinquent behaviour, and early substance misuse and associated psychosis. ASPD, then, is usually associated with previous diagnoses of oppositional defiant disorder, conduct disorder, attention deficit hyperactivity disorder, and low educational attainment. Conduct disorder itself has robust associations with childhood trauma (Briggs-Gowan et al 2010), the presence of which has been described as ubiquitous (Greenwald 2002). While the rate of conversion from conduct disorder to ASPD varies from 40-70% depending on the study (Robins et al 1991; Moffit et al 2002; Loeber et al 2002; Simonoff et al 2004;), the fact that the risk factor most predictive of adult antisocial personality is the severity and extent of prior conduct symptoms suggests that childhood and adolescence should be a focus for early intervention strategies to prevent ASPD. This is important as ASPD frequently results in adverse outcomes including unstable relationships, increased rates of unemployment, poor and unstable housing, imprisonment and premature death through reckless behaviour (NICE 2010). Clients with ASPD are also at greater risk of depression, self-harm and suicide, in part due to drug and alcohol misuse. The characteristic pattern of recidivistic behaviour not only impacts on self-concept and marginalizes the person, further limiting life opportunities (Salekin, 2008); it also traumatizes families, as well as having wider societal costs. Violent and offending behaviour impacts victims, and there are the costs of policing and other initiatives to curb antisocial behaviour, and general costs to the criminal justice system including the costs of detention and other punitive measures (NICE, 2010).

Unlike those with borderline personality disorder, those with ASPD are 'treatment rejecting' rather than 'treatment seeking' (Tyrer et al 2003) and when they do present it is often under coercion and/or for treatment of a comorbid condition. As such, they are difficult to retain in treatment and engagement is paramount. Recent guidelines for the treatment of ASPD (NICE, 2010) concluded that the experience of many people with ASPD was of being excluded from services and from decision-making concerning their

care. Furthermore, when those with ASPD present for treatment of comorbidities, they are less likely to be treated, even though standard evidence-based interventions are just as likely to be effective. If they are seen by mental health services, much of the focus remains around risk, when it is clear that many need treatment of comorbid mental disorders including depression, anxiety, psychosis and substance misuse in addition to wider issues including physical health, vocation, housing, welfare, relationship and parenting needs, requiring linkage to other services.

While a range of therapies have been developed for BPD (Kernberg, 1984; Linehan 1993; Ryle, 2004) and early intervention services established (Chanen 2009), pharmacological (Khalifa et al 2010) and psychological (Gibbon et al 2010) interventions for ASPD are limited. Cognitive behavioural approaches have gained in prominence (NICE 2010); principally to reduce offending behaviour (Landenberger & Lipsey, 2005; Lipsey et al 2007; Lipton et al., 2002; Tong & Farrington 2006; Wilson et al 2005) though there is little supporting evidence. The National Institute for Health and Care Excellence (2010) reviewed the literature and found only one suitable trial of psychological treatment for ASPD in the community (Davidson 2008), a CBT intervention on 39 participants. The study found no effect for CBT on anger or verbal aggression compared with treatment as usual, but did find a small, non-significant effect for social functioning and physical aggression compared with treatment as usual. Similarly, for the treatment of symptoms or behaviour associated with ASPD, NICE found one trial that investigated anger 'management' on 31 offenders (Vannoy, 2004), but was deemed too low quality to provide recommendations. While there was consistent evidence that group-based cognitive and behavioural interventions were effective for the treatment of offending behaviour in young people (less than 17), in community and institutional settings and adult males over 21 in criminal justice settings, there was no effect on those aged 18-20 years.

The lack of interventions aimed at the underlying precursors relative to 'management' of end-state symptoms highlights an imperative for trialling alternative approaches. We outline the rationale and key elements of a six hour intervention targeted at clients with ASPD. While the original target group was a 15-25 year old, predominately male cohort, suffering with a first episode psychosis and ASPD/traits, the principles underlying the intervention are applicable to other externalising disorders, with or without psychosis.

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Streetwise, Self-wise, Other-wise: A novel intervention to diminish victimisation in psychiatric patients with substance use disorders

Workshop

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Keywords: Double diagnosis, addiction, substance dependence, training, street-skills, intervention

Introduction/Background

Starting in the seventies of the last century, a de-institutionalising has taken place in psychiatry in the Netherlands, shifting care for psychiatric patients to non-residential care. This means that psychiatric patients become a part of society again, because they live in regular housing, and because smaller-scale treatment centers and residential care has moved towards locations within cities. A consequence of deinstitutionalisation is that psychiatric patients are more vulnerable for victimisation (Attkison et al., 1992; Lehman, 1999; in Brekke et al., 2001). Despite deinstitutionalisation, which could possibly lead to destigmatisation, public opinion about psychiatric patients is still negative (van 't Veer e.a., 2005), for instance concerning societal burden and agressiveness of psychiatric patients. Despite the fact that psychiatric patients are more frequently victim by what happens to them in society. A group which is especially vulnerable is the group of psychiatric patients with both a substance dependence and co-morbid psychiatric problems (van Weeghel et al., NWO-VCVGZ 2009; Kikkert et al., 2011; van 't Veer, 2005).

In the Netherlands, on a national level, about 5% of the population becomes a victim of violence every year. In a recent publication it turns out that victims have emotional problems related to the crime, specifically if the victims are from vulnerable groups within society (Lamet & Wittebrood, 2009). Patients with both substance-related and comorbid psychiatric disorders (Double Diagnosis-Addiction and Psychiatry: DD-AP), are a high risk group in this respect. Recent survey research by Kikkert and Dekker (2011) shows that DD-AP patients from Amsterdam become a victim about 10 times more often compared to the general population from Amsterdam (violence, money-related, and vandalism delicts). Especially within the category of violence victimisation, the DD-AP group becomes a victim more often: 8 times more often in case of sexual assaults, 4.5 times more often as victim of threat, and 13 times more often as a victim of physical injury. Also compared to the local population in Amsterdam – where chances of victimisation are higher than in the Netherlands in general – chances of victimisation are enhanced in the DD-AP group (e.g. 10-fold higher chance of victimisation through physical injury). From this review, it can be concluded that DD-AP patients become the victim of more serious victimisation by violent victimisation and serious money-related crimes. 53% of the DD-AP patients was victimised at least once in the last year.

Methods

Given the higher chances for victimisation in larger cities, and the denseness of treatment for psychiatric patients with addiction problems in urbanized areas, it is very relevant to harness DD-AP patients against this higher chance for victimisation. For DD-AP patients, no evidence-based interventions are available to diminish the chance for victimisation, and interventions like "street-skills" training have only been implemented "practice-based" (van Weeghel e a., 2009). Given this, we developed an intervention to reduce vulnerability for victimisation and to diminish the consequences of victimisation in DD-AP patients.

Risk factors for victimisation

Severity of psychiatric symptoms, substance use, and being a victim or perpetrator of victimisation early on are all important risk factors for victimisation (van Weeghel et al., 2009, Khalifeh, 2010, Stevens 2012). Other risk factors are ethnicity, quality of social relations, and interpersonal problems. Especially these risk factors frequently co-occur in DD-AP patients (Topp, 2012).

Objectives of the project

Objective of this research is gaining knowledge on effectiveness of a training aimed at diminishing victimisation in DD-AP patients.
The intervention that will be evaluated comprises several parts, based on knowledge on interventions to diminish victimisation in other populations:
- Targeted information to patients on what they can do to prevent victimisation, to diminish or avoid risk situations, and to learn behavioral strategies on what to do in risky situations risks (Perese, 2008).
- Learning skills to improve personal safety, such as conflict skills, enhancing coping strategies that diminish tension during stressful situations. Improved coping skills are also related to diminished alcohol use (Monti et al., 1994).
- Methods of the intervention will be:
- Educational training, based on Perese (2007), using brain storming, group discussion, resulting in active information processing of effective preventive efforts that are within control of the participants
- Social skills and attitude training (consciousnes of own attitude, bodily posture, eye contact, effect on others), coping strategies and emotion regulation
- Assertiveness in coping with external threat, learning to understand one's own and others' anger, learning problem solving skills

Objectives of the workshop

In this workshop, the proposed research project will be summarized shortly, the intervention that has been developed "Streetwise, Self-wise, Other-wise" will be presented, and active discussion with the audience will be held, to discuss the contents and form of this training intervention for SUPD patients. Afterwards, parts of the intervention will be performed in small groups by the workshop participants, and as a third part of the workshop, experiences with these parts of the training is discussed plenary.

Educational goals:

Gaining knowledge about victimisation in the comorbid substance use disordered, psychiatric population (SUPD), and the knowledge base on potential mechanisms of action to diminish the chance for victimisation
Learning and experiencing the way in which street skills and social skills can be improved as part of the intervention, by practicing parts of the proposed intervention.

Acknowledgements

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Anger Treatment: Case Formulation and the Stress Inoculation Approach

Workshop

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Abstract

Anger dysregulation is a transdiagnostic problem. It occurs in various personality, impulse control, and in a variety of mental health conditions resulting from trauma. Anger treatment should be grounded in assessment of anger control deficits and be case formulated.

CBT anger treatment based on the "stress inoculation" approach will be presented. Techniques including cognitive restructuring and arousal reduction in conjunction with provocation scenarios will be illustrated. Obtaining leverage for change through a "preparatory phase", which is crucial in work with offender populations, will be covered, including application to clients with intellectual disabilities.

Achieving therapeutic change by addressing symbolic structures associated with anger and aggression will be discussed. The interface of this individual-based approach with a group-based treatment will be illustrated.

Educational Goals

4. Understanding of case formulation from anger assessment and anger dysregulation model.
5. Awareness of arousal reduction techniques, including breathing, muscle relaxation, and imagery.
6. Skills in cognitive restructuring for anger experiences, with attention to key symbolic structures.
7. Practice use of provocation hierarchy procedures in stress inoculation format

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Chapter 7 – Application of new technology

Ambient healing environment design for an acute psychiatric ward

Paper

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Keywords: Healing environment, ambient experience, acute psychiatric ward, seclusion, support room, interactive wall, early-intervention

Abstract

In this paper a people-centred design and creation process is described for a healing environment for acute psychiatric wards. In the realized healing environment several ambient aspects can be controlled by the client via an interactive wall, to empower the client in the healing process. The combination of the ambient aspects with various carefully designed physical aspects aims to create a healing environment that improve the recovery process of clients, improve staff morale, and eventually reduce the number of seclusions. The work described in this paper is a joint effort between Philips Research and the GGzE mental health institute in the Netherlands and is realized in a new build acute psychiatric ward of the GGzE. Currently, a validation study is being executed to gain insights in the number of seclusions and satisfaction of clients and team members with the newly designed rooms.

Introduction

Healing Environments

Healthcare delivery systems in general become increasingly patient-centred instead of disease- centred (Davidson et al., 2005) and focuses to become healing environments (Bazuin & Cardon, 2011; Dijkstra, Pieterse, & Pruyn, 2006; Ulrich, 1995). For caregivers, these are supportive environments that improve staff performance and morale (Lusk & Lash, 2005). For patients, a healing environment is designed to promote the recovery processes or to help to adapt quicker the specific chronic conditions. Environmental features might also support recovery, minimize coercion, violence, and aggression.

Three physical aspects can be defined in the design of healing environments (e.g., Harres et al., 2002; Karlin & Zeiss, 2006). Firstly, architectural features specify the permanent building features such as room size, spatial layout, and nursing stations (Gross et al., 1998; Karlin & Zeiss, 2006; Shattell et al., 2008; Stolker, et al 2006, Thomas et al 2002). Secondly, the interior design features that are less permanent, like art, plants, or furniture. Thirdly, ambient aspects include noise levels, lighting, and odours (Boyce, 2003; Ulrich, 2008).

In healing environments for acute psychiatric wards the room design also has to be taken into account, because clients in different stages of escalation have different needs in terms of room design (Kuijpers, 2009). Comfort rooms, relaxed low-stimuli rooms on the ward, can be designed to calm clients down when there is a fear of losing control (e.g., McDaniel, 2009). When a client is losing control a higher secure environment such as support rooms are suggested (Champagne, 2008; Kuijpers 2009). Support rooms can be used as an early intervention to prevent escalation or as a transition between the group and the seclusion room. These client rooms give the staff additional options to personalize treatment, and are expected to improve the safety in the ward because they are more personal and humane compared to seclusion rooms

(Shattell et al., 2008; van der Schaaf et al. 2013). When a client is acting out, seclusion rooms are used in the Netherlands.

Up to now, in-client mental health institutes have been conservative in using interior and ambient aspects in the design of their ward. To contrast with somatic healthcare design, for example, in PET CT uptake and MRI rooms, physical and ambient solutions such as an interaction between nature videos, music, and dynamic lighting are implemented increasingly because it reduces client anxiety and fear (Philips, 2013). Next, we will describe the design process of healing environments in a new acute psychiatric ward of the GGzE mental health institute in the Netherlands that also incorporates ambient aspects.
Creating ambient healing environments in an acute psychiatric ward

Needs assessment
A people-centred design approach was used to gain insights in the current practices and needs during a seclusion intervention. To start with, workshops were conducted in which workflows and accompanying feelings were collected in two sessions; one with the staff and one with peer-support-workers. Both groups were involved in each iteration of the design process, as active participation of the user has shown to increase the acceptance and engagement in new wards (Gross, 1998). In the analyses of the workshops special attention was paid to correlations or mismatches of the feelings of both groups.

From the analysis of the workshops a list of needs was derived and these were clustered into the following categories; the need for contact, safety, stay in here and now, information, keep own identity, choices, supporting health, and personalization. Several studies confirm that these needs impact safety and perception of the ward and they thereby replicate existing work (Duxbury & Whittington, 2005; Middleboe et al., 2001; Nijman et al., 199; Shattell et al., 2008; van der Schaaf et al. 2013). Next, we will describe how these different needs were implemented to create a healing environment for acute psychiatric clients.

Architectural aspects: Support rooms and seclusion rooms are realized in a high care part of the new crisis unit at the GGzE mental health institute to support the most vulnerable clients. Figure 1 shows a support room in this ward. The support and seclusion rooms are equipped with round corners to make the room appear larger and to prevent shadows appear in the corners (Philips, 2013). The floor in the rooms is divided into two coloured zones. One public zone, where the caregiver enters the room, and one private zone at the bedside of the client. The division gives the client a sense of privacy since it prevents the caregivers to immediately enter the private space of the client when entering the room. Speakers were placed symmetrically in the ceiling, as we learned from the workflow analysis that asymmetric room aspects could evoke negative thoughts (especially for some autistic clients). In one of the corners of the room an interactive wall was installed. The interactive wall consists of a touch screen behind safety glass on which different applications can be installed. These applications empower clients to remain to have a feeling of control in the restricted environment of seclusion and other high safety rooms. And aim to reduce traumatic experiences in seclusion rooms, to help de-escalate clients, and improve interaction between client and staff.

Figure 1. The support room (left) and a close up of the interactive wall (right) in the support room. The support room is a high care client rooms equipped with ambient experience, dynamic lighting, and an interactive wall.

Interior aspects: The seclusion rooms are solely equipped with a bed, and are smaller than support rooms. Support rooms are made more comfortable and are additionally equipped with a table with chairs (which are in the public space) a closet and a beanbag.

Ambient aspect: Via the interactive wall several ambient features can be chosen by the client. The ambient features are based on the ambient experience concept of Philips and adjusted to fit high secure environments of acute psychiatric wards (Philips 2013). This audio visual intervention combines dynamic lighting with videos of nature settings (i.e., ambient experience themes) and provides a holistic room design. One of the ambient themes contains a slide show of Eindhoven, the city where most clients come from. This ambient theme was designed to give the clients a feeling with here and now. In addition to these ambient experience themes, the other needs that were extracted from the workflow analysis were translated into applications on the interactive wall, see Table 1. The client can use these applications whenever he likes to.

Table 1. The needs and the accompanying applications implemented on the interactive wall. The interactive wall gives the client choices and a feeling of control.

Need	Feeling	Application
Safety and information	Reducing anxiety	Showing time and day program
Social attention and contact	Reduce feeling of being abandoned	Video call with staff or relatives, share drawing
Stimuli and entertainment that provide distraction	Reduce boredom	Puzzles, games, radio
Being in control, stay in here and now and, personalization	Reduce feeling of powerlessness	Select photos, video themes, radio, dynamic (colored) light settings

Coloured LED cove lighting is built into the ceiling of the rooms, projecting indirect light on the walls. Indirect lighting produces fewer shadows on the wall which can benefit clients who are anxious or suspicious (Philips, 2013). In one corner of the room the lighting can be dimmed, which can create a zone from where the client overlooks the room and feels safe in the back (i.e., prospect-refuge theory, Appleton, 1975). Lighting can also be used to promote the day-night rhythm (e.g., Benedetti, et al., 2013; McCloughan et al., 1999; van der Walle, et al., 2009). The client can personalise and control the room by adapting the intensity and colour of the lighting in the room, making use of the interactive wall.

Staff control screen: To optimize the acceptance of the interactive wall not only the clients but also the caregivers need to have a feeling of control over the system. Therefore, a control system for the caregivers was designed, for details see Speelpenning et al. (2013). This system enables caregivers to include the guidance plan, en- disable applications, and specify settings that are available in the client room. In such a way caregivers are able to individualize the treatment to each client separately.

Intake room: To create a whole ward design, the intake room and corridors are also equipped with ambient features. Via a touch screen in the intake room, the client can chose an ambient theme that will be active in the intake room as well as in room where the client will be staying. By choosing a theme upon arrival the client can get a feeling of being in control and feel welcome from the first contact moment. In the corridor, coloured dynamic cove lighting is present. This lighting can be used to guide the client from the intake room to the client room preventing the staff to touch the client, or walk in front of the client to direct the way. This guidance is expected to reducing client anxiety and increasing staff safety.

Validation study

An extensive validation study is started to investigate the influence of the interventions on the number of admissions and the duration of stay in the seclusion and support rooms. The client and staff experience will also be evaluated. The first results will be expected autumn 2013.

Summary

The GGzE and Philips co-created a healing environment for seclusion and support rooms in a high secure psychiatric ward. A people-centred design approach was used to create rooms that fulfil the needs of both the clients and the staff. An interactive wall is the main asset in the rooms and empowers the clients to get control over several aspects in the room aiming to promote recovery. An evaluation of the rooms is currently running.

Acknowledgements

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Creating a User Interface for staff to control ambient healing environments in acute psychiatric wards

Paper

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Keywords: User interface design, mental healthcare, ambient healing environments, staff control, contextual research.

Abstract

A new concept aiming to reduce seclusion of clients in mental healthcare is presented in this article. The concept, which has been installed as a prototype at the GGzE institute in Eindhoven includes dynamic lighting and a large interactive touchscreen. The concept is designed from a user perspective with the aim of reducing stress and anxiety for both staff and client. An important aspect is the large interactive screen with adaptable functionality that can be matched to specific needs of the client at different stages of escalation and recovery. Coupled to this is a control system that empowers the staff to control the therapeutic environment and set the sensory stimuli to an optimum level for the mental state of the client. This publication focuses on the design considerations and implementation of the staff screen. The concept illustrates the possibility of using technology to reduce seclusions in mental healthcare.

Introduction

A frequent trigger for psychosis in mental healthcare (MH) is the lack of feeling of control over emotions and actions [1]. It is therefore ironic that the standard treatment for psychosis is that clients are isolated in a solitary room where all control is removed. Seclusion naturally leads to frustration, stress, fear and hostility [2-4]. The concept of a healing environment is that the physical environment and the control over it are actively used to encourage the patients' well-being [5] and increase the motivation and safety of the staff [6]. The three dimensions of a (healthcare) environment are; ambient features (sunlight, sound and odor), architecture (window, spatial layout) and interior design (furniture) [5].

Until now, very limited research has been undertaken to explore how technological innovation can contribute to a healing environment in mental healthcare. Since multimedia is popular in the modern society as it stimulates people and gives them a sense of control over their life, it is a logical step to use the same multimedia principles to create an adaptable environment that supports the recovery of clients. Such a therapeutic environment should empower both the client and staff to take control over the situation, allow influencing the (healing) environment, and support the staff and client in open communication.

The concept of giving control over the MH-environment has been embodied in a research prototype which has been installed at the GGzE institute in Eindhoven. The system consists of dynamic lighting, sound and projection, floor zoning and a large interactive touchscreen (see Figure 1). Coupled to this screen is a staff-control system (see Figure 2) that can be used to match the aspects of the interactive touch screen to the specific needs of the client at the different stages of escalation and recovery. It is speculated by many mental health caregivers that the optimum level of audiovisual sensory stimuli for a MH-environment depends on the mental state of the client. The difficulty of a psychiatric ward is that it typically hosts mentally ill clients who might not always know the best stimuli level for their recovery. To obtain the right level of stimuli the staff consults the client and/or intervenes when the client himself is not aware of the optimum stimulus level for recovery.

Figure 1 Interactive screen in client room

Figure 2a + 2b Staff UI installed in control room
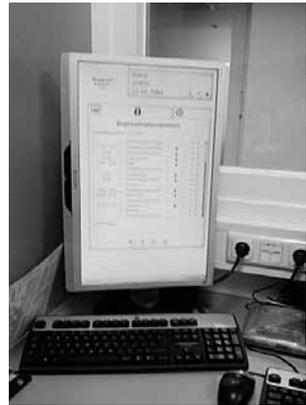
The focus of this publication is the design considerations and the implementation of the staff-control system which is part of the total concept. The staff-control system has been developed via contextual research where the needs of the staff were evaluated in an iterative process and used to improve the next demonstrator.

Needs and issues of target group

Seclusion rooms are used for individuals who become a danger to themselves or others during periods of extreme emotional instability. Seclusion of clients should be seen as an absolute last resort, that traditionally provides a low stimulus level environment with a high level of safety, quietness and structure [3, 7]. Seclusion is a controversial intervention which can be traumatizing for both client and staff [4], therefore it is vital to consider both the clients and staff needs when considering alternatives for seclusion.

Sense of control
Traditional seclusion rooms have a minimalistic design with clients being excessively dependent on the staff e.g., the staff controls the lighting conditions, the radio, access to all daily needs such as food, drinks and personal hygiene. This dependency often leads to a lack of trust towards the staff, a feeling of privacy violation and an increase in the feeling of stress. A sense of control over what is happening is a very important aspect for clients. Situations that are perceived as uncontrollable can be very stressful and can therefore have a negative effect on wellness [8, 9]. The loss of control may influence both the mental and physical health of the individual [10, 11]. Research shows that cancer patients with greater perception of control have been shown to be less depressed [12]. To improve outcomes it is important to reduce or eliminate environmental stressors, provide positive distractions, enable social support and

give a sense of control to the individual [13]. The newly designed interactive screen allows the client to control various room parameters (e.g., brightness of light, volume), and can run different applications (e.g., a photo wall application, drawing module, and communicator). The majority of the functionality can be accessible by the client at all psychosis levels. The staff-control system allows the staff to enable the different functionalities. By empowering clients with some control over their situation this may contribute to improving the speed of de-escalation [14].

Contact
Interaction between staff and client is vital in promoting recovery and has to be built on mutual trust. The contact moments are crucial in establishing this relationship but as van der Werf (2003) indicates, separation rooms may even have a negative impact on this relationship [2]. This contributes to communication issues and promoting aggression and frustration of the client [15]. To establish mutual trust it is important to provide clarity and structure in the contact. The client often has a high need for information to understand the structure of the daily rhythm and regulations (e.g. time of day and when contact moments take place). Furthermore, in psychiatric hospitals there is often significant pressure and stress for staff [16]. To optimize their workflow, there is a need for a clear and structured information provision. For the staff it is important to know who is in which room, what the agreements are and when the best moment is trying to establish contact with the client. The newly designed interactive screen supports the communication by opening a communication channel between the staff and client that makes use of e.g. a communicator and a tailored guidance plan application.

Contextual research to design a staff user interface

An important aspect of the interactive screen is the staff-control system and it's User Interface (UI). The staff-control system was integrated into a new workflow where technology has until now been absent. The system needs to be used by staff in a high stress environment and therefore should be self-explanatory. To create acceptance, the staff was actively involved in the development of the staff-control system which was developed via contextual research. In an iterative process the needs of the staff were evaluated, focusing on functionality and interaction design. Three sessions were performed. The first focused on the needs of a staff-control system. From these needs, features were created and implemented in a first specification. In the second and the third iteration the functionalities were tested making use of user scenarios, co-participation and usability tests.

Results

The results of the contextual research were integrated into a functional research prototype of the staff-control system. The functionalities were distributed over three tab menu' (i.e. a guidance plan menu, an application control menu to turn on/off applications, and a settings menu to control volume, brightness, level, day/night modus, clock module and language). The homepage gives an overview of occupancy of the rooms and provides the possibility to start a video conference with the client. The staff UI can be controlled from any PC (e.g. in the control room) or tablet in the psychiatric ward.

Sense of control
The staff-control system allows the staff to adapt the settings and availability of the functionality in the high care rooms. Depending on the level of psychosis, the staff can enable various applications on the interactive screen which are specifically developed to support the recovery process.

While the sense of control is a primary need for the clients, it is also an important aspect for the work environment of the staff. It is stressful for the staff to be unable to treat clients with extreme emotions in a humane manner. Providing alternative ways to help them could therefore also reduce staff anxiety. To comply with the high safety levels in high secure wards it is important for the staff to select the available functionality and in some extreme cases restrict the available applications for a client. If the amount of stimuli is not appropriate for the level of psychosis, the staff can disable this functionality. The staff allows the client to set his own environmental settings, but when the level of stimuli exceeds, the staff is able to overrule the settings with the staff-control system, see Figure 3.

Figure 3 Room specific menu of staff-control system; on top the client info, and three tabs: the guidance plan (left), the application control (middle) and settings (right)

From the contextual research we have learned the importance of the staff-client interaction. Decisions of the staff should be clearly communicated, e.g. if the staff disables a function, this icon is than 'crossed out' rather than that this function disappears. The latter would make the client more suspicious which can harm the already vulnerable relation between them. The staff-control system allows the staff to tailor the settings (e.g. brightness and volume) of the room to the psychosis level and needs of client. In addition, the clock mode, language of the rights and guidelines and timeslot of the night mode can be adjusted. During the night, the interactive screen in the high care room switches to the night mode, lowering the brightness of the screen during the night.

Figure 4 Volume enabled (left), disabled by staff (right)

Communications
To meet the staff's need of having an overview of occupancy of the high care rooms, the homepage of the staff-control system provides this overview. This displays relevant information; name, username and date of clients' birth. The information is coupled to the interactive screen in the high care rooms and can be easily adjusted. The overview aims to improve staff-staff communication.

To provide a basic structure for the client, the staff can enter a guidance plan. The guidance plan includes the time and detailed description of activity, number of staff members, and additional notes. A default guidance plan can be used to ease the insertion of a plan. The plan appears in the high care room directly after it is shared. This digital guidance plan replaces the paper based version and can be safely used even in the most extreme levels of psychosis. To make the guidance plan easy to understand, it makes use of standard icons, see Figure 5.

Figure 5 Icons used in guidance plan

To enhance the staff-client interaction and communication between both, video-conference functionality is available. Visual contact with the caregiver can enhance trust for the client. Video-conference allows more flexibility and can even be used in extreme situation in which it is considered not to be safe for the staff to meet the client in person. It is anticipated that both the enhanced communication and empowering of the client with the control of the room may help lower the number of incidents and enhance de-escalation in such support rooms.

Conclusion

The learning's from the user experience tests were used to develop a system to support the de-escalation of clients. The staff UI which is a crucial element of the overall prototype running at the GGzE institute in Eindhoven, as it enables the staff to adjust several aspects of the high care rooms to optimally adjust the rooms to the needs of each individual. The client has a high need for control, but at the same time the staff should also be able to intervene; the staff-control system allows the staff to control functionalities displayed on the screen on the high care room. The concept allows having an open discussion about which of the applications (photo wall, drawing module, communicator, etc.) is accessible to the client at the current psychosis level. This gives clarity about the restrictions and opens the communication between staff and client. It is speculated that the presented concept gives the client the feeling of being in control which may lower the number of incidents and enhancing the de-escalation process. Therefore, the staff-control system does not only add technology it is also designed to improve the workflow of the staff.

In this iterative process we have seen that the co-creation with a high involvement of the staff is very effective. To develop a successful concept, the collaboration from experts from the field in an early phase is crucial. In April 2013 an evaluation study was started that includes the investigation to the experience of both clients and staff with the new prototype. Results are expected at the end this year. If the staff-control system meets expectations, it will strongly benefit by an improved staff-client interaction and experience for both parties.

Acknowledgments

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The feasibility of implementing Internet-based interventions for psychosis, violence risk assessment, and anger management within mental health services

Paper

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Background

Computer-aided psychotherapy is a promising way to increase accessibility to evidence-based treatment of many mental disorders. Systematic reviews of these interventions find a growing evidence for their effectiveness, efficacy, and cost-effectiveness. Most studies are randomized controlled trials (RCT) and discuss screening and the dissemination of computer-aided psychotherapy programs within health services. Internet-based interventions seams to be best suited to treat problems that are more psychological in nature, and most studies have focused on problems related to e.g. panic, anxiety, and depression.

There is even some evidence regarding patients suffering from psychosis and schizophrenia. Online delivery of psychoeducation and psychotherapeutic treatment has considerable potential to improve a patient's well being. The use of Internet offers several advantages over standard clinic-based delivery models, as well as disadvantages for patients, staff and therapists. Research suggests the acceptability and effectiveness of such interventions in psychosis, effective for both patients and for their supporters. Further, persons with schizophrenia had a large and significant reduction in positive symptoms and a large and significant increase in knowledge of schizophrenia and prognosis, compared with their counterparts in the usual care condition.

Such findings suggest that Internet-based interventions has the potential to revolutionise psychosis treatment and early intervention through increasing the accessibility of evidence-based interventions, reducing the stigma, stress and anxiety associated with face-to-face care, and providing around-the-clock peer and professional support to patients and their families. This approach could even be a tool in relapse prevention.

Internet-based technologies have the potential to transform psychosis treatment by enhancing the accessibility of evidence-based interventions, fostering engagement with mental health services, and maintaining treatment benefits over the long term.
Would it be feasible to use these new media to deliver quality services for users and caretakers, in the field of violence risk assessment, psychosis treatment, and anger management?

Aim

This presentation reviews the current evidence on technology- and Internet-based interventions in general, and for schizophrenia / psychosis in particular, including potential benefits, risks, and future challenges. Further, some thoughts about the future trends in technology, opening up for a totally new way to plan for new interventions. Finally, recommendations are proposed for developing Internet-based interventions for psychosis (prevention, screening, treatment, and relapse prevention), violence risk assessment, violent and anger management. An outline for a feasibility study will be presented, based on how we can learn from other areas of Internet-based interventions.

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Chapter 8 – Ethical and legal perspectives

"Zero Tolerance" of violence in mental health care: practice guidance in Scotland

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Introduction

The Mental Welfare Commission for Scotland is a statutory body with several duties under mental health and incapacity law. Our overall aim is to ensure that care, treatment and support are lawful, respect the rights and promote the welfare of individuals with mental illness, learning disability and related conditions. Among our functions are the duties to give advice and promote best practice.

We heard of several situations where criminal justice agencies have been involved following violence by people receiving care and treatment for mental illness or learning disability. Some services described this as a "zero tolerance" policy. But there were problems. Some practitioners, patients and carers thought that the involvement of police was inappropriate. Sometimes, practitioners were dissatisfied with the actions of criminal justice agencies. There were some occasions when staff or patients thought that police should have been involved but were not.

Violence is unacceptable, but when it relates to mental ill-health within a care setting, the issues are complex. When applied to mental health and learning disability settings, the term "zero tolerance" carries a risk of misinterpretation of care providers' responsibilities(1). We thought that more guidance was needed. Mental health staff and criminal justice agencies may also have difficulty deciding how best to proceed following such incidents.

We did not intend the guidance to address violence fuelled primarily by alcohol or drugs or violence in public places. Also, we made it clear that the guidance did not cover allegations of assault by staff. Service users have every right to complain to hospital managers and/or the police.

In the context of this guidance, "zero tolerance" refers to policies of service providers regarding violence towards staff (and also to other service users). Violence has a broader definition than physical assault and is defined as "incidents where persons are abused, threatened or assaulted in circumstances related to their work involving an explicit or implicit challenge to their safety, wellbeing or health." We adopt the same definition in relation to behaviour toward other service users in a health or social care setting. It is particularly important that other service users feel safe. Our guidance also includes reminders on how to prevent violence (2).

Context and legislation

The concept of "zero tolerance"
The phrase "zero tolerance" appears to have emerged in the USA in the early 1970s as a form of policing that allows no crime or anti-social behaviour to be overlooked. It has developed many other uses since then. In 1999, the UK Government launched a campaign against violence toward healthcare staff. This encouraged staff to report all violent incidents in order that healthcare workers were given the full protection of the law.

Health and safety law applies to risks from workplace violence just as it does to other risks arising from work. Employers must ensure that they are familiar with health and safety legislation. Briefly, the relevant pieces of legislation covering Scotland are the Health and Safety at Work Act (1974), Management of Health and Safety at Work Regulations (1999) and Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) (2012).

It is beyond the scope of this guidance to give an exhaustive list of possible offences for which a person may be charged. However, acts which could result in charges being brought include threatening behaviour, damage to property and actual assaults.

Role of criminal justice
Tackling crime and the causes of crime are key priorities for the police. Ethical recording of crime is integral to modern policing and it is vitally important that crime recording and disposal practices are capable of withstanding rigorous scrutiny. Policing is much more than arrest and possible prosecution. Community safety is important and this extends to care settings. The police will assess the situation. In Scotland, they are required by law to report the matter to the Procurator Fiscal if they consider that a crime has been committed.

If the police report an incident to the Procurator Fiscal (PF), this may result in a decision to prosecute. The PF has considerable discretion and will consider whether prosecution is in the public interest. If there is sufficient evidence to prosecute, other factors are taken into account, including:
- Seriousness of the offence;
- Length of time since the offence took place;
- Interests of the victim and other witnesses;
- Age of the offender, any previous convictions and other relevant factors;
- Local community interests or general public concern;
- Any other factors at his/her discretion, according to the facts and circumstances of the case.

The majority of cases reported to the PF do not result in prosecution. The victim can request an explanation if there is a decision not to prosecute.

Role of the Health and Safety Executive (HSE)
HSE is the regulator for health and safety in the workplace in Great Britain. HSE inspectors enforce health and safety law in healthcare establishments, such as hospitals, clinics, etc. They visit premises to investigate accidents, ill health or complaints. They may also carry out inspections and may offer advice or guidance. If there is a serious risk to health and safety, the inspector may take enforcement action, such as serving an Improvement Notice, which allows time for the recipient to comply, or a Prohibition Notice, which prohibits an activity until remedial action has been taken. In the most serious cases, HSE inspectors can report offences to the Crown Office and Procurator Fiscal Service, who will decide whether or not to prosecute. The HSE has guidance on workplace violence (3).

The consultation process

We asked a variety of stakeholder organisations and concerned individuals to send accounts of their experiences of responses (or lack of them) to violence by people receiving care and treatment for mental health problems or learning disability. Following this, we held a national consultation event to examine these cases. We asked participants to examine the cases and come to a view on the appropriateness of police involvement.

We looked into the factors that staff took into account when deciding what action to take following a violent incident. In particular, we wanted to know how staff made decisions on whether or not to involve the police. These were:

1. The severity of the incident.
2. The views of the victim.
3. The events leading up to the incident.
4. The perception of the person's mental state and motivation for the incident. (This relies on judgements and assumptions that may or may not be correct.)
5. The person's views and capacity to learn from the incident.
6. The views of others who know the person well.
7. The person's legal status.
8. The risk of recurrence.
9. The impact on other service users.

Regardless of whether the police are involved, it is essential to record all violent incidents. This is important for future risk management, including justification of grounds for compulsory treatment. There may also be a need to report any injury to the health and safety enforcing authority.

If police are called, they must legally investigate regardless of the views of the complainant. This does not necessarily mean that the perpetrator will face criminal charges. Action may be immediately necessary to manage an ongoing incident and de-escalate the situation. It reinforces the seriousness of the event for the perpetrator and the victim. The independence of the police may be helpful when investigating the incident and assisting with future risk management. The police may need to detain and/or interview the perpetrator. There are potential adverse effects of police involvement. It may increase anxiety and cause stress to vulnerable victims and witnesses. It may damage therapeutic relationships and trust. It may raise unrealistic expectations that there will be action taken under criminal procedures. Using police involvement as "punishment" may not address the cause or have any therapeutic benefit. Charges and a possible criminal record could have serious consequences and result in unfair discrimination at a later date. It may also interrupt present and future care and treatment.

It is very important that services keep records of violent incidents. Managers should review serious incidents. They should also look for patterns of reports of less serious incidents. A session for staff to discuss what led up to the incident and how it was managed. Staff and other service users can be badly affected by a serious incident and may need group or individual support.

Conclusions: Policy guidance

The essential outcomes from all incidents of violence in mental health and learning disability care settings are ensuring the safety of all persons and ensuring that the needs of the person for care and treatment (and the needs of any others affected by the incident, including staff) continue to be met in a safe and appropriate care setting.

Employers should have arrangements in place to control, as far as is reasonably practicable, the risks of injury to employees, service users and others from work-related violence. Organisations should have clear and consistent policies on dealing with violence. These should give general guidance to staff on situations where police involvement is indicated. Each incident needs to be treated on its merits. Managers should avoid rigid policies, especially if this creates a culture that is seen by service users and carers as "punishment". Policies must be clear, easily understood and readily available so that everyone understands the reasons for any action taken following a violent incident.

Having taken the views of stakeholders into account, our advice on the development of policies in response to violent incidents is:
- The first and overriding concern is immediate action to make sure that the incident is brought to a close and everyone who is safe and supported.
- There must be an urgent reassessment of risk and implementation of a management plan to address and control, as far as is reasonably practicable, the risks identified. This must ensure that the person and any other service user involved continue to receive safe and effective care and treatment.
- The victim of any assault has the absolute right to report the matter to the police.
- If the victim does not report the matter, the benefits and potential risks of involving the police need to be considered on an individual basis. Involvement of the police must be based mainly on the severity of the incident (or likely severity had there not been effective intervention) and the risk of recurrence.
- Staff should take care when making judgements about involving the police following relatively minor incidents on the basis of their view of the person's capacity and motivation. In particular, we advise against involvement of police solely as a means of punishment of behaviour that staff deem unacceptable.
- While taking note of the above point, staff should give police their views on the person's capacity in relation to the incident. This will help the police form a view on the likelihood of criminal intent.
- In any case where an individual is removed to police custody following an episode of violence, there must be procedures in place to ensure the provision of any necessary continuing mental health care and treatment, including necessary medication.
- Police involvement may lead to criminal charges. An appropriate adult should be present when any person who is known or suspected to have a mental disorder is interviewed by the police.
- Even if charges are not contemplated, the police can be helpful in contributing to the overall risk management of the individual and the environment.
- There must be a blame-free culture of learning from incidents and supporting staff and others involved. Involvement of specialists in behaviour management and/or forensic mental health should be

considered if the risk of recurrence is high, regardless of whether or not the person has been charged or convicted of an offence.
- Communication, communication, communication. Staff must explain their actions to the person, the victim and witnesses. Where appropriate, they should also give an explanation to the person's carers and listen to their views. Appropriate information or alerts on ongoing risk should be available but must be reviewed to ensure they are still relevant.
- The local authority has responsibility for protection of adults at risk in terms of the Adult Support and Protection (Scotland) Act 2007. Policies should be agreed with the local Adult Protection Committee (APC).
- There should be liaison between staff and police (especially community or adult protection coordinators) over specific incidents and general risk management.
- Prevention is better than cure. Managers should pay attention to published evidence on good care environments and practices that reduce the risk of violent incidents.

On the basis of these conclusions, the Mental Welfare Commission for Scotland produced the guidance document Zero tolerance; measured response in 2012 (4). Everyone agreed that there should be "zero tolerance" of lack of action to keep staff, patients and others safe.

Acknowledgements

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Overvaluing autonomy

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Abstract

There is a dynamic relationship between the concept of mental illness, the care of the mentally ill and the law. Legislation is a societal consideration to the way it views and cares for people with mental disorder. Current capacity based legislation and practice overvalues autonomy to the detriment of other ethical principles. A balanced ethical approach would consider the patients' right to treatment, their relationships and interactions with society and not solely the patients' right to liberty and autonomous decision making. We ask to take into account ethical principals such as beneficience, non-maleficience and justice as equally valid ethical concepts, rather than the current overreliance, especially in the developed world, on the principle of autonomy. This can help prevent undesirable outcomes by assessing a patient's situation holistically, including the consequences of decisions for relevant relationships.

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Violence as Event: What does it mean and for whom? A review of the anthropological literature

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Introduction

As clinicians, how do we conceptualise violence? Generally, we see it as a symptom or risk factor, or both. In short, it is a problem. For example, the Oxford Handbook of Psychiatry lists types of aggression: instrumental/predatory and expressive/defensive, explains them in terms of universalising theories, e.g. evolutionary or Freudian, and then describes therapeutic approaches to it.[1] The anthropological position is somewhat different to the biomedical or even the biopsychosocial models, both generally and with regards to violence specifically. The key research method in anthropology is ethnography, a qualitative approach in which the researcher conducts participant observation. This involves spending significant amounts of time with informants, often living amongst them, doing what they do, and learning to live life as one of them, typically for months or years. As Alex Cohen describes it in one of the papers to be discussed,

> We served as companions, confidants, and biographers. My colleagues and I shared meals, drank coffee, and hung out with informants; played cards and chess with them; listened with interest and made notes about or recorded our conversations both lengthy and brief. We visited informants in their apartments or hotel rooms during periods when they were off the streets. We took them out to eat at local restaurants. In short, we took an active part in their lives.[2]

For Cohen, this led to "rich, detailed understandings of their lives", including hearing the voices of people who might have been excluded when using other methods of research. One of the pioneers of participant-observation, Bronislaw Malinowski, described its value in discovering the "imponderabilia of actual life".[3] From this, anthropologists are able to interpret the "webs of significance" that make up local cultures, and thus tell stories from the particular perspective of the informants themselves, considering what their behaviours mean for them.[4] This leads to a different interpretation of violence which may be educative for us as clinicians.

In this essay, I will explore some of the anthropological literature on violence in the mentally unwell, in the hope of extracting some lessons for clinical practice. It will not be exhaustive of all the available ethnographic studies, but will draw a common thread between several interesting and significant works, concentrating less on self-harm and more on violence against others.

Review

All of the studies situate the behaviours of their subjects in their local environments, in many cases the same environments in which the anthropologists were living for the duration of the research. For the mentally unwell people studied, this environment is tough. They must tolerate poverty, joblessness, financial precarity, frequent homelessness, crime and drugs. In such environments, violence is frequently visible and takes on the appearance of normality. Philippe Bourgois's In Search of Respect: Selling Crack in El Barrio, records extreme physical and sexual violence so often that he haltingly warns of the risk of the anthropologist "falling prey to a pornography of violence" in writing up his/her findings.[5] Even when that violence does not directly involve the informant, its "traumatic nature and prominent public visibility contribute to a sense of an omnipresent threatening reality that extend[s] far beyond the statistical possibility of becoming a victim".[6] Within this "culture of terror",[6] violence becomes a part of daily life, impossible to ignore and socialising those who witness it. For them it becomes normal.

Bourgois describes the systems, structures and cultural norms that support and allow this situation - so different from that which most of us would describe as normal or even acceptable - as an example of structural oppression, arguing that they influence and dictate the behaviours of those unlucky enough to be born into these situations such that they are unable to move away from them. In another study, Rob Whitley describes very similar circumstances as "social defeat".[7] He discusses the idea put forward by Selten and

Cantor-Graae that social defeat is a risk factor for developing schizophrenia. In their formulation, social defeat is defined as "a subordinate position or 'an outsider status'".[7] They see many of the aspects of life mentioned above and in the ethnographies described as examples of social defeat: "homelessness, loneliness, unemployment", etc.[7]

The purpose of this essay is not to explain violence away, nor to make the claim that there is a deterministic quality to acts of violence when they do occur. The point is to fully illustrate the answer to the question of what it means when it does occur. Experiencing "social defeat" does not necessarily lead to schizophrenia, and being surrounded by violence does not necessarily lead one to act in a violent manner oneself.

Whitley describes the idea of social defeat but actually takes issue with it for in his study; his informants are far from defeated. They resist the pervading fear of crime and violence against them by organising, by making improvements to their homes, and more importantly for this essay, by being prepared to confront people. This preparation includes carrying objects that may be used in self-defence, such as umbrellas and canes. Of course, being prepared for violence means that informants are sometimes involved in acts of violence, but what is important for Whitley is that this violence is not accepted passively, but instead resisted. In the model of social defeat as aetiological factor for schizophrenia, this means resisting not just the direct consequences of physical violence (i.e. physical harm to oneself), but also its indirect consequences as envisaged by the medical model. It means resisting mental illness itself. As such, they are "active strategies of empowerment",[8] not only indicating, but in themselves also engendering "a sense of agency [and] confidence".[9]

Bourgois takes a similar line in describing violent behaviour as a strategy to circumvent the circumstances of structural oppression. In essence, it is a strategy of survival. Below, I quote an exchange between two of his main informants, crack dealers in El Barrio who are also addicts themselves, describing why it is necessary not only to engage in violence, but to be seen to do so:

> *Primo:* You could be a nice and sweet person in real life but you gotta have a little meanness in you and play street. Like, "Get the fuck outta my face." Or "I don't give a fuck." That way you don't let nobody fuck with you later...
> *Caesar:* You've got to be a little wild for this neighbourhood, Felipe. [Gunshots] What did I tell you? You can't be allowing people to push you around, and then people think that you're a punk and shit like that.[10]

Bourgois acknowledges that some of the acts of Primo and Caesar described in the text seem "irrationally violent" or "barbaric".[10] He writes of his own emotions in hearing their accounts of rape and bullying, his own profound dislike and disgust at Caesar in particular. In one episode, Bourgois writes of holding back tears as Caesar proudly recounts a beating he had perpetrated upon a child with cerebral palsy, having forgotten that Bourgois' own child had recently been diagnosed with the same disorder. However, he uses his own emotion not to judge Caesar and Primo, but to further his analysis by "reinterpret[ing their actions] according to the logic of the underground economy as judicious public relations and long-term investment in one's 'human capital development'".[10] In this way he is able to argue that structural oppression exists and shapes the lives of Primo and Caesar, but not that it determines their actions. They exhibit a contradictory agency which allows them to forge "strategies of resistance" like Whitley's informants, many of which are violent.

Bourgois and Whitley's arguments differ on the results of these strategies. For Whitley, the sense of empowerment gained in acts of social resistance contributes to recovery, particularly in the domains of existential and social recovery. For Bourgois, they fit into the cycle of structural oppression: "Caesar... embod[ies] the social injustice of a nation that systematically chews up its most vulnerable citizens and spits them out onto inner-city streets where their desperate celebration of suffering terrorizes themselves, their neighbours, and their loved ones".[11] He goes further in adding a psychological aspect to his argument; the inhabitants of El Barrio internalise an inner sense of worthlessness fostered by violence. This in turns leads to more violence, which further augments the sense of worthlessness, and so on.

While these two trajectories are different, they are not mutually exclusive. As Whitley notes, certain strategies of resistance can impact on other aspects of recovery as conceptualised by him, in particular, functional recovery. For example, carrying a knife may lend the carrier a sense of empowerment, of resisting "social defeat", but may also lead to arrest and prosecution which may then lead to unemployment, an aspect of "social defeat" in itself. The cyclical nature of structural oppression reveals again.

Alex Cohen discusses another typical aspect of life for the mentally unwell: boredom. Like the other studies mentioned so far, his is based in extreme circumstances. His research subjects are not just mentally

unwell, but also homeless, living precarious lives on Skid Row in Los Angeles, "a place where life was dominated by boredom and inactivity, only interrupted by brief periods of violence and terror".[12] Like Bourgois and Whitley, he notes unemployment, poverty and crime as aspects of normality for the people living on Skid Row. In his own life he finds meaning in his work and relationships, and is aware of how this is exhibited in the way he speaks and acts. He compares this to that which might be presented by the media in films and on television, how characters in soaps typically have jobs, families, projects, deadlines, etc.

He finds these tropes reappearing in the delusions of many of the people whom he interviews, who infuse their apparently repetitive lives with meaning by imagining themselves bound up with the lives of famous and important people such as Robert F. Kennedy and Mother Teresa. In this way, he argues, they replicate the "eventfulness" of the lives of people whom they see as normal.[13] More relevantly for this paper, this is not just demonstrated in their delusions, but in their actual behaviours, i.e. they seek to alleviate the boredom of a life without close personal, family or work ties by pursuing drugs and its associated acts, some of which may include violence. As he writes, "The individuals we knew had few other avenues by which they could satisfy their need for meaningful social interaction and excitement".[13] Again, violence is understood as a possible response to social defeat. This response is one which not just has meaning, but actually creates it by virtue of its "eventfulness", as interpreted by the perpetrator him/herself.

In a quantitative study, Mathias Angermeyer, a psychiatric sociologist, asks what this means not for the mentally unwell person him/herself, but for the general public (which, of course, includes many unwell people). He finds that there is an acute increase in the "social distance" between the mentally unwell and the general public after prominent acts of violence committed by people described as mentally ill.[14] While he is careful to demarcate between schizophrenia and personality disorder, he points out that most journalists are not so careful. Instead, members of both groups are portrayed as mentally ill, and any crimes committed by them are prominently described as such. There were two highly publicised attacks on famous people in Germany in 1990, and one in 1993, the first two by people diagnosed with schizophrenia, the latter by a person with severe personality disorder. Following these events, random samples of people were surveyed, asking questions relating to the degree of intimacy and social involvement the respondents would be willing to enter into with a mentally unwell person. This included variables such as whether or not they would sublet their apartment to such a person, whether they would employ him/her, whether they would be happy for him/her to marry into their family, etc.

On all of these measures, the amount of people willing to enter into such relationships with mentally unwell people decreased after the 1990 violent attacks, and then rose again in the following years, before falling again after the 1993 attack. This is what he means by an increase in social distance. As such, what he describes as increased social distance sounds very similar to social defeat, i.e. an environment in which a person who is thought to have a mental illness can not find a home or a job, or enter into a meaningful long-term relationship. This returns us to Bourgois's argument regarding the cyclical nature of structural oppression: a violent act is an agentic act in response to social defeat, but only serves to reinforce the social defeat against which it itself is a response.

Society makes little allowance for structural explanations of behaviour, instead treating individuals as agents responsible for their own actions. Therefore, a structural explanation of the origin or the meaning of a violent act has no truck. Instead the commission of an act which may be a strategy of survival becomes the very means by which its perpetrator is held down in an environment of social misery. That is, society notes the individual's response to the situation, without taking account of the situation itself. The individual is punished or medically treated, or both, as appropriate, but no action is taken to treat the wider issues.

Conclusion

As clinicians, what can we learn from these studies? Since the environments studied in several of these papers are extreme, the relevance to our daily practice may be called into question. However, several aspects of life for our own clients may hold true. Certainly, we see the characteristics of social defeat regularly: unemployment, degradation of social relationships, financial precarity, etc. The loss of meaningful social activity in one's life to which this may lead can be easily understood and, I argue, should be more widely considered. However, boredom also has a more immediate and obvious relevance to inpatient practice, in which service users are kept in unstimulating environments for days, weeks, months or years, unable to work or build social relationships that have a non-institutional character.

One key lesson I hope to draw from these studies is theoretical: by understanding certain behaviours as symptoms rather than responses by human agents to complex and challenging environments, we run the risk of neglecting an aspect of their experience. However, if we simply allow ourselves to see behaviours

deterministically, as functions of structure and environment, this is equally dehumanising. Seeing a violent act as a response, imbued with meaning, to the particularities of a situation does not mean that it was the only possible response. Like those without mental illnesses, people with mental illnesses devise strategies for survival which are dynamic and contingent, aided by internal algorithms which are being continuously modified, both consciously and unconsciously. The meanings they draw from their actions are also dynamic and contingent, and may also be strategies in and of themselves. These behaviours not only find, but also create meaning as events in the lives of the mentally unwell.

Violent behaviour may benefit existential recovery, but is morally and practically undesirable, as well as leading to situations in which it hinders functional recovery, e.g. prosecution, arrest, further unemployment, etc. The cyclical machinery of structural oppression becomes visible as the actions of the mentally unwell, which are responses to their environments, serve to recreate those very same environments. Therefore, this raises questions regarding the wider responsibilities of the mental health worker in finding ways to alleviate structural inequalities. We must be more than clinicians serving individuals, as we serve those individuals better by devoting more time and effort to advocacy for and with the mentally unwell, to remove the factors of life that contribute to the social defeat of certain groups in society.

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Factors associated with the perception of Angry and Aggressive Behavior among psychiatric nursing staff

Paper

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Introduction

During the last decades the psychosocial work environment in psychiatric in-patient care has been characterized by ongoing change and a demanding work situation for the staff (Cleary, 2004; World Health Organization [WHO], 2007). Angry and aggressive behavior is a commonly recognized problem in psychiatric in-patient care and the nursing staff is often engaged in aggressive encounters at work (Currid, 2008; 2009; Taylor & Barling, 2004). Moreover, several studies have found that the work in psychiatric care is stressful (Hamaideh, 2011; Leka et al., 2012; Sørgaard, Ryan & Dawson,. 2010) and may create Stress of Conscience (Dahlqvist, Söderberg & Norberg, 2009; Tuvesson, Eklund & Wann-Hansson, 2012). This study addresses the relationships between the perceptions of Angry and Aggressive Behavior, and the work environment, Perceived Stress and Stress of Conscience, while also acknowledging the role of Moral Sensitivity, Mastery and nursing staff (registered nurses and nursing assistants) characteristics (age, gender, occupation, work experience). An understanding of the relationship between these aspects may contribute to new ways of reducing and managing aggression and improving the nursing staff's working conditions. The aims of the study were to investigate in what way aspects of the work environment and stress were related to Angry and Aggressive Behavior among nursing staff in psychiatric in-patient care. The aim was also to describe if there were any differences between how nurses and nurse assistants perceived Angry and Aggressive Behavior.

Methods

This study was approved by the Regional Ethical Review Board (No. 380/2008).

Sample
The participants were a convenience sample of registered nurses and nursing assistants from twelve general acute in-patient wards. All nurses and nursing assistants who worked daytime and had worked at the unit for at least two months were invited to participate in the study. The questionnaires were returned by a total of 38 registered nurses (response rate = 54.3%) and 55 nursing assistants (response rate = 50.5%). The average length of employment on the current ward for the total sample was 9 years and the average length of experience in psychiatric care was 18 years. The majority of the participants were females (78%), permanently employed at the ward (86%) and the mean age was 48 years (21-65 years).

Questionnaires
Personal information and work experience were obtained aboutparticipants' occupational status, age, gender, type of employment, length of experience on current ward, and length of experience in psychiatric care.

Angry and Aggressive Behavior - Angry and Aggressive Behavior was assessed using a subscale from the revised Ward Atmosphere Scale (WAS) (Tuvesson et al, 2010), originally developed by Moos (1997). The Angry and Aggressive Behavior subscale measures the level of which patients argue, become openly angry or display other aggressive behaviors. The subscale comprises nine items and and is rated on a four-point scale ranging from Totally disagree (0) to Totally agree (3).

Stress of Conscience Questionnaire - The Stress of Conscience Questionnaire (SCQ) was used to assess stress due to troubled conscience. The SCQ consist of nine items and a total Index of all nine items was used (Maximum score = 225), as well as two aggregated subscales, "Internal Demands" and "External Demands and Restrictions (Glasberg et al., 2006).

Perceived Stress Scale - The PSS was developed by Cohen, Kamarck and Mermelstein(1983) and comprises 14 questions. The participants rate their answers on a five-point scale, from Never (0) to Very often (4), with higher scores (maximum score = 56) indicating higher levels of perceived stress.

Moral Sensitivity Questionnaire - The revised Moral Sensitivity Questionnaire (MSQ) was used to assess an individual's awareness and ability to sense the moral nature of a situation and the vulnerability of others. The revised MSQ comprises nine statements and the participants answer on a six-point scale ranging from Total disagreement (1) to Total agreement(6) (Lützén et al, 2006). The MSQ was used as two subscales, "Moral Strength" and "Moral Burden", and two single items (number 1 and 9).

QPSNordic 34+ - Psychological and social aspects of the work environment were assessed using items from the short version (QPSNordic 34+) of the General Nordic Questionnaire for Psychological and Social Factors at Work (QPSNordic) (Dallner, et al., 2000; Lindström, et al., 1997; Lindström, et al., 2000). Sets of items corresponding to subscales of the full version of the QPS Nordic were tested for internal consistency according to the criterion of a Cronbach's alpha value of > 0.70. This procedure resulted in five subscales: Empowering Leadership, Role Clarity, Control at Work, Support from Superiors, and Organizational Climate. Each item is answered on a five-point scale, ranging from Very seldom or never (1) to Very often or always (5).

Mastery - Mastery was measured with the Mastery scale developed by Pearlin and Schooler (1978). The scale consists of seven items and assesses the respondent's feeling of having control over his or her life. The participants were asked to rate the items on a four-point scale ranging from Strongly agree (1) to Strongly disagree (4), and was used as an total index

Data analysis
The Statistical Package for Social Sciences (SPSS) was used in order to analyse the data. Nonparametric statistics were used including descriptive statistics to analyse characteristics of the participants and response distributions of the subscales. The Mann-Whitney U-test was used for detecting differences between nurses and nursing assistants, and Spearman rank correlations for analyzing relationships between variables and for identifying which variables to include in the multivariate analysis. Logistic regression analyses were used for the multivariate analysis.

Results

Nursing staff's perceptions of Angry and Aggressive Behavior
The result showed that the mean score concerning the factor of Angry and Aggressive Behavior was 1.08 for the nurses and 1.07 for the nursing staff (theoretical range = 0-3). The nursing staff's response distribution for each of the nine items of the Angry and Aggressive Behavior factor is presented in Table 1. The mean scores indicate a value at the lower to middle end of the scale for both staff groups. Lowest values were found for the items that involved aspects of the nursing staff (item nr 4, 7 and 8). The result of the Mann-Whitney U-test showed no significant differences between nurses and nursing assistants concerning Angry and Aggressive Behavior. There were also no significant differences between individual characteristics in terms of age, gender, and professional experience.

Table 1: Mean scores for the items (minimum=0; maximum=3) of the factor Angry and Aggressive Behavior

	Mean score		
	Nurses (n: 38)	Nursing assistants (n: 55)	Total sample (n: 93)
Patients often gripe	1.32	1.55	1.45
Patients often criticize or joke about the staff	1.53	1.46	1.48
Patients in this program rarely argue	0.95	1.07	1.02
Staff sometimes argue openly with each other	0.51[1]	0.48[1]	0.50[2]
Patients sometimes play practical jokes on each other	1.08	0.85[2]	0.95[2]
It is hard to get people to argue around here	1.19[1]	1.26[4]	1.23[5]
Staff here never starts arguments	0.84[1]	0.82[1]	0.82[2]
In this program, staff think it is a healthy thing to argue	0.61[2]	0.60[1]	0.61[3]
Patients here rarely become angry	1.68	1.55	1.60

1. 1 missing value. 2. 2 missing values. 3. 3 missing values. 4. 5 missing values. 5. 6 missing values

Bivariate analyses

The bivariate analyses are presented in Table 2. There were six significant associations between Angry and Aggressive Behavior and the independent variables. Three reached a level of $p < 0.05$ (Stress of Conscience, Organizational Climate, Internal Demands). Another three variables reached a level of $p < 0.1$ (Empowering leadership, Moral Strength, External Demands and Restrictions) and were kept as variables for the logistic regression analyses.

Table 2: Correlations between Angry and Aggressive Behavior and independent variables

Variables	r-values
Individual characteristics	
Age	- .095
Experience on actual ward	- .044
Experience in psychiatry	- .069
SCQ	.216*
Internal Demands	.270*
External Demands and Restrictions	.183**
MSQ	
Sense of Moral Burden	.028
Moral Strength	- .181**
Item nr 1	- .072
Item nr 9	- .121
PSS	.037
Mastery	- .053
QPS 34+	
Empowering Leadership	- .179**
Role Clarity	- .087
Control at Work	- .127
Support from Superior	- .066
Organizational Climate	- .250*

Multivariate analyses

The six independent variables that showed an association with Angry and Aggressive Behavior ($p < 0.1$) were entered in a forward stepwise conditional logistic regression. The results are presented in Table 3. The analysis of the factor Angry and Aggressive Behavior resulted in two significant factors: Internal Demands and Moral Strength. Belonging to a group that rated a high level on Internal Demands increased the likelihood of perceiving a high level of Angry and Aggressive Behavior by more than three times. Low scores in the Moral Strength factor were significantly associated with a high level of Angry and Aggressive Behavior, indicated by an odds ratio of 0.33.

Table 3: Variables of importance to Angry and Aggressive Behavior (AAB)

Dependent variable	Independent variable	p	OR	95% CI for OR
AAB[1]	Internal Demands	0.006	3.76	1.469 − 9.615
	Moral Strength	0.021	0.33	0.125 − 0.842

Note: Analyses based on a forward stepwise conditional logistic regression ($p = < 0.05$).
The model exhibited acceptable goodness-of-fit (Hosmer-Lemeshow test, $p > 0.05$).
1) 20.1% explained variance (Nagelkerke R2)

Conclusion

The results indicate that low Moral Strength and Stress of Conscience made the nursing staff more vulnerable to perceiving high levels of Angry and Aggressive Behaviors. Taking these aspects into consideration when making improvements in the work place could help to prevent and manage aggression in clinical psychiatry. In clinical practice it is important to enable the nursing staff to develop their Moral Strength and to create a work place that focuses on preventing Stress of Conscience. One way of doing

this could be to create a work environment that stimulates moral discussion and reflection and supports the nursing staff in developing and sustaining their moral convictions.

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Reporting violence in psychiatry to the police or not; research on the decisive factors

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Background

Research has shown that caretakers regularly encounter (severe) violence on the ward (Van Leeuwen & Harte, 2011; Foster, Bowers & Nijman, 2007; Nijman, Bowers, Oud & Jansen, 2005). It also appeared that only a fraction of the violent incidents are prosecuted (Harte, van Leeuwen & Theuws, 2013). This could partly be explained by the fact that victims often choose not to report these violent acts to the police (Harte, van Leeuwen & Theuws, 2013; Kumar, Fischer, Ng, Clarke & Robinson, 2006). In The Netherlands a campaign was started to stimulate caretakers who were victimized, to report this to the police. However, to be able to support the victims of violence on the psychiatric ward and to advise them in their decision to report violence to the police or not, it is necessary to know the factors that play a role in this decision and to find out which barriers are experienced in practice.

Method

Dutch Mental health professionals were requested to fill in a nationwide online questionnaire on their personal experience with (the threatening of) physical violence caused by patients in the past five years. 1534 Mental health professionals became victim of a total of 2648 violent incidents. Victims had to answer questions about the nature and the consequences of the violent act. They were also asked whether or not they reported the incident to the police and what their considerations were for this decision.

Results

It appeared that the majority of the incidents, almost three quarters (n=1534), had not been reported to the police. (Note: Because of missing values on some of the variables, the number of incidents fluctuates in this paper.)The reasons that victims gave for their decision are described in Table 1. Respondents were allowed to provide more than one reason. Therefore, the total number of reasons not to report (n=1827) exceeds the number of incidents.

Table 1: Reasons not to report an incident to the police for all incidents that were not reported to the police (n=1827) and incidents regarded as severe that were not reported to the police (n=106)

Reasons:	All incidents (n= 1827)		Severe incidents (n=106)	
	Frequency	Percentage	Frequency	Percentage
Reporting was not necessary	657	36.0 %	27	25.5 %
Incident was not severe enough to report to the police	448	24.5 %	14	13.2 %
The incident was handled within the institution	365	20.0 %	21	19.8 %
Didn't come to the victim's mind	289	15.8 %	24	22.6 %
Aggression is seen as an occupational hazard	258	14.1 %	21	19.8 %
Reporting to the police is seen as useless	193	10.6 %	19	17.9 %
Reporting can't be done anonymous	108	5.9 %	4	3.8 %
Victim was afraid to disturb the therapeutic relation	69	3.8 %	4	3.8 %
Victim has bad experiences with reporting to the police	63	3.4 %	4	3.8 %
Discouraged by colleagues and/or manager	59	3.2 %	8	7.5 %
Reporting was too stressful for the victim	52	2.8 %	5	4.7 %

Fear of retaliation	43	2.4 %	3	2.8 %
Lack of time	34	1.9 %	5	4.7 %
Victim thought he was self to blame for the incident	16	0.9 %	2	1.9 %
Fear to break professional confidentiality	12	0.7 %	-	-

The victim's decision not to report a violent act is often based on rational motives. It seems that victims often regard reporting the incident to the police (n=657) as not necessary or the incident didn't seem severe enough for reporting (n=448). A number of victims didn't report because they feared retaliation, reporting was too stressful for the victim, the victim thought he was (partly) self to blame for the incident, or it was not possible to anonymously report the incidence to the police. Moreover, it appears that the policy of the institution has a large effect on the willingness of the victim to report the incidence to the police. This can be concluded from the fact that some victims decided not to report the incident because the possibility to do so didn't come to their mind, they think that violence is an occupational hazard and some say they had been discouraged by their environment.

The incidents differ in nature and severity and it can be argued that it is not necessary or appropriate to report all these violent acts to the police. For the examination of the barriers that victims experience, the considerations of those who encountered severe violent acts are of extra interest. To be able to study the considerations of this specific group, incidents with an impact that can be expected to be large were selected. First, the incidents that are severe because of the nature were selected, like stabbing, holding hostage, attempted strangling and rape. Subsequently, incidents that had resulted in severe injuries, like concussion, fractures, biting wounds, stab wounds, eye injuries and unconsciousness, were taken apart. It appeared that in total 106 incidents met one of these criteria for a severe incident. The frequencies are displayed in Table 2.

Table 2: Severe violent incidents (n=62) and incidents with severe injuries (n=48) that were not reported to the police.

Severe violent incidents (n=62)	Frequency
Stabbing with weapon or object	1
Holding hostage, lock-up, tie	9
Attempted strangling	52
Rape	-

Incidents with severe injuries (n=48)	Frequency
Concussion	4
Fractures	5
Biting wounds	31
Stab wounds	5
Eye injury	2
Unconscious	1

In Table 1 the reasons not to report the incident to the police are displayed for the 106 severe incidents separately. As was to be expected, the percentages of reasons as "Reporting was not necessary" and "Incident was not severe enough to report to the police" have dropped compared to the reasons of the total group of victims that had decided not to report. However, within the subgroup of victims of severe incidents, arguments that are (in some way) related to the work environment appear to be more prevalent, like "It didn't come to the mind", "Aggression is seen as an occupational hazard" and "Reporting to the police is seen as useless". Eight persons, who were the victim of a severe violent act, indicated that they had been discouraged by their colleagues or manager.

It was also examined whether or not characteristics of the victims were related to the decision to report an incident to the police. Therefore, a comparison was made between victims who had decided to report to the police and those who had decided not to report. 882 of the victims of the 2275 incidents were male (38.8%) and 1393 were female (61.2%). The results in Table 3 indicate that men that are the victim of a violent incident, more often report the incident to the police than women (Chi-square= 7.86, df=1, p<0.01).

Table 3: Victim's gender and the decision to report the incident to the police or not

	Not reporting		Reporting	
	Frequency	Percentage	Frequency	Percentage
Men (n=882)	617	70,0 %	265	30.0 %
Women (n=1393)	1049	75,3 %	344	24.7 %
Total (N=2275)	1666		609	

The age of the victims is categorized and displayed in Table 4. In this table, frequencies for those who reported and those who didn't are displayed separately. As can be seen, older victims are somewhat more inclined to reporting an incident to the police than younger victims are (Chi-square=6.95, df=3, p<0.10).

Table 4: Victim's age and the decision to report the incident to the police or not

	Not reporting		Reporting	
Age	Frequency	Percentage	Frequency	Percentage
19-29 (n=765)	580	75.8 %	185	24.2 %
30-39 (n=620)	457	73.7 %	163	26.3 %
40-49 (n=463)	334	72.1 %	129	27.9 %
> 50 (n=428)	295	68.9 %	133	31.1 %
Total (N=2276)	1666		610	

Respondents were also asked for their function. As can be seen in Table 5, the majority of all the victims were nurses (n=1435, 63.5 %), followed by socio-therapists (n=563, 24.9 %). These employees seem to be most vulnerable for violence from patients, as they spend most of their time during work with the patients on the ward. Examination of the results in Table 5 reveals that victims who are on the more senior positions in the organization, like doctors, psychologists and managers, more often report an incident to the police.

Table 5: Victim's function and the decision to report the incident to the police or not

	Not reporting		Reporting	
Function	Frequency	Percentage	Frequency	Percentage
Nurse (n=1435)	1064	74.1 %	371	25.9 %
Socio-therapist (n=563)	413	73.4 %	150	26.6 %
Doctor (n=43)	24	55.8 %	19	44.2 %
Activity- or art therapist (n=23)	20	87.0 %	3	13.0 %
Psychologist (n=23)	15	65.2 %	8	34.8 %
Manager (n=62)	39	62.9 %	23	37.1 %
Other (n=112)	77	68.8 %	35	31.3 %
Total (N=2261)	1652		609	

Conclusion and discussion

When relating some characteristics of the victims with their decision to report an incident to the police or not, it seems that those who are male, older and have a higher position in the organization are more inclined to report a violent incident to the police. It should be noted that these characteristics are very much related, since the employees on the higher positions in mental health care institutions are more often men that are relatively older than those employees that spend much time with the patients on the ward. However, it is remarkable that those employees who experience the most violence –more frequently female and younger employees - are more reluctant to report this to the police. There are several possible explanations for this result. First, since they are acquainted with more violence, nurses and socio-therapists, might accept this violence as a part of their job in psychiatry. Second, perhaps those employees on the ward are less informed about the possibility of reporting to the police (and a possible a judicial reaction). These hypotheses need to be further explored.

It also appeared from this study that, even when the incident is regarded as severe, practical and emotional factors can deter victims from reporting to the police. Arguments not to report a severe incident were, among others, 'Didn't come to my mind' and 'Aggression is an occupational hazard'. Some even report that they had been discouraged by their colleagues or manager.

Mental health professionals regularly encounter violence. Especially care workers on the ward seem to be vulnerable to this violence. It is the responsibility of the employer to take measures to prevent future violence and provide a safe environment for the employee. If, however, despite all precautions, a violent incident does occur, it is the task of the employer to support, inform and advise the victim in their decision.

Acknowledgements

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Mental Health Nurses' Experiences of Patient Assaults

Paper

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Introduction

Violence against healthcare professionals is a major problem in today's health sector across the globe (Anderson & West, 2011). Amongst all the health care professionals, nurses are the most likely to be assaulted (Chappell & Di Martino, 2006). Moreover, violence towards mental health nurses has been both a reality and concern due to increasingly violent patient population and the devastating effects on the victim (McKenna et al., 2003; Needham et al., 2005). No story about violence is complete without recognising the terrible effects of violence on those involved in the conflict as well as innocent bystanders (Hader, 2008). Since Florence Nightingale's time, nurses have been in the forefront caring for wounded patients. And they will go on doing so (Hader, 2008). The frequency of aggression towards nurses in healthcare settings is increasing and well documented, posing a major occupational health and safety hazard (Bain, 2000; Privetera, Weisman, Cerulli, Tu & Groman, 2005). Not only has the number of incidents increased but also the severity of the impact has caused profound traumatic effects on the victims (Privetera et al., 2005). Although reports of the nature and sources of aggression are numerous, the experiences and responses of the victims remain unexplored (McGowan, 2001; Uzun, 2003).

Violence is a pervasive problem across the globe and therefore New Zealand is no exception to this. Despite the high incidence rates of workplace violence within New Zealand especially within the healthcare sector, there is very little research on the problem, its causes, aftermath and prevention (Bentley, Catley & Jackson, 2011). There are international studies conducted on the effects of assaults on nurses, however there is no evidence of reporting the effects of assaults on mental health nurses in New Zealand (Coggan, Hooper & Adams, 2002; Bentley et al., 2011). This study aimed to explore and describe mental health nurses' experiences of patient assaults among nurses working within the mental health services of the Otago region of the Southern District Health Board (SDHB).

Methodology

The research method adopted for the study was thematic analysis. The research was ethically approved by the Lower South Regional Ethics Committee, Dunedin, Board of Studies and Maori Research Division, University of Otago and Health Research Office of the Southern District Health Board. To protect the anonymity of the participants and the confidentiality of the data/ information, the participants were referred by pseudonyms. The sampling method used for the study was the purposive non-probability sampling scheme because the participants selected had all experienced some form of violence from patients and would best answer the research question. Participants were invited by displaying an invitation poster in all areas of the mental health services and also electronic copies of the poster and information sheet were sent via electronic mail. Fourteen participants volunteered to take part in the study. Data were collected using semi- structured interviews that were audio-taped and transcribed by a transcriber. Following in- depth thematic analysis the emergence of three overarching themes and 24 sub- themes was apparent.
Findings

The professional and demographic characteristics suggest that the participants were an appropriate ratio of the proposed participants for the study. Of the 14 participants selected, eight were female and six were male. Thirteen participants were registered nurses and one was an enrolled nurse. At the time of the interviews, eleven participants were employed in clinical positions, two in managerial positions and one in a clinical expertise role.

Theme 1: Nature of Assaults
The participants found that the increase in aggression and violence was related directly or indirectly to numerous factors like personality traits, professional expertise, and clinical roles, static and dynamic factors. There was the common acceptance that violence and aggression are ever present within mental healthcare settings. The experience of assaults as shared by the participants stated that there was a

perceived violation to personal safety irrespective of the nature of the assault. This threat to safety crossed boundaries of work and invaded social circles and personal spaces. This risk of workplace violence was significant in both hospital and community settings with an evident increase in the incidence of violence in the community over the recent years. Despite the ever present nature of violence and non-acceptance of aggression as part of the job, participants agreed to verbal abuse being the most prevalent form of abuse. The participants perceived verbal abuse to be expected on a day to day basis and identified this to be used therapeutically to role model appropriate behaviours for clients.

"... Violence is something that you do not like to have happen but it is a possibility it may happen. That is the nature of what you look after when you do psychiatry."

"I mean it is not part of our job. It is our right to actually work in a safe environment and we need to actually take that on board."

"When you're in the community you are very much on your own. So you have to anticipate that things could happen a lot more but in the in-patient unit the patients are usually a little bit more acute. So they've both got their issues. I don't know whether you could say one was more likely to pose issues than the other, they're about the same."

"It's funny because I think we are all subject to verbal abuse, working in mental health. It comes and goes."

Theme 2: Impact of Assaults
Workplace Violence against mental health nurses is a significant problem that impacts on the different facets of life. Workplace violence can have an impact on the emotional lives of individuals and these consequences include fear for self, anxiety, frustration, vulnerability, grievance, distress and anger. Emotional consequences are very often the first effects to emerge which pave the way for more profound and long term personal and professional changes. Personal and professional changes are very often interlinked because of the nature of the work of mental health nurses with involvement of self in the therapeutic process. A few participants highlighted the impact to be the beginning of a new learning process where skills were relearned and there was enhanced practice and expertise gained. The negative consequences of violence included loss of self- esteem, confidence and burnout.

The impact of workplace violence extended beyond the workplace and caused strained family and social relationships as shared by a few participants. The physical consequences were described on a continuum of mild effects like bruising, abrasions, pain and swelling to more serious conditions like head injuries, asphyxia and sensory deficits. The physical consequences had indirectly paved the way for financial constraints in terms of loss of regular income, cost of medical treatments and long term leave from work for the recovery process. The participants also shared their views on facing the patients who perpetrated the assaults. Mixed responses were expressed with most participants highlighting the lack of remorse among patients and continuing intimidation towards targeted staff members. A few participants also reinforced the need to break the ice of fear for self and lower the threshold of impact of workplace violence among mental health nurses.

"Probably as a nurse, the worst thing was the memory loss, but what I started doing was just carrying pieces of paper and writing things down, because it was the only way sometimes I could remember."

"Well I took it as learning experiences. It did enhance my practice and my awareness of keeping myself safe and that my actions can have a reaction to the individual I'm talking to or to the group."

"I was very resentful, quite angry and ended up sort of saying to my colleagues that I did not want to work with her at this stage as I was a bit too angry and it wouldn't be therapeutic."

"...I was absolutely exhausted and it showed in the house. Luckily I had a husband who just took over the care but on one occasion it came to a crunch. One night I came home and I lifted my daughter by her hair, I couldn't cope any longer with the general parenting role."

Theme 3: Support Strategies

The participants highlighted the importance of supporting assaulted nurses in all aspects of life in their road to recovery. Peer support was identified as the most common support strategy for various reasons which include the closeness and the immediate availability to the injured staff. Management support was clearly acknowledged to be better than yester years but the participants also brought to the fore the lack of input from management on a personal stance. The positive influences of Clinical Supervision and Critical Incident Stress Debriefing as support strategies related to factors like time of occurrence, appropriate utilisation and interaction between individuals involved in the processes were reinforced.

Legal implications brought to light the clear lack of support in proceeding with charges against assailants both from management and the police. This was based on the perception that nurses had to expect violence as part of working within the mental health services. The participants also expressed that being more personally supported would ease their recovery and return to work.

"I think they're (management) a bit come and go; I'm not sure whether they're that supportive. I think it is more supportive now but I don't think it's perhaps as strong as it could be."

"Debriefing is definitely useful but the person has to be in the right frame of mind to talk about it because the natural human instinct is each time something happens somebody comes up and goes, 'Are you all right?'"

"... And I kind of felt like that from the Police as well, 'You've got to expect to be hit, you work in mental health.'"

"We can't avoid it, how we deal with it is important because if we don't get back on that bike, the fear takes over and it gets blown out of proportion."

Table 1: Summary of Findings

Theme 1: Nature of Assaults	Theme 2: Impact of Assaults	Theme 3: Support Strategies
Violence- Is it part of the job?	Emotional Impact	Peer Support
Feeling Vulnerable	Physical Impact	Managerial Support
Violence Precipitants	Personal Impact	Clinical Supervision
Violence Occurrence	Professional Impact	Defusing and Debriefing
Sequence of Violence	Family Impact	Defensive Practice
Violence exposure	Social Impact	Best Support Person
Perception of verbal assaults	Financial Impact	Legal Implications
	Patient Response	Change across the years
		Feeling Supported

Discussion

The experience of being assaulted as shared by the participants is an interlinked relationship of the three overarching themes. It is this interdependent relationship of the themes that outlines the research aim- 'To explore and describe mental health nurses' experiences of patient assaults'. The integrated analysis of the data identified four preordaining components of workplace violence. They are precedents, nature of abuse, defining elements and aftermath. Each component addresses a particular phase of the process of workplace violence. The four components are interlinked to each other and it is this combined simultaneous occurrence that eventuates as workplace violence.

The relativity between these components is an interesting point. One should consider them as a continuum, but to do so would disregard the symbiotic relationship that exists. This clearly highlights the importance of all the factors and the process that is collectively formed. The differentiation between them is that the first three components are judged to result in the fourth; the aftermath of workplace violence. The strong link between the precedents and defining elements of workplace violence determine the nature of abuse which subsequently marks the intensity of the impact. There is always the possibility of a cyclical process with regards to the four components of the workplace violence process. If at any point, timely precautions or interventions are implemented, this enables the minimization and elimination of the occurrence of workplace violence and its aftermath. However if the combined occurrence of the four components is pronounced with nil effective interventions, this will result in the potential increase in the occurrence and resumption of the workplace violence cycle. The cycle is displayed in the figure below:

Figure 1: The Workplace Violence Cycle
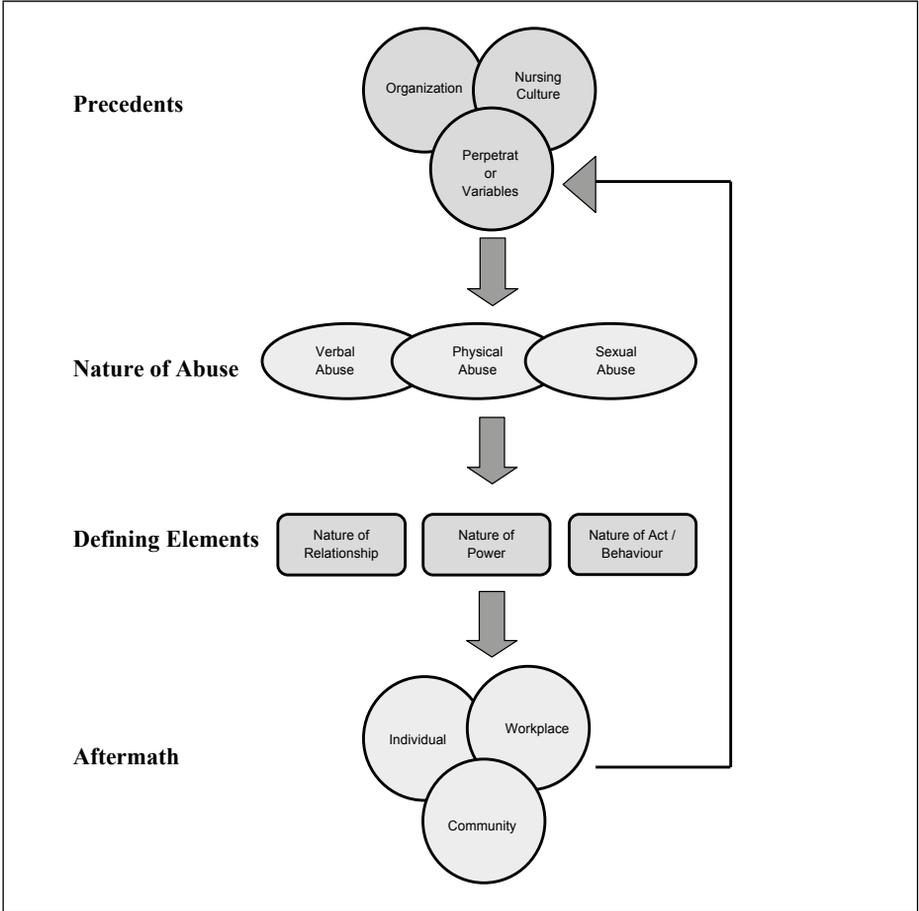
Implications

Clinical Practice
Policies form an essential element in providing guidance for both management and employees. Therefore, for policies to be effective, these need to be driven by the identified needs of nurses. Likewise, clinical nurses need to be willing to participate when asked to share their insights, experiences and problem solving skills within the workplace.

Education
The findings of this study bring to the fore the heightened risk of violence that mental health nurses are faced with which are beyond their level of skill at times. Attention needs to be given to clinical issues and competence in dealing with aggression and violence. There is a need for nursing educational programmes which are focussed on preparing nurses to meet the current challenges and demands in addressing workplace violence. While current challenging behaviours and risk minimisation programmes offer training in dealing with aggressive behaviours, they possess limited scope, as they do not account for the complexity and variability in situations within the work settings.

Research
Further research needs to be aimed at describing and understanding the problem of workplace violence. The true nature and extent of the problem must be further explored which will possibly assist in setting parameters and uncovering patterns associated with the problem.

Conclusion

This study has offered an exploration of nurses' experiences of assaults perpetrated by patients and has proposed potential solutions to the problem. Nurses have a vested interest in addressing workplace violence. Hereby, nurses should be committed partners in the campaign against workplace violence if violence and its negative consequences are to be reduced. It is hoped that this research will convey important insights and meaningful connections that will help keep the issue of violence towards nurses to the forefront and assist in shaping our understanding of workplace violence, specifically within the context of nursing.

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Learning Objectives

The presentation aims at helping the participants
- Develop an overview of the New Zealand context of workplace violence perpetrated by patients within the mental health services.
- Recognize the impact of workplace violence on the different facets of life among assaulted mental health nurses and the available support strategies.

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Mental Health Nurses' Experiences of Patient Assaults

Poster

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Abstract

With the advancements in technology, there has been a significant reduction in the classical risk factors at the workplace like biological, chemical and physical harms. But with the turn of the era, much attention has been focused on psycho-social stressors at work which are thought to affect employees' occupational functioning and health. Amongst all healthcare professionals, nurses are the most likely to be assaulted. Moreover, violence towards mental health nurses has been both a reality and concern due to increasingly violent patient population and the devastating effects of violence on the victim.

The study aims to explore and describe mental health nurses' experiences of patient assaults. Thirteen Registered Nurses and one Enrolled Nurse working in different nursing positions within the Southern District Health Board (Otago region) - Mental Health Services were interviewed using a semi structured interview format. The data gathered from these interviews was interpreted using thematic analysis and coded into 24 sub-themes. The sub-themes were related to the sequence and impact of assaults on the participants. Through an ongoing interpretative process, three over-arching themes emerged. The themes were analysed further to allow conceptual meanings to be interpreted relating to the experiences of patient assaults.

The major findings of the study related to the nature and impact of assaults and supportive strategies associated with violence against mental health nurses. Perpetrator risk factors include mental health disorders, substance abuse and situational crises. The injuries sustained by the nurses include lacerations, head injuries, dislocations, asphyxia and bruises. Psychological harm has also occurred including Post Traumatic Stress Disorder. Some of the injuries sustained have required weeks of recovery. In other cases, nurses have chosen to change areas of practice because of their fears and concerns. Protective strategies for combating negative consequences of violence include practicing self-defence, social support, reporting violent activity or threats of violence to authority and police and a supportive and consultative workplace culture with access to counselling services and assistance in all aspects including finances.

Although physical injuries heal relatively quickly, emotional and psychological wounds linger for longer and can interfere with personal and professional lifestyles for months or years after the incident. Employers need to provide better support services to health care professionals who are assaulted and the legal system needs to acknowledge that assaults against nurses is a violation of human rights and violence is not to be tolerated as part of working in mental healthcare services.

Educational Goals

1. To develop an overview of the New Zealand context of workplace violence perpetrated by patients within the mental health services.
2. To recognize the impact of workplace violence on the different facets of life among assaulted mental health nurses and the available support strategies.

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Strengthening the Pavement of Good Intentions: Ethical and Legal Implications of Restraint and Seclusion Strategies

Workshop

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Pat Risser, Mental Health Consultant and Advocate, USA

Keywords: Restraint, recovery, trauma, rights

Introduction

In this presentation, we will be focusing on the the daily decisions made by well-intentioned people to impose seclusion and restraint. Their good intentions, however, have often had devastating outcomes Strengthening the road paved with good intentions may lead us away from the hell people have experienced over the years and towards a future where restraint and seclusion are seldom if ever imposed.

The authors of this paper, at first glance, would appear to have intractable and opposing positions on the subject of restraint and seclusion in human service settings. Bob is an expert on how to restrain people in such settings, whilst Pat is an expert at having been restrained in such settings. Bob is the CEO of an organization teaching the prevention and, if needed, use of restraint and an adjunct assistant professor of psychiatry. Pat is a Board member of the National Association of Rights Protection and Advocacy, an affiliation of attorneys, advocates, former patients, clients, and residents of psychiatric hospitals.

Ethics

According to Solomon (1994), "Ethics is a way of life, a seemingly delicate but in fact very strong tissue of endless adjustments and compromises. It is the awareness that one is an intrinsic part of a social order, in which the interests of others and ones' own interests are inevitably intertwined." The adjustments and compromises made on the subject of restraint in human services must be made from a common values base, an understanding of what restraint is, and what restraint does.

In *Prometheus Bound*, Aeschylus tells the story of Prometheus, who was chained by two servants of Zeus, Power and Violence, because Prometheus dared to help helpless humanity. This is our beginning point from an ethical perspective. Prometheus opposed the gods in their subjugation of humanity, and brought fire to humans to increase their safety. Almost 2,500 years later, it appears not much has changed! Force and violence continue to be used to mechanically, chemically, physically or socially restrain other human beings.

What we are presenting is an ethical framework for change that does not require litigation or acrimony between the participants. One often hears the word "unethical" used as a weapon to disarm the arguments of the opponent in discussion regarding change to human service systems. We are not saying that people who have a different position are then unethical. We do not want to engage in that kind of dialogue. It is our belief that if we are to practice the politics of positive change, we must do so in a way that affirms all people, including people who may disagree with us.

The Mental Health Consumer-Carer Forum in Australia (NMHCCF, 2009) is a national example of the kind of relationship that can exist between consumers of mental health services and the carers who provide mental health services and supports. It is important to understand that change in human service systems where restraint and seclusion are used must come, is coming. That change, unfortunately, often comes in response to deaths due to restraint and seclusion, or as a result of litigation. The authors have experienced the horrors of change due to the former, and they have seen the healing that takes place in the latter. Voluntary and cooperative change seems to lead to more stable and enduring positive change.

The settings in which mental health services are provided and received are complex systems of regulatory and relational expectations. Often, the systems in which the work is done is itself toxic and creates conditions in which workplace violence thrives. (Bowen et al, 2012) Other factors at play include the neurobiological effects of trauma and their effect on behaviour, which are well documented (Perry et al, 1995).

Imposing Restraint vs. Applying Restraint

In a review of American federal and state regulations regarding the use of restraint and seclusion by Protection and Advocacy, Inc., (PAI, 2005), all regulations used the phrase "application of restraint." This same language is used in regulations in the United Kingdom. It is the contention of the authors that this is a continuation of the use of Force and Violence. Restraint is imposed, it is not applied.

One applies a treatment, and there is general consensus that the use of restraint is re-traumatizing, that it is not treatment, yet we continue to use language that tacitly affirms the use of restraint as a treatment. Seldom is treatment applied where it may be considered more dangerous than that for which treatment is sought.

People with histories of trauma may at times be in need of brief interventions for safety whilst at the same time maintaining the human rights to be free from restraint and free from harm. This requires a relationship of mutual trust be developed between the advocates, the clinical staff, the regulatory systems, the families and patients, the administrative staff, and the direct support professionals.

Restraints and seclusion are considered major tools in the management of human behavior. Most however, consider restraints and seclusion not as treatment but rather, as indicators of treatment failure. If treatment were effective and working then there would be no need to resort to the use of aversives such as restraints and seclusion. More effective "treatment" will consist of building meaningful relationship with the person. Years ago restraint was considered a treatment option within mental health and other services, but today most countries have followed the lead of the National Association of State Mental Health Program Directors (NASMHPD, 1999) in understanding that restraint is not treatment, but an indicator of treatment failure. Many of the skills and concepts in the use of seclusion and restraint that were acceptable and even "best" practice in 1980 are now either prohibited or restricted practice.

Pat Risser describes the horror of his own experience by noting that the real terror was the loss of humanity. While lying on the bed restrained, he heard the cries of the person in the next room, "Oh no! Please let me go. Please don't do this to me. You're hurting me, please stop. Please let me out of here!" These cries went on through the night. Pat lay there in fear from those who could care so little; who could be so emotionally scabbed over and so distant from their humanity that they were not moved by these pleas. What cold and callous beasts must these people be? How could anyone care so little?

Ann Palmer, a mental health advocate and former mental health patient in the UK, writes eloquently of her experience. She says that, "When professionals label our circumstances, I want to tell them, we're drowning and you're describing the water." Our focus in this paper is not on describing the water, but rather in learning how to swim together so we may offer to each other our common humanity and a mutually improved quality of life. (Palmer, 2008)

In a relationship where we focus on our common humanity, we will need a common language to talk with each other, when there are barriers such as roles, boundaries, and the fears borne of past experiences with people of similar backgrounds. Often, in human services, those of us with a "professional label" have a language that sounds like the common language of our country, but it is filled with jargon and complex words. We need to have common words and then define them so we can achieve the mutual understanding needed to talk from our hearts and heads, and talk with each other, and not just to or at each other.

A New Direction

We would support the use of the concept and language reflecting the imposition of restraint. This term is used in the Keeping All Students and Staff Safe Act (S 2020, 2011), and in several policies and procedures of organisations serving persons affected by disabilities. The authors agree that restraint is a coercive act and, even when done with the best of intentions, is a violation of rights.

It may be that it was, at the time a necessary violation, but it was a violation nonetheless and should be recognized as such. We impose restraint, we do not apply it. We impose our will upon another, we don't apply it.

In order to move away from coercion, we need a goal to move towards, and that goal is contained in the word "Ubuntu." Some may know this word as the name of the computer operating system powered by Linux software. Linux is what is known as "open source code" and is freely accessible to anyone who thinks they can improve the quality of the product. Linux has created a community of users who see in each other a common humanity. This is the meaning of the word in Africa, an understanding that my humanity is bound up in your humanity, and that when I build you up or tear you down, I do the same to myself. Ubuntu can be Africa's gift to the world, says Archbishop Emeritus Desmond Tutu. (Nussbaum, 2003).

In the course of our relationship with each other, we have had to learn to forgive and to ask forgiveness. Whilst the authors did not know each other prior to working together in addressing issues of restraint and seclusion, each of us knew other people who were not necessarily a positive presence. However, we grew our relationship by starting from a place of mutual respect and a strong sense of our common humanity.

Since the 1970's "Best Practice" in the treatment of mental health disorders, substance abuse, intellectual and developmental disabilities, has changed markedly. What we must realize and affirm is that our best practices today may, in years to come, be looked at with the same feelings we have as we look back at the human service system of the mid-twentieth century. In the past, we did the best we could with what we had. We have different tools and different perspectives today, and whilst we must own the past we cannot change it, we can only learn from it together and move forwards in the spirit of Ubuntu.

Balancing Rights and Duty of Care

Workers in in human service organisations have the right to work in a safe environment and be free from harm. In many countries, workers have the right to disengage from the immediate environment if they feel their own health and safety is compromised. At the same time, employers have a duty of care to ensure the safety of the individuals served, as well as of the individuals providing services.

Likewise, consumers of human services have the right to receive those services in ways that provide them with safety as well, and are free from aversive interventions.

Figure 1

Responsibilities
Duty of Care
Moral and Ethical Issues
Promote safety for all people

Rights
Personal Freedom
Effective treatment
Respect safety of all people
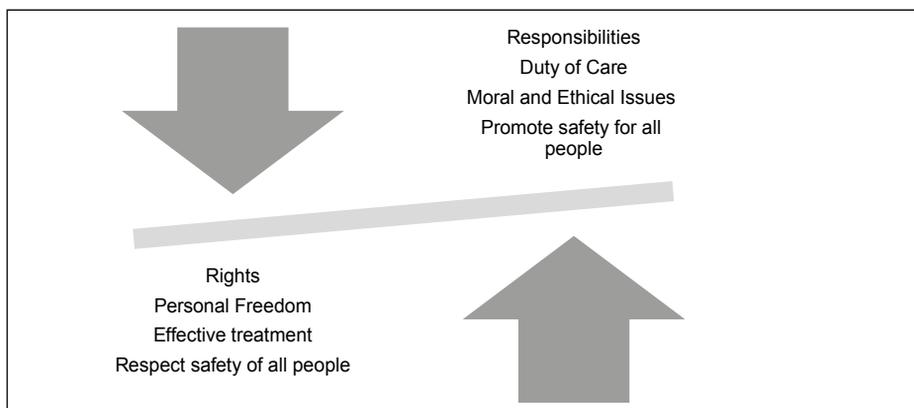
Balancing the safety of people whilst maintaining their security is a complex task, with legal responsibilities for both that are often in competition with each other. As a result, there is a "no man's land" between consumers and carers fraught with minefields. The only way through, in the opinion of the authors, is for us to realize we are not enemies, and that instead of attacking each other, we should find ways to work together to attack the problems.

Immediate Threat of Harm

In almost all laws regarding the use of force, the term "imminent risk of harm" is used to justify the use of what are termed "restrictive interventions" in many countries. The US Department of Justice (TDADS, 2009) and proposed legislation for restraint use in schools in the US (S. 2020, 2011) use the term "immediate risk of harm" which provides a higher degree of safety for the individual on whom restraint may be imposed.

Almost any act can be construed to carry with it an imminent risk of harm. What is needed is an understanding that only if the potential harm is immediate, i.e. in the next few seconds, can any restrictive procedures authorised by law and regulation be used. The test of immediacy is described in Figure 2 below. An imminent risk of harm may happen, and it is still possible to de-escalate. An immediate threat of harm occurs at a higher stage in the Crisis Cycle, and is less responsive to verbal or physical requests for de-escalation. As a result, the threat of harm is more likely to occur. (Harper, 2010)

By using the higher test of immediacy, the rights of individuals served are secured to a higher degree. It is this higher degree of safety that requires a higher degree of competence on the part of caregivers to assess dangerousness or threat.

Increasing the competence of staff also increase the safety of individuals served and secures their rights and the rights of staff to safety. By working together, we can find ways to increase the safety of all people. When we truly "see" the other, we will be more competent in helping them de-escalate before things reach an immediacy crisis point.

It is the goal of the authors, in assessing the broad range of human service systems, to improve the ability of all people to regulate and take responsibility for their behaviour. This would apply to individuals served as well as to those individuals who provide services and supports at all levels of the human service system. We are aware of the strides that have been made in various organisations and communities around the world.

We are also aware of the many times when rights are violated and injuries occur. Deaths occur as a result of the use of restraint. There is also a daily death that comes from the wounding of the heart, soul, and mind of each person who has started on the road to recovery, only to be pushed back by experiences in which their rights were violated. Their healing was reversed by the re-traumatizing effects of restraint and seclusion, and the hope of recovery became the nightmare of restraint.

It is by forming relationships with each other that we can, together, survive this nightmare and realize the dream of a life without shackles. The National Mental Health Consumer Carer Forum statement on seclusion and restraint contains this statement from Professor Ian Hickie:

"As with so many areas of mental health, it is not as if we lack an evidence-based approach, we just choose not to fund or deploy it. There is now clear evidence from overseas about a better and more effective approach to patient care. Early indications from the Australian pilot of the same approach seem to demonstrate its merit when applied here, rendering seclusion and restraint unjustifiable and outmoded forms of clinical practice." (NMHCC&F, 2009)

We know what to do. For far too long people in various settings of care have shown extreme patience waiting for us professionals to "get it." We have been unwitting servants of coercion, with the names Force and Violence behind many of our actions. Lifting up the rights of individuals served will only lift up our own rights as well, for it is in the spirit of Ubuntu that we walk together on the road called recovery.

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The Place of Ethics in Mental Health Nurses' Clinical Judgment in the Use of Seclusion

Poster

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Abstract

This presentation will provide findings from a qualitative study exploring the place of ethics in mental health nurses' clinical judgments on the use of seclusion. Mental health nurses, in consultation with immediate team members, make the decision to seclude patients when they are a danger to themselves or others. This involves clinical judgment, defined by Tanner (2006) as "an interpretation or conclusion about a patient's needs, concerns, or health problems, and/or the decision to take action (or not), use or modify standard approaches, or improvise new ones as deemed appropriate by the patient's response" (p. 204). Seclusion as an intervention has ethical implications for nurses and patients. Nurses must maintain their duty to protect those they care for from harm while keeping in mind patients' rights. At present, we have limited understanding of the way nurses navigate this tension, described by Taxis (2002) as an ethical quagmire. The research approach used was interpretive description (Thorne, 2008). A sample of Registered Psychiatric Nurses and Registered Nurses were recruited to participate in semi-structured interviews. The research questions were: 1.What are mental health nurses' experiences with the use of seclusion in inpatient mental health settings? 2. What are mental health nurses' perceptions of the factors that influence the judgment to seclude a patient in a mental health setting? 3. What consideration is given to the ethics of this practice when secluding a patient? The themes relating to the place of ethics and clinical judgment in the use of seclusion will be reviewed.

Educational Goals

1. To explore the ethics related to using seclusion as an intervention.
2. To share the findings of a qualitative study on nurses' clinical judgments in their use of seclusion.

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The Place of Ethics in Mental Health Nurses' Clinical Judgment in the Use of Seclusion

Paper

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This presentation will provide findings from a qualitative study exploring the place of ethics in mental health nurses' clinical judgments on the use of seclusion. Mental health nurses, in consultation with immediate team members, make the decision to seclude patients when they are a danger to themselves or others. This involves clinical judgment, defined by Tanner (2006) as "an interpretation or conclusion about a patient's needs, concerns, or health problems, and/or the decision to take action (or not), use or modify standard approaches, or improvise new ones as deemed appropriate by the patient's response" (p. 204). Seclusion as an intervention has ethical implications for nurses and patients. Nurses must maintain their duty to protect those they care for from harm while keeping in mind patients' rights. At present, we have limited understanding of the way nurses navigate this tension, described by Taxis (2002) as an ethical quagmire. The research approach used was interpretive description (Thorne, 2008). A sample of Registered Psychiatric Nurses and Registered Nurses were recruited to participate in semi-structured interviews. The research questions were: 1.What are mental health nurses' experiences with the use of seclusion in inpatient mental health settings? 2. What are mental health nurses' perceptions of the factors that influence the judgment to seclude a patient in a mental health setting? 3. What consideration is given to the ethics of this practice when secluding a patient? The themes relating to the place of ethics and clinical judgment in the use of seclusion will be reviewed.

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Impact of prosecution for violence in hospital on the continuing rate of violence and on staff safety

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Detective Constable Jayne Payne, Thames Valley Police, Hospital Liaison Officer, Broadmoor Hospital, England

Introduction

Patients arrive at forensic services in the UK either from the Courts following the commission of a violent crime or from prison where they are serving a sentence typically for a violent offence. Our role is both to support recovery from the underlying disorder and to reduce risk of future similar incidents. We use a range of approaches including pharmacotherapy, psychotherapeutic approaches from a variety of backgrounds, and broader social therapies. However we have historically been reluctant to enforce the same legal consequences on our patients for violent behaviour in hospital as are applied in wider society.

In the high secure hospitals in the UK in recent years we have increasingly promoted the use of legal sanctions for non-trivial violent behaviour. This paper sets out the background to and the results from that initiative at one high secure hospital, Broadmoor.

In many ways the situation until recently in psychiatric services is analogous to that 20 years ago in respect of domestic violence, Police and prosecution attitudes were characterised by a hands off approach:
"It's none of our business"
"What do you expect if you marry someone like him / work with people like that "
And from a judge a few years ago: "isn't this behaviour exactly why he was sent to Broadmoor in the first place?"

But unlike other institutions such as prisons dealing with violent offenders we do not have a system of punishment or tariffs to apply when a patient assaults a member of staff or another patient. In prisons in the UK the Governor may adjudicate following an assault and add days to the sentence; in the hospital system we can move the aggressor to a more restricted treatment area but no more than that. Later the significance of the event may be challenged by lawyers representing the patient at tribunal hearings considering discharge: the record we make in the notes may be disputed and we may be accused of exaggerating. The absence of a formal independent record of violence in in–patient settings may contribute to incomplete assessment of risk, as was noted more that 20 years ago in the important case of Christopher Clunis.

In order to address the difficulties this situation presented we began some years ago to increase the number of assaults we reported to the local police and to press for prosecution in appropriate cases. We made this intention explicit in our local liaison meetings with the police, which had previously focussed on external security issues rather than internal safety issues. It is fair to say we met with some resistance and surprise initially, both from the usually rather junior officers sent to investigate the alleged offences and the local magistrates when such offences went forward to prosecution. However we made the most of every opportunity at police and court liaison meetings to explain our concerns and emphasise that we expected the same level of support for our staff at work as the staff in the local Hospital Emergency Department could expect: Emergency Departments being recognised to be high risk settings for staff dealing with intoxicated casualties and sometimes their intoxicated assailants.

It is acknowledged that this process was not designed as a planned experiment with data on levels of assault collected before and after a single well-designed intervention, but rather a continuing dialogue which requires consistent messages to be delivered as personnel change in the local police, prosecution and court services. However a number of important milestones have occurred along the way which should be highlighted alongside the data we have collected.

One of the unanticipated consequences of this approach was that this local relatively low – crime area of suburban Berkshire began to figure in police statistics as a higher crime area, which merited further

analysis and resource investment. This contributed to the case for the appointment of a liaison police officer based at Broadmoor in 2008. The role of this person is to support the hospital more generally in respect of the criminal justice system e.g. when there are trials forthcoming for our patients who have been admitted pre-trial, but also to investigate by taking statement and preparing a case for the prosecution authorities when there is a serious assault at the hospital: whether the victim is a member of staff or another patient.

When cases are successfully prosecuted and the Hospital is asked for advice on sentencing we acknowledge our role in the continuing treatment of mentally disordered offenders and do not seek to simply dispose of such assailants back to the Criminal Justice System and to prison. We typically support the imposition of a restricted Hospital Order under UK mental health legislation which increases the scrutiny to which decisions on transfer and discharge are subject, for those patients who are not already subject to such an order. Alongside this, and for patients who are already subject to restricted hospital orders, we recommend fines and compensation orders. For patients who are subject to hospital orders, who are typically rather well off, given the very limited demands on their income benefits, thereby receive a significant financial sanction as well as the criminological sanction of the record of a further conviction. In one recent case of the prosecution of a repeatedly assaultative patient, who was already on a restricted hospital order, and who severely assaulted a psychologist at another hospital before transfer to Broadmoor, the sentencing Judge asked for details of the savings the patient had accumulated. On being advised these amounted to some £9,000 (€10.400) he ordered £8,500 compensation to the victim, £ 250 compensation to another member of staff more peripherally involved and £250 contribution to prosecution costs. The assailant later mentioned to his Consultant Psychiatrist "I'd better learn to keep my fists to myself"

In order to facilitate prosecution for non-trivial offences we have developed a template statement on behalf of the Hospital, available on request to the author, which provides evidence which the Court can include in considering sentence. This includes details of the financial and human impact of assaults on the running of the Hospital. We detail the number of days lost by ill health following assaults on staff. We detail the financial cost of employing additional staff to fill the vacancies resulting from staff sickness following assaults. We emphasise that the great majority of assaults which our patients commit are not the direct result of their mental disorder for which they should not be considered responsible, but are part of a more general pattern of disorganised or instrumental aggression which all treatment approaches have a role in extinguishing. We also emphasise that the support for prosecution is not the discretionary responsibility of an individual member of staff who has been assaulted, but a matter of agreed hospital policy which the senior management are committed to and can attend Court if necessary to explain. This is also emphasised in Community Meetings across the hospital, to minimise the likelihood of the repeated targeting of an individual member of staff who has been assaulted and whose assailant has been prosecuted. Equally we emphasise our commitment to the prosecution of patients who assault their fellow patients: the safer running of the hospital is in the best interests of both staff and patients.

The consequence of this approach is illustrated in the table below. This demonstrates a five fold increase in the rate of prosecutions for patients at Broadmoor over some four years, from about 10% reported assaults prosecuted to over 50% prosecuted. Perhaps most importantly, there is early non-significant evidence of a reduction in the number of assaults occurring.

Year ending	Assaults reported to police	Successful prosecutions	% prosecuted
March 2010	95	9	10
March 2011	79	14	18
March 2012	93	42	45
March 2013	62	36	58

In addition we are now seeing significant compensation awards being paid as a matter of routine. In 21 cases of assault on members of staff for which we have full details, the mean compensation awarded was £193; range £75 – 1000: (mean €222 range €86 – 1150). Additional court costs averaging £85 (€100) were imposed in 6 cases.

For assaults on patients we have details in four cases: in three of these compensation awards averaging £90 (€105) were made. In the fourth the aggressor, who was transferred from prison for treatment, was sentenced to return to prison for a further period of time at his request, and against our advice that he be made subject to a restricted hospital order.

Conclusions

It is our considered view that the routine approach of holding patients accountable for their actions unless their clinical team judge them to be exceptionally unwell is one which promotes responsibility and recovery. We believe it contributes to a safer hospital and a clearer focus on the reality of rehabilitation which is increasing self determination.

We will continue data collection which we anticipate will demonstrate a gradual downward trend in the number of incidents of assault in the hospital and the benefits of continued partnership work with the Criminal Justice System in the robust management of such incidents. We expect this will promote the shared understanding across the hospital that actions have consequences and detention in a high secure hospital does not provide an automatic excuse for instrumental violence. We are committed to promoting the efficiency of our services particularly in respect of reducing expensive in-patient detention and the earlier in a period of care a patient understands that assaults on staff or fellow patients have significant consequences, the sooner we can begin to work together on alternative strategies to deal with the underlying conflicts more appropriately.

It is our view that along with physical security, our walls and locks, and relational security, our sensitivity to the mental states of our patients, this aspect of procedural security – the robust formal multiagency response to violence in hospital - is an important limb in our security and therapy strategies.

Acknowledgements

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Chapter 9 – Innovative strategies for reducing coercive measures

Violence reduction in inner-city adult acute mental health wards - 'A SCRiPT for Safety'

Paper

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Background Review

Acute behavioural disturbance presenting with violent behaviour frequently occurs in psychiatric units. A National Audit of Violence (RCP, 2005) found that over a third of service users had been attacked and threatened and almost a half had witnessed this on the ward. Violence and aggression within inpatient psychiatric environments has a significant impact on patient interventions, treatment outcomes, patient and staff safety and the therapeutic environment.

Aims

50% reduction in violent incidents on an acute adult psychiatric unit in a busy inner city hospital.

Method

A review of the literature was initially performed to determine what interventions/changes needed to be tested within the ward to reduce violence. A rapid cycle testing approach was used to test each change and develop the processes for delivery using a quality improvement methodology (multiple cycle PDSA approach) to lead to the development of a clinical toolkit that could in the future be spread to other wards, the S.C.R.i.P.T (Safer Care Responses in-Patient Treatment) involves combining risk management interventions such as assessment, prediction, zoning and planning with escalation interventions.

Findings

Data was collected for 22 weeks in the pre-intervention period. Before interventions were tested the average number of incidents per week was 3.045. Data was collected over the subsequent 22 weeks whilst interventions were delivered which led to a 58% reduction in incidents to 1.273. Paired t-tests were performed demonstrating that this was a statistically significant difference (p

Conclusions

The study demonstrates that simple multi-professional team risk reduction interventions executed and tested regularly could result in a significant drop in violence. Organisational savings due to reduced violence include reduced staff absenteeism, shorter lengths of stay, increased productivity and decreased recidivism and re-hospitalisation. Trusts should focus on the development and implementation of effective strategies aimed at violence reduction.

Educational Goals

Overall aim of the paper: To present a positive result in violence reduction through combining a literature review of evidence base and quality improvement methodology of testing and re-testing change in the clinical setting until a systemised framework of validated interventions with effect was developed. The presentation aims to promote collaborative multi-professional research and will be presented jointly.

1. The listener will be informed of multi-professional collaborative risk management and the clinical toolkit for violence reduction.
2. The listener will be able to evaluate the impact of the SCRiPT in an inner-London hospital setting, have knowledge of the frequency of violence related incidences prior to the interventions and the test-re-test cycle performed. Patient evaluation data should be available for pre and post test interventions.
3. Be informed of processes in quality improvement research, joint research collaboration with multi-professionals in quality improvement methodology adn the subsequent spread plan for trust-wide implementation of the SCRiPT.

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The effect of physical space on aggression in psychiatry

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Introduction

Following the relocation of a Dutch hospital early in 2009, staff noticed a reduction in aggressive incidents. Although the patient and staff circumstances remained the same, the relocation was to a newer building that housed the psychiatric admission ward in a cleaner and more spacious environment. The new ward had more comfortable and better furnished common rooms and the patients had single rooms. However, the reduction in aggression was never formally assessed due to the lack of reliable use of assessment instruments. This experience led the authors to design a study to assess whether there is a correlation between the physical space and the rate of aggressive and violent incidents on closed psychiatric admission wards.

Research method

The research was designed as retrospective survey, with a simple random sample. The sample was taken from a nation-wide sampling frame and the population consisted of all psychiatric admission wards in the Netherlands.

Ten wards were contacted directly and asked to participate in the study. Three of the ten wards did not participate for varying reasons: One ward refused to take part in the research, because they were too busy to participate. Another wanted to participate, but was excluded because the staff members regularly worked on different wards. This makes the measurement of the aggression difficult since the staff members have to differentiate between the aggressive incidents on the different wards they work on. A third ward was excluded because the contact person, despite the intention of participant did not respond to the telephone calls and emails after the first contact.

Two sets of data were collected from each of the wards. Firstly, a telephone interview with a ward manager identified key aspects of the physical space on the ward. Since no published questionnaire was identified for this, a convenience list was developed and used. The list contained variables such as; the number of patients that have to share facilities like living rooms or bathrooms, or whether the patients have single rooms. The list was compiled from discussion with experts on the design of closed admission wards.

Second, all staff members from the participating wards were personally invited, by email, to complete the 'Perception of Prevalence of Aggression Scale' (POPAS). In order to increase the response rate, this questionnaire was made available on a personalised, secured and easy to use internet site. Staff members received an invitation and a reminder to complete the questionnaire after two and four weeks. After six weeks, the website closed and it was no longer possible to complete the questionnaire.

The POPAS is a scale that is devised to reliably measure aggression without measuring aggressive incidents (Oud 2000). The POPAS has a high internal consistency, with a Cronbach Alpha of 0,91 (Oud, 2005). It has been previously used to explore the types and prevalence of aggression in Irish emergency departments (Ryan & Maguire, 2006) and to measure the aggression carer-relatives of people with psychosis experience (Loughland et al., 2009). One benefit of the POPAS is that it counteracts the underreporting that is often found in other research, for example Woods et.al., 2008 found that 6.5 times less incidents were reported than occurred when using an incidence based measuring tool for aggression. Abderhalden et al. (2007) also claimed that their incidents were underreported by thirty percent. Therefore, the POPAS is an alternative way to measure aggression that has the promise to be more reliable than, or at the very least as reliable as, the incidence based methods.

For this research, it was essential to be able to measure aggression in an efficient, reliable and retrospective manner. The POPAS matched these criteria. When administrated through the Internet, it takes approximately ten minutes to complete and since the POPAS asks about the last year, it paints a quick picture about aggression in the last year.

To analyse the data, nonparametric tests were used, i.e. Mann-Whitney U (nominal vs. interval data) and Spearman's rank correlation coefficient (ordinal vs. interval data). These tests were chosen as they provide reliable results even in cases with a relatively small sample and without a normal distribution.

Results

The ten wards were widely distributed across the country and included both cities and rural areas. Of the staff members who received an invitation to complete the questionnaire (N=95), 52 completed the questionnaire. This equated to a response rate of 55 percent (35% - 79% for each of the individual wards) which was similar to other research (Baruch, 1999) and according to Bryman, 2008, sufficient for analysis. The majority (52%) of the respondents had a bachelor (or similar) degree. 36% of the respondents has a middle or lower professional education and 10% had a bachelor degree with additional training. The last two percent of the respondents had a master's degree. Results of the Mann-Whitney U tests between the nominal variables of the questionnaire and the ordinal variables of the POPAS suggested some association but failed to reach statistical significance (p<0.05). Results of the Spearman's rank correlation coefficients, between interval variables of the questionnaire and the four factors of the POPAS, did show some statistically significant relationships. The first two correlations were between the number of patients on the ward and both verbal and physical aggression (rs = -0.927, p = 0.003 and rs = -0.873, p = 0.010). These negative correlations suggest that more patients on the ward are related to less verbal and physical aggression. A further set of correlations was between the number of seclusion rooms on the ward, corrected for the number of patients on the ward, and both verbal and physical aggression (rs = 1.000, p = 0.000 and rs = 0.964, p = 0.000). The positive correlations suggest that having more seclusion rooms is associated with more aggression. The final set of correlations between the number of staff during the morning and afternoon and all types of aggression (rs = -0,788 to -0,867, p = 0.012 to 0.035). This relation holds up for all kinds of aggression to oneself and sexual aggression when corrected for the number of patients on the ward (rs = -0.873, p = 0.010 and rs = -0.837 and p = 0.019). These negative correlations show that less aggression occurs when there are more staff on the ward.

Discussion

Common sense suggests that physical space influences aggressive behaviour, in many circumstances, including psychiatric hospitals. For example, a psychotic patient with low frustration-tolerance is less likely to become aggressive if he has the possibility to rest in the privacy of a single room rather than a shared room. However, it is quite remarkable how little evidence-based information there is available on the topic. The research that has been conducted shows widely differing methods and small, or very specific, cohorts or samples meaning that the generalisation of the findings is problematic and further research is necessary. This study attempted to provide an innovative and well thought-out research design to explore the association between physical space and aggressive incidents. The greatest challenge was to measure aggression in an efficient and retrospective way, instead of the usual time-consuming prospective methods of measuring aggression using incident based methods. A validated questionnaire (POPAS) was used to retrospectively measure the perception of aggression in staff members. The main advantage of this method was that the underreporting of aggression should be less of a problem, in situations where underreporting is usually high (Tenneij et al., 2009; Abderhalden et al., 2007). Other advantages of this measure of aggression are the efficiency and the opportunity to measure aggression retrospectively. On every ward that was included, at least five different staff members completed the questionnaire and the average response rate was 55 percent. In general, this design turned out to be a very practical way to measure aggression.

One purpose of our research was to determine the effect of single rooms on aggressive behaviour. However, no statistically significant correlation was found. In our opinion, this could be explained by the small sample (seven wards) and the strong T-test of the Mann-Whitney U-test. For a relation to be significant in the Mann-Whitney U-test, the relation has to be very strong, which is not likely to happen with a small sample. Another conclusion is off course that the hypothesis should be rejected. Future research and a larger sample are needed. This research has two limitations due to the limited time and resources available. Firstly the sample size (i.e. number of wards) is quite small (N=7). A larger sample would lead to greater statistical power to determine whether there was a significant association between physical space and aggressive incidences. The second limitation is the information about the physical space on the wards. Since the data had to be collected by telephone (as visiting the wards was too time-consuming) only a limited amount of information could be collected. The variables had to be limited to easily identified elements that could be collected with minimal risk of respondent bias. This resulted in fewer variables and thus fewer correlations than originally hoped. Ideally, data on the variables would have been collected by the author visiting the individual wards so that more data could have been collected and in a more objective manner.

Conclusion and future work

The results of this research show that physical space does have an association with aggression on closed admission wards of psychiatric hospitals in the Netherlands. With more patients on the ward, fewer seclusion rooms per patient and more staff per patient during the morning and afternoon associated with less aggression.

The results of this research partially counter the current evidence that is found by Daffern et al. (2004) and others. Although, it concurs with evidence found by Palmstierna et al. (1991), Krakowski and Czobor (1997) and Ng et al. (2001). Results of this research suggest that psychiatric hospitals should adapt the current physical space on their closed admission wards and consider the results of this study when designing new buildings. Furthermore, as the results from this study show that the number of staff on a ward during the daytime is associated with aggression; wards should aim to have as high a level of staffing as possible at these times. It is likely that aspects of physical space other than those measured in this study are also associated with aggression and future research should aim to investigate these further. Future research could employ a similar design as used in this study but include a larger sample and more extensive and objective measures of physical space, by researchers visiting wards rather than a telephone interview with ward managers.

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Successful Seclusion & Restraint Reduction in a Large Civil & Forensic Mental Health System 2000-2010

Workshop

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Abstract

From 2000 to 2010 this nine-member psychiatric acute care hospital system used 17,622 restrictive measures (Mechanical restraint, physical restraint or seclusion) in response to patients who were in psychiatric or behavioral crisis. During this span the system significantly decreased its use of Seclusion, Mechanical restraint and Chemical restraint by more than 99% (p<.05).

The objective of this study was to assess the use of Seclusion, Mechanical Restraint and Physical Restraint as used in this hospital system and to identify the diagnostic and demographic differences in patients who were exposed to these violent procedures. This study also identified the reasons why these measures were used and any adverse physical effects attributed to their use.

Currently, several hospitals in this system of care prohibit the use of seclusion and one hospital has eliminated both the use of seclusion and mechanical restraint. Floor control physical restraint techniques, (prone or supine restraint), are no longer permitted and short time limits have been placed on all uses of restraint. In March 2005 the hospital system discontinued the psychiatric use of PRN orders severely limiting the use of chemical restraint. This innovative workshop will detail the actions taken by hospital system (Staff training, response teams, leadership, policy changes, clinical alerts, use of clinical data) to affect this change including legacy data on incidents of patient-to-patient and patient-to-staff assaults.

Educational Objectives

1. To understand the dramatic reduction in the use of all coercive procedures within the nine-member acute care psychiatric hospital system based in the northeast United States.
2. To describe the strategies used to accomplish these changes in clinical practice.

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Psychiatric Use of Unscheduled Medications in the Pennsylvania State Hospital System: Effects of Discontinuing the Use of P.R.N Orders

Workshop

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Abstract

The potential use of medication as a form of chemical restraint became an issue for the Pennsylvania, State Hospital system as they began to reduce and eliminate the use of seclusion and restraint. There were concerns that sedating medications would be substituted for the use of these procedures. A study published in the October 2003 edition of the Psychiatric Services Journal on the psychiatric use of PRN orders (Pro Re Nada, or as the needed) at Arkansas State Hospital concluded that psychiatric medications administered by PRN order overexpose patients to psychotropic medications and may be given for staff convenience.

The objective of this prospective study was to assess patient exposure to unscheduled psychiatric medications in all nine Pennsylvania State Hospitals. Unscheduled medications were defined as those administered by PRN or STAT physicians order. Starting in March 2004 through May 2005 the state hospital system conducted a study that assessed the unscheduled use of 46,913 psychiatric medications. During this span the use of psychiatric meds given by PRN or STAT order significantly declined from 88 per 1,000 days-of-care to 17 per 1,000 days-of-care (p<.001). This study led Pennsylvania to a new state policy in March 2005 that prohibited the psychiatric use of PRN orders in their state hospital system. This change resulted in a safer hospital system because aggression, patient-to-patient assaults with injury, adverse drug reactions and the use of seclusion and restraint decreased during this span when compared to baseline.

This innovative workshop will discuss the issues, concerns, methods and results raised by this positive change and the systems approach (policy changes, leadership, staff training and clinical data) used to improve this important clinical practice.

Educational Objectives

1. To summarize a unique approach used by a hospital system to accomplish system-wide change in its civil hospitals and forensic services.
2. To understand the immediate and long-term effects of this change on hospital safety measures, (falls, assaults, med errors, restraint, and seclusion)

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The Psychiatric Emergency Response Team Process: A Non-Violent Approach to Supporting People in Crisis

Workshop

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Abstract

The objective of this study was to assess the use of Psychiatric Emergency Response Teams (PERT) in supporting patients in crisis in a large, urban state psychiatric hospital. This study also evaluated the specific reasons for a PERT call and the success of this team approach in supporting the patient without the use of any physical intervention. A successful PERT intervention is defined as any response to a crisis where a physical intervention was not required. During this six-year study period there were 1,523 PERT calls of which 66% did no require a physical response (restraint or seclusion) ($p<.05$). During this span, as the need for physical interventions declined, so did the length of time a patient was in restraint or seclusion. Patients and Staff viewed this change as a growing trust in an approach that was non-violent or coercive.

The PERT process is a highly structured, interdisciplinary team approach at supporting a person in a psychiatric or behavioral crisis in an organized and safe manner. This positive approach also provides a planned response to a potential psychiatric emergency.

This workshop will detail the evolution of PERT in a large hospital system and present the policy changes, staff training, and the required leadership coupled with the use of measureable data in promoting a non-offensive approach in supporting people in crisis.

Educational Objectives

1. To understand the differences and risks between a "Gang" and a "Response Team" approach to supporting a person in a psychiatric or behavioral distress.
2. Participants will understand the staff initial and long-term training issues involved with the implementation and development of effective Psychiatric Emergency Response Teams.

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The Safewards Model and Cluster RCT

Paper

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Background

Conflict (violence, self-harm, suicide, absconding, substance/alcohol use and medication refusal) and containment (as required medication, coerced intramuscular medication, seclusion, manual restraint, special observation etc.) place patients and staff at risk of serious harm. The frequency of these events varies between wards, but there are few explanations as to why this is so, and a coherent model is lacking.

Aims

The Safewards model provides a comprehensive explanation of these differences. The model will be described with its evidence base.

Methods & Results

The Safewards model depicts six domains of originating factors, giving rise to flashpoints that have the capacity to trigger conflict and/or containment. Staff interventions can modify these processes. A cluster RCT of a complex intervention based on the Safewards model is underway. This large study involving thirty wards at fifteen hospitals in England will be complete at the time of the conference, and the outcome will be presented.

Conclusion

There are significant implications for methods for reducing risk and coercion on inpatient wards.

Educational Goals

1. Explanation of variations in conflict and containment rates between wards
2. Generation of new strategies for promoting the safety of patients and staff

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National guideline for physical restraint in the Netherlands

Paper

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Background

Various coercive practices – especially physical restraint and seclusion – have been highly prevalent in Dutch mental health care. Several comparative studies, which included other European countries, resulted in increased awareness on the issue of physical restraint. The government of the Netherlands therefore started in 2006 a nationwide coercion reduction programme to stimulate alternative practices.
Violence and aggression have been identified as the most frequent reason for the use of coercive measures (Gutheil, 1980, Mason, 1994, Morrison & Lehane, 1996, Currier, 2003). Verbal interventions and de-escalation is always the first option to prevent incidents. However, in extreme cases staff members need to use physical restraint to prevent further adverse incidents. Although this intervention has been used frequently, until recently national guidelines and quality standards were lacking.

Coercive measures and physical restraint damage the therapeutic relationship. Use of physical restraint dangerous and psychologically disturbing for the patient and for staff. Physical restraint is regarded as an intrusive intervention, which needs to be used as a last resort, and - when unavoidable - the proportionality needs to be taken in account. Safe physical restraint is extremely important for all age groups, however children and adolescents admitted in mental health care settings need to be approached in an even more delicate way due to unequal body impact issues.
In 2011, the Dutch Association of Mental Health and Addiction Care (GGZ Nederland) decided to develop a national guideline for safe and secure physical restraint. The core mission of this guideline is to guarantee the proportionality and subsidiarity of the actual intervention and to abolish poor and unsafe practices. In addition, instructions for debriefing techniques are provided to enhance retrospective risk analysis and options for pro-active risk management by staff members and management alike.

GGZ Nederland developed the national guideline for physical restraint with mental health care practitioners and educational organisations that are specialised in teaching various methods of physical restraint. The developed guideline has been approved as best practice in 2011 by all member organisations of GGZ Nederland. Consequently, all training institutes have to comply with the national standard.

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Educational Goals

- To demonstrate the guideline for physical restraint in the Netherlands
- To discuss the need of research on physical restraint methods used in mental health care institutions

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A new managed care model in emergency psychiatry: The Crisis Response Center of Tucson, Arizona, U.S.A

Paper

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Keywords: emergency psychiatry, managed care, managed Medicaid programs, inpatient psychiatric beds, community psychiatry, centralized crisis management, violence risk management

Introduction

Arizona - one of the fastest growing states in the USA – has been a pioneer in managed Medicaid systems since the mid 1980s. Arizona was the last state to implement Medicaid in 1984 – almost 20 years after the original federal legislation was passed in the 1960s. Medicaid in Arizona was called the Arizona Health Care Cost Containment System. The title emphasized the managed care/cost control approach to medical and psychiatric services. This cost containment system was not only the newest Medicaid program, but it was also the first managed care Medicaid program in the United States. Managed state Medicaid plans are characterized by contractual relationships between the state government payers and non-government for-profit or non-profit providers who agree for a fixed amount of money to provide a range of services for the designated Medicaid population. (1) Medicaid is the primary insurance program for mental health services among the severely mentally ill not only in Arizona but also throughout the United States. (2)

In the provision of providing mental health services, the managed care model is primarily a cost savings approach that emphasizes the least expensive level of care in the "least restrictive setting"—a complex euphemism that emphasizes human rights issues and discourages inpatient psychiatric hospitalization. Minimizing psychiatric hospitalization is a major cost savings goal of all managed care interventions. (1) This paper discusses the creation and implementation of a second generation managed mental health care model in Tucson – located in Pima County and the second largest metropolitan area in Arizona - that uses a centralized crisis system as the hub of managed Medicaid mental health services to further minimize hospitalization.

The Crisis Response Center and second generation managed mental health care

In psychiatry, the main historical tool of managing violent behavior has always been psychiatric hospitalization. During the hospital stay, a wide range of treatment interventions are utilized to stabilize the patient and to decrease the risk of violence upon discharge. Violence management thus becomes a central and critical aspect of admission, continuing hospitalization and discharge. (1,2,3)

Traditional managed care used a number of "tools" to prevent and decrease the length of time of psychiatric hospitalization. These "tools" to limit hospitalization include strict criteria – "medically necessary treatment" - for authorizing payment for inpatient admission and strict criteria for paying for a continued stay in the hospital. When it comes to paying for psychiatric hospitalization, the imminent risk of violent behavior is the criterionthat justifies admission, continuing stay and discharge in an inpatient psychiatric unit. The goal of managed care is to encourage the shortest stay possible by monitoring the progress of the patient on the unit. The impact of traditional managed care on the length of stay in psychiatric units in Arizona and the United States has been to tremendously decrease hospitalization from nearly a month in the early 1980s to approximately a week by 2010. (1,2) The new crisis center managed care model implemented in Tucson in 2011 is continuing to minimize and shorten length of stay mostly by avoiding hospitalization in the first place.

In Tucson, Arizona, there have been four major players in this story of the transformation of services from a traditional managed care model to a centralized managed care crisis model. These players are the State of Arizona, the Community Partnership of Southern Arizona, Pima County and the Medical School of the University of Arizona. (4,5) The State of Arizona contracts with the Community Partnership of Southern Arizona. The Community Partnership contracts for managed care mental health services in Pima County, a population area of over one million. Pima County owns the health care campus that includes a general

medical hospital, a psychiatric hospital and the Crisis Response Center. The county also operates the Pima County Jail. This county jail houses the largest institutionalized group of people with mental illness: 25% of the estimated 2000 inmates have a mental disorder. This was two and a half times the total number of psychiatric hospital beds in Pima County (200). Pima County is also financially responsible for mentally ill patients involved in involuntary psychiatric commitment. Pima County contracts with the Medical School of the University of Arizona for operating and staffing both hospitals. The Community Partnership runs the Crisis Response Center.

Change often requires crisis. The ongoing perceived crisis predicament of Kino Hospital – the original name of the county hospital - was the main match igniting the change from the traditional model to the crisis center model. In the 1980s and 1990s, the occupancy of the psychiatric units in Kino Hospital was always near 100% while the general medical units averaged less than 50% and often around 25%. The county thus was essentially supporting a near empty medical hospital and overwhelmingly full psychiatric units. The hospital was financially failing and the county was responsible. The local media – newspapers and television news - criticized the county for decades for this financial albatross. (7)

In the early 2000s, a series of high profile scandals hit Kino Hospital: a psychiatric patient died in the process of being restrained and the pharmacy suddenly had a million dollars of drugs disappear. An investigation by the state nearly resulted in the hospital's closure. The county arranged in 2004 to turn over management of the hospital to the physicians' group of the University of Arizona Medical School. The County entered into a twenty-five year lease agreement with University Physicians Healthcare in 2004. The purpose of this unique public/private partnership was to transition the hospital from one focused mainly on psychiatric services to a full-service hospital that provided comprehensive medical services to an underserved population, and to reduce taxpayer support of the hospital. (4,5,7)

The development of both a new psychiatric hospital and a new crisis center were also part of the agreement. A master plan was developed that included an upgraded and expanded psychiatric facility, state-of-the-art research and training programs and a crisis response center. The need for these new psychiatric facilities was justified by the large number of people in Pima County with mental disorders— an estimated 60,000 with 30,000 currently enrolled in services. Further justification made clear the lack of psychiatric care facilities as a regional issue that impacted not only mental health service providers and jail and juvenile facilities, but also hospital emergency rooms and law enforcement personnel throughout Southern Arizona. The solution to this problem was the construction of a second building that would function as a psychiatric urgent care crisis center. When it came to savings for the taxpayer, it was estimated that the potential cost savings, because of diversions from the jail, could amount to $6.5 million a year. The Crisis Center was thus seen as a way to prevent people with mental disorders from entering and being warehoused in jails, also as a way to decrease involuntary commitment and, finally, a way to decrease psychiatric hospitalization. The marketing campaign by the county for the bond promised 80 to 100 psychiatric beds in the new psychiatric hospital. The bond was successfully passed with 60% voter support. (4,5,7)

The new psychiatric hospital and the Crisis Response Center were opened in 2011. One year later over 12,000 people had been served. The Community-Wide Crisis Line had answered 135,390 calls resolving 95% of the crises over the phone. Other emergency rooms had transferred over 2,700 people to the Crisis Center. The Center saw thousands of people without any insurance as well as being the crisis gateway for the vast majority of mentally ill people who were seen in the community. The Community Partnership instructed its providers to use the Crisis Center for all their clients who were in crisis or might need hospitalization. Everybody was served, including children, adolescents and adults. There were eight beds for children. There were also an additional fifteen beds for longer-term stabilization. In addition, the Center coordinated outreach services to help the police in complex mental health situations. The Center was particularly critical for law enforcement as it was designed to provide a quick drop off point for mentally ill patients picked up by police officers. Specialized construction allowed officers to drive up directly to the facility and quickly transfer their patients to the Crisis Center. (5)

Thus the Center became the new gateway to virtually all emergency psychiatric services, especially, inpatient psychiatric beds. Open 24 hours a day, 7 days a week and 365 days a year, comprehensive mental health crisis screening provided triage services for clients. 23 hour holding chairs were also available. These were comfortable reclining chairs that allowed people to sleep in them overnight. The 23 hours provided a short period of cooling off time to see if the crisis could be resolved before an inpatient hospitalization was required. The client could also be transferred by car back to the provider agencies of the Community Partnership or other service locations in the community. (5)

On February 26th 2013, the Community Partnership submitted to Pima County leadership the Crisis Response Center Annual Report. (5) The summary of the operation of the facility included the following

points: Crisis behavioral health services for adults and children were achieving many of the goals envisioned for the facility which were to reduce jail incarceration of individuals with mental illness and/ or substance abuse issues, reduce Emergency Department visits in hospitals, reduce inpatient psychiatric hospitalizations and reduce incarceration and hospitalization of children and youth. Required program service components such as the call center, mobile acute crisis teams, crisis stabilization services, sub-acute inpatient care for adults, secure and rapid law enforcement/first responders transfers, nonemergency crisis transportation services and peer support were successfully operating, Their report ended with the conclusion that in a very short period of time, the Crisis Response Center had become a national model.

Consequences

The Crisis Response Center – the new engine of second-generation managed care – has now been opened for two years. What are the consequences of this new program? As noted in the annual report, in terms of heavy consumer use, the Center was a clear success. In terms of decreasing psychiatric hospitalization the Center was also a success. There were some promises that the County had not kept, however. The new psychiatric hospital built by the County had only 48 beds, not the initially recommended 80 to 100. The county further saved money by decreasing the number of days they would pay for involuntarily committed patients. While the number of new people who were initially involuntarily committed skyrocketed, the number of these same involuntary commitments that were eventually dropped – one of the goals of the new system - also skyrocketed: increasing to nearly 75%. (8) Thus 75% of all people involuntarily committed became either voluntary patients or were immediately discharged. This fact caused serious concerns for both families and community providers. Many people who had their involuntary commitments dropped were subsequently recommitted because they had become much sicker in the community as a result of not being compliant with treatment and not being stabilized in a hospital. Many of these, who were recommitted, once again, had their involuntary commitment proceedings dropped. Many of the commitment proceedings were dropped because of the lack of psychiatric beds and the huge demand for them. Thus the total lack of psychiatric beds in the system created pressure to both drop involuntary commitments and to prevent psychiatric hospitalization. Before the Crisis Center was built many Emergency Rooms in town would just hold on to these patients till a psychiatric bed was available. The new Crisis Center simply released them. The county was not the only entity responsible for decreasing psychiatric beds. The Community Partnership closed sixteen long-term psychiatric beds when the Crisis Center opened to help finance the Center. Within Pima County there was also no expansion of crisis residential beds or other housing alternatives. Thus the decisions by the county and the Community Partnership both significantly decreased the number of available psychiatric beds and prevented many patients from ever entering the hospital. The effect of these strategies, decreasing the total number of psychiatric beds, observing patients in 23 hour holding beds then discharging to the community and dropping involuntarily committed patients, significantly decreased inpatient psychiatric hospitalization.

To date there are no studies of the total impact of the Crisis Center. Anecdotal information, however, reveals a number of problems. (8) In a panel that I participated in on mental health at a local Catholic Church, a clearly distraught and angry woman told the story of her son who had multiple visits to the Crisis Center, was never hospitalized and committed suicide. Another member of the audience also angrily commented about not being able to get services for his son who had been violent towards himself and others with multiple calls to the police and multiple releases from the Crisis Center.

Many providers, patients and family members are concerned with the rapid revolving door turnover from the Center. Providers from the agencies are often dismayed when patients they send to the Center for assessment are immediately sent back to them in the same clinical state that they were sent to the Center to treat. For example, when I asked a group of 30 providers at a medical staff meeting of a local provider agency how many had benefitted from the Center, not one of the providers raised their hand. In talking to patients the reaction is mixed. Some patients feel the Center has been helpful. They speak of a less stigmatizing environment then the emergency rooms in general hospitals. Many others however are frustrated by the revolving door reality. Many patients do not like the 23-hour holding chairs and will not return again. Ironically, this frustration contributes to the goal of decreasing psychiatric hospitalization. In addition, many homeless who go to the Center report being discharged back to the streets. (8)

The Center was recently fined by the state of Arizona because of a series of violations. (6) These violations included not having consent forms signed, concern of an overuse of chemical restraints, lack of training in staff who restrained patients, inappropriate structural problems that resulted in several attempted hangings, and low employee to patient ratios. As a result of inappropriate medical care there has been at least one death. Former employees comment about the high level of violence at the Center with multiple injuries of nurses and psychiatric technicians occurring after being attacked by patients. There has been significant concern about extremely low staffing ratios that put the employees at higher risk of being injured. The

most evident problem of the Center, however, is the revolving door phenomena: many patients, rather than being stabilized, were being seen repeatedly.

Conclusion

The Crisis Center was conceived during a time of both government crisis and the ability to obtain new financial resources through the passage of a County bond. It was implemented in 2011 during the second greatest economic contraction in the last hundred years. The Crisis Center has certainly been successful in some goals such as volume management and decreasing psychiatric hospitalization, but it has failed at any semblance of stabilizing chronically ill clients. Inpatient hospitalization is becoming less and less of an alternative in managing violent risk situations for the mentally ill. A significant percentage of the thousands of people who are discharged from the Center are not psychiatrically stable. The Crisis Center has become a partially successful, but also a problematic model for these recession era times. Despite these problems, this second generation managed care model will certainly be looked at as a solution for centralized, crisis-based mental health care because of the significant cost savings achieved by minimizing psychiatric hospitalization. Is this savings truly worth the costs and consequences for the surrounding community?

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No more solitary confinement! One to one guidance to restore connection with the patient during coercion and confinement

Paper

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Abstract

The Dutch Health Care Inspection gives a very clear statement in their assessment framework of 2012-2013: Seclusion is no solitary confinement. And that's quite a change of thought in comparison with the true Dutch tradition of solitary Seclusion. Even though, the new rules are not even that revolutionary: every 15 minutes a slight look at the patient, and every hour 5 minutes of face to face contact, but only in daytime, and the patient may refuse. And moreover, nothing is said about the aim of the contact. And, even though it may not be the purpose of the Inspection of Health Care to interfere in the way of interpersonal conduct, that's what it is all about!

In our own hospital, we have to deal with patients who committed a severe offence or disrupted the ward of a regular mental health hospital. We still have to use seclusion sometimes to deal with the extreme aggression or disruptive behavior on the very intensive care wards. In a major project minimizing coercion and seclusion which took place from 2009 until 2012, we achieved a lot of improvement, with far more and better use of alternatives, like the comfort room, use of concerned relatives, and the use of a de-escalating supporter. But more important is the change of culture: the way we think about what safety really means on both sides and the meaning of a close contact with the patient, no matter the behavior!

We found that reducing the aggression or disruptive behavior on the wards, is maybe less about how to use the right aggression prediction scale instrument, or the specific use of medical treatment, but about the right use of interpersonal conduct. In our philosophy, the side effect of using coercion and seclusion severs the connection between care giver and patient. So, the aim of coercion needs to be about restoring contact and connection. But we know by experience, that it's impossible to be in real contact with a patient who has hit or otherwise assaulted you.

In this presentation we will provide our way of restoring contact and engagement. We have formed a specific selected small team of care-professionals, who will give one to one guidance. Restoring engagement is their specific goal. They help the care givers on the wards to be able to connect again with the patient. They give one to one guidance themselves when the others are not neutral anymore, on the ward, and during seclusion. In this way, we are able to say: no more solitary confinement!

But how to organize such a team and what kind of competences do you need to give such one to one guidance? And what are the effects on the number of (the time in) seclusions, the influence on the behavior, and above all, the sense of coercion by the clients themselves? We are willing to provide these answers together with the first results of a starting investigation of these effects of our form of one to one guidance.

Educational Goals

To learn more about de-escalation skills such as using your own being, and the essence of restoring contact.

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Specialists in de-escalation: the de-escalation supporter[1]

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Introduction and summary

In this paper the author writes about the success of an experience based intervention for the reduction of coercion and seclusion: the de-escalation supporter, within the clinics of intensive care of Inforsa, Arkin, Amsterdam. In the search of the heart of the seclusion and coercion problem, we found that the key lies in changing the frequent emotional distance between caregivers and care receivers. Handling aggression and trying to de-escalate is about reflecting to yourself and about being able to meet the emotional needs of the other. The de-escalation supporter shows that a lot of coercion and seclusion can be prevented by such an attitude.

Reducing coercion

From approximately the year 2000, a lot of psychiatric clinics in the Netherlands started up different projects to reduce coercion and seclusion. They seem to be quite successful in reducing the amount of seclusion, and especially the time of seclusion. (Noorthoorn., 2012). Since that moment, a lot of "best-practices" are in circulation (Voskes e.a., 2011). Best practices of innovative, creative interventions, such as for example: using the first five minutes of contact when the patient is entering the clinic, using a relapse aggression prevention plan, making use of experienced experts, using specific methods to de-escalate, altering the physical environment (in the spirit of "healing environment"), such as comfortrooms and Intensive Care Units, altering working processes (using e.g. the crisis monitor), or using supportive and reflective activities (evaluation, training and data feedback). (Voskes,., 2011) It all helps to achieve a different and less restrictive environment, with far less use of coercion and seclusion.
Like all other Mental Health Clinics in the Netherlands, reducing coercion and trying to change and diminish the use of seclusion, is also a very important goal in our very intensive care clinics, even though we have to deal with (potentially) very aggressive psychiatric patients, who disrupted the ward of a regular mental health clinic, or committed an offence.

An escalating atmosphere

When we started our project for reducing coercion, in 2009, we tried to identify the heart of the seclusion and coercion problem. Because we felt that the disorder, or misbehaviourcould not be the cause of the use of seclusion and/or coercion, but far more the culture on our wards. This has also been confirmed by other authors (see also Lendemijer, 2000 and van der Werf 2009). The latter discovered that the use of seclusion divers dependedlargely on the clinic or ward, within a range of 1 to 90% on the regular acute wards).

We found on the wards there seemed to be a lack of connection and contact between staff and patients (caregivers and care receivers). Because of the severe danger of aggression and of the sometimes tense atmosphere on the wards, caregivers tended to focus on physical and emotional distance, instead of closeness. The purpose of staying in our clinics seemed to be a change of behavior and not a change of dealing with emotions. For that reason caregivers sometimes reacted in a very strict way to any form of misbehaviour or agitation.

So, keeping emotional distance, can be a matter of 'coping with the difficult situation', when you get overwhelmed caused by the destructive atmosphere on the ward. And it is quite understandable that the empathy has 'left you', when a patient kicks you in your stomach while you are helping with the injection of the medicines, or when the patient starts to scold and rage right in your face…. And you can't stand still when the only thing you do is running after the patients, trying to calm them down, without success….
Another cause of the lack of connection, can be the way caregivers think (and are educated) about the reason and cause of the behavior problems. (van der Werf,, 2009). When you think (or are told) that aggression is a way of 'dysfunctional learned behavior', than the solution will be restricting this behavior.

This means staying neutral, feeling in control, don't react on what the patient expresses, directly or indirectly, follow the rules and regulations and if necessary, confine the patient. Confine at least until he calms down, is able to reflect on his behaviour, or until the regulations tell you.

A third reason of a more restrictive culture is closely related to the former two. Because, when you as a caregiver focus on the (mis)behavior, often feel overwhelmed and are not used to reflect enough on your own emotions, you can only think that you're out of control and this being out of control needs to be 'repaired'. Feelings of helplessness can be converted in frustration and resistance ("I don't want this, it needs to be stopped!"). In order to feel in control and comforted again, you can project these feelings on the patient, thinking that he is 'trying to manipulate you, or behaves this way on purpose, because he is after you'… The only way out, is the use of force and repression.

In fact this internal process is a 'parallel process' with the patient. It can also be the reason of the destructive behavior of the patient himself.

Key to de-escalation

In order to stop this escalating parallel process of feeling powerless and neglected, ('with the back against the wall') on both sides, we need to be convinced that we as a caregiver, in the first place, have to change, and not the patient! And this is indeed a major challenge, in a culture where everybody is quite busy trying to find the proper 'evidence based intervention'.
A confirmation for the discovery that we have to reflect on ourselves, and that aggression is a result of an escalating interaction problem, has been given by some specific care givers. The next incident happened some years ago (and still happens sometimes):

"While all the caregivers gather at the window walled office of the ward, feeling scared or angry, and staring at the patient on the ward, who is in rage and demolishing the ward, the majority beliefs that police has to come to overpower the patient. No one dares to do it themselves. One caregiver however, starts opening the closed door to the ward, telling the others that he is going to have 'a chat' with him (the patient)… All the others are astonished and stare at him. They are not able to stop him. This particular caregiver walks to the enraged patient and after a short while they walk together to the room of the patient. Everyone in the office can't believe what they just saw there. …"

When we thought about this, at that time, we noticed that a few specific caregivers were extremely good in calming down very disrupted or angry patients. They seemed to be more impassive to the destructive emotions. Therefore we asked these specific caregivers, to be available for escalating situations throughout the clinic: the de-escalation supporter was born.
Nowadays we have enough de-escalation supporters to be available for the whole clinical building (that means 8 wards of the forensic clinic and 5 wards of the long term intensive care wards) throughout day time (one in the day and one in the evening). They are however not permanent available, as they work on their own ward and are called in when needed.

De-escalation supporter

But what does this de-escalation supporter do exactly and what are the ingredients for their success?
It's funny to realize that up to today we are still analyzing this process and finding out why it works. Sometimes it appears as a 'miracle', or as a natural gift from a specific caregiver. But slowly we realize what it's really about. The first condition is the way you experience the other, by feeling or noticing his appeal. Do you only sense the aggression, hearing the 'noise', or do you notice his emotional appeal, can your still hear the 'words', or better, the needs, the despair, through the noise.

And secondly, can you make contact with it, with this vulnerable side, despite his behavior. Are you able to recognize the other as a person? Can you give him confirmation who he is, and not how he acts. Can you give him the honor of being (someone special)? [2]
Thirdly, when you sense the needs, and are able to meet the other, you need the 'guts' to do something! Dealing with aggressive behavior is not soft, feeling empathy however does have sometimes that 'soft tone'. But you need both. When a lot of other caregivers around you can feel scared, or angry because of the misbehavior, and even when the doctor with his "clinical look" argues that the patient is a danger for his vicinity, you need to stand up for him, saying: "I think we need time and space for contact, please give me some credits".

So, you don't need to be impassive for the destructive emotions of the patient, but also of these of your own co workers. You need to have a very sensitive, but stable personality, a rare combination.

And at last, being able to do so, you need to think in opportunities, in new ways, outside the well known 'box', being a non-conformist, amongst people and amongst ideas.

Professionalized psychiatry care is often very much regulated, so everyone knows how to act, and the patient gets the proper structure. The way to deal with the aggression and ways of repression are sometimes precisely described, in order to prevent that care workers get overwhelmed. It's the delicacy and subtle way of superiority that the successful de-escalation supporter finds a way to persuade the others to find the 'third way', so that escalation and suppression can be prevented.

Different roles

The roles of the de-escalation supporter can consist of four different parts.

First of all, the de-escalation supporter can be called for a de-escalating situation with the patient only, like the example described before . Secondly, the role can be of a mediator. There is an impasse and both parties (patient and staff members) are often fed up with the situation and everything they say works as a verbal escalator. The third role comes often together with another role. Because emotions grow on both sides and sometimes the first need is to find the 'emotion valve' of the caregivers. Steam must be released first, before you can get further, and sometimes that's all you need. The attitude you need to 'meet the needs' of the care receiver, the patient, is the same you need for the team of caregivers: giving confirmation how they feel, trying to neutralize and finding escapes.

The fourth role is the coordination of an escalation. When (verbal) de-escalation did not succeed and a physical intervention is needed to calm the patient or to bring him to a safer place, it's very important the de-escalating atmosphere is continued. Reflection: how does everyone feel for themselves, tranquility: no high emotions, think in ease and at last, close contact: taking over the autonomy and control only where absolutely necessary, but give it right back where ever possible.

Conclusion: It works

Our experience is that finding the right attitude, making real contact with the patient as a human being, even when he acts extreme, definitely works. A large amount of coercion and seclusions are prevented, patients themselves relax when they see a de-escalation supporter, or even ask for them sometimes.

It works…. a patient is cross, demanding other medication and threatens a doctor. After first escalation, the doctor demands assistance from the police, thinking the patient is enragedand wants him dead. The de-escalation supporter asks for some time, meets the patient in the garden (where he is at that time, against the rules), and within 10 minutes of recognition, confirmation and mirroring his behavior in a gentle way, they walk together to his room, being able to have a conversation again, even with the doctor….

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Endnotes

1. This paper about the de-escalation supporter, is closely related to my other paper: "No more solitary confinement! 1on1 support to restore connection with the patient during coercion and confinement" and has partly the same contents
2. In this way of thinking we are much influenced by "De Theorie van de Presentie" (theorie of the presence), with its relationship based programming and professional caring. Read e.g. the books of Andries Baart or www.presentie.nl

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Leading the Way: How an Organization's Leadership Promotes Least Restraint in a Canadian Psychiatric Hospital

Poster

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Abstract

There is strong evidence in the literature to support the use of seclusion reduction initiatives on acute mental health units (Cadeyrn, Gaskin, Stephen, Elsom, & Happell, 2007). It is also recognized that the leadership team of an organization plays a key role in achieving the goal of least restraint (Waqar Azeem, Aujla, Rammerth, Binsfeld, & Jones, 2011). Our drive to effectively and efficiently reduce incidents of aggression and maintain the safety of patients and staff in health care, specifically in high risk areas, is impacted by the realities of resource availability. The literature demonstrates that training programs have contributed to increased feelings of confidence in managing aggressive clients or feelings of self-efficacy (Wang, Hayes & O'Brien-Pallas, 2008). Organizations have been called on to recognize that coercive or violent interventions cause trauma and are to be avoided and replaced by trauma-informed care (National Association of State Mental Health Program Directors NASMHPD/National Executive Training Institute NETI, 2005). A pre-cursor to the effective implementation of restraint minimization programs is a clear organizational policy that is published and disseminated to let employees know that management is committed to reducing violence (Wang, Hayes & O'Brien-Pallas, 2008). The seclusion reduction initiatives undertaken at a Canadian Hospital will be reviewed and the successes and challenges of implementing these initiatives will be shared. These initiatives include policy changes to a restraint minimization focus and creating seclusion clinical practice guidelines. An evaluation of the implementation of education programs such as NASMHPD's Six Core Interventions for seclusion and restraint reduction, Nonviolent Crisis Intervention course, and training on de-escalating and managing patients will be reviewed. Quality improvement initiatives such as outcome measurement tools on seclusion use, patient safety plans, and post-seclusion debriefing sessions will also be reviewed.

Educational Goals

1. To share strategies of how an organization's leadership team can support a philosophy of least restraint.
2. To share the challenges of implementing seclusion and restraint initiatives.

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Paper

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There is strong evidence in the literature to support the use of seclusion reduction initiatives on acute mental health units (Cadeyrn, Gaskin, Stephen, Elsom, & Happell, 2007). It is also recognized that the leadership team of an organization plays a key role in achieving the goal of least restraint (Waqar Azeem, Aujla, Rammerth, Binsfeld, & Jones, 2011). Our drive to effectively and efficiently reduce incidents of aggression and maintain the safety of patients and staff in health care, specifically in high risk areas, is impacted by the realities of resource availability. The literature demonstrates that training programs have contributed to increased feelings of confidence in managing aggressive clients or feelings of self-efficacy (Wang, Hayes & O'Brien-Pallas, 2008). Organizations have been called on to recognize that coercive or violent interventions cause trauma and are to be avoided and replaced by trauma-informed care (National Association of State Mental Health Program Directors NASMHPD/National Executive Training Institute NETI, 2005). A pre-cursor to the effective implementation of restraint minimization programs is a clear organizational policy that is published and disseminated to let employees know that management is committed to reducing violence (Wang, Hayes & O'Brien-Pallas, 2008). The seclusion reduction initiatives undertaken at a Canadian Hospital will be reviewed and the successes and challenges of implementing these initiatives will be shared. These initiatives include policy changes to a restraint minimization focus and creating seclusion clinical practice guidelines. An evaluation of the implementation of education programs such as NASMHPD's Six Core Interventions for seclusion and restraint reduction, Nonviolent Crisis Intervention course, and training on de-escalating and managing patients will be reviewed. Quality improvement initiatives such as outcome measurement tools on seclusion use, patient safety plans, and post-seclusion debriefing sessions will also be reviewed.

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Reducing the time patients spend in seclusion at a Medium Secure Unit (MSU) In the North West of England; Utilizing a 'Human Factors', approach to inform decision making

Poster

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Abstract

Senior nurses on four wards at the MSU received non-technical training in error avoidance at a Medium Secure Unit. There was recognition that once seclusion is initiated staff find it difficult to terminate seclusion. Using incident data, and Improvement Methodology (i.e. Plan Do Study Act (PDSA) cycles) it was observed that seclusion reviews often took place in a non-structured manner, with door closed and a lack of thought around the communication strategy. Whittington & Richter (2005) suggested that staff mitigate anxiety generated by aggression and violence by avoidance coping and over control. These errors in thinking will often lead to a patient being subjected to a closed door seclusion review and the continuation of seclusion due to conflation in the appraisal of imminent threat of violence.

The team have combined four approaches to reduce errors when undertaking Seclusion reviews
1. Use of the National Decision Making Model (DMM) in the form of a checklist to aid decision making
2. Staff Briefing prior to entering the room (i.e. including contingency planning)
3. A rehearsed communication plan (what to say and what not to say)
4. Debriefing following each seclusion review

The NDMM is a values based tool which provides a simple logical and evidence based approach to making and evidencing decisions. A key decision early in the process is always can we assess risk and converse with the patient with the seclusion room door open or perhaps by re-associating the patient under supervision. The checklist ensures that all the information is at hand whilst ensuring policy compliance and options available are considered so that an agreed course of action can be taken.

These considerations are re-examined at the staff briefing. The discussion will allow each team member to identify their skills and deficits, relationship with the patient and also to make clear each persons role within the seclusion review. A communication strategy will be identified cognisant of the patients diagnosis, needs and concerns (i.e. what to say and what not to say) which can be critical in achieving a desirable outcome. The decision regarding the conditions under which the seclusion review will take place (i.e. door open / door closed / in association) will also be made at this point.

Debriefing takes place following the seclusion review regardless of the outcome (i.e. seclusion continued / seclusion terminated). This program is currently at the 'Act' phase of the PDSA cycle, and we hope to incorporate preliminary findings in the poster

Educational Goals

Cognitive: enhance decision making around the termination of seclusion
Affective: Moderate staff anxiety and enhance emotional control to enable objective seclusion reviews
Psychomotor: Identification of roles and contingency plans including restraint as a last resort

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Conflict Management Program: Fidelity Scale in Psychiatric Care

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Introduction

In psychiatric in-clinic care aggression is a safety hazard for staff and patients. Staff members need to be well trained in managing verbal and physical aggression in such a way that medicinal restraints and seclusion are only used as last resort with the aim to control dangerous situations (Goedhard, 2010). Furthermore, every psychiatric institution has an organizational culture consisting of shared values, norms, rituals, traditions and certain behavior patterns of its employees. Part of this is the variety of norms and values that exist with regards to patients' and staff safety (Smits, Wagner, Spreeuwenberg, Timmermans, van der Wal, & Groenewegen, 2012). Patient safety culture was defined as "…the product of individual and group values, attitudes, perceptions, competencies and patterns of behavior that determine the commitment to, and the style and proficiency of, an organization's health and safety management" (Nieva & Sorra, 2003, p.18).

In the Netherlands, safety has received high priority in the healthcare system from the Geestelijke Gezondsheidorg Nederland (GGZ Nederland), which works on client safety with the program *Veiligheidsmanagementsysteem* − VSM (Handreiking veiligheidscultuur, 2012). The VSM, or safety management system, focuses on aggression, medication safety, suicide prevention, somatic co-morbidity, discipline, and fire safety. The system includes 6 basic elements: Safety policy and strategy; Safe culture; Prospective risk analysis; Safe incidents reports; Continuous improvement of client/staff safety; Client participation in the safety policy and strategy.

In addition, new methods, such as the Response Crisis Intervention Model for Conflict Management (Windcaller, 2010) – from now on named the Response Method – have been created as strategy to counter aggression in crises situations. The main aim of the Response Method is to create an organizational and cultural norm for safety and non-violence (Windcaller, 2010). The method is founded on the notion of self-assessment for the individual practitioner as well as the management team. It provides means of modifying behaviors that contribute for the escalation of conflicts. An important aspect of the philosophy behind the method is to regard a crisis situation as an opportunity for learning pro-active conflict management skills. Furthermore, in terms of crisis intervention, the method stresses the importance of making the scene safe: It is a goal-oriented protocol to improve effective communication, teamwork, and self-control, contributing to an environment that is safe and empowering.

Another relevant assessment in psychiatric organizations is patient safety culture, which can be assessed by the COMPaZ, a questionnaire based on the Hospital Survey on Patient Safety Culture – HSOPS Nederland ((EMGO/NIVEL, 2006; Smits et al., 2012). This self-report questionnaire consists of about 41 questions and statements with a five-point Likert scale to measure patient safety culture, has its items structured according to 11 dimensions: Collaboration between wards; Teamwork within wards; Handoff and transitions of shifts; Frequency of event reporting; No punitive response to error; Open communication; Feedback and communication about error; Supervisor/manager expectations and actions promoting safety; Management support for patient safety; Adequate number of employees; Overall perceptions of safety.

The aim of the present research was to assess whether the Response Method was effectively implemented in an in-patient psychiatric care in the Netherland, and whether it had a positive impact on patient safety culture. This lead to 2 research questions: To what extent was the Response Method implemented in the wards? Which effect did this implementation have on the safety culture in the wards?

Method

The research was conducted in 5 in-patient wards (named 20/21; 23; Spectrum; HAT; and DTC) of a mental health care organization in Zeeland, the Netherlands. First, interviews for the Response Method

Fidelity Scale were individually conducted and analysed. Afterwards, the results were compared per ward to the COMPaZ results.

For the Response Method Fidelity Scale, researchers interviewed 1 team leader, 1 Response coach, 3 clients and 3 staff members in each ward. The interviewers also had to analyse 3 patient files in each ward. Informed consent was obtained from all the participants. Response rates can be found in Table 1.

Table 1: Response rates of the Fidelity Scale in each ward – 20/21, 23, Spectrum, HAT, and DTC.

	20/21	23	Spectrum	HAT	DTC	Total	Total without DTC
Manager	1	1	1	1	0	4/5	4/4
Response coach	1	0	1	0	0	2/5	2/4
Staff	3	4	3	3	1	14/15	13/12
Clients	2	0	3	3	2	10/15	8/12
Files	3	3	1	1	0	8/15	8/12
Total	10/11	8/11	9/11	8/11	3/11	38/55	4/4

The fidelity of the Response Method was measured with the Response Method Fidelity Scale, constructed by the mental health organization to assess the following aspects: Implementation and Organization; Training of Teams; Communication – Work Consultation; Communication – Evaluation ; Communication – Team discussion; Consultation with Client; Trainer/Coach; Team Leader and/or Trainer/Coach; and Clients. The items were scored on a 5-point Likert scale, according to the criteria from 1 = Poor fidelity to 5 = Excellent fidelity to the model on each particular aspect of the Response Method. Averages were calculated on different subscales and total scores were computed.

The second part of the questionnaire applied a checklist to measure the extent to which the Response Method was used. The interviewee had to choose a recent incident and describe it to the interviewers, who had to score each of the 36 items with a yes or a no.

Results

Analysis and Conclusion of the Response Method Fidelity Scale
The following contains a qualitative analysis of the results obtained from the interviews. The analysis was based on the model fidelity assessing the fidelity scores of each dimension and the mean scores on the Likert scale for each item. Table 2 present the results obtained.

Table 2: Fidelity scores for four wards in each dimension

Ward	20/21	23/Woonhuizen	Autism Ward	HAT
Implementation and Organization	4	5	2	4
Training of Teams	5	5	5	4
Communication	4	4	4	2
Evaluation	4	5	4	4
Team Discussion	3	5	2	2
Consultation with client	4	4	4	4
Trainer/coach	5	3	4	1
Manager and/or trainer/coach	4	4	3	3
Clients	3	2	3	4
Client file	2	2	1	1
Implementation in the workplace	3	3	4	3
	41	42	36	32
Model fidelity protocol	3.727	3.818	3.273	2.909

As can be seen in Table 2, the results indicated relatively strong aspects of all the wards with regards to the Response Method in Implementation and Organization; Training of Teams; Communication; and Evaluation. These categories respectively scored on or close to the maximum score. Exceptions in these categories were the significantly lower scores of the Autism ward Spectrum on the level of Implementation and Organization of the Response Method, as well as the score of 2 by the HAT ward with regards to communication within the ward itself. With regards to the teams that offer the Response Method training, all wards – without exception – scored on or close to the maximum score. This indicated that the Response Method was taught by the desired amount of two certified trainers. On the other hand, categories that showed notable weaknesses in all wards were Team Discussion; Consultation with Client; Trainer/Coach; Clients; Client files; and Implementation in the workplace. The final outcomes on the Response Method Fidelity Model were very close together for all wards investigated, with the exception of the HAT ward. With a result of 2.909, this ward had the lowest outcome of all. When examining this result in more detail, it becomes apparent that low scores in the Trainer/Coach category, together with equally low scores in the Client File category, mostly caused this low result. However, some caution is needed in interpreting these results, as they can be explained in more than one way and should not immediately be attributed to any kind of formal malfunctioning in the ward. In this particular case, the specific categories of Client File and Trainer/Coach got their low score due to the absence of a Response Method trainer/coach, or team leader at the time of the interviews; and due to insufficient or denied access to the patient files. Since all missing values have been given the score of 1, this accounts for the low score in these particular categories for the HAT ward, as well as for the low total score obtained by this ward. The highest fidelity score was obtained by Ward 23/Woonhuizen, with particularly strong dimension in Implementation and Organization, as well as Training of Teams, Evaluation, and Team Discussion.

Comparison of the fidelity scale and COMPaZ
Considering that the Response Method Fidelity Scale and the COMPaZ have each a different focus, the outcomes of the Response Method Fidelity Scale showed the implementation of safety measures, whilst the COMPaZ focused more on the communication between employers. Consequently, only some correlations could be found.

Both the results of the COMPaZ and the fidelity scale showed that, in general, the staff appreciates teamwork and changing of shifts. The COMPaZ results indicated that teamwork, exchange of services and actions of the manager were highly appreciated, but not always well performed. Cooperation, as well as communication between team members and between wards had a great variation in the results of different wards. When compared to the Response Method Fidelity Scale results, similar outcomes can be translated into a lack of agreements surrounding Team Discussion, and factors that can affect the quality of Teamwork on the wards, in terms of the amount of staff members that has followed the Response Training and the frequency of practice of the Response Method. The COMPaZ results indicated that not all staff members felt that patients' safety had a top priority within the organization, and this could be seen in the Response Method implementation.

Conclusion

Overall, the results obtained by the Response Method Fidelity Scale investigation showed that employees were appropriately trained in the Response Method and that communication and evaluation was done accordingly. Especially within the wards, communication and thorough evaluations were strong contributors to create a safe environment. Moreover, staff members felt safe to report incidents and clients reported a noticeable positive change in conflict management. Likewise, organization and implementation of the method in the wards was found to be respectable. The COMPaZ results indicated that patient safety culture was not found to be especially high. Even though communication and cooperation within the wards was considered to play an important role in patient safety, the involvement of the management could be promoted.

Although all staff and clients strived for a good safety culture and a good implementation of the Response Method, this was not always realized. Group discussion and supervision for staff members, for example, was not frequently done and there was much confusion as to what it exactly entailed and who should participate. Group discussions could be done more effectively on a structured basis. Moreover, clients were not sufficiently informed about the possibilities of the Response Method, especially with regards to the opportunity to enroll in the Response Training for clients. Additionally, not every ward got the appropriate amount of support in implementing the Response Training, since many trainers were missing. Increasing the (availability) of certified trainers could enhance effective implementation of the Response Method. Furthermore, there appears to be room for improvement with regards to collaboration amongst different wards. On a more general note, due to lacking data, the scores obtained by means of the Response Method Fidelity Scale for the different wards may paint a more negative picture than reality.

The comparison of the COMPaZ results with the Response Method Fidelity Scale outcomes indicated that the general feeling of safety in the investigated wards of the organization could be improved. Furthermore, it seems that effective implementation of techniques such as the Response Method can enhance conflict management and patient safety culture. By polishing the implementation of the Response Method in the organization its safety culture is most likely to improve.

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International seclusion figures, literature and conditions for international comparisons

Paper

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Abstract

Violence and aggression have been identified as the most frequent reason for the use of coercive measures (Gutheil, 1980, Currier, 2003). When de-escalation is ineffective, staff makes use of more intrusive techniques to coerce and control the patient (Whittington, et al. 2006). Reviews of the literature on seclusion and restraint in European countries showed widely disparate rates (Janssen, et al. 2008, Steinert, et al. 2009, Keski Valkama, 2010). The authors noted that the use of coercive measures is not vigorously monitored as well as there were quite different methods used to report the used coercive measures.

In the last five years in a number of European countries activities take place for accurate registration of used coercive measures (Martin, et al. 2007, Janssen, et al. 2011), to use the outcomes in feedback or evaluation sessions, to support reduction in its use (Steinert, et al. 2009). However in Finland a nationwide register is available (Kaltiala-Heino, et al. 2000), but the authors questioned Finland's placement on the international statistics. Moreover, little information is available about the use of coercion in psychiatric setting s over different countries and within different legislative areas and treatment cultures.

This session discusses the conditions necessary for accurate registration of coercive measures, as underlying condition to make comparisons between European countries. For this discussion the literature is studied and colleague researchers are consulted to define, register, calculate and report the use of coercive measures.

Results

The most important conditions for an accurate registration method are: uniform and clear definitions, easy to fill in, reporting all coercive measures, it must portraying the daily practice, it must sensitive to changes through time, uniform calculation methods to report unambiguous results, and the results must be useable for feedback purposes in teams and management.

Educational Goals

Attention to unambiguous way of recording and reporting of coercive measures, as a condition for comparisons between countries.

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The use of a swaddle as an alternative in reducing the number of fixations at seclusions

Poster

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Abstract

The high number of segregations, the many accidents as a result of aggression and last but not least the harmful effects on psychological level for the patient after seclusion were the basis for a culture change at "De Knoop", an observation and treatment unit for people with mild to moderate intellectual disability and an additional psychiatric problem. To this end, a working group was established whose main task was to develop a new vision in order to 1) reduce the number of seclusions, 2) develop alternatives for the seclusions, 3) improve the quality of seclusions and 4) increase the quality of the living and treatment climate.

In the developed vision seclusion is seen as an intensive treatment, where interaction has a central place and where skilled care is provided in a space where incentives can be offered.. The vision on fixation in seclusion also evolved. It is now seen as a protective intervention, only used when strictly necessarily and that is situated in a broader context of prevention and protection. A patient can be fixed only if the physical or mental integrity of the patient himself or others are threatened by the behaviour or condition of the patient and if alternative measures and interventions are ineffective. Before, each patient who impedes a safe withdrawal of staff from the seclusion room was automatically fixed. The practical development and application of a swaddling blanket as an alternative to this type of coercive measure was part of the third objective and it has significantly reduced the number of fixations.

Educational Goals

1. There are fewer accidents due to physical aggression during the seclusion intervention
2. Employees use no more 'fixation' to leave a seclusion room in a safe manner.

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Does a Patient-Directed Admission Process Reduce Violence?

Poster

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Background

This 25-bed adult acute psychiatric hospital has developed a culture of care and admission process resulting in the majority of patient's perception of feeling welcomed and virtually eliminated violence during the initial one hour admission window. These two elements may contribute to reducing length of stay and enhance support for establishing a therapeutic rapport between staff and the patient which will support patient's journey towards recovery.

Aims

The purpose of this paper is to describe the patient experience of admission, the admission process, and the application of Sanctuary Model® and trauma informed care principles with consideration to Maslow's hierarchy of needs. The data suggests that this approach contributed to the near elimination of violence upon admission to a 25-bed acute, adult, psychiatric hospital over a twelve-month.

Design

This retrospective, descriptive study uses an anonymous, self-administered questionnaire (SAQ) called the Patient Satisfaction Survey, comprised of 13 Likert Scale questions with room for narrative comments and collected from patients just prior to discharge. Data for this paper were derived from the responses to one of these questions, which reads: "The extent to which I felt welcome during the admission process at PMC was. . ." Other data include the recorded number of violent acts (requiring seclusion/restraints) that occurred during the admission process into the inpatient unit for both voluntary and involuntarily admitted patients over a twelve-month period.

Result

From January 1, 2012 to December 31, 2012, there were 825 admissions (monthly mean of 68.75). This included 402 involuntary and 419 voluntary admitted men and women. There were zero incidents of violence requiring mechanical/device restraints during admission. Three patients (

Conclusion

These data suggests that a patient-directed, trauma informed approach using during the process of voluntary or involuntary admission to an acute adult psychiatric hospital can significantly reduce violence, ease sanctuary trauma, improve patient perceived experience and provide an opportunity for establishment of a therapeutic, trust-centered relationship.

Educational Goals

1. Describe development of culture Salem Health's Psychiatric Medicine Center (PMC)
2. Discuss application of a patient-directed/trauma informed approach to the admission process.
3. Report data related to violence during admissions to PMC.

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Nurses' intuition as an explanatory variable for the length of restraint

Poster

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Introduction

The nurses' decision-making of the use of physical restraints is described as a complex trajectory primarily focused on safety (Goethals et al 2011). However, in a vignette study to evaluate the use of seclusion, personnel 's characteristics i.e. work setting, the frequency of participation in the practice of seclusion, experience with the use of seclusion and education were at least as important as patient characteristics in explaining the decision of mental health professionals to seclude (Mann-Poll et al 2011). An interview study reported that during the S/R episodes nurses portrayed their behavior as more concentrated in observing and evaluating the patient than providing emotional care. When trying to determine when to end the S/R they expected the client to respect a number of conditions to gradually return to the ward and behave as he had done before the crises erupted (Larue et al 2010). We wanted to study the actual process of evaluating the restraint patient's status in ord er to be able to have a more comprehensive understanding of the process.

Materials and methods

The data was collected between 1.9.2009-30.6.2010 from three hospitals in the Helsinki Metropolitan area: Aurora Hospital (emergency unit and three acute wards), Kellokoski Hospital (two forensic units) and Helsinki University Hospital (difficult to treat patients – ward), in all 100 beds. For each restraint patient the nurse in charge of the follow-up of the patient filled in a visual analogical scale (VAS) every hour of the duration of the restraint episode. First, the VAS was made to evaluate the patient's most severe behavior during the last hour. Thereafter, the nurses were asked to assess how they would expect the patient to behave if the restraint was to be terminated immediately. The VAS was completed for seven different problem behaviors: hurting oneself, hurting others, jeopardizing one's own safety, obstructing treatment of others, damaging property, drinking water excessively and some other serious reason the restraint was started for. Furthermore, if the patient was as leep while restraint, that was reported.

Results

Only data for patients who consented to take part in the study was used (approx. 50% of all restraints). We analyzed 9436 VAS-sheets of 261 restraints for 94 different patients. There were 200 different nurses who we involved in the assessments. As expected the patients' clinical status calmed during the first hours of the restraint and after 4 hours 52% of the restraint patients were asleep. However, the patient's expected behavior was rated disturbed for much longer. The expected behavior was not related to the patient's present behavior, but was related to the nurse who did the assessment and to the time of the day. The moment to terminate the restraint was less related to the expected behavior of the patient than to the ward where the patient was treated. The exact results will be presented in tables.

Conclusion

The decision to end the restraint does not necessarily arise from the patient's clinical condition, but is related to the ward routines and personnel's characteristics.

Educational Goals

To understand the complexity of the decission-making process in the use of coercive measures.

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'You don't Know What You're Doing'. The governance of training in the prevention and management of violence and aggression as an approach to reduce coercive strategies in forensic settings

Poster

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Abstract

Best practice in managing aggression and violence in psychiatric and forensic settings is guided by the Mental Health Act Code of Practice and NICE guidelines. The Mental Health Act Code of Practice states: "Interventions such as physical restraint, seclusion or rapid tranquillisation should be considered only if de-escalation and other strategies have failed to calm the patient... Managing aggressive behaviour by using physical restraint should be done only as a last resort and never as a matter of course. It should be used in an emergency when there seems to be a real possibility that harm would occur if no intervention is made". However, effectiveness in managing aggression or violence is in doubt: a Cochrane review in 2001 (Salias) found that in the absence of any controlled trials in those with serious mental illness, no advice can be made about the efficacy, advantages or harmfulness of restraint. Recent update to the review (Muralidharan, Fenton 2008) found that the types of physical restraint currently used vary and no explicit methodology exists. The original model for physical restraint used within the UK, called Control and Restraint, abbreviated to C&R, was developed by the prison service in 1981 in response to the growing number of violent incidents within prisons and the often poor outcome for both prison staff and those detained in prisons (Wright, Gray, Parkes, Gournay 2002;Rogers, Miller, Paterson, Bonnett, Turner, Brett, Flynn, Noak, 2007). However, following the adoption of physical restraint training by more mainstream mental health services, a distinct differing of directions has occurred between the prison service and mental health services (Rogers et al, 2007). With the adoption of restraint training within mainstream Mental Health Services, adaptation of techniques has occurred resulting in no clear standardised approach across the mental health estate (Butterworth and Harbison, 2010). Although a national accreditation scheme for restraint training in learning disability settings, no such accreditation framework exists in mental health leaving organisations vulnerable in terms of dfending the quality, efficacy and suitability of programmes taught, in particular in relation to the physical skills taught and used in practice.

Questions to Consider
Are we teaching the right things; do staff understand them and are they able to replicate them in clinical practice; are these techniques the least restrictive and effective available; if an external organisation is proving the assurance of practice what due diligence has been carried out to ensure that they provide credible and research based solutions.

Case Studies
Details will be provided of an organisation who were concerned about their PMVA practice and how they sought an external partner to work with them in a different approach

The Solution
Details of what was introduced to the service is described including the challenges overcome (the transition from one system to another; the use of pain free techniques in the face of opposition); and the outcomes achieved (the reduction in restraint and seclusion, injuries, complaints, and lost time).

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Chapter 10 – New directions in the assessment of risk, prevention & protective factors

Variables related to the bed-blocker phenomenon in an acute psychiatric ward

Poster

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Background

The term "bed-blockers" was created in the 1970s to indicate those patients who, after completing diagnostic tests and therapeutic treatment, continued to occupy hospital beds unnecessarily. Due to economic reasons, this phenomenon has been increasingly investigated, but few studies evaluated it in psychiatric wards.

Aims

To assess the frequency of psychiatric long-term hospitalizations and related variables.

Methods

From a database of an acute psychiatric ward (SPDC-Modena), all hospitalizations from 1-1-2005 to 31-12-2010, with duration =o> the 90th percentile (28 days) were selected. Frequency, psychiatric diagnosis and co-morbidities of this sample (n=345) were compared with those of all other admissions in the same period (chi square test). The sample was divided into two subgroups, according to the median duration of hospitalization: A (245 hospitalizations up to 46 days) and B (100 hospitalizations exceeding 46 days).

Demographic data (age, gender, nationality), clinical variables (psychiatric and organic diagnosis, according to ICD-9-CM, VGF and CGI-I scores at the discharge, pharmacotherapy), inpatient care problems (extra-psychiatric clinical activities, aggressiveness with or without restraint, provision of residential care services) and discharge needs (protected structure, nursing home, new hospitalization, home care, economic support, etc.) of A group were compared to B group (univariate and multivariate logistic regression).

Results

The 345 hospitalizations represented 8% of all psychiatric hospitalizations and differed significantly from others due to higher frequency, in "schizophrenia and other psychotic disorders" and associated organic co-morbidities.

The variables significantly related to the length of hospitalization were: "inpatient and outpatient care network" as a protective factor, "aggressiveness with restraint" and "non psychiatric clinical activities" as risk factors.

Conclusions

The risk of psychiatric long-stay appeared to be related to the same clinical factors which can induce institutional dependence. Integrated collaboration between hospital and outpatient services could significantly counteract this clinical and social issue.

Educational Goals

1. To highlight the risk and protective factors of bed-blocker phenomenon in acute psychiatric wards.
2. To verify if aggressiveness, with or without restraint, may be a cause of long stays in acute psychiatric wards.

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Dark Knights: Donning the Archetype

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Abstract

This paper explores the identification with the archetype of the dark knight in the preparation for rampage violence. The author reviews numerous incidents of mass casualty shootings and highlights how the shooters objectify their target. The clothing and accessories used by the attackers are investigated not only for their tactical significance, but also in affiliation with societal archetypes of anti-heroes.

Introduction

On June 7, 2013 in Santa Monica, California, twenty three year old John Zawahri set his house on fire and killed his brother and father before hijacking a car and killing three others on his way to the Santa Monica College library. Two facts in this case stand out clearly and resonate closely with other cases of mass casualty violence: The shooter was male. The shooter dressed all in black.

The iconic black trench coats worn by Klebold and Harris are a particularly vivid image from their April 20th, 1999 Columbine attacks. This aesthetic pattern is imitated by dozens of additional shooters throughout the following decade. Further promoting the images of the dark knight are dozens of examples from movies, television, literature, and video games. Rampage violence is always premeditated and during this premeditation, the potential shooter fantasizes about how he will become known by a society that continually pushes him to the margins.

Neo, the protagonist in the movie *The Matrix*, is an example of this image. Clad in black, he drops a bag full of weapons and begins his assault in the lobby of an office building. The ring wraiths chase the hobbits in *The Lord of the Rings*. Darth Vader and Darth Maul embrace the dark side of the force in the *Star Wars* movies. Lord Voldemort and the Death Eaters hold close to the forbidden magic of the *Harry Potter* series. Each of these characters cloak themselves in a uniform designed to transform them in as they complete their mission. They become the anti-hero. Even in Batman, the "Dark Knight" is a revenge-driven figure— the ultimate anti-hero of sorts—and he, of course, dons the all black outfit.

The perpetrators adopt the personas of these dark figures as a way to provide refuge from responsibility, encouragement, and incentive to carry out the attack. They wear military fatigues and costumes to overcome their own hesitation about carrying out the attack. Dressed as a monster, they find a greater meaning in their behaviors and communicate a message to society with their actions. It is a message of revenge; a message of chaos and destruction. It is a stance against good and God; it is a declaration against humanity.

Anders Breivik offers one of the clearest insights into staging and preparation of his attack through detailed journaling left as an appendix in his 1500-page manifesto prior to killing 77 and injuring over 300 on July 22, 2011. He creates a fabricated military uniform with medals, unit insignia, and other regalia. He fantasizes about starting a movement in his country against the Muslim faith. He sees his actions as a crusade. He dresses the part of a modern day Knights Templar.

Societal Archetypes

The archetypes, or old patterns, are well discussed in Carl Jung's psychoanalytic theory. Jung believed these human motifs or universal mythical characters reside in our collective unconscious. We resonate with these images and philosophies held by the nurturing earth mother, the consummate trickster, and the questing hero.

These form the stories we seek out in popular literature, movies, and video games. Most of us briefly escape into these archetypes as a respite from our everyday existence and to heighten our own sense of

meaning. We escape from our spouses, term papers, work responsibilities, and everyday sameness to find an emotional connection to something that matters.

This concept is all around us. Many successful films and literature play with the concepts of light vs. dark, as well as themes of the wounded hero, the outcast, and the devil. Examples include:

- Darth Vader and Darth Mail in the *Star Wars* movies
- Neo in the film *The Matrix* as firing his weapons in flowing black leather with dark sunglasses
- Sauron, the ringwraiths, and the orc hordes in *Lord of the Rings*
- Stephen King's character of Walter (the Man in Black) in *The Dark Tower* Series
- J.K. Rowling's Lord Voldemort and the Death Eaters in *The Harry Potter* series
- Batman in the movie the *Dark Knight*
- Todd McFarlane's character *Spawn* adorned in red and black surrounded by flames
- Brandon Lee in *The Crow*
- School shooting from American Horror Story (season I)
- Bram Stoker's *Dracula* (or any vampire for that matter: see Lestat and Marius from Ann Rice's novels, the *Twilight* series, etc.)

The conflict between good versus evil/ light versus dark is well understood as a universally symbolic image. Light implies hope, renewal, and innocence. Darkness leaves us with images of despair, chaos, and the unknown. Some male rampage shooters are drawn to defining themselves through the darkness. They become more than themselves as they escape into their violent fantasies.

Those who are lost in society strive for a voice, a sense of meaning and purpose. It often happens that their goals, careers, loves, and even daily existence take on a cold and distant dimness. They lose sense of their larger part in the human community and strive to find some sense of greater meaning and purpose. For some, they find this in creating violence so powerful society must stop and pay attention to them. They no longer are the forgotten or ignored. They become infamous.

James Holmes, in his 2012 Aurora, Colorado attack selected a movie theatre as the stage for his performance. He dressed as the Joker character in The Dark Knight movie and slaughtered dozens while dressed in military black fatigues and body armor. As he fired into the darkness, characters on the silver screen did the same. The explosions of gunfire blasting from the theatre's Dolby surround sound system offered a resonant background for his AR-15 exploding into flesh, bone, chairs, and concrete. The Batman movie provided a ghostly echo to his actions. For a young man lost in his career, lacking a sense of purpose or place, he defined himself through violence.

On Valentine's Day 2008, Steven Kazmierczak stood in front of a terrified lecture hall. He had horrific images of a skull impaled with a knife tattooed on one arm and a depiction of the Jigsaw killer from the Saw torture film on the other (Keen, 2008; Sander, 2008; Vann, 2008). Black trench coat draped around him, he fired his shotgun with a blank look on his face. It was his moment of fame, his moment of meaning. People watched him, attended to him. He was present, noticed, and important. He had done something that mattered.

Holmes and Kazmierczak took to the stage to define themselves. To find some twisted meaning and purpose after failing to find their own place in the world. Both clothed themselves, literally and figuratively, in the image of the dark warrior, the punisher. They would no longer be forgotten, lost, or ignored.

The Clothing of the Martyr and the Anti-Hero

There are two explanations for the type of clothing and accessories mass shooters choose. First, is this an individual who is dressing tactically to complete his/her mission? Few online stores or military surplus shops sell tactical vests, kneepads, thigh rigs and harnesses in colors such as red, pink, or yellow. Choices are more typically: black, olive drab, camouflage. Colors and styles are designed to allow for easy access as well as to blend into surroundings. Shooters may choose these items for similar reasons, or they may be limited in their choices due to what colors and types are available.

The second reason shooters outfit themselves in this style of tactical gear is more psychological in nature. Meloy refers to this as "identification warning behavior." He writes, "Identification warning behavior – any behavior that indicates a psychological desire to be a 'pseudo-commando' (Dietz, 1986; Knoll, 2010), have a 'warrior mentality,' (Hempel et al., 1999), closely associate with weapons or other military or law enforcement paraphernalia, identify with previous attackers or assassins, or identify oneself as an agent

to advance a particular cause or belief system" (p. 265). Kimver Gill demonstrates this as he poses as a, self-described, "Angel of Death" brandishing his Berretta Storm 9mm rifle.

We see these pseudo-commando and warrior mentalities played out in the recent June 2013 shooting in Santa Monica, California. John Zawahri is just the latest manifestation of a pattern of males who outfit themselves in a costume, which reflects their desire to be known. If they fail at being the hero; it leaves them the anti-hero to transform into. This donning of the archetype creates a sense of meaning and purpose for these lost individuals. It gives them a brief escape from their lives of failure and broken connections and allows them to rise and become something more powerful.

Few images of the anti-hero resonate as strongly as Jared Loughner. He shaves his head and leaves us with his iconic mugshot of himself as a killer. While the mental health and sanity of these individuals is always called into question, one might argue that Loughner, in changing his appearance (similar to Holmes), speaks more to the – albeit disturbing – clarity of thought.

On July 22, 2011, Anders Breivik detonated a bomb killing eight and then killed an additional sixty-nine youths on Utoya island. Breivik believed his attack was justified and he wrote a 1500 page manifesto about the evils of the Muslim population and how it should be eradicated from Norway. Prior to his attack, Breivik assembled an intricate military dress uniform complete with medals. Breivik acquired a Ruger mini-14 along with ten 30 round magazines and a rapid fire trigger modification. He named this gun Gungnir, after the spear of Odin (Englund, 2011; Shane, 2011; Breivik Manifesto, 2011).

In the Norway shooting case, we see the degree to which Breivik collected military style weapons and clothing, going so far as to create a fictitious uniform for himself emulating a modern-day Knights Templar. He names his weapon after the spear Odin hurled to begin the Æsir-Vanir War.

In 2006 in Quebec, Canada, Kimver Gill went on a shooting spree outside of Dawson College. Images of Gill emerged from social media with him wearing a black leather trench coat and brandishing a 9mm Beretta storm rifle as well as large hunting knives. The social media trail left by Gill provides a rare first-hand account of how he saw himself. The following is a profile description from a website he frequented called www.vampirefreaks.com:

"His name is Trench. You will come to know him as the Angel of Death. He is male. He is 25 years of age. He lives in Quebec. He finds that it is an O.K. place to live. He is not a people person. He has met a handful of people in his life who are decent. But he finds the vast majority to be worthless, no good, conniving, betraying, lying, deceptive, motherfuckers. Work sucks . . . School sucks . . . Life sucks . . . What else can I say. Metal and Goth kick ass. Life is like a video game, you gotta die sometime."

Gill refers to his darkness and as someone who will punish others. He describes his avatar, *"Head to toe, all black. Boots as black as tar. Cloak lashing to and fro with the wind."* His hatred for those around him, for humanity in general, comes through in his writings as well. He offers this as a chilling, prophetic revelation prior to his attack, *"The disgusting human creatures scream in panic and run in all directions, taking with them the lies and deceptions. The Death Knight gazes at the humans with an empty stare, as they knock each other down in a mad dash to safety. He wishes to slaughter them as they flee" (Payne, 2006; Rondi, 2006).*

Discussion and Implications

We face an uphill battle as these individuals escape into fantasy; imagining themselves living out some dark scheme to reclaim power lost or attention lacking from those they desire. These 'dark knights' feel separate, forgotten, and extraordinary from those around them. In their frustration they seek refuge and solace in their fictions and daydreams. In their brokenness they become separate from society, left ultimately to their revenge and simulated vindication.

To take them off their 'pathway to violence', we must address two fundamental problems. The first is separating the truly dangerous individuals from those who are merely anti-social or those who choose fantasy and individuality over more regular participation in society. Study and analysis of mass-casualty shooting events and risk factors for violence may provide some assistance in this differentiation.

Second, there is the challenge of reconnecting these lost souls to the rest of society. They feel rejected or dissimilar from those around them. Addressing their distance, lack of empathy, and social alienation is essential to bring these 'dark knights' back to a larger sense of connection, to a larger participatory place in the community, and to reclaim their lost sense of meaning and purpose in life.

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The Structured Interview for Violence Risk Assessment (SIVRA-35)

Workshop

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Abstract

American colleges and universities require increased ability to perform violence risk assessments as a function of their behavioral intervention and threat assessment teams. The Structured Interview for Violence Risk Assessment (SIVRA-35) is a thirty-five-item inventory used to assist Behavioral Intervention Team (BIT) members and clinical staff in conducting a more thorough and research-based violence risk assessment to prevent rampage mass casualty attacks.

Introduction

The SIVRA-35 is an informal, structured set of items useful for those staff and faculty who work in higher education to use with individuals who may pose a risk or threat to the community. The SIVRA-35 is not designed as a psychological test and it is not designed to assess suicidal students. It is a guided structured interview useful for classifying risk into low, moderate, and high categories.

Risk and Threat Assessment

The ideal approach to violence risk assessment is found in utilizing an individual trained and experienced in violence risk assessment to interview the subject. The SIVRA-35 serves as a starting place for BIT members to conduct a more standardized, research-based violence risk assessment with individuals determined to be at an increased risk.

While risk and threat assessment cannot be predictive, multiple agencies (FBI, Secret Service, Department of Education, US Post Office, ASIS International, the Society for Human Resource Management, and ASME-ITI) have suggested risk factors to attend to when determining the potential danger an individual may represent. Several prominent experts in campus violence and workplace threat assessment have also recommended key considerations salient when assessing risk and threat (Meloy, 2000; Byrnes, 2002; Turner & Gelles, 2003; Deisinger, Randazzo, O'Neill & Savage, 2008; Meloy, Hoffmann, Guldimann, & James, 2011).

Based on these risk factors, the SIVRA-35 places key research into the hands of those faculty and staff meeting as front-line decision makers to assign sanctions, treatment, and make determinations about continued enrollment for the student who poses a risk.

SIVRA Administration

The utility of the SIVRA-35 depends first on the rapport developed between the assessor and the subject. The assessor should avoid rattling off SIVRA-35 questions in a formal and potentially off-putting manner. The best way to obtain accurate data is through a conversation with the individual based on mutual respect and a stated commitment to serving the best interest of the individual. This will decrease the individual's defensiveness (some degree of defense is normal given the nature of the interview) and will lead to more genuine responses.

There is no set of risk factors or list of concerning behaviors that can predict a future violent event. SIVRA-35 is a useful reference tool when conducting a structured interview during a violence risk assessment. Ideally, the assessment should take place after the assessor has reviewed incident reports, available documents related to conduct in the educational setting and in the immediate community, and any other information that has led to the initial concern. Any violence risk assessment involves static and dynamic risk factors, contextual and environmental elements, and mitigating factors. There is no current tool or computer model that can accurately predict future violent behavior, and no tool is ever a substitute

for professional expertise. Therefore, the use of structured professional judgment in combination with documentation and consultation with trusted colleagues is the current best practice.

While the SIVRA-35 primarily assists those conducting violence risk assessments through narrative and structured questions, there is a quantitative, numeric scoring key to further assist staff in their decision making. A single administrator will either ask questions directly to the person being assessed or review relevant incident reports and other forms of data to determine a true or false answer for each item.

SIVRA 35 Items

1. ***There is a direct communicated threat to a person, place, or system*** (ASIS and SHRM, 2011; Meloy et al., 2011; Drysdale et al., 2010; Randazzo and Plummer, 2009; ATAP, 2006; Turner and Gelles, 2003; O'Toole (2002).

2. ***The student has the plans, tools, weapons, schematics and/or materials to carry out an attack on a potential target*** (US Post Office, 2007; ATAP, 2006; Turner and Gelles, 2003).

3. ***The student displays a preoccupation with the person or object he/she is targeting*** (Meloy et al., 2011); ASIS and SHRM, 2011; ATAP, 2006; Turner and Gelles, 2003).

4. ***The student has an action plan and timeframe to complete an attack*** (Meloy et al., 2011; ATAP, 2006; Turner and Gelles, 2003).

5. ***The student is fixated and focused on his target in his actions and threatening statements*** (Meloy et al., 2011; O'Toole and Bowman, 2011); ASIS and SHRM, 2011; US Post Office, 2007; Turner and Gelles, 2003).

6. ***The student carries deep grudges and resentments. He can't seem to let things go and collects injustices based on perceptions of being hurt, frustrated with someone, or annoyed*** (O'Toole and Bowman, 2011; ASIS and SHRM, 2011; Randazzo and Plummer, 2009; ATAP, 2006; Turner and Gelles, 2003).

7. ***The target is described negatively in writing or artistic expression. There is a narrow focus on a particular person that has a level of preoccupation or fascination with the target. There is a pattern of this behavior, rather than a one-time act*** (Meloy et al., 2011; O'Neill, Fox, Depue and Englander, 2008).

8. ***There has been leakage concerning a potential plan of attack*** (Meloy et al., 2011; O'Toole and Bowman, 2011; ASIS and SHRM, 2011; Randazzo and Plummer, 2009; ATAP, 2006; Turner and Gelles, 2003; O'Toole, 2002; Vossekuil et al., 2002).

9. ***The student has current suicidal thoughts, ideations and/or a plan to die*** (Randazzo and Plummer, 2009; Dunkle et al., 2008; US Post Office, 2007; ATAP, 2006; Turner and Gelles, 2003; O'Toole, 2002; Vossekuil et al., 2002).

10. ***The student talks about being persecuted or being treated unjustly*** (Meloy et al., 2011; O'Toole and Bowman, 2011; ASIS and SHRM, 2011; US Post Office, 2007; ATAP, 2006; Turner and Gelles, 2003).

11. ***The student has engaged in 'last acts' behaviors or discusses what he wants people to remember about his actions*** (Meloy et al., 2011; ATAP, 2006; Turner and Gelles, 2003).

12. ***The student seems confused or has odd or troubling thoughts. The student may hear voices or see visions that command him/her to do things*** (ASIS and SHRM, 2011; Drysdale et al., 2010; Dunkle et al., 2008; US Post Office, 2007; ATAP, 2006; Turner and Gelles, 2003).

13. ***The student displays a hardened point of view or strident, argumentative opinion. This is beyond a person who is generally argumentative or negative*** (Meloy et al., 2011; ASIS and SHRM, 2011; Randazzo and Plummer, 2009; ATAP, 2006; Turner and Gelles, 2003; O'Toole, 2002; Byrnes, 2002.

14. ***The student has a lack of options and/or a sense of hopelessness and desperation*** (ASIS and SHRM, 2011; Randazzo and Plummer, 2009; US Post Office, 2007; ATAP, 2006; Turner and Gelles, 2003; O'Toole, 2002).

15. ***The student is driven to a particular action to cause harm*** (Meloy et al., 2011; US Post Office, 2007; ATAP, 2006; Turner and Gelles, 2003).

16. ***The student has had a recent breakup or failure of an intimate relationship. The student has become obsessed in stalking or fixated on another person romantically*** (ASIS and SHRM, 2011; Drysdale et al., 2010; Randazzo and Plummer, 2009; ATAP, 2006; Turner and Gelles, 2003; Vossekuil et al., 2002).

17. ***The student acts overly defensive, aggressive or detached given the nature of this risk/threat assessment. Seeks to intimidate the assessor or displays an overly casual response given the seriousness of the interview*** (O'Toole and Bowman, 2011; ATAP, 2006; Turner and Gelles, 2003; O' Toole, 2002).

18. ***The student displays little remorse for his actions, lacks understanding for the view for potential victims, and acts with a detachment or bravado during the interview*** (O'Toole and Bowman, 2011; ATAP, 2006; US Post Office, 2007; Turner and Gelles, 2003; O'Toole, 2002).

19. ***The student has a weapon (or access to weapon), specialized training in weapon handling, interest in paramilitary organizations or Veteran status*** (Meloy et al., 2011; ASIS and SHRM, 2011; US Post Office, 2007; ATAP, 2006; Turner and Gelles, 2003; Vossekuil et al., 2002).

20. ***The student glorifies and revels in publicized violence such as school shootings, serial killers, war or displays an unusual interest in sensational violence. The student uses weapons for emotional release and venerates destruction*** (Meloy et al., 2011; ASIS and SHRM, 2011; US Post Office, 2007; ATAP, 2006; Turner and Gelles, 2003, O'Toole, 2002; Vossekuil et al., 2002).

21. ***The student externalizes blame for personal behaviors and problems onto other people despite efforts to educate him/her about how others view these actions. The student takes immediate responsibility in a disingenuous manner*** (O'Toole and Bowman, 2011; US Post Office, 2007; ATAP, 2006; Turner and Gelles, 2003; O'Toole, 2002).

22. ***The student intimidates or acts superior to others. The student displays intolerance to individual differences*** (Meloy et al., 2011; O'Toole and Bowman, 2011; ATAP, 2006; Turner and Gelles, 2003; O'Toole, 2002).

23. ***The student has a past history of excessively impulsive, erratic or risk taking behavior*** (O'Toole and Bowman, 2011; ASIS and SHRM, 2011; Randazzo and Plummer, 2009; US Post Office, 2007; Turner and Gelles, 2003).

24. ***The student has a past history of problems with authority. The student has a pattern of intense work conflicts with supervisors and other authorities*** (e.g. Resident Advisor, Conduct Officer, Professor or Dean) (O'Toole and Bowman, 2011; ASIS and SHRM, 2011; US Post Office, 2007; ATAP, 2006; Turner and Gelles, 2003; O'Toole, 2002).

25. ***The student handles frustration in an explosive manner or displays a low tolerance for becoming upset. This is beyond avoiding responsibility or calling mom/dad or a lawyer*** (O'Toole and Bowman, 2011; ASIS and SHRM, 2011; Turner and Gelles, 2003; O'Toole, 2002).

26. ***The student has difficulty connecting with other people. The student lacks the ability to form intimate relationships. The student lacks the ability to form trust*** (Randazzo and Plummer, 2009; US Post Office, 2007; O'Toole, 2002).

27. ***The student has a history of drug or substance use that has been connected to inappropriate ideation or behavior. Substances of enhanced concern are methamphetamines or amphetamines, cocaine or alcohol*** (O'Toole and Bowman, 2011; US Post Office, 2007; ATAP, 2006; Turner and Gelles, 2003).

28. ***The student has mental health issues that require assessment and treatment*** (Randazzo and Plummer, 2009; Dunkle et. al, 2008; US Post Office, 2007; ATAP, 2006; Turner and Gelles, 2003; O'Toole, 2002).

29. ***The student has poor and/or limited access to mental health and support*** (Harvard Mental Health Letter, 2011, Dunkle et al., 2008; ATAP, 2006).

30. ***Objectification of others (perhaps in social media or writings)*** (O'Toole and Bowman, 2011; O'Toole, 2002; Byrnes, 2002).

31. ***The student seems obsessed with another person, location or behavior the individual has little control over*** (ASIS and SHRM, 2011; Meloy et al., 2011; US Post Office, 2007; ATAP, 2006; Turner and Gelles, 2003).

32. ***The student has oppositional thoughts and/or behaviors*** (US Post Office, 2007; ATAP, 2006; O'Toole, 2002).

33. ***The student has poor support and connection from faculty, administration and staff. The student has an unsupportive family system and peers who exacerbate bad decisions and offer low quality advice or caring. They experience evaporating social inhibitors*** (Randazzo and Plummer, 2009; US Post Office, 2007; ATAP, 2006; Vossekuil et al., 2002).

34. ***The student experiences overwhelming, unmanageable stress from a significant change such as losing a job, a conduct hearing, failing a class, suspension or family trauma. This stress is beyond what would normally be expected when receiving bad news*** (Drysdale et al., 2010; Randazzo and Plummer, 2009; US Post Office, 2007; ATAP, 2006).

35. ***The student has drastic, unexplained behavior change*** (ASIS and SHRM, 2011; Randazzo and Plummer, 2009; US Post Office, 2007; ATAP, 2006).

SIVRA Scoring

The SIVRA-35 can be scored from 0-70, indicating a numerical level of risk. Scores from 1-20 indicate a low risk for violence, scores from 21-40 indicate a moderate risk, and scores from 41-70 indicate a high risk. The SIVRA-35 will help those assessing violence risks to organize their thoughts and perceptions in a standardized manner and bring the current literature to the task of evaluating an at-risk individual. Items 1-12 are critical items that carry with them an additional scoring rule. If 4 or more of these first 12 items are marked either 1 or 2, then the individual is placed into the high category.

The SIVRA-35 is scored online. More information available here: www.nabita.org/resources/sivra-35/

Scores from 1-20 Indicate a Low Risk:
Scores from 0 to 9 are more likely to indicate personality conflicts, abrasive social interactions and some potential mental health concerns. Low risk scores in the 10 to 20 range indicate the presence of some concerning information or observed behaviors without the evidence to suggest a direct-action plan towards a violent attack. Connection with the student by a trusted and caring staff member will help in monitoring the student behavior and hopefully keep it from worsening, instead encouraging more positive, risk-mitigating interventions such as developing social connections, focusing on academics, seeking counseling support, and looking for new ways to handle stress.

Scores 21-40 Indicate a Moderate Risk:
Moderate risk scores require action from the BIT team or referral source to address the identified risk of violence. Scores in this range indicate the presences of a plan and/or a set of behaviors, attitudes or personality traits that could lead to a future attack. Immediate steps should be taken to address the individual's attitude, behaviors, and thoughts in order to redirect him/her from the path of violence the individual is clearly moving down. This may require counseling, residential life staff, student conduct, and law enforcement to each be actively involved in discussing the case and finding ways to lessen the risk and steer the individual away from the pathway towards violence. It may be that the student will need to leave campus for a time, depending on the severity of his or her actions.

Scores 41 -70 Indicate a High Risk:
Decisive and quick action is required to thwart a potential violent attack whether on an individual or on campus. Multiple departments will be involved in this case to better address concerns for the community and campus safety. If the student's whereabouts are not currently known, locating the student for further assessment is essential. Most extreme risk cases will require some separation —as permitted by law and campus policy— from campus to allow for further assessment, information gathering, and potential campus and/or criminal charges. Efforts should be made to notify and work with those who can help mitigate risk (e.g. parents, extended family, friends) while the BIT engagement continues.

Discussion and Implications

The SIVRA-35 is a front-line set of 35 risk factors useful for college and university BIT and threat assessment team members as a guide to initially assess the potential risk for rampage, mass-casualty

violence. The SIVRA-35 draws from existing research and recent cases of rampage violence to create a starting place for administrators and decision makers to begin assessing the risk for danger of violence in their campus community.

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Institutional Risk Processes for Violence: Institutions Viewed through the PRISM

Paper

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Abstract

People in forensic institutions are violent not only because who they are, but also, because where they are. The institutional environment – its physical structure, the coherence of its organisation, the qualities of its staff and the services it provides – can serve either to exacerbate or ameliorate the violence potential of its inmates. PRISM (Promoting Risk Intervention by Situational Management; Johnstone & Cooke, 2008) is as a set of structured professional guidelines (SPJ) designed to assist in the reduction of institutional violence by focusing on institutional factors – in the broad sense – rather than just the risk factors inherent in individual patients or prisoners.

PRISM has been used as widely as the UK, Scandinavia, New Zealand and Barbados to evaluate the functioning of forensic hospitals and prisons, not only to evaluate the risk factors that operate, but also, to develop coherent risk management plans designed to obviate the violence risk posed. Systematic case studies can lead to effective interventions; however, they can also provide useful information about theory and explanation of violence risk through analytic generalisation. The process of development undertaken to produce PRISM helped answer the "What?" question, that is, what institutional risk factors are important for violence risk? To move from assessment to intervention, and on to effective change, it is necessary to answer the "Why?" question. Why, for example, might lack of staff training, or lack of clear management, or poor information systems increase violence risk? Risk factors can be regarded as markers of the underlying risk processes that individually, and together, increase the likelihood of violence and shape its topography. In this paper, multiple case studies (from a number of countries) will be used to demonstrate the systematic formulation of the risk processes that operate within institutions (e.g., deprivation, tension, frustration, sense of injustice etc). It will be demonstrated that systematic analysis of cases can provide an explanation of the mechanisms whereby institutional factors may provoke a response from those experiencing them. The relevance of risk processes for institutional management will be discussed.

Educational Goals

1. Understanding role of institutions in violence
2. Systematic assessment of institutions using PRISM

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The incremental validity of a bio-psycho-social approach for violence risk assessment

Paper

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Introduction

The formal launch of the bio-psycho-social model (BPSM) of medicine dates back to the seventies [1]. The mechanisms behind violent behavior among persons with psychiatric disorders are complex and involve psychological, social and biological factors. While a substantial part of risk assessment research has combined psychological and social factors, neurobiological factors have for the most part been investigated without involving or even controlling for the impact of the two other main groups of risk factors [2]. Even if numerous theoretical models of violence have been introduced, most of these models fail to integrate a tripolar understanding. Recently, however, some authors have paidmore attention to bio-psycho-social approaches to violence in mentally disordered people with focus on both theoretical [3] and empirical [4] research. The basic assumption of the BPSM is that the underlying factors and behavioural manifestations of violence are the result of neurobiological, individual, environmental and socio-economical causes. However, (i) The specificity of the proposed underlying factors for understanding the development of violence is unclear, (ii) Underlying factors are often assumed to reflect specific aspects of neurobiological functioning. However they are very often monitored indirectly by using behavioural rating scales, (iii) The complexity of the interaction between BPS factors is augmented by the fact that they all are subject to change. These arguments points in two compatible directions: To continue the work on breaking complex underlying factors into well-defined components to better understand their association with violence, and to investigate possible interactions between underlying factors that increase the risk of violence. This requires adequate and reliable construction of multivariate prediction models [5].

The multivariate model approach is based on the assumption that model variables should not only be evaluated in isolation for their predictive validity, but rather on their added (incremental) predictive validity beyond existing or established predictors. To further recognize the role of the new factor in the model one has to assess whether it is a correlate, risk factor or causal factor. Correlates are simply variables that are associated with for instance violence, but they are generally not predictive or causal. Risk factors are correlates that are shown to predict another variable (e.g. violence). To show that a variable is a risk factor it has to precede the outcome (violence). Causal risk factors can change and when they do so they impact the risk for violence. A few studies have indicated biological measures as risk factors, e.g. low central concentration of serotonin metabolites. Results from a growing number of investigations have identified biological variables as correlates or biomarkers of violence. An example of this is low values of total cholesterol (TC). Several cross- sectional studies have identified a significant correlation between low TC and violence [6-8]. In most hypotheses the effect of low cholesterol on aggression is linked to decreased serotonin in the central nervous system caused by reduced serotonin transport through cell membranes [9]. Therefore, it is important to emphasize that TC is treated as a correlate and not as a risk factor. A biomarker may be of a rapid or a slowly fluctuating type, but it is very unlikely that it will remain completely stable and unchangeable. Measures of biomarkers may be obtained by standard hospital procedures (e.g. routine blood samples), or by specialized medical examination that is not part of standard hospital procedures (e.g. fMRI).

Patients own perceptions of risk for future violence have been sparely examined in the literature, but results from two recent studies of patients from (i) forensic psychiatry [10] and (ii) acute psychiatry [11] indicated that patients' self-report of risk had acceptable validity in predicting severe violence within the first two months after discharge from forensic hospitals, and in predicting any violence within the first three months after discharge from an acute psychiatric ward.

There have been notable advances over the last three decades in violence risk assessment of mentally disordered persons. In spite of this the ROC-AUCs of current instruments lie around .70 [12] This finding indicates the need for assessment of additional risk markers and factors. In this research we combined a biological marker and self-reported risk of violence with a ten-item screen. The Violence risk screening-10 (V-RISK-10) is a structured screen with good reliability and predictive validity [13, 14].

The main aim of this investigation was to test different BPS models for violence risk assessment. Baseline variables (V-RISK-10, patients own perception of risk for future violence (SRS), and lipid levels) were rated or measured at admission, and compared with violent behavior recorded during hospital stay and the first year after discharge.

Method

Setting and subjects
The study was conducted at the acute psychiatric ward in Ålesund Hospital and included all acute admitted patients during one year (n=489) who gave written consent to participate in the study (n=254). Some patients were lost during follow-up and some had incomplete forms so the final study population consisted of 134 patients. Among follow-ups (n=134) there was significantly more patients who were involuntary admitted, more patients with bipolar disorders, and longer median hospital stays compared to the missing patients (n=355).

Measures

Total cholesterol (TC)
TC, high density lipoprotein (HDL), low density lipoprotein (LDL) and triglycerides were measured in blood drawn between 08 and 09 am within the first three days after admission, with a fasting period from 12 pm the day before.

SRS
Our literature search failed to show any empirical research on patients' self-reported "direct" opinion of subsequent violent behavior. Due to lack of other available instruments, a two-item self-report screen (SRS) with a seven-point scale was constructed to measure the patients' judgments of their subsequent risk for violence. The patients were asked to respond to two questions pertaining to two timeframes: For the time you are staying in the ward/for the first three months after discharge from the ward; what is your opinion about the risk that you: Will threaten other people by acting violently? Will act violently against others? For each question, the patients choose one of the seven respond options to express their risk estimate: no risk (will definitely not happen), low risk (will hardly happen), moderate risk (limited to certain situations), high risk (in many situations), very high risk (almost permanent risk), don't know the risk, and, will not answer about the risk [11].

V-RISK-10
TheV-RISK-10 [15] is a10-itemchecklist developed for acute psychiatry [16, 17]. The items are: 1. Violent threats, 2. Violent acts, 3. Substance abuse, 4. Major mental illness, 5. Personality disorders, 6. Lack of insight, 7. Suspiciousness, 8. Lack of empathy, 9. Unrealistic planning, and 10. Future stress-situations. Each item has a brief scoring instruction presented in the scoring form. Items are scored on a three-point scale (Table 1): 0 (No – The item definitely is absent or does not apply), 1 (Maybe/moderate – The item is possibly present, or is present only to a limited extent), 2 (Yes – The item is definitely present), Omit (Don't know –There is insufficient valid information to permit scoring the item).

The V-RISK-10 was constructed to include factors predictive of later violence. It is a structured clinical screen with historical, clinical and future risk assessment items. This means that it is a clinical guide to early detection of possible violence risk and not an actuarial instrument. The latter contains fixed and explicit algorithms to estimate the specific probability or absolute likelihood that a person will engage in violence in the future. The forerunner of the V-RISK-10, the Ps33, was inspired by the HCR-20, but the present 10-item version is substantially different from the Ps33. For instance, four of the items tap information concerning both past and present identification of the individual risk factor.

Outcome measures
During hospital stay, violence was monitored by the Report Form for Aggressive Episodes (REFA) [18, 19]. Shortly after the occurrence of an episode in the ward, information about the time and the characteristics of the situation, the precipitating factors, the persons involved, and the severity of the episode, were recorded. The inpatient episodes were recorded as threats or acts. Violent episodes that occurred after discharge were recorded in scoring schemes. Data from criminal and police records concerning violent threats and

acts included convictions, charges, and withdrawal of charges for violent crime by reason of insanity were combined with hospital data into a common outcome variable. The episodes were categorized into threats, less severe acts, and severe acts with operational definitions of each category. The scores on each category were: No, not present, Yes, present, or Don't know if present.

Statistical analysis
Data were analysed using SPSS version 16.0. Bivariate and multivariate logistic regression analysis was used to compare the TC, SRS, and single items and total-scores of V-RISK-10. We used a backward procedure in the multivariate single variable analysis. Exp (B) was used as odds ratio for occurred episodes.

Results

TC was a significant predictor of violent behaviour during follow-up in all bivariate analysis of the ten single items of V-RISK-10 (p-values between 0.005 – 0.001). The same goes for the ten single items and SRS (p-values between 0.030 - 0.001). TC and SRS were both significant in bivariate analysis of these two variables (p-values = 0.001 and 0.011, respectively). The SRS was not significant in bivariate analysis with V-RISK-10 total-score (p-values = 0.345 and <0.001, respectively), while both TC and V-RISK-10 total-score were significant in bivariate analysis with these two variables (p= 0.010 and <0.001, respectively). All ten single items of V-RISK-10, the SRS and TC were entered into a backward logistic regression analysis to obtain the best prediction model. Results showed that only TC (OR=0.27, 95% CI=0.13-0.54, p<0.001), V1 (violent acts, OR= 4.8, 95%CI=1.5-15, p=0.008), V3 (substance abuse, OR=4.2, 95%CI=1.3-13, p=0.014, and V10 (future stress situations, OR=4.8, 95%CI=1.4-17, p=0.015) remained significant.

Discussion and conclusion

We report results from a comparison of total cholesterol and patient self-report (SRS), and also when total cholesterol and SRS values were compared to single items of the V-RISK-10. Low cholesterol was a significant predictor of inpatient and outpatient violent behavior during the first 3-4 months after blood sampling at admission. SRS was also a significant predictor of violence at 3-4 months follow-up, which also was the case for V-RISK-10. The multifaceted risk assessment model yielded a significant increase in explained variance beyond that of the V-RISK-10 alone, and in multivariate analyses TC significantly accounted for variance beyond that of SRS and V-RISK-10. The association between low cholesterol and aggression has been linked to impulsive aggression but not to predatory aggression [20-22]. A recent predictive validity study of the HCR-20 showed that prediction of future violent events was particularly complicated in disorders characterized by impulsive behaviour [23] The significant contribution of TC as a biomarker for violent behaviour indicates that risk assessment of persons with impulsive violent behaviour may be enhanced by including biological markers
However, the results of our investigation must be interpreted with caution due to the small sample size. Other limitations are: (i) A high number of staff recorded the outcome measures, and episodes may have been underreported, (ii) Due to the follow-up procedures, violence from patients discharged into community may have run undetected more often than in patients followed up by psychiatric services, (iii) Consenting patients had lower rates of post-discharge violence than the non-consenting sample, and (iv) Differences between the subsamples indicate that non-consenters were characterized by more severe illness and a lack of insight. Taken together these differences may limit the external validity of the results. Future research may want to involve large-scale prospective study designs, other candidate biomarkers, and more advanced assessment of psycho-social factors. At last but not at least we suggest that epigenetic research may be of paramount significance to further development of reliable and valid bio-psycho-social models for risk assessment of violence.

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Nurses' contribution to prevent seclusion in acute mental health care – a prognostic study protocol

Paper

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Abstract

Background
Seclusion is an intervention widely used in Dutch mental health care. The intervention can be effective in acute situations to avert (further) aggression or self-harm. However, seclusion is also a controversial intervention that may not have any positive effect with regard to symptom improvement. In general patients report negative effects after being secluded e.g. anxiety and having had a traumatic experience.

The main reason for seclusion is not manageable aggressive behaviour of a patient. Earlier studies reported several risk factors that may contribute to seclusion, regarding patients' characteristics, but also with regard to staff characteristics, working protocols and unit characteristics. Because of unequivocally results there is the need for a longitudinal prospective study to examine staff- and unit determinants in association with seclusion.

Aims
The objective of this study is to determine which nursing staff and unit characteristics are associated with seclusion following aggression in hospitalized adult psychiatric patients. We hope to create a predictive model to estimate the risk of seclusion on an acute psychiatric ward.

Methods
We will conduct a prospective observational study on a closed psychiatric ward of an academic hospital. Patients are aged 18 – 65 years and are admitted when their psychiatric condition leads to an immediate threat to the patient themselves or their surroundings.

All nurses on the ward are all qualified nurses and registered in the Dutch registration of healthcare professionals. They are trained every six months in techniques of verbal de-escalation and safe physical restraint. For both nurses and the patients baseline characteristics are monitored. Every shift (day, evening, night) data are gathered on the patients, nurses and unit. Data are retrieved from the electronic patient chart, including information of the Brøset Violence Checklist. Furthermore, the exchange of information among nurses is measured using the Grid instrument. Data will be analysed using multilevel regression analysis. Data will be collected for a period of 2 years, which started January 2013.

Results
The primary endpoint in our study is the incidence of seclusion. As a secondary endpoint, the duration of the seclusion is measured. These endpoints are measured using the Argus registration system and will be linked to predictors of seclusion, with special focus on the nursing staff- and unit determinants.

Introduction

Seclusion is an intervention widely used in Dutch mental health care (1). In 2008 11% of the patients admitted to psychiatric hospitals where secluded during the period of time of their admission (1). Although international comparison is difficult, due to a great variety in coercive measures, it is estimated the Netherlands has one of the highest numbers of seclusions in Europe (2). The main reason to decide for seclusion is the result of a patient being aggressive, against staff, fellow patients or goods. The aggressive behaviour causes serious safety hazards in the hospital, creating an unsafe environment for other patients and healthcare professionals. Violent situations are probably well known to all working in the field of psychiatry in which patients or personnel were endangered or even hurt by aggressive patients. These

situations justify the use of seclusion (3). But seclusion is a controversial intervention that has no proven therapeutic effect (4). Moreover, patients report negative effects after being secluded e.g. they feel extreme anxiety, anger, and experience feelings of being abandoned (5). Seclusion seems to be a traumatic experience and do not contribute to their recovery in the long run. Therefore, in 2004 the Dutch Ministry of Health, Welfare and Sports ordered that the Dutch mental health care seclusion rates should decrease by at least 10% each year (6). In 2010, however this goal was not achieved; the Health Care Inspectorate reported only a 5,5% decrease (7).

Several studies reported risk factors that may contribute to seclusion in mental health care. Young, male patients, especially when they are diagnosed with schizophrenia or bipolar disorder are at higher risk of being secluded during an admission (8). But also characteristics of the psychiatrists and nurses as well as the environment are believed to influence the seclusion rate.

However, the results are unequivocal and most of these studies were performed retrospectively and had several methodological limitations. For example, Nijman et al (1994) found no significant associations between staff factors and seclusion on a closed psychiatric ward (9). Vollema et al (2012) found significant associations between seclusion and the subjective feelings of safety among nurses (OR = 1,773, p = 0,005) (4). Janssen et al (2007) found male-female staff ratio and variability in team's work experience significantly associated with seclusion rates (both variables p < 0,001) (10). The question remains whether nursing staff factors and unit characteristics may influence the risk of seclusion following aggression on an acute psychiatric ward, a question that should be answered in robust, longitudinal prospective studies (4).

We therefore designed this study to determine which nursing staff and unit characteristics are associated with seclusion following aggression in hospitalized adult psychiatric patients. By answering this question we hope to identify predictive factors from which we can estimate the risk of seclusion on an acute psychiatric ward. This insight may contribute to the development of specific interventions to prevent seclusion and therewith improve the safety of the psychiatric patients and the healthcare professionals.

Method

Design
We will conduct a prospective observational study on a closed psychiatric ward of an academic hospital. The endpoint of our study is seclusion. Seclusion is defined in the Netherlands as the restraint of a patient for care and treatment in a designated seclusion room that is approved by the government (an empty room containing only a mattress and a blanket) (4). Whether the patient resists to the seclusion or not is not an objective of our study. Short separations of patients in a so-called 'safe room' at the ward are not being investigated in this study.

The Medical Ethics Review Board of the Academic Medical Centre reviewed our study protocol and decided that ethical approval was not required according to the Dutch Medical Ethics Law. Informed consent of individual participants was not necessary because of the minimal additional impact on the integrity of our study participants, as routine care is monitored and no extra interventions are employed.

Setting & participants
The study is performed at the Academic Medical Centre in Amsterdam, the Netherlands. The closed psychiatric ward is situated in the psychiatric department and is referred to as the intensive care. The ward consists of two separate units with each six rooms. Each patient has a separate bedroom and adjoining bathroom. Both units have their own living room, consulting room, kitchen and a room where smoking is allowed. Both units have access to a central garden. The nursing station is situated at the centre of the ward and serves both units. Both units have three standard patient rooms, one room designed for physically disabled patients, one room with the possibility to lock the door from the outside and one room that can be stripped to be a safe room (also with the possibility to lock the door from the outside). Four seclusion rooms are situated outside the ward, of which a maximum of two can be used at the same time. Two of the seclusion rooms are facilitated with a toilet. All four seclusion rooms have radio and an intercom installation.

Patients are aged 18 – 65 years and are mostly admitted to the hospital on an involuntary basis. Patients are admitted to the ward when there is an acute danger for themselves or their surroundings, due to their psychiatric condition. Most of the patients are diagnosed with schizophrenia or a bipolar disorder.

The nurses at the ward are all qualified and registered in the Dutch registration of healthcare professionals and student nurses. All registered nurses are trained every six months in techniques of verbal de-escalation and safe physical restraint.

Measures

The baseline characteristics of both nurses and patients will be listed. Data will be gathered at each turn of the shift. This means that data are collected three times every 24 hours. The nurses are informed about the fact that the study is conducted at the ward, but they are not informed on the exact hypotheses of the study.

For the group of nurses information is gathered about baseline characteristics. Information is gathered about nurses' experience, educational level and level of employment. Also personal information like age and sex is used. Information about the stature of the nurse is gathered from length and weight. Also, the stature of the nurses is rated. This is considered to be a qualitative variable, rated by two assessors independently. All these data are chosen because they might influence aggressive behaviour by the patients and the decision for seclusion. For example, an older and experienced male nurse of two meters tall might intimidate the patient more than a young female student nurse. Information about patients who are admitted at the ward will be gathered from the electronic patient record. The patient baseline characteristics are informative for the generalization of our study. We gather information about the sex, age, ethnicity, legal status, diagnosis and so on. Information about the patients' history on aggression and seclusion is gathered as well.

Unit characteristics are measured from the schedule programme and from the electronic patient record. We gather information about the unit for each shift. We record which nurses and patients are present at the ward. In this way, we can measure the influence of combined nursing staff factors in order to examine the team influence on seclusion.

For each patient on the ward, the Brøset Violence Checklist (BVC) (11) is assessed twice a day. The BVC is a validated risk assessment tool containing two components. The first component is an objective list of symptoms, which can predict aggression, for example agitation, clamour etc. The second part is a subjective assessment on the risk of aggression, from 1 to 5. The subjective assessment is expressed in a number from 1 (risk of aggression is subjectively assessed as absent) to 5 (risk of aggression is subjectively assessed as very large). The BVC is part of the regular care in our hospital.

We gather information about aggressive incidents from the safety measurement system and from our electronic patient record by examining the daily nursing reports. No structured method of assessing aggressive incidents is used on the ward.

The primary endpoint in our study is the incidence of seclusion. As a secondary endpoint, the duration of the seclusion is measured. The endpoints are measured using the Argus registration system (12). The duration of seclusion gives additional information about the role of seclusion at the ward. When patients are taken out of seclusion, there is a risk that they will get secluded again. Taking patients out of seclusion fast may lead to a higher incidence of seclusions (13). By taking into account the duration of seclusion we tend to give a more accurate picture of the situation on the ward.

The Argus system is a registration system gathering information on involuntary admissions and coerced treatment, of which a psychiatric hospital is obligated to use. From which data must be presented regularly to the Dutch Health Care Inspectorate (IGZ). This system registers every time a patient is secluded, together with the duration of the intervention. These data give a reliable representation of the amount and duration of seclusions on the ward. Information about the reason of seclusion is gathered from the daily nursing report.

Analysis

Our analysis starts with describing the baseline characteristics of the population of nurses and patients. Nominal and ordinal variables are described by proportions and frequencies. Continuous variables are described by mean and standard deviations or median and range in case of a Non- Gaussian distribution.

The goal of the statistical analysis is to create a valid prediction model to predict seclusion based on the measures as stated in the previous section. The data that we want to use in the prediction model are both (individual) nursing characteristics and unit characteristics. These are two different clusters of data. Our analysis will take into account the correlation within the clusters. For this reason, multilevel regression analysis is used. The dependent variable is involuntary seclusion, according to the definition given in the previous sections. The model is being built by the enter method. For this, a P- value of 0,1 is used. To validate the model, we intend use a bootstrapping procedure.

Because of the nature of the study, missing data cannot be ruled out. For the analysis we accept some missing data, but we watch the standard error closely. If necessary, we use the expected value to impute in our data. All analyses will be performed using SPSS software.

Conclusion

Seclusion is a unavoidable, but controversial intervention with negative consequences for patients. Our study will contribute to gain more insight in nurses' factors that influence the seclusion rate is essential to develop interventions and create a safe environment for these vulnerable patients.

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'The conversation room' experience with reducing coercive measures

Paper

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Background

A high degree of control, restraint and stigmatization can seriously jeopardize milieu-therapeutic initiatives at one Regional Security Ward in Norway.

Aims

Improving the possibility for therapeutic communication. Dialogue and focus on maintaining relations may be one of the most important means to counteract valuable results.

Method

Empirical knowledge from 6 years of practice following the work of a focus group. The focus group included 12 psychiatric nurses with more then 10 years experience from a regional security ward in Oslo, Norway..

Results

Patients are admitted mainly from local security wards with limited resources and competence. In these cases, patients are often locked in mechanical restraints for several weeks awaiting transfer to Regional Security Ward or an an acute situation requiring high levels of attention in a locked environment.

Conclusions

The staff must be available when the patient needs to talk and there must be a suitable room for the discussion.

There are some key principles when using milieu therapeutic conversation rooms. Regardless of the individual patient's behaviour and needs, we will always refer personal conversations to the staff responsible for that patient, and all conversations will take place in the conversation room. Most conversations with therapists or milieu contacts are initiated or wanted by the patient. These can be planned conversations regarding practicalities, confidential and personal matters. The conversation room should be a place that represents safety, security, and being treated with respect.

But there are some challenges. If the patient refuses to enter the conversation room voluntarily, two members of staff will take hold of the patients' arms and wrists. This measure is often enough to facilitate a constructive dialogue within a controlled framework. Even in cases where the patient is being held down on a couch with staff on either side, the conversation room is at the same time real and symbolic. Use of the conversation room and

physically restraining the patient reduces the need for mechanical restraint.

Educational Goals

The staff must be available when the patient needs to talk andthere must be a suitable room for it.

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Facial Emotion Recognition and Crime Trends in Patients with Bipolar Affective Disorder

Paper

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Background

It is well known that patients with Bipolar Affective Disorder (BAD) are more prone to violence and have more criminal behaviors than the general population. There is also a strong relationship between criminal behavior and inability to empathize with other other people's feelings, thoughts and facial expressions and this increases the risk of crime and violence (1).

Although there is growing awareness about neurocognitive impairments in euthymic bipolar affective disorder (BAD), the paucity of knowledge about social cognitive ability in these patients is surprising (2). Social cognition is a mental process underlying social interactions. The process of facial emotion recognition is important for normal socialization i.e., maladjusted interplay with others, aggressive and other antisocial behaviors that might be the results of failure to be appropriately guided by the social cues of other peoples (3).

In this study, we aimed to investigate the deficits of facial emotion recognition skills in BAD patients who committed an offence, by comparing not committed an offence in patients with BAD.

Methods

Fifty five BAD patients who committed an offence as a case group and 54 BAD patients who had not committed an offence – the control group were included. The criminal history and criminal records were obtained by looking into court files and interviewing patients. The criteria for exclusion were i) younger than 18 or older than 65 years old age, ii) mentally retarded, iii) visual problems, iv) cerebral or cerebro-vascular diseases, epilepsy etc., v) scoring above 8 points on the Hamilton Depression Rating Scale or over 6 points ontheYoung Mania Rating Scale, vi) bipolar affective disorder subtype other than BAD-1.

Patients were assessed as euthymic in each case by scoring lower than 7 points on the Young Mania Rating Scale, and lower than 9 points in the17-item Hamilton Depression Rating Scale and the presence of normal functioning for at least 2 months (2). Facial Emotion Recognition Test, Sociodemographic Data and Clinical Follow-up Form, Hare Psychopathy Checklist, and Young Mania Rating Scale were applied to both groups.

Facial Emotion Recognition Test
This computer-based test involved happy, surprised, fear, sad, disgusted, anger, and neutral facial expressions of four male and four female models' photos from Ekman & Friesen's series. In this study, 56 mixed photos, eight number of each emotion were used. These photos were integrated on a computer presentation by using SQL database in Visual Basic NET software program and administered to all participants via a laptop.

Results

There were no significant differences between case and control groups in mean ages (35.1±8.8; 34.9±7.9 years respectively), distribution of gender (percentage of men is 89.1 and 88.9, respectively) (p>0.05) while the occupational and marital status, level of education, living place were significant between groups (p<0.05). In addition, the mean age onset of disease (26.1±8.0; 23.4±6.7 respectively) and suicide attempts in previous history (32.7% vs 25.9% respectively) were non-significant (p>0.05). The duration of illness (9.0±6.5 vs 11.5±6.8 years), and the scores on the Hare Psychopathy Checklist (8.6±6.3 vs 6.3±2.9 points), rate of treatment non-compliance(9.1% vs 0.0%) and history of substance abuse were significantly different between case and control groups, respectively (p<0.05).

The deficits of facial emotion recognition ability of the case group who committed an offence were significant for facial expression of fear and the sum of the test results, as well, were likely to be significant

for angry facial expression by comparing the control group who did not commit an offence. It is remarkable that, the patients in case group misidentify the negative facial emotion expression (sad) as a positive facial emotion expression (happy and neutral). In addition, the patients who committed an offence had a longer response time of recognition of facial emotion by comparing the patients who had not committed an offence. However, this difference was significant for happy, frightened, disgusted, angry facial expressions and the sum of the test, but not significantly for sad, surprised, and neutral facial expressions. Although they did not reach the the level of psychopathy, the Hare Psychopathy Checklist scores were significantly higher in the case group who committed an offence than the control group who not committed an offence.

Conclusion

Fear and sad facial emotions are considered to serve as social reinforcers that condition a child to avoid engaging in antisocial behaviors that elicit such expression. In a meta-analysis of 20 studies that was conducted on antisocial populations to assess facial emotion recognition ability, a consistent link was shown between deficits in fear emotion recognition and antisocial behavior (3). In the current study, the ability to recognize fearful facial emotion was significantly worse in euthymic patients with BAD with delinquent behaviors than non-delinquent ones. In addition, we revealed that mean score of Hare Psychopathy Checklist is significantly higher in delinquent euthymic patients with BAD. Furthermore, euthymic patients with BAD who had delinquent behaviors were found to misidentify sad faces as happy or neutral faces. Thus, our findings seem in line with the proposal of psychopathic traits which suggests that facial and vocal expression of fear or sad emotions are the most distressing cues which may inhibit the maintenance of aggressive behavior in normal individuals (4) in which recognition of these emotions are problematic in euthymic patients with BAD who had delinquent behaviors in the current study.

The deficits of facial emotion recognition skills in BAD patients who committed an offence may be related to inability to empathize which gives rise to criminal behavior. When the information of facial emotion recognition skills of BAD patients who committed an offence increase, foresight of criminal behavior will increase and it will be possible to develop preventive interventions, as well as inhibit the repetition of criminal behavior.

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Translation of risk assessment to risk management:challenges and solutions

Paper

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Abstract

In this paper recommendations are made for bridging the gap between risk assessment and risk management. Adequate risk assessment does not necessarily guarantee the development of effective risk management strategies. In clinical practice the translation of risk assessment to risk management is often difficult and complex.

From ten years of clinical experience working with structured professional instruments in a Dutch forensic psychiatric hospital and prospective research results on the HCR-20 (e.g. de Vogel, 2005) and the SAPROF (e.g. de Vries Robbé & de Vogel 2011), this paper aims to addresses the issue of effectively translating the structured assessment of risk and protective factors to the development of achievable and realistic risk management planning in clinical reality. This challenge will be exemplified by a complex high risk case example from clinical practice in The Netherlands. Suggestions will be offered on how to effectively transfer risk assessment results with the HCR-20/V3 and the SAPROF to risk management planning and violence risk prevention. Best practice guidelines are offered for improving the incorporation of risk assessment outcomes in clinical decision making.

Educational Goals

- Learn about the implications of risk assessment for clinical interventions
- Learn about risk management planning
- Learn about dynamic risk (HCR-20/V3) and protective (SAPROF) factors

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Violence on the ward: Characteristics of mental health professionals who have an increased risk of becoming victims of inpatient violence

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Background

Several studies indicate that the prevalence of violence against mental health care workers is high and the nature of these incidents can be very severe [1-3]. For example, findings from two British studies on the prevalence of in-patient violence showed that a nurse would have a ten to sixteen per cent chance, per year of sustaining injuries as a result of this violence [2, 3]. Additionally, the incidence of other types of violence, such as verbal aggression and threats seem to be much higher [2-4]. The consequences of inpatient assaults can also be very serious. For example, in one study twelve per cent of the victimized health care professionals had been physically injured [5].

In addition, fifteen per cent of the respondents to a German study on the consequences of violent incidents reported they sustained serious injuries, such as unconsciousness, fractures or deep cuts [6]. Besides the possible physical consequences of in-patient violence, it seems that psychological consequences can also be substantial [1, 7, 8]. Because of the great impact of violence on victims, as well as on colleagues and fellow patients, many efforts have been made to reduce inpatient violence. However, in order to protect mental health care workers from inpatient violence, it is important to know if there are specific groups of mental healthcare professionals who are especially vulnerable to become victim of this type of violence.

Method

Dutch mental health professionals working in inpatient facilities were approached to fill in an online questionnaire on their personal experiences with physical violent incidents caused by patients in the past five years. They were asked about the prevalence, nature and personal consequences of violent incidents.

Results

1534 Mental health professionals became victim of a total of 2648 (physical) violent incidents. The findings demonstrate that in-patient violence is a serious problem on all types of wards, which has grave consequences on staff as well as on patient care. The number of experienced incidents and characteristics of the respondents are presented in Table 1.

Table 1. Number of experienced incidents per type of respondents*

	Number of respondents	Percentage of respondents	Number of experienced incidents	Average number of experienced incidents
GENDER (n=1294)				
Male	406	31.4%	882	2.2
Female	888	68.6%	1398	1.6
AGE (n=1293)				
19 - 29	407	31.5%	765	1.9
30 - 39	310	24.0%	623	2.0
40 - 49	262	20.3%	463	1.8
50 - 59	274	21.2%	395	1.4
60 - 68	40	3.1%	34	0.9
FACILITY (n=1292)				
General psychiatric hospital	717	55.5%	1496	2.1
Protected residential facility	160	12.4%	171	1.1
Forensic psychiatric facility	155	12.0%	232	1.5
Psychiatric ward general hospital	40	3.1%	68	1.7
Addiction treatment and care	78	6.0%	91	1.2
Youth psychiatry (age >12)	82	6.3%	133	1.6
Other	60	4.6%	86	1.4
TYPE OF WARD (n=1257)				
Closed short term treatment	257	20.4%	631	2.5
Closed long term treatment	239	19.0%	545	2.3
Closed long-stay	121	9.6%	247	2.0
Open short term treatment	121	9.6%	146	1.2
Open long term treatment	168	13.4%	223	1.3
Open long-stay	254	20.2%	347	1.4
Other	97	7.7%	125	1.3
FUNCTION (n=1258)				
Nurse	640	50.9%	1438	2.2
Socio-therapist	329	26.2%	564	1.7
Doctor	38	3.0%	43	1.1
Activity-coordinator	32	2.5%	20	0.6
Art therapist	18	1.4%	3	0.2
Psychologist	47	3.7%	23	0.5
Manager	38	3.0%	62	1.6
Other	116	9.2%	112	1.0

* The number of respondents differs per item due to missing data

It appears that some professionals are more vulnerable to become victim of inpatient violence. For instance, most incidents occurred in closed wards, with an average of 2.5 incidents per respondent on closed wards for short-term treatment, and 2.3 incidents per respondent for closed wards for long-term treatment. Additionally, men were relatively more often victimized than women (2.2 incidents per male respondent versus 1.6 incidents per female respondent). Overall, younger professionals in the age of 19-39 seem to be more vulnerable for inpatient violence than their older colleagues. Respondents in the age of 19-39 experienced relatively more incidents than older health care workers in the age of 40-68. Psychiatric nurses are the profession that reported most incidents (2.2 incident per responded nurse),

whereas therapists, such as art therapists and music therapists were clearly the least affected mental health workers, with only 0.2 incidents per responded therapist.

Table 2. Number of severe physical assaults* per type of respondents**

	Number of incidents	Number of severe physical assaults	Percentage of severe physical assaults
GENDER (n=1294)			
Male	882	41	4.6%
Female	1398	71	5.1%
AGE (n=1293)			
19 - 29	765	36	4.7%
30 - 39	623	36	5.8%
40 - 49	463	24	5.2%
50 - 59	395	15	3.8%
60 - 68	34	1	2.9%
FACILITY (n=1292)			
General psychiatric hospital	1496	75	5.0%
Protected residential facility	171	7	4.1%
Forensic psychiatric facility	232	13	5.6%
Psychiatric ward general hospital	68	2	2.9%
Addiction treatment and care	91	7	7.7%
Youth psychiatry (age >12)	133	4	3.0%
Other	90	3	3.3%
TYPE OF WARD (n=1257)			
Closed short term treatment	631	39	6.2%
Closed long term treatment	545	29	5.3%
Closed long-stay	247	12	4.9%
Open short term treatment	146	6	4.1%
Open long term treatment	223	3	1.3%
Open long-stay	347	14	4.0%
Other	125	7	5.6%
FUNCTION (n=1258)			
Nurse	1438	75	5.2%
Socio-therapist	564	23	4.1%
Doctor	43	2	0
Activity-coordinator	20	3	15%
Art therapist	3	0	0
Psychologist	23	0	0
Manager	62	1	1.6%
Other	112	6	5.4%

* Severe physical assaults: stabing and/or cutting, taking hostage, attempted strangulation and rape.
** The number of respondents differs per item due to missing data

As Table 2 shows, some professionals seem to have an increased risk of becoming victim of a severe assault (defined as: stabbing and cutting, taking hostage, attempted strangulation and rape). Relatively, most severe assaults happened in facilities for addiction treatment and –care (7.0%) and in forensic psychiatric facilities (5.6%). On closed wards, 4.0 per cent of the incidents are severe assaults, whereas 3.1 per cent of the incidents on open wards can be defined as severe. It is striking that more than one in

seven activity-coordinators who became victim were assaulted severely. However, this number may be biased by the relatively low response rate of these professionals.

Table 3. Number of severe physical injuries* per type of respondents**

	Number of incidents	Number of severe physical injuries	Percentage of severe physical injuries
GENDER (n=1294)			
Male	882	33	3.7%
Female	1398	48	3.4%
AGE (n=1293)			
19 - 29	765	28	3.7%
30 - 39	623	17	2.7%
40 - 49	463	20	4.3%
50 - 59	395	14	3.5%
60 - 68	34	2	5.9%
FACILITY (n=1292)			
General psychiatric hospital	1496	58	3.9%
Protected residential facility	171	2	1.2%
Forensic psychiatric facility	232	8	3.4%
Psychiatric ward general hospital	68	3	4.4%
Addiction treatment and care	91	1	1.1%
Youth psychiatry (age >12)	133	9	6.8%
Other	90	0	0
TYPE OF WARD (n=1257)			
Closed short term treatment	631	23	3.6%
Closed long term treatment	545	23	4.2%
Closed long-stay	247	11	4.5%
Open short term treatment	146	4	2.7%
Open long term treatment	223	7	3.1%
Open long-stay	347	11	3.2%
Other	125	2	1.6%
FUNCTION (n=1258)			
Nurse	1438	56	3.9%
Socio-therapist	564	18	3.2%
Doctor	43	0	0
Activity-coordinator	20	0	0
Art therapist	3	0	0
Psychologist	23	0	0
Manager	62	3	4.8%
Other	112	3	2.7%

* Severe physical injuries: stab- and/or cutting wounds, concussion, fractures and torn muscles, unconsciousness, biting wounds and eye injuries
** The number of respondents differs per item due to missing data

When focussing on only the most severe physical injuries (concussion, unconsciousness, fractures or torn muscles, stab- and/or cutting wounds, biting wounds and/or eye injuries) there was only a small difference between males and females (3.7% of the male victims were severely injured compared to 3.4% of the female victims). In general, managers were the profession with the highest rates of severe physical injuries

(4.8%%) followed by nurses (3.9%), and socio-therapists (3.2%), whereas doctors did not report any serious injury. Staff working on closed wards for treatment or residence most often became victim of the as most seriously defined injuries meaning that 4.0 per cent of the incidents, which happened on these wards, resulted in serious injury. Interestingly, older personnel (age 40-68) seem to be more often seriously injured than younger personnel (age 19-39) (4.0 for older victims versus 3.2 for younger victims).

Conclusion and discussion

Some specific professionals were identified as having an increased risk of getting harmed by in-patient assault. Staffs working on closed wards most often became victim of (severe) assaults, and are at the greatest risk of sustaining severe injuries. Also male professionals and younger professionals are victimised more frequently, however older professionals are more often severely assaulted.. Overall nurses and socio-therapist are the professions with the highest rates of victims of inpatient assault.

Further research is needed to explain why these groups are especially vulnerable. This can provide important information on the reduction of violence by targeted prevention.

Acknowledgements

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Violence risk assessment in women: Results from a Dutch multicentre study

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Introduction

Violence risk assessment in female forensic psychiatric patients is still a relatively unexplored area. Results so far suggest that violence risk factors differ at least to a certain degree between female and male patients, and consequently, that the existing structured risk assessment instruments are not sufficiently suitable for use with female patients. For example, research results on the predictive accuracy of the widely used HCR-20 for female samples have not been convincing (De Vogel & De Vries Robbé, 2013; McKeown, 2010). Recently, gender-sensitive risk assessment guidelines for female (forensic) psychiatric patients have been developed in addition to the HCR-20 / HCR-20^{V3}: the Female Additional Manual (FAM: De Vogel et al., 2012) with the goal to provide mental health professionals working with women with a clinically relevant and useful additional tool for more accurate, gender-sensitive assessment and management in violent women.

Studies into female populations generally encounter several difficulties; most importantly small sample sizes (see also Burman et al., 2001). Given the relatively small number of female forensic patients in the judicial system, collaboration between different settings is essential. In 2012, a retrospective study was started into characteristics of female forensic psychiatric patients from four different institutions in The Netherlands. The major aim of this study is to gain more insight into criminal and psychiatric characteristics of female forensic psychiatric patients, especially characteristics that may function as risk or protective factors for future violence. A second aim is to examine the predictive validity of a number of frequently used risk assessment tools with respect to their value for use with female populations. Overall, this may lead to a better understanding of this specific and growing group of forensic patients and enable mental health professionals to provide the most adequate risk assessment and management for women, thereby preventing violent (re)offending. In this paper, we will present the first results from this still ongoing Dutch multicentre study, focusing on the psychiatric and criminal characteristics.

Method

An extensive list of criminal, demographic, psychiatric and treatment characteristics was coded by a group of trained and experienced researchers based on file information of 297 women who are - or have been admitted to four different forensic psychiatric facilities in the Netherlands between 1984 and 2013 (Van der Hoeven Kliniek, Oldenkotte, FPK Assen and Woenselse Poort). For all women, the Psychopathy Checklist-revised (PCL-R; Hare, 2003) and the historical factors of the FAM and the HCR-20 were coded. For all female patients who had been discharged with a follow up time of at least three years living in society, the FAM / HCR-20 dynamic factors were coded as well. In addition, several other tools were coded; such as the recently published Historical, Clinical, Risk Management Version 3 (HCR-20^{V3}; Douglas et al., 2013) and the Structured Assessment of Protective Factors for violence risk (SAPROF; De Vogel et al., 2009, 2012) for the assessment of protective factors. The assessments were related to incidents during treatment in order to examine the predictive validity of the FAM and the other tools.

General and psychiatric characteristics

Mean age at the time of admission to the current or most recent treatment setting was 35 years (SD = 9.7, range = 18-65). The majority (84%) of the female patients was born in The Netherlands. Overall, this group of women was highly traumatized; 71% had been (sexually, physically or emotionally) victimized during childhood (most often within the family context) and 51% during adulthood (most often by an intimate partner(s)). Almost half of the women were in an intimate relationship at the time of their index-offense (40%) and many had children (53%). Most of these women, however, were not capable of taking care of their children. The majority of these children (75%) were not living with their mother, but in foster

homes, child protection settings or with relatives. There were 23 cases of maternal filicide; 15% of the mothers who killed their child(ren).

With respect to psychopathology, we found high levels of co-morbidity; 75% of the women had diagnoses of both Axis I and II disorders, with Axis II disorders prevailing. The Borderline Personality Disorder (BPD) was most prevalent; 59% of the women were diagnosed with BPD and another 22% with traits of BPD. 14% had a high level of psychopathy, as assessed with the PCL-R and applying the lower FAM cut-off scores. Many of the women (69%) had a history of substance abuse, mostly alcohol abuse, and 30% committed their index-offense under the influence of alcohol or drugs.

Most of these women had previously been in treatment; 38% before the age of 17 and 82% during adulthood (57% mandatory admission to a psychiatric setting). The majority of these women (76%) had at some point dropped out of prior treatment, for example, because of violent incidents, rule-breaking behaviour or serious suicide attempts. 29% of the women had a history of prostitution. A substantial number of women had a history of self-harm (40%), suicidality (61%) or severe self-neglect (15%). With respect to reported incidents during their present or most recent treatment the following was observed: 33% physical violence to others; 45% verbal threats to others; 45% self-destructive behaviour; 54% manipulative behaviour (e.g, conning and manipulating others, claiming to be pregnant or seriously ill, intentional use of sexuality for personal gain); and 8% firesetting during treatment (usually in their own room).

Several of the characteristics described above can be defined as risk factors according to the literature, like victimization, prostitution, substances abuse, treatment dropout, suicidality and pathology - especially psychopathy - (see De Vogel et al., 2012).

Criminal characteristics

The majority of the women in the present sample (72%) had had police contacts before their index-offense for which they were most recently admitted; 52% had been convicted before for any type of offense, while 20% had had police contacts that did not result in a judicial consequence (mostly official dismissals by reason of mental insanity). The mean number of previous convictions of the group that had been convicted was 4 (SD = 4.7, range = 1-30), with property offenses and violent offenses being most prevalent. The mean age at first conviction was 23 years (SD = 9.1, range = 12-63) and the mean age at index-offense was 33 years (SD = 9.7, range = 17-64). Index-offenses concerned: 24% homicide; 23% attempted homicide; 27% arson; 3% sex offenses; 14% other violent offenses; and 9% property / other offenses. 87% of the women committed their index offense alone, 13% with an (often male) accomplish. In 80% of the cases there were direct victims of the index-offense, most often within the close environment of the women: (ex) partner (20%), own child(ren) (16%), other family members (10%), treatment staff / supervisors (9%); and friends / acquaintances (26%).

Risk assessment tools

In the current study, first the FAM / HCR-20 Historical risk factors were examined more in-depth and comparisons were made between subgroups. For instance, women with a high level of psychopathy were found to have significantly higher scores on several FAM / HCR-20 factors (e.g., Prostitution, Problematic behaviour during childhood, Young age at first violent incident) and more incidents of manipulative behaviour during treatment in comparison with women with low levels of psychopathy.

Second, analyses were carried out on the predictive validity of the FAM / HCR-20 Historical items and the PCL-R for incidents during treatment (N = 297) With respect to incidents during treatment, we found the FAM / HCR-20 Historical subscale score to be a significant predictor of incidents of physical violence, verbal violence, verbal threats and arson. Furthermore, the FAM / HCR-20 Historical subscale score significantly predicted if a woman had to be transferred to another ward in the treatment setting, usually because of serious problems. The PCL-R total score demonstrated significant predictive validity for incidents of manipulative behaviour and verbal violence during treatment.

Conclusion and future directions

This study presented an overview of characteristics and risk factors of Dutch female forensic psychiatric patients. Most notably, the majority of the female forensic psychiatric patients show severely problematic personal histories with respect to victimization, psychopathology, substances abuse, self-harm / suicidality and violent behaviour. Preliminary findings indicate that the FAM Historical item scores are a good predictor of inpatient violence towards others and self-harming behaviour. Further comparison between subgroups of female patients and more in-depth analyses of the various risk assessment tools used in the

present study will be carried out in the near future. For example, we will analyse recidivism data of a subgroup of women (n = 78) who have been discharged before 2010 to assess the predictive validity of the different tools for official reconvictions. Furthermore, this group of female forensic patients will be compared to a matched sample of male forensic patients and possibly to female prison populations and non-forensic psychiatric female patients. Suggestions will be provided with respect to gender-sensitive violence risk assessment, psychopathy and risk management of women in (forensic) psychiatry.

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Learning objectives

- Learn about violence risk factors, violence risk assessment and psychopathy in female forensic psychiatric patients
- Learn about the Female Additional Manual (FAM)

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Using the SOAS-R scale in the Psychiatric Department of the Lausanne University Hospital (DP-CHUV): lessons and limits after five years

Paper

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Keywords: Psychiatric hospitals, Violence, Aggression, Assessment, SOAS-R

Introduction and/or background

Since 2008, the psychiatric department of the Lausanne University Hospital (DP-CHUV), Switzerland, has employed the scale "Staff Observation Aggressive Scale- Revised" (SOAS-R) to assess aggressive and violent incidents in their in-patient units. A large group of patients with different psychiatric disorders and age groups (children/adolescents, adults, elderlies) were concerned by this assessment.

Method

The aim of this study is to describe the results of the assessment (nature and prevalence of aggressive behavior towards staff or others targets, patients' and victims' characteristics, differences among victims' from different services,…).
- The study was performed in the DP-CHUV in seven specific acute hospitals located in the Canton de Vaud:
- Two adult psychiatric services (PGE: 7 wards, 95 beds; PRANGINS: 5 wards, 74 beds).
- Two psychogeriatric services (SUPAA: 5 wards, 80 beds; GIMEL: 1 ward, 20 beds).
- The child and adolescent psychiatric service (SUPEA – 1 ward – 10 beds).
- The toxidependency service (PCO – 1 ward – 8 beds).
- A "mixed" (adult and psychogeriatric) service (CPNVD, 4 wards, 42 adult beds + 14 psychogeriatric beds).

The SOAS-R is a standardized scale allowing classification of aggressive behaviors (physical assaults; verbal assaults and assaults against property). This scale consists of five columns (1) provocation; 2) means used; 3) target of the incident; 4) consequence(s) for the victim; 5) measure(s) used to stop the aggression), pertaining to describe the contexts of the violent or aggressive acts occurring in the wards involved (Nijman, 1999; Nijman, 2002). The severity of the incidents is measured using the SOAS-R-scoring system (0-22 points) and the SOAS-gravity score (0-100 with a VAS) filled in by the victim. The SOAS is reported after each violence incident.

The assessment of violent incidents in DP-CHUV using the SOAS-R shows two specificities compared to other institutions using the same scale:
- Considering that the problem of violence concerned and implied all the people working in our institutions, all personnel working in these hospitals (nursing staff, medical staff, administrative staff, security staff, students, etc…) have been consequently advised to the possibility of using this tool in case of observing any violent act.
- To limit what is called "the reporting industry" (De Niet, 2005), in case of verbal violence, the victims should fill the SOAS only if they feel threatened.

More information on patients were collected (age, gender, type of admission, principal and secondary psychiatric diagnoses according to ICD-10) using the hospitals data bases. Data were analysed using the Statistical Package for Social Sciences (SPSS) and R environment for statistical analysis.

Results

General characteristics
The analysed data set contains 11902 hospital stays with a total of 361045 treatment days. A total of 1239 incidents (1316 declarations) were registered during the study period. Aggressive incidents were recorded from 500 patients (7.5%) of the 6623 patients hospitalised during this time. Among 500 violent patients, 216 of them (43.2%) were responsible for more than one incident, while 45 patients (9%) were responsible

for more than 5 incidents. 40 violent episodes (3.23%) were caused by external persons (family, relatives, friends). The global incidence rate per 100 treatment days for the DP-CHUV was 0.34. This rate varies among different services, from 0.54 (PGE) to 0.13 (SUPAA).

Table 1: General data

	N beds	N incidents	N hospital stays	N hospital days	N patients	N SOAS patients	% STOAS stays	% STOAS patients	**Incident rate per 100 hospitalization days**	Reporting periods
PGE	95	834	5660	155550	2790	305	8.0	10.9	**0.54**	07.2008 - 12.2012
SUPAA	80	137	1846	104880	1442	65	4.0	4.5	**0.13**	01.2009 - 12.2012
SUPEA	10	59	449	13740	299	27	8.0	9.0	**0.43**	01.2009 - 12.2012
PCO	10	50	657	10223	409	31	5.0	7.6	**0.49**	01.2009 - 12.2012
PRANGINS	74	62	1819	40790	1281	29	1.0	2.3	**0.15**	06.2011 - 12.2012
GIMEL	20	35	210	11823	176	13	3.0	7.4	**0.30**	05.2011 - 12.2012
CPNVD	56	62	1261	24039	891	30	1.0	3.4	**0.26**	11.2011 - 12.2012
DP-CHUV	345	1239	11902	361045	6623*	500	//////////	7.5	**0.34**	/////////////////////////

* During an hospital stay, a patient may be transferred into another service

Verbal aggressions, combined or not with other types of violence (physical or object aggressions) represented 66.5% (n = 875) of the situations. On the other hand physical aggression was present in 53.2% (n = 687) of violent events combined or not with other types of violence. Most violent incidents occured during the daytime, more frequently in the afternoon (2 pm – 8 pm; n = 491; 39.5%) than in the morning (7 am – 1 pm; n = 342; 27.6%) or the night (22 pm – 7 am; n = 273; 22.1%). Distribution was uniform throughout the days of the week. A quarter of incidents (n = 326; 27.2%) occurred within the first week but 44.2% of the incidents (n = 530) occurred from the second month of hospitalization. The corridors of unit (n = 342, 28 % of the incidents), the seclusion room (n = 193, 15.6% for the DP-CHUV but 19.6% (n = 188 incidents) for the adult services) and the patient's room (n= 221, 17.8% for the DP-CHUV but 51.8% for the psychogeriatric services) were the places where incidents occurred more frequently. Hospital staff (mostly nursing and medical staff) were most frequently the targets of the aggressions (n = 1014; 77.1%). Nurses were the principal targets of the aggressions. Almost a quarter of the declarations showed that the patients could also be the target (Total: 22.8%). In the majority of the situations, the victims expressed their feeling as being threatened in the situation (67.4%). More than a quarter of aggressive situations (25.3%) had caused physical pain but, fortunately, only 40 victims (3 %) needed a treatment by a physician. Regarding the type of intervention, the staff controlled the situation more often by talking with the patients (52.3%), by administering medication (35.3%) or by using seclusion room (29.8%).

Patients' characteristics
Regarding patients characteristics, the results (table2) showed some differences between SOAS and non-SOAS patients.

Table 2: Differences between SOAS and non SOAS patients

Variable	Non-SOAS	SOAS	Test	Statistic	P-value
Age (mean)	48.53	42.64	t-test	5.96	<0.0001
Gender (Man) [#(%)]	2815 (90.37)	300 (9.63)	Chi-square	63.12	<0.0001
Gender (Woman) [#(%)]	3346 (95.38)	162 (4.62)			
Involuntary admission	4621 (91.31)	440 (8.69)			
Voluntary admission	6643 (97.11)	198 (2.89)			
Average lenght of stay	30.14	56.53	t-test	-8.68	<0.0001
Schizophrenia, schizotypal, delusional disorders - Mental disorders due to psychoactive substance use	70.12	29.88	Chi-square		
Schizophrenia, schizotypal, delusional disorders - Others	90.97	9.03			
Mood (affective) disorders - Mental disorders due to psychoactive substance use	89.92	10.08	Chi-square		0.0066
Mood (affective) disorders - Others	95.79	4.21			

Violent patients (SOAS patients) differed from non-violent subjects (Non-SOAS patients) in being younger, were more often men and more often hospitalised without their consent (involuntary admission). According to the ICD 10, a higher risk was also found 1) in patients with a principal diagnosis F2 (Schizophrenia, schizotypal, delusional disorders) associed with secondary diagnosis F1 (Mental disorders due to psychoactive substance use), and 2) with a principal diagnosis F3 (Mood (affective) disorders) associed with secondary diagnosis F1.

SOAS scores and gravity scores
The severity of all declarations on the SOAS scale ranged from 1 to 21, with a mean severity to 13.05 and a median to 13.00. SOAS scores vary according to the type of violence. When violence is physical, associated or not with another form of violence, SOAS scores were higher. SOAS scores differed too according to the services (figure 1): PCO (mean = 10.7 ± 0.53; median = 11.0) present the lowest scores. On the contrary, GIMEL (mean = 15.3 ± 0.55; median = 16.0), the SUPAA (mean = 14.9 ± 0.31; median = 15.5) and the SUPEA (mean = 14.5 ± 0.48; median = 15.0) present highest scores.
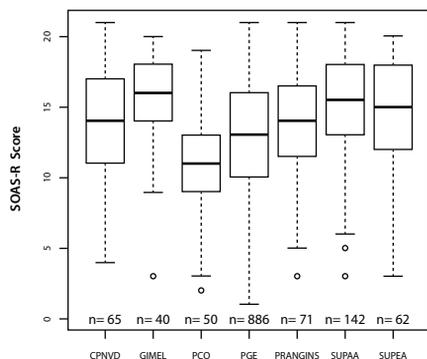
Figure 1: Boxplots of SOAS-R
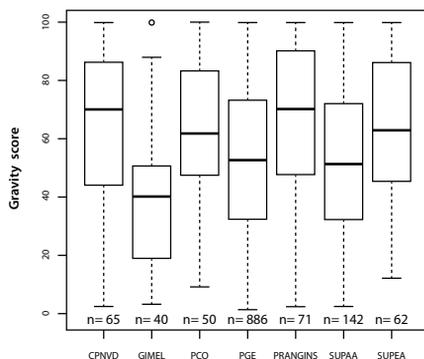
Figure 2: Boxplots of gravity scores according services

Gravity scores range from 1 to 100 points on the VAS. More than half of the declarations (54.8%) present gravity scores > 50 points and 30.5% present gravity scores > 75. According services, results present some differences (figure 2). The mean and the median of the gravity scores may be increased according to certain elements present or not in the declaration (table 3).

Table 3: Means ans median og gravity score versus different elements

Name	Mean 0*	Mean 1**	Median 0*	Median 1**	Obs 0*	Obs 1**	P-value
Provocation not understandable	53.1	58.2	52	56.5	1040	274	0.0055
Means used: Hand (hitting, punching, etc...)	53.4	56.2	52	58	955	359	0.0021
Dangerous method: Knife	53.6	76.8	53	86	1282	32	0.0000
Target: Patient self	53.1	66.7	52	71	1209	105	0.0000
Target: Other persons	53.7	64.3	53	68	1258	56	0.0070
Consequences: No	56.5	38.7	56	37	1145	169	0.0000
Consequences:Felt threatened	47.3	57.5	48	58	427	887	0.0000
Consequences:Pain > 10 mn	52.8	65	51	69.5	1160	154	0.0000
Consequences: Visible injury	53.3	60.5	52	65	1157	157	0.0005
Consequences: Need a treatment	53.6	68.2	53	68	1263	51	0.0003
Consequences: Need a treatment by a physician	53.6	71.7	53	70.5	1274	40	0.0000
Measures to stop aggression: Peroral medication	52.8	58.5	52	59	996	318	0.0079
Measures to stop aggression: Parenteral medication	53.4	60.7	52	61	1168	146	0.0100
Measures to stop aggression: Held with force	52.5	58.1	51	58	915	399	0.0000
Measures to stop aggression: Seclusion	51.5	61	51	62	948	366	0.0000
Measures to stop aggression: Physical restrant	53.8	71.8	53	73	1283	31	0.0002

0*: With negative response in the items   1**: With positive response in the items

Finally, we were curious to assess the correlation between SOAS scores and SOAS gravity scores. Figure 3 scattered these scores for all reported incidents. A correlation of 0.26 was calculated which ascertains the existence of a positive linear dependence. In the SUPAA, a psychogeriatric service (figure 4), the correlation between SOAS scores and gravity scores is not reported.
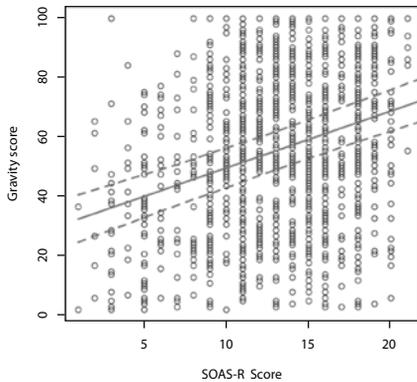
Figure 3:
A scatter plot of gravity score versus SOAS-R score for DP-CHUV with their regression line ($\varrho=0.26$) and the corresponding 95% CI
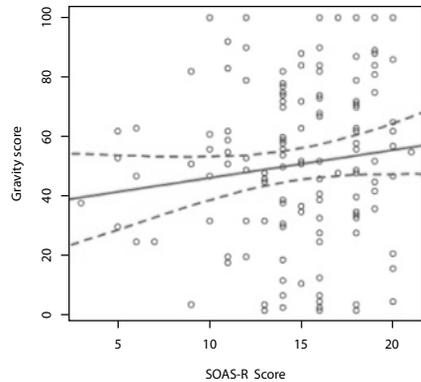
Figure 4:
A scatter plot of gravity score versus SOAS-R score for SUPAA with their regression line ($\varrho=0.09$) and their corresponding 95% CI
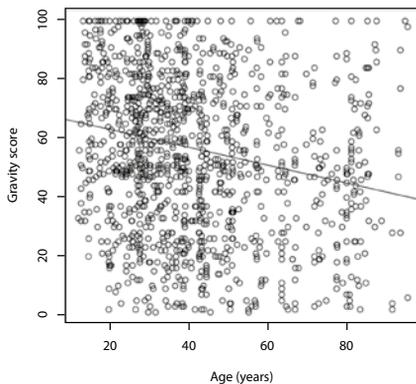
Figure 5:
A scatter plot of gravity score versus age($\varrho=-0.18$)

Comparing the age for SOAS patients and SOAS gravity scores (figure 5), we can note the negative correlation ($\varrho=-0.18$) between the age of the patients and the SOAS-gravity scores.

Discussion

This study is the first one realized in the DP-CHUV. The important data collected since five years provides in depth information about the nature, frequency and severity of violence acts occurred in different acute psychiatric services. Some of these results are in agreement with several previous studies developed in the

international literature: In comparison with non-violent patients, violent patient were younger, men. Some psychiatric disorders can increase the risk for a violent act (e.g. F2 and F3 diagnoses, associated with an abuse substance disorder - F1-). One third of the incidents were serious. Nursing staff are the principal target of the incidents. Special attention must be given to develop training and strategies to prevent and to cope with patient's violence behaviour. After the incidents, special attention on victim's psychological support is needed. The link between violence and constraint or coercion seems to be important. A patient can be aggressive because he is involuntarily hospitalised, or wants to leave the seclusion room, the hospital or the ward without authorisation. Moreover, putting the patient in a seclusion room is a practice used to prevent and contain violence and to decrease symptomatology. It can be also a place with risks for nursing or medical staff. The total incidence rate per 100 hospitalization days is rather low (0.34 incident) comparing those reported from literature (Abderhalden 2007; Salamin 2010; Nijman 2005). Furthermore, differences between services can be questioned. These results must allow us some assumptions to explain this low incident rate for the DP-CHUV and the differences between services: Under reporting? Better violence prevention management? Specific procedures to report incidents? No uniform violence definition between caregivers? …). Whatever these assumptions, we should not either forget that comparisons between institutions are difficult to do or must be done with precautions. *"The expression of ward incident rates has been unclear and disorganized, resulting in incomparability between studies and lack of precision"* (Bowers 2002, cited by Abderhalden, 2007). The results of these study shows that verbal violence can have an impact equally important to victims than physical violence. This point is really interesting. It reminds over the subjective aspect on the violence act impact on victims. It also raises questions about the structure of the SOAS-R scale and the SOAS-R scores structure.

Finally, the results underscore the necessity for our institution to assess violent incidents. The information collected help us do violence risk management and to better support victims. However, questions remain regarding the meanings attributed in using this tool as information and communication support with the patient and multidisciplinary team: How do we use the SOAS-R in clinic? What is the support perceived by staff?

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The importance of analysing aggression incidents for preventing violence: using a pack of cards based on PRISM

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Introduction and/or background

In 2008 the Dutch government started a national programme to enhance patient safety in mental health care in the Netherlands. The Dutch Association for Mental Health and Addiction Care (GGZ Nederland) coordinates this programme. One of the major aims of this programme is to raise patient safety awareness, create organizations that keep on learning and use incidents to improve quality of care.

We started the national programme with compiling a list of most frequent incidents that happen in mental health care organizations. It turned out that aggression incidents are the most frequent of all.

The key to understanding aggression and to influence aggression is to investigate all factors that contributed to aggression incidents. Therefore (mental) healthcare workers must analyze the incidents they report. This proved to be a major challenge for mental health care organizations in the Netherlands.

To enhance patient safety and reduce aggression incidents we developed a practical tool that will help organizations to investigate aggression incidents.

The main paper Aggression incidents happen regularly, especially in closed psychiatric wards. We started this project in 2012 by interviewing some mental healthcare workers. We noticed that talking about aggression incidents isn't easy for most caregivers. To admit that something went wrong is difficult, even when the caregiver didn't do anything wrong.

Since 2011 aggression incidents can be reported in a digital system. These systems can produce different reports, e.g. for a team or management, during a specific time interval, allocated by severity etc. Some teams discuss these reports but most of the time they only take notice of the total amount of incidents. Teams don't evaluate aggression incidents thoroughly, unless it is a serious incident. And when they report the incident a lot of patient related factors are mentioned.

Theoretical input

After the series of interviews we studied literature that was recommended by the people we interviewed. Several studies made clear that patient characteristics are only one of the contributing factors in aggression incidents. The following aspects were found:
- Ward circumstances e.g arousal, staffing, competence of employees.
- Interaction between patients (antagonizing) or between employee and patient e.g patronize/provoke patients, interrupt patients, ignore mutual agreements, overestimate patients
- Treatment aspects: e.g restraining measures, change of medication, hospitalization shorter than two days
- Environmental aspects e.g privacy for patients, (walking) space, the possibility for staff to keep overview
- Time: e.g day/night, before/after weekend/leave
- Specific patient characteristics: male, age between 20-39, schizophrenia, organic brain syndrome or dementia.

When an incident is evaluated thoroughly, it is important not to look for an offender but to look for weaknesses in the system. According to PRISM (Prevention and Recovery Information system for Monitoring and Analysis, a method used in health care to analyze incidents) there are 4 basic factors that can contribute to incidents:
- Institutional factors: conditions that are not taken care of on an organization level.
- Technical factors: shortage or defect of devices, equipment or building
- Employee factors: employee interventions.
- Patient related factors: patient characteristics and interaction between patients.

We combined this information in a model.

Aggressiemodel (GGZ Nederland 2013)
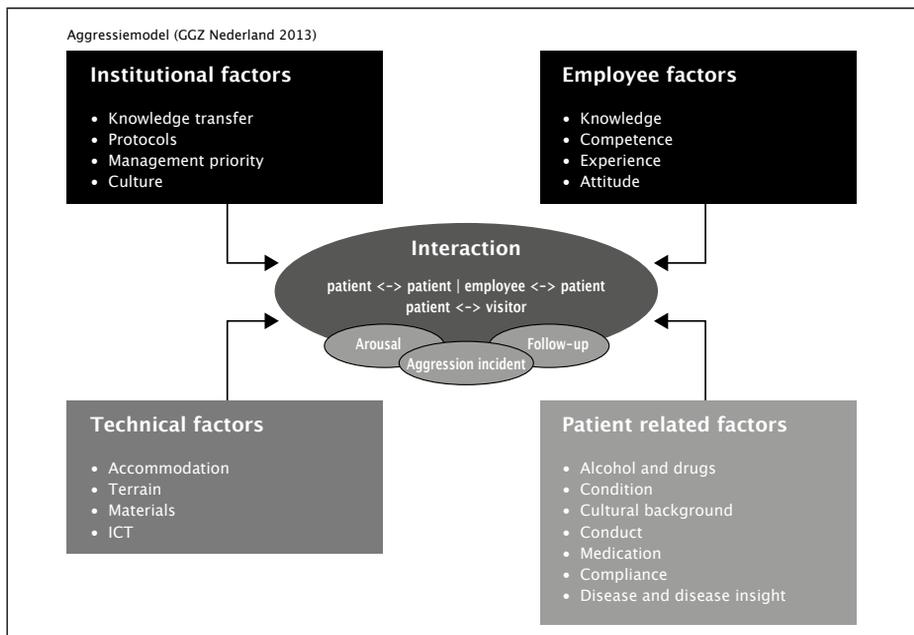
This model makes it clear that patient related factors are only one of the triggers for aggression. Aggressive behavior is not only the result of what people feel or think. It can be triggered by the interaction between patient and employee or by the way the organization organizes things. However this model alone won't help teams to evaluate aggression incidents thoroughly.

Practical tool

We decided to develop a practical tool to evaluate aggression incidents that:
1. is simple to use, it doesn't require intensive education
2. is not time consuming
3. generates a common language to discuss incidents which is blameless
4. helps objectify sensations of caregivers and patients that were involved in an aggression incident
5. helps to comprehend what happened
6. structures how incidents can be analyzed identically
7. detects root causes
8. gives concrete input for improvement
9. and helps to prioritize

Again we studied literature and files of reported incidents and made a list of 77 examples of contributing factors to aggression incidents. We organized two expert meetings to discuss this list. Among the experts were psychiatrists, psychotherapists, mental health care nurses, quality staff and safety staff. We reduced the list to 38 triggers. With the help of a graphic designer we figured out a playful form that matches our 9 starting points: an aggression analyze pack of cards
The pack of cards comprises 38 cards. On the A side the triggers, on the B side the root cause factors (institutional, employee, technical, patient).
For instance:
card 5 A side: staffing : not enough staff due to illness or leave. B side: Organizational factor/management priority
card 14 A side: the electronic key isn't functioning. B side: Technical factor/material
card 19 A side: the task doesn't match the qualification of the employee. B side: Employee factor/ qualification
card 35 A side: the medication makes the patient restless. B side: patient related factor

How to use the pack of cards?

After an aggression incident people tend to freeze, especially when the incident was severe. They feel either guilty or impassive. We assume this pack of cards literally helps people get moving and helps figure out contributing factors that are less obvious at first. After an aggression incident happened, the employee or team and the manager take the pack of cards. Each of them takes several cards of the pile that contributed to the incident according to them. These cards are placed on the table. Then they turn around the cards. Since every root cause has its own colour in one instance it is clear which factors where involved in this specific incident. They mark these cards on the score form. The pack of cards can be used to evaluate a single aggression incident or to evaluate a cluster of incidents.

> **Manager instructions**
> - collect about 10 incidents that were evaluated with the pack of cards
> - check out if there is a trend in the incident reports (ward circumstances, interaction, treatment aspects, environmental aspects, time, patient characteristics)
> - check out if the recurrence risk is estimated wright or wrong
> - check which cards are drawn repeatedly and what factors dominate
> - make an easy report
> - organize a staff meeting to discuss the report with the team
> - discuss the dominating root causes
> - let the team prioritize what needs action right away
> - make smart improvement plans, using the input of the team

Patient safety cycle

The pack of cards is a tool that helps raise safety awareness among mental health care workers. It's a practical tool to analyze incidents. The schedule below makes clear how this tool helps to improve quality of care.
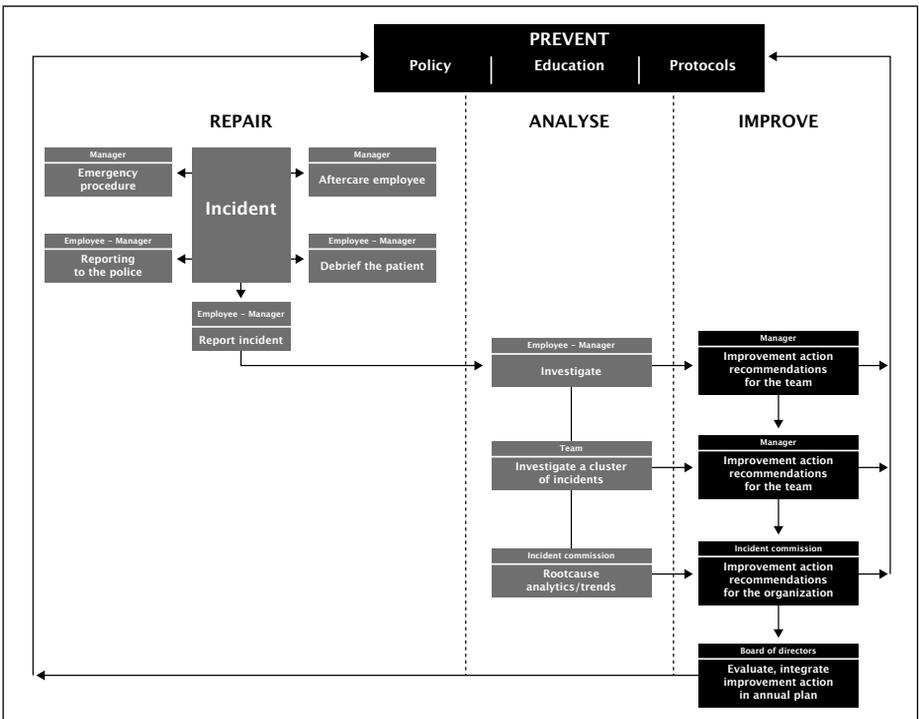
Conclusion and/or Discussion

In the 1.5 year this project took, we worked intuitively. We used the principle of progressive insight, each new insight leading to the next step.

Our ambition is to offer teams a practical tool that helps raising safety awareness and reduce aggression incidents. Our tool is not an evidenced based instrument.

Two months ago we offered the pack of cards and a manual to all mental healthcare organizations. Some of them responded enthusiastically and plan to implement this tool in several wards.

The Dutch Occupational Health and Safety Inspectorate has embraced the tool and manual. We made sure that bothworkers unions, employers organization and Inspectorate agree on this tool.

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Relationship between the incidence of violence in emergency medical services and type of assistance provided

Poster

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Abstract

Background
Several studies have shown that the emergency medical services, along with those of psychiatry, are susceptible to significant levels of violence but it is not clear whether the type of assistance provided (hospital or pre-hospital) is related to this phenomenon.

Objectives
To determine the risk of violent episodes within the emergency services of a Regional Health Service and to identify a relationship between the types of assistance provided and a higher perceived risk of violence.

Methods
The study setting was the Emergency Medical Service of a regional health service (South-eastern Spain) which includes 8 hospitals providing emergency medical services and 11 mobile emergency units. The POPAS questionnaire was translated into Spanish and adapted according to the type of emergency services provided in order to measure perception of 12 different types of violence. The response scale included the number of annual episodes, identifying the main aggressor (Patient / family member or colleague). The questionnaire was directly given to all healthcare personnel within both services and was returned anonymously. In order to avoid bias, extreme values (>80th percentile) were excluded and also those workers with less than one years experience.

Results
516 healthcare workers replied. Of these, 390 fulfilled the study inclusion criteria. The number of annual violent episodes perceived by all workers merged from 6.8 (non-threatening verbal aggression) to 0.01 (severe physical aggression). The main exponent in all types of aggression was either the patient or a family member (82.5%). Episodes of demeaning treatment and incitement to disharmony were significantly more frequent within the emergency hospital service whereas those from the mobile emergency units were more likely to suffer physical violence, - threats (p<0.01)

Conclusions
Episodes of violence are increasingly common phenomena in the emergency services, especially the verbal type. The main protagonist of the aggression is, for all forms of violence, either the patient or family. Nevertheless, the type of violence is associated with the type of assistance provided. Psychological violence is more common in emergency hospital service, whereas mobile emergency units are more likely to suffer physical violence.

Educational Goals

Determine the actual risk of violence, the type of violence and differences by assistance provided to facilitate knowledge of this phenomenon in our regional health service they can establish successful prevention strategies in the future.

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Kennedy Axis V: clinimetric properties assessed by mental health nurses

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Introduction

The Kennedy Axis V is an instrument for the assessment of the global functioning of the patient. The instrument is constructed in seven subscales: psychological impairment, social skills, violence, activities of daily living and occupational skills, substance misuse, medical impairment and ancillary impairment (Kennedy 2003). In the Dutch version, an additional scale is used: motivation for treatment (Mulder 2000). The Kennedy Axis V captures strength and risk factors in patient functioning and can assist in the assessment of the risk for violence and other adverse patient outcomes. The instrument is also one of the key scales used in a short-term risk assessment model, the Crisis Monitor (van de Sande et al. 2011). This model is recommended as best practice for short-term risk assessment by the Dutch Inspectorate of Health (Inspectorate of Health 2011).

Method & results

We conducted a cross-sectional study with the aim to evaluate the inter-rater reliability and clinical utility of the instrument when used by mental health nurses in daily care of patients with mental illness. Therefore, the instrument was implemented on one inpatient, one outpatient and one adolescent ward in a university hospital in the Netherlands. We chose to evaluate the instrument on the adolescent ward because the 'clinimetric' properties have not been studied within a population of children or adolescents. However, the author of the instrument states that the instrument can be used for all populations above the age of 5 (Kennedy 2003). The inter-rater reliability was measured based on the scores of two different nurses for the same patients. The clinical utility of the instrument was evaluated with a clinical utility questionnaire.

The results revealed a substantial level of agreement between nurses (intra-class correlation coefficient and Pearson 0.79). Considering the clinical utility of the instrument, the nurses had some problems with using the instrument. They found it difficult to score the instrument and use interventions according to the scores.

The nurses on the adolescent unit experienced considerable rating problems and therefore it was decided to stop using the instrument after one month. Additional data were collected using focus-group interviews. The nurses experienced a lack of expertise to score the instrument for their adolescent population and the training was insufficient to use the instrument in this population. However, there were positive experiences as they found it useful to assess the functioning of the patient in a more objective way.

After this study, the nurses on the clinical ward continued to use the instrument. After one year, we evaluated the clinical utility again using part of the questionnaire. This revealed that nurses needed less time to score the instrument; they found the instrument more useful, had less rating problems and were better able to use interventions according to the scores. Moreover, the instrument became part of the routine care and nurses had more specific observations.

Conclusion

The Kennedy Axis V has a substantial level of agreement between nurses. The instrument has reasonable clinical utility but an extended period of time is needed for the nurses to become accustomed with rating the instrument. The implementation process is crucial. Therefore, a range of implementation strategies is recommended. The use of the instrument with adolescents is different from adults and needs to be studied further.

In this presentation, we would like to clarify and interpret the findings of our study and our experiences with the instrument after the study. The implementation of risk assessment instruments is crucial and we hope to highlight some common issues when introducing a risk assessment instrument in clinical practice. Finally, we would like to discuss the difference in risk assessment between adults and adolescents.

This is a summary of our study published in:
Faay, M.D.M., van de Sande, R. Gooskens, F. & Hafsteinsdóttir, T.B.
Kennedy Axis V: Clinimetric properties assessed by mental health nurses (2012).
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Dynamics in risk assessment: change in risk and protective factors during treatment

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Introduction

Clinical assessment of dynamic risk and protective factors for violence risk can provide valuable information for treatment. In this paper results will be presented on changes in risk assessment scores over time in clinical practice. The aim in treatment is to reduce risk factors and at the same time build up protective factors in order to ensure a safe return to society. As patients move through the different stages in treatment and gradually gain more liberties and freedom, their risk level is expected to lower accordingly. In order to complement commonly used risk focused assessment tools in forensic psychiatry, such as the Historical Clinical Risk management-20 (HCR-20; Webster et al, 1997) or its successor the HCR-20[V3] (Douglas et al 2013), in 2007 the Structured Assessment of Protective Factors for Violence risk (SAPROF; De Vogel et al, 2007, 2012) was developed as a positive counterbalance. The SAPROF was created in response to the demand of clinicians in forensic psychiatry for more focus on positive, changeable and treatment related issues in risk assessment and is intended as a positive and dynamic supplement to the assessment of risk of future (sexually) violent behavior. The tool was quickly adopted internationally and is now available in over 10 different languages.* In De Vries Robbé and De Vogel (2013) the background and content of the SAPROF is explained further and its protective factors are illustrated in a case example.

Clinical practice

Being mainly dynamic in nature, the SAPROF aims to not only assess protective factors, but to also inform treatment of potential intervention opportunities. In 2007, the SAPROF was implemented into general risk assessment practice for violent and sexually violent offenders in the Van der Hoeven Kliniek, The Netherlands, complementing traditional risk assessment with the HCR-20. The dynamic positive approach to risk assessment made the SAPROF easy to implement alongside the HCR-20 as it appeared motivating to both clinicians and patients to have risk- and protective factors as part of the assessment. In clinical practice the dynamic factors of the SAPROF and the HCR-20 have since proven to be helpful in formulating treatment goals, evaluating treatment progress and stimulating positive risk communication. By doing so, these tools have offered valuable guidance in narrowing the gap between risk assessment and violence prevention and have enabled a more positive and dynamic approach to the prevention of future violence.

Research

As the greatest value of the dynamic factors in the HCR-20 and the SAPROF is their ability to guide prospective treatment planning, confirmation of their ability to measure meaningful change is essential. Studies on the dynamic Clinical and Risk management scales of the HCR-20 have shown that these risk factors can indeed change for the better during clinical intervention (see for example Douglas, Strand, & Belfrage, 2011). Research on the SAPROF in Dutch samples of violent and sexually violent offenders has shown the changeability of the dynamic protective factors during treatment (De Vries Robbé & De Vogel, 2012; De Vries Robbé, De Vogel, Douglas, & Nijman, submitted). Moreover, it was found that the changes in protective factors scores during treatment were predictive of no future violence after treatment. This indicates that those patients who improve the most on their protective factors during treatment recidivate the least after treatment, and thus that the SAPROF can be used as a tool to guide clinical intervention and evaluate treatment progress. In addition, it was demonstrated that the combined use of the HCR-20 (risk) and SAPROF (protection) together showed better violence predictions than the HCR-20 alone (De Vries Robbé, De Vogel, & Douglas, 2013).

Present study

The present prospective clinical study incorporates assessment scores on the dynamic Clinical and Risk management factors of the HCR-20 as well as on the dynamic protective factors of the SAPROF. The study

sample consists of over 400 clinically multi-disciplinary coded risk assessments of forensic psychiatric patients (male and female) at a Dutch forensic psychiatric hospital, convicted for violent or sexually violent offenses. Risk assessment scores were compared for patients at different stages of treatment and related to aggressive incidents. Results show that as patients move through the different treatment stages, their risk level as reflected by their combined risk and protective factor scores, reduces accordingly. Good predictive validity for aggressive incidents was found for each tool individually, as well as for the combination of both tools. The joint effect of decrease in HCR-20 risk factors and build-up of SAPROF protective factors showed to be a strong predictor for the decline in aggressive incidents over the course of clinical treatment. Predictive validities were good for patients with violent offending histories as well as for patients with sexual offending histories, and for patients with Major Metal Illnesses as well as for those with Personality Disorders. Interestingly, different factors appeared to be most predictive of aggressive incidents in the different groups of patients. Moreover, it was found that the value of protective factors was greatest during the community reintegration stages of treatment. These results indicate the usefulness of dynamic risk and protective factors for informing effective clinical treatment and for evaluating changes in individual risk levels over time.

Conclusion

At the 8th European Congress on Violence in Clinical Psychiatry research results are presented on the clinical value of the dynamic risk factors of the HCR-20 and the dynamic protective factors of the SAPROF, two structured risk assessment tools intended to offer treatment guidance and inform clinical decision making. Results demonstrate the usefulness of the dynamic factors in both tools for evaluating treatment change and predicting aggressive incidents. This study shows the value of a dynamic two-sided approach to violence risk assessment in forensic clinical practice.

Acknowledgements

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*German and Italian versions 2010; Spanish, French, Swedish, Norwegian and Portuguese versions 2011; Russian version, Dutch and English 2nd Edition 2012; Danish version 2013; Chinese, Japanese and Youth Version in preparation.

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Development of Combined Assessment of Psychiatric Environments (CAPE) Profiles – Psychiatric Inpatient Version

Paper

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Background

Individuals who require psychiatric hospitalization are among the sickest and most vulnerable of those with mental illnesses. Initially, while their illness stabilizes, they require a safe environment. As they move towards discharge, the focus of care shifts to the identification of resources needed for them to live a meaningful life in the community. Shifting the focus requires a nursing staff oriented towards building a unit culture that imbues hope, self-direction, and empowerment. For some inpatient units this will involve a culture change. However, we currently lack tools for assessing these change efforts. The purpose of this project was to develop and test a measure that will evaluate safety and person-centered care in inpatient psychiatric settings.

Aims:

1. Identify through the literature, service-user focus groups and staff interviews potential items for the proposed patient and staff versions of the CAPE.
2. Obtain staff and service-user rankings of the proposed items for the CAPE profiles.
3. Establish the reliability and validity of the CAPE profiles.

Methods

1. An initial list of items was formulated from the literature, focus groups and interviews to identify ways service-users and staff define the events that occur during inpatient treatment that have significance and value to the individual in the context of creating a safe unit and promoting recovery via patient-centered care.

2. A descriptive design was employed using key informant interviews and questionnaires to define and elaborate dimensions and items of the CAPE profiles. The items were then prioritized and organized into a pilot version of the tool.

3. The tool will be tested on six inpatient psychiatric units. Staff and service-user scoring of the tool will be used for item analysis and examining the relationship of scores to restraint use and aggression and violence. Staff scores will be examined in relation to staff's ratings of control over practice, staff retention and perceived safety.

Results

Staff interviews and service-user focus group data were analyzed to develop the initial items for the CAPE profiles, which were organized according to the following dimensions: respect, engagement, satisfaction/significance, choice/involvement, achievement. The tool will be tested on six inpatient units; we anticipate the pilot study will be completed in Summer 2013.

Conclusions

This tool represents an important measure of quality and safety on inpatient psychiatric units. A major strength is that the items for the CAPE profiles were developed based upon input from both service-users and nursing staff.

Educational Goals

1. Discuss development of the CAPE profiles
2. Describe the relationship between dimensions on the CAPE profiles, restraint use and aggression and violence.

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Prevention of violence in psychiatric inpatient care – aspects of ethics and safety in encounters with patients

Poster

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Abstract

Violence in the workplace is a serious work environment problem. Concern about risk of violence may in itself cause daily psychological distress for patients and staff members. It has been shown that verbal aggression, without physical violence, can cause back pain and other pain among staff especially in workplaces where support from management is weak (1). An unsafe care environment with risk of violence also leads to poorer quality of care (2). A therapeutic relationship creating a sense of trust is important in providing a safe treatment milieu (3).

There has been a lot of research on risk assessment and prevention of violence (eg 4-7). We believe that the prevention of violence is not only a question of method, but also a question of values. A project being prepared, focusing on ethical and safety aspects of violence prevention in encounters with patients will be presented.

Aim

To develop a model for psychiatric inpatient care to deal with violence effectively within an ethical approach. The specific research questions are: 1) How do patients and staff describe experiences of violence? and 2) What suggestions do patients and staff have to prevent incidences of violence?

Method

The critical incidence technique will be used to identify, analyze, and with staff members and patients discuss successful and unsuccessful experiences of dealing with incidents of violence, including not only value conflicts but also conflicts of interest in these situations. Questionnaires to and individual and focus group interviews with patients and staff members in psychiatric inpatient care will be used.

Expected results

From the empirical data a model for management of violence in psychiatric inpatient care will be developed. The implementation of the model should be evaluated in future studies.

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Educational Goals

We hope that people reading our poster will be stimulated to reflect upon the significance of ethics, and of the therapeutic relationship, for preventing violence in psychiatric inpatient care.

Such reflections may give us feed-back on the theoretical frame of reference and on the design of our planned study. We are also interested in finding European partners to enlarge this to an international study.

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Prediction and prevention of violent recidivism through risk assessment with the Short Term Assessment of Risk and Treatability (START)

Paper

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Forensic psychiatry aims to reduce violent recidivism and to improve patients' psychiatric and social well-being through treatment interventions guided by risk assessment. Risk assessment based on only long-term historical factors provides limited handholds for treatment interventions, instead short-term assessment of dynamic risks and strengths is required (Douglas & Skeem, 2005; Ward & Brown, 2004).

Various instruments have been developed for this purpose, e.g., the Structured Assessment of PROtective Factors (SAPROF; de Vogel, de Vries Robbé, de Ruiter, & Bouman, 2011) and the Clinical Inventory of Dynamic Reoffending Risk Indicators (CIDRRI; Philipse, Koeter, Van Der Staak, & Van Den Brink, 2005) and the Short Term Assessment of Risk and Treatability (START; Nicholls, Brink, Desmarais, Webster, & Martin, 2006; Webster, Nicholls, Martin, Desmarais, & Brink, 2006). However, most research has focused on the predictive rather than the preventive effect the use of these instruments has on violent outcomes. Additionally, most prediction studies are limited by small sample sizes, restriction to clinical settings or risk assessments completed by research assistants using case files, or a combination of these limitation (e.g., for the START see: Braithwaite, Charette, Crocker, & Reyes, 2010; Desmarais, Nicholls, Wilson, & Brink, 2012; Wilson, Desmarais, Nicholls, & Brink, 2010).

Therefore it remains both unclear whether predictions based on the assessment of historical risk factors can be improved by inclusion of dynamic risks and strengths and whether the use of risk assessment instruments actually helps to prevent recidivism (Douglas & Kropp, 2002).

The Risk Assessment and Care Evaluation (RACE; www.trialregister.nl: NTR1042) study aimed to fill these gaps in our knowledge through a cluster randomized controlled trial in which the START was combined with shared decision making (Troquete et al., 2013). The intervention included shared decision making because it has been shown to increase client satisfaction, treatment adherence and quality of life (Joosten et al., 2008). The study took place in out-patient forensic psychiatry and assessments were carried out by case managers as part of daily practice. For this setting, we will report on the predictive and preventive effect of dynamic risk assessment on violent outcome as well as client social and mental well-being.

1. Participants will learn about predictive qualities of the START when used in clinical out-patient practice.
2. Participants will learn whether the use of dynamic risk assessment, combined with shared decision making, reduces violent recidivism.
3. Participants will learn whether the use of dynamic risk assessment, combined with shared decision making, has positive effects on client quality of life and psychiatric and social functioning.

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An exploration of the broader and applied concept of clinical aggression across a spectrum of healthcare and related settings: translating measurement, prevention and management evidence into practice

Symposium

Joy Duxbury, Sabine Hahn, Bridget Hamilton, Sanaz Riahi, Marie Gerdzt
England

Title of Symposium

An exploration of the broader and applied concept of clinical aggression across a spectrum of healthcare and related settings: translating measurement, prevention and management evidence into practice.

Background

For some time violence has been as a problem confined only to healthcare workers in high risk areas such as mental health. However, internationally the prevalence of clinical aggression across a broad spectrum of healthcare environments is on the rise. Interventions undertaken to manage episodes of clinical aggression include the application of a number of coercive practices including physical, mechanical and chemical restraints and seclusion. Yet there are serious risks associated these. Furthermore these interventions can act as a barrier to the delivery of person-centred care. Nurses comprise the largest proportion of the health workforce and therefore play a central role in preventing episodes of clinical aggression in practice: yet there remains a critical gap in the research evidence informing prevention and management in a range of clinical areas.

Aim

In this symposium we present evidence arising from the original research of a newly established International Research Collaborative on Clinical Aggression (i-RCCA) and consider implications for knowledge translation and impact.

Method

From a review of the literature on aggression in a range of different areas we will start this symposium by exploring the definition, incidence, scope and behavioural indicators of the problem across a range of clinical fields in the UK and beyond. We will critically explore the notion of clinical aggression as a concept and term that spans all healthcare areas. A series of papers from a number of international colleagues will then be presented giving a more detailed analysis with exemplars of clinical aggression, its management and evaluation in the arenas of emergency departments, mental health, medicine and surgery spanning different countries.

Conclusion

Patient aggression and violence is not only confined to mental healthcare settings. In order to learn from experiences and applied research in a range of clinical areas, we must first be a position to reliably measure, recognise the scope and breadth of clinical aggression worldwide. Through greater sharing, networking and the translation of evidence with a critical eye, we can promote a programme of proactive work across the spectrum of healthcare when aiming to prevention and manage aggression in this field.

Educational Goals

To critically discuss the concept of clinical aggression with an international panel of experts. To explore through a range of research exemplars, implications for research, practice and international comparison.

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Prevalence and precipitants of aggression among psychiatric inpatients in Alexandria: An exploratory Study

Poster

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Abstract

Background
There is a long-standing debate over the relationship between mental illness and aggression. Multiple etiological factors contribute to the occurrence of aggression. Precipitants and risk factors of inpatient aggression are important to be defined so as we can prevent it, or interfere in the right time to end it.

Aims & hypothesis
• To estimate the prevalence rate of aggression in psychiatric inpatients in El Hadara University Hospital of Alexandria, Egypt.
• To determine patterns and precipitants of aggression among studied sample.

Methods
220 patients were recruited and consented for this study. Patients with suspected organic cause were excluded. The study was conducted over an 11 month period. April 2009 -March 2010.

Data collected
Socio-demographic data, smoking and substance abuse history, family history of psychiatric illness and aggression, past history of aggression and time of aggressive event that occurred during the hospital stay.

Assessement by
Psychiatric diagnosis using DSM- VI- TR.
Brief Psychiatric Rating Scale (BPRS) for evaluating baseline psychopathology of psychiatric patients.
Overt Aggression Scale – Modified (OAS-M) to screen for presence of inpatient aggression.

Results
• Forty six patients of the (20.9%) showed aggression. The distribution of the 46 aggressive cases according to the four aggression subtypes of the scale was: 11 patients had aggression against objects, 15 patients had aggression against others and 7 patients had aggression against self.
• Precipitants of aggression were: involuntarily admission, lack of insight, non-compliance with medication, borderline personality, smoking and substance abuse, diagnosis of drug induced psychosis and bipolar mixed episode, higher levels of hostility–suspiciousness on the brief psychiatric rating scale (BPRS). Previous aggressive behavior was a consistent predictor of future violence.

Conclusion
Aggression is not a rare condition among psychiatric inpatients. Nonetheless, it is difficult to estimate the role of single factors in determining aggressive behavior, because aggression is a complex phenomenon linked with a variety of biological, psychopathological and social factors.

Educational Goals

Being able to detect the high risk patients, decrease the psychosocial effect of aggression on patient and on staff.

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'Development of a Training DVD for analysis of incidents of violence and aggression'

Workshop

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Keywords: violence; scenarios; recognition; de-escalation; policies; training.

Introduction/background

Violence in health and social care settings is recognised as a major international concern, attracting the attention of governments, intergovernmental agencies, nongovernmental private sector associations, policy-makers, scientists and researchers (International Labour Office [ILO], International Council of Nurses [ICN], World Health Organisation [WHO] and Public Services International, 2002). WHO defines violence as "the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, mal-development or deprivation" (2002: 4).

The majority of incidents of violence and aggression occurring within health and social care settings are perpetrated by service users (NIOSH, 2002). Those professionals working in the settings are often the target of these incidents (LePage et al., 2003). The types of incidents experienced include physical and verbal assaultive behaviours including: hitting, biting, cursing, threatening, choking, pinching, scratching, punching, pulling, kicking, pushing, head butting, striking or injury with a weapon or item (NHS Security Management Services[SMS], 2009; Martin, 2003).

The effects of violence for individuals and organisations are well documented within the literature. These include physical injury, increased stress levels, reduced self-confidence and self-esteem, increased sickness and absenteeism. The consequences may be compromised productivity, low staff morale, problems with recruitment and retention, which ultimately affect the quality of service provision, offered by the organisation for service users (Nationla Institute for Health and Care Excellence [NICE], 2005).

Organisations are required to develop effective strategies for the prevention and management of violence perpetrated by service users and many organisations and service providers have successfully developed protocols and procedures for the management of violence perpetrated by service users. The majority emphasise the recognition, prevention and de-escalation of violence and aggression and contain recommendations for staff training in these areas (NHS SMS, 2009; NICE, 2005; National Institute of Mental Health in England [IMHE], 2004; WHO, 2002; Royal college of Nursing [RCN], 1998). Training in the recognition and management of potentially violent situations can assist to prevent situations escalating to the point where violence occurs. However as Farrell and Cubit (2005) identified, when conducting a review of aggression management training programmes, many of the 28 available training programmes concentrate on restraint techniques, the use of seclusion and the management of violence through pharmacological interventions. Less attention is paid to the other components: the recognition of the warning signs and triggers, the point at which intervention is necessary and the prevention of violence through the direct management of difficult situations, which are threatening and have the potential for violence to occur – these remain causes for concern and it is consequently these components, which this training resource package seeks to develop and integrate.

Aim and objectives

The primary aim was to produce a training package consisting of the materials required for the education of health and social care professionals in the recognition, prevention and management of service user violence and aggression.
The specific objectives of the training package were to:
1. Create a forum where violence can be discussed.
2. Encourage reflection on individual and team responses to threatening situations.
3. Facilitate assessment of potentially violent or threatening situations.
4. Enable workshop participants to plan for adverse situations.
5. Encourage a review of practices in relation to National and local policies and procedures.

Methods

This project, supported by an internal university grant, concerned the construction of a DVD comprising 25 scenarios involving actual or potential service user violence and aggression, placing the viewer in a position of responding to the situation. The viewer is placed in the role of health or social care professional faced with a potentially threatening and difficult situation which requires a response to the circumstances presented. The scenarios are informed by the research into violence and aggression in health and social care conducted by the authors (see Skellern and Lovell, 2008; Lovell, Skellern and Mason, 2011, Skellern and Lovell, 2011; Lovell and Skellern, 2013). The scenarios are set in a range of locations (e.g. community; residential; hospital out-patient) and demonstrate different circumstances involving encounters of potential or actual violence and have relevance to many professional groups (e.g. nursing; social work; health visiting; independent sector workers). There was no intention to represent any real individual, names or personal details, event, company or product; the individuals in the scenarios are actors and all of the materials included are fictitious. However the underlying principles of the situations illustrated are pertinent to all health and social care professionals, service users and settings.

The DVD is accompanied by a comprehensive training manual, adaptable to different organisational requirements and with accessible information relating to the principles of de-escalation, an example training session, individual scenario description, including suggested discussion points, and useful reference material. It is anticipated that the materials contained in the training resource package will assist the facilitator to encourage reflection, discussion and exploration of the underlying social, environmental and interpersonal factors, in conjunction with the specific situational influences contributing to potential violence. The intention is also to facilitate examination and review of national and local policies and practices, with the overall goals being to minimise the likelihood of violence, maintain the health, safety and well-being of care workers and service users, and improve the quality of services currently provided by health and social care organisations.

Discussion

The training resource package provides an alternative way of teaching health and social care professionals about the issue of violence and aggression. The DVD contains snapshots of incidents, which prompt the viewer to respond to the situation. Each scenario lasts between 7 and 60 seconds, and provides sufficient information to convey the presence of danger, distress, tension and/or the likelihood of violence. It requires the viewer (as the health and social care professional) to consider how best they should react to the situation, in order to diminish the potential or actual threat of aggression escalating into violence. De-escalation involves a complex, interactive process which relies on a range of factors revolving around the professional's self-awareness, ability to read situations, and experience of knowing which particular aspect of the process (e.g. posture, use of humour or mirroring) to employ and how it relates to other aspects, such as tone of voice or use of space. Such intricacy in the application of de-escalation, in conjunction with the avoidance of provocation or confrontation, sets it apart from other approaches to managing situations. As important as the technical involvement in physical intervention practices may be in working as part of a team and preventing injury to those involved, the practical application of recognising a potentially threatening situation, preventing de-escalation techniques is central to the management of violence and the overall service strategy adopted. Violence may sometimes be unpredictable and complicated, and the individualized framework surrounding the service user, comprising a person centred plan (Paterson, Leadbetter & Miller, 2005) and comprehensive risk assessment, are pre-requisites for the recognition, prevention and de-escalation of violence perpetrated by service users.

The training resource package will assist to facilitate extensive discussion of professional-service user interaction, and consideration of the interpersonal, environmental, situational and social factors in the context of local and national guidelines, policies and procedures for the prevention and management of violence.

Conclusion

The management of violence requires a unified, coherent, systematic approach. Recognition of potentially violent or threatening situations is essential and de-escalation techniques are complex skills to teach and acquire. Whilst theoretical knowledge of the warning signs is integral ensuring such consistency, it may not be sufficient in preparing professionals to recognise, prevent and manage violence. Increasing self-awareness, familiarity with colleagues and the environment, challenging assumptions and stereotypical beliefs may also require an element of experiential learning, meaningful discussion and reflection on emotional reactions. The training resource package can be delivered as a stand-alone training session or as an accompaniment to existing organisational training programmes employed in the prevention and

management of violence perpetrated by service users. It is intended that the materials within the training resource package can assist to enhance the knowledge and skills of the professionals working within individual organisations and encourage the staff team to work cohesively and consistently to recognise and prevent violence from occurring. The health, safety and well-being of professionals and service users is central to promoting service quality within health and social care organisations, and this training resource package has been designed for this purpose.

The training resource package will be presented in workshop form to delegates, which will also demonstrate how it could be used for teaching purposes in a classroom situation. The training resource package.is currently available for purchase by interested parties (individuals, trainers, organisations, etc.) to assist to educate the professionals working within organisations which provide health and social care services in the recognition, prevention and management of violence perpetrated by service users.

Acknowledgements

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To purchase the DVD please visit: http://shopfront.chester.ac.uk/

Psychiatric patients need a more active role in managing their own aggression

Paper

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keywords: dysfunctional impulsivity, alexithymia, aggression management, psychiatry

Introduction

People spend a lifetime learning to cope with their impulses. At home, at school, at work, in society we cope with our aggressive impulses. Psychiatric patients might occasionally have to work harder to maintain control. A tendency in mental health care is taking over this control. A major challenge for psychiatric patients is to deal with their (potential) aggressive impulses. Policy in mental health care predominantly focuses on training workers to deal with aggressive patients; and, indeed, such a professional approach has been shown to contribute to prevent aggressive incidents. However, a more profound, and in the end a more effective solution might be to learn patients to better cope with their own impulses themselves.

Compared to forensic psychiatry, approaches to restrain patients' aggression in mental health care have focused on environmental factors, such as offering a friendly atmosphere and a clear organisation on the ward. Less attention has been devoted to intra-personal, intrinsic factors of patients that might be related to their aggressive behaviour. In forensic psychiatry, intrinsic factors have been found to influence aggressive behaviour both in patients in a heterogeneous group (ref. 1-3) and in patients in a homogeneous group, e.g. patients with schizophrenia (ref. 4). To gain insight into the influence of these intrinsic factors, in 2011, a research was conducted at the Dutch mental health care institutions Emergis and RGC, specifically paying attention to the relationships between dysfunctional impulsivity, alexithymia, the occurrence of aggressive behaviour and willingness to change behaviour. If the aggressive behaviour of (clinical) patients in mental health care can (also) be related to intrinsic factors, such as an increased level of dysfunctional impulsivity and alexithymia, it is justified to question the adequacy of the current approach of aggression aimed at environmental factors. An additional approach in which patients have a more active role in addressing their own aggressiveness might be justified.

In figure 1 the relationships examined are indicated.
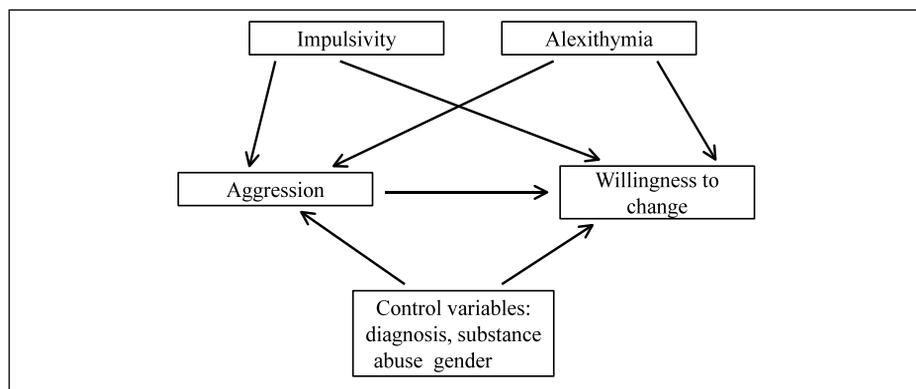
Figure 1 Conceptual model of the relationship between two independent variables, impulsivity and alexithymia, four control variables, diagnosis, substance abuse, gender and age, and two dependent variables, aggression and willingness to change.

The hypotheses are that an increased levels of impulsiveness and of alexithymia lead to more aggression. Through stepped and linear regression analysis statistically quantifiable influences of impulsivity,

alexithymia and the four control variables on both aggression and willingness to change behaviour were examined. It was explored whether patients with elevated levels of aggressive behaviour indicate a stronger desire to change this behaviour.

Clinical patients (N = 86) were recruited among inpatients of emergency departments (29), prolonged treatment departments (30) and protected housing communities (25). The participants gave informed consent to anonymously include their personal (medical) data in the study and they further filled out self-report questionnaires. Aggression was measured the AVL-AV, a Dutch translation of the Aggression Questionnaire Short Form of Buss and Perry. The AVL-AV measures four factors: Physical Aggression, Verbal Aggression, Anger and Hostility (ref. 5). To assess the validity of the self-reports we further included measurements of aggressive incidents as reported by wards (taking into account duration of hospital stay and severity). This scale is named Incident involvement. Impulsivity was measured by the Dickman Impulsivity Inventory, DII, subscale Dysfunctional impulsivity[1] (ref. 6). Alexithymia was operationalized by the Bermond Vorst Alexithymia Questionnaire, BVAQ (ref. 7). The instruments, AVL-AV, DII and BVAQ, have shown good concurrent validities in psychometric research (ref. 5-7). Additionally, we requested all patients to indicate their willingness to participate in a training program to reduce their aggressive behaviour, or aggressive feelings.

1. Dysfunctional impulsivity is the tendency to act with less forethought than most people of equal ability do when this tendency is a source of difficulty.

Results and discussion

Some characteristics of the participants are given in table 1. It shows mean scores and standard deviations of aggression, measured by the AVL-AV (total scale and subscales), dysfunctional impulsivity and alexithymia. Data of psychometric research –done by others- showing scores of reference groups on the same instruments, are also included in table 1 (appendix). Table 1 shows relatively high levels of dysfunctional impulsivity in psychiatric patients compared to a reference group. Furthermore, compared to males, female patients reported relatively higher levels of hostility (this difference has shown to be significant). Findings revealed that patients with higher levels of self-reported dysfunctional impulsivity also indicated higher levels of self-reported aggression. Impulsivity showed significant correlations with all self-report scales of aggression [r = 0.46 (AVL Total), r = 0.29 (AVL Physical aggression), r = 0.36 (AVL Verbal aggression), r = 0.39 (AVL Anger), r= 0.30 (AVL Hostility) and all p-values < 0.01]. Impulsivity is not correlating significantly to the other scale of aggression, Incident involvement. No clear relationships were found between Alexithymia factors and aggression.

Both the hypothesis stating that an elevated level of impulsivity leads to more aggression and the hypothesis stating that an elevated level of alexithymia leads to more aggression are analysed in three stepped regression analyses. Table 2 (appendix) shows the influences of the control variables (step 1), alexithymia (step 2) and impulsivity (step 3) on aggression as self reported (AVL Total and AVL subscales) and as reported on the ward (Incident involvement).
Impulsivity influences the self-reported aggression significantly; the analyses show this effect on all scales (table 2). Incident involvement, aggression reported on the ward, has not shown to be influenced significantly by impulsivity.
Alexithymia influences the aggression scale AVL Hostility significantly. This influence however is ambiguous. Two factors of alexithymia influence Hostility in the expected positive direction; two other alexithymia factors influence Hostility in a negative direction.

The different variables on aggression, the self-report on AVL and the report on the wards through Incident involvement, show some interdependence. The scale AVL Physical Aggression is correlating significantly to the scale Incident involvement (r = 0.28, p < 0.05). This indicates a consistency between a patients' own belief of his or her aggressiveness and the opinion of others.
Increased levels of dysfunctional impulsivity lead to more aggression is the hypothesis confirmed in this study. The observed effects and also the relatively high levels of dysfunctional impulsivity among psychiatric patients call for more attention to this personality trait in approaching aggression.
Increased levels of alexithymia do not lead to more aggression; so the hypothesis on the influence of alexithymia is not confirmed. Regression analyses show ambiguous effects on self-reported Hostility. It can be useful to study influences of alexithymia or some of its components on aggression of psychiatric patients any further. Both literature and this study give motives to do so (ref. 8-13).
Patients showing higher levels of self- reported aggression as well as patients with higher levels of incident involvement expressed significantly stronger wishes to change their potentially aggressive behaviour. Although willingness to change behaviour is measured through a single question, it is an indication supporting an approach that gives patients a more active role.

Conclusion

What is the relevance in practice?

The focus of aggression management should move towards the source of aggression. This is an implicit result of this study. Because the personality trait impulsivity influences patients' aggression, an environmental approach of aggression, such as training the staff, can not be sufficient. Suitable courses in which patients are trained to manage their aggressive behaviour of aggressive feelings are a necessary additional approach. This will provide patient's a perspective, not only within the health care institution (where a trained staff is present), but also outside in society. Patients themselves are supporting a different approach of aggression in mental health care. Patients showing aggression more often are also indicating they would like to learn to handle their own aggression themselves.

Screening dysfunctional impulsivity (maybe combined with a screening on other aspects, such as aggression history) might identify patients with higher risks of aggressive behaviour. This and previous studies show the (strong) relationship between dysfunctional impulsivity and aggression. (ref. 10, 14). A new screening instrument should be developed. This can help to offer a course in aggression management to the right patients, who might profit participating most.

Current aggression management courses are mainly being offered to patients (mostly men), whose aggressive behaviour is a prominent part of their problems. This raises the next questions: Are current courses aggression management also suitable for patients who only occasionally show aggressive behaviour and whose aggressive expressions are relatively mild? How can women be approached best; could they attend aggression management courses that also address hostility and how to cope with it?

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The results of this study titled 'Zelfregulatie van agressie bij psychiatrische patiënten: een nieuwe benadering' by M. de Schutter et al. are published in Maandblad Geestelijke volksgezondheid, MGv, Jaargang 68, nummer 2, maart 2013.

Appendix

Table 1: Means and Standard Deviations of scores on AVL-AV, total scale and the four subscales, on Dysfunctional Impulsivity and Alexithymia compared to data from psychometric research.

	Mean (Standard Deviation)			
	Emergis-RGC		Forensic psychiatry[d]	
	Clinical patients n= 42 male	Clinical patients n= 42 female	Clinical patients n= 138 male	Non-Clin. patients n= 206 male
AVL-AV[e]	27.74 (9.71)	28.21 (9.04)	28.16 (7.47)	32.82 (10.32)
Physical Aggression	7.17 (3.28)	6.07 (3.56)	8.58 (3.06)	9.31 (3.34)
Verbal Aggression	6.07 (2.55)	5.64 (2.69)	5.96 (2.13)	7.33 (2.90)
Anger	6.55 (3.52)	6.83 (3.15)	6.44 (2.68)	8.01 (3.06)
Hostility	7.95 (3.41)	9.67 (3.51)	7.18 (3.01)	8.17 (3.09)
			General Flemish population[e] n= 315; 159 male, 156 female	
Impulsivity[b]	2.64 (2.57)	3.76 (2.87)	1.81 (2.43)	
			Dutch students n= 375[f]	
Alexithymia[c]	116.45 (11.27)	114.76 (17.36)	86.36 (17.66)	

Notes

a   AVL-AV= Dutch translation of the Aggression Questionnaire Short Form of Buss and Perry
b   Dysfunctional impulsivity (subscale DII)
c   Alexithymia total scores BVAQ
d   Reference groups; psychometric research of Hornsveld et al. in forensic psychiatry in the Netherlands. (22)
e   Reference groups; psychometric research of Claes et al. in the Flemish General population. (23)
f   Reference groups; psychometric research of Vorst and Bermond among Dutch students. (24)

Table 2: Results of six three stepped regression analysis of the variables predicting aggression on AVL total scale, the AVL subscales and the scale Incident involvement.

	Step	F	Explained Variance (R^2)	Added Variance (ΔR^2)
AVL Total	1	0.31	.03	
	2	1.60	.13	.10
	3	17.05**	.30	.17**
AVL Physical	1	0.66	.06	
	2	1.58	.15	.09
	3	6.70*	.23	.07*
AVL Verbal	1	1.15	.10	
	2	0.35	.12	.02
	3	11.55**	.24	.13**
AVL Anger	1	0.24	.02	
	2	0.73	.07	.05
	3	14.04**	.23	.16**
AVL Hostility	1	1.45	.12	
	2	4.40**	.33	.21**
	3	4.09*	.36	.04*
Incident involvement	1	1.18	.10	
	2	0.29	.12	.02
	3	0.11	.12	.00

* Significant at .05 , ** Significant at .01

Step 1 : Influence of control variables
Step 2 : Influence of Alexithymia (five subscales are tested)
Step 3 : Influence of Impulsivity

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Prospective Validity of the Structured Assessment of Protective Factors (SAPROF) Instrument for Violence

Paper

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Background

Simultaneous measurement of both risk and protective factors is necessary to predict adequately the initiation and maintenance of violent behaviours. The Structured Assessment of Protective Factors (SAPROF) instrument was developed in the Netherlands (Vogel et al., 2012) to assess protective factors for the risk of future violent behaviour or sexually violent behaviour in offenders and forensic psychiatric patients. However, given the relative novelty of this instrument, its empirical foundation still needs strengthening. The study discussed here seeks to address this shortcoming in the UK and with service users beyond forensic services.

Aim

To assess the prospective validity of the SAPROF scale in a sample of general acute mental health service users

Methods

This is a prospective validation study assessing the relationship between SAPROF scores at baseline and violence rates six months later. The study aims to recruit 150 service users in three NHS trusts in England; adults who meet diagnostic criteria for a primary diagnosis of a serious mental health disorder with or without a history of violence. SAPROF is being used in conjunction with HCR-20 (Webster et al., 1997), and PCL:SV (Hart et al., 1995). Incidents of violence are being assessed using LiVA (Nathan et al., 2006). ROC analysis and regression analysis will be used to test its prospective validity - to establish associations between various combinations of predictor variables (SAPROF, HCR20, PCL:SV) on the one hand and the primary outcome measure (frequency and severity of violence assessed on a continuous scale) on the other. In addition, to identify any 'added value' provided by SAPROF, two models in particular will be compared: SAPROF alone and SAPROF in combination with HCR20.

Results

As this is a newly developed study, this paper will present interim results, focusing on the violence profile of general acute mental health service users and highlighting issues linked to recruitment and the utility of risk based assessment tools within this non forensic population.

Conclusions

Plans for the second stage of the study and links with previous studies in this area will be discussed.

Educational Goals

Discuss the benefits and limitations of using SAPROF within acute mental health services and its place in the assessment of risk, prevention and protective factors.

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Using the checklist 'V-RISK-10' to identify future risk of violence in both psychiatric and dependency disorders emergency units

Paper

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Background

Violence risk assessment is an important part of clinical emergency psychiatry. However, existing assessment procedures are poorly adapted for this purpose. In order to overcome this, V-RISK-10, a recently developed checklist consisting of 10 items, was introduced to physicians at a psychiatric emergency unit and a dependency emergency unit.

Aim

The aim of this study was to evaluate the usefulness of V-RISK-10, by testing its validity and internal consistency and compare those properties between a general emergency psychiatry and a dependency emergency unit.

Method

The study was performed during a period of two months at both a psychiatric and a dependency emergency unit for adults, in an urban area in Sweden with a catchment area of about 1.9 million inhabitants.

Procedure

The V-RISK-10 was introduced for the physician in charge, as an additional procedure to be used immediately after the regular examinations of the patients. Once filled in, the scoring sheets were collected for study purposes. More than 95 % of the returned questionnaires were complete and subsequently included in the analyses. After six months, the patients were tested checked in the official national Register of Persons Suspected of a Crime. A registration in this register was considered to be a reliable indicator whether the patient had committed an act of violence.

Results

About 3.5% of the assessed patients were registered as a suspect for at least one violent crime within six months after the assessment. Validity and internal consistency of V-RISK-10 was high, especially for patients in the general emergency psychiatry group. Of interest is that the predictive validity of the ratings for the dependency emergency patients was lower than for the psychiatric group of patients.

Conclusion

The V-RISK-10 appears to be a reliable instrument to use to predict violence from psychiatric emergency patients, but considerably lower for dependency patients. This study shows that it is both possible and realistic to achieve accurate violence risk assessments whereby the physician in charge performs the assessment in the psychiatric emergency room by the guidance of a simple, structured clinical assessment guide such as the V-RISK-10. Howewer, predictions of violence in dependency patients is not equally valid, implicating that other procedures for assessing their risk of violence are needed. Specific details of the results will we presented.

Educational Goals

This study shows that:
1. it is both possible and realistic to achieve accurate violence risk assessments whereby the physician in charge performs the assessment in the psychiatric emergency room by the guidance of a simple, structured clinical assessment guide such as the V-RISK-10

2. the V-RISK-10 appears to be a reliable instrument to use to predict violence from psychiatric emergency patients, but considerably lower for dependency patients.

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Assessing aggression risks in patients of the ambulatory mental health crisis team

Paper

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Keywords: Aggression, Violence, Community Mental Health Services, Personality Traits

Introduction

The prediction of violent behaviour of psychiatric patients is not an easy task. 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 that don't necessarily have the agreement of all the parties concerned. The East Brabant Mental Health crisis team felt they needed to find out more about the risk factors associated with aggressive behaviour of their patients during outreaching crises contacts. In order to prevent dangerous situations, a method to assess risks, before patients in psychiatric crises are contacted might be helpful.

An overview of the literature shows that in forensic psychiatry in particular much has been learned already about methods for predicting violent or delinquent behaviour. Methods for risk assessment, can be divided into various types (Hildebrand, 2004; De Vogel, 2005), such as clinical judgment, fully based on the knowledge and experience of the caregiver involved, and actuarial risk assessments such as the Violence Risk Appraisal Guide of Harris, Rice and Quinsey (in: Quinsey et al., 1998) that 'calculate' risk solely on the basis of certain objectively quantifiable factors. Finally a method exists that could be described as a combination of the former two, called Structured Professional Judgments. Such a standardized risk assessment is carried out by an expert with the help of a checklist with scientifically grounded risk factors, as is the case with Historical, Clinical and Risk indicators (HCR-20; Webster et al., 1997).

Scientific research shows that actuarial risk assessment tends to be more accurate than clinical predictions (Monahan & Steadman, 1994; 2001; Grove et al., 2000; Borum, 1996). Research done by De Vogel (2005) further indicates that structured clinical risk assessment may be superior to purely actuarial risk assessment. In using structured clinical risk assessment instruments, static factors (such as history of aggression), dynamic factors, which can vary (such as the patient's current condition), and sometimes also factors concerning situation or context (such as a patient's living environment) are taken into account in relation to one another.

To summarize, the literature shows that there are many instruments available for estimating the risk of aggression in various settings, but that there is no single instrument that is suitable for all situations. In addition, most of the above mentioned instruments are not intended for predicting risks in the short term. It would appear that there are fewer instruments available for predicting aggression in the short term (up to one week) (Nijman et al., 2002). One exception is the Brøset-Violence-Checklist (Almvik et al., 2007; Bjorkdahl et al., 2006) which is used in the closed acute psychiatric ward.

As it turns out, there are few specific instruments for psychiatric crisis teams when it comes to predicting risks prior to crisis visits. A possible reason for the difficulty in making such assessments is that crisis team members often do not know the patient in question, which means they have to get by on the rather scanty information provided by others (often the general practitioner) during the patient's registration. This study seeks to find whether it is possible, on the basis of such limited information, to predict the risk of the patient displaying aggressive behaviour during the crisis visit.

So we tested the predictive validity of the Checklist Risk Crisis intervention (CRC) used in the 24-hour psychiatric crisis service. This instrument was specially designed to assess aggression risks of outpatients in psychiatric crisis, before the team member goes to visit the patient.

Method

The study was carried out by the members of the crisis team of Mental Health Institute Oost-Brabant in the Netherlands. The crisis team members completed the CRC before all outreaching visits to patients in

psychiatric crisis (March 2006 to December 2009) In addition, if patients showed any aggressive behaviour during the visit, this was documented using the Staff Observation Aggression Scale-Revised(SOAS-R). Also the list of team members being on duty was available, as well as information on the psychological profiles (NEO-PI-R), from the crisis team members themselves.

The CRC contains a number of items that may be related to an increased risk of aggression. For instance:
- Who called in the crisis team?
- What is the first assessment of the patient's condition/diagnosis?
- Are there any other patient-related risk indicators such as prior aggression, possible paranoid delusions, etc.?
- Are there any indicators of increased risk in the patient's living environment, such as the presence of dangerous pets, possible weapons, etc.?

Results

An earlier study concerning the years 2003-2005 (Penterman & Nijman), indicated that with the items of the CRC, about 90% of the outreaching crisis contact might be correctly classified as involving aggressive patients or not. In the replication study (2006-2009) more recent results of research will be conducted. Potential associations between psychological characteristics of the crisis team members and the aggressive incidents will also be addressed.

This study was designed to shift the focus of aggression research, which traditionally focuses on the personality traits of the aggressive patient, to the interaction between the patient and others and also any environmental factors that play a role in the occurrence of aggression. Of the six factors on the main "Conscientiousness index", three factors were significantly positively associated with the reporting of aggression, namely, Efficiency (C1), Orderliness (C2) and Reliability (C3). Individuals that exhibit these qualities are "competent, prudent and effective in facing the challenges of life" (C1), "precise, orderly and systematic" (C2) and "strictly adhere to standards and ethical principles" (C3). Correlations between C1, C2 and C3 and the percentage of emergency service contacts for which aggression was reported were, respectively, 0.49, 0.52 and 0.64 (all P values < 0.05 In addition, much of recent risk assessment research is concerned with the prediction of aggression without much attention to the underlying causes. In line with this, renowned researchers Skeem and Monahan recently observed that "the time is ripe to shift attention from prediction violence to understanding its causes and preventing its (re)occurrence" (Skeem & Monahan, 2011, p. 38). This pursuit should also include the interaction and communication style of mental health employees as possible major influencers on the occurrence or absence of aggression in mental health. If certain communication styles were found to be associated with a reduced risk of incidents, then mental health staff should be trained in this regard.

Discussion

As it turned out, various CRC items were related to patient aggression, as documented by the crisis team members after visits. Many of these relations seem to possess a considerable amount of 'face validity', for instance the relation between reports made by the police and aggressive behaviour during crisis team visits. In addition, many of the found associations correspond with what we already know from the literature about predicting aggression, such as the fact that prior aggression is one of the best predictors of future aggression.

Either way, since the CRC needs to be completed prior to each crisis visit, more routine and standardization will be incorporated into the assessment of crisis team caregivers of possible risk factors.

A study of a group of 74 patients with the diagnosis of schizophrenia were interviewed about the most aggressive situation they experienced in their life and the data will be discussed.

And a short film with a interview with a worker in this field will be shown. The interviewed staff member of the crisis team in this film will address the impact that the aggressive behavior of their patients has on them.

Conclusions

1. The clinical view together with the structured list (i.e. the CRC) also called the structured clinical view predicts aggressive behaviour of out patients rather good.
2. The results indicate that the use of the so-called Checklist of Risks Crisis team (i.e., the CRC) presented in this presentation in advance of outreaching crisis team visits is useful in assessing aggression

risks. This may create more possibilities for specific precautionary measures, such a calling in police assistance.

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All things being equal? Predictive validity of the HCR-20 among heterogeneous groups of secure psychiatric inpatients

Paper

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Aims and hypothesis

To compare the differential predictive efficacy of the Historical, Clinical and Risk-Management-20 (HCR-20) for physical aggression by gender and diagnosis in the largest and most heterogeneous known dataset of risk assessment and inpatient aggression data.

Background

The HCR-20 is the most widely used structured violence risk assessment tool in medium secure units in England and has demonstrated good predictive validity for inpatient violence. However, previous research has utilised relatively small, homogeneous samples and little is known about whether its predictive ability varies between different clinical and demographic groups.

Methods

This study was conducted at St Andrew's Healthcare among patients in mental health and intellectual disability care pathways (N=640). Demographic (age, ethnicity, gender), clinical (diagnosis) and routinely collected risk assessment data (HCR-20) were collated. Data for frequency and severity of incidents of verbal and physical aggression were collated for the 12 months following assessment.

Results

404 of 640 patients were still present at 12 months follow-up. ROC analysis revealed that the HCR-20 total, Clinical scale and Risk Management scale were predictive of both physical and verbal aggression; the Historical scale was not a significant predictor of either type. The HCR-20 demonstrated superior efficacy for women, older people ($\geq$39 years), and for those with a personality disorder compared with those with mental retardation, schizophrenia, schizotypal or delusional disorder or co-morbid schizophrenia/personality disorder.

Conclusions

This study provides further evidence about the predictive validity of the dynamic scales of the HCR-20 for inpatient aggression. However, it reveals differences in efficacy between groups. Further development and optimisation of the HCR-20 may be required. An alternative explanation is that interventions to prevent aggression are more effective among some groups. Future research should address these important issues.

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Assessment and treatment of aggressive behavior in an emergency context requires an interdisciplinary approach: Emergency doctors and psychiatrists in acute agitation; birds of a feather?

Workshop

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Background

There exist local and international differences in the assessment and care for people who present with acute agitation or aggressive behavior in an emergency context. Neither a psychiatric nor a somatic cause may be missed.

Aims

The development of clinical guidelines, that are required to come to a more uniform and evidence based policy.

Methods

An extensive review of the literature and own scientific research.

Results

Next to a psychiatric and psychosocial evaluation, 'medical clearance' plays an important role in this context. The emergency department in a general hospital can offer an adequate assessment by the collaboration of psychiatric and somatic caregivers, specialized in emergency medicine. Especially for patients without psychiatric history, with somatic problems, with abnormal vital parameters, with substance abuse,… this approach is required. If a patient with aggressive behavior refuses assessment and – if needed - treatment, an involuntary admission can follow. This is a legal, beside a medical decision. Also in those cases it is necessary that next to a psychiatric, a potential underlying somatic emergency is diagnosed or excluded, because it might require urgent care in a setting where (intensive) somatic treatment is provided next to psychiatric treatment. Discussion with the legal authorities is important, to develop a more uniform policy, whereby the patient can get – on indication - an interdisciplinary assessment and treatment in an appropriate setting as a general or psychiatric emergency setting or a psychiatric intensive care unit.

Conclusion

Patients with acute agitation or aggressive behavior deserve a biopsychosocial assessment and – if needed – treatment in a setting where specialists in somatic and psychiatric emergency medicine work together, if needed in collaboration with the judge if an involuntary admission can not be avoided.. In the context of this workshop recommendations for clinical practice will be formulated to initiate an interactive discussion.

Educational Goals

- Knowing the importance of 'medical clearance' next to psychosocial evaluation in the context of an acute behavioral crisis.
- Developing evidence based practices in emergency psychiatry for interdisciplinary based assessment and care where needed in collaboration with the legal authorities.

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Dynamic relationship between multiple START assessments and violent incidents over time

Paper

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Background

The Short-Term Assessment of Risk and Treatability (START, Webster et al., 2009) is a structured tool for making professional judgements about the potential for violence and other risky patient behaviours in mental health settings based on an assessment of individual strengths and risks. Its predictive validity for violence has been examined in terms of the relationship between a single assessment and subsequent events but the dynamic fluctuations in the relationship between assessed risk level and subsequent events over time is not well-understood. This is important given the emphasis on dynamic factors in risk assessment and management. Previous longitudinal research has identified changes in how staff respond to repeated aggression by the same individual (Whittington et al., 2011) but the relationship between repeat aggression and repeat risk assessments is unclear.

Aim

To examine the relationship between multiple START assessments and multiple incidents over time.

Method

Design: a longitudinal design was adopted with repeated START assessments on specified patients linked to zero, one or repeated violent incidents involving that patient.

Setting

The study took place in a medium secure unit (MSU) in England providing assessment, care and treatment services for mentally disordered offenders from the region who present some degree of risk but are not considered sufficiently dangerous for high secure care (i.e. not presenting 'grave and immediate' danger). The unit has 66 beds on 6 wards (1 female) and there were 110 admissions in the 26 month recruitment period (October 2008 - December 2010). Almost all of the patients in the service are detained under the Mental Health Act and about three quarters have a previous psychiatric history.

Sample

All patients in the Unit during the recruitment period were eligible to be included. It was intended that START assessments would be conducted as routine clinical practice every two weeks on every patient but assessment rates per patient were highly variable and not all assessments were completed in full. Assessments with more than 4 missing items on both Risks (R) and Strengths (S) subscales were excluded i.e. assessments were only included if there were 6 or more completed items on one or other subscale. Where there were 1-4 missing item scores, these were imputed from the completed items.

As a result of this process, there were 469 assessments included on 48 patients. (43.6% of admissions during the recruitment period). There were between 1 and 25 assessments per patient (median=8.5 assessments).

Measures

Short Term Assessment of Risk and Treatability (START): this was completed following procedures set out in the instrument manual (Webster, Martin et al. 2009). Scores on each scale (Strengths and Risks) could range from 0-40. The START had been introduced into routine assessment as an aid to clinical decision making on the unit in 2007, one year prior to the commencement of the study. Assessors had received formal training in how to complete the instrument.

Aggression: data on aggression were extracted from a hospital database on which incidents were routinely recorded by staff. Three categories of aggression were included: actual or attempted physical aggression directed at another person; property damage: and verbal threats, verbal abuse or physical intimidation.

Base rates for aggression on the unit over the recruitment period were examined and there were 342 aggressive incidents overall (mean=13.1 per month). Where incidents over this time period could be linked to an individual patient (n=282 incidents, 79 patients, median =2 incidents per patient), there was a clear skew with 5 patients involved in 28.1% of incidents and 54 patients (68%) involved in 1 or 2 incidents. Data on the reliability and validity of the recording system are not available.

Results

The sample mean (sd) age was 38.7 (sd 13.1) years and 6 participants (12.5%) were female. These characteristics did not differ significantly from those for the overall admissions during the study period. Most patients (n=42, 87.5%) in the sample had a primary diagnosis of schizophrenia with the remainder diagnosed with schizoaffective disorder or another diagnosis. In this respect, the sample differed significantly from the overall admissions population which had a higher proportion of schizoaffective disorder diagnoses.

The mean Risk score for the sample was 22.07 (sd 8.79, range 6-40) and the mean Strengths score was 20.2 (sd 6.79, range 7.4-34).

The main longitudinal analysis will be reported at the conference. Risk of violent episodes following within-individual differences in START scores will be presented. We will also present estimations of the intra-individual clustering of both START measures and risk of violent episodes.

Conclusions

The results will be considered in the context of methodological issues and the current literature.

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Using research findings to develop and implement caring modalities for nursing staff following violent episodes

Poster

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Problem and Purpose

Violence carried out by patients against nursing staff is unsettling and disruptive to the therapeutic milieu of inpatient behavioral health units. Registered Nurses (RNs) and Behavioral Health Associates (BHAs) are expected to demonstrate acceptance and nonjudgmental care to every patient. This expectation needs to consider the complex individual and team response to an episode of patient violence resulting in actual or threatened injury to nursing staff. Basic education, training and organizational policies framed in caring science are needed to guide the institutional organizational response to RNs and BHAs who experience an assault by a patient.

The Nursing Theoretical Framework

Watson's Theory of Human Caring guided the caring healing modalities that are part of the innovative approaches for the plan to allow employees to heal and feel supported and cared for.

Relevant Literature

The empirical literature revealed gaps in the following two areas: (1) The response to an incident of patient violence resulting in injury to the nursing staff; (2) The issues arising as a result of caring for a patient who had caused injury to nursing staff.

Nurse researchers working at the Einstein Healthcare Network recognized the need to explore Registered Nurses' (RN) and Behavioral Health Associates' (BHA) responses to caring for patients that have been violent, resulting in injuries to the staff on inpatient behavioral health units. Through a qualitative study titled Registered Nurses' and Behavior Health Associates' Responses to Violent Inpatient Interactions on Behavioral Health Units, focus groups were conducted to collect data and thematic analysis examined issues. The major themes of the study included: sharing information about violence, intervening therapeutically, intervening non-therapeutically, recognizing team influences, experiencing emotions following violence, and understanding the work environment. The findings of this study revealed rich data that is meaningful and applicable to the psychiatric nursing community. This study was especially relevant to the urban healthcare network where the data were collected.

Evidence Based Practice Project

The project team comprised of nursing leadership, a researcher, educators, and the Behavioral Health Shared Governance council, formulated a comprehensive, innovative plan of caring modalities grouped into three learning experience modules.

In Module I nursing leadership uses screening framed in caring science to address RNs' and BHAs' emotional reactions to violence by patients thus enhancing their ability to intervene therapeutically. Module II addresses the team influence through event debriefing, dialoguing and reflecting. Module III implements an educational program for RNs and BHAs to enhance their ability to continue to care for patients with authentic presence and trust as a response to patient violence.

Outcomes

Developing site specific evidence based innovative approaches allowed for creation of a caring –healing environment focused on safety for staff and patients, improved staff well-being and the safety of the patient care environment.

Educational Goals

1. Congress participants will identify six themes related to Registered Nurses' (RN) and Behavioral Health Associates' (BHA) responses to caring for patients that have been violent, resulting in injuries to the staff on inpatient behavioral health units.
2. Congress participants will identify 3 healing modalities rooted in Watson's Theory of Human Caring aimed at improving staff well-being and the safety of the patient care environment.

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Violence Prevention in a Psychiatric Unit

Poster

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Abstract

Psychiatric units are one of the most frequent setting of violence against medical staff. This affects the physical, emotional and psychological well-being of the staff and has an impact on their quality of care and the interactions with patients inside the unit.

Screening for predictors of violence among psychiatric patients admitted to the unit will help prevent the occurrence of violent behaviors and thus decrease the prevalence of such behaviors against nurses and medical staff

The Social Dysfunction and Agression Scale (SDAS) is administered to all patients admitted to our psychiatric inpatient unit. We will retrospectively review the charts of all patients admitted over a year period and measure if aggressive behaviors against medical staff were correlated to the SDAS scores.

A positive correlation will allow the staff to have a tool that can help them identify patients at risk of violence in order to improve management of these patients.

Educational Goals

- Risk assessment
- Violence prevention

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Structured short term risk assessment and caring for patients in crisis – An overview of empirical research and risk management practice development in acute psychiatric wards in the Netherlands

Paper & Poster

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Background

Short term risk assessment by psychiatric trained staff in daily practice appears to be strongly driven by tacit knowledge. In the Netherlands approximately 30 % all aggressive incidents in acute wards resulted directly into a seclusion intervention (1). Although rarely used relevant clinical decision making support tools are available for daily practice in acute psychiatric settings (2). Psychiatric nurses may in their frontline position establish a key role in the process of risk communication in the multidisciplinary team. Several studies indicate that systematic short term risk assessment and risk evaluation can enhance the quality of clinical decision-making to enable safe practice (13). Support of an evidence informed risk model can reduce the false negatives and false positive risk appraisals in working with patients in a crisis episode (4). The incorporation of structured observation instruments can refine clinical judgment in psychiatric emergencies (3).

Intervention

A set of complementary validated observational instruments (Crisis Monitor) is integrated in a crisis monitoring model in acute daily practice. For this purpose the Broset Violent Checklist (5), Kennedy-Axis V (6), Brief Psychiatric Rating Scale (11), Scale of Dangerousness (7), and the Social Dysfunctioning and Aggression Scale (10) were used. The hypothesis was that this Crisis Monitor model may improve the quality in decision-making during the entire admission episode in acute psychiatric wards. The model can support clinical pattern analysis on escalation and recovery patterns to enable tailor made individualized treatment planning.

Conducted studies

A. In a cluster randomized clinical trial the following hypothesis was reviewed; structural and frequent applications of risk sensitive observation instruments enables the staff to improve their risk management arsenal in order to reduce severe aggressive incidents and coercive interventions. This research proposal was approved by a regional medical ethical committee and the research protocol and the preliminary findings were frequently discussed with a committee of service-user representatives. All consecutively admitted patients were included in the study (n=596). The study was performed during 40 weeks. The first 10 weeks were used to as a baseline. After this baseline period, the experimental and control clusters were randomly allocated. In the experimental wards observational instruments were integrated in standard care planning. The control wards went on with care as usual

Results

In the cluster RCT (40 weeks) all admitted patients were included in the study (n=617), within this sample 18, 6 % was secluded at least for a few hours. The experimental units and control-units had similar seclusion rates before randomization. In addition to this the reported aggression incidents in both research clusters were comparable. At the experimental wards aggression incidents were reduced to 78%, whereas in the control wards an increase of 12% was identified.). The number of seclusion hours decreased at the experimental wards towards 68% and in the control wards towards 27% [chi-sq. =122 :(1) p<0,000).

At the experimental wards the mean duration of seclusion per patient was 17 hours (sd 17,6), at the control wards 27 hours (sd 27,5). (t=1, 98; p=0, 05). The Total number of patients exposed to seclusion and the amount of involuntary medication did not show significant differences. The number of enforced injections was too limited to allow statistical analysis on this issue. From this perspective longitudinal monitoring is required. Data-control regarding inequalities in patient characteristics did not influence the results substantially.

The aim of a complementary study was to investigate the validity of two structured observation tools, the Brøset Violence Checklist (BVC) and the Kennedy Axis V), as an aid in seclusion-related clinical decision-making. Research findings indicate that the symptoms and behaviour of acute psychiatric patients can fluctuate drastically within hours, and that structured daily risk assessments can reduce the risk of aggressive incidents and the duration of seclusion. In this study, 7403 day-to-day risk assessments were collected over 10 725 admission days (72% of the maximum number of structured assessments). A total of 7055 daily assessment scores from 301 acute psychiatric patients were used for the multilevel analysis. The sample demonstrated that dynamic and static factors were related to seclusion. Dynamic factors included dysfunctional scores on the item 'confusion' of the Brøset Violence Checklist, and psychological impairment and impairment of social skills on the Kennedy Axis V. Static factors included non-Western descent, male sex, age less than 35 years, unmarried, and to some extent, a personality disorder. McFadden's pseudo R2 value showed that most of the final model was related to the dynamic factors. We concluded that the incorporation of the BVC and the Kennedy Axis V into standard practice was helpful in identifying patients at high risk of seclusion.

Implementation approach in clinical practice

Testing the application of the CrisisMonitor in clinical practice seemed to be a double loop innovation. In the experimental wards several challenges had to be faced. From this perspective six major components (14) were relevant; a.) consistent leadership in research and ethics, b.) utilization of research based instruments, c.) reflective practice d.) structured risk reasoning, e.) learning from post incident evaluations. f.) dialogue with service users. Seclusion and restraint reduction programs in the USA indicate long term and time consuming processes (14). We also used this model in the process of training more teams in several acute psychiatric facilities in the Netherlands.

Conclusion

A cluster randomized clinical in a high risk environment appeared to be feasible in this study. Data control and clinical supervision by scientist practitioners in this process is highly recommended (14, 15). Structured short term risk assessment can support seclusion and violence reduction programs in acute psychiatric wards significantly. Nurses can play a key role in data-collecting and practice development in risk management in acute psychiatric facilities. The Kennedy Axis V appears to be a reliable (18) and helpful tool (17) to be used in combination with the Brøset Violence Checklist in acute psychiatric wards. However consistent use of multi-level innovation strategies in a longitudinal framework is recommended (16, 17).

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Educational Goals

1. Reflection on critical decision-making supported by evidence informed observation tools for systematic evaluation in day to day practice.
2. Reviewing the practical feasibility of working with systematic short-term risk assessment in multidisciplinary teams on acute psychiatric wards.
3. Evaluation of collaborative work of scientist practitioners, psychiatric nurses, psychiatrist and managers in an acute setting.

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Chapter 11 – Other related themes

Action methods in working with anger and rage in individual and group therapy

Workshop

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Keywords: anger, rage, action methods, doubling, role reversal, empty chair

Abstract

Anger is one of the fundamental feelings although people tend to undermine its importance or avoid its expression. According to Sue Parker Hall (2009) anger is an emotion which contributes significantly to an individual's physical and psychic well-being. It is always related to a situation that happens in the here and now and it contains the capacity to think and use rational arguments.

There is more than one kinds of anger that a therapist may meet in therapy such as focused or non-focused anger, suppressed or repressed anger, expressed or non-expressed anger, unfinished anger and acting-out. Many clients have stereotypes that block them from dealing constructively with their anger. Some of these stereotypes are the following ones:
'I never get angry', 'When you love somebody, you can't feel angry with him', 'If I express my anger, I won't be approved any more', 'Anger is inferior feeling'.

When a client brings his anger in therapy room he then needs to be supported and motivated to:
• recognize his anger
• explore his anger
• understand his anger
• express his anger
• reprocess his attitude towards anger
• find new and constructive ways to deal with his anger

On the other hand the therapist's tasks are to:
• give time and space for discussion about anger
• offer opportunities to explore anger
• use parallel process and be congruent with the client
• model a healthy relationship with anger which contains verbal expression of anger and set boundaries
• help the client to identify gain and loss of anger
• support the client to uncover any other feeling behind anger such as anxiety, grief, sadness, etc.

Sue Parker Hall argues that most adult clients who keep complaining about their anger and ask clinical help, they are actually experiencing a deep personal inability to process their own emotional being and are dealing with hot rage rather than anger.

What is hot rage? Hot rage is one of the two forms of rage which seems to be a primary coping strategy that the individual uses when he experiences a traumatic situation he can't cope with. Hot rage is consisted of intense expressions of anxiety and aggression and the individual feels highly aroused on all levels. Any manifestation of hot rage is a cry for help since the client hopes that someone may come and rescue him.

Cold rage, the second form of rage, is consisted of passivity and apathy since the individual feels low motivated to react or do anything and seems like having no energy to support his self or his needs. He actually withdraws and adapts to the idea that nobody will come to save him.

The therapist has to spend a lot of sessions in interviewing the client on issues around anger in his life since this feeling is often connected with psychosomatic illness (e.g. asthma, arthritis, etc) or panic attacks and anxiety disorders.

Many therapists tend to work on client's anger when the client is presenting as a primary issue his depressive mood so as to motivate him find an energy for reconnecting with life and feel more energetic about it.

Action methods, according to Ed Jacobs (1992), are very useful in therapy for the following reasons:

1. they help clients to have a more concrete picture of a concept
2. they can be used to dramatize a point
3. they speed up the therapeutic process and this process can sometimes be quickened
4. they facilitate learning process since people are visual learners
5. they enhance learning because people learn through experience

Action methods help the client to access both cognitively and emotionally his anger in sessions. One of the most famous psychodrama techniques is the one of the empty chair which gives client all possibilities to address his anger to the person he is angry with and have a dialogue with him through several role reversals. Empty chair technique can be also used to symbolize the part of client's self that is angry or he is angry with.

Another action method is this of doubling; Adam Blatner (1997) suggests that double helps the client to express emotions and may speak out the anger that the client is experiencing. The double technique is the most important technique in psychodrama since it provides a lot of services such as stimulating interaction, giving effective suggestions or interpretations and providing support to the client.

Role reversal, another psychodrama technique, aims to help the client understand both his own and other's process and explore further any relationship. The client is often invited to role reverse with other people or even himself and open internal or external dialogues.

Miniatures and props can be used in therapy to help the client focus on anger and his relationship with it. Ed Jacobs (1992) states that any prop can be used in therapy as long as the therapist is able to listen carefully to the client and to link it with his anger.

Writing and drawing can also help the client to express his anger and focus on live events that contributed to his present emotional state of being.

There are a lot more that can be presented in this article but when we are trying to describe something that happens in action, is quite difficult.

Anger and rage are hugely important in our lives and every therapist should focus on these as well as work personally on his relationship with these two feelings so as to be able to manage effectively his own transference and counter-transference issues in therapy.

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250 Years of psychiatric diagnoses and violent behavior

Paper

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Introduction

What is a mental disorder in 2013? What was a mental disorder at the end of the 18th century? In 2013, the Diagnostic and Statistical Manual 5 contains around 500 defined mental disorders. (1) In contrast, in 1806, in Phillipe Pinel's Treatise on Insanity, there were five. (2) The 2013 Manual defines a mental disorder as a "syndrome characterized by clinically significant disturbance in an individual's cognition, emotional regulation, or behavior that reflects a dysfunction in the psychological, biological or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational or other important activities." (1. P. 20)

This paper addresses the relationship between specific mental disorders and intentional injury—violence towards self and interpersonal violence towards others—over the last 250 years. The two major conclusions of the paper are first, that mental disorders have been, are, and will be intimately related to intentional injury and secondly, that the profound expansion of the numbers of mental disorders have exponentially increased the impact of mental disorders in total societal violence towards self and others.

250 Years of mental disorders and violence

In 1806, the English translation of Phillipe Pinel's 'Treatise on Insanity"—one of the earliest and most influential textbooks on mental disorders—was published. Pinel classified insanity into five "species": Melancholia or delirium on one subject exclusively, Mania without delirium, Mania with delirium, Dementia and finally, Idiotism.

When it came to intentional injury, the first three diagnoses—Melancholia, Mania with delirium and Mania without delirium—were strongly associated with violence towards both self and others. The chapter on Melancholia had a section for suicide predisposition. Interpersonal violence was also a feature of melancholia: "Those deluded and dangerous beings can commit most barbarous homicides in cold blood." (2. P 142) When delirium—a term referring to multiple psychotic symptoms and often confusion—was present, the acts of violence were generally related to the delusions. In Mania without delirium, the violence was primarily associated with uncontrolled fury or rage, not delusions. While this level of maniacal fury could be directed at oneself, it was primarily—in Pinel's examples—directed towards others. Pinel sums up the specific character of Mania without delirium in this way: "It may be either continued or intermittent. No sensible change in the functions of the understanding; but perversion of the active facilities, marked by abstract and sanguinary fury, with a blind propensity to acts of violence." (2. P. 156)

Dementia, the fourth species of insanity, was a state of near global confusion characterized by psychotic symptoms that did not appear connected to the emotions. The lack of emotional connection made violence less of an issue in this, at times, terminal state. The final species of insanity was Idiotism. This diagnosis differed from Dementia in that "total or partial obliteration of the intellectual powers and affections: entire absence of speech or want of ideas." The patient was in a state of near complete intellectual, perceptual and emotional collapse. Pinel's clinical examples range from a near catatonic presentation following a traumatic war experience to the thyroid deficient "cretins" of Switzerland. This category included people with mental disorder symptoms who also had epilepsy.

What was critical for Pinel was the ability of all these five clinical states to change into each other. "Insanity does not in general preserve the same character throughout the whole of life. The different species are mutually interchangeable. Melancholia is not infrequently exasperated into mania. Mania is depressed into idiotism; and idiotism is in its turn exalted into mania, as a first step towards the recovery of reason." (2. P. 172-173) In the asylum where Pinel spent most of his professional career, nearly three fifths of the patient's diagnoses were Mania with delirium, Mania without delirium and Melancholia. Each of these

diagnoses was heavily associated with violence. The other two fifths, however, were not excluded from the risk of violence since their condition could change into a mania with or without delirium or melancholia.

In retrospect, these five diagnoses represented the most clinically severe forms of mental disorders: severe psychosis, severe cognitive deficits, inability to function in nearly all areas of life or—in Mania without delirium—a level of violent behavior based on emotions that rendered the person an extreme danger to all around them. From a 21st century perspective, these were not just severe mental disorders, they were the severest of mental disorders: not the current contemporary 5% of the population labeled as severely mentally ill but more like the .005% of the population. Thus in France at the end of the 18th century, the diagnostic classification of those believed to be truly insane was very small, very violent towards self and others and not able to function outside an institution. By the end of the 19th century the diagnoses of mental disorders were significantly expanding. Now, in the twenty-first century, the clinically, severest of the mental disorders represents a very small number of all the people with mental disorder diagnoses.

In 1892, the Dictionary of Psychological Medicine edited by Daniel Hack Tuke was published with 144 contributors from all over Europe. (3) The number of mental disorders in European psychiatry had increased significantly. There was no universal European system of classification. There was however significant overlap between languages when it came to the clinical and causal descriptions of insanity. (3. P. 1381)

In general, there were two overlapping themes of classification. The first was based on symptoms and clinical presentations, like Pinel's, while the second was based on the presumed cause of the symptoms. When it came to causes of mental disorders, many observations had been made in the vast networks of mental institutions that had come to dot the European and North American landscapes over the last ninety years. These observations included the following: medical diseases, especially infections, were often associated with severe mental disorder symptoms; drugs such as alcohol, cocaine, opiates, bromides were also associated with severe mental disorders; mental disorders ran in families indicating an inherited component; certain periods of life seemed to be associated with the onset of mental disorders especially adolescence and senility. Women were considered extremely vulnerable during pregnancy, after delivery and during menopause. Severe emotional trauma was also associated with psychotic symptoms. Brain diseases and brain injuries were often associated with mental disorders.

During this time, in the late 19th century, there were two primary types of violent behaviors associated with mental disorders: impulsive and planned. "Destructive acts, the result of impulse, or unpremeditated violence as distinguished from designed, are met with in many forms of acute and chronic insanity. They include homicidal and suicidal acts, destruction of furniture and clothing, self-mutilation, stealing and dangerous forms of passionate excitement.". (3. P. 354) Imbecility and epilepsy were felt to be highly associated with unplanned violence especially in women. Predicting when violence would take place was extremely problematic. "It is difficult to say of any one suffering from insanity that he is dangerous to himself or others, and it is equally difficult to say that he is not. Explosions of violence occur when least expected, and we may be apprehensive of bad results where we find in the issue that there was no occasion for anxiety. There is no form of insanity where they may not occur…" (3. P. 355)

One of the major problems was that once a person with a mental disorder had become violent, it was highly likely the person would be violent again under similar circumstances. "And so it is with the suicidal or homicidal impulse – when once either has been exhibited, it is sure to be repeated if any condition of anemia or exhaustion occurs. Statistics tend to show that about 22% of those who become insane develop destructive habits." (3. P. 355) Suicide and homicide were separate types of violence, but they were often connected. "Suicidal and homicidal impulses are often connected in the insane, but there is no necessary clinical connection between the two; we see homicidal patients who take the greatest care of themselves, and again there are suicidal patients who are harmless to others." (3. P. 355-356)

One particularly severe psychotic disorder stands out when it comes to planned interpersonal violence: Persecutory Mania or the Mania of Persecution. Primarily defined by French psychiatrists, this diagnosis predated the Paranoid type of Dementia Praecox (paranoid schizophrenia) of Emil Kraepelin that was also heavily associated with persecutory delusions and violence towards others. (4) Persecutory Mania was seen as often starting in adolescence and characterized by social withdrawal, auditory hallucinations—and most importantly—severe persecutory delusions. Because of the persecutory delusions, this diagnosis was often associated with interpersonal violence. "The number of assaults committed by individuals laboring under persecution-mania is extremely great; if we were to count those which have been published under different titles since the days of Pinel and Esquirol, we might fill volumes." (3. P. 930) What is especially important about this statement is the implicit observation that the overall same clinical condition— hallucinations, paranoid delusions —had been recognized for years but labeled with different names.

Paranoid Schizophrenia—the 20th century incarnation of Persecutory Mania—lasted till 2013 when the sub-category of paranoid was dropped from the diagnostic criteria of Schizophrenia in the Diagnostic and Statistical Manual 5. (1. P. 99-100)

In 1892, the most dangerous diagnosis towards others was Homicidal Mania or Homicidal Monomania. According to Bucknell and Tuke—two of the most influential British psychiatrists of the second half of the 19th century—this was by far the most significant of all the mania diagnoses. (5) Homicidal Monomania was characterized by two types of homicidal syndromes. (3) Neither of the two syndromes included persecutory delusions. The first syndrome was marked by the constant OBSESSION to murder. The second type was characterized by the "attack of a homicidal impulse" which appeared abruptly, was not pre-meditated and was nearly impossible to predict. Homicidal monomania was different from the homicidal acts precipitated by the severe psychotic, delusional, mood and fury- based disorders. In homicidal monomania, there were few other symptoms other then the two noted above. Along with Homicidal Monomania there was also Suicidal Monomania, a similar disorder also characterized on the one hand by obsessions and on the other by unpredictable impulses.

The major non-psychotic disorder was Neurasthenia. (3) (There were other non-psychotic disorders that became especially important at the end of the 19th century especially Hysteria and Hypochondriasis.) Neurasthenia was characterized by fatigue, anxiety, somatic symptoms and mild depression affecting mostly the upper classes. In many ways, Neurasthenia, Hysteria and Hypochondriasis mark the beginning of the 20th century diagnostic world. The outpatient private practices of the 20th and 21st centuries would soon see these conditions and their diagnostic children as literally its bread and butter. In 1892 Neurasthenia was viewed as a condition between normality and the severe mental disorders noted above. Violent behavior was generally not a major concern. This is an important point: the violent behaviors observed by the psychiatrists of the 1890s were predominantly associated with the severe mental disorders not the less severe ones. (Homicidal and Suicidal Manias are clearly seen as severe mental disorders even though they are not associated with psychotic symptoms.)

One hundred years later in the Diagnostic and Statistical Manual 5 (DSM 5) of 2013, the situation was reversed. The mental disorders most associated with violence towards others were the non-psychotic disorders. One of the key new principles in the organization of DSM 5 is the separation of mental disorders into internalizing disorders characterized by anxiety, somatic concerns, mood swings, depression and the externalizing disorders characterized by behaviors that directly impact others. (1. P.13) The two major DSM 5 chapters on the externalizing disorders are titled 1) Disruptive, Impulse-Control, and Conduct Disorders and 2) Substance Related and Addictive Disorders. The theory is that separating these disorders into internalizing and externalizing might aid in the identification of biological markers, especially genetic, as well as environmental risk factors. Interpersonal violence is clearly a feature of the externalizing disorders. In the chapter on the Disruptive Disorders the following diagnoses are included: Oppositional Defiant Disorder, Intermittent Explosive Disorder, Conduct Disorder, Anti-social Personality Disorder, Pyromania, Kleptomania and Other Specified and Unspecified Disruptive based disorders. These latter two disorders are notably vague in the necessary criteria for diagnosis allowing for significant slippery slope diagnostic issues. The externalizing disorders most associated with violence in the DSM 5 are the Substance-Related and Addictive Disorders. In state prisons, nearly 80% of prisoners with or without another mental disorder had a history of regular use of alcohol or other drugs. (6) In some of the large urban homicide studies alcohol is associated with over 50% of all murders. (7) Alcohol abuse, dependence, intoxication and withdrawal are all mental disorders. The substance related disorders have long been known to have the greatest impact on violent behavior towards others and, in terms of societal impact, are the mental disorders most associated with community interpersonal violence. (8)

It should be noted that the mental disorders not included in these externalizing disorders also have a long history of intentional injury towards self and others especially the psychotic and mood disorders as we have seen. Other non-externalizing disorders also heavily associated with violence towards self and others include the trauma and stress based disorders, the organic or neuro-cognitive disorders, the anxiety disorders, the dissociative disorders as well as others. (9,10)

Despite the separation between internalizing and externalizing disorders the clinical and epidemiological reality is that nearly all mental disorders are associated with an increase in the risk of intentional injury especially when compared to people who have no mental disorder. (8) The Neuro-cognitive Disorders — especially delirium and dementia—are very closely associated with violence towards others. (11) Moderate or severe dementia might be the most interpersonally violent of all the mental disorders with over 50% of people with this diagnosis exhibiting agitated or aggressive behavior towards others. In some studies the percentage increases to 80%. The severe mental disorders are also associated with both violence towards self and others. People with schizophrenia are four times more likely to engage in violent acts then people

without schizophrenia, (12. P. 1449) The mood disorders, anxiety disorders, dissociative disorders, stress and trauma disorders and schizophrenia are also associated with an increased risk of suicide. (13)

What has taken place in the last 250 years that explains why so many psychiatric disorders are intimately related to violence towards self and others? The severe mental disorders of the 19th and 20th centuries were always associated with violence towards self and others with specific symptom constellations resulting in higher risk patients. However, epidemiologically these extreme severe cases were a fairly small percentage of the population and did not contribute significantly to overall societal violence. Today, in the U.S., the psychiatric diagnoses most associated with interpersonal violence are the externalizing disorders—especially substance abuse. The stress disorders—a set of internalizing disorders—however, clearly play a major role in interpersonal violence, and in conjunction with the substance related disorders, are probably very over represented especially in areas like domestic violence. (6,14,15) In the 19th century, stress induced disorders plus intoxication would not be viewed as mental disorders. It is the exponential growth of these non-psychotic diagnoses in the psychiatric classification field that has led to so many instances of interpersonal injury as well as suicides becoming associated with mental disorders. An example of this is that in the 1880s a coroner in England estimated that insanity was associated with 20% of suicides: this was because suicides caused by substance abuse or by stressors, were ruled out as suicides related to mental disorders. (16) In the 21st century 90% of suicides are considered related to mental disorders because stress induced, substance induced, or suicides associated with Anti-social personality disorder are all considered suicides directly related to mental disorders. (12)

The expansion of mental disorders over the last hundred years into the non-psychotic disorders has resulted in the net of mental disorders associated with intentional injury expanding exponentially. If one viewed homicide through the same all encompassing diagnostic lens through which suicide is currently viewed, it is likely that the majority of interpersonal violence towards others would be associated with mental disorders. The total might even reach 90%.

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Potential Lethality of Restraint In Seated Positions: Case Examples And Experimental Measurement Of Lung Function

Introduction

This oral presentation examines important patient safety implications of seated restraint positions which may be used during the management of aggression.

Case Example

A 46 year old man was removed from the UK on an aircraft under immigration law. He was restrained in a seat on the aircraft, bent forwards at the waist and held in this position by security contractors. After approximately 10 minutes of restraint he was found to be unconscious and subsequently died.

There was no evidence of pre-existing ill health, delirium, stimulant drugs, or significant trauma. Death is attributed to restraint asphyxia.

Laboratory Investigation of Lung Function In Seated Positions

Previous studies of death during restraint have focussed on lying positions, particularly 'prone restraint'(Barnett et al. 2012). This study extends this work to seated restraint positions (Parkes et al. 2011).

Lung function in a standing control position was compared with lung function in seated positions using 40 volunteers. No significant reduction in lung function was detected in an upright seated position. When participants were leant forwards whilst seated, we observed significant reductions in their lung function. The application of restraint holds in the seated, leant forward position resulted in a non-significant further reduction in lung function. Reductions in lung function were greater in those participants with higher body mass index (BMI). Results, for participants with BMI >25, include mean reduction of Forced Vital Capacity (FVC) to 55.3% of standing control and mean reduction of Forced Expiratory Volume (FEV1) to 49% of standing control. The greatest effect recorded in an individual participant was a reduction of FVC to 19.4% of standing FVC in the same participant.

Seated restraint positions with the person leant forward result in significant reductions in lung function and may increase risk of death during restraint. The risk will be further increased where the person exhibits higher BMI. In a worst case analysis, a reduction of more than 80% in lung function may be caused by seated restraint using very limited levels of force.

Discussion

The relevance of restraint position to sudden death during restraint and a particularly 'positional asphyxia' has been debated (Parkes 2002). Authors have questioned whether the degree of restriction in lung function demonstrated during laboratory simulation of restraint positions was sufficient to result in fatality (Chan et al. 2004). Others have attributed deaths following restraint to 'excited delirium,' postulating that death results from autonomic arousal and hyperthermia, often associated with use of stimulant drugs such as cocaine (Vilke et al. 2012).

The case example given here shows no evidence of delirium or stimulant drug use. Our laboratory study demonstrates substantial reductions in lung function, even in healthy people and utilising very limited levels of force.

Clinicians involved in the management of aggression, setting policy, training staff or investigating fatalities should be aware of the potentially severe risks of restraint in a seated position.

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Project for the reduction of staff injuries caused by patient aggression

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Abstract

Sha'ar Menashe Mental Health Center (MHC) is one of the largest and most modern mental health care facilities in Israel. The Maximum Security Unit at Sha'ar Menashe MHC treats extremely violent psychiatric patients in Israel. During 2005, twelve staff members suffered physical injuries as a result of patient aggression, and were consequently on sick leave (410 absentee days). In 2006, the numbers more than doubled: 31 staff members were physically attacked by patients and were on sick leave following the injuries incurred, totaling 797 absentee days.

Analysis of the reasons for patient assaults revealed that the factors responsible for patient aggression included staff and treatment atmosphere, leadership, intra-staff communication, professional knowledge, experience, staff satisfaction with the workplace, and sense of personal safety.

The steering committee for quality and excellence prioritized reducing the incidents of aggression to at least the 2005 levels. Methods: Three focal points were determined: 1. physical security, 2. improved staff communication, 3. investigation of critical incidents, In conjunction with the Ministry of Health, a mandatory 3 day workshop was offered to all staff members from the department heads to housekeeping staff. The first day of the workshop concentrated on physical self-defense training; the aim of the second day was to improve staff communication and on the last day, staff members learned how to use a critical incidents investigation model. Staff attitude questionnaires were completed before and after the workshop.

Results
Following the workshop that took place in 2007, there was a significant reduction in critical incidents that involved staff injuries in the hospital in general and in the maximum security unit in particular. Eighty one staff members were injured during the year before the workshop and 58 in the year after. Since 2008 there are yearly workshops on preventing violence and aggression for the entire hospital staff. Five years after the first workshop there were less than 30 injured staff members a year.

Conclusions
This project focused on human resources and moved from the micro to the macro, from personal to systemic levels. With the support of the hospital administration and involvement of the Ministry of Health, the educational intervention of the workshop significantly contributed to the reduction of patient aggression that impacts the hospital environment and the lives of the employees. We conclude that staff injuries resulting from patient aggression can be reduced.

Introduction

Sha'ar Menashe Mental Health Center is the largest and mental health care facility in Israel. The Maximum Security Unit at Sha'ar Menashe MHC treats extremely violent psychiatric patients. During 2005, twelve staff members suffered physical injuries as a result of patient aggression, and were consequently on sick leave with a total of 410 absentee days. In 2006, the numbers more than doubled: 31 staff members were physically attacked by patients and were on sick leave following the injuries incurred, totaling 797 absentee days.

The authors present a plan of action initiated in the hospital, and the results as measured over the next five years in terms of the extent of harm to personnel. In addition we will show how a training program positively affected the reduction of work accidents and loss of work days.

Sha'ar Menashe MHC serves a catchment area of 700,000 people from diverse populations and religions, urban and rural communities and from all socio-economic classes. The hospital has 520 beds and 570

employees. The Forensic Psychiatry Unit serves the entire country. It is a maximum secure unit that includes four forensic departments with a total of 128 beds. The hospital is affiliated to the Rappaport Faculty of Medicine in the Technion, Israel Institute of Technology and is a teaching center for all fields of clinical instruction in Israeli universities and colleges.

Background

Mental Health personnel are at high risk for injury resulting from violence in the workplace (Chen, Hwu, & Williams, 2005; Rippon, 2000). Three decades ago Lipscomb and Love (1992) described the severity of the phenomenon, alerting policy makers in the health system.

The magnitude of the problem has been steadily rising in recent years (Merecz et al., 2006). Hillbrand et al. (1996) reported that more than 2% of the institution's budget was spent on salaries of employees hired to replace personnel who were absent from work owing to patient inflicted injuries. Research findings suggest that there is an especially high rate of violence in psychiatric, geriatric and emergency departments (Shields & Wilkins, 2009).
In 2010 there were reports of 2528 violent incidents towards medical personnel in hospitals and in the community (Security Division, Ministry of Health (2010).

Though the aggression was directed at various health personnel, about a quarter of the victims of physical violence and half of the victims of verbal aggression were nurses Only about 22% of the assaults result in filing a complaint, and police intervention (Security Division, Ministry of Health (2010). 2010). Violence towards medical personnel in Israel was investigated in depth by Landau (2004and included emergency departments in 25 medical centers not including mental health centers..Findings show that 75% of emergency department personnel in Israeli hospitals experienced violence in the year before the study.

Violence in the psychiatric system
Violence by patients with mental disorders and been described as "the dark side of mental disorders" (APA, 1997) with high rates in psychiatric institutions. In most instances, the victims of violence are among the nursing staff (Chen et al., 2005; Flannery et al., 2010; Lanza et al., 2006; Love & Hunter, 1996; Owen et al., 1998). Studies performed in the United States, Canada, Belgium and Australia show that 26%-56% of the staff that treats psychiatric patients in hospitals and in the community have been victims of assault (Dhumad et al., 2007; McKinnon & Cross, 2008). In a study conducted in New Zealand among medical students, between 36%-56% of the students who had rotations in psychiatry were assaulted by patients during their rotations (Coverdale et al., 2001). Psychiatric nurses in the United States reported that each year one in four nurses was assaulted by patients, and required sick leave (Cameron, 2006). Woods and Ashley (2007) noted that more than half of the psychiatric staff was harmed by patients during their careers. An Australian study in closed psychiatric wards revealed that 78% of the subjects of patient assaults on staff were nurses 4% doctors, 2% psychologists and 2% social workers. The explained difference was that the nursing staff is with the patients 24 hours a day. In addition, the primary treatment of the violent patient is by the nursing staff, especially during outbursts (Owen et al., 1998). The nurses that work in forensic units describe their work as an ongoing conflict between the desire to heal the patient as expected of a nurse, versus the basic need to avoid harm inflicted by patients (Jacob & Holmes, 2011). Most assaults on nurses are in closed psychiatric departments and in forensic psychiatry units. This article is focused on the safety climate in the work environment and its contribution to the reduction of patient violence towards staff in the hospital.

Safety climate in the work environment
Griffin & Neal (2000) conceptualized safety climate including the following components: values of the administration (management concern for employee well-being) organizational and management methods (quality of safety systems, training and reporting procedures) communication and employee involvment in a healthy and safe work environment (Anderson & West, 1998; Griffin & Neal, 2000; Mearns et al., 2003). Safety climate is reflected in the behavior of the employees (Cox & Flin, 1998). It is known that in fields such as health where there are high levels of uncertainty and high risk in decision making processes, it is especially important to foster a climate of safety (Gittel, 2002). In a study conducted in England in 2006 the level of aggression towards staff was found to be steadily increasing. The British Ministry of Health believes that violence in the workplace violates the trust of the employees in the health system because the system has difficulties protecting them – and it creates a sense of anxiety and pressure that might affect their performance. The cost of treatment of the employees who are assaulted is reflected in sick days, cost of recruiting personnel replacements and legal fees (British Medical Association, 2007).

A high safety climate of an organization is reflected in less aggressive incidents (Catlette, 2005). A Zero Tolerance program developed in England determined that violence in the workplace was every incident

where an employee in the health system is threatened or verbally or physically assaulted by a patients or another person under work related circumstances (Great Britain. National Health Service (Scotland), 2003).

Study Hypotheses:
A positive relationship will be found between the safety climate and a decline in violent incidents of patients towards their caregivers in forensic departments in the hospital. That is, when the employees feel that their work environment is safe, the extent of injury resulting from patient violence will decline.

Methods

The steering committee for quality and excellence prioritized reducing the incidents of aggression to at least the 2005 levels. Methods: Three focal points were determined: 1. physical security, 2. improved staff communication, 3. investigation of critical incidents, In conjunction with the Ministry of Health, a mandatory 3 day workshop was offered to all staff members from the department heads to housekeeping staff. The first day of the workshop was devoted to physical self-defense training, the aim of the second day was improving staff communication and on the last day, staff members learned how to use a critical incidents investigation model. Staff attitude questionnaires were completed before and after the workshop.

Study variables
Safety climate was evaluted using three domains of the Offshore Safety Questionnaire (Mearns et al., 2003). Communication about safety (Questions 1-6), Management commitment to safety (Questions 7-13), and Written rules and procedures and willingness to report incidents (Questions 14-21). Reliability of the instrument was 0.7 (Mearns et al., 2003).

The number of employees injured as a result of patient violence – was examined using internal reports to the head of risk management in the hospital.

Days absent from work because of work accidents – the number of absentee days resulting from patient assaults was drawn from data in the hospital human resources department.
In this study, the unit of analysis was a department with its entire multidisciplinary staff (doctors, nurses, practical nurses, psychologist, social worker, occupational therapist, secretary). Measurement was performed before and after the implementation of the program of action. The questionnaires were distributed to all employees before and after the workshop and the findings were drawn from those questionnaires regarding the safety climate. Findings regarding the number of assault victims and loss of workdays owing to violence in the forensic units were collected from organizational reports.

Results

Table 1 - The number of aggressive incidents towards staff before and after the intervention program

After the intervention program		Before the intervention program			
2008	2007	2006	2005	2004	Year
80	98	232	108	91	Number of Incidents

The number of violent incidents declined by about one third after the implementation of the intervention program (in 2008 there were 80 incidents) compared to the number of violent incidents before the program (in 2006 there were 232 incidents).

Table 2 – Loss of work days before and after the intervention program

	Before the intervention program			After the intervention program			
Year	2004	2005	2006	2009	2010	2011	2012
Forensic 1	---	4	141	16	24	69	22
Forensic 2	40	217	266	195	42	73	24
Forensic 3	9	4	175	78	21	62	---
Forensic 4	55	185	215	98	214	247	245
Total	104	410	797	387	301	451	291

Table 2 presents a steady decline in the loss of work days in the forensic departments. Prior to the intervention program loss of workdays in the forensic unit was 797 days in 2006, compared to 291 days in 2012, after introduction of the intervention program there was a significant decline of violent incidents.

Table 3 – number of employees assaulted before and after the intervention program

	Before the intervention program			After the intervention program			
Year	2004	2005	2006	2009	2010	2011	2012
Forensic 1	--	1	10	1	1	2	2
Forensic 2	3	7	10	6	2	4	1
Forensic 3	1	1	4	3	1	2	--
Forensic 4	4	3	7	6	5	7	4
Total	8	12	31	16	9	15	7

Table 3 shows that prior to the intervention program 31 patients were injured in the forensic departments in the hospital compare to ony 7 who were imjured because of violence. The decline is us presented from the initiation of the intervention program.

Table 4 – mean safety climate at work before and after implementation of the intervention program

	Before the intervention program			After the intervention program		
	Communication concerning safety issues	Commitment of administration to safety	Procedures and safety reports	Communication concerning safety issues	Commitment of administration to safety	Procedures and safety reports
Forensic 1	4.28	3.76	4.35	4.55	4.28	4.68
Forensic 2	4.17	3.8	4.1	4.41	3.78	4.37
Forensic 3	4.15	3.85	4.5	4.83	4.00	4.93
Forensic 4	4.15	3.9	4.4	4.75	4.14	5.06
Total	4.28	3.76	4.35	4.55	4.28	4.68

Table 4 reveals an improvement in the conceptualization of safety climate in the workplace after the implementation of the intervention. This is especially notable in the dimensions of commitment of the administration to safety and procedures and safety reports.

Discussion and Conclusions

During 2006 at Sha'ar Menashe Mental Health Center the staff coped with a significant increase in the number of violent patient assaults that resulted in employees absence from work for extended periods of time and loss of a total of 797 work days in one year (Table 2). The violent outbreaks also undermined the sense of safety of the hospital employees (Cox & Flin, 1998).
The hospital's steering committee for quality and excellence sought to determine the causes and extent of the aggression and performed and investigative analysis together with the hospital director, and the results pointed towards several possible reasons for the phenomenon:
• Patient-related reasons
• Stucture and crowding
• Therapeutic methods
The staff and treatment atmosphere including: leadership, inter staff communication, experience and professional knowledge, worker satisfaction with the workplace and the sense of personal safety

In light of the Steering Committee's findings, a training program pertaining to coping with all aspects of violence in the workplace was developed to provide the multidisciplinary caregivers with the tools necessary to cope with violence and increase their sense of safety, based on Zero Tolerance (Great Britain. National Health Service (Scotland),, 2003). In 2007, the workshop "Return home safely" was launched in the forensic psychiatry departments. The entire multidisciplinary staff from physicians to maintenance workers participated in the workshop, which lasted for three full days of training as follows:

Day one: A professional trainer from Wingate Institute (Israel's National Center for Physical Education and Sport) instructed participants on issues of personal safety, self-defense skills, and methods for restraining patients with reduced exposure of caregivers and patients to violence.

Day two: An organizational consultant specialist in interpersonal communication among care teams provided the staff members with tools for better inter-staff communication.

Day three: A retired senior officer from the Israel Defense Forces, a specialist in conducting investigations taught the staff how to conduct investigations, based on the model used in the IDF, and emphasized the importance of teamwork in organizational learning processes.

Beginning in 2008. Refresher courses have been conducted on a regular basis, and the staff decides which module (personal safety, communication, investigation of incidents) they are interested in receiving each year.

Data collected in the hospital reveal perception of the safety climate among employees in the forensic departments was higher after the workshop than before (Table 4). Th number of violent assaults towards the staff across time, after the workshops are lower than before the program was initiated (Table 1). In addition, loss of work days in the hospital was reduced after the implementation of the intervention (Table 2) and the number of employees that were attacked also declined (Table 3).

We learned that in order for the intervention to be effective, it is important to maintain the organic department structure and to strengthen the leadership components within each department. To that end, the workshops were developed to included at least 80% of the nuclear staff. The natural line of command of the staff was strenthened in each of the interventions after the trainers were briefed in all three modules of the program.

The concept of leading was extended beyond the official department heads, by empowering the staff to take leadership in various situations. The manager of an incident is the most senior person present during the outbreat of the incident, and he/she must conduct the incident to successful completion.

Similarly, sectoral delineation was intentionally rejected, and emphasis was focussed on multidisciplinary teamwork. Though each profession has its unique characteristics, when problems need to be solved, teamwork must be unified and goal oriented.

The administration's commitment to continuity – the project was successful, but a central component was the commitment that this was a long-term initiative that would continue for years. Throughout the years, the administration initiated interventions when weaknesses were identified.

Emphasis on the uniqueness of the profession, and maintaining medical therapeutic identity, althouth the interventions included learning self-defense and the workshops included discussions of the role of the patient, throughout the entire intervenion, the therapeutic component was emphasized.

Staff members were not asked to renounce their professional identities, rather to emphasize them and find ways to cope with violence using professional tools unique to the field of psychaitry, leading to professional empowerment.

Communication – A key message that was strengthened during the intervention was that the departments are well informed regarding the problems and have the professional knowledge to solve them. After this was repeatedly demonstrated, efforts were directed to impart the knowledge to the entire staff. The importance of interpersonal communication among the staff was accentuated by staff requests for additional communication workshops.

The intervention program "To Return Home Safely" succeeded in returning the sense of safety to the employees in the forensic psychiatry departments at Sha'ar Menashe Mental Health Center, and in significantly reducing the scope of violence in the wards.

There are currently future plans for dealing with violence in the hospital. First, continuation of the refresher courses. Second, yearly follow-up of the number of work accidents and the number of injured employees, and developing a training program according to the findings. Last building a support model for employees, post injury.

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Psychiatric nurses'experiences with anger and social support in Japan

Poster

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Introduction

There have been mnay activities related to mental health in the workplace by psychiatric liaison nurses, but in Japan, there are only a few dozen psychiatric liaison nurses, so it is difficult for nurses to utilize them. Therefore, a framework for cooperation with superiors and colleagues who are in the same workplace is strongly recommended.

We have clarified the current status of social support for psychiatric nurses, as well as anger and its development as experienced by them in interactions with patients. We have also examined how nurses should interact with each other as a team.

Method

1. Design: qualitative descriptive study based on a semi-structured interview.

2. Subjects: 20 nurses working in psychiatric hospitals.

3. Questionnaire items (excerpt):
   1. Episodes of a personal experience of anger toward patients.
   2. What did you want to do (desire) and what was your actual response when you felt angry?
   3. When you were having a difficult interaction with a patient, what did you want people around you (colleagues and patients) to do?

4. Research Question:
   RQ 1: In what types of situations do psychiatric nurses feel angry?
   RQ 2: What course is taken by the anger that is experienced by psychiatric nurses?
   RQ 3: we will investigate the way in which nurses should act as a team.

5. Ethical consideration:
   We ensured that subjects incurred no penalties for early termination of their participation. Furthermore, we have ensured that data gathered and conclusions drawn will not be used outside the scope of this study. This study was approved by the Nagoya City University Ethical Review Committee.

Results

1. The settings in which psychiatric nurses felt anger were classified into the following four scenarios
   1. Physical violence
   2. When a patient did or said the same thing many times over
   3. Items due to the pathology of borderline personality disorder (4) Verbal aggression

2. It was understood that the process from the "evocation of the psychological response of anger to the "letting go of anger was divided into three phases.

3. When anger was experienced, the psychiatric nurses who achieved the following six items could let go of the anger while getting social support from people around them.:
   1. The existence of an adviser.
   2. Being able to grasp affirmatively the result of action taken as a reaction.
   3. Being able to reflect on their own actions objectively.
   4. Being able to clearly divide their work and private lives.
   5. Not feeling that they were the only ones who could interact with the patients.
   6. Having the courage to apologize to patients if they knew they were in the wrong.

Discussion

Nursing managers have the responsibility of appropriately grasping which nurses should have counselling and what type of social support they need (for example, making people take time off, holding meetings on this problem for the entire ward). It is important not to focus on an investigation to determine the cause and a countermeasure. As discussed above, in a workplace where people actually feel that "I am protected and not alone.,it is possible to help nurses who are hurt to regain their footing. In order to create that kind of workplace, we propose the establishment of a "place for consultationsthat is available to nurses of all ages.

Educational Goals

• affective
• social-support

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The Causes of Violence Applied to Health Personnel Working at Family Health Centers as reported by Patients/ Families

Poster

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Background

Violence experienced by health personnel at the workplace have increased in recent years. These events negatively affect healthcare organizations, health professionals, patients, and their families, and cause them harm .

Aims

This study was planned to determine the reasons of violence applied to health personnel working at Family Health Centers (FHC) es reported by patients/ families.

Method

This descriptive study was conducted with 251 patients, who volunteered to participate in the study and were selected by stratified sampling method out of 7051 patients admitted to all of the FHCs in Trabzon/ Turkey in one day. Written permission was grantedfrom the Provincial Health Directorate in January 20, 2013. The data were collected between March 7th and 28th, 2012 by a questionnaire composed of 8 questions regarding the demographic characteristics of patients and 15 questions regarding violence and its reasons reportedby health personnel.

Results

54% of the patients were women, 27% were housewives, 74% were married, 55% had 1-3 children, and 43% had secondary/high school education. 31% of the patients saw the violence applied to health personnel in these centers, and 27% explained that violence was mostly verbal, such as shouting, swearing. In addition, 23% stated that patients/families that applied violence were mostly male, while 17% reported that health personnel being victims of violence were women. The patients with secondary/high school education supported these findings at a higher degree (p <0.05).

12% of the patients thought that out of the health personnel, physicians, secretaries (12%) and nurses (11%) deserved violence, and 35% stated that they wish to apply violence to health staff. However, 10% of the patients stated that they applied violence to health personnel before and 9% explained that they applied verbal violence. These patients stated that the violence applied to health staff stem from the health system (45%), from the health staff (26%) and from patients/ their families (24%). System-induced violence was correlated with the prolongation of waiting time for examination/outpatient (42%), health personnel-induced violence was correlated with the insensitive and indifferent behaviors of the health staff (54%), patient/ their families-induced violence was correlated with the impatient and unsympathetic acts of patients/ their families (69%).

Conclusion

It was determined that health personnel experienced violence and especially verbal violence applied by patients/their families at FHCs, and most of these events occurred due to insufficiency of the health systems.

Educational Goals

1. to explain the causes of violence.
2. to identify the negative consequences of violence on health staff

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The Causes of Violence directed at Health Personnel Working at Community and Family Health Centers

Poster

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Background

There is an insufficiency of detailed studies in Turkey on the dimensions, causes and consequences of violence against health personnel. However, the cases of violence against health staff and complaints on this matter have increased recently.

Aims

This research was planned to determine the causes of violence directed at health personnel working at Community and Family Health Centers (CHC and FHC) as reported by these staff.

Methods

Written permission was grantedfrom the Provincial Health Directorate on January 20, 2012. This descriptive study was conducted with 454 health personnel out of the total 859 health personnel at all CHCs and FHCs in Trabzon/ Turkey, who were selected by stratified sampling. The data were collected between March 7th and 28th, 2012 by a questionnaire composed of 8 questions regarding the demographic characteristics of the patients and 15 questions regarding violence against the health personnel and its causes.

Results

50% of the health personnel were nurses, 56% were women. 76% of the health personnel saw or experienced the violence applied to health personnel and explained that this violence was mostly (%72) verbal, such as shouting and swearing. Physicians supported this view more ($p < 0.05$) than others. In addition, 54% of the health personnel stated that patients/ their families that committed the violence violence were male, 42% indicated that the victims of the violence were women, and 33% stated that the victims of violence were nurses.

Furthermore, 2% of the health personnel stated that they deserve the violence applied by patients/ their families. 69% of the health personnel stated that violence stems from the health system, 56% from the patients/ their families, and 12% from the health personnel. System-induced violence was correlated primarily with the prolongation of waiting time for examination/outpatient (%59), patient/ their families-induced violence was correlated with the impatient an unsympathetic behaviors of the patients/ their families (%87), and health personnel-induced violence was correlated with the insensitivity/ indifference of the health personnel (%41). However, physicians and married health personnel supported the insensitivity and indifference of the health personnel more than the other groups ($p < 0.001$).

Conclusion

It was determined according to the views of the health personnel working at CHCs and FHCs that health personnel experienced violence, especially verbal violence applied by patients/ their families and most of these events occurred due to the insufficiencies of the health system.

Educational Goals

1. to explain the causes of violence applied by patients7 their families.
2. to cope with violence applied by patients/ their families.

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Does a Patient-Directed Admission Process Reduce Violence?

Paper

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Does a Patient Directed Admission Process Reduce Violence during Admission?

This paper is a descriptive retrospective study initiated to identify instances of violence that occur during a one hour window at the time of admission. By using a recovery-oriented, therapeutic culture and trauma informed clinical practice, this adult acute psychiatric facility appears to have virtually eliminated violence requiring seclusion or restraint (SR) during admissions over a twelve-month period. The ultimate goal of an acute hospitalization is to stabilize an individual, both mentally and emotionally, and then provide the means and education that will successfully enable individuals to achieve recovery after discharge. In 2012, the Substance Abuse and Mental Health Services Administration (SAMHSA, 2012) recently revised the definition for recovery as "a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential." Moller and McLoughlin (2013) discuss the importance of a recovery focused approach to nursing care outcomes while pointing out that there is a lack of published nursing research on this topic.

SR does not have direct therapeutic value but sometimes are justified if the individual cannot "commit to the safety of themselves or others." SR can create barriers to treatment and recovery (NAMI, 2003) (APNA, 2001) and Taylor et al (2012). Establishing a violence free therapeutic milieu from the first moment of an admission will improve the patient experience and staff satisfaction, as well as promoting a "safe place," which is often lacking in settings that serve this population.

While appearing to be a simple process, the full course of an admission is much more complex than one might suspect and begins from the moment a consumer is identified to be in need of acute care (e.g., personally calls for help, family or friends call for help, public safety interaction, etc.) until completion of the admission interview on the unit. Improving care at this point of the admission experience will contribute to the success of the overall process.

Literature Search

There is a lack of data in nursing literature that establishes reliable baselines related to violence at this particular stage in the admission journey or how this violence effects engagement in acute treatment. It may be that violence during the admission process is rare. However, professional nurses are "responsible for acquiring the empirical evidence needed to make informed decisions," and cannot rely solely upon anecdotal experiences and beliefs (Stein, 2013).

Salem Health System Librarian Paul W. Howard, MLIS, PhD searched Ovid MEDLINE® with 827 initial results, which, after other filtering identified 165 articles relating to risk and various discussions on clinical decision making parameters. No literature was located related to isolating acts of violence at the various points of an admission to the acute psychiatric facility. An expanded search in PsychInfo also failed to yield articles on this specific topic.

Background

Salem is the Oregon State capitol and contains multiple institutional facilities such as the State Mental hospital, multiple correctional settings, long term residential, and many less restrictive resources. In 2011 the 454-bed Salem Hospital provided emergency department (ED) and urgent care services to 121,125patients, making it the busiest ED in the state (Salem Health, 2013). The Psychiatric Medicine Center (PMC) is one of only ten "holding facilities" in the state meaning that it can receive and detain patients requiring assessment and mental health services. PMC is located on the Salem Hospital campus, is a 25-bed adult co-ed acute psychiatric unit, which had 825 admissions in 2012 with a near equal amount of voluntary (419) and involuntary (406) patients during 2012. The immediate mental health service area

for Salem covers a sixty-mile radius. This concentrated service area contains a high number of vulnerable individuals who suffer from chronic mental illness, often in combination with substance abuse.

Need for the Elimination of Violence

Violence during psychiatric stays has been determined to hamper patient directed care by reinforcing previous traumatic experiences, resulting in consumer re-traumatization, as well as concurrently traumatizing staff members. At least 85% of community psychiatric patients have suffered past traumas which can lead to poor coping skills. Negative behaviors are symptoms of past traumas and lack of control. Transferring as much control from staff to patient as possible is the essence of trauma informed care (Chandler, 2008). Mental health care workers experience more violence than all other service providers except law enforcement workers at a rate of 20.5 per 1,000 persons. (DeSanto et al, 2013) This translates to increased expenses related to low staff morale and lost work hours, (Taylor, et al, 2012) which is likely underreported (Zuzelo, Curran, & Zeserman, 2012). Both patients and staffs can suffer long term consequences related to the associated traumatic stress.

A Trauma Informed Culture: Creating Sanctuary

In 2002 The Sanctuary® Model (Bloom, et al, 2003) was introduced to PMC by then Medical Director, Maggie Bennington-Davis, M.D., after an onsite consultation with Sandra Bloom, M.D. PMC used mechanical restraints 60 times and seclusion 200 times in 2002. At that time there had been several sentinel events, where patients died as a result of restraint use and inappropriate use of controlling force by care providers (Korn, 2008.). In response, Bennington-Davis and PMC Administrative Director, Tim Murphy, introduced the "Engagement Model" which stresses the "relationship dynamic between the treating professional and the treated patient." The concept of this model is to minimize conflict and maximize collaboration and cooperation between patient and staff. Ultimately, the implementation of this model resulted in the virtual elimination of SR at PMC. This is the start of a journey described in "Seclusion and Restraint: The Model for Eliminating Their Use in Healthcare" (Murphy & Bennington-Davis, 2005). Ongoing adaptations and improvements by subsequent Nurse Manager, Linda Nagy, MSN, CNS and most recently by the current manager, Lori Kessler, BSN, RNC, continue to evolve.

The Data

This study focus' on two questions: 1) "How welcomed did patients feel at the time of admission?" and 2) "How often during the first one hour of the admission process did violence take place which was severe enough to warrant SR?" To measure the first question, patients are given a two-sided questionnaire to self-complete (voluntarily and anonymously) just prior to discharge. Our question is the first on a thirteen-question survey which asks about the patient's perception of care related to various service disciplines (i.e., nursing, social workers, therapy services, psychiatrists, and dietary). Survey responses are rated by using a Likert-type scale. For question1: The extent to which I felt welcome during the admission process at PMC, a hearty response of 585 surveys were collected out of a total 822 discharges (71%). 59% reported feeling "Very Good" and 27% felt "Good" about how welcomed they felt during the admission. Of note, nearly half of these patients (49%) had been admitted involuntarily, yet overall, 86% of these patients responded with felt good or very good.

The second question identified incidents of violence requiring SR during the first hour of admission. With 825 admissions throughout 2012, seclusion occurred three times during the admission hour (out of the total of 30 seclusion events during that year) for a frequency of 03%. Two of these individuals were too violent for the open milieu and were discharged directly from seclusion to jail. There were zero mechanical restraints used during 2012, and hands-on manual restraint (holding a patient briefly for administration of an IM medication) was required thirteen times for a total of 22 minutes in 2012. Data for physical holding restraints is incomplete as PMC's policy to report this form of restraint did not begin until June of 2012.

Discussion

It is impossible to script an entire process, and so it is imperative that staff have a shared culture in the establishment of a beneficial and therapeutic milieu. This includes creation and use of the physical environment (e.g., functional layout, line of sight, amount of window area, size of day room, etc.,), verbal and body language of staff, expectations of patients in the milieu, and intentional interventions. Social interactions are complex and the management of a therapeutic milieu in an acute psychiatric setting can easily shift into chaos without focused intention by staffs.

One essential construct in a trauma informed environment, is that all interactions stem from an attitude of "what happened to you," instead of "what is wrong with you" (Murphy & Bennington-Davis 2001) and (Bloom, 1994). The influential power of language can create either a golden moment or a black, trauma inflicted memory. Staff's nonverbal clues (e.g., saying, "Welcome" but message is conflicted by tone and posture saying, "Don't you dare think about getting violent with me!") are powerful. Staff can develop skills to take advantage of this technique or be unskilled and risk instigating an un-therapeutic interaction which pits patient against staff.

To promote a culture of safety, staff must use genuine communication that expresses support rather than control, while also communicating clear expectations that holds the patient accountable for their behavior and active participation in treatment, which will lead to recovery (Goetz, Taylor-Trujillo, 2012). PMC's policy is to always have security staff present during the anteroom portion of admission as the admitting two staffs assure a complete skin evaluation while inconspicuously checking clothing for contraband. Additionally, one staff member is dedicated to observing all incoming patients by camera and audio for safety back up.

Some malleable scripting can guide the nurse toward the goal of expressing "welcomeness" while simultaneously evaluating the patient's ability for collaboration and readiness to participate in treatment. Scripting can also provide an anchor for patients who have previously been admitted at PMC, to re-experience past perceptions of "welcomeness," thereby jumpstarting collaborations.

The ability to respond to simple choices reveals a patient's level of organization. Asking first, if someone is hungry or thirsty, opens up an avenue for a full sentence response. The response might be a clipped "no," or "yes," or "I haven't eaten a thing all day." They may respond with "They gave me a sandwich full of demon poison," or "I would like a prime rib dinner," or "My stomach hurts; I haven't been able to eat in a week." Or there may no response at all. This simple interaction gives the staff person much information that determines their next interaction. One person may be aggressive; another may be offended at an attempt toward humor, while another might be too disorganized to understand any words being spoken. The experienced mental health professional utilizes these simple cues to quickly evaluate risk for violence to self or others, thought content, state of mood, readiness for learning, cognitive organization and other valuable data. Inflammatory terms such as "we need to search you" or "take your clothes off" can pique past traumas. It is therapeutic to reframe statements; "we have some fresh scrubs for you. Do you have any cuts, bruises or sores? We want to make sure you are ok."

Traumatic experiences from prior hospitalizations can be replaced by positive experiences in a trauma informed culture. Those patients experiencing their first hospitalization can be better prepared to achieve recovery if an immediate therapeutic rapport is established during the admission process.

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250 years in the psychiatric mangement of violent behavior

Paper

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Introduction

Violence towards self and others—intentional injury in public health terms— has always been an important clinical management issue in psychiatry. Episodes of violent behavior can be associated with a wide array of psychiatric symptoms. These range from intense emotions such as anger, severe anxiety or severe depression, to psychotic symptoms such as hallucinations and delusions, to complex combinations of symptoms that are often present in a delirium or in dementia. These include cognitive symptoms such as confusion with perceptual disturbances and delusions as well as intense emotions such as severe anger. The breadth of psychiatric disorders, ranging from global symptomatic disorders like dementia to stress-based symptoms such as the adjustment disorders, means that most psychiatric disorders have an increased risk of intentional injury. The fact that mental disorders increase the risk of violence towards self or others is evident in the majority of epidemiological studies over the last thirty years. (1,2,3,4,5) None of this is new. Violence towards self and others has always been associated with mental disorders from ancient times to the twenty-first century. (6,7)

250 Years of the management of excitement or agitation

Approximately 250 years ago, in the second half of the 18th century, William Cullen, a Scottish Medical Professor, introduced the concept of excitement: a state of increased energy and restlessness that he contrasted with collapse, a state of lethargy and decreased responsiveness. (8) The word excitement was used for the next two hundred years to describe a dangerous clinical state commonly seen in psychiatric disorders that often warranted immediate treatment in order to prevent a violent act from occurring. (9) By the late 20th century the word agitation had replaced excitement. Contemporary emergency psychiatry textbooks emphasize agitation as a common presentation in psychiatric urgent cares and emergency rooms. (5) Controlling excited or agitated states has been problematic because the clinical interventions are often coercive. These coercive interventions are known as restraints. Restraint is defined as a measure or condition that keeps someone or something under control or within limits. Restraint, in the psychiatric management of violence, includes hospitalization or confinement, "bed rest", seclusion, mechanical restraint, manual or muscular restraint as well as chemical restraint. (10, 11,12)

Time is a major factor in the clinical management of excitement. If the cause of the excited behavior is transitory, such as intoxication, the agitation will resolve itself within hours. If the cause of the excited behavior is a delirium, the behavior might terminate within hours or days or weeks. Environmental or situational disturbances associated with violent behavior such as seen in adjustment disorders or acute stress situations can often resolve themselves within hours with non-pharmacological interventions. Psychological interventions ranging from threats —using fear to change behavior—to empathetic support and education have a long history in violence management. (5,13)

Chronic mental disorders associated with violent behaviors are much more problematic and often require long-term management strategies including hospitalization during violent episodes, long-term chemical treatment and complex community management. These strategies are ideally present in the severe mental disorders such as schizophrenia, schizoaffective disorder, bipolar disorder and dementia. These chronic disorders are often characterized by intermittent episodes of violent behavior towards self or others. The prevention and management of these episodes of violent behavior form an important part of the core history of clinical psychiatry. (7,8,14)

This paper will review 250 years of these management techniques demonstrating one of the central continuities in psychiatric disorders: the continued association of mental disorders and violence towards self and others. From ancient times rooms, private madhouses, asylums, and psychiatric hospitals that specialized in treatment for mental disorders were conceptualized as facilities that would control the violence associated with these disorders. (15) Psychiatric symptoms that were not associated with violent

behaviors were often treated in the community. However, if violent behavior was present, the question of where the safest management could best take place became paramount.

The choice to manage acute violence in inpatient settings has remained remarkably consistent over these two and a half centuries. Influential writings by physicians who treated the mentally ill from the mid 18th century to the 21st have always emphasized the importance of inpatient psychiatric treatment in the course of violence management. Other reasons for psychiatric hospitalization have waxed and waned over these centuries but imminent violence remains the central justification for inpatient hospitalization even in the for-profit world of managed mental health care in the contemporary United States. (16,17)

While the function of psychiatric hospitalization as the location of violence management has remained, the types of management within the hospital have seen many changes. In the late 18th and early 19th centuries mechanical restraint was common. Even during the period known for the abolishment of mechanical restraints – roughly 1800 to the 1860s - strait-jackets, seclusion rooms and manual restraint were used if the patient became violent. As the size of hospitals grew there were different levels of acuity management with some wards being designated for the disturbed or chronically excited patient. Furniture was bolted to the floor, screens covered windows, and heavy garments that could not be ripped were worn by the patients. These units generally had more staff per patient as well as other management approaches that decreased the risk of harm to self or others. In the second half of the 20th century, mechanical restraints, muscular restraints and seclusion rooms were generally replaced by chemical restraints in psychiatric hospitals. In the twenty-first century, mechanical restraints in American hospitals are found primarily in Emergency Rooms and general hospitals where they are used to control the agitation of delirium or explosive violence. (5,7,12,18)

Before examining the history of chemical restraint, I would like to review the somatic treatments of psychiatry and their role in decreasing excitement. Somatic is defined as "relating to the body". These treatments were generally non-chemical approaches to altering the internal physiology of the body through a number of physically invasive procedures. These procedures included the following: Bleeding—the production of an acute anemia through sudden blood loss; Cathartics and Purges—causing severe dehydration through prolonged vomiting or diarrhea; Electroshock—producing seizures by running electrical currents through the brain; Lobotomy—the interruption of neurological circuits by the destruction of brain tissue; Insulin Shock—the creation of a prolonged hypoglycemic coma ; Hydrotherapy—the use of different water based treatments that changed the temperature of the body and Fever Therapy— the induction of fever, through the injection of malarial blood. (7,8,19)

The main clinical goal in treating excitement or agitation has been to sedate or produce sleep or tranquilize the patient. The depletion therapies – bleeding, vomiting, and diarrhea - caused sedation by physically weakening the person through anemia or dehydration. One of the most unusual "treatments" was known as the circular swing. (20) This caused diarrhea, vomiting, vertigo and nausea by violently rotating the person around on a suspended chair. It was hard to be violent when one was severely nauseated. The "benefits" of the depletion therapies could also be associated with the side effect of delirium. All treatments had side effects, and for the physician the central clinical question was whether or not the treatment was worth the side effects. Hydrotherapy probably had the least side effects of all the somatic treatments—though some people were scalded to death in poorly temperature controlled tubs. (21) All these somatic treatments had indications for calming the most disturbed patients. They were often used in combination. (9)

The chemical therapies of the 18th century were a continuation of the previous two thousand years. There were a limited number of drugs available from plants, such as opium, that were used to calm the patient and cause sedation and sleep. In the 19th century a wave of pharmacological interventions swept through most Western European and American insane asylums. These included a large group of sedatives both synthetic and natural that were used to sedate excited patients. They included the following drugs: alcohol, cannabis indica, the bromides, chloroform, ether, paraldehyde, chloral hydrate, urethane, hypnal, sulphonal, opium and morphine, codeine, hyoscyamine and hyoscine, conium (hemlock) and calabar bean (physostigmine). (7)

The problem with these forms of treatment was once again the side effects. By the 20th century conditions such as bromism in which patients outside the hospital would use large amounts of bromides and develop a delirium, was a common reason for admission to a psychiatric hospital. (22) It was in this treatment environment of the failure and dangers of chemical treatment that the somatic therapies such as hydrotherapy, electro-shock and ultimately lobotomy became popular. Lobotomy in particular was seen as a treatment associated with a long-term solution despite the problematic side effects. (19)

The state of excitement management just before the revolutionary introduction of chlorpromazine was described by Oskar Diethelm in the 1950 edition of his textbook: Treatment of Psychiatry. (9) The first step in managing severe excitement was hospitalization. If the person did not come voluntarily the intramuscular combination of morphine and hyoscine could be given to sedate the patient for the transfer to the hospital.

In the hospital, hydrotherapy was the first line treatment. Hydrotherapy techniques included the continuous bath treatment that could last from one to 24 hours or cold wet packs in which wet sheets were wrapped mummy style around the body. If hydrotherapy was not effective, insulin shock treatment was often used. In some patients electroshock was the treatment of choice. Some authors advised combinations of both insulin shock and electroshock. Another method to treat extreme excitement was prolonged sleep therapy in which the continuous use of barbiturates, administered by rectum, produced up to ten days of sleep. Diethelm summarized which patients responded best to lobotomy: "The patients who seem to react favorably are those who suffer from strong emotional disorders leading to persistent attempts at self-mutilation or suicide, and aggressive outbursts which are dangerous to others." (9, p.164) The sedatives and hypnotics that he recommended were combinations of paraldehyde and chloral hydrate and in some cases barbiturates and bromides. These meds were primarily for sleep. Hospitals were particularly critical for managing excitements in that hydrotherapy, electroshock and insulin shock could only be used in hospital settings.

Chemical restraint involved either the oral, rectal, intramuscular injection —first introduced in the 1850s—or intravenous push—not widely used till after the 1950s—of chemical compounds both natural and synthetic that altered the general mental status of the patient. The name categories for the drugs that do this reflect their clinical use: sedatives, hypnotics and the tranquilizers, major and minor. Until the 1950s most chemical agents were used to obtain sleep—hypnotics—or to produce sedation—sedatives. Many of the agents did both. It was not until the pharmacological revolution of the 1950s that specific symptom clusters such as anger, depression, anxiety, delusions, hallucinations, agitation and mood swings were targeted by chemical compounds. There were also no chronic chemical treatments till the 1950s. Prior to this period, the drugs that were used were targeted for acute management only. (9,19,23)

The psycho-pharmacological revolution of the 1950s was dramatic in the management of excitement and the potential prevention of violent behavior in psychiatric disorders. Chlorpromazine transformed inpatient psychiatric units in Europe and North America. (24) The earliest accounts of chlorpromazine emphasize its long-term tranquilizing qualities and its unique ability to decrease aggression. Unlike the sedatives of a few years earlier it could be taken during the day and the patients could function. If taken daily this medication could provide long-term treatment of excited behaviors in different psychiatric disorders—not to mention that it also decreased psychotic symptoms long associated with violence. There are numerous first hand accounts of raging, noisy, screaming disturbed wards being calmed almost literally overnight by the introduction of chlorpromazine. (24)

The introduction of anti-depressants and mood stabilizers also introduced the possibility of long term maintenance treatment of the severe depressions and mood disorders often associated with both suicide and aggression towards others. The benzodiazepines, also introduced in the late 1950s, were much safer then the earlier sedatives. Following their widespread use in the 1960s, the benzodiazepines both became and remain major calming drugs in emergency rooms, psychiatric hospitals and virtually everywhere else. (25)

Over fifty years have passed since chlorpromazine and the other drugs of the psychopharmacologic revolution were introduced, and while many new compounds are on the market, one can realistically ask how much real advancement has there been from the first generation of the psychiatric drug revolution to the present. What has become clear is that by now—the middle of the second decade in the twenty-first century—the choices in clinical management of acute excitement and violence involves multiple compounds with multiple routes of administration including the latest in terms of inhaling the anti-psychotic for near instant relief of symptoms. Chemicals as both forms of treatment and restraint are now the mainstay of psychiatric treatment for both acute violent behavior as well as for the psychiatric symptoms that put a person at risk of violent behavior—severe depression, confusion, mood swings and anger, psychotic symptoms and severe anxiety. (5,14,25)

The most dramatic change in contemporary violence management, however, is in the configuration of mental health services especially in the United States. Psychiatric hospitalization has become an extremely time-limited treatment modality for violence management. From the peak of inpatient hospitalization in the 1950s, the number of total psychiatric beds has decreased by nearly 90%. The long-term psychiatric state hospital is virtually extinct. (25)

There are two major new settings for people with severe mental disorders: the first is the community which includes short-term hospitalization with a wide array of housing/non-housing settings ranging from highly staffed, supervised settings such as skilled nursing facilities to the streets. For mental disorders, skilled nursing facilities are primarily for people with dementia and related conditions. The spectrum of services in geriatric psychiatry ranging from skilled nursing facilities to home health care allows a higher quality of treatment for the majority of mentally ill geriatric patients especially when compared to the severely mentally ill adult population and children and adolescents. (25,26)

For severely mentally ill adults, living situations are frequently in unregulated board and care homes, low income rental apartments, trailer courts, subsidized housing for the more fortunate, with families or friends or on the streets. In essence, it is the housing of the unemployed and extremely poor. The services available for this population will vary depending on the state Medicaid program and the outreach components within it. Generally these programs emphasize chemical treatment with varying levels of crisis and case management including highly staffed assertive community treatment teams. (26) Very few states have a comprehensive spectrum of housing facilities comparable to those available for geriatric patients. Homelessness is a perennial problem that is just a benefit cut or a monthly rent increase away. If a hospital stay is required to manage acute self or other directed harm, it is extremely short and most severely mentally ill patients will leave hospitals with significant symptoms still present making re-hospitalization very common.

The second major setting for the mentally ill in the United States are the local jails and state prisons. (27) Most likely any metropolitan county will have two to five times the number of patients in their local jails and prisons as they do in their psychiatric hospitals. Jails and prisons are virtually the only long-term institutional settings for the adult mentally ill. Nearly half of the mentally ill in jails and prisons have a recent history of violent behavior towards others. (27) Psychiatric treatment and violence management – especially self-directed - in the jails and prisons has become a major concern of psychiatry and is facilitating the development of the sub-specialty of Correctional Psychiatry. (28)

The impact of the Affordable Care Act in the U.S. on mental health care is not clear. One of its major components, the expansion of Medicaid, is being blocked by nearly half of the states in the U.S. The failure to expand these programs will be extremely harmful for hundreds of thousands of mentally ill people probably resulting in continually increasing mentally ill populations in jails and prisons. In states that do expand mental health coverage to this population, there should be a significant increase in services. However, most of these Medicaid plans will probably be managed mental health care plans. It is unlikely that they will be increasing housing alternatives, psychiatric beds or non-chemical treatment programs. In Tucson, Arizona, which has been under a managed Medicaid model for the last twenty years, the violence management model is a centralized crisis center that emphasizes preventing psychiatric hospitalization and returning mentally ill people to the community as quickly as possible. This model is being touted as a new national standard despite the fact that it perpetuates the current major problems in the field: the lack of psychiatric beds for stabilization, and the lack of an adequate housing spectrum. In short, it is primarily a cost savings model that accomplished its savings by minimizing psychiatric hospitalization and residential treatment. (29)

Conclusion

The history of the management of excited or agitated behavior associated with mental disorders has gradually shifted from the psychiatric institution to the community with chemical treatment/restraint being the most used form for managing the excited/agitated person with a mental disorder. Community care specializes in the self-harm spectrum and the interpersonal violence spectrum of threats, misdemeanors, non-criminally prosecuted aggravated assaults and the post-prison population. Short-term psychiatric hospitalization and long term community case management are the service delivery systems used to manage intentional injury. At the same time, jails, prisons and forensic psychiatric hospitals have become the location of treatment/management for people with mental disorders who have committed serious felony level crimes, extreme aggravated assaults and homicide. These long-term facilities are virtually the only long-term institutional care available for the adult severely mentally ill patient. Ideally, much of the felony level interpersonal violence could be reduced by a comprehensive, community mental health system that emphasized appropriate supervised housing, substance abuse treatment, aggressive case management of patients at high risk of violence and the expansion of long-term psychiatric hospitalization instead of prison for the continually dangerous mentally ill.

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The Mental Machine – Perspectives on High Security Asylums in the 20th Century

Workshop

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Abstract

In the late 19th and early 20th century asylums were considered as the most modern treatment health politics and administration could offer. Slowly asylums changed character from being institutions of hope and healing to become closed communities with hidden secrets about the interior life, often associated with degradation and shame. Why did this happen? Three presentations approach this from three angles by discussing particular challenges associated to the combination of crime and insanity in asylums. The method used in these presentations is hermeneutic text analysis.

1. Øyvind Thomassen: The Modern High Security Asylum in the 20th century – politically, clinically and scientifically explained.

The presentation will discuss general results from our ongoing study of two entire asylum populations during the period two Norwegian high security asylums were in operation (1895-1987). The project has developed new explanations of the establishing of the asylums, new understandings of how patients were treated and the institution understood by the patients and additional understandings of the closure of the asylums in the 1970s and 80s.

2. Hilde Dahl: Law and psychiatry in the early 1900s - competitive epistemologies with a common agenda?

A new Penal Code came into effect in Norway in 1902, internationally recognized for its innovative approaches to criminal insanity. However, the new regulations became difficult to practice. A prevailing notion of incorrigibility, lead to a claim of permanent custody in order to protect society. To meet this claim, a securing sanction was introduced in 1929 to handle these mentally ill repeat offenders. The presentation will discuss the scientific controversy between psychiatrists and lawyers on this subject during the period 1920 and 1929 and how it influenced the legal position of forensic experts in Norwegian courts.

3. Eivind Myhre: Sex Offenders in High Security Institutions in the interwar period: Practices and Conceptions of Sexuality and Masculinity within the Institutionalization of Criminal Insane.

Men and sexual offenses were a highly relevant and controversial issue in Norwegian public scientific controversies during most of the 20th century. The presentation will first discuss the background and common features among sexual offenders and if they were significantly different from other patient groups during the period 1920-40. Second, the presentation will discuss how several legislative changes related to sex offenders were discussed and implemented in Norway during the period the period 1920-40. Did these changes, and the contemporary public debate about sexual morality, have any impact for sexual offenders admitted to high security asylums?

Educational Goals

Improve cognitive and reflective abilities among psychiatrits, health workers and political decision makers and administrators

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Routine recording of inpatient aggression: challenges, solutions and experiences from a large treatment facility after 6 years of recording aggressive incidents

Workshop

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Abstract

There are many reasons for routinely monitoring inpatient aggression. These include the evaluation of individual treatments; evaluation of policy innovations at the levels of wards or whole facilities; monitoring the burdon for staff and risk for burn-out; research into patient-related and environmental risk factors for aggression and into the effectiveness of particular treatment interventions.

However, sufficiently reliable aggression data are difficult to obtain, especially in the long run. Official incident figures have been shown to represent only the tip of the iceberg, and a decline of recording quality over time can lead to misleading conclusions.

In 2007, Trajectum, a Dutch treatment facility for adults with mild or borderline intellectual disability, developed a method for recording inpatient aggression based on the Modified Overt Aggression Scale (MOAS; Kay, Wolkenfeld & Murril, 1988). The method had to meet the following requirements:

- little burden on ward staff;
- reliable data about mild as well as severe aggression;
- useful for clinical, management and research purposes;
- low maintenance efforts.

After 6 years of application on about 30 wards and about 50.000 recorded incidents of aggression, it can be concluded that the Trajectum method largely meets these requirements. Today, the incident data are regularly used by clinical staff, management and researchers, the recording process is widely accepted and requires little maintenance efforts, and the method has been transferred to several other inpatient facilities.

The aim of the workshop is to present the Trajectum method for recording inpatient aggression. In a practical and interactive way, we will address issues, such as implementation (e.g., instruction), quality maintenance (e.g., booster sessions), data-monitoring (e.g., under-reporting), infrastructure (e.g., software; management), communication (e.g., feed-back of results), and costs. In the discussion of challenges and the demonstration of possible solutions, the participants are encouraged to look at these issues from various perspectives (e.g., ward staff, management, researchers and patients) and to contribute own experiences.

Educational Goals

1. After the workshop, the participants will have knowledge about a practical method for routine recording of inpatient aggression, including implementation and maintenance issues.
2. They will also have an enhanced understanding of the challenges one faces in monitoring aggression and possible solutions.

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From Building to Body; predicting aggression on different levels

Symposium

Prof. dr. Henk Nijman, Drs. Floor van Dijk, Dr. Eric Noorthoorn, Altrecht Aventurijn, Den Dolder, The Netherlands, Drs. E. Kuijpers, The Netherlands, Drs. A. Bousardt, GGNet, The Netherlands

Contributions to the symposium are made by:

1. Drs. Floor van Dijk, psychiatrist and director of Altrecht Aventurijn, Den Dolder, the Netherlands (chair and introduction to the session. Title of lecture: From Building to Body; reflections on triggers of violent behavior on various levels)
2. Dr. Eric Noorthoorn, senior researcher at Altrecht Aventurijn (title of lecture: Predicting the use of seclusion on the basis of ward design features, patient characteristics, and staffing variables)
3. Prof. dr. Henk Nijman, senior researcher at Altrecht Aventurijn (together with drs. Ap Zaalberg of the WODC of the Ministry of Justice, the Netherlands) (title of lecture: Predicting violence and psychopathology in forensic patients with diet related blood parameters?)
4. Drs. E. Kuijpers, (together with Prof. dr. Henk Nijman) (title of lecture: Predicting aggression on the basis of changes in electrodermal activity of forensic psychiatric patients?)
5. Drs. A. Bousardt, psychologist and researcher at GGNet (title of lecture: Predicting inpatient aggression by the assessment of clinical risk factors and self-reported impulsivity in subgroups of forensic psychiatric patients)

Educational goals

To learn more about factors associated with inpatient aggression on various levels.
The relative contribution of ward architectural variables, staff variables and patient variables in triggering aggression is addressed. As far as the patient variables are concerned, the focus will be on prediction of inpatient aggression on the basis of diet related blood parameters, electrodermal activity (skin conductance), psychiatric diagnoses and risk assessment and impulsivity scores.

From Building to Body; reflections on triggers of violent behavior on various levels

F. van Dijk

In this introduction to the symposium, various forms of violence that are seen in society, as well as in mental health care settings, are addressed. Recent incidents of extreme violence which are extensively covered by the media, may give the impression that aggression and violent crime are rapidly increasing in Western society. But is this true? In many West-European countries, rates of violent offenses are not rising, and in some countries, among which the Netherlands, crime seems to be declining. Nevertheless, the threshold for using violence appears to be low in certain subgroups (e.g., hooligans), and the perception of safety of the general public is reducing as a result of incidents receiving much attention in the media. To introduce the wide variety of factors that play a role in causing aggressive behavior an overview of social, psychological and biological triggers of aggression is provided. The symposium focuses both on environmental triggers of aggression (e.g., ward architecture), as well as individual psychological, psycho-physiological and neurobiological determinants of aggression.

Predicting the use of seclusion on the basis of ward design features, patient characteristics, and staffing variables

E.O. Noorthoorn, P. van der Schaaf, W.A. Janssen & H.L.I. Nijman

In a recent study, van der Schaaf et al. (2013) identified 14 design features showing a significant effect on the risk of being secluded. Earlier, Janssen et al. (2012) found seclusion use to be related to ward size and bipolar and schizophrenic disorders on admission wards. Apart from that, Janssen et. al (2008) as well as Bowers (2007) found staffing characteristics to have an effect on the use of seclusion. In the current study, covering data on 198 wards and 27.080 patients, all these characteristics were included in a single model, to identify the contribution of the various components. A multilevel mixed models

poisson regression analysis on time in seclusion divided by the total time admitted to the ward, showed age, sex, a bipolar disorder, a psychotic disorder, private space per patient, having one's own furniture/personal furniture, the type of view from the patient's room, the facility and security level as well as the number and differentiation of staff per patient were associated with seclusion duration. Depression showed an inverse association to seclusion time. Mcfaddens' R2 improved by 0,24 on patient characteristics. Ward characteristics added a 0,13 to Mcfaddens' R2 , while personnel characteristics added a mere 0.01 Mcfaddens R2. In other words, primarily patient characteristics together with a number of items related to ward security level and patient autonomy predict most of the variance in the model. The findings imply that design features of the ward and the individual environment of the patient are important factors in the prediction of time in seclusion, while staffing was found to have near to no effect.

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Predicting violence and psychopathology in forensic patients with diet related blood parameters?

H.L.I. Nijman, A. Zaalberg, E. Bulten, A. Wouters, C. van der Staak & J. Wielders

Fifty-one patients from a closed forensic psychiatric department in the Netherlands participated in the current cross-sectional study. From these 51 patients, blood samples were collected, and questionnaire based information was gathered. To be more precise, aggression was both assessed by means of self-reports on the Dutch version of the Aggression Questionnaire (AQ), and rated by staff members by means of the Social Dysfunction and Aggression Scale, (SDAS). Current psychopathology was quantified with the widely used Revised Symptom CheckList (SCL-90-R) and with the 28 item version of the General Health Questionnaire (GHQ-28). The levels of magnesium, iron, lead, copper, zinc, vitamin B6, vitamin D, and the various fatty acids (among which omega 3 and omega 6), were analyzed in the blood samples of the participants. In line with earlier findings, it was found (among others) that several fatty acids were associated with measures of aggression. In the lecture the correlations between the diet related blood parameters with aggression and psychiatric symptoms will be presented in detail, and the potential implications of these findings for the prevention of aggression are discussed.

Predicting aggression on the basis of changes in electrodermal activity of forensic psychiatric patients?

E. Kuijpers, H.L.I. Nijman & P. de Looff

A well-known technique to assess (psychological) arousal is to measure the Skin Conductance Level (SCL). Although widely used in experimental psychological research, this technique has not been used often in (locked) psychiatric admission settings on patients who are at a high risk of engaging in aggressive behaviour. One of the obvious reasons for this is that measuring skin conductance, until recently, required a substantial amount of equipment. As technology progressed, however, it became possible to develop small wearable devices in the form of regular watches or wrist bands to measure the SCL and other psycho physiological parameters (see Kuijpers et al., 2012). In the lecture the results of a study are described in which 12 forensic psychiatric patients wore these wristbands for two days. Potential agitation and aggression were documented each half hour by means of a (slightly modified) version of the Social Dysfunction and Aggression Scale (SDAS). Of the 414 half hourly SDAS scores obtained in this way, 37 showed (8.9%) elevated aggression scores. It was investigated whether aggressive behaviour was associated with a significant increase (in fluctuations) of the SCL prior to the aggressive behaviour.

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Predicting inpatient aggression by the assessment of clinical risk factors and self-reported impulsivity in subgroups of forensic psychiatric patients

A.M.C. Bousardt, J.W. Hummelen, E.O. Noorthoorn, M.C. Overduin & H.L.I. Nijman

Aggression is a major issue in forensic psychiatry. While many studies look into prediction of aggression recidivism by means of risk assessment tools only, the current study investigates the ability to predict inpatient aggression (as measured by the Social Dysfunction and Aggression Scale; SDAS, Wistedt et al., 1990) as well as treatment violations by means of self-reported impulsivity (UPPS-P; Whiteside & Lynam, 2001; Cyders et al., 2007) and a Dutch risk assessment tool (HKT-30; Working group Risk Assessment Forensic Psychiatry, version 2002) as predictors. During a one year follow up study, HKT-30 at admission and 1366 SDAS weekly assessments were obtained for 52 patients, a coverage of approximately 78% of the admission of forensic patients at a single large ward. Findings showed that high scores on the SDAS outward aggression items were predicted by high scores on the impulsivity and hostility clinical judgements (HKT-30) in combination with high scores on self-reported negative urgency and sensation seeking (UPPS-P). High scores on the SDAS self-directed aggression items were also predicted by high impulsivity and hostility judgements in combination with negative urgency, but not sensation seeking. Instead, positive urgency and lack of premeditation added predictive power to the model. We also noticed that in certain subgroups of psychiatric patients, the UPPS-P was especially sensitive in predicting aggression. For example, cluster B personality disorders only predicted both outward and inward aggression in combination with subscales of the UPPS-P. Other subgroups that, in combination with UPPS-P subscales, were associated with aggression were: cluster A personality disorder (inward aggression), psychotic disorder (inward and outward aggression), autistic disorders (outward aggression) and drug abuse (inward and outward aggression). From these preliminary findings, we estimate aggression to be mediated by impulsivity in patients with certain disorders. However, as the findings were based on a small number of patients, they need to be viewed with caution.

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Clear communication and procedures at admission or transfer: procedural differences between countries and what we may learn from another over countries?

Workshop

E.O. Noorthoorn, C. Bervoets, L. Goderis, J. Duxbury

Abstract

Over the past years, over several countries containment of patients in the ambulatory setting while being transferred to or between hospitals has lead to a number of (near) accidents, often with a high media profile. Incidents occurring in the Netherlands, Belguim and some years ago, also England show a comparable common denominator.

Discussions occur between professionals of different organizations, over hours and hours, while the patient stays either at at home, at police office, or at a hospital facility insufficiently equipped for handling complex and often dangerous patients. Especially patients too complex for directly accessible hospital facilities seem at risk. Specialized facilities are full, the patient needs to be transported over a large distance, while the receiving party is reluctant to admit.

As a consequence the patient is not treated and denied adequate care while several actors ranging from the local authorities, district attorney, the police, the family doctor, the psychiatrist, hospital admission professionals medical directors and many others discuss what to do, the patient remains in need of most immediate highly specialized care. In the aftermath of these incidents health authorities look into the cases in great detail, allowing some study where procedures either or not went wrong.

In this workshop the differences between the mental health acts of England, the Netherlands and Belgium will be discussed against the background of a number of case histories. How far should we go in the protection of patients' individual rights and when should we decide to take over the rights on behalf of the best interests of the patients is discussed against the background of these cases. How and to which detail are responsibilities between organizations described? The consequences and risks of the specific historically grown differences in procedures for admissions between these three countries will be discussed in order to formulate proposals leading to a more adequate referrals and admissions at specialized institutes.

Educational goals

1. To learn more about factors associated with idiosyncratic patient risk at admission
2. Discuss pro's and cons between admission regulations over countries to learn from each others experience

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The Causes Of Violence Applied To Health Personnel Working At Hospitals By Patients/Their Families According To Health Personnel

Poster

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Background

Violence is observed in hospitals where high concentration of people are seen, due to reasons like lack of communication, experiences, objectives, environmental conditions, attitudes, personality traits, individual needs, stress, and unable to empathize with the others.

Aims

This research was planned to determine the causes of violence applied to health personnel working at hospitals by patients/their families, from the point of view of the health personnel.

Methods

After permission was taken from the Provincial Health Directorate on January 20, 2012, this descriptive study was conducted with 798 health personnel out of 3379 health personnel working at 12 hospitals in Trabzon/Turkey, who volunteered to participate in the study and were selected by stratified sampling method. The data was collected between March 7th and 28th, 2012 by a questionnaire composed of 8 questions regarding the demographic characteristics of the patients and 15 questions regarding violence against the health personnel and its causes.

Results

53% of the health personnel in the hospitals were nurses, 67% were women, 70% were married, and 43% had bachelor degrees.

Of the health personnel, 74% had seen or experienced the violence applied to health personnel and explained that violence was mostly (%70) verbal, such as shouting and swearing. In addition, physicians observed or experienced the verbal and physical violence more than the others ($p < 0.01$). Besides, 59% of the health personnel who had witnessed violence stated that patients/families that applied violence were male, 48% indicated that the victims of the violence were women, and 41% stated that the victims of violence were nurses. Furthermore, 2% of the health personnel stated that they deserved the violence applied by patients/families.

Of the health personnel, 68% stated that violence stem from the health system, 58% from the patients/families, and 15% from the health personnel. System-induced violence was correlated primarily with the prolongation of waiting time for examination/outpatient (%53), patient/families-induced violence was correlated with the impatient and unsympathetic behaviors of the patients/ families (%85), and health personnel-induced violence was correlated with the insensitivity/ indifference of the health personnel (%43). However, physicians supported more that violence stem from system and the insensitivity and indifference of the health personnel ($p < 0.01$).

Conclusion

It was determined according to the views of the health personnel working at hospitals that health personnel experienced violence, especially verbal violence applied by patients/families and most of these events occurred due to the insufficiencies of the health system.

Educational Goals

1. to determine the violence applied to health personnel working at hospitals
2. to explain the causes of violence in hospitals

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Physical restraint in psychiatric inpatient care

Poster

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Background

Physical restraint has a long history of usage in psychiatry. Although it was used in very broad indications in the past, nowadays its usage is regulated legally in well-defined professional frameworks.

Aim

To determine the most common reasons for using physical restraint in psychiatric inpatients in the University Psychiatric Hospital Vrapèe.

Methods

All patients who were physically restrained during their hospitalization in the University Psychiatric Hospital Vrapèe in the period from 1st of May till 31st of July 2011 were included in the study.

Results

During the study period 106 patients were physically restrained. Schizophrenia was the most common diagnosis of physically restrained patients (48.1%). Physical aggression was the most common (39.6%) reason for physical restraint, and magnetic fasteners were most often used as restraint technique (50.0%). Decisions about restraint were made by physicians in more than half cases.

Conclusion

Physical aggression was the most common reason for physical restraint of psychiatric patients in the Psychiatric University Hospital Vrapèe.

Educational Goals

Better understanding of reasons for using physical restraint in psychiatric inpatients

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The reliability of the diagnosis set by the Checklist Risks Crisis service

Poster

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Introduction

If an unknown patient is admitted to the psychiatric emergency service it is important to know what the psychiatric state is. There is, as far as we know, little investigation after the quality of a diagnosis given in an emergency situation in mental health. Robins and colleagues suggest that the diagnosis that was given in a psychiatric emergency service in 88 % of the cases agreed with the initial diagnosis that was not known during the crisis (1). Different studies also suggest that it is possible to make a reliable diagnosis in the psychiatric emergency service (2,3). With the aid of the Checklist Risks Crisis service (=CRC) one can make an assessment of the state of the patient prior to the emergency contact (4). The aim of this study is to investigate if the CRC is a good instrument to make a reliable assessment of the state image.

Method

The participants in this study are people admitted to the psychiatric emergency service and who have not been treated (before) in the mental health. They were admitted after a crisis for an intake/ assessment and if needed treatment was given afterwards. The instrument that was used was the CRC, a Dutch screening tool. The primary aim of the instrument is to systematically assess the risks that aggression would occur in the emergency contact. For the diagnosis, the DSM-IV classification system was used, which was reported in the patients dossier and defined in the first intake/assessment. From descriptive statistics, numbers and percentages of the different state images in crisis and dossier diagnosis were defined. The Pearson Chi Square test was used to test if there is a link between the state and the dossier diagnosis.

Results

In the period between January 2009 to January 2011, 159 persons were admitted to the psychiatric emergency service, who were not in care or had not been in care before at the mental health service. 129 of these persons gave permission to use their data.

Discussion

The results show that there is strong agreement between the estimation of the state image and the diagnosis defined afterwards. With that we can cautiously conclude that the CRC is a useful instrument to estimate mental state during a psychiatric crisis.

Educational Goals

1. To have knowledge of the Checklist Risks Crisis service.
2. To know that certain state images are linked with more or less aggression in a psychiatric emergency contact

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Integrating advanced research training into higher professional development for senior psychiatrists: the Liverpool SAPROF Experience

Poster

Alina Haines, Khurram Sadiq, Fahad Javaid, Oladipupo Omodunbi, Fayyaz Khan, Rhiannah McCabe & Wahid Zaman
Liverpool, United Kingdom

Background

The University of Liverpool and their partner mental health service provider, Mersey Care NHS Trust, are currently undertaking a study examining the prospective validity of the Structured Assessment of Protective Factors for Violence (SAPROF) in acute mental health settings. This follows a completed study in 2011, which examined the concurrent validity of SAPROF. Mersey Care and other local NHS Trusts also provide clinical experience for higher trainees (pre-consultant level) in psychiatry. Many of these trainees are seeking advanced research experience as part of their overall role. An innovative collaboration was established therefore between the training network (Mersey Deanery), the University and Mersey Care NHS Trust to involve five Higher trainees in the design, implementation, analysis and write-up of a research project.

Aim

This collaboration aims to facilitate trainees to engage in research and gain first hand experience, while offering help to the research team in terms of recruitment and data collection in five different sites within three NHS trust .

Methods

The trainees work in three different NHS Trusts. Of the 5 trainees, 4 are general Adult Psychiatry trainees whereas one is getting trained in Old Age Psychiatry. Each trainee has a target of recruiting at least 30 participants.

The trainees are offered regular research supervision and training to work towards achieving the competencies required to undertake the research at their respective trusts. They have also attended courses on the use of relevant assessment tools (e.g. SAPROF, HCR-20 and Psychopathy Checklist Revised (PCL-R).

The study has two phases of Data Collection T1 and T2, baseline and 6 months later. At baseline, data from SAPROF, HCR-20 and PCL-R are collected. At the follow up, data on any incidents of violence over the preceding 6 months are collected in addition to the baseline assessments. .

Results

It was challenging as the trainees had to balance their role as a researcher as well as a clinician. It was also a challenge to find time to do the research work.

There was an inter-rater reliability exercise amongst the investigators reviewing 6 patients each.

There were initially some recruitment issues like low turn over of patients and missed outpatient appointments by the patients which were overcome by timely measures.

Conclusion:

This is the very first collaboration between University of Liverpool and Mersey Deanery. It has been a successful partnership and an exciting and a unique experience for the trainees.

The project requires a lot of co-ordination that is successfully undertaken by the SAPROF team.

Educational Goals

To share the journey of Trainees from being a Clinician to a Researcher and dealing with the challenges which arise while enacting both the roles.

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Report of a Behavioral Crisis Response Team lead by Psychiatry

Poster

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Background

Behavioral crises are sensitive and difficult incidents in hospitals. Lack of training may lead responders like security personnel to intervene using physical restraint, when, a verbal, environmental or pharmacological intervention may have been successful. Also, doctors or nurses may lack adequate training in safe physical restraint, leading to dangerous outcomes for patients and health care staff. At our tertiary care, academic, inner-city medical center we developed a behavioral Crisis Response Team. It is a 24/7 'on-call' team composed of the patient's primary nurse (who most commonly activates the CRT), a Psychiatrist, a Psychiatric nurse specialist, Psychiatric aide, and a Uniformed Public Safety Officer. We evaluated how the teams followed policy and procedure over 26 months to determine completeness of documentation, what variables influence calls or outcomes of calls (demographics, admitting diagnosis, intervention used, co-morbid psychiatric diagnosis, etc.)

Method

We did a retrospective review of operator call logs & patient records of CRT calls from June 2010 to August 2012. We studied the number of calls per day, types of disturbances, gender, age, location, number of responders, diagnoses, medication used, use of restraints and documentation of the incident.

Results

During the study period, calls to CRT were 42 (2010: 6 months), 49 (2011), & 97 (2012: 8 months) for a total of 188 calls. There was a 10% increase in calls during night shifts (7:00 PM -5:00 AM) accounting for 54.9% (n=184), compared to the day shift (45.1%). Aggression or combativeness calls were most frequent (26.4%; n=140); then, agitation (22.9%), and verbal aggression (15%). The majority of calls were for males 75.3% (n=97) and the most common age group was 31 to 50 (46.8%; n=94). Restraints were used 62% of the time (n=90); top three locations for CRT calls were Psychiatry Inpatient Unit (16%), Emergency Department (15.5%), and Neurology Stroke Unit (11.3%).

Discussion

Psychiatrists have a prominent role in resolving behavioral crises. Our calls nearly doubled since the initiation & may represent more awareness of the program and the prompt response rate of the CRT (>5 minutes). Preliminary results show missing data & point to the need for more investigation and analysis to determine if specific incident problems, diagnoses or skills of the healthcare team resulted in documentation failure. We can now target awareness and specific skill training so patients& staff can have a safer environment and health care providers feel more confident when these incidents occur.

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Universal Behavioral Precautions: A Workshop for Development of a Hospital Crisis Response Team lead by Psychiatry • Safer Team, Safer hospital for All • Using Universal Behavioral Precautions as a Consultation Liaison Psychiatrist

Workshop

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Abstract

Violence prevention and behavioral crises are among the most difficult and sensitive situations that occur in a hospital setting. Patients with delirium, (affects 15-60%[1] of hospitalized patients form drug interactions, infections, alcohol or other drug intoxication or withdrawal, head trauma, etc.), dementia, and others may act in ways that are dangerous to themselves and others. Lack of training may lead responders like security personnel to intervene using only physical restraint when, in fact, a verbal, environmental or even, pharmacological intervention may bebeen successful. Alternatively, doctors or nurses may lack sufficient training in safe physical restraint when necessary, leading to dangerous interventions for the healthcare staff and patients alike. If employees feel threatened or are unable to respond effectively to patients with an altered mental state (regardless of the cause), then patient outcomes could potentially be adversely impacted. Crisis Response Teams, often found in Psychiatric and Residential care settings,[2] offer a an interventional model of care that can prevent violence, ensure patient safety and support staff. In our setting a heightened awareness of ensuring patient and employee safety led our University Hospital Psychiatric Team to develop a Behavioral Crisis Response Team to support staff in the medical-surgical units to deal with behavioral crises. Our trained team approach provides skills and expertise used in Psychiatric inpatient units along with a Consultation Liaison Psychiatrist. We offer this workshop to provide a framework for others to adapt for their health care settings.

At the end of the workshop the participants will demonstrate knowledge of the options for dealing with behavioral crisis in the health care setting, including the intervention model.
1. At the end of the workshop the participants will demonstrate knowledge of early indicators for recognition of increased risk of violence through body language, verbal threats, etc., as signs of risk for the loss of behavioral control.
2. At the end of the workshop the participants will demonstrate knowledge de-escalation techniques.
3. At the end of the workshop the participants will demonstrate knowledge of the components of an effective Behavioral Crisis Response Team.
4. At the end of the workshop the participants will demonstrate knowledge of basic components of hands on interventions and principles for the indications for and the safe use of restraints
5. At the end of the workshop the participants will demonstrate understanding of how to approach response team development in their own institution.

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Prevalence of Violence prior to admission to an Acute Psychiatric Unit in Victoria, Australia

Poster

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Abstract

Violence to self and others may occur with psychiatric morbidity. Patients admitted to an acute psychiatric unit are likely to be very ill needing containment for their safety and that of others, and needing urgent treatment. While there is a large body of literature on both violence to others and self harm and suicidal behaviours, there appears to be little information of such behaviours before, and leading admission to hospital.

This study was of violence to others and self, in patients admitted to an acute psychiatric unit in the immediate period before admission.

The patients reported on in this study were all seen by a single psychiatrist at admission (or soon after), for treatment to an acute psychiatric unit. The decision to admit an individual was made by the local Psychiatric Crisis Assessment and Treatment Team (CATT). The assessing psychiatrist collected information from all available sources, i.e. interview with the patient, family and carers, from other services (CATT, doctors, case managers, Ambulance and Police services, etc.), and notes made by them. Violence was defined as the threat of, and actual harm, (1) to others (humans and animals) and property, and (2) self harm (suicide). (Extreme situations leading to death would not lead to admission to hospital, i.e. an acute general psychiatric ward).

Violence / self harm reported here included thoughts, hallucinations, and actual acts. Severity of such phenomena was assessed on a linear scale, 100 being extreme and caused death (and not included in this study), 70 and over being severe, and 90 would have definitely lead to death if not for intervention (often including medical). It was recorded if violence was the apparent reason for admission. Other patient characteristics such as demographic data, diagnosis, etc. were also recorded.

Over a five year period, data from 657 patients seen by the psychiatrist was available for analysis. Violence / self harm was seen in 69%. Of the latter 26% showed violence to others, 59% self harm, and 16 % showed both violence to others and self. Of those showing violence / self harm, the latter behaviours were the reason for admission to hospital in the majority. The demographic data of the individuals and the characteristics of violence / self harm will be presented in the poster.

In conclusion, there is a high prevalence of violence / self harm in those being admitted to the acute psychiatric unit. A significant proportion of these are of severe intensity and would need containment / treatment in hospital.

Educational goals

To determine the prevalence of violence / self harm in those being admitted to an acute psychiatric unit, and to determine the characteristics of the violence / self harm, and of patients.

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The prevalence of state anger and trait anger within psychiatric outpatients

Poster

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Abstract

Anger is a clinically relevant emotion. Within individuals with social anxiety disorder anger is associated with less satisfaction about their cognitive behavioral treatment and with premature termination from treatment (Erwin, Heimberg, Schneider, & Liebowitz, 2003). Similarly, patients meeting criteria for Post-Traumatic Stress Disorder with high levels of anger before treatment benefited less from exposure therapy. Furthermore, anger presumably interferes with common therapy factors, such as a strong therapeutic alliance (DiGiuseppe & Tafrate, 2010), motivation in treatment, resistance to change and less collaboration in goal setting (Hubble, Duncan, & Miller, 2004). Therefore, it may be valuable to enquire about anger difficulties in patients. This poster presents information about the prevalence of anger in psychiatric outpatients. Implications for therapy will be discussed.

Educational goals

- It is important that clinicians routinely screen for the presence of dysfunctional anger given its high prevalence
- Clinicians might benefit from treating anger on a symptomatic basis

Literature

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Chapter 12 – Race, gender & ethnicity perspectives

Psychopathy in women: Results from a Dutch multicentre study into risk factors of female forensic patients

Poster

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Abstract

The assessment of psychopathy in female forensic psychiatric patients is still a relatively unexplored area. A number of reviews have been published on the use of the Psychopathy Checklist-revised (PCL-R; Hare, 2003) in female samples (Logan, 2009; Nicholls et al., 2005; Vitale & Newman, 2001). In general, a lower prevalence of psychopathy among women compared to men was found, as well as lower scores on the PCL-R. Good support was found for the reliability of the PCL-R in women, but only modest support for its predictive validity. It can be concluded from the reviews that there is considerable evidence that psychopathy is an important risk factor for violence in women, but that the effect is not as strong as it is for men.

In this poster, we will reflect on psychopathy in women and present results from a Dutch multicentre study. In 2012, a retrospective study was started into violence risk factors of female forensic psychiatric patients. The PCL-R, as well as several risk assessment tools and an extensive list of criminal, demographic, psychiatric and treatment characteristics were coded based on file information of 310 women who are - or have been admitted to four different forensic psychiatric facilities in the Netherlands. Comparison will be made between women scoring low (0-13), moderate (14-23) or high on psychopathy (24-40) on several criminal, demographic and psychiatric characteristics, including victimization, diagnoses, and incidents during treatment. For all female patients who have been discharged with a follow up time of minimum three years living in society, PCL-R codings will be related to recidivism data in order to examine predictive validity of the PCL-R for women. Furthermore, for a subgroup of female patients, PCL-R codings will be compared to those of a matched male sample. Finally, suggestions will be provided with respect to the gender-sensitive assessment of psychopathy in women.

Educational Goals

1. Learn more about psychopathy in women
2. Learn more about violence risk factors of female forensic psychiatric patients

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Chapter 13 – Service users and family perspectives

The construction of the cooperation system about the support for victims suffered from domestic violence by their husbands: With action research for supporters

Poster

Yuko Yasuda
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Introduction

Mothers and children who experience DV are plagued with fear and anxiety on a daily basis, and are driven into psychological and social isolation devoid of options. Therefore, it becomes necessary to provide victims with psychological and social resources in their daily lives that prevent them from becoming isolated and enable them to recover their dignity while providing them with official protection through a framework of social systems. In order to do so, there is a need to unite macro frameworks in the form of law and institutions with micro practice in the form of substantial support. In other words, what is important here are perspectives drawn from collaborative frameworks consisting of professionals from different fields.

Aims

The first aim is to clarify the kinds of activities that private support groups relating to DV have been continuing to put into practice in different areas, as well as how collaborative networks have been set up between related bodies and groups from both inside and outside prefectures. The second aim is to examine the current situation surrounding collaborations relating to DV support between different professionals, such as on-site support workers (welfare/psychology) and lawyers (judicature), as well as the potential for further developing collaborations in the future.

Method

I Interviewed with two study cooperators.
Period was June 2012 - January 2013. Participants were 7 private support groups and 1 female lawyer. Content was the interviews focused on the following items: 1. Content of victim support at the stage of recovery (support for mothers, children and families (mother and children)); 2. Initiatives to bring victims of DV together; 3. Difficulties facing support workers and organizations in the course of providing ongoing DV support and solutions/measures to deal with these; 4. The current situation of and future prospects for collaborative networks consisting of other related bodies and groups from both inside and outside prefectures along with persons connected with judicial matters, such as lawyers, and local governments.

Results and Discussion

Private support groups take a range of forms, from connections and support provided through a national organization called the National Women's Shelter Network, to such things as allocating telephone consultations, dispatching instructors, and sharing knowledge. Collaboration with public bodies (local government and the police) is carried out through such things as dispatching instructors, the joint implementation of programs, and the provision of subsidies or outsourcing. Also, they have networks in place with lawyers that allow them to consult with lawyers when experiencing difficulties in the course of

providing direct support while building collaborative relations and making referrals to each other as the need arises.

Educational Goals

Collaboration between on-site support workers (welfare/psychology) and lawyers (judicature/jurisprudence)

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Describing The Positive Patient Care Experience within a Forensic HDU Rehabilitation Ward by using an Electronic Patient Feedback System

Poster

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Abstract

One of the four key themes for all NHS organisations during 2012/13 was to increase the pace on delivery of the quality, innovation, productivity and prevention (QIPP) challenge. The NHS Operating Framework aims to produce a greater focus on outcomes in future years and respond to the QIPP challenge. The framework puts patients at the centre of decision making with their experience of health and supporting care services a major motivation for further improvements in clinical care. In relation to patient feedback, NICE guidelines advocate 'using the views of service users to monitor and improve services'. One of the CQC standards states that patents 'should expect to be respected, involved in your care and support, and told what's happening at every stage'. Identifying positive and negative aspects of the patient experience can influence health outcomes, which in turn has an impact upon their rehabilitation, recovery and social inclusion.

Aim

To conduct a survey of patient care experience by employing an electronic patient feedback system and make recommendations for future use within the regional forensic service.

Results

Allowing the patient to feedback their experience of care on a busy forensic HDU with the use of the Meridian Desktop indicated that over 77% express satisfaction with the service provided. Of those patients who provided their opinion, all felt comfortable about making a complaint and having had their care plan discussed with them. Trend maps indicated that this satisfaction remained constant on a monthly basis. The greatest discomfort was felt by 39% of patients who were concerned that their privacy and personal information were being compromised by clinical staff. In addition over 35% of patients raised concerns over being able to contact staff if they need to do so.

Recommendations for future use of electronic patient feedback system:
- Development of an implementation strategy and action plan to facilitate service wide use of electronic feedback system including introduction of a protocol.
- Establishment and consolidation of local governance arrangements
- Agreement of effective and relevant mechanisms for communication and higher level reporting on implementation and impact on patient experience
- Creation of a Project Board to provide leadership, oversight, monitoring and future audit to ensure service improvement within Trust services.
- Such a Project Board to be accountable to the Trust Management Team.

Educational Goals

1. Service user feedback as a means to promoting cognitive ability.
2. The improvement of the patient experience in the attainment of better long-term health outcomes.

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Systemic and family psychotherapeutic contributions in a forensic psychiatric ward for rehabilitation

Poster

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Abstract

Hegoa is a forensic psychiatric ward in the Centre Hospitalier Jean-Titeca, Brussels. Our intention is to rehabilitate psychotic people who have been found "not guilty by reason of insanity". In Belgium, these people are placed in a psychiatric ward of a prison. Our project tries to help these individuals out of prison back to society through a 1.5-year psychiatric hospitalization. The way we understand the historicity of this medical and legal status is through a relational break forcing the individual to "offend" in order to restore his or her sense of security. At a certain point, the individual with his psychotic structure is incapable of accommodating himself within legal boundaries and this coerces the subject into (often violent) offends. Our aim is to restore psychological and interpersonal functioning and balance through our multidisciplinary team. Our team is composed of psychiatrists, individual and family psychologists/ psychotherapists, a criminolo gist, psychiatric nurses, an occupational therapist, a social worker, and a physiotherapist. Each patient is followed by one member of each discipline throughout his stay.

These individuals' acts took them out of the social life. We meet them at a life stage where they are confronted with a range of belonging needs. Our work aims to reopen the belongings field (family, cultural, relational, and professional) and to make them true actor of their relationships in order to allow them developing a more complex identity, not confining them to offenders or to a mentally ill.

At first, we aspire to establish an individual's social network map, which helps us to become acquainted with any third person that matters for the patient. This map can also serve as an invitation for systemic therapy.

Afterwards, the patient nurse and the systemic therapist attempt to meet the patient and his important others. Our aim is to try to understand which relational issues are at stake and how they emerge. Our approach is founded on Ausloos' "split co-therapy" who allows each speaker to keep his specificity, thus allowing coexistence of several vantage points. The systemic therapist focuses on the system functioning whereas the patient's nurse will help the patient to demarcate him.

In some cases, patients are only to rely on broader institutional caregiving. In these cases, we strive to develop alternative bonds with (rehabilitative) networks. The key idea is to rehabilitate relationally in order to prevent relapse (and thus reoffending). Therefore, practical outpatient continuity of relation is crucial.

Educational Goals

Systemic psychotherapeutic contributions in a forensic psychiatric ward

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Accumulated coercive events (ACEs) and quality of life after admission to psychiatric hospital

Poster

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Background

Coercion is a complex construct, as it encapsulates the level of perceived coercion and the use of physical coercive measures such as restraint and seclusion. Furthermore, individuals can experience a single episode of coercion or multiple episodes throughout their admission. Therefore, measuring accumulated coercive events (ACEs) gives a more accurate account of the extent of coercion experienced during psychiatric admission. In addition, there is a concern that the experience of coercion can influence the longer term outcome for individuals. Despite the importance of this issue, there has been limited research on quality of life after the experience of psychiatric admission and coercion.

Aims

We aimed to determine:
1. The level of ACE's experienced by individuals during admission
2. Demographic and clinical characteristics associated with ACEs
3. Objective and subjective quality of life one year after discharge
4. Whether ACEs are associated with objective and subjective quality of life

Methods

Design: Prospective cohort study
Sample: Voluntarily and involuntarily admitted inpatients from three psychiatric hospitals in Ireland
Measures: Baseline: SCID, MacArthur Perceived Coercion Scale, Birchwood Insight Scale and information from clinical file about coercive interventions
Follow up at one year: MANSA - Manchester Short Assessment of Quality of Life, Objective Social Outcomes Index
Analysis: Univariate, bivariate and multivariate

Results

Of the 162 individuals included in the study, 65% were male, 46% had a diagnosis of a psychotic disorder and 49% were involuntarily admitted. A total of 68% of individuals experienced at least one coercive event. Individuals with a psychotic disorder, lower functioning, less insight and more positive or manic symptoms experienced more coercive events during admission.

After one year, the mean objective and subjective quality of life scores were both 60% of the highest possible scores. Lower levels of depressive symptoms and less hopelessness were associated with higher subjective quality of life one year after discharge. Individuals who experienced more coercive events during admission were more likely to live in supported accommodation one year after discharge. However, accumulated coercive events during admission were not associated with overall objective and subjective quality of life one year later.

Conclusion

The experience of coercion is unfortunately common in hospital admission, whether voluntary or involuntary. However, it does not appear to influence either subjective or objective quality in the year following discharge.

Educational Goals

1. Understand the complexities of the experience of coercion on admission
2. Understand the longer term consequences of coercion on quality of life

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Chapter 14 – Sexual offending & aggression

To Tell or not to Tell

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Abstract

The underreporting of rape is well known, however there is less information on women who fail to disclose their experience to anyone. This online study suggests that 24% of 242 women who were non-disclosing compared to those who had disclosed were significantly less likely to seek treatment for emotional injuries. Also, almost two-thirds of non-disclosing women believed the abuse was their fault versus 39.1% of women with prior disclosure. Of clinical interest is that regardless of disclosure pattern, there was no significant difference in reports of depression, anxiety or PTSD and the majority of respondents endorsed support for online counseling over telephone or individual contact.

Background

For centuries, rape thrived on prudery and silence. The silence lifted when consciousness-raising groups (CR) became the major organizing tool of the re-emergence of the women's rights movement in the late 1960s. These CR groups involved informal groups of women discussing their experiences with incest, child, adolescent and adult rape. Prior to that time, women who disclosed a sexual assault to law enforcement risked censure, scorn, indifference, or loss of credibility [1].

Early published evidence by Smith, Letourneau, Saunders, Kilpatrick, Resnick, & Best, (2000) indicated restricted disclosure of women who reported being raped. Smith and colleagues gathered representative data from 3,220 Wave II respondents from the National Women's Study telephone survey regarding the length of time women who were raped before age 18 delayed disclosure, to whom they disclosed, and variables that predicted disclosure. There were 288 women who reported at least one rape prior to their 18th birthday. Fully 28% of child rape victims reported that they had never told anyone about their child rape prior to the research interview and 47% did not disclose for over 5 years post rape. Close friends were the most common confidants. Younger age at the time of rape, family relationship with the perpetrator, and experiencing a series of rapes were associated with disclosure longer than one month. Shorter delays were associated with stranger rapes. Logistic regression revealed that the age at rape and knowing the perpetrator were independently predictive of delayed disclosure.

Relevant to these findings, Fisher et al. (2003) identified key factors that contributed to rape reporting included the impact of self-blame, the seriousness of the incidents, type of victim-offender relationships, certain victim characteristics (e.g., age, income level, education level, race, etc.), and the contextual characteristics of the crimes.

Starzynski et al (2005) emphasized that deciding who to tell about sexual assault is an important and potentially consequential decision for sexual assault survivors A diverse sample of adult sexual assault survivors in the Chicago area was surveyed about sexual assault experiences, social reactions received when disclosing assault to others, attributions of blame, coping strategies, and PTSD. Women disclosing to both formal and informal support sources experienced more stereotypical assaults, had more PTSD symptoms, engaged in less behavioral self-blame, and received more negative social reactions than those disclosing to informal support sources only.

Research shows that survivors with lower levels of posttraumatic stress or depressive symptoms are less likely to seek help from formal social systems (Lewis et al., 2005; Starzynski, et al, 2005). In addition, survivors who blamed themselves for causing the rape were less likely to disclose the rape to formal social systems [2]. Although studies have shown that survivors with less severe psychological symptomatology are less likely to seek assistance, it is still unclear what prevents these survivors from seeking help.

In a mail survey with 155 respondents studying how social reaction to rape disclosure affects sexual assault victims, Ullman (1996) found negative social reactions were strongly associated with increased psychological symptoms, while most positive social reactions were unrelated to adjustment [3]. The only social reactions related to better adjustment were being believed and being listened to by others.

Wolitzky-Taylor et al (2011) interviewed a national sample of 2,000 college women about rape experiences in 2006 and found Only 11.5% of college women in the sample reported their most recent/only rape experience to authorities, with only 2.7% of rapes involving drugs and/or alcohol reported [4]. Minority status (i.e, nonwhite race) was associated with lower likelihood of reporting, whereas sustaining injuries during the rape was associated with increased likelihood of reporting.

Currently, there is developing published evidence on rape reporting and disclosure. Using a prospective study to identify predictors of sexual assault disclosure, Orchowski and Gidycz (2012) examined the responses of 374 support providers and learned women most often disclosed a sexual assault to a female peer supporting the findings over 10 years ago by Smith et al. (2000).

Despite the feminist movement of the 1970s, which marked the beginning of the era of rape reform in the United States, to fast-forward to 2013, two findings that affect a victim's mental health have not changed. First, sexual assault remains the most widely underreported violent crime and second, victims typically do not seek help after coercive sexual encounters [5,6].

Second, statistics from the National Violence Against Women Survey (NVAWS) indicate that only 19.1 % of the women and 12.9% of the men who were raped since their 18th birthday reported their rape to the police [7]. Indeed, the underreporting of sexual assault persists in bearing the infamous label of "the hidden crime," and poses serious problems on an individual and societal level [8].

Parallel with the incidence of rape being far more extensive than reported in official statistics is the fact that the large majority of rapists are never apprehended. In 2007, there were 90,427 incidents of rape reported to law enforcement that resulted in only 23,307 arrests (FBI, 2008) or 25.8% of reported cases [9] Victimization data show a higher number of rapes and sexual assaults—191,670 [10], which means that potentially more than half of rapes and sexual assaults go unreported (and therefore unpunished) to law enforcement [5]. Clearly the vast majority of rapists are never brought to justice as FBI clearance rates for rape averages about 50% per year.

From a public policy perspective, official estimates of the incidence and prevalence of sexual assault that are used for planning program initiatives are likely underestimated; therefore, individuals and areas that are at high risk for sexual assault are likely failing to receive adequate attention. In addition, the failure to report precludes the arrest of offenders, which limits the degree to which the criminal justice system can serve as a deterrent to sexual assault crimes [5].

Rape and Self-Disclosure-Keeping a Secret with Silence

From an individual perspective, Gaffney's review of studies (2011) notes that sexual coercion can cause a variety of mental health problems. The issue of self-disclosure – that information about oneself that a person is willing to reveal to others – is an important area of clinical inquiry. Rape traditionally has not been a socially acceptable issue for disclosure. In decades past it has been often seen as something that lessened the worth of the victim and that was the victim's fault. Thus, Irving Goffman's classic analysis of stigma and the management of spoiled identity is particularly useful in analyzing the disclosure of a rape. Goffman (1963:3) uses the term stigma to indicate "an attribute that is deeply discrediting" in a certain social context [11]. Goffman distinguishes between cases where the stigma is known to others already or evident immediately (the individual is discredited), and cases where the stigma is not known by others and not immediately perceivable (the individual is discreditable). As Goffman states, when an individual's "differentness is not immediately apparent, and is not known beforehand. . . then . . .the issue is. . . that of managing information about his failing. To tell or not to tell; to display or not to display; to let on or not to let on; to lie or not to lie; and in each case, to whom, how, when, and where." The issue becomes "the management of undisclosed discrediting information about self" (p.42).

Secrets, especially those involving incest, rape, and abortion, are closely aligned with non-disclosure. Georg Simmel defines secrets, as "consciously willed concealment" (1906:449) that involve a tension that when revealed breaks its power that can result in positive or negative outcome [12]. Secrecy sets barriers. A secret disclosed may advance to betrayal. Simmel describes a secret being surrounded by temptation and possibility of betrayal; and the external danger of being discovered is interwoven with the internal danger of giving oneself away (Simmel, 1950:334). As long as the rape remains cloaked in secrecy, the victim only has to manage that information internally; once the rape is disclosed, the victim has to manage the external reactions.

Jack (1991, 1999) and Jack and Ali (2010) describe the phenomenon of "silencing the self" as a behavior common to women where information is withheld in the context of all types of relationships [13-15]. Whether a relationship is experienced with violence or through rape or without these experiences, Jack contends through her Theory of Silencing the Self women do not share certain thoughts, or feelings that would contradict what others expect of them because it jeopardizes relationships with others and how they are "seen". Congruent with the social stigma that surrounds disclosure, women avoid conflict and silence their voice which often leads to a loss of self as well as feelings of shame and anger. Ironically, avoiding conflict and abiding by societal expectations are found to be protective and normative in many cultures and yet Jack (1991) found in her original work that the very secret or silence kept was strongly correlated with clinical depression [13].

Jack and Dill (1992) identified four particular sub-concepts of silencing the self-behaviors from the qualitative analyses of data she collected through a large longitudinal study that included conversations with women talking about their lives and depression [16]. The four self-silencing sub-concepts/behaviors are called (a) Silencing the Self, (b) the Divided Self, (c) Care as Self-Sacrifice, and (d) the Externalized Self. The first sub-concept/sub-scale, Silencing the Self, for which the theory was named described how women often do not ask directly for what they need or tell others what they are feeling. The second sub-concept/sub-scale, the Divided Self, described how women present a compliant exterior to the public when they actually feel hostile and angry. The third sub-concept/sub-scale, Care as Self-Sacrifice, described how women put the feelings and needs of another before their own. The fourth sub-concept/sub-scale, the Externalized Self, described how women judge themselves by external standards . In the end, the "self" for women is focused in a context of others needs and it is the "self-in-relation" that drives behavior choices to disclose or not to disclose [13,17].

The issue of rape disclosure and moving away from silencing one's voice has psychosocial and clinical importance. One model of rape counseling is to encourage clients to report and talk to members of their social network as support for experiencing a stressful situation. The dilemma, however, is that the decision to tell or not to tell someone about a rape tends to be a difficult one and many women will experience decisional conflict that is related to the uncertainty regarding outcomes that will result from the choice. Regret of disclosure emerges as a potential outcome [18]. Not to disclose can be viewed as self-protective as the individual has control of the information and preserves relationships without conflict [13]. Telling others dilutes the control.

We were interested in studying patterns of rape disclosure as basic to assessing coping and adaptation to a traumatic event. This paper presents data from a larger rape study with the intent to provide specific implications for counseling victims regarding disclosure of the information. Thus, the research questions for this study were: a) What was the pattern of disclosure for rape using an anonymous web-based survey?; b) What was the symptom response based on whether the respondent had disclosed prior to the survey or disclosed at time of survey?; and, c) What type of follow-up was preferred by respondents?

Methods

Design
This study utilized a descriptive cross-sectional design. Participants completed the study via REDCap Survey, a web-based, online survey tool. Online surveys have been established as an effective means of obtaining a large sample of rape victims [19,20].

Setting
Data was collected via an online survey. A web-based procedure was chosen as it has several benefits. First, the use of a web-based survey has been established as an effective means of obtaining a large sample of rape victims [19,20]. Further, the use of an online study allows for elimination of missing data by prompting participants to address non-completed items. Finally, this methodology was selected because it offers participants the ability to complete study instruments at their convenience, offers privacy and confidentiality at the time of participation, and affords the participant an opportunity for safe disclosure.

A script was available online as soon as the participant accessed the study link via REDCap Survey. Potential participants were screened online. Once an exclusion criterion was met, no other information was gathered. If deemed eligible, the subjects were provided with informed consent. After they read and acknowledged understanding by answering three questions covering material contained within the consent, the participant was allowed to proceed to access the study packet online. All information was collected via participant self-report. Participants were allowed to save responses online and return to finish the packet at their convenience. If the participant elected to log off and log back on to complete the study packet, the first screen reiterated the fact that nobody would be able to contact them for any reason. All data collected from participants were kept online.

Questions were created by the principal investigator to determine whether the participant had previously (before answering this survey) disclosed that they had an unwanted sexual experience (completed rape), to whom they disclosed if they affirmed disclosure, and their preferences for follow-up. The questions relative to prior disclosure were contained in the beginning of the survey and were as follows: 1) Is this the first time you are disclosing that you had an unwanted sexual experience? Yes/No; 2) If you have told one or more people about this incident, whom did you tell? Please check all that apply; 3) If you checked "other" above, please fill in the relationship you have with the person you told about the most recent incident of unwanted sexual contact. Please do not put in a personal name, but only identify your relationship with that person. Branching logic was employed so that participants would only see questions 2 and 3 if they answered "No" to question number 1. The question relative to follow-up preferences was contained toward the end of the survey and stated: For experiences such as the one I had, I feel more comfortable disclosing the situation: a) online anonymously with no way for anyone to re-contact me; b) online with a way that someone could follow-up with me in the future; c) in person face-to-face; d) on the telephone anonymously with no way for anyone to re-contact me; and, e) on the telephone with a way that someone could follow-up with me in the future.

Sample
This study included a convenience sample of 242 adult female victims of completed rape drawn from the population of females aged 18-64 in the United States and internationally. The subjects recruited into the study met the following inclusion criteria: (1) between the ages of 18-64; (2) $\leq$ 5 years since their most recent incident of rape; (3) ability to understand English; (4) no recent report of psychosis; (5) the ability to complete study instruments; and, (6) female gender. Individuals were excluded if they met the following exclusion criteria: (1) most recent incidence of rape happened while participant was < 18 years of age (2) unable to understand the informed consent as evidenced by incorrectly answering three (3) questions designed to determine understanding content of the study. Determination of an incidence of rape for inclusion was screened for using the Sexual Experiences Scale Short Form Victimization [21,22].

The sample was recruited in a variety of ways. First, recruitment was accomplished using email messages inviting participation in the survey. Emails were sent out through ResearchMatch as part of an opt in list of individuals who had previously given their contact information for that purpose, as well via the clinical trials registry maintained by the sponsoring University. A description of the study along with a link was provided in the email. This link led to the dedicated study website, specifically designed to provide comprehensive information on the study, a toll free telephone number to contact a live person if the potential participant so chose, and a link that would provide direct access into the study itself. Responses went directly into the REDCap survey system, designed and maintained by Vanderbilt University. This provided a tracking mechanism for responses, prevented the release of any information and/or data to an outside server, and increased response rates.

Additional methods included: informative advertisements placed on national screening and online support websites, and in domestic violence shelters, rape crisis centers, offices of psychiatrists, and psychotherapists, local emergency room departments, primary care office lobbies, and public venues such as college bulletin boards, grocery stores, bathroom stalls, libraries, social media sites such as Facebook, and police departments. Other techniques included posting informative public service announcements on local radio channels, and direct marketing of the study online to organizations in which the principal investigator is affiliated. Specialist health care providers, home health agencies, church groups, and support groups may also have referred participants to the study based on flyers supplied to their organizations.

Strategies to enhance participant recruitment and retention included ensuring anonymity, with no way to link any participant to any particular response, and the ability to complete the study packet in more than one sitting. All information was collected via participant self-report and IRB approval was given by a local University. Participants were allowed to save responses online and return to finish the packet at their convenience. All data collected from participants were kept online. Answers to survey questions determined whether the participant had previously (before answering this survey) disclosed that they had

an unwanted sexual experience, to which they disclosed if they affirmed disclosure, and their preferences for follow-up were posed. Branching logic was employed so that participants would only see questions 2 and 3 if they answered "No" to question number 1. Also used in this data analysis were questions related to current mental health and 3 standard measurement tests for anxiety (State Trait Anxiety Inventory -trait portion only), depression (BDI-II), and PTSD (PDS). Participants were also asked questions related to their insurance status at the time of their most recent assault, and questions related to medications they currently take for anxiety, depression or sleep disturbance. There was no compensation for study completion. A total of 384 completed the study consent form and at least some portion of the study. Of those, 242 (63%) completed all of the study instruments sufficiently for inclusion in the analysis of the research questions. There were no statistically significant differences between the completers and non-completers on any demographic factor.

The 242 participants ranged from 18 to 56 years in age with a median age of 27 years (25th-75th IQR: 23.8/33.3). The sample was primarily Caucasian (n = 218, 90%), with the remaining identifying themselves as African American (n = 18, 7%), or other (n = 6, 3%). The majority of the sample reported being single/ not partnered (n = 185, 76%). Participants lived in all regions of the United States; Northeast (n = 41, 17%), Southeast (n = 18, 8%), Midwest (n = 40, 17%), South (n = 97, 41%), and West (n = 20, 9%) with 9% reporting living outside the U.S. (n = 20). Although the majority of the sample was well-educated, and reported having at least a Bachelor's (n = 100, 41%), or Master's degree (n = 54, 23%), they were less affluent, with 70% of the sample reporting incomes of $60,000 or less (range <$25,000 to >$100,000). The majority of the sample (n = 171, 71%) reported having no children, or having any religious preference (n = 146, 60%). Those reporting having non- governmental health insurance (POS, PPO, HMO) was slightly higher (n = 143, 59%), than those having insurance that was government subsidized (Medicaid, Medicare, MediCal) (n = 99, 41%). The majority of the sample (96%) denied living with their abuser (n = 232).

Analysis
Frequency distributions summarized the number of participants who reported non- disclosure before the survey and those who had disclosed prior to the survey. Cross tabulations were constructed to determine the percentages of individuals who affirmed first time disclosure with reporting of follow-up preferences. Chi square Test of Independence was used to test for differences in the distributions.

Findings
The demographic characteristics of those citing first-time disclosure and those reporting having disclosed previously are summarized in Table 1. Statistically significant differences between the two groups were observed in ages of the participants and presence of children. A higher proportion of those stating first time disclosure reported having children (n = 24 of 58, 41%) than in the group citing prior disclosure (n = 47 of 137, 34%). Those who admitted to first time disclosure were, on average older than those who cited previously disclosing. While not statistically significant (p=.055), within the group citing first-time disclosure approximately half (n = 30 of 58, 51.7%) reported having some form of governmental subsidized insurance while a considerably smaller respective proportion (n = 69 of 184, 37.5%) was seen in the group citing prior disclosure.

There were no statistically significant differences between the first-time and non-first-time responders in terms of type of unwanted experience, nor for relationship between the perpetrator and victim. See Table 2. Finally, there was no statistically significant difference between the responder groups in terms of type of follow-up preferred (p = .153). The majority of participants, both those that had previously disclosed (n = 123, 70.3%), and those who admitted to first time disclosure (n = 46, 79.3%) reported they preferred online follow-up to both the face-to-face and telephone options (Table 3).

Post-Hoc Analysis of Disclosure Groups
Current use of medication for depression, anxiety and sleep for those who had previously disclosed and those who had not are summarized in Table 4. There were no statistically significant differences in the rates of use of the types of medication between the groups.

Follow-up with providers for physical and emotional injuries was evaluated for those who had previously disclosed and those who had not (summaries in Table 5). Results indicated that there was a statistically significant difference between the groups in rates of seeking treatment for emotional injuries with both medical providers (p = .003), and non-medical therapist/counselors (p <.001) In both cases, a higher proportion of those admitting to first time disclosure reported never seeking treatment for emotional injuries from medical provider (52 of 58, 90%) or a therapist/counselor (46 of 58, 79%) than those who had previously disclosed (65% and 42% respectively). The overwhelming majority of those citing first time disclosure (n = 46, 70.3%), cited they had never seen a non-medical therapist/counselor for emotional injuries, whereas the majority (57.8%) of those citing prior disclosure reported seeing a therapist/counselor

more than five times. As expected, given that one group cited no prior disclosure, there was a statistically significant difference in reporting the assault to police.

The difference in the rates of feeling good about oneself between the groups was not statistically significant (45% vs. 54%), yet there were statistically significant differences in the reported belief that the abuse was their fault with 63.8% of those reporting first-time disclosure believing the abuse was their fault versus 39.1% of those with prior disclosure (Table 6). Further analysis was completed to determine whether differences exist in rape trauma presentation/ symptomatology (depression, anxiety) and diagnosis of PTSD among women who have and have- not disclosed the event. Descriptive summaries of the two groups is presented in Table 7. There were no statistically significant differences between the groups in terms of depression (p = .466), or anxiety (p = .465) (Table 7). In addition, there were similar proportions of those who met the criteria for a diagnosis of PTSD (p = .481) within each of the groups (Table 8).

Most respondents (76%) in this study had disclosed an unwanted sexual experience that happened within the previous five years. Of clinical interest, however, 24% had never disclosed until asked on this survey. Of the 184 who had previously disclosed, persons told included friends, medical professionals, family members, spouse or partner, police, co-workers, clergy, academic staff, domestic violence, rape crisis and hot line staff, with one woman disclosing to a local newspaper.

Discussion

The decisional conflict around disclosing a rape either to others or to police has a long history. That almost a quarter (24.5%) of this sample reported to police is closer to the 19% suggested by Tjaden & Thoennes (2006), but less than the 47% reported by Catalano et al., (2009) [7,23].

Not only is rape a seriously underreported crime, it is also an undertreated crime. Only a small number of women seek treatment with one-fifth or 21% who sought treatment from a medical provider for an emotional injury, and almost half (49%) from a counselor or therapist. This pattern is somewhat lower than Amstadter and colleagues (2008), who reported that 38% sought treatment from a medical professional, and 54% from a mental health specialist 24. Medication use in our study was low in contrast to Smith et al. (2005) who reported that visits to providers to obtain prescriptions for anti-depressants rose dramatically between 1995-1996 from 13.8 visits to 35.5 visits [25]. Plichta and Falik (2001) cite a significant relationship between intimate partner violence and taking medication for depression and anxiety [26]. We found almost identical rates of those reporting crimes in this study perpetrated by an intimate partner (n = 97) and non-intimate known (n = 106). There were significantly less reported incidents by a stranger in this sample (n = 40). This finding agrees with most prior studies [7,19,20,26-28], but disagrees with findings by other researchers [29,30], where about half of participants were found to have been raped by a stranger.

There were 30% (n=74) of the women in our study who reported taking anti-depressant medication with 25% (n=61) taking medication for anxiety, and 24% (n=57) for sleep. These findings could be due to the low rate of treatment for emotional injuries. However, almost half (48%) report that they do not feel good about themselves since their most recent abuse incident, and 45% said they feel the most recent incident of abuse was their fault. This pattern is consistent with other studies specific to rape, citing self-blame as significantly related to psychological distress [29,31,32].

There are several limitations that are noteworthy. First, the sample did not use random sampling and was comprised of a convenience sample of adult participants who self-reported one or more incidents of rape within the past five years. This approach limits generalizability of the study to those participants who were aware of the study based on the limited recruitment mechanisms employed decided to participate, and the findings cannot necessarily be generalized to survivors of other possible traumatic experiences. Second, this study was a cross-sectional design, and therefore no causal inferences can be made. Third, the instruments used in this study were not necessarily specific to rape and thus may have more limited ability to assess certain symptoms or outcomes specific to an experience of rape such as fear of sexual contact. Another example exists related to the measure of PTSD. Although this measure mentions the concept of rape as one possible traumatic experience, it cannot be determined by virtue of the questionnaire if the diagnosis of PTSD is solely or most significantly related to the rape experience. Furthermore, the measure of PTSD was distinctly different than the measures of depression and anxiety in that the measure of PTSD did not measure the continuum of symptoms. It is likely that more and stronger associations would have been found if the measure had allowed for measurement on a continuum. Fourth, the preference for online follow-up (as opposed to face-to-face or telephone) may be an artifact of the chosen methodology. That is to say, women more likely to self-select for participation in an online study regarding sexual experiences and disclosure may also be more likely to (a) be frequent internet users and (b) prefer e-based communication. Finally, this study did not ask individuals the reason they chose to disclose to certain

persons. Ullman & Filipas (2001) study on 323 sexual assault victims reported that telling more persons about the assault was related to more negative and positive reactions. Given the equivocal findings, it is strongly recommended that this question be asked for future research.

Rape-Related Dymamics

Carter-Snell & Jakubec's (2013) conducted an in-depth analysis of 100 data-based articles (out of a total 2,116) on interpersonal violence to determine the relative impact of selected risk and resiliency factors pertaining to mental health impacts [33]. Since mental health counselors can do little about risk factors after the assault (e.g., severity of violence, prior trauma), our focus is on secondary prevention and identification of resilience factors.

Our study found that irrespective of disclosure, victims of rape do not readily seek treatment for psychological or symptom remediation when we know that silencing themselves in addition to the experience of trauma is highly correlated with clinical depression [13,15]. In trying to explain this lack of victim help-seeking behavior, several researchers have put forth suggestions. Koss (1994) posited that interviewer effects and other factors such as others overhearing an interview may be responsible for victims' unwillingness to disclose [34]. Campbell, Dworkin, and Cabral (2009) focus on the negative mental health effects of rape instead of the recovery aspect, and consider the role of personality characteristics, preexisting mental health conditions, biological/genetic factors, use of force and/or threats, and substance use not examined in previous models [35]. Campbell and associates (2001) and Ledray (1998) suggest the avoidance of treatment could be due to fear that counseling could result in a) further incidence of abuse (e.g. perpetrator becomes aware that victim is disclosing), or b) result in re traumatization based on having to recount the story over and over again (e.g. to multiple medical practitioners, law enforcement) [36,37]. Jack (1991) would support the notion that women in violent and non-violent situations struggle to be direct, open, and honest with what they need and feel because of the more dangerous feeling of losing relationships with others if they did so [13].

The researchers argue that the impact of disclosure by using their autonomous voice is integral to victims' post-assault psychological healing, and that should victims of rape blame themselves, they may not disclose the event to anyone. They continue to suggest, as does Kilpatrick et al., (1992), that failure to disclose is probably resulting in inadequate treatment and that failure to disclose then denies them opportunities for support [38].

A major finding in this study was the importance of self-blame as diagnostic of the non-disclosing group. Self-blame reflects a psychosocial mechanism of self-criticism and low self-evaluation in which the individual accepts personal responsibility for negative events. Janoff-Bulman's (1979) classic study of self-blame in rape victims distinguishes 2 types of self-blame—behavioral and characterological [39]. Behavioral self-blame is control related, involves attributions to a modifiable source (one's behavior), and is associated with a belief in the future avoidance of a negative outcome. Characterological self-blame is esteem related, involves attributions to a relatively nonmodifiable source (one's character), and is associated with a belief in personal deservingness for past negative outcomes. Self-blame is another way of translating Jack and Dill's (1992) findings that women often put others before themselves (care as self-sacrafice) [16]. In her study of 38 rape crisis centers, behavioral self-blame, and not characterological self-blame, emerged as the most common response of rape victims to their victimization, suggesting the victim's desire to maintain a belief in control, particularly the belief in the future avoidability of rape.

Given that our study found the percentages of those with and without PTSD in both the disclosure and non-disclosure groups were almost identical, we suggest attention be given to the power of self-blame, secrecy and non-disclosure as self-protective mechanisms. The lack of significant differences between the disclosure groups, suggests that rape trauma is present irrespective of disclosure, and that disclosure in itself is not cathartic to the point that rape survivors experience symptom remission. But, self-blame appears to be an incapacitating factor in the recovery process. This self-blame finding could be attributed to the fact that those who have previously disclosed may have sought professional treatment and thus, may have worked toward resolution of self-blame.

Implications for Practice

Carter-Snell & Jubenec (2013) argue that effective secondary prevention of adverse mental health consequences following rape depends upon the identification of resilience factors [33]. This would allow the professionals to draw on these strengths to promote the client, and to shape interventions in a manner informed by evidence. An example would be to help the individual to reframe events to reduce self-blame, or to identify individuals or agencies that may provide positive reactions and supportive resources.

Additionally, Carter-Snell & Jubenec (2013) recommend studying the mental health impact of education programs for the community, police, and health professionals related to use of responses such as psychological first aid and positive responses to rape disclosures [33].

Rape involves concern regarding disclosure, secrecy and self-silencing, stigma and the organizing emotion of self-blame. In a sense, this requires counselors assuming a role as a clinical detective in assessing for the red flags with non-disclosing clients. Inquiry about any type of unwanted sexual experience needs to be considered of all clients with the knowledge that it may take some time for an affirmative answer to surface.

For those clients who do disclose, we recommend that this issue of disclosure and self-blame be part of a counseling plan that is aimed at helping victims talk through the positives and negatives of disclosure and to help the victim predict those they tell (or have told) will be supportive and understanding, or blaming. The steps that counselors and therapists can take for counseling the victim on the issue of self-disclosure include:
1. Gather information from the victim to help make a prediction whether those told will be supportive or not. Inquire about the person's prior reaction to stressful news.
2. Have the victim predict the person's reaction.
3. Weight the advantages or telling with the disadvantages of telling.
4. Support the victim's decision whichever side she or he wishes to take. Talk through what is anticipated in terms of support as well as if the person told turns out to blame or discredit the victim. Be sure the victim can handle both reactions.
5. Request that the victim report back the reaction to the counselor in order to provide support for whichever way the reaction went. Additional counseling will be needed if the person blamed the victim and was not supportive.

Summary

Disclosure of unwanted sexual experiences remains a major problem. To date, there is no study less than 10 years old that has attempted to update incidence and prevalence. Moreover, the reports that do exist present divergent findings. In order to pursue development of studies aimed at testing prolific treatment interventions, we must first glean a more accurate and concrete understanding of the true depth of the number of survivors and also begin to identify more acceptable methods for disclosure.

Web-based anonymous surveys have demonstrated effectiveness in other populations. The finding that regardless of disclosure pattern, the majority of respondents supported online counseling was impressive. The overwhelming majority of participants in both groups cited that online follow-up was preferred to either telephone or face-to-face contact. Brief and colleagues (2013) were able to successfully recruit 600 Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) veterans into an alcohol and PTSD treatment study on-line in about six weeks [40]. The outcomes showed favorable effects on a) drinking days, b) percent heavy drinking days, c) average drinks per drinking day, and d) PTSD symptomatology. The advantage of this approach is the potential for an incredible reach to those in rural areas, to those unable or unwilling to combat the stigma, and to those who live in areas with few mental health resources. Given this study's findings that regardless of disclosure pattern, individuals prefer the use of the Internet to traditional counseling modalities. Thus, it is reasonable to assert that this method could be optimal for providing the most cohesive and accurate estimates to date from a broad, diverse population.

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The Influence of Perpetrator Type on Psychological Health Outcomes in Victims of Rape

Paper

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Abstract

The purpose of this study was to explore the potential influence of perpetrator type (intimate partner, non-intimate known, stranger) on RT presentation (depression, anxiety, PTSD) via an anonymous web-based survey. The target population was a convenience sample of 243 adult female victims of rape drawn from the population of females aged 18-64 in the United States and internationally. Findings revealed that perpetrator/victim relationship was not significantly associated with either depression (p = .621) or anxiety (p = .345). There was also no statistically significant difference among the perpetrator/ victim relationship groups in the rates of PTSD (Likelihood Chi-Square = .865). Within the group of participants with PTSD, there was a statistically significant difference among the perpetrator/victim relationships groups in the rates of delayed onset of PTSD symptoms (p = .040).

Introduction

Each year between 302,000 and 2.7 million women in the United States are raped [1,2]. This wide range is driven by the actual number of reports to police of rape, and findings that suggest only 19% [2] to 47% [3] of rapes are reported [4]. Traditionally, the rape perpetrator has been categorically portrayed as the monster, deviant, lurking in bushes and in alleyways, waiting for the unsuspecting victim [5,6]. Although this form of perpetrator and victimization does exist, it is neither the only, nor the most prevalent form according to most individual studies [1,6-9]. A meta-analysis examining rape treatment outcome research found that 51.6% of victims were raped by strangers [10,11]. This finding was similar in studies by Frazier (2003) and Resick et al (1988), that 45% and 54% of victims respectively were assaulted by a stranger [12,13]. Victims who reported knowing their attacker most often categorized the relationship as "acquaintance" (50.8%) or "friend (30.8%)[14]. Contrary to some other studies, categorizing of the relationship as a "date" comprised only (9.6%) of cases, spouse/partner (4.0%), and family member (4.9%). There is a lack of congruency and agreement in what constitutes an intimate partner versus an acquaintance which may account for these differences.

Rape victims typically suffer from depression, anxiety, and post-traumatic stress disorder (PTSD). These psychological sequelae are collectively known as rape trauma (RT). Estimates of depression following rape in adult women range from 12% to 87% 15-18. Post rape anxiety rates range from 28% to 90% [15,17,19-21], and from 50% to 95% for PTSD following a rape [18,22-24].

The type of relationship between victim and perpetrator is important as this may impact both reporting of the assault [12,25-29], and treatment seeking behaviors 30-37. These findings suggest that the victim and perpetrator is an important component of the rape experience; however, it is unclear whether or not the perpetrator-victim relationship influences the psychological sequelae of RT (depression, anxiety, and post-traumatic stress disorder). Thus, the purpose of this study was to explore the potential influence of perpetrator type on RT presentation.

For the purpose of this research, rape was defined and categorized using the RT syndrome framework of Burgess and Holmstrom[38] and the Sexual Experiences Survey (SES –SFV) [39,40]. This study, as depicted in figure 1, was guided by a model that proposed that perpetrator type directly influences RT.

Figure 1.
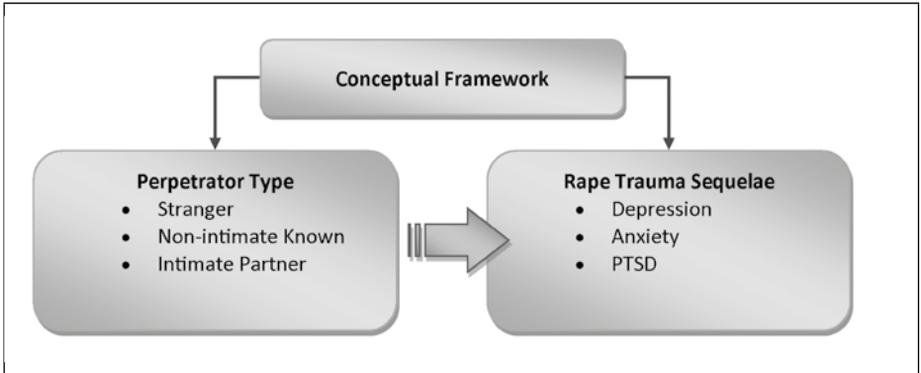
Methods

This study utilized a descriptive cross-sectional design. The target population was a convenience sample of 243 adult female victims of rape drawn from the population of females aged 18-64 in the United States and internationally. Inclusion criteria were: (1) between the ages of 18-64; (2) ≤ 5 years since their most recent incident of rape; (3) ability to understand English; (4) no recent report of psychosis; (5) the ability to complete study instruments; and, (6) female gender. Those under 18 were excluded as they could not give legal informed consent and those over 64 could have age-related confounding medical conditions. Individuals more than five years post-rape may present with different symptomatology (e.g., sequelae and coping changes the longer time since most recent occurrence).

Subject Recruitment
Multiple recruitment methods were used. Emails were sent nationally through ResearchMatch, an opt in list of individuals who had previously given their contact information for that purpose, as well as a clinical trials registry maintained by Vanderbilt University. A description of the study along with a link was provided in the emails. This link led participants to the dedicated study website, specifically designed to provide comprehensive information on the study, a toll free telephone number to contact a live person if the potential participant so chose, and a link that would provide direct access into the study itself Informative advertisements placed on national screening and support online websites. Advertisements were also placed in domestic violence shelters, rape crisis centers, offices of psychiatrists, and psychotherapists, local emergency room departments, primary care office lobbies, and public venues such as college bulletin boards, grocery stores, bathroom stalls, libraries, social media sites such as Facebook, and police departments in the State of New Jersey. Other techniques included posting informative public service announcements on local New Jersey radio channels

Procedures
Permission to conduct the research study was obtained from the Vanderbilt University Institutional Review Board (IRB). Online informed consent was obtained from all participants prior to enrollment into the study. Data was collected via an online survey. A web based procedure was chosen as; 1) web based surveys have been effective in obtaining a large sample of rape victims [41,42]; 2) it offers participants the ability to complete study instruments at their convenience; 3) it affords privacy and confidentiality; and, 4) it can serve as an opportunity for safe disclosure. Potential participants were screened online using a series of IRB approved questions. Once an exclusion criterion was met, no other information was gathered. If deemed eligible, the subjects were provided with informed consent documents to read. After they read and acknowledged understanding by answering three questions covering material contained within the consent, the participant was allowed to proceed to access the study online. If questions were answered incorrectly they could not advance to the survey. All information was collected via participant self-report. Participants were allowed to save responses made directly online and return to finish the study convenience.

Measures

Perpetrator Type. The following question was developed by the authors was asked to determine the perpetrator/victim relationship, "Please choose the answer that best reflects the relationship between you and the perpetrator."

"The perpetrator was: A) a current or ex-spouse; b) boyfriend/girlfriend; c) same sex partner; B) The perpetrator was someone I knew. The person was: a) a family member (e.g., biological or adopted mother/ father, biological or step brother/sister, aunt/uncle, cousin, grandparent); b) someone I knew but was not related to (e.g., friend, neighbor, clergy member, bus driver, teacher, other acquaintance); C) The perpetrator was: someone I had never met before."

Psychological Outcomes (RT). Three instruments were used to assess psychological outcomes after incidence of rape in the proposed research study.

Depression: Beck Depression Inventory (BDI-II). The BDI-II is 21-item self-report instrument intended to assess the existence and severity of symptoms of depression [43]. Each item consists of four self-evaluative statements asking respondents to rate their symptoms from the last 2 weeks. There is a four-point scale for each item ranging from 0 to 3. Questions include items on a variety of feelings (e.g., sadness, loss of pleasure, self-dislike, indecisiveness, fatigue). Included is a question specifically on suicidal thoughts or wishes. Cronbach's alpha in this study was .95.

Anxiety: State Trait Anxiety Inventory (STAI-Y). The State Trait Anxiety Inventory – Y [20] is a 40-item self-report questionnaire. The most recent version differentiates temporary or emotional state anxiety from long-standing personality trait anxiety in adults. The scale is written to be used with adults over 18 who can read at a sixth grade level. Range of scores is 20-80, with higher scores indicative of higher anxiety. For the purposes of this study, only trait anxiety was measured. Whereas state anxiety refers to a more short term state, (e.g., response to a more immediate stressor) trait anxiety attempts to measure more of a personality characteristic (e.g., the stable tendency to respond with state anxiety as an anticipatory mechanism). Since the study aims to assess anxiety and its respective associations to other sequelae (e.g., depression, PTSD) after incidence of rape within a five year period, it is appropriate to measure only the more long standing trait oriented form of anxiety. Based on norming of the instrument in a variety of populations, our sample experienced a mean level of anxiety (M = 51.3, SD = 13.73, range 23-79) that was higher than those found in a sample of general medical/surgical patients with a history of psychiatric complaints (n = 34, M = 44.6). Cronbach's alpha for this study was .95.

PTSD: Posttraumatic Stress Disorder: Posttraumatic Stress Diagnostic Scale (PDS). The posttraumatic stress diagnostic scale [44] is a 49 item instrument that assesses all six DSM-IV™ criteria for PTSD, and is designed to aid in the detection and diagnosis of PTSD. The PDS uses the DSM-IV diagnostic criteria for PTSD and may be administered repeatedly over time to help monitor changes in symptoms. This instrument is designed to be used with adults aged 18-65 and is written at an 8th grade reading level. The normative base of this instrument is diverse and thus offers an advantage over other PTSD instruments that have been normed primarily on men suffering from combat-related trauma. Initial norming was done with a group of 248 men and women between the ages of 18 to 65 who had experienced a traumatic event at least one month before they took the test. The diversity of the sample was represented by individuals in women's shelters, PTSD treatment clinics, VA hospitals and with staff of fire stations and ambulance corps. High internal consistency, good test-retest reliability and good validity have been reported [44,45]. Another more recent study compared the PDS to the CAPS in a sample of 138 women who were victims of domestic violence. Findings confirmed a high rate of PTSD in the sample with both instruments [46].

Statistical Procedures: To test for differences in rape trauma presentation/diagnoses (depression, anxiety, PTSD) among groups of women who have experienced different types of perpetrator/victim relationship (intimate partner, non-intimate known, stranger), participants were grouped into categories by reported perpetrator/victim relationship (intimate, non-intimate known, stranger). Multivariate Analysis of Variance (MANOVA) was used to test for differences in depression and anxiety among the three groups. Chi square Test of Independence was used to test for those same differences among the distributions of post-traumatic stress disorder. Responses with missing data for any of the instruments were omitted from the final analyses for that instrument.

Results

A total of 384 completed the study consent form and at least some portion of the study. Of those, 243 (63%) completed all of the study instruments sufficiently for inclusion in the analysis. There were no statistically significant differences between the completers and non-completers on any demographic factor. A description of the sample can be found in table 1.

Characteristic	Not Complete (N=141) N(%)	Complete (N=243) N(%)	p-value
Race			.109
Caucasian	91(82.7)	218(90.1)	
African American	16(14.5)	18(7.4)	
Other	3(2.7)	6(2.5)	
Education			.544
12th Grade/GED	12(10.9)	15(6.2)	
Some College —Did Not Graduate	24(21.8)	47(19.4)	
2 Year Degree	10(9.1)	26(10.7)	
4 Year Degree	40(36.4)	100(41.3)	
Graduate Degree	24(21.8)	54(22.3)	
Marital Status			.268
Single/Not Partnered	78(70.9)	185(76.4)	
Married/Partnered	32(29.1)	57(23.6)	
Residence Area			.873
Northeast	18(16.4)	41(17.4)	
Southeast	6(5.5)	18(7.6)	
Midwest	23(20.9)	40(16.9)	
South	45(40.9)	97(41.1)	
West	11(10.0)	20(8.5)	
Outside the U.S.	7(6.4)	20(8.5)	
Children			.327
Yes	38(34.5)	71(29.3)	
No	72(65.5)	171(70.7)	
Health Insurance Type			.872
Governmental (Medicare, Medicaid, etc.)	46(41.8)	99(40.9)	
Non-Governmental	64(58.2)	143(59.1)	
Religious Preference			.442
Roman Catholic	15(13.6)	38(15.7)	
Protestant	18(16.4)	47(19.4)	
Jewish	2(1.8)	7(2.9)	
Muslim	3(2.7)	1(0.4)	
Buddhist	1(0.9)	3(1.2)	
No Preference	71(64.5)	146(60.3)	
Annual Household Income			.385
Less than $25,000	0(0)	58(24.8)	
$26,001 - $40,000	0(0)	60(25.6)	
$40,001 - $60,000	1(50.0)	43(18.4)	
$60,001 - $80,000	0(0)	13(5.6)	
$80,001 - $100,000	0(0)	20(8.5)	.
Over $100,000	1(50.0)	20(8.5)	
Prefer Not To Answer	0(0)	20(8.5)	
Currently Lives with Abuser			.568
Yes	6(6.0)	11(4.5)	
No	94(94.0)	232(95.5)	
Age	Median (IQR)*	Median (IQR)*	
Age (years)	27.00, (23.3,33.8)	27.00, (23.8,33.3)	.924

Summaries of the depression and anxiety values (Table 2), as well as prevalence of PTSD for each type of trauma group are presented (Table 2). Findings revealed that perpetrator/victim relationship was not significantly associated with either depression (p = .621) or anxiety (p = .345). There was also no statistically significant difference among the perpetrator/victim relationship groups in the rates of PTSD (Likelihood Chi-Square = .865). Within the group of participants with PTSD, there was a statistically significant difference among the perpetrator/victim relationships groups in the rates of delayed onset of PTSD symptoms (p = .040). Participants in the intimate partner and stranger groups had higher mean levels of depression (M = 22.3) and anxiety (M = 52.5/52.4 respectively) than those who experienced rape by someone considered non-intimate but known to the victims. Participants who met the criteria for PTSD were fairly evenly distributed throughout all three groups; intimate partner 47%, non-intimate known (44%); stranger (49%). No statistically significant differences were observed in terms of symptom duration (p = .235), severity score (p = .339), or level of impairment (p = .300).

Table 2. Summaries of Depression and Anxiety*.

	Intimate (n=97)	Non-Intimate Known (n=106)	Stranger (n=40)	F (df=2,240)	p-value	Eta-squared
	M(SD)	M(SD)	M(SD)			
BDI – II	22.3(14.0)	21.0(13.6)	22.3(15.4)	0.48	.621	<.01
STAI-Y (Trait)	52.4(13.1)	49.9(13.7)	52.4(15.3)	1.07	.345	.01

Multivariate Analysis of Variance (MANOVA) was used to test for differences in depression and anxiety among the groups. Wilk's Lambda = 0.990, F(4,478) = .603, p = 0.661

Table 3. Summary of PTSD. Chi square Test of Independence was used to test for those same differences among the distributions of post-traumatic stress disorder.

	Intimate (n=96)	Non-Intimate Known (n=102)	Stranger (n=39)	p-value
PDS	N(%)	N(%)	N(%)	.865
With PTSD	45(47)	45(44)	19(49)	
Without PTSD	51(53)	57(56)	20(51)	

Chi square Test of Independence was used to test for differences among the distributions of post-traumatic stress disorder in the groups.

Discussion

The characteristics of the sample in this study were similar to those of previous reported studies with a few unique differences. The mean age for completers in this study was 30.11 years, similar to other studies [47,48], but higher than most other previous studies specific to rape and sexual abuse [22,49-51]. The exceptions were the study by Basile and colleagues (2004), in which multiple forms of abuse were examined relative to intimate partners and PTSD only (mean age 39.6), and Bengtsson-Topps & Tops (2007) in which overall abuse in females seeking psychiatric services was examined (mean age 39.0) [52,53]. The majority of participants in this study were single or not partnered (76%), and Caucasian (90%). This finding is consistent with the latest 2010 ACS demographic and housing estimates set forth by the U.S. Census Bureau 2010, related to race (current population 50.8% female, 74.2% Caucasian)[54], as well as previous studies in this populations [51,55], and similar to marital status, with slightly more than 50% of the U.S. female population (50.5%) reporting they are single [54,56].

The majority of the sample was well educated. These findings are similar to the study by [57], but higher than the percentages reported in the current U.S. Census data, (17.7% with a Bachelor's degree; 10.4% with a graduate degree). Thus, the participants in this study appear to be more highly educated those in the general population, as well as in other studies [47]. This may be attributable to the on-line nature of the study, which did necessitate access to and knowledge of computers. This study evaluated income using slightly different cutoffs than those found in the U.S. Census report, however, income data appears to be proportionally equivalent, with 50% of participants in the 2010 U.S. Census reporting incomes of ≤ $50,000/year. Mean income figures reported in the current study were similar to those of other studies [58,59].

Any distinct variability is likely because many studies in this population have been done with college students [51], who on average, earn less than those who are older, and/or working full time. The majority of the sample in this study reported having no children, which is consistent with current U. S. population estimates, that 33.1% of households currently have one or more persons under age 18 in the household.

Analysis of the perpetrator/victim relationship relative to outcomes revealed no statistically significant differences among the groups related to psychological outcomes. Since this is the first known study that has attempted to examine the perpetrator/victim relationship related to a diagnosis of depression and anxiety, no comparison can be made. This study does, however, agree with findings by Ullman et al (2007), [60] who found that perpetrator/victim relationship was not a significant correlate of PTSD, but differs with findings by Masho & Ahmed (2007)[59], who found that prior knowledge of the offender was associated with PTSD. It should be noted that in the study by Masho & Ahmed (2007), the construct of perpetrator/victim relationship was not delineated other than to ask participants if they had prior knowledge of the offender. Therefore, differences in findings due to categorizations used may have occurred.

The post hoc analysis of PTSD revealed a few specific interesting findings related to PTSD. First, the presence of delayed onset of symptoms was the only statistically significant variable in the post hoc analysis of PTSD. Of the 25% of those with PTSD found to have delayed onset of symptoms, those who had been raped by a person considered to be a non-intimate known to the victim comprised more than twice that of either those raped by intimate partners, or strangers. This finding suggests that being raped by someone that is known, but with whom you had no intentional intimate relationship, results in a delayed response to the traumatic event, whereby participant took time to assimilate what happened before they began to be symptomatic. Second, of those diagnosed as positive for PTSD in this study, > 98% possess chronic as opposed to acute symptoms, and more than 95% were raped by a non-intimate known to them. These findings suggest that those raped by a non-intimate known may be at greater risk for delayed symptoms that will linger for a longer period of time. By contrast, findings from this study reveal that participants raped by an intimate partner demonstrated more severe symptoms and level of impairment. No studies could be identified that sought to measure this PTSD construct specifically in survivors of rape; thus, no comparison can be made in the population of rape survivors.

The fact that the current study did not find differences among the groups related to RT suggests that the nature of relationship between the perpetrator and the victim is not, in itself, the sole reason why RT symptoms are present or absent. Since almost equal percentages of depression, anxiety and PTSD were found among all three groups, the perpetrator/victim relationship should be not necessarily be considered as a marker, in itself, or reason to separate or alter treatment for any of the negative psychological sequelae.

Strengths and Limitations

This study is unique in that it constitutes the first known study conducted solely online that sought to identify differences among RT presentation/diagnoses, and delineate realistic categories of perpetrator/victim relationships among groups of women who experienced one or more incidents of rape.

This study illuminated differences in RT outcomes (depression, anxiety, PTSD) based on the perpetrator/victim relationship (e.g., higher mean scores for depression and anxiety, and higher percentages of those diagnosed with PTSD were found for those reporting intimate partner or stranger rape, than those from a non-intimate known). Although no significant differences were found based on the relationship between the perpetrator and victim, this was the first study that attempted to look at depression and anxiety with regard to the perpetrator/victim relationship.

There are several limitations to the study and all findings should be considered in light of these limitations. First, the study utilized a cross sectional design, no causal inferences can be made Second , it was comprised of a convenience sample of adult participants who were Caucasian, and self-reported one or more incidents of rape within the past five years.,. Third, the measure of PTSD did not measure the continuum of symptoms and it is likely that more and stronger associations would have been found if the measure had allowed for measurement on a continuum. Finally, other confounding factors may exist. For example, the study only examined participants who self-reported that their most recent rape experience occurred within the past five years. Since many participants reported that they had multiple rape incidents, and no interviews were conducted, it is unknown if this incident was actually the one participants referred to when answering the questionnaires. Furthermore, there were no controls put in place for those who had more than one incident of rape, or for those who may have experienced other traumatic events. Thus, unknown confounding factors may impact study findings. Despite these limitations, the present study contributes unique knowledge relative to survivors of rape.

Recommendations for Future Research

Study findings can be used to guide future research through the following aspects. In this study the majority of the study participants were Caucasian, and all of the participants experiences were within the past five years. Future studies should attempt to obtain a more racially diverse sample, and include experiences over the course of one's lifetime with controlling for time since the most recent experience.

Findings from this study will serve as the basis for future studies with all genders, and for longitudinal research in this population. Longitudinal research will facilitate prediction of outcomes over time, which could have critical clinical implications. This information could contribute to clinicians' ability to identify trauma victims in the greatest need of assistance, and guide more effective intervention approaches aimed at addressing the psychological and psychosocial sequelae associated with RT syndrome.

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Childhood Narratives of Perpetrators Who Sexually Abuse Children

Paper

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Background and Brief Literature Review

Neither theory nor research has provided sufficient guidance for prevention of child sexual abuse or effective treatment of perpetrators. The developmental precursors of sexual offending are poorly understood. Biological, cognitive, behavioral, social learning, personality, and evolutionary theories have been proposed. [1] A widely promulgated hypothesis is that adults who perpetrate sex crimes against children have themselves been abused in childhood, and thus replicate this act to reverse the role of powerless victim. [2] Support for this hypothesis has been found by several researchers. [3, 4, 5] In one study, 60% of pedophiles, compared with 4% of controls, reported sexual advances by an adult during childhood; 60% concordance was found between acts experienced as a child and acts committed in adulthood. [4] 66% of sex offenders reported childhood sexual abuse in a recent study by Hulme and Middleton.[5] In contrast, other research shows that many perpetrators have not been abused 6, 7, raising questions about other possible etiological factors. Simons et al. [3] criticized the state of the science because most studies are conducted with incarcerated samples who could overemphasize past abuse to justify their crimes. Furthermore, most researchers employed structured questionnaires that did not permit rich descriptions of childhood experiences.

Aim of the Study

Few researchers have conducted nondirective interviews in which offenders could talk freely about their childhood years. Therefore, the aim of this qualitative study was to enhance understanding of childhood experiences of perpetrators against children.

Method and Procedure

The sample consisted of community-dwelling adult sex offenders who had been convicted of sexually abusing a child. All had served time in prison and/or on probation. Prospective study participants were identified through an online sex offender registry or through therapists who told them about the study. Participation was entirely voluntary and not associated with their therapy or conditions of their probation. The research methodology was a blend of narrative inquiry, mainly following Riessman's approach,[8] and phenomenology, following the philosophy of Merleau-Ponty, [9] as interpreted by Thomas and Pollio. [10]

The phenomenological interview allowed researchers to enter the world of sex offenders in a nonjudgmental way, inviting them to describe what their world was like growing up. Merleau-Ponty's phenomenology seeks to elicit a "direct description of our experience as it is" [9], p. vii without prematurely applying theoretical conceptualizations. Audiotaped interviews, lasting 60-90 minutes, were conducted after the study had received IRB approval and participants provided informed consent. The interview focus was childhood, and participants were gently redirected if they began to discuss experiences of adulthood such as their time in prison. After a broad opening question, subsequent questions were posed primarily to elicit elaboration or clarification. Common motivations for study participation were "to help people learn and not go the route I had to" and "to help people to not prejudge offenders."

Demographic Characteristics of the Participants
We interviewed 23 community-dwelling sex offenders (21 men, 2 women) who ranged in age from 20s to 70s. Education of the sample ranged from high school equivalency to PhD. Most were Caucasian, but 2 were Asian and 1 was African American. Occupations ranged from manual labor to professional practice (e.g., dentistry, clergy, engineering).

The majority had been involved in 1 or more heterosexual marriages and had children and/or stepchildren. 2 men explicitly identified as homosexual, but one of them had always concealed his sexual orientation

from his wife. Almost all participants were currently participating (or had participated) in cognitive-behavioral therapy, provided either within prison or community settings. All resided in the southeastern United States.

Data Analysis

A sequential 2-stage analysis was employed, first ascertaining the narrative motif of each participant's story as a whole.[8] In the phenomenological stage, selected interview transcripts were read aloud and thematized in 2-hour sessions of an interdisciplinary interpretive group that meets weekly. The aim of this stage of the analysis was to identify meaning units in each transcript and then global themes across all transcripts. Rigor of the analysis was enhanced through the processes of bracketing and journaling, which not only facilitated research reflexivity but also constituted an audit trail for the project.

Findings

Childhood stories were diverse, defying easy categorization. While some participants were reared in a 2-parent home, many others exhibited profound sadness because they lost, or never knew, their mother or father. While some described chaotic homes with neglectful alcoholic parents, others reported no alcohol or drugs in their homes. 2/3 experienced trauma (psychological, and/or physical abuse) that interfered with a secure sense of being loved and valued. Half were sexually abused; half were not. Sexually abused interviewees reported a variety of adult female abusers such as babysitter, Sunday School teacher, aunt, and grandmother, in addition to older female step-siblings and other older females outside the family. Male perpetrators included grandfather, cousins, scoutmaster, neighbors, and older schoolmates.

The narrative analysis identified 4 types of narratives: *"There Was No Love;" "Love Left;" "Love Was Conflated with Sex;"* and *"A Pretty Good Childhood."*

There Was No Love. Narratives of participants in this group (n = 6 men) were characterized by chronic longing and loneliness because parents were never emotionally available to them. Some childhood homes were filled with screaming and beatings, while others were less tumultuous but bleak ("I didn't have anybody who cared," "I couldn't talk to nobody"). None of the participants in this group had the opportunity to see a healthy loving relationship between parents. Phenomenological analysis revealed 3 themes within this type of narrative:

1. ***Giving up:*** This theme depicted resignation that they were unlovable; some still wonder why their parents could not love them.
2. ***Trying to elicit parental attention/reaction:*** Some participants described desperate attempts such as setting fires, running away, and stealing.
3. ***Trying to create an alternate world:*** Some participants found nature an anchor or nurturer; they stayed outside as much as they could, and built tree forts and underground forts where they felt secure.

Love Left. Within this narrative motif, the participants (n = 2 men, 1 woman) described an early awareness of being loved, which was disrupted by death or desertion. The central theme that emerged from these stories was "It just all went away."

Love Was Conflated With Sex. This set of stories (n = 6 men) was characterized by multiple experiences of precocious sexual activity (consensual in some cases) and sexual abuse by a variety of perpetrators. As children, these participants never learned what love was; it was conflated with sex. Phenomenological analysis revealed 3 themes within this type of narrative:

1. ***Not knowing that the early sexual behavior was inappropriate.***
2. ***Welcoming the warmth and intimacy of the precocious sexual behavior:*** For children who were lonely and had nobody to talk to, the warmth of bodily contact with other bodies at least provided some kind of connection, even if outsiders would interpret the sexual contact as abusive.
3. ***Feeling powerless when bodies were used by others:*** In contrast to pleasurable aspects emphasized by some participants, other narratives conveyed inability to resist when peers or adults took advantage of them sexually. Some felt compelled to provide sex to peers to buy friendship.

A Pretty Good Childhood. This group of stories (n=7 men, 1 woman) involved intact parental marriages or the replacement of 1 parent by a stepparent or grandparent perceived as loving. The households were financially secure, and parents were often attentive and even indulgent. These stories provided few clues regarding the etiology of sex offenses that the narrators later perpetrated against children.

Global Themes

Two themes were found across all four types of childhood narratives; *Not Fitting in at School* and *Longing for What Was Missed in Childhood*.

1. ***Not Fitting in at School.*** Even when home life is bleak, some children find affirmation of their worth at school, from their teachers and/or classmates. Participants in this study almost universally reported that they did not fit in at school, because they were socially or athletically inept, physically unattractive, or members of a stigmatized group (e.g., poor, non-Caucasian). Some did not fit because of learning disabilities, such as dyslexia, but others were smarter than their peers, which was equally disadvantageous. Pejorative self-descriptors were common (e.g., 'frail, skinny, nerdy, dorky, shy, odd, square, ugly').
2. ***Longing for what was missed in childhood.*** Most narratives were characterized by unrequited longing, especially for a father's love. Only 7 of the 23 participants described a close relationship with their fathers; even the participants who sought to portray a happy childhood admitted that they needed more from their fathers. Half the sample never knew their real fathers, were abandoned by them through death or desertion, or were treated cruelly by them. Some participants also spoke of lack of closeness with siblings, mothers, and peers.

Discussion

The present study contributes to the relatively small literature devoted to in-depth understanding of the childhood experiences of perpetrators of sex crimes against children.

Findings of the study counter a number of societal stereotypes and previous empirical evidence. For example, many participants cried and expressed remorse when telling their stories, which does not accord with societal perceptions of psychopaths beyond redemption. The methodology of this study does not permit causal claims but highlights childhood issues that deserve more attention from researchers, clinicians, educators, and policymakers. The majority of the sample did report some type of childhood abuse, although it was sexual for only half. Abandonment, neglect, and emotional abuse left a residue of chronic sorrow that remained evident to this day, visible in participants' affect and voices during the interviews. When we compared our findings to key factors shown to contribute to surmounting childhood abuse, [11] our participants did not report attentive teachers or parents of friends, nor did they develop reparative relationships with peers or compensatory areas of mastery, such as academics or athletics. They had not moved beyond the childhood trauma, as thriving survivors do.[12] Our findings led us to agree with Waldram [13, 14], that cognitive-behavioral treatment may not be optimal for all perpetrators, as it is not designed to facilitate recovery from severe early trauma and loss. Grief work with an empathic therapist will be necessary.

Although the sexually abused-sexual abuser hypothesis has not been universally supported, either in our research or that of others, a sizeable proportion of our sample did report excessive sexualization and/or sexual abuse in childhood. Yet none of the study participants had ever received any psychiatric treatment until they themselves were convicted of crimes as adults. Childhood cries for help, such as stealing and suicide attempts, did not result in adult recognition of their distress. Screening and case finding to identify victims of child sexual abuse must be intensified so that early treatment can be initiated. According to Finkelhor, [15] if victims are supported and comforted, they have no need to abuse others. Lambie et al. [16] reported that men in their "resilient non-offenders" sample received emotional support from a wider variety of sources than their "victim-offender" counterparts.

Many new questions arise from the present study. Surprisingly, a third of the sample portrayed an idealized happy childhood. Some told the interviewers that they considered their childhood stories uneventful, even "boring." If an offender's childhood years were indeed safe, secure, and happy, what seeds were sown (and when) for a deviant choice of sexual object? It is possible that some of these offenders are still protecting family members, and/or themselves, from recognition that they were exposed to harmful influences, or in actuality, abused. Self-protective beliefs have been identified in previous studies of abuse survivors. For example, a participant in a previous study by the first author said she was unsure if she had been sexually abused and "does not care to ever know." [12, p. 162] Additional research should be conducted on perpetrators with no history of childhood trauma.

Strengths of the study include (a) accessing a diverse sample of community-dwelling child sex offenders, and (b) permitting the offenders to reflect on their childhood experiences without constraints of structured questionnaires. Because the researchers had no affiliation with the justice system or treatment facilities, participants had less motivation to lie or manipulate. Limitations of the study include (a) inability to review correctional case files or therapist records and (b) inability to generalize to sex offenders who remain incarcerated and/or untreated. Most of our participants have received some psychotherapy, and some were continuing in therapy at the time of the interviews.

Pessimism about efficacy of sex offender treatment pervades both professional and popular literature. Therefore, policymakers favor long prison sentences for offenders as well as severe restrictions after

release. It is doubtful whether current policies are adequately informed by research. Olver and Wong reported that recidivism of offenders can be reduced with treatment. [17] Additional research is needed, both on early childhood interventions and rehabilitative interventions for adults.

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Childhood Sibling and Peer Relationships of Perpetrators Who Sexually Abuse Children

Paper

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Background and Brief Literature Review

Despite a call by Dhawan and Marshall [1] for investigation of the early lives of sex offenders, very little research has been conducted on the childhood experiences of perpetrators who sexually abuse children, and there is almost no focus on their sibling and peer relationships. Extant literature is dominated by quantitative studies of the demographic characteristics and personality pathologies of incarcerated offenders. Qualitative studies have focused more on interviewees' adult crimes than their childhood history. Research has shown that there is no direct causal link between being sexually abused as a child and subsequently abusing others later. [2] Unanswered questions remain, however, about other childhood developmental issues, such as problematic relationships with siblings and peers, which could contribute to adult sexual crimes against children.

Childhood Sibling Relationships

Although the majority of children have siblings, and children spend a vast amount of time with siblings, relationships among siblings have been much less studied than other family relationships. [3] The quality of sibling relationships is linked to peer social competence, as noted by theorists such as Minuchin [4] and researchers such as Kim et al. [5] If children are growing up in households of abuse, sibling relationships could assume even greater importance, possibly compensating for parental abuse and neglect, but perpetrating additional abuse in some cases.[6,7] Siblings may model their parents' abusive behavior.

Childhood Peer Relationships

A child's experience with peers provides a context for development of many essential capacities, including emotional regulation and conflict resolution skills. Conversations with peers help children and adolescents develop understanding of others and themselves.

Maltreatment by parents or siblings could have a deleterious effect on a child's ability to form healthy relationships with peers.[8] A child may doubt that anyone could like him or her. Furthermore, the child may display submissive/nonassertive behaviors with playmates, signaling that he is an easy target for peer victimization. [9]

Purpose of the Study

Many perpetrators of child sexual abuse have a history of childhood abuse by parents, but little is known about their experiences with siblings and peers. This gap in the literature prompted the present investigation, a secondary analysis of a unique data set.

Method and Procedure

The purpose of our original study was to explore the childhood experiences of a community-dwelling sample of adult sex offenders who had victimized children. Potential participants were identified through an online sex offender registry or through therapists who told them about the study. All had been convicted of sexual offenses against children and had served time in prison and/or probation. We used a blended research methodology derived from the phenomenological philosophy of Merleau-Ponty [10], as interpreted by Thomas and Pollio [11], and from the tenets of narrative inquiry, as elucidated by Riessman. [12]

After IRB approval and obtaining informed consent, we conducted private, in-depth, non-directive, face-to-face, audiotaped interviews, each lasting approximately 60-90 minutes, with 23 convicted sex offenders. Descriptions of sibling and peer relationships were prominent in the resultant narratives, facilitating this secondary analysis of the data. As noted by Szabo and Strang,[13] secondary analysis is a cost-effective mode of inquiry that makes maximum use of existing data, allowing researchers to ask new questions of the data. Members of the team followed the procedures of Thomas and Pollio [11] to identify meaning

units in the transcripts, to cluster meaning units into themes, and to select verbatim quotes to support each theme. To the extent possible, participants' own words were used to name the themes. Rigor of the analysis was enhanced by reading transcripts aloud and developing preliminary themes in an interdisciplinary interpretive group.

Demographic Characteristics of the Participants
Participants were (1) adult male or female (>age 18); (2) self-identified as having sexually abused a child; (3) not currently incarcerated or facing criminal charges; and (4) willing to participate in a private confidential interview. Education ranged from high school equivalency to PhD. Ages ranged from 20s to 70s. Most were Caucasian, but two were Asian and one was African American. Occupations ranged from manual labor/technical to professional (dentistry, clergy, engineering). There were 21 males and 2 females. The majority had been involved in 1 or more heterosexual marriages and had children and/or stepchildren of their own. 2 men explicitly identified as homosexual, but one had always concealed his sexual orientation from his wife. Almost all participants were currently participating (or had participated) in cognitive-behavioral therapy, either within prison or community settings.

Findings

There was considerable heterogeneity among participants and their reports of childhood experiences. 2/3 of the sample of sex offenders had experienced childhood abuse, including abandonment, neglect, emotional, and/or physical abuse. Half reported sexual abuse; half did not. 1/3 claimed a "pretty good childhood," denying childhood trauma.
In our report of the original study, we discussed four types of narrative motifs (see Thomas et al., elsewhere in these Proceedings). This paper presents the findings of the secondary analysis on sibling and peer relationships. Themes will be illustrated by quotes from the participants.

Sibling Relationships
3 themes were found in the transcripts of the 20 participants who had siblings (3 were only children):

1. ***"We really just didn't have a relationship"***
   This theme depicted lack of connection to brothers and sisters, often because the participant felt different (smaller, dumber, wide age difference), e.g., "Even with 3 brothers I felt lonely." This theme also included reports of being treated like "garbage" by siblings, competing with them for attention of neglectful parents, fighting with them, and being scapegoated for their misconduct.

2. ***"We kind of learned to protect each other"***
   This pattern was most evident in households of physical abuse, e.g., "We piled in and jumped on dad to get him off one of my sisters." One participant, the only boy among 5 sisters, often took parental beatings with a belt for misbehavior of his sisters, and during adolescence he would fight boys who cast aspersions on his sisters ("Your sister's a bitch. We went out on a date and she wouldn't put out").

3. ***"We were real close"***
   This theme included healthy sibling closeness as well as inappropriate physical closeness. Healthy bonding was mainly evident in the narratives of participants who had claimed a "pretty good childhood;" these were the only participants who described having fun with their siblings. Some participants who experienced egregious abuse by parents did identify one sibling who was a companion and confidant ("I could trust her; I didn't trust my parents or my relatives"). Also within this theme, however, were examples of incestuous sexual activity: "we did things to each other that I guess normal brothers and sisters don't do;" "the kissing by my stepsister felt really good; I never thought of it as being molested." Narratives of these participants depicted lack of awareness that the sexual behavior was wrong; its warmth and intimacy was welcomed, in fact, in households of neglect and abuse.

Peer Relationships
5 themes were found in the transcripts of the 19 participants who talked about peers. Despite the heterogeneity among participants, ***not fitting in at school*** was a pervasive theme. Participants reported that they never fit in at school, which they attributed to their perceived unattractiveness (big-eared, buck-toothed, too skinny or too fat); social or athletic ineptness; learning disabilities; or other personal qualities. Study participants used pejorative self-descriptors such as "nerdy, dorky, odd, ugly."

Picked on and bullied was a second prominent theme. Participants reported verbal abuse, such as being called names and "made fun of." Narratives also included beatings by schoolmates, neighbor children, and cousins. In one extreme incident, the participant was forced into a freezing pool in the middle of winter. Bullying was especially prominent among participants who were non-Caucasian and/or poor.

These quotes are illustrative: "I was the only non-white person in the school, you can imagine what life was like, a nightmare;" "We would have to go to the dollar store and I would get picked on because of my clothes and my shoes."

Theme 3, Unable/afraid to get close, was exemplified in quotes such as:
"I just didn't let anybody get close to me. It was just like a defense. I thought they would hurt me like my mom did;" "I was always by myself and kept things to myself;" "I had a friend once and my younger brother took him away from me;" "Every time I had a friend or two, it seems like they had better friends than me and better things to do with other friends than me."

The theme of *Sex as cost of friendship/substitute for friendship,* was exemplified in quotes such as: "They wanted to have sex with me, that's what it cost to have a friend;"
"I didn't want it [sex], but I felt that's what I had to do;" "Everybody was just using me."

These words of participants conveyed their sense of powerlessness when peers began to take advantage of them sexually. One man, who referred to himself as "the weak one," saw no way to resist his bigger, older peer: "I just had to let him do it whenever he required and forced me to. I had nowhere to go and nobody to go to." Despite this painful introduction to sex, eventually it became a substitute for friendship, since he was unable to make friends. Sex became his "only fun, it was the only way I knew."

The final theme depicted *Peers as substitutes for intimacy in the family*, illustrated in:
"He was kind of the brother I never had;" "What I found myself doing when life turned to hell at home, I would spend time over at my friends' houses because their families weren't as dysfunctional as mine."

Discussion

The present study illuminates childhood issues that deserve more extensive scrutiny. With few exceptions, neither sibling nor peer relationships adequately promoted participants' capacity for developing and maintaining healthy relationships in adulthood. In general, participants felt unloved as children and described themselves as lacking in self-worth. The majority of the sample had experienced multiple forms of childhood abuse from their parents. The parental abuse was compounded by sibling abuse in some (but not all) cases. Sibling abuse has been shrouded in secrecy except for a few classic studies such as Wiehe's. [7] Sibling bullying and sexual abuse are underreported and therefore untreated. [7, 14]

Bullying by peers was thematic in this study of sex offenders, including verbal abuse and coerced sex. Peer sexual aggressors included neighborhood playmates, schoolmates, and cousins. "Traumatic sexualization," as described by Finkelhor, [14] can include (a) being forced to engage in inappropriate sexual activity and/or (b) engaging in sex to garner rewards. Both were described by our study participants. For some, peers provided their first introduction to sex; for others, adults such as Sunday School teacher, babysitter, scoutmaster, or family member had already violated them.

Early intervention with children who are victimized is imperative. None of our victimized study participants received any psychiatric treatment until they were convicted of crimes as adults. They told no one about the inappropriate sexual activity initiated by siblings or peers, and their parents did not pay attention to their childhood cries for help, such as running away, stealing, or suicide attempts. Efforts to detect child victims of sibling and peer abuse must be intensified. The development of valid screening tools would be useful to preschool caregivers, primary health care providers, and psychiatric clinicians.
Vizard [2, pp. 507-508] warns, however, that standardized instruments with "a 'tick box' approach to assessment of these children is not sufficient to identify all their needs, no matter how well validated the psychometric measure or risk assessment instrument, so a clinical assessment by a trained mental health professional and a diagnostic formulation will also be needed."

Clinicians should be aware that the best predictors of sexual abuse are inappropriate sexual knowledge, sexual interest, and sexual acting out. [15] If incestuous activity is discovered between siblings, treatment should be promptly instituted. Teachers and school counselors must be more vigilant in identifying lonely children who do not "fit in" with peers and submit to unwanted sex in an attempt to buy friendship. The phenomenon of bullying is known to contribute to depression and suicide [16] and must be combated more vigorously in schools. Trauma-focused cognitive behavioral therapy has shown promise in treatment of abused children in 6 randomized controlled trials. [17]

Strengths of the study include (a) accessing a sample of child sex offenders who were diverse with regard to age, education, and occupation, and (b) allowing the offenders an opportunity to reflect on their childhood experiences without constraints of structured questionnaires. Because the researchers had

no affiliation with the justice system or treatment facilities, participants had less motivation to lie or manipulate.

Limitations of the study include (a) the inability to review correctional case files or therapist records, and (b) the standard caveat regarding studies employing secondary analysis (i.e., the interviews were not focused specifically on sibling and peer relationships and therefore some accounts were not as detailed as would be desirable). Because most participants had received psychotherapy, they were undoubtedly different from untreated child sex offenders. Further, some participants were in ongoing therapy and therefore in varying stages of gaining insight into their early lives and behaviors. These study findings should not be considered generalizable to the population of child sex offenders.

It is hoped that this research project will provide some new directions for further research and other clinical interventions with abused/sexualized children at risk for becoming perpetrators themselves. Until societal preventive actions and early clinical interventions are more successful, the crime of child sexual abuse will continue to be far too common.

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The Relationship of Adverse Childhood Experiences with Quality of Life in Adults Who Themselves Have Committed a Sex Offense Against a Child

Poster

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Background

Exposure to adverse childhood experiences threatening a child's health, survival, development, dignity, or happiness can lead to lifelong physical and mental health problems

with deleterious effects on quality of life (QOL). Quality of life is a multidimensional construct that takes into account individuals' position in life within the context of their own culture and value system in relation to their own goals, expectations, standards, and concerns (WHOQOL Group, 1996). While a few studies in the general population revealed that adverse childhood events affect QOL persisting into adulthood, no study has looked at the relationship between adverse childhood events and QOL in adulthood in those who have perpetrated sex offenses against a child.

Aim

To test whether QOL is lower for adult child sex offenders who themselves endured adverse experiences as children.

Methods

A descriptive, correlational design was used. The sample consisted of 188 community dwelling adult child sex offenders enrolled in a psychological support group, but no longer in the prison system. Men and women 18 years of age or older were included if they speak, read, and write in English. Instruments consisted of a demographic data form, the Adverse Childhood Events Scale (ACES), and the abbreviated World Health Organization Quality of Life Scale (WHO-QOL BREF). For each of the ten items of the ACES, we tested the difference in quality of life between persons who had experienced an adverse childhood event and those who had not experienced that particular adverse childhood event using t-tests. Correlations between the number of adverse childhood experiences and quality of domains were calculated using Spearman's rho. Statistical significance was set at $p < 0.05$.

Results

The sample was predominantly male (89%), heterosexual (83%) and from the southeastern United States (100%). Approximately 79% completed high school (41%) or some college (38%). Almost half the sample (46%) was unemployed, but others worked full-time (33%) or part-time (11%). Approximately 53% reported current tobacco use, and 13% drank alcohol. Twenty-eight percent of the sample had at least one disability. Common physical problems included hypertension (24%), arthritis (17%), diabetes (11%), heart disease (9%), back pain (8%), and lung disease (3%). Psychiatric conditions mentioned were depression, bipolar disorder, PTSD, anxiety, and ADHD. Neurological issues included epilepsy and neuropathy. Significant correlations were observed between the number of adverse childhood experiences and the physical (r = -0.23), psychological (r = -0.19), level of independence (r = -0.19), and social relationships (r = -0.24).

Conclusions

Persons who experienced more types of adverse childhood experiences had significantly poorer quality of life in all four domains: physical, psychological, level of independence, and social relationships.

Educational Goals

1. To discuss adverse childhood experiences of adults who themselves have committed a sex offense against a child.
2. To analyze the relationship of childhood averse events with quality of life in persons who themselves have committeed sexual offenses against children.

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Male Sex Offenders' Capabilities to Meet Their Goals: An Explanatory Model of Male Sexual Offending

Paper

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Adult sexual contact with children is bewildering to most, but in order to prevent future victimization we must seek to understand the offender. Sex offender research has historically focused on the deficits of sex offenders, giving only limited attention to their capabilities. Capabilities are the offenders' abilities to regulate their emotions, manage their behavior, deny their actions or deceive others about them, experience personal insight, and maintain interpersonal relationships. These attributes are important because they serve as the foundation for treatment and indicate how offenders who are refractory to treatment use their strengths to continue their abusive activities. An explanatory model (EM) is needed to help understand how offenders' beliefs and attitudes influence their behaviors, as well as to guide investigations of reported abuse, recidivism risk assessments, and treatments. The purpose of this study was to identify offenders' capabilities in order to identify their goals and their ability to meet those goals. An EM is proposed to explain child sexual abuse from the offender's perspective and take into account both the influence of the offender's social environment and interpretation of personal behavior in order to prevent further sexual abuse.

Methods

Qualitative methods adapted from grounded theory allowed the research team to handle an extensive data set and consider child sexual offending from multiple perspectives. Specifically, dimensional analysis was used to unravel and uncover dimensions, properties, contexts, conditions, and consequences of complicated concepts. This approach was chosen during preliminary data analysis as multiple dimensions emerged while attempting to understand the offenders' views of their sexual offenses.

Participants included 21 males convicted of a sexual offense against a child who were registered in the state. Inclusion criteria included at least minimal cooperation with the risk assessment process, average to above average intelligence, and stable mental status with no signs of thought disturbance. Offenders assessed as mentally disabled and offenders whose victims were within 3-5 years of the offenders' ages were excluded. The average age of the sample was 39 years, 2 were African-American and 15 were Caucasian. The offenders had a total of 37 reported victims, ages 3-15 years. The majority of the convictions included sexual abuse (33%), sexual assault (19%), or rape (14%).

Data were collected from offender risk assessment records compiled by the Sex Offender Screening and Risk Assessment (SOSRA) Program. SOSRA conducts in-depth assessments of all offenders required to register in the state. The records include documentation of the charges, the official version of the offense from the perspectives of the victim(s) and law enforcement, interviews with the offenders, in which they provide their versions of the offense, and the offender's written responses to an Incomplete Sentences Test (IST). ISTs allow for subjective responses to open-ended stems and are used in the risk assessment to identify relevant interview topics. The offenders whose records were reviewed for this study were legally required to participate in the risk assessment process, and thus, participation was involuntary. Hence, the offenders' responses to the ISTs were likely to reflect their attempts to portray themselves and their actions in the best possible light and were, therefore, useful in identifying their capabilities from their perspective.

The explanatory model began with a two-dimensional matrix of "Goals" and "Resources." The goals were either pro-social, which were activities that enhanced life, welfare, and interpersonal relationships, or pro-offense, which demonstrated that the offender would attempt to re-offend without detection. Goals were identified by comparing the offender's version of the offense to the official version of the offense. Pro-social goals were revealed in those who accepted responsibility. Pro-offense goals were revealed in

those who did not accept responsibility, had attitudes of indignation and self-righteousness, a lack of self-control, limited capacity for foresight, and maladaptive values.

The offenders had developed resources through their personal experiences and their social and intimate relationships. Their resources were either adequate or inadequate. Adequate resources included something or someone they could turn to if they had trouble, positive memories and insight, and life experiences that they could draw on to solve problems. Inadequate resources included inappropriate means, limited scope, incoherence, and a lack of skill to adjust to life-changing circumstances.

A third dimension was added to the analysis, "Self-appraisal," which reflected offenders' own assessments of their capabilities and resources. Their self-appraisals were either realistic or unrealistic. The offenders' perceptions of their childhood experiences, relationships with their families of origin, competencies and relationships as adults, as well as their references to their offenses, their views of themselves and others, and others' views of them, were analyzed.

Results

The central explanatory theme that emerged from this data was the offenders' abilities to meet their goals-capabilities. Their capabilities reflected their resources, which were either adequate or inadequate, and their self-appraisals, which were either realistic or unrealistic.

Four cases emerged from analysis:
1. The offender had adequate resources to meet pro-social goals: the good guy beset by trouble;
2. The offender had adequate resources to meet pro-offense goals: the repeat offender;
3. The offender had inadequate resources to meet pro-social goals: the people pleaser; and,
4. The offender had inadequate resources to meet pro-offense goals: the pretender.

The good guy beset by trouble.
This offender had adequate resources to meet his pro-social goals. He used his capabilities to return to socially responsible behavior. He admitted to his offense, verbalized remorse for the trouble he had caused his victim, his family, and society, and sought sex-offender treatment. He had a supportive family, multiple competencies, and a realistically positive self-appraisal.

The good guy beset by troubles had resources that laid a foundation for saying and doing what is generally seen as "right" and pleasing to society. He expressed conventional views of intimate relationships and spiritual or religious matters. When discussing his job, he saw himself as a hard worker and hoped others viewed him in the same manner. His education, accomplishments, talents, and family achievements met or exceeded the social norms. He saw the law in a good light. His family of origin was available and supportive, and his recreational activities were aimed at pleasing others.

The good guy was motivated to act in a way that would protect society from his deviant thoughts and behaviors. His values included fairness and ethics in life, and he described himself as a good person overall, with irrelevant or trivial flaws. He discussed sex with modesty and propriety. The general population and norms of society were seen positively, with the goal of benefiting others. He also demonstrated willingness to change his thoughts and behaviors. When discussing his offense, he expressed regret and acknowledged his wrongdoing. He discussed the changes he would like to make in the world, not only for himself, but also for the world as a whole. The attitudes of others towards him were important and taken into consideration.

The repeat offender.
This offender had adequate resources to meet his pro-offense goals. He used his capabilities to please himself, denied committing an offense, and refused to participate in treatment. It is likely that he threatened or blamed his victim for the offense. He isolated himself and had a condescending attitude towards others. His competencies were related to personal abilities rather than social accomplishments and he had an unrealistically positive self-appraisal.

The repeat offender's background fostered an apathetic attitude towards offending. His view of marriage was that it might be acceptable for others, but his own experiences with it were negative. He was reluctant to comment on his own work ethic, and when identifying his competencies, he did not mention social accomplishments, only personal abilities. The law was seen as wrong and viewed as more harmful than helpful. He demonstrated minimal attachment when discussing his family and he enjoyed solitary recreational activities.

The capabilities of the repeat offender were self-focused and aimed at pleasing himself. He expressed concern about what was right and fair only in regard to his own benefit. He listed personal capabilities that were so extreme that they became his flaws– otherwise his flaws were minimal. Recollections of past experiences that provoked feelings were used to blame others for his actions and his sexual comments were vague in an attempt to appear minimally deviant. The offender's intent to avoid disclosing information was apparent and his goals were difficult to attain as long as he was incarcerated. Upon release into society, he was prepared to focus on his pro-offense goals. He had minimal insight into the severity of his offense and expressed no remorse for the victim. He expressed no need to be understood by society or to understand anything for himself. Any changes the offender would make in this world were focused on himself, in relation to his incarceration, and he did not care whether others thought negatively of him.

The people-pleaser.

This offender had inadequate resources to meet his pro-social goals. He used his capabilities to talk the talk, but not walk the walk. He admitted to his offense, but rationalized his behavior. He would have liked society's trust, but he was evasive and manipulative. He wanted positive social and family relationships but his self-perception was grandiose. He appeared to actively participate in treatment but had no true insight.

The people-pleaser's resources were insufficient to support his attempts to appear pro-social. He had the means to achieve pro-social goals, but cooperating with society was not his main focus. His marriage might have originally been a strong point in his life, but was now viewed as a weakness. Competencies at work were important and he was able to demonstrate some insight into his downfall as well as his capabilities. His view of the law focused on how it had affected his own life. His family of origin might have been supportive, but the offender was slow to identify their shortcomings. He enjoyed living in isolation.

The people-pleaser attempted to convey intent to comply with social norms, but his capabilities were insufficient to be pro-social. His values were aimed at what shouldn't be in life, instead of what should be. His perception of himself was that he was amiable, but he still got into trouble. When recalling emotional situations, he was able to admit to the unhappiness that was a result of his offense. He attempted to cover his pro-social insufficiencies by providing socially acceptable comments about sex. He commented very little on his ability to share his thoughts and feelings with others. He appeared to be insightful about the general population and norms of society and saw that both good and evil exist, but were contradictory of one another. His goal was to protect society from his offense but this was difficult for him to attain since his real aim was to protect himself from his offense-related thoughts and behaviors. He felt definite remorse for his offense and regret for the consequences it caused. However, he was quick to rationalize the situation and explain his side of the story. His desired changes were directly related to the results of his offense. Through it all, he made little reference to the importance of society's view of him, but demonstrated intent to appease society.

The pretender.

This offender had inadequate resources to meet his pro-offense goals. He used his capabilities to continue his offense-related patterns but his conscience troubled him. He admitted to his offense, but focused only on how it had affected his own life and denied the need for treatment. He felt that he had been treated unfairly and just wanted others to like him. He had incongruent values and a history of failed relationships, but a good family background and positive competencies.

Like the repeat offender, the pretender's resources supported a pro-offense thinking pattern. However, this offender did demonstrate some concern about how others would think of him because of his offense. His experiences with marriage had not been positive, but he understood that they could be. His work was relatively unimportant but he did identify some accomplishments of which he was proud. He viewed the law as necessary but there were changes he would make to it. He was ambivalent about the resources acquired from his family life; he appeared to have had social support, but he had experienced some emotional turmoil. He enjoyed recreational activities that required interaction with others, but not in large groups.

The pretender's abilities appeared to make him capable of continuing his offense-related patterns, but his conscience seemed to haunt him at times. His values focused minimally on what was fair for himself. His view of himself was that he was an overall good person, but he was able to see that he had played a role in his mistakes. His mistakes troubled him and were a source of concern. Of all the offenders, he saw the least need to sugarcoat his opinion of sex. He had difficulty sharing any information about his life and he perceived that others also had issues with being honest. His ability to meet his goals was limited by his perception of his offense and his desire to appear harmless to others. He focused on the impact of

his offense on his own life and thought he had been treated unfairly. He wanted others to like him and understand him. He wished to change the circumstances of his own life, but did not focus on changes needed in the world.

Discussion

The offenders' pro-social or pro-offense goals were demonstrated in their attitudes toward their offenses. Their capabilities of meeting their goals, however, were based on the availability of resources. For example, while the good guy and the people-pleaser both wanted to please society, only the good guy had adequate resources to do so. While the repeat offender and the pretender both conveyed the intent to re-offend without detection, the pretender did not have the ability to do so because he was too concerned about society's views of him. Thus, it may be hypothesized that the good guy will not re-offend and the repeat offender will re-offend but not get caught, because he has adequate resources to do so; in contrary, the people pleaser and pretender will reoffend and get caught because they have inadequate resources to meet their goals.

The men in this study seemed to know whether they intended to continue offending or whether they would try to protect society from their behavior. However, they did not directly reveal their intentions to meet either pro-social or pro-offense goals. Nevertheless, if we can identify the offenders' resources and capabilities, demonstrated by their attitudes toward personal experiences, intimate relationships, and social relationships, their goals will be more apparent. Treatment providers initially should focus on identifying offenders' goals and then assess the offenders' ability to meet their goals. In particular, an offender's ability to disclose details of the offense and his insight regarding the effects of the offense contributes to his capability to meet his goal. Revealing his past ability to develop and maintain relationships also demonstrates the resources he has available to support himself as he attempts to meet his goal.

After identifying the offenders' capabilities and resources, a treatment provider will have a good sense of whether the offender is sufficiently or insufficiently able to meet his pro-social or pro-offense goals. Treatment plans can then be individualized to increase the offenders' capabilities and resources to meet pro-social goals and minimize abilities to meet pro-offense goals. With a focus on their capabilities and resources, offenders who continue to demonstrate the sufficiency to meet pro-offense goals can be more carefully monitored and further legal and community notification can occur.

Acknowledgements

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A Research-Based Model of the Meanings of Violence to Perpetrators

Paper

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Background

For our conceptual framework, we drew upon principles of hegemonic masculinity (Connell, 2005; Donaldson, 1993; Kimmel, 2008) symbolic interaction theory (Blumer, 1969; Bulmer, 1984; Gilgun, 1999, 2012, 2013), and critical discourse analysis (CDA) that examines ideologies of power embedded in texts (Fairclough, 2001; Wodak, 2001). Practitioners of CDA maintain that the analysis of texts through the perspectives of power can lead to identifying, understanding, and transformations of ideologies of power and the practices that follow from them (Fairclough, 2001; van Dijk, 2001, 2006; Wodak, 2001).

Aims

This paper aims to document a model of interpersonal violence that accounts for the meanings of violence to perpetrators.

Methods

The method was life history interviews with 95 men and 12 women known to have perpetrated several types of interpersonal violence including incest, child molestation, physical assault, attempted murder, and murder. The life history is the prime research method of the Chicago School of Sociology whose roots extend to the nineteenth century German philosophy of Dilthey & Simmel (Bulmer, 1984; Gilgun, 1999, 2012, 2013). Life histories are first-person accounts whose purpose is to understand the intersections of individual meanings with social and cultural beliefs and practices. Seventy-five of the informants were interviewed five or more times each, while 32 were interviewed one time each. The sample is primarily of middle and working class persons of European decent, with nine African-Americans and three Native Americans, aged 19 to 54. Data analysis involved open, axial, and selective coding (Strauss, 1987; Corbin & Strauss, 2008). We began analysis with a set of pre-established codes, called sensitizing concepts (Blumer, 1968) that we derived from our conceptual framework. Examples are power, control, ideologies of masculinity, and women's subordination. To avoid finding what we expected, we did negative case analysis (Bogdan & Biklen, 2008; Gilgun, 2005). During analysis, we identified other codes, such as thrills and chills.

Results

Acts of violence that mystify outsiders make sense and are compelling to perpetrators. Physical aggression, including murder, are acts of control and abuses of power that, with some exceptions, bring intense gratification. Child molestation gives sexual pleasure, intimacy, and love. Perpetrators may be oblivious to the effects of their violence, may dismiss or justify it, or may enjoy it. We found that perpetrators draw upon ideologies of entitlement, male supremacy and women's subordination as guidelines for their actions. Men and boys whom perpetrators defined as subordinate were targets of violence.

Educational Goals

1. To enhance understanding of the perspectives of perpetrators of interpersonal violence
2. To use these understandings to contribute to policy, prevention programs, and interventions

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Chapter 15 – Specific populations: child & adolescent

Effects of collective violence attributed to organized crime in a border community USA/ MEXICO

Symposium

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Keywords: Collective Violence, Mental Health, Children, Organized Crime, Trauma

Background

A sub-type of violence known as collective violence, which includes both direct and indirect exposure to violence, has also been shown to be responsible for a considerable burden of physical and mental health morbidity. According to the World Health Organization, "collective violence" includes the instrumental use of violence by people that identify themselves as members of a group, which could be transitory or with a more permanent identity, against another group of individuals in order to achieve political, economic, or social gain.

Most studies about children's exposure to collective violence include the psychosocial effects as a result of violence within the community, war, or guerrilla conflicts. Additionally, there are studies about the effects of direct and indirect victimization related to disasters such as acts of terror, genocide, or extreme acts of violence. Collective violence attributed to organized crime has received a high degree of public attention in Mexico lately with intense media coverage. According to data published, drug-related violence in Mexico escalated at an unprecedented rate in the last 5 years. Assassinations in Mexico have increased with thousands of drug-related deaths occurring in Ciudad Juarez in the state of Chihuahua, Mexico, sister city to El Paso, Texas, USA

In 2008 the violence emerged in Ciudad Juarez and it became considered one of the most violent cities of the world. The number of homicides linked to the organized crime in 2008 was 1332 compared with 136 in 2007. In the following years, according to INEGI, the number increased with 2230 in 2009 and 2738 in 2010. The municipality balance at the end of 2010 was reported as: 10,000 orphans, 100,000 people immigrated to look for safer territories; there was a great economic cost of violence with 25,000 abandoned homes, the closure of almost 10,000 businesses due to extortion, kidnapping, the harm on new investment and new business, and the loss of many jobs.

News about mass murders of men, women, and children, including activists and bystanders, mutilations, and a large number of acts of terror, including bombings, kidnappings, torture, and decapitations would be broadcast and rebroadcast for days or months by radio stations, newspapers, and television networks.

Families on the border area faced direct victimization resulting from the loss of family members through death, torture, and kidnapping. Mental health providers in El Paso, Texas, have seen increased numbers of Ciudad Juarez children and adolescents who cross the border in search of help for psychiatric and psychological problems resulting from the effects of gang wars in their country.

Chronic exposure of children to violence has shown to trigger a panoply of serious mental health problems often manifested by depression, anxiety, acute stress disorder, post-traumatic stress disorder, sleep difficulties, somatic symptoms, complicated bereavement, substance abuse, and antisocial and suicidal behaviors, among others.

This symposium presents findings in the USA/Mexico border of the effects and treatment of children exposed to collective violence attributed to organized crime.

Study 1 – Children's mental health and collective violence: a Binational study on the United States-Mexico border.

Authors: M. Leiner, H. Puertas, R. Caratachea, C. Avila, A. Atluru, D. Briones, & C. De Vargas
Published in the Revista Panamericana de la Salud. 2012 May; 31(5):411-6.

Background
Cumulative adverse events contribute to a higher vulnerability of children exposed to traumatic experiences [1]. A large number of studies have indicated that exposure to community violence, including armed conflicts or war [2-7] and gangs [8, 9], has profound detrimental effects on children [10-13].

Poverty alone is a predictor of problems among children, with long-lasting effects, and poverty with exposure to collective violence has been recognized to have a cumulative effect [14, 15]. However, we could not find studies that examined both the effects of poverty and collective violence (attributed to organized crime). The objective of this study was to investigate the risk effects of poverty and exposure to collective violence attributed to organized crime on the mental health of children living on the United States-Mexico border. We compared the mental health of children living in poverty in a population of Mexican/Americans living in El Paso, TX, United States, with a population of Mexican children living in poverty and exposed to collective violence attributed to organized crime in Ciudad Juarez, Chihuahua, Mexico. The comparison of children living on either side of this border region provides a natural environment to study the interaction of poverty and community violence. In the United States, El Paso is rated one of the safest major cities [16] in terms of exposure to crime, while Ciudad Juarez has been characterized as the most violent city in the world for the third year running [17].

Methods
A repeated, cross-sectional study measured risk effects by comparing scores of psychosocial and behavioral problems among children and adolescents living on the border in the United States or Mexico in 2007 and 2010. Patients living in poverty who responded once to the Pictorial Child Behavior Checklist (P+CBCL) in Spanish were randomly selected from clinics in El Paso, Texas, United States (poverty alone group), and Ciudad Juarez, Chihuahua, Mexico (poverty plus violence group). Only children of Hispanic origin (Mexican–American or Mexican) living below the poverty level and presenting at the clinic for nonemergency visits with no history of diagnosed mental, neurological, or life-threatening disease or disability were included.

Results
Exposure to collective violence and poverty seemed to have an additive effect on children's mental health. Children exposed to both poverty and collective violence had higher problem scores, as measured by the P+CBCL, than those exposed to poverty alone.

Discussion
The objective of this is study was to investigate the risk effects of poverty and exposure to collective violence attributed to organized crime on the mental health of children living on the United States-Mexico border.

Comparing psychosocial and behavioral scale scores in the United States children and adolescents between 2007 and 2010 did not yield a significant difference in Problem Scale Scores, with the exception of one scale (Somatic Complaints scores). In Mexico, there were significant differences in Problem Scale scores when comparing 2007 and 2010, with higher scores reported in 2010.

The significant resulting interaction between group (United States/Mexico) and time (2007/2010), with higher scores reported by children and adolescents living in Mexico in 2010 in Rule Breaking, Aggressive Behavior, and Social Problems scales, seems to indicate an additive effect of poverty plus exposure to collective violence in this group. Vulnerability of younger children in Somatic and Social Problem scales was found among children in Mexico in 2010 in the youngest group, as a result of the interaction between group (United States/Mexico), year (2007/2010), and age groups (6-9, 10-12, and ≥13 years), although the

effect sizes were small. These findings seem to indicate that problems reported by parents have increased in 2010 in a city that has been considered one of the most violent cities of the world not at war.

The results of this study show high rates of mental health problems in children in this area, both in the United States and Mexico. However, there are higher rates of psychosocial and behavioral problems for the children on the Mexican side of the border during 2010. Although we cannot rule out economic, social, and cultural factors, there is evidence of an additive effect of poverty plus exposure to collective violence.

Study 2 – Young Children's mental Health in a community affected by Collective Violence: A Binational Study

Authors: M.T. Villanos, H. Puertas, J. Peinado, C. Avila, D. Blunk, C. De Vargas, and M. Leiner

Background

Most studies about children's exposure to collective violence include the psychosocial effects as a result of violence within the community [18-21], war, or guerrilla or military conflicts [3, 22-26]. Additionally, there are studies about the effects of direct and indirect victimization related to disasters such as acts of terror, genocide, or extreme acts of violence [27-34]. Collective violence attributed to organized crime has received a high degree of public attention in Mexico lately with intense media coverage. News about mass murders of men, women, and children, including activists and bystanders, mutilations, and a large number of acts of terror, including bombings, kidnappings, torture, and decapitations can be broadcast and rebroadcast for days or months by radio stations, newspapers, and television networks.

This extraordinary occurrence of stressful events can have a profound effect on children's sense of security, leaving strong feelings of vulnerability resulting in emotional and psychological trauma, even though these events are only presented by the media [35-37]. Stressful changes affect the mental and physical health of individuals. There is evidence that acute trauma, such as witnessing an earthquake, alters the cerebral microstructure of the limbic system [38]. The threatening, intrusive images portraying extreme acts of violence in media coverage include frightening images that are usually very intense, portray actual events with acute suffering, and are often presented unedited [39, 40].

Second-hand victimization via exposure to these events via the media represents a form of indirect trauma and has been shown to affect children's psychosocial, behavioral, and emotional responses even months to years after the exposure took place [41]. Moreover, viewing media footage of geographically remote events led to posttraumatic symptoms in those children who interpreted the footage as threatening to themselves [39].

The effects of collective violence attributed to organized crime and poverty were reported in a previous study of children 6 to 16 years old that found significant behavioral changes in children exposed to collective violence [42]. For this study, we compared the effect of exposure to poverty and collective violence among younger children living in Ciudad Juarez, Chihuahua, Mexico to that among children living in poverty in El Paso, Texas. Ciudad Juarez was characterized to be one of the most violent cities in the world [43], whereas El Paso, Texas was named the city with the lowest crime rate in the United States with a population of over 500,000 residents [44].

Methods

A cross-sectional study measured risk effects by comparing scores of psychosocial and behavioral problems among younger children living on the border of the United States and Mexico in 2010. Patients living in poverty who responded once to the Pictorial Child Behavior Checklist (P+CBCL) in Spanish were randomly selected from clinics in El Paso, Texas, United States (poverty alone group), and Ciudad Juarez, Chihuahua, Mexico (poverty plus violence group).

Results

There were significant effects of group (United States/Mexico) in all of the problem scales (emotionally reactive, anxious and depressed, somatic complaints, withdrawn, sleep problems, attention problems, and aggressive behavior) with small effect sizes. In addition, significant effects of group were found in the total scales (internalizing, externalizing, and total problems scales) with higher scores for the Mexico group in all scales (small effect sizes). There were significant effects in all DSM scales, including DSM affective, DSM anxiety, DSM pervasive, DSM ADH, and DSM oppositional defiant (small effect sizes), with higher scores for the Mexico group. Effects of age (1.5, 2, 3, 4, or 5 years of age) were significant, with higher scores among younger children in withdrawn/depressed problems (small effect sizes). Effects of group and age were also found, with higher scores for Mexican children at all ages with only one exception at 3 years old. Effects of age were found in the externalizing scale (small effect), with higher scores reported at 1 and

3 years of age. Effects of age were found in the DSM pervasive scale, with scales higher in the Mexican group in all ages with the exception of 3 years of age.

Discussion

Crime victimization has been shown to be a major and public problem that increases the risks to victims of suffering from trauma-related disorders, including PTSD, suicide, substance abuse, future criminal behavior, health and social problems, and future poly-victimization [46]. It has been found that trauma history, including direct victimization, is often not evaluated or treated appropriately. This implies that victims of indirect victimization have even less opportunity for rehabilitation or support services. In addition, studies of the effects of crime victimization, which is considered direct exposure to violence, generally focus on adults, leaving an important gap in the effects of indirect victimization on children [47]. Some studies have found that indirect victimization does not predict aggressive behaviors [48], and others indicate systematically that aggression is present at short or long term [49-51].

Responses of children to indirect exposure to collective violence are determined by individual level risks factors that include socioeconomic level; family context, including parental distress; appropriate child care; personal characteristics; and the severity and amount of exposure [54]. This article provides information that indicates that behavioral problems are displayed with higher frequency among children exposed to poverty and collective violence when compared to children exposed only to poverty. Effective planning of systematic detection and treatment of children as young as 18 months exposed to trauma are necessary to diminish the mental health problems caused by the collective violence attributed to organized crime.

Study 3 Case Report – The impact of collective violence on a 12-year-old boy from Mexico: An interdisciplinary assessment and treatment approach

Author: Cecilia De Vargas

Case Report

A 12-year-old Latin American male from Ciudad Juarez, Mexico was admitted to the El Paso Psychiatric Hospital in El Paso, TX following several months of severe agitation. He reported disorganized thoughts and behaviors, sadness, hyper arousal, insomnia, and nightmares. The child experienced repetitive dreams in which his family and he were killed. He voiced his fear that his family and he would be murdered by the drug cartels. The child refused to leave the house, which necessitated home-based school assistance. He also did not want his mother to leave the house. The child developed a fear that his brain would be cloned because of his knowledge of computers and video games.

Stress Factors

The collective violence in Ciudad Juarez, Mexico escalated in the years prior to the onset of this child's symptoms. The child's mother was kidnapped at gunpoint by members of the drug cartels in Ciudad Juarez five months prior to the child's admission to the hospital. The child's male cousin was also kidnapped in Ciudad Juarez a year before the child's hospital admission. The family has experienced financial problems due to the violence in the city. The child had been transferred from a private to a public school due to the family's financial constraints.

Developmental History

The child had an uneventful birth after a full-term pregnancy. His birth weight was within the normal range. The child met all developmental milestones on time and experienced no psychomotor, speech, language, social, or mood deregulation problems.

Family History

The child lives in Ciudad Juarez, Mexico with his parents. The child also lives with his 10-year-old and 15-year-old brothers. Other extended family members of the child also live in Ciudad Juarez.

School History

The child is a good student and has no behavioral problems in school. The child reported that he was bullied by other classmates in the public school to which he had transferred.

Social History

The child is social and has several friends. He favors violent video games. He explained that his preference for violent video games stems from the reality of violence in his town and in his life.

Medical History

No major medical problems were reported. A head MRI, EEG, and a comprehensive series of laboratory tests were completed in Ciudad Juarez, Mexico. All results were within normal range. The child has a normal height and weight for his chronological age.

Psychiatric Family History

The child's mother has a history of posttraumatic stress disorder (PTSD). The child's younger brother exhibits symptoms of generalized anxiety disorder (GAD). According to the child's parents, two maternal great uncles suffer from "schizophrenia or bipolar disorders."

Examination of Mental Status at Admission

The child was physically well-developed, casually dressed, and well groomed at hospital admission. The child exhibited visible anxiety and a hyper-vigilant/mistrustful attitude. His speech was rapid but coherent with an elevated tone of voice. The child's thought content revealed a fear that his family and he would be killed by the drug cartels. He said that he sometimes wondered if a bullet had already hit his forehead. He feared that his brain would be cloned by either the police in Ciudad Juarez or the doctors at the hospital because he was an expert in computers. The child frequently worried that his mother had been sexually abused when she was kidnapped. He also worried that his cousin may be raping a girlfriend because he witnessed them kissing at a party. The child misidentified plumbers who had recently worked at his house in Ciudad Juarez as disguised drug traffickers who were going to kill his family. The child feared for his mother's safety every time she returned to Ciudad Juarez after visiting him in the hospital. However, despite this child's pervasive anxiety and his need to repeatedly talk about his fears, the child questioned the veracity of his experiences and felt relief when the staff verified facts with the family. He was well-oriented to the time, place, and persons involved in each experience, but was confused about the circumstances. He exhibited gaps in memory regarding the psychosocial stressors of the past few years. He denied that he had any death wishes or suicidal or homicidal ideas or plans. He became anxious and irritable when his peers screamed or had outbursts. The child functioned within an average range of intelligence, but his insight and judgment were impaired. His affect was labile and his mood revealed anxiety, irritability, and fear. The child drew a picture of his mother when she was kidnapped at gunpoint and identified this experience as the "worst stressor" in his life.

Hospitalization Course

A comprehensive medical work-up was completed during the child's hospital admission. All laboratory tests were within normal range. A medical assessment was conducted by a pediatrician and was reported to be normal. The child did not exhibit acute violence. No mechanical or chemical restraints were necessary.

The child was diagnosed with PTSD as well as a mood disorder - not otherwise specified. He received interdisciplinary treatment interventions for two weeks in the inpatient child and adolescent unit at the El Paso Psychiatric Center. He received 1 mg of Risperidone and 0.25 mg of Clonazepam twice a day and 150 mg of Sertraline once a day. Support therapy was combined with elements of trauma-focused cognitive behavioral therapy and was provided to the child on a daily basis. He also participated in milieu, recreational, and group therapies and showed a remarkable improvement that manifested as the return of logical and organized thinking, a calm affect and mood, and improved insight and judgment. He concluded that he had been confused and anxious from the overwhelming circumstances. He also voiced his fears about returning to Ciudad Juarez after his discharge from the hospital.

Discharge Plan

The child was discharged to the care of his family in Ciudad Juarez. He was referred to a child psychiatrist at Texas Tech University Health Sciences Center (TTUHSC) in the Department of Psychiatry in El Paso for medication monitoring and management. A referral was made to a therapist at the El Paso Child Guidance Center for individual and family interventions.

Results and Conclusion

There was a correlation between the child's exposure to collective violence and the child's severe symptoms of PTSD. An interdisciplinary assessment and treatment plan was provided by a child and adolescent psychiatrist, psychiatric nurses, psychiatric residents, and licensed professional counselors. A combination of pharmacotherapy, trauma-focused psychotherapy, and family therapy was used to treat this child. This interdisciplinary approach has resulted in the partial remission of acute trauma symptoms as measured by both the Behavioral Assessment of Symptoms in Children (BASC) and the accomplishment of the goals and objectives that were outlined in the treatment plan. This case report therefore illustrates the benefits of an interdisciplinary approach to the treatment of PTSD in a 12-year-old boy exposed to collective violence.

Study 4 – Impact of Collective Violence on Children's Mental Health: Comprehensive review of recent literature

Author: Cecilia De Vargas

Background

According to the United Nations Children's Fund (UNICEF) State of the World's Children - Childhood Under Threat report (55), armed conflicts are one of the primary threats to children, leaving 2 million children murdered, 6 million children disabled, and 20 million children homeless in the last decade. Children may become either direct victims of collective violence by being killed, injured, tortured, raped, prostituted, or displaced or indirect victims by losing their families or witnessing traumas experienced by others. In the United States, anxiety and other stress disorders have been observed among children after the 2011 attack on the World Trade Center in New York City (56), the 1993 bombing of the World Trade Center, and the 1995 bombing of the Murrah Federal Building in Oklahoma City (57). In Mexico, an unprecedented recent escalation of drug-related crime, particularly in Ciudad Juarez, is associated with serious mental health problems among children and their families, as documented by a review of the Justice in Mexico Crime Indicator Database (58) and works by Leiner (59) and Turati (60). In other countries with armed conflict, the presence of mental health problems among pediatric populations has also been documented (61-65).

Among children exposed to collective violence, the most commonly identified psychiatric conditions are anxiety, acute stress disorder, and post-traumatic stress disorder (PTSD), followed by depression, psychosomatic problems, sleep disorders, and externalizing and disruptive behaviors (66). Across studies, male children are usually exposed to more violence than female children and are at a higher risk of developing PTSD, whereas female children are at a higher risk of developing depression and becoming suicidal (55). In Darfur, Sudan, a high tendency of violence toward female children and women has resulted in shame, depression, and suicide in this population (55. A longitudinal study of young children living near the Gaza Strip revealed that 37.8% of children exposed to war were diagnosed with PTSD, with their mothers reporting depression, anxiety, and trauma-related symptoms (62). Furthermore, children who are displaced or living in refugee camps are usually subject to significant stress and at a high risk of developing emotional or behavioral problems. In particular, anxiety, depression, and somatic complaints have been observed among Cambodian adolescents living in refugee camps or other countries (67). Also, Rwandan orphans reported high rates of PTSD ten years after the genocide (68).

Previous studies have identified both risk factors associated with developing PTSD or other mental health problems and protective factors contributing to resilience among children exposed to collective violence (61-65 & 69). Across studies, primary risk factors include the severity of trauma, duration of exposure to trauma, proximity to tension areas, history of previous traumas, displacement of families, family instability, insecure maternal attachment, and maternal depression and PTSD. Some studies also indicate lack of social support, media influence, child labor, and cultural differences as risk factors. At the individual level, protective factors include positive personality disposition, good communication and pro-social skills, normal intelligence, good emotional regulation, and effective coping and problem-solving skills. At the social and cultural levels, family stability, secure maternal attachment, proximity to the mother, and good educational, political, religious, and community support are important factors contributing to resilience.

Discussion

The studies reviewed here are not without methodological limitations. For instance, most studies were cross-sectional due to the practical difficulty of completing longitudinal research in war zones. Furthermore, although authors report the use of valid and reliable instruments to screen for psychiatric symptoms in children and their parents, questions have been raised about the application of instruments developed mainly in the western hemisphere to places with different ethnicities and cultures. It is also at times unclear how specific psychiatric conditions such as PTSD can be inferred based on self reports. Despite their limitations, however, the information obtained by these studies is valuable for understanding the deleterious impact of collective violence on children worldwide and identifying associated risk and protective factors.

Conclusion

Given the findings of these studies, communities should be aware of the need to identify children who are at risk of developing mental health problems due to exposure to collective violence. Also, programs should be developed and funding should be dedicated to additional research aimed at identifying resilience factors, preventing serious sequelae, and developing effective treatments for affected children. Collaboration among government agencies, educators, mental health providers, pediatricians, clergy, and other community partners is essential for accomplishing these difficult but noble tasks.

Study 5 – Narrative on the Journey of the El Paso Child Guidance Center in the Treatment of Traumatized Children and Adolescents

Cathy Gaytan & Cecilia De Vargas

Over the past several years there has been a rise in the number of children, adolescents and adults who have been exposed to traumatic events requesting mental health services at the El Paso Child Guidance Center. Clinic administrators and the clinical team comprised of licensed therapists and a child psychiatrist recognized a lack of appropriate assessment tools and therapeutic skills needed to address specific trauma related symptoms. The clinic faced extremely limited financial resources and a lack of exposure to experts in the field of mental health treatment of trauma symptoms.

To address the issue, the Clinical Director began to research evidence based trauma treatments by subscribing to and reading peer reviewed journals specific to children and adolescents and trauma, researching and contacting Universities and clinics throughout the country with a focus on research and treatment of trauma related symptoms in children and adolescents, and identifying funding sources which could potentially fund training for therapists. The Director began a routine review of the National Child Traumatic Stress Network (NCTSN) website to download free materials to assist in educating families about various trauma related topics such as how to support a child who has been exposed to a traumatic event. The Director developed trainings for local agencies and the school districts to educate community members and fellow agencies on how to identify and refer children and adolescents who have been exposed to traumatic events to the clinic for treatment. The Director began to develop collaborations with fellow agencies who typically work with victims of crime, such as the Child Advocacy Center, the Center Against Family Violence, the local children's hospital, and the Crime Victim's Compensation Program. Through these collaborations, clinic staff was eligible to receive training free of charge on an evidence based treatment for children with trauma related symptoms, which included traveling to another city.

The Clinical and Executive Director successfully wrote two grants which funded training for clinic staff and therapists from other local area nonprofit mental health agencies in a second evidence based trauma treatment. Some of these monies were also used to pay for ongoing monthly consultation with the trainer for ongoing skill development and refinement.
Clinic staff began to view trainings from the NCTSN website during weekly treatment team meetings.

These online trainings gave clinic staff exposure to experts in the field of trauma treatment who otherwise would have been too costly to bring into the city.
Through building relationships with personnel at trauma centers around the country, the Clinical Director was able to locate a University in another state conducting a research project on using telemedicine technology to conduct training on an evidence based parenting project. The clinic successfully joined the research project and staff are being trained in a third evidence based trauma treatment.

The use of brainstorming, collaboration, informal literature reviews, and constant research has led to the El Paso Child Guidance Center transforming itself into a training clinic in an underserved area with an improved ability to effectively treat trauma symptoms in children and adolescents.

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Contextual Factors and Disclosures of Child Sexual Abuse During Forensic Interviews

Poster

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Purpose

The purpose of this poster is to describe the conditions under which children disclose child sexual abuse during forensic interviews when children are believed to have been sexually abused.

Background

Children's capacities to provide relevant details in forensic interviews are related to several factors including age (Hershkowitz, Horowitz, & Lamb, 2005; Kogan, 2004; Ungar et al, 2009), relationship to perpetrators (Alaggia, 2004; Hershkowitz, Lanes, & Lamb, 2007; Staller & Gardell, 2005), perceived lack of family support or fears they will not be believed (Demarni, Cromer, & Goldsmith, 2010), perpetrator threats (Jensen et al, 2005; Paine & Hansen, 2002), and fears that disclosure will break up their family (Gilgun, 2010; Ullman, 2003). Previous research has focused on individual characteristics of the children and disclosure. We hypothesized that children who provide significant details of sexual abuse during forensic interviews have experienced high degrees of family support and low degrees of perceived negative consequences for disclosure.

Methods

We did content analysis of 62 videotaped forensic interviews where children disclosed child sexual abuse. The analysis took place in a six-month period in 2011 to 2012. Forensic interviews took place from December 2010 to March 2011. We used a structured coding format that had a 90% agreement in a test of inter rater reliability. Quantitative data included demographics, relationship of children to the alleged perpetrator, type of abuse allegation, and number of details provided by the child during the interview. Details included any words related to time, place, people, events, and descriptive words used by the children regarding the abuse. Fieldnotes tracked the children's affect in the interviews and recorded contextual information not contained in case files.

Results

Findings showed three patterns of disclosure associated with several contextual factors. Pattern 1 is comprised of children who readily disclosed with significant detail during forensic interviews and had usual amounts of interviewer rapport building and support (n=35). Pattern 2 is comprised of children who disclosed with significant detail but who required multiple instances of interviewer rapport building and support (n=14). Pattern 3 is comprised of children who disclosed with minimal detail and who required a high interviewer rapport building and support in comparison to other children (n=13).

Contextual factors associated with these patterns of disclosure are family support or lack of support, perpetrator bribes and threats, fears of consequences such as breaking up the family, and comfort or discomfort in using sexual terms. Supportive families, fewer fears of consequences, fewer perpetrator threats, and comfort in using sexual terms were associated with children's ready disclosure, or Pattern 1. Children who displayed Pattern 3 had unsupportive families, perpetrators threats, substantial fears about consequences of disclosure, and discomfort in using sexual terms. Pattern 3 showed multiple instances of avoidance of talking about the sexual abuse and also were more likely to have experienced other traumas, such as witnessing family violence. Children who displayed Pattern 2 showed a mixture of characteristics of Pattern 1 and Pattern 3.

Implications

Many professionals provide services to children and families where children have been sexually abused. This study provides information to about issues that facilitate and interfere with the disclosure of child

sexual abuse. Information from this study positions professionals to provide parents with support and information that will in turn facilitate parents' support of their children.

Educational Goals

1. Participants will be able to identify the patterns of disclosure among children who have been sexually abused.
2. Participants will be able to describe how patterns of disclosure are associated with contextual factors, such as family support, children's thinking about the consequences of disclosure, presence or absence of alleged perpetrator threats, and children's comfort in talking about sex.
3. Participants will be able to apply findings from this study to assess children's readiness to disclose and provide support when contextual factors may inhibit disclosure.

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Short- term psychopathological effects on children and adolescents who suffered different forms of abuse

Paper

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Background

The body of literature focused on child maltreatment has amassed substantial evidence demonstrating the relationship between child maltreatment and the development of a variety of short-term and long-term negative outcomes in child. Thus, child abuse and neglect represent a risk factor of primary importance for individual's health [1]. Negative consequences of child maltreatment in adult life have been reported and child maltreatment has been linked to depression, mood and anxiety disorders, eating disorders, personality disorders, dissociative disorders, Post Traumatic Stress Disorder (PTSD) and substance dependence [2, 3, 4, 5, 6].

Mnaystudies demonstrated a strict association between child maltreatment and the onset of externalizing mental health problems, such as attention deficit/hyperactivity disorder, conduct disorder, oppositional defiant disorder, autism and antisocial personality, and internalizing mental health problems, such as anxiety, depression, panic disorder and post-traumatic stress disorder [1, 5,7, 8, 9, 10, 11, 12, 13, 14, 15,16,17].

However, studies on the long-term effects of child maltreatment have some limitations, since they are based on self-reported retrospective measures of child abuse and neglect. Moreover, in the literature there are few studies about the short-term effects in maltreated children.

The aim of this study was to evaluate the short-term effect of child abuse and neglect on the health and the development of children and adolescents. In order to analyze the role of protective and risk factors on the development of child psychopathology, individual characteristics (i.e. gender and age of child at the time of maltreatment, Intelligence Quotient), abuse characteristics and familiar characteristics (presence/absence of a first or second level relative with psychiatric disorder) were explored.

Methods

Children and adolescents who were consecutively attended at the Child Psychiatric Unit of the Pediatric Hospital Bambino Gesù in Rome between January 2011 and March 2012 were enrolled in the present study. In the six months prior to the study all had suffered different forms of maltreatment (physical, sexual, emotional abuse and neglect). Different characteristics including population (gender, age at time of visit, family history of psychiatric disorders, cognitive development, and neuropsychiatric status) and abuse were considered.

The sample was clustered into three groups of participants: preschoolers (range age 2-6 years old): 60, pre-adolescents (range age 7-12 years): 99 and adolescents (range age 13-18 years): 26. Males were 90 and females 95.
All 185 children had suffered different forms of maltreatment: 40 children had suffered sexual abuse, 70 psychological abuse, 27 physical abuse and 48 had suffered different types of neglect. Moreover, 120 children had been abused by a family member and 65 by someone outside the family; 153 had suffered repeated maltreatment.
Total IQ (Intelligence Quotient) mean of the children was 100.8.
Finally 58 participants reported family history of psychiatric disorders.

Measures

Psychopathological diagnoses were established according to the Diagnostic and Statistical Manual of Mental Disorders-fourth edition criteria (DSM-IV-TR) [18].

In particular, we considered four categories of psychopathological diagnoses: internalizing disorders (anxiety and depressive disorders), externalizing disorder (attention deficit/hyperactivity disorder, oppositional-defiant and conduct disorders), PTSD, subclinical PTSD (sPTSD).

The diagnosis of PTSD was established in preschoolers following the algorithm proposed by Sheeringa [19]. For preadolescents and adolescents the diagnosis of PTSD was established according to adult criteria. For all participants sPTSD was defined as a syndrome characterized by at least one symptom each of cluster [20].

Different diagnostic evaluations were conducted, depending on the child's age.

Developmental level was evaluated using the Griffith's Mental Development Scale [21] or the Leiter-R [22]

In pre-schoolers clinical observations of children's behavior were made during play sessions and the parents filled out the Child Behaviour Checklist (CBCL) [23],and the Trauma Symptom Checklist for Young Children (TSCYC) [24].

In the school-aged group psychiatric diagnoses were defined using the Schedule for Affective Disorders and Schizophrenia for School-Age Children-Present and Lifetime Version (K-SADS-PL) [25].

The children's parents were also requested to fill out the CBCL 6-18 [26]. The children completed the Children Depression Inventory (CDI) [27], the Multidimensional Anxiety Scale for Children (MASC) [28], two self-report questionnaires for a specific evaluation of mood state, and the Trauma Symptom Checklist for Children [29].

A medical history was obtained for all children and they were submitted to neurological and physical examinations. Family relationships were also evaluated by clinically observing sessions including all family members. Moreover, in order to determine whether there were any family psychiatric disorders, a detailed family history was taken for each patient.

Statistical Analysis

A series of χ2 analyses on raw scores on categorical variables and one-way ANOVAs on continuous variables were performed. Furthermore, p values were adjusted by Stepwise correction.

Results

Our results documented as 7.6 % of the children displayed a PTSD, 51.3% a sPTSD, 24.3% an internalizing disorder, 11.9% an externalizing disorder and 4.9% no symptoms.

No significant differences emerged in the distribution of psychiatric disorders in maltreatment forms we considered [X2 (1) =20.8, p=.05].

In preschoolers the number of physical abuse was statistically lower than the others form of maltreatment [sexual X2(1) =9, p< .01; emotional X2 (1)=10.7, p< .01; neglect X2(1)=3.6, p< .05]. In pr-eadolescents, emotional abuse was more frequent than others forms of maltreatment [sexual X2(1) = 16.9, p< .001; physical X2(1)=14.3, p< .001; neglect X2(1)=4.1, p< .05]. In adolescents the distribution of different forms of maltreatment did not differ [X2(3) = 1.4, p =.7]. When we compared the three different age groups on different forms of maltreatment, we found that in pre-adolescents emotional abuse was more frequent than two other groups [preschoolers X2(1) = 7.3; p< .01; adolescents X2(1) = 33.3; p<.01]. Moreover sexual abuse was more frequent in pre-schoolers than adolescents [X2(1) = 6.3; p< .01]; no differences emerged from the comparison of the others age groups referred to sexual abuse.

Furthermore, we analyzed the distribution of psychiatric disorder in each age groups, no differences were found in these comparisons.

An analysis on gender was also conducted. In males, the most frequent form of maltreatment was emotional abuse [sexual X2(1) =13, p< .01; physical X2(1) = 7.7, p<.01; neglect X2(1)= 6.1, p< .01]; in females physical abuse was less frequent [sexual X2(1) =9, p< .01; physical X2(1)= 12.1, p<.01; neglect X2(1) = 9.8, p<.01].

In females, sexual abuse was more frequent than in males [X2(1) = 4.9; p<.01], while in males, there is no form of maltreatment prevalent than females.

If we consider the two groups based on gender only externalizing disorders were more frequent in males than females [X2 = 8.9, p<.01].

Finally, regarding family psychiatric disorders, data showed that age at the time of abuse in children with family history of psychiatric disorders was lower (age mean=5.82, sd =2.96) than age of children without family history of psychiatric disorders (age mean =7.41, sd = 3.46; F = 7.40, p =.001).

Discussion

Our data analysis of the mental health of children and adolescents who have suffered different forms of abuse showed that more than half of them did not meet the full criteria for a psychopathological disorder; namely, the prevalent short-term reaction showed by abused children was characterized by symptoms of sPTSD. This data was supported by recent studies whose report that in the general population of children potentially traumatic events are fairly common and do not often result in PTSD symptoms and, except after multiple traumas or a history of anxiety, the prognosis was generally favorable [20,30].
Despite the maltreatment exposure was related to higher risk of mental disorders in short term in comparison to prevalence among general population [31, 32].

Furthermore, the rate of PTSD after exposure to a traumatic event was lower than that reported in studies of adults [33, 34]. There are different reasons for this; as the DSM-IV criteria were developed from the adults PTSD literature, they may not accurately reflect severe responses to trauma in children. Research in children also suggests that the optimal algorithm for PTSD may require substantially fewer symptoms than that required for diagnosis of the disorder in adults [35, 36,37]. According to these data our results underscore the importance of a correct evaluation of childhood trauma since clinical signs are primarily subclinical or isolated.

Our data showed that no significant differences emerged in the distribution of psychiatric disorders in maltreatment forms. However, in the literature there are a lot of retrospective studies about long term effect in association to different form of maltreatment. Nevertheless a recent meta-analysis found no evidence that any specific type of trauma is a stronger predictor of psychosis than any other. These findings suggest that other adversity-related variables such as age of exposure and multi-victimization might be more strongly related to psychosis risk than exposure type, which, it has been argued, might affect the specific psychotic symptoms experienced [6].

Data analysis showed that no differences were found in the comparison between psychopathological disorders and age groups. Literature in preschooler shows that violence exposure (including sexual abuse and physical abuse) was significantly associated with symptoms of depression, PTSD, ADHD, and conduct problems while non-interpersonal events were primarily associated with anxiety [38].

A significant risk factor for lower age of exposure to the experience of abuse in children was a family history of psychiatric disorders. The potentially negative effects of parental PTSD and other psychopathologies on care-giving and related detrimental effects on children have been studied [39, 40]; the prevalence exposure to potential traumatic events was significantly associated with contextual risks in children's lives, such as living in a single-parent home, high parenting stress, and clinical levels of parental mood and anxiety symptoms [38].

Future goals of our research will focus on the possibility to analyze in more detail the short term psychopathological effects of abuse in specific age groups; in addition, we would like to use information gathered in medical history to identify other risk and protection factors, for both the abuse and the possible development of psychopathological disorder. Finally, it would be very interesting to follow up the long-term effects on mental health.

Furthermore scientific studies on the associations between exposure to trauma and early psychopathology suggest the potential for interesting research on the genetic, neurodevelopmental and family processes involved in early developmental pathways.

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A brief biography of the paper presenter

Stefano Vicari, MD, is the head of the Child Neuropsychiatry Unit of the Pediatric Hospital Bambino Gesù in Rome. His major contributions have been in the field of Developmental Neuropsychology. He has worked both clinically and experimentally with children with autism, intellectual disabilities, genetic disorders and learning disabilities. His interests are both scientific and clinical: he has pursued basic research questions to better understand the underlying source of deficits in several groups of children with developmental disorder but now is translational work is aimed at applying the findings of his work in clinical and rehabilitation protocols.

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Coercion in adolescent psychiatric care: Can it be diminished?

Poster

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Background

In Finland, about 40% of adolescents have experienced some type of restraint procedure during their in-patient treatment period. The Ministry of Social Affairs and Health in Finland aims to diminish the use of coercion as much as 40% by the year 2015.

Aim

To describe the project to reduce the use of mechanical restraint in a department of adolescent psychiatry in one hospital district in Finland. In this presentation, some preliminary findings of the project will be presented.

Method

The presentation is based on ongoing project where the data is being collected from Finnish adolescents units (5-7 units/official restraint reports) treating 13-17 year-old adolescents, in two(four) psychiatric hospitals in one Finnish Hospital District. The number of mechanically restrained 13-17-year old adolescents will be collected from the statistics of the National Institute for Health and Welfare and it will be proportioned to the hospital days of the wards. In the presentation, the methods to diminish the use of mechanical restraint and the numbers of restraints during the years 2006-2012 will be presented.

Results

The data will be analyzed with descriptive statistics.
The following questions will be answered:
1. How frequent has the use of mechanical restraint been during those years?
2. Has the number of mechanical restraints changed during those years?
3. What has been done already to diminish the number of mechanical restraints?
4. Are there some alternatives to the mechanical restraint in the field of adolescent psychiatry?

Conclusions

The prevalence of mechanical restraint and the number of lengthy mechanical restraint episodes have been high in the department of adolescent psychiatry of the hospital district. There is a need to develop new methods to deal with the violent behavior of adolescents in the adolescent psychiatric wards. Based on the preliminary findings, some methods to diminish the use of mechanical restraints and suggestions for the future development needs will be presented.

Educational Goals

The next two questions will be answered:
1. Is it able to diminish the use of mechanical restraint in adolescent psychiatric wards?
2. How is it able to diminish the use of mechanical restraint in adolescent psychiatric wards?
(cognitive domains)

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Risk assessments in clinical practice: Can training in structured assessment methods improve social service evaluations of delinquent youths?

Paper

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Abstract

According to Swedish studies, there is often a lack of reference to empirically based risk and protective factors in evaluations of youth within the social services. In recent years, several structured assessment methods have been developed to address these issues. Two examples are Adolescent Drug Abuse Diagnosis (ADAD) and Structured Assessment of Violence Risk in Youth (SAVRY). Previous research supports the reliability and validity of these methods, but in most studies researchers have conducted the assessments. Whether the methods are valid and contribute to the quality of evaluations in clinical practice is less well known.

This presentation draws on preliminary findings from a research project in which three groups of social workers within the social services in Stockholm were recruited: social workers trained in ADAD, social workers trained in SAVRY, and social workers trained in neither of the methods. A total of 138 evaluations of delinquent youth were analysed alongside self-reports from the adolescents and their parents at baseline and at a 1-year follow-up.

Aims of the project are to investigate if training in ADAD and SAVRY will:
1. result in evaluations that to a greater extent rely on empirically based risk and protective factors?
2. improve the precision of the expressed risk and protective factors?
3. improve the validity of predictions of relapse in criminal behaviour?
4. result in better matching between risk profiles and interventions suggested by the social workers.

Preliminary results are promising in favour of the structured assessment methods, which will be discussed during the presentation.

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Inappropriate treatment of children and adolescents with psychiatric disorders in Slovenia

Poster

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Abstract

In this contribution, we discuss the treatment of children and adolescents in Slovenian Residential Treatment Institutions. Due to the specific population, we focus mainly on the Residential Treatment Institution Planina.

Planina is the only Residential Treatment Institution in Slovenia that treats children and adolescents with so-called multiple disabilities. This means children and adolescents with conduct and intellectual disabilities. From the perspective of its founder (Government, the Ministry of Economy, the Ministry of Education, Science and Sports), the Residential Treatment Institution Planina is considered a part of the educational system, so the objectives, tasks and content of the education, compensation and correction part should be equivalent to the rest of the educational system (Framework educational program ... 2004). However, year after year practitioners discover, that due to the escalating difficulty and emergence of new forms of disorders, perceived in children and adolescents (mental disorders, outstanding autoagressive and heteroagresivno behavior, serious offenses), the declared and prescribed legal provisions are objectives of residential treatment are largely not implemented. Despite numerous warnings about the seriousness of the issue, legislative authority for this type of disorder did not provide suitable programs and specialized institutions for this purpose - practice shows, that the current concept and doctrine of Residential Treatment Institutions in Slovenia does not meet declared objectives. As seen at the end of the contribution, a slight shift was made in 2012 at the micro level, when the Government approved funding Residential Treatment Institution Planina for medical staff - at the micro level mainly because we cannot yet accept every child and adolescent requiring educational medical treatment in Slovenia due to understaffing.

Educational Goals

The legal and organisational issue of treatment children with mental disorders, outstanding autoagressive and heteroagresivno behavior, serious offenses

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Reduction of Aggression in adolescents with autism – a critical factor for a successful treatment?

Poster

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Abstract

In 2010 a special ward at the Dr. Leo Kannerhuis, autism expertise centre in the Netherlands, was opened. This ward is called the LLA and specializes in care for adolescents with high functioning autism, who are obstructed in their development due to their autism spectrum disorder. They are coping with problems on multiple levels (at home, at school, with friends). The main objective of the treatment is guiding them to an optimal integration in society, independent if possible, with adjustments if necessary. The aim is that, at the end of the treatment, the patient can be placed in a less restrictive treatment facility.
Since the launch of this ward the development of every patient was measured by the Youth Outcome Questionnaire (Y-OQ, Lambert et al., 2006). Both patients and their personal caregivers filled in this questionnaire every 3 months, 5 times in a row. All patients that were placed at the LLA at the start in 2010 were included (n=12, response=100%).

The data is analyzed using the n=1 method (Bartels et al., 2008). The responses to the questionnaires were analyzed, searching for significant changes over time. We also analyzed the extent to which patients, at the end of the treatment, could be placed in a less restrictive treatment facility (the aim of the treatment). Finally, the differences between the groups that did and did not achieve this aim were analyzed. Six patients were placed into a less restrictive treatment facility (achieving the aim) and five were placed into a treatment facility which was not less restrictive, sometimes even more restrictive. For one client it was not clear whether he was placed to a less restrictive facility or not, so he is excluded from the analyses. To calculate the differences between these groups an analysis of variance is executed.

The results of this analysis showed that the group that didn't achieve the aim (the group that wasn't placed to a less restrictive facility) showed more aggression compared to the group that did achieve the aim of the treatment. They showed more aggression at the start of the treatment as well as during the treatment.
Based on these results a specialized treatment program is developed, including a set of interventions and a set of questionnaires to evaluate the program. From May of 2013 and onwards, for every patient a questionnaire called the RePro (Hendrickx et al., 2003) is filled out, to assess the individual risks concerning reactive and proactive aggression. Subsequently, in the period between May and October 2013, after every incident concerning aggression, the SOAS-R is completed (Nijman et al., 1999; 2005). This is the baseline measurement.
The next intervention is an individual training on regulation of emotions for patients and a training for caregivers on how to handle aggression. This will be implemented in stages so after every stage the changes in aggression can be measured.
The ultimate aim of the treatment program is to diminish the number of incidents concerning aggression and to increase the number of patients that achieve the aim of the treatment and can be discharged to a less intensive treatment facility.

Educational Goals

Tools to empower teams in dealing with agression.

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Chapter 16 – Specific populations: elderly

Aggressive behavior occurrence among elderly psychiatric inpatients in Psychiatric Hospital Hronovce during the years 2004-2012

Poster

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Abstract

The phenomenon of aggressiveness in some elderly people and its manifestations may represent a social problem which is closely related to geriatric psychiatry and especially to inpatient care. In younger persons aggression corresponds more to constitutional, situational, social and ethical - moral factors which can be involved in aggressive behavior. In elderly is that first mental disorder and related states e.g. of confusion which determines. We focused on mapping the occurrence of aggressive manifestations during inpatient psychiatric care of elderly people.

Method

Retrospective analysis, collected data were coupled with aggressive manifestations of hospitalized patients in Psychiatric Hospital Hronovce over eight years (2004 - 2012). Aggressiveness was evaluated in terms of age, diagnosis, sex and type of violent behavior (verbal, brachial, aggression against things, repeated signs).

Results

There were 201 different aggressive events out of 2091 hospitalized patients during eight years. Those 201 were committed by only 106 that means 5.0% patients showed aggressive behavior. And only 0.8 % of total number of patients (18 of 2091) accomplished multiple attacks which were up to half of all events (97 of 201). The most frequent aggressive attacks were associated with psychotic disorder and dementia. Its prevalence in dementia grows with older age. Its incidence was approximately equal in both sexes (male 51,7%) but males outnumbered females when serious violent attacks with injury were assessed. The most serious aggressive behavior (with physical aggression resulting to injury) occurred 34 times and was accomplished in 16 inpatient (0.8% out of all inpatients), all of them were males.
In terms of age distribution, the most aggressive behavior involved the age group older than 85 years (36%) with maximum of attacks associated with dementia. Most of psychotic aggression (schizophrenia diagnosis, schizoaffective disorder, and mania) was recorded in the group from 65 to 75 years old.

Educational Goals

Aggression, elderly people, inpatient care, psychiatric diagnosis.

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Chapter 17 – Specific populations: forensic

Understanding clinical psychopathy: Exploring cognitive and affective functioning and developing a new self-report measure

Paper

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Keywords: Psychopathy; Cognition; Affect; Explicit Processing; Schema

Introduction

Psychopathy was first defined by Cleckley (1982) as consisting of a specific set of personality traits and behaviours. Since Cleckley's early description, the Psychopathy Checklist-Revised (PCL-R; Hare, 1991) has been developed. A factor analysis of the PCL-R identified two stable correlated components. Component one was found to relate to a number of interpersonal traits, whilst component two was associated with various chronically unstable, socially deviant behavioural characteristics (Hare, Hart, and Harpur, 1991).

Cooke and Michie (2001) revisited the factor structure of the PCL-R and argued that three rather than two psychopathic components could be determined from the items. They proposed that psychopathy is therefore more reliably underpinned by interpersonal, affective, and lifestyle features. Their model placed more emphasis on an affective component, highlighting the importance of affect in psychopathy. Cooke and Michie (2001) also placed a reduced emphasis on criminality and more emphasis on abnormal personality. The current view of psychopathy (i.e. that held by Hare et al. 1991) as a behavioural entity, has ultimately resulted in the PCL-R neglecting important aspects of psychopathic functioning, such as cognition and affect, as these form part of the core elements of personality. Thus, there is a requirement for a new measure of psychopathy that attends to processing in more detail.

Like Cooke and Michie (2001), Cleckley (1982) also argued that criminality was not an essential feature of psychopathy. Instead, he proposed that those with psychopathy suffer from a psychological deficit (both cognitive and affective) that predisposes them to behave in a manner that is harmful to themselves and others (Wallace, Schmitt, Vitale, and Newman, 2000). Thus, it becomes apparent that cognition and affect are integral aspects of psychopathy and yet this is not well researched, particularly with regards to cognition. Cleckley (1982) also acknowledged that individuals with psychopathy present with a 'mask of sanity', whereby they appear to be genuinely empathic, to have good intelligence, and have an absence of irrational thinking. It is only when such individuals have to put these skills into practice that their cognitive and affective deficiencies become evident (Cleckley, 1982).

Research has identified that those with psychopathy tend to have cognitive deficiencies in attention/ information processing and behavioural inhibition. More specifically, individuals with psychopathy have been found to have deficits in response modulation (Wallace, Newman, and Bachorowski, 1991). Response modulation represents an individual's ability to adapt to their environment when selecting and employing cues. This is problematic for those with psychopathy, as they have difficulties in processing information outside their primary focus of attention whilst engaging in goal-directed behaviour (e.g. Jutai and Hare, 1983; Williamson, Harpur, and Hare, 1991; Lorenz and Newman, 2002). This leads them to select and respond to inappropriate cues. Individuals with psychopathy are therefore less likely to

appreciate the consequences of their actions and as a result encounter difficulties when engaging in the later steps of information processing/social problem solving specified by Huesmann (1998) i.e. they carry out an inappropriate response, attend to the wrong element of feedback, and then encode the dysfunctional script for future use.

A psychopath's inability to evaluate their own response set and acknowledge the consequences of their actions may result in events that give rise to the development of maladaptive cognitive schemas (Wallace et al. 2000). Schemas are an important element of cognitive functioning that have a basis in early life experiences. Maladaptive cognitive schemas, in combination with an abnormal personality style, explain why those with psychopathy are generally associated with offending behaviour. This is not to say that they do not possess adaptive cognitive schemas. Instead, such individuals may find it more difficult to access these schemas given their past life experiences and deficits in response modulation.

In addition to their cognitive deficits, those with psychopathy have been found to have deficits in affective processing (e.g. they have been found to extract less information from affective stimuli than do other individuals; Williamson et al. 1991). Central to describing this deficit is Beck's theory of emotional disorders (Beck, 1987). According to Beck's theory, specific emotions result from the cognitive appraisal of a situation (Patrick, 2006). The nature of the appraisal influences the emotion experienced. As Patrick (2006) notes, Beck's theory relies heavily on the concept of schema, which is central to an individual's personal view of the world. Beck argues that specific emotions result from the cognitive appraisal of the effect events have on one's self or personal views (e.g. self or personal schema). For example, Patrick (2006) describes that the emotion of anger is a consequence of the appraisal of an unwanted violation that one perceives to be either offensive or threatening. Cognitive schemas are also often associated with biases that arise from emotional dysfunction, information processing challenges, and past personal learning history (Patrick, 2006), which encourage individuals to misperceive threats or to over-emphasis threat. Given that psychopathic individuals are commonly found to present with both information processing challenges and poor early maladjustment (Frodi, Dernevik, Sepa, Philipson, and Bragesjö, 2001) it is not surprising that they have dysfunctional cognitive schemas, which lead to distorted self-evaluations and biased attributions of causality. These dysfunctional schemas may impact upon their ability to effectively understand and react appropriately to other people's feelings and circumstances (e.g. Kroner, 1995).

The concept of processing (both cognitive and affective) is thus crucial when understanding psychopathy as it forms an element of 'true psychopathy', i.e. psychopathy as abnormal personality as opposed to criminal personality (Cleckley, 1982). There is therefore a need to explore this area in more depth to gain a greater understanding of processing in psychopathy and to extend our theoretical understanding of this construct.

Method

Participants
Three hundred and eighty one participants were sampled. Ninety-five were male prisoners and 286 were university students (138 men and 148 women). The response rate for the forensic sample was 23.8%, and for the student sample it was 40.9%.

All prisoners were recruited from a Category B private prison. The average age of the prisoners was 31.48 years (SD = 9.02). Of the prisoners sampled, 88 provided details of their index offence: 19 were convicted of a violent offence (16.7%); 18 for drug-related offences (15.8%); 31 for acquisitive offences (27.2%); and 20 for offences, such as breach of restraining order, which were placed under the category 'other' (17.6%).

The mean age for the student sample was 23.34 years (SD = 6.84). The average age for men in this sample was 23.23 years (SD = 6.34), and for women it was 23.45 years (SD = 7.31).

Materials
The study employed the following measures:

Psychopathic processing and personality assessment – version one (PAPA-1): This is the new self-report measure of psychopathy based on the findings from the previous study. The measure consists of 53 items (i.e. I am only interested in myself; I do not feel guilty when I cause others to feel pain or hurt) that look at an individual's unhelpful, antisocial/psychopathic personality style at one end of the scale, and a caring responsibility style at the other, and one item that examines stability of the self. The measure has also been designed to explicitly examine psychopathic processing (both cognitive and affective).

The Levenson self-report psychopathy scale (LSRP; Levenson, Kiehl & Fitzpatrick, 1995): This is a 26 item (i.e. Success is based on the survival of the fittest, I am not concerned about the losers) self-report measure, which separates the construct of psychopathy into two components' primary and secondary. It examines the traits and behavioural characteristics often associated with the construct, i.e. irresponsibility and callousness.

Schema: Positive and Negative, and Affect assessment – version two (SPANA-2; Wilks-Riley and Ireland, 2011): This questionnaire focuses on cognition and affect. It explores individual's beliefs about themselves and others. It examines their positive and negative cognitive schema, as well as negative affect. In terms of negative schema the measure tapped into feelings of trust, abandonment, worthlessness, views of others as uncaring, abusive, and intolerant (i.e. I am not cared for; Other people are demanding). Positive schema was assessed through items (i.e. I am a caring person; I am an easygoing person) that captured the following traits: hardworking; caring; happy; easygoing; worthwhile; and calm controlled. The negative affect component of the measure examined an individual's expression of both emotion and feelings (i.e. Other people think I am emotionally cold; I am not in touch with my emotion). It consists of 65 items.

Procedure

Following ethical approval, 20 university students were recruited to pilot the PAPA-1, i.e. assess its readability and layout. The pilot was successful and the PAPA-1 was employed in the full study.

Students approached for the full study were required to return their completed questionnaires to the secure box in the student support room. Prisoners completed all three questionnaires during a period of lock down. Prison Officers collected the questionnaires directly from the prisoners, via sealed envelopes.

Summary of results

The main findings of the study were as follows:

- PAPA-1 correlated with the LSRP, demonstrating concurrent validity of the PAPA-1 with an existing self-report psychopathy measure.
- A three-factor model of psychopathy was extracted from the PAPA-1 for both the prison and student sample. In prisoners the model had a negative interpersonal component, an affect and confidence component, and a hostile others and negative affect component. Students were underpinned by a negative interpersonal style component, affect and confidence component, and a controlled lifestyle component.
- Negative cognitive schema was found to be more prevalent across the two samples when compared to positive cognitive schema and negative affect.
- For both prisoners and students, psychopathy positively correlated with positive cognitive schema, negative cognitive schema, and negative affect.
- Psychopathy was positively predicted by certain types of positive (calm controlled and caring) and negative (abandoned and intolerant of others) cognitive schema. Negative affect also positively predicted the construct.
- Psychopathy was also negatively predicted by certain types of positive (happy/sociable).

Discussion

This research highlighted that cognition and affect are important aspects of psychopathy. Self-report psychopathy was predicted by certain types of maladaptive and adaptive cognitive schemas, as well as negative affect. Negative cognitive schema was found to be more prevalent across the two samples when compared to negative affect and positive cognitive schema. Furthermore, the new self-report measure developed from the previous study, i.e. the PAPA-1, was identified as having good internal consistency and concurrent validity with an existing self-report measure of psychopathy.

A three-component solution was extracted from the PAPA-1. This model was not consistent with the model delineated by Cooke and Michie (2001). Cooke and Michie's (2001) model proposed that psychopathy was underpinned by interpersonal, affective, and lifestyle features. However the three-factor model identified in the current research placed more emphasis on the role of cognition and affect in psychopathy. This was the case for both samples. The difference in the two models may be due to the fact that the current research is using a broader sample, i.e. students and prisoners, to investigate the role of cognitive and affective functioning in psychopathy than that employed by Cooke & Michie (2001), who focused solely on prisoners.

Positive cognitive schema, negative cognitive schema, and negative affect all positively correlated with the self-report psychopathy. Negative cognitive schema had the strongest association with psychopathy and was found to be the most dominant variable in both populations. Individuals with psychopathy have been found to have deficits in response modulation, which ultimately give rise to life experiences that promote the development and manifestation of maladaptive cognitive schemas. Wallace et al. (1991) recognised that those with psychopathy are unable to process information that is not central to an event especially when engaged in goal-directed activity. This leads them to select and respond to inappropriate cues. As a result, such individuals have problems when engaging in the later steps of information processing derived by Huesmann (1998), i.e. they carry out an inappropriate response, attend to the wrong element of feedback, and encode the dysfunctional script for future use.

In contrast to the existing literature (e.g. Seager, 2005), positive cognitive schema was found to predict and have a positive association with psychopathy. This may reflect the low base rate of psychopathy in the populations sampled, as research tends to associate the construct with dysfunctional schemas that promote perceptions of a hostile world (Seager, 2005). The finding may also reflect biases in the method used to collect the data. Individuals with psychopathy are associated with increased levels of deception and lying (Snowdon, Gray, Smith, Morris and MacCulloch, 2004). This makes reliance on self-report problematic. Future research should assess psychopathic processing using implicit as well as explicit measures to avoid malingering and impression management. Lorenz and Newman (2002), for example, highlight the benefit of using implicit measures, as they identified that high levels of psychopathy are more likely to be associated with implicit (indirect) measures, but not explicit (more overt) measures. Nonetheless, the finding may imply that individuals with psychopathy possess adaptive schemas but find it more difficult to access them (Wallace et al. 2000). For example, it could be speculated that when the participants were completing the measures they were not engaged in goal-directed behaviour and could therefore access their adaptive schemas more readily. This requires further investigation.

In line with Beck's theory, negative affect was positively associated with psychopathy. Beck's (1987) theory of emotional disorders states that maladaptive cognitive schemas, which arise from distorted self-evaluations and biased attributions of causality, i.e. deficits in response modulation and information processing, impair a psychopathic individual's ability to understand, experience, and react appropriately to other people's feelings and circumstances. These deficits ultimately promote and sustain high levels of negative affect, i.e. anger, as other individuals may react negatively towards the psychopath's inappropriate responding. This theory fits in with the current findings as high levels of psychopathy correlated with high levels of negative affect.

Limitations
This research is not without its limitations. As discussed, assessing psychopathy and psychopathic functioning via self-may prove problematic given that those with psychopathy have been characterised as manipulative and deceptive (Roberts and Coid, 2007). In order to manage potential reporting biases, such as malingering and impression management, the inclusion of an implicit assessment to examine psychopathic processing would prove useful. This would also further understanding of the role of cognitive and affective processing in psychopathy at an implicit level.

Arguably, students and prisoners with high levels of both intelligence and psychopathy may have anticipated the purpose of the measures and consciously manipulated their responses to skew the results. This could have been prevented by setting a fixed time limit for the completion of the measures. None of the measures used in this study had a timing element. As noted by Hoaken, Shaughnessyn and Pihl (2003), a time limit would bring out a psychopathic individual's impulsive responding. It would interrupt the social-information processing of those individuals with cognitive deficits, i.e. the psychopath. Such individuals may become overwhelmed by the time limit and the numerous response options, forcing them to draw upon their natural tendencies.

Implications
The research indicated that both explicit cognition and affect are important aspects of psychopathy. It can be argued that explicit affective and cognitive processing is associated with, and is an influential predictor of, self-report psychopathy. In order to further understand the role of psychopathic functioning and examine how the associated psychological theories, i.e. response modulation, information processing, and Beck's theory of emotional disorders, apply to psychopathy, more research is required to investigate implicit processing in psychopathy across different populations.

Author's note

This study is the second in a series of three that together form the first author's PhD research. If you would like any information relating to the other two studies, please contact Michael Lewis on the contact details presented on page one. Thank you.

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Neuropsychological executive functions as predictors for response to treatment in violent offenders

Paper

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Introduction

Violence constitutes a serious social and public health problem in Mexico, with homicides representing approximately 1.5% of all deaths occurring between 2000 and 2008 (Hernandez-Bringas & Narro-Robles, 2010). Two reliable government sources single out 2008 as the year with the highest level of violence in Mexico. Regarding persons who have committed violent offences, a study that interviewed 1321 inmates in prisons in the Mexico City metropolitan area revealed that 63% of all inmates are in prison after being convicted of a violent crime (Bergman, Azaola & Magaloni, 2009). Other studies have pointed out that violent crimes lead to more severe social consequences due to injury or damage to victims, loss of property and progressive widespread social decomposition (Dowden, 1999; Henderson, 1986).

Inmates frequently engage in additional violent behaviors while in prison and usually the only intervention aimed at managing these behaviors consists of additional punishment such as isolation or relocation to very high-security facilities. Numerous research studies have suggested that a significant proportion of these inmates have neuro-cognitive and neuropsychological characteristics which interfere with treatment strategies and seem to lead to recurring criminal behavior once inmates leave the prison (Arias & Ostrosky, 2008; Brower & Price, 2001; Enns, Reddon, Das & Boukos, 2007; Fishbein & Sheppard, 2006; Fishbein, et al, 2009; Henderson, 1986; Hoaken, Allaby, & Earle, 2007; Marceau, Meghani & Reddon, 2008; Riggs, Greenberg, Kusch´e & Pentz, 2006).

Several authors have also suggested that neuropsychological deficits of violent offenders are associated to altered executive cognitive functions and therefore to such abilities as adapting to changing interaction demands and social development (Arias & Ostrosky, (2008); Fishbein & Sheppard, (2002, 2006, 2009); Marceau, (2008); Riggs, et al, (2006) and Yechiam, et al, (2008). These deficits, in turn, affect such skills as behavioral inhibition, decisionmaking related to environmental conditions, goal-oriented behaviors, socially adaptive behaviors and sensitivity to consequences to their own behaviors. Other problems include defective cognitive regulation, faulty interpretation of contextual cues, perceiving normal situations as threatening, constant need for immediate impulse satisfaction, incongruous emotional expression, and inability to reflect, analyze and solve difficult situations (Bechara, et al, 2000; Damasio, 1998; Goldberg, 2002, 2006; Slachevsky, et al, 2005) Finally, other associated problems include poor ethical judgment and moral behavior (Anderson, et al, 2008; Oliveira-Souza, et al, 2008; Tirapu-Ustarroz, et al, 2008). All these characteristics get easily linked with new offences both inside custody facilities and outside once inmates get released.

Some studies have further associated the possible origin of these cognitive and behavioral deficits with diverse types of risk factors including genetic, prenatal and environmental. These factors seem to affect the development of higher order executive functions, including their biological, cortical, subcortical and biochemical substrata (Eluvathingal, et al, 2006; Fishbein & Sheppard, 2002; Giancola, 2006, 2007; Barrat, 1997; Garcia-Molina, 2008; Gorenstein, 1982; Riggs, et al, 2006).

Some recent proposals point out that executive functions deficits hinder performance on cognitive-behavioral curricular materials aimed at re-educating prison inmates, since it requires adequate higher nervous activity including the establishment or widening of cognitive and emotional regulatory repertoires (Fishbein & Sheppard, 2006, 2009). These functions are especially necessary while working through complex interventions which have shown a high level of effectiveness (Allen, et al, 2001; Andrews, et al., 1990; Devon, et al, 2004; Devon, et al, 2005; Friendship, et al, 2003; Landenberger y Lipsey, 1999; Lipsey,

et al, 2001, 2007; Lösel, 2000; Polaschek et al, 2005; Ralph y Brown, 2004; Redondo 2000, Redondo, et al, 2001; Tyson 2004; Urbaniok, et al, 2006; Van Voorhis, et al, 1995).

It is thus necessary to develop adequate assessment procedures in order to identify factors associated to cognitive and emotional self-regulation as well as neuropsychological deficits in pathologies linked to violent behavior. Such procedures are very likely to be critical for the design of interventions aimed at preventing or rehabilitating individuals with recurrent violent behaviors mediated by executive functions (Brower & Price, 2001; Fishbein, et al, 2002, 2006, 2009; Henderson, 1986; Marceau, Meghani & Reddon, 2008; Riggs, Greenberg, Kusch´e & Pentz, 2006).

A pioneer study by Fishbein, et al, (2009) evaluated the role of executive neuropsychological deficits on behavioral problems of inmates, and their predictive value for treatment effectiveness. A total of 224 voluntary inmates from four prisons in the state of Maryland participated. Through a battery of neuropsychological tests the study evaluated executive functions and other psychological and behavioral variables associated to violent behavior. Measures included reactivity to provocations, prison records of good behavior and a scale to assess commitment to treatment and responsiveness to treatment. The study results showed that deficits related to behavioral inhibition were a significant and better predictor for treatment outcome than psychological antecedents as compared with other measures. The study, however, used a relatively limited series of executive functions assessment tools so the addition of other measures would allow for a finer grain analysis of their predictive value.

Although research findings have suggested that cognitive-behavioral interventions are among the most effective for custodial populations, they rarely point to their association or effect on the recurrence of offenses. Thus, as suggested by some authors it becomes necessary to include neuro-cognitive components in this analysis, since these components may be a factor in interventions' low effectiveness (Redondo, 2003).

Thus, the purpose of the present study was to examine the predictive value of a corrective intervention treatment based on strategies directly linked to neuropsychological executive functions assessed through a relatively extensive testing battery containing tasks associated to performance linked to pre-frontal cortex activity.

Method

Participants
Participants included 24 male inmates from a penitentiary in Mexico City. Their ages ranged between 21 and 49 years, they were characterized by having committed violent crimes and having received repeated punitive actions by the prison administrators, due to recurring offences inside the prison. In accordance with technical requirements of several of the measurements used, inmates who showed high levels of psychopathy, were illiterate, were older than 49 years, showed active mental disorders or had pathologies which would interfere with the study's procedures were not included for data collection.

Participants mean age was 31 years with a standard deviation (SD) of 1. Average schooling was 9 years (high school), SD=2.5. Average sentence in prison was 9 years SD=7 with an average prison time served of 4 years, SD=3. The average score in Hare's psychopathy scale was 24, SD=4.2. Two percent had served time in juvenile institutions earlier. Forty percent reported a stable couple relationship but only 17% are actually married and 30% were single. Regarding the felony perpetrated which led to conviction, 80% was for aggravated robbery and the remaining 20% included very similar percentges of homicide, rape and some modality of kidnapping. A 60% were serving time after their first offence and 40% por repeated offences. The majority of participants had received more than one disciplinary action for various incidents inside the prison. Of these 50% were for robbery, extorsion, violent quarrels and indiscipline, among others; another 20% had been punished specifically for indiscipline and 20% for violent quarrels.

Those inmates who abandoned the study due to their legal process such as relocation to other facilities, early release, etc. were excluded from the analysis. Those who interrupted the treatment due to disruptive behaviors (assault, violent fighting, etc.) or unjustified dropout were kept in the analysis. These were evaluated after the end of the overall treatment process in order to examine possible changes in response to treatment measures.

Measurement
Psychopathology was assessed through the MINI neuropsychiatric scale; the PCL-R scale was used to evaluate psychopathy (scores over 30 points excluded potential participants). Executive functioning was assessed through the Frontal Lobes and Executive Functions Scale (Flores, Ostrosky & Lozano (2008,

2012). Response to treatment was evaluated through a combination of records such as punitive actions by prison administrators, prison technical records, security personnel records and the Reactivity to Provocation Scale (Novaco, 2004). This scale evaluates four dominions of reactions to provocation: a) cognitive, b) physiological activity, c) behavioral, and d) anger level.

Intervention
The components of the treatment programs were implemented on the basis of the Reasoning and Rehabilitation program (Ross & Fabiano, 1985; Ross, et. al 1988). The program, which has shown effectiveness when applied to inmates from diverse socio-cultural contexts, included the following eight modules: 1. Motivational interviewing (Miller & Rollnick, 1999); 2. Self-control; 3. Meta-cognition; 4. Cognitive interpersonal problem-solving skills; 5. Social skills; 6. Emotional control; 7. Critical reasoning, and 8. Awareness regarding the victim.

The intervention was completed in three small-group weekly sessions to a total of 37 sessions, each lasting 2 to 3 hours. Motivational interviewing was conducted one week previous to the remaining treatment modules. The total duration of the intervention encompassed four months.

Results

In order to explore the predictive value of the neuropsychological functions in the context of the intervention a Regression analysis was conducted along the scores obtained by participants in the task-tests for frontal lobes and the pretest-posttest diferences on the reaction to provocation scale. Table 1 shows the neuropsychological tasks which significantly predict response to treatment.

Within the tasks associated to orbito-medial frontal areas, the crossing task of the maze test significantly predicted the response to treatment in the B segment of the scale. The Iowa cards test predicted the level of anger in provoking situations. Scores in the B segment of the Stroop task significantly predicted both the activity and behavioral dominions. Within the card sorting task, maintenance mistakes significantly predicted the behavioral dominion. The subtotal score of all orbito-medial associated tasks significantly predicted the behavioral dominion, with the Stroop-B and card-sorting tasks showing the largest contribution.

Regarding the tasks associated to functions of the anterior pre-frontal area, Semantic classification of all abstract categories significantly predicted performance on the activity dominion, while the meta-memory tasks significantly predicted the B segment of the scale.

Table 1. Novaco reaction to provocation scale (Asterisk denotes statistically significant values)

Area	Subscale	Cognitive Change			Activity Change			Behavioral Change			B Scale Change		
		b1	Prob >F	Prob >|t|	b1	Prob >F	Prob >|t|	b1	Prob >F	Prob >|t|	b1	Prob >F	Prob >|t|
Orbito-medial	Maze Crossing	0.5	0.64	0.83	1.14	0.14	0.87	0.70	0.43	0.74	3.85	0.05*	0.96
	Total Gambling Score	1.38	0.31	0.70	0.48	0.60	0.58	0.61	0.55	0.70	1.22	0.60	0.04*
	Stroop B (Correct)	0.02	0.84	0.62	0.18	0.02*	0.007*	0.20	0.02*	0.006*	0.05	0.79	0.29
	Card Sorting Maintenance (Errors)	1.41	0.31	0.15	-0.71	0.45	0.85	1.91	0.06	0.01*	-1.2	0.61	0.37
	SUBTOTAL	0.02	0.84	0.73	0.10	0.11	0.07	0.17	0.019*	0.01*	0.01	0.96	0.64
Anterior prefrontal	Semantic Classification Abstract categories Total	0.03	0.97	0.58	1.19	0.19	0.03*	1.16	0.25	0.06	3.16	0.17	0.83
	Meta-memory Positive (Errors)	-0.44	0.73	0.81	0.90	0.30	0.96	1.33	0.17	0.70	3.64	0.097	0.003*
	SUBTOTAL	-0.5	0.47	0.59	0.13	0.79	0.55	-0.2	0.69	0.92	-0.4	0.722	0.87

Table 2 shows the results for tasks associated to functions of the dorso-lateral areas, particularly for visuo-spatial working memory. Self-directed signaling while persevering as well as successively subtracting 7 from 100 significantly predicted activity. Time records of the successive addition task significantly predicted activity and level of anger in situations of provocation (segment B). Alphabetic sequencing during the first trial significantly predicted mastery of activity.

Regarding tasks linked to functions of the dorso-lateral areas, specifically executive functions proper, the labyrinth time records significantly predicted cognition in the B segment of the scale. In the semantic classification task, the average of animals mentioned significantly predicted cognitive performance. Performance in the Hanoi Tower test with 3 and 4 tokens significantly predicted the pretest-posttest treatment difference in the scale B segment.

Table 2. Novaco reaction to provocation scale (Asterisk denotes statistically significant values)

Area	Sub-scales	Cognitive Change			Activity Change			Behavioral Change			B Scale Change		
		b1	Prob > F	Prob >|t|	b1	Prob > F	Prob >|t|	b1	Prob > F	Prob >|t|	b1	Prob > F	Prob >|t|
Dorsolateral. Memoria de trabajo	Self-directed signalling while persevering	- 0.5	0.65	0.84	- 1.7	0.03*	0.38	- 2.03	0.02	0.28			
	Subtracting 100-7. (Time)	- 3.03	0.054	0.13	- 2.6	0.011*	0.07	- 0.85	0.48	0.96	- 4.7	0.07	0.55
	Subtracting 100-7. (Correct)	- 0.04	0.92	0.64	0.15	0.15	0.62	0.13	0.68	0.21	0.24	0.74	0.07
	Addition (Time)	- 4.1	0.02*	0.05	- 2.07	0.10	0.3	- 2.83	0.04*	0.131	- 7.5	0.01*	0.12
	Addition (Correct)	- 0.04	0.85	0.66	- 0.14	0.41	0.72	- 0.08	0.67	0.54	- 0.64	0.13	0.70
	Alphabetic sequencing on 1st Trial	0.06	0.95	0.40	0.59	0.48	0.049*	- 0.02	0.98	0.20	- 3.1	0.13	0.30
	SUBTOTAL	- 0.05	0.57	0.78	- 0.04	0.49	0.86	- 0.04	0.57	0.91	- 0.19	0.26	0.75
Dorsolateral. Funciones ejecutivas	Maze (Time)	- 2.78	0.023*	0.08	- 1.64	0.05--	0.32	- 1.2	0.18	0.62	- 4.48	0.032*	0.51
	Semantic classification (Animals average)	4.47	0.01*	0.007*	1.02	0.44	0.16	1.36	0.40	0.66	2.36	0.47	0.09
	Hanoi Tower 3 Tokens (Movements)	- 1.13	0.38	0.74	- 1.19	0.16	0.70	- 0.09	0.63	0.95	- 4.19	0.05*	0.68
	Hanoi Tower 4 Tokens (Time)	- 2.17	0.11	0.49	0.52	0.58	0.09	0.5	0.64	0.83	1.05	0.65	0.03*
	SUBTOTAL	- 0.17	0.16	0.26	- 0.05	0.50	0.85	3.2	0.06	0.18	- 0.24	0.25	0.69

The total of areas linked to functions of the Orbito-medial areas significantly predicted Behavioral mastery (F prob.< F 0.019; T prob. < t 0.01).

Discussion

The main findings of the present study suggest that, in order to properly characterize, diagnose and evaluate populations showing severe emotional and behavioral control problems require extensive, comprehensive, sensitive and specific neuropsychological models. Such models should encompass a wide repertoire of neuropsychological tasks including the ample range of executive activities of the frontal sectors. (Flores & Ostrosky, 2008; Jodar-Vicente, 2004; Lopera, 2008 and Riggs, et al, 2009). An additional advantage of this approach involves avoiding biases derived from evaluating only a reduced numbre of tasks.

These findings also confirm the predicting role of executive functions for treatment effects (Riggs, et al, 2006), especially with participants in penitentiary custody (Fishbein y Shepard, 2002, 2006, 2009). This conclusion, in turn, stresses the need for re-assessing in more inclusive and just dimensions the neurocognitive conditions of individuals with emotional and behariorial self-control who are to undergo interventions aimed at integrating the habilitation or rehabilitation of higher order neuro-cognitive associated with executive functions (Fishbein & Shepard, 2006, 2009) .

The present findings are also consistent with others in the sense that tasks associated to behavioral inhibition can predict response to treatment (Fishbein, 2006, 2009). Behavioral inhibition has shown a high level of coherence with the behavioral domain provided that it reflects, to a large extent, the difficulties to inhibit one's own behavior in situations of provocation.

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The enduring myth of the violent client', living group climate and aggression in a forensic psychiatric setting

Workshop

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In Holland and most western countries, the aim of secure residential treatment for adults with severe psychiatric and behavioural problems, designated as clients, is problem stabilization, recovery and rehabilitation. Clients are treated in living groups by trained group workers (social workers and mental health nurses). Mandated treatment in groups, is not without problems: forced treatment and loss of control by clients and unequal distribution of power at the living group result almost inevitable in conflict and aggression. Nevertheless, recent research shows that clients can profit from secure residential treatment (Soeverein et al., 2012).

Recent research on secure residential treatment shows that an open living group climate is crucial for stabilization, growth and recovery of incarcerated clients. Characteristics of an open living group climate are safety and structure on the one hand and flexibility and contact with group workers on the other hand, which has been shown to promote social learning and recovery.

An open living group climate is hard to establish in practice, because import problems of clients, such as mental disorders, and deprivation due to incarceration can easily lead to a closed climate, which is characterized by great power imbalance between group workers and clients and among clients themselves, repression as well as negative group dynamics.

Living group Climate (PGCI)

After extensive research in an adult forensic psychiatric institution (and a secure juvenile correctional institution) a valid and reliable questionnaire, the Prison Group Climate was developed, measuring living group climate quality (Van der Helm, Stams & van der Laan, 2011).
From a confirmative factor analysis of the data four main climate elements (the scales of the instrument) were derived:
1. support from group workers
2. growth and learning
3. repression (negative): extreme power imbalance and unprofessional behaviour by group workers (the 'Zimbardo' effect)
4. atmosfere (security, structure, flexibility and trust between inmates)

This innovative questionnaire enabled further research into the link between living group climate and aggression (Van der Helm et al, 2012). An open living group climate, was associated with greater treatment motivation, an Internal locus of control, active coping, empathy development, stabilisation but above all: less aggression (Ros et al, submitted). This study examined the relation between institutional climate (support, growths, atmosphere, and repression) and aggressive incidents using data of 72 patients in a secure (forensic) mental health clinic and a clinic for prolonged intensive care. Longitudinal analyses showed that support from nurses was negatively associated with aggressive incidents. The relation between growth and aggressive incidents was mediated by support. Mental health nurses could have an important contribution to decreasing aggression incidents in secure mental health care facilities by offering support and possibilities for growth to the patients.

But responsiveness of staff in the face of severe aggression is very difficult as violence has impact on staff, also designated as transactional processes. Transactional processes refer to an ongoing reciprocal exchange between a person and his experiences with the world around him (Sameroff, 2009). Patients in secure care and correctional institutions experience daily transactional processes through interactions with group workers and nurses. The perceptions of group workers and nurses regarding team functioning, their professional attitudes, organizational culture and leadership are crucial for effective professional behaviour (Lambert et al., 2011; Van der Helm et al , 2011). To be able to attain therapeutic goals, group workers and nurses must be sensitive to the balance between on the one hand 'therapeutic flexibility and

openness' and on the other hand 'restrictive control and closeness' in living group climate (Van der Helm & Stams, 2012). Staff must be able to remain calm ('low Emotional Expressiveness', EE) and search for problem solving opportunities instead of forcing or avoiding conflict by giving in. This is difficult when someone tries to bite you. To attain these difficult and conflicting goals, support of nurses and group workers is as crucial as support of clients ('parallel processes', van der Helm & Stams, 2012).

Inforsa is providing support for group workers and clients in a very special way: 'de-escalating support officers'. These officers are an example of the Inforsa vision that contact should be the most important base from where treatment can start.

De-escalating support officers are experienced and highly motivated staff members who intervene with negative transactional processes and help nurses or group workers restore their professional behaviour and calm down patients. This helps clients and staff as well. Experiences at Inforsa are highly promising: both clients and staff experience more support from the organisation and each other.

Support for patients as well as staff results in less mutual aggression and problem solving is enhanced, compared to forcing or giving in. This way a therapeutical community, were staff and clients working together to attain positive results with very difficult and often psychotic clients is getting shape.

More research is needed in this area as Marshall & Burton argue (2010), but the first results are promising. The Inforsa programm is based on a vision of so called 'connected care'. Our clients often have a lack of connection with their family, friends, work and society, sometimes since early childhood. Often they have nowhere to go and nobody wants them. Their behaviour is based on distrust and a hostility bias. It is our job to be a steady and reliable partner and develop contact with the client. Because when somebody feels that he is understood, heard, and knows that his presence is acknowledged, contact and approach will not only be easier, it also will be reciprocal. This contact is the base of a trusting relationship, where we can connect with the goals of the client. This way, clients are able to reflect on their thoughts, and to practice new behaviour. Because of this, our clinic has chosen three core values: trust, responsibility and connection.

To realize these values, a few elements in the treatment area are essential. These are to define as the core concepts: 'sustainable connection' and 'relationship'. Our group of clients is to characterize with a lack of inner and social cohesion. And the only way to repair the lack of cohesion, is trough reestablishing connection.

It is through the relationship with our clients that we can design and execute our so called 'connected care'. And based on the experience of connected care, we hope that we can establish sustainable connection when the treatment in our hospital is finished.

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Ethical issues regarding psychiatric inpatients necessitating prolonged seclusions

Paper

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"Psychiatry is a medical discipline concerned with the prevention of mental disorders in the population, the provision of the best possible treatment for mental disorders, the rehabilitation of individuals suffering from mental illness and the promotion of mental health. Psychiatrists serve patients by providing the best therapy available consistent with accepted scientific knowledge and ethical principles. Psychiatrists should devise therapeutic interventions that are least restrictive to the freedom of the patient and seek advice in areas of their work about which they do not have primary expertise..."

Madrid Declaration on Ethical Standards for Psychiatric Practice1996, enhanced 2011.

This article deals with an attempt to cope with ethical dilemmas associated with nursing care of psychiatric inpatients in seclusion for extended periods of time at Sha'ar Menashe Mental Health Center.

In the Forensic Psychiatry Unit of Sha'ar Menashe Mental Health Center there are currently seven patients who, owing to their mental states and extreme uncontrolled aggression towards others, have been in long-term seclusion, i.e.,months or years.

In 2012 a nurses' think tank was established to cope with the ethical dilemmas associated with the nursing care of these patients. In a year-long project, the think tank suggested policy changes to adapt to this patient population. Results were reflected in a 70% decrease of staff assaults by these patients.

Literature review

With 520 beds and 300 staff nurses, Sha'ar Menashe Mental Health Center (MHC), affiliated to the Rappaport Faculty of Medicine, in the Technion, Israel Institute of Technology, is the largest psychiatric hospital in Israel. The 200 bed national forensic center includes four closed wards and one rehabilitation department. Treatment of psychiatric inpatients in compulsory hospitalization is a complex professional challenge that presents ethical dilemmas, including the need for use of physical restraints, and seclusion.

Seclusion has been reported to:

1. Reduce environmental stimuli for patients
2. Isolate patients to prevent self-harm or harm to others.
3. Therapeutic punishment / behavior modification (Mason, 1994).

Psychiatric nurses reported that seclusion was a legitimate therapeutic tool for behavior modification, however, patients considered seclusion a form of punishment (Happell & Harrow, 2010; Keski-Valakama, Sailas & Eronen, 2010; Van Doeselaar, Sleegers & Hutschemaekers, 2008).

Secluded patients reported that seclusion intensified their feelings of rejection and social ostracism and served as a method for the staff to control them. Patients responded to seclusion with regression, and additional outbursts (Bower, McCullough & Timmons, 2003; Holmes, Kennedy & Perron 2004; Van De Sende et al., 2011).

In 1996 the World Psychiatric Association determined that seclusion must be limited to situations of violent or life-threatening behavior of the patient (Frueh, 2005). Similar pronouncements were written in the principles of ethical treatment in mental health in England (HMSO, 1990) and in Australia (NSW DoH, 1994). The Israeli Law for the Treatment of the Mentally Ill (1991) allows the medical and nursing staffs in psychiatric hospitals to limit personal freedom when there is danger to the patient or his surroundings. The law delineates the conditions necessary to implement this intervention (Ministry of Health, 1991). Noteworthy, Israeli law does not differentiate between patients that require short- and long periods seclusion.

Nursing care of secluded patients, especially those in long-term seclusion, presents complex ethical dilemmas. Qualitative studies performed in Australia and France, revealed that seclusion was an infringement of a broad spectrum of rights beginning with their autonomy and their basic right of freedom, via potential invasion of their privacy (in most psychiatric hospitals in the western world there are cameras in the seclusion room to facilitate monitoring of the patients), and freedom of information Patients revealed that they were not always informed of the reason for or the course of seclusion (Cano et al., 2010; Muir- Cochrane & Holmes, 2001).

Clinical psychiatric nurses in Israel who are at the patient's bedside are supposed to provide quality care while abiding by ethical principles as expressed in the Israeli Nurses Code of Ethics (2004). What happens when preserving the freedom of the patient conflicts with patient and staff safety? Nurses caring for patients in long-term seclusion are often faced with conflicts between protecting patients' rights, freedom, privacy and dignity and insuring a safe environment for fellow patients and staff.

Aim of study

In Sha'ar Menashe MHC there are currently seven patients who have been in seclusion for periods ranging from one month to years of solitary confinement. They all have diagnoses of schizophrenia, are treatment refractory and are secluded because of unpredictable severe aggression that they exhibit towards the staff and other patients.

Method

This study utilized Participatory Action Research methodology–. There is a strong correlation between the investigation and the steps taken. The aim of the new knowledge derived from this study was to provide answers for nurses dealing with prolonged seclusions. Cooperation of the nursing staff, empowerment and learning processes in the clinical arena were essential components of the research process (Zabar ben Yehoshua, 2001).

Owing to their familiarity with the subject we believed that the nurses in the forensic department would raise relevant issues expressed in the clinical arena, and were therefore chosen to participate in the project. Their involvement would reduce resistance to change and create high commitment to implementation of the findings.

Staff recruitment was through postings to the forensic unit in the hospital intranet. Eight nurses with over ten years' seniority in the forensic unit were eventually chosen because they had first-hand clinical experience with the subject matter. Participants identified two central dilemmas:.

- How to maintain a safe environment for the other patients and for the staff, while preserving the autonomy of the patients in long-term seclusion.
- How to abide by legal and professional procedures, and encourage professionalism among the nursing staff while providing creative solutions to treat these patients.

We then divided the staff into three work groups focused on the following:

1. Procedural changes necessary to adapt treatment to patients in long-term seclusion.
2. Building a treatment program for patients in long-term seclusion, allowing for gradual supervised periods outside of the seclusion room while maintaining safety and security of those in the environment.
3. Adapting the seclusion room to long-term seclusion.

Participants in the project met monthly and collected data by conducting interviews with staff members, and formulated a plan of action based on the recommendations of the working groups. Recommendations were implemented in one department and following evaluation when found appropriate they were implemented in additional departments. Ongoing feedback from the nursing and the multidisciplinary staff was collected and presented to the administration, in order to extend the activities to other sectors.

Results

Table 1 – Work Groups: Findings and recommendations

Work Group	Subject	Recommendations	Actions taken
1	Patient isolation procedure: changes needed to adjust the treatment for patients in long-term isolation	• Definition – what is long-term seclusion? Under what conditions can the option of long-term seclusion be used? • Change in the time frame of instructions for long-term seclusion • Change in time periods that the "supervising nurse" is required to provide a written report concerning the secluded patient. • Determination of frequency of multidisciplinary clinical discussions for evaluation of the need for continued seclusion	• Position paper to bring attention to the phenomenon and demand that policy makers develop appropriate procedures. • In accord with the decision of the hospital director a clinical committee was established consisting of a multidisciplinary team to specifically examine each case of prolonged seclusion and give recommendations for further treatment.
2	Nursing intervention programs for patients in long-term seclusion, increasing therapeutic alternatives, supervised gradual removal of the patient from the seclusion room while maintaining safety and security of the environment.	• Each department developed intervention programs for patients in long-term seclusion. • The program included an attempt to take the patient from the seclusion room to general areas. This was done gradually and many members of the multidisciplinary staff participated in building and implementing the program • Departmental training programs on coping with patients in seclusion were implemented during staff meetings in all departments that deal with the phenomenon.	• Three treatment programs were developed for three different patients in the Forensic Psychiatry Departments. Two were unsuccessful and one is ongoing and succeeded in reducing by fifty percent the number of hours the patient is in seclusion.
3	The therapeutic milieu – adapting the seclusion room to long-term seclusions as required by the presented cases	Physical adaptation of the long-term seclusion rooms to the needs of the patient – in a manner that would provide for more independence: • Installation of a table and bench unit in the room and affixing it to the floor. • Construction of a buffer outside the seclusion room to allow the patient freer access to the bathroom and shower. • Installation of a television screen just outside the seclusion room to allow the patient to watch various TV programs that are then projected onto the wall for viewing.	• Table and bench units were installed in the seclusion room and affixed to the floor. • A fenced buffer zone was built adjacent to the seclusion room. When the door to the seclusion room is opened the patient has free access to the bathroom and shower. (This was done only in the departments where the bathrooms and showers were next to the seclusion rooms and both, including the buffered passageway remained in direct visual contact with the department staff. • Televisions were installed outside of the four seclusion rooms, and enable the patients in seclusion to watch television programs that are then projected onto the walls of the seclusion rooms.

Discussion

The working groups collected data and maintained work diaries, The changes implemented contributed to a reduction in the number of assaults on the staff and a reduction in the total number of hours of seclusion

Working Group no. 1 – focused on procedural changes for long-term seclusion. The recommendations including guidelines for long-term seclusion, were written up in a position paper that is being submitted to the head of psychiatric services in Israel The position paper can serve as the basis for work policy for similar cases of prolonged seclusion, such as in prisons.

Working Group no. 2 – developed a nursing intervention program for patients in long-term seclusion, and raised therapeutic options that enable supervised and gradual removal of the patient from the seclusion room while maintaining the security and safety of the environment. They kept daily records of the nursing activities that are currently required and those that are necessary in order to improve the level of nursing care provided for patients in long-term seclusion. The programs developed in this project had mixed reactions, some from staff members devoted to the task, that had a different view of patients in seclusion and others who expressed reservations concerning the chances of success of this project and refused to take an active role. In 2010 there were 63 violent incidents toward the staff in the Forensic department 50 of them directed towards the nursing staff, 14 of the incidents resulted in physical injury that required medical intervention. More than 50% of these attacks were while treating patients in long-term seclusion.

The total of injured nurses' missed work days was 221. Studies conducted throughout the world regarding violence towards psychiatric staff showed that psychiatric nurses are the objects of attacks more than other professionals in psychiatry, owing to the duration of time that the various professionals spend with patients. The nursing staff spends 24 hours a day in the vicinity of the patients and other staff members tend to count on the nurses to treat and restrain the violent patients especially during outbursts (Owen, 1998; Moylan & Cullinan, 2011). Six months after completion of the project, the number of assaults by patients in long-term seclusion on staff decreased by over 70%. In one department we succeeded in implementing the intervention program in its entirety. There is ongoing training of the nursing staff in the departments during staff meetings that include reference to ethical and emotional aspects of coping with patients in long-term seclusion.

Working Group no. 3 – dealt with adapting the seclusion room to the needs of patients in long-term seclusion. The Law in Israel does not differentiate between psychiatric patients that require short- and long-term seclusion (Law for the Treatment of the Mentally Ill 1991). In section 13.3 D in the Procedure site states that "Seclusion should take place in a special room that ensures the safety of the patient. The room shall be accessible and close to the nurses' station and within the nurses' line of vision. In the room, there must not be objects with which the patient can harm himself." The seven patients upon whom I have based the content of this document have been in seclusion for years. The behavior of these patients does not include elements of self-injury. The above ban does not allow for the patient to have personal objects that might improve their conditions. According to policy, the seclusion room has two beds securely fixed to the floor. Since the seclusion room is in effect the "patient's room", the situation is such that prior to the initiation of this project secluded patients ate their meals while sitting on the floor, with the bed serving as a table. Introducing a table and bench unit that is affixed to the floor would allow the patient to eat meals in a more humane manner, and preserve human dignity. The addition of an anteroom buffer zone to the general area of the seclusion room where the patient can move and take care of his hygiene needs in privacy, contributes to positive feelings of patients in seclusion. Patients can take advantage of their time in the semi-open buffer zone for conversations with employees, without the latter fearing for their own safety. A study conducted in Norway that deals with open area seclusion found that that method reduced negative feelings of the patients and the staff towards seclusion and contributed to reduction of the duration of the patients' stay in seclusion (Bjorkly, 1995).

Conclusions

The project of coping with ethical dilemmas in the nursing care of the patient in long-term seclusion continued for one year Based on t recommendations of the working groups in the action research program, a therapeutic program was developed that included training sessions for the nursing staff. Structural changes made in the seclusion rooms included hook up to radio and television broadcasts, and a buffer zone that created an open area passage way for the patients from the seclusion room to the nearby bathroom and showers. Table and bench units were installed in each room to allow patients to eat in a comfortable and humane manner. All of the above, served as a model for nursing intervention with patients in seclusion. As a result of all of these activities, the conditions of the secluded patients improved and patients' attacks on the nursing staff were significantly reduced.

The current situation requires legal attention re policy revision. Until an appropriate policy is published, the administration of the hospital together with its employees is working to improve the conditions of these patients, within the boundaries of the existing procedures. As a result of the changes implemented, these patients now benefit from an improved standard of living including occasional barefoot walks in the outdoor department courtyard to see the sky!

Issues with ethical implications occur daily in nursing practice. The ability of psychiatric nurses to look out for the patients' best interests is at the core of action aimed at providing quality nursing care. The Israel Nursing Code of Ethics defines nursing practice and describes it as a system of dynamic relationships between the nursing staff and the patients. It aims to support the independence of nursing personnel however because it aims to deal with broader philosophical meanings s, the code does not provide the tools to translate guidelines to practice.

In the future we will continue to face ethical dilemmas that concern patients who require psychiatric hospitalization. The model presented in this project for coping with ethical dilemmas via Participatory Action Research can has proven to be beneficial. The model that we developed will be replicated for use in other hospital departments and can be implemented in other settings, such as prison wards.

Acknowledgements

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Applying clinical formulation to reduce violence and support recovery in an Adult Forensic Psychiatric Service: The specific needs of patients with neurocognitive deficits

Paper

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Abstract

Research examining the association between neuropsychological impairments and violence in psychiatric populations has revealed a picture of inconsistent findings. Whilst some studies report links between violence and impairment in executive function, the relationship between cognitive deficits and other factors is complex and presents particular challenges for treatment and management.

Service Audits and review within an Adult Forensic Psychiatric in-patient unit in the North West of England revealed that a significant proportion of the patient population presented with cognitive deficits, impacting on a range of areas but in particular those surrounding social/interpersonal functioning. In order to more effectively meet the needs of this population, a dedicated ward area and approach was developed in order to specifically address these deficits alongside the other presenting difficulties experienced by patients.

In our presentation we will describe and reflect on the models of treatment and care that have been implemented and developed over the period that the ward has been operational.
We will outline patient profiles and discuss how neuropsychological factors (including more generalised intellectual limitations as well as specific executive and communication deficits) are considered in combination with patients' other needs (e.g. symptoms of psychosis, affective disorder) in order to develop a comprehensive risk formulation. This is then used to inform day to day management planning, with a range of targets including the reduction of violence, working with strengths and promoting recovery.

Core elements of our approach include the application of specific assessments, clinical formulation of risks and needs and multidisciplinary staff training and support. We will focus on how interdisciplinary and collaborative work with staff and patients emphasise the application of theory in practice, in terms of developing specific care plans that prioritise a formulation-driven and patient-centred approach to care and treatment.

A preliminary evaluation of implementation and effectiveness will be discussed and individualised case examples will be used to anchor reflection and highlight both successes and challenges.

We conclude with an examination of the implications for service development, with attention to areas including the best use of finite resources and relevant contextual targets around quality and effectiveness.

Educational Goals

- Clinical effectiveness
- Interdisciplinary staff education and training
- Reflective practice
- Clinical formulation in practice

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Lack of Insight: No Longer a Bar to Forensic Rehabilitation

Workshop

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Keywords: Forensic, Rehabilitation, Insight, Pathways, Violence, Psychiatric

Introduction

PiC Locked Rehabilitation Services are recovery orientated services for people who need help to address the disabilities associated with mental disorder; typical patients are those who have not made a rapid recovery and may experience continuing difficulties in personal functioning and relating to others. Their individual needs cannot be met by less intensive mainstream adult mental health or community forensic services due to violence risk. It has been suggested that the focus for rehabilitation services is: "… on the treatment and care of people's severe and complex mental health problems who are disabled and often distressed, and who are or would otherwise be high users of inpatient and community services. The aim is to promote personal recovery, whilst accepting and accounting for continuing difficulty and disability". The importance of positive psychology and recovery principles as underpinnings to rehabilitation are central, and it is generally accepted that rehabilitation is achieved by the development and maintenance of skills within a collaborative and empowering environment that instils hope, provides interventions that limit the impact of the disability and develops goals for the future. These principles are also linked into the successful identification and management of risks, especially violence and sexual violence, and the overall achievement of positive life goals to achieve optimal levels of functioning for each patient.

At any time, around one percent of people with Schizophrenia receive intensive inpatientrehabilitation . Delayed recovery may be due to treatment resistance, cognitive impairment, severe negative symptoms, substance misuse and challenging behaviour, including violent behaviour and sexually violent behaviour. There is good evidence that, with further treatment in a suitable rehabilitation setting, even those patients whose difficulties are considered to be most challenging are able to progress successfully to supported community living.

The focus for Locked Rehabilitation Services is to mitigate the severe consequences of psychiatric disorders and for patients to begin to live successful integrated lives now. This workshop focuses on the issues of compliance and insight in forensic rehabilitation as two distinct constructs. Traditionally the common problem of lack of insight has been a bar to progress for detained psychiatric patients with forensic histories; particularly those who pose risks of sexual or physical aggression.

Outcome

In the last eighteen months, the authors and their colleagues have developed a unique programme of compliance based rehabilitation. This pathway is an entirely new approach to this patient group. A second pathway is also used, which is based upon a more traditional insight based approach. The use of the two constructs has enabled two distinct forensic rehabilitation pathways to be developed for difficult and risky patients to progress into community settings in a safe and managed way.
The two identified Care Pathways for patients follows the same four phases, and there are clear timelines provided for each Care Pathway. In summary, the pathways are:

Care Pathway 1 • Self Management	Care Pathway 2 • Joint Management
• Preparing to live optimal life in the future • Able to self-manage • Able to transfer learned skills • Empowering and encouraging skill growth	• Living optimal life now • Reliant on other people • Reliant on relational security • Prevention of deterioration of skills • Increase compliance

Care Pathway One is for those patients who have completed some previous treatment and have developed and internalised some skills. These are patients for whom it has been identified that they will benefit from intensive rehabilitation and the practice of these skills, in realistic settings, to ensure they can continue to utilise the practical and interpersonal skills they have developed. They will be able to generalise these skills as part of their progress towards community living and successful integration and the achievement of their life goals. The focus on community practice within a framework of continuously assessed and managed risk ensures the successful generalisation of skills to community based settings, using graded exposure techniques to ensure a successful journey to recovery and community re-integration. Care Pathway One patients are identified as being able to learn to manage their own risks and ultimately to achieve their life goals, but they need support and practice in order to achieve this.

Care Pathway Two is for longer-term more complex patients; these may include patients whose primary risk factors are aggressive or sexually problematic behaviours, complex mental health issues, cognitive deficits and/or interpersonal difficulties. Care Pathway Two is aimed at those patients for whom traditional treatment pathways have not, to date, ameliorated the risks, or enhanced skill development enough to enable their move to community settings and independent living, but who have progressed enough to enable the level of physical security to be reduced. Most psychological treatment programmes are reliant upon the development of self-management skills (for example those aggression and sex offender treatment programmes delivered in the Prison system and secure psychiatric care). Care Pathway Two specialises in the intensive practice of these skills in a real-life environment, but aims towards joint management with staff for those patients for whom the development of these self-management skills is impaired, for example, by cognitive impairments, specific personality traits or negative symptoms.

Care Pathway Two patients will be dependent upon expert external management and support (as opposed to insight based self-management) for a significant length of time. Therefore the intensive rehabilitation work is aimed at developing compliance skills, in order for them to effectively engage with this external management (see Diagram above). The definition of treatment under the Mental Health Act (England and Wales) includes treatment for the prevention of deterioration and the management of the risks to self and others; it is primarily this prevention and management that the intensive rehabilitation programme for this second group of patients focuses on. This is important to explain the continued care of these patients in the rehabilitation setting, for example at a Tribunal, whose role it is to review the legality of detention.

Any deterioration within a patient's mental state, including phases of active symptomatology, can be managed within either of the Care Pathways, thus ensuring continuity of care provision at times of relative crisis. The MDT input is focused upon intensive rehabilitation, within a framework of occupational therapy and psychological models, delivered in conjunction with nursing staff who are trained in these approaches with the provision of specialist input as required. The Locked Rehabilitation environment helps to prevent the destabilisation of the rehabilitation process by, for example, preventing access to illicit substances, alcohol use and a range of potential victim groups. Managing the de-stabilisers present in a patient's environment enables the patients to function at a higher level of functioning, whilst developing community skills. Destabilisation is also minimised by the structure, routine and the provision of a relatively low stimulus environment, where stresses are jointly managed and the development and practice of skills is supported.

Comprehensive and robust risk assessment processes are essential, utilising appropriate structured clinical judgement tools in conjunction with established risk indicator profiles to determine day to day risk fluctuations. This, combined with strong relational and procedural security, enables patients within the Locked Rehabilitation Services to have improved quality of life and achieve positive life goals via intensive rehabilitation, either with increasing independence or within a framework of externally managed risk (recognising that the Care Pathway Two patients have shown themselves unable to manage their own risks but able to engage with joint management).

The identification, assessment and rehabilitation of patients within these pathways guides treatment and management strategies, and can only be successful if it utilises an interdisciplinary whole team approach.

Workshop Summary

Using a variety of interactive exercises, attendees at the workshop will be able to gain an understanding of the independent constructs of compliance and insight, and how they apply to forensic risks. They will also be able to explore the relevance of these constructs to risk management, including the 'graphic equaliser' analogy and the utility of it in fully understanding the two pathway approach. The impact on choices about assessment and treatment will also be explored. Central to successful rehabilitation are the choices that the

whole team constantly make so that individual's strengths and risk profiles are used to tailor exposure to the environment both inside and outside the hospital.

This workshop will use composite case examples which represent typical features of patients who are currently being treated on these two pathways within psychiatric rehabilitation settings within the NW of England. The facilitators have a wide experience in successfully managing and treating sexual and violent offenders through the pathways of secure care into the community. This experience, and the problem of treating patients who lack insight, led to the development of this unique approach in which senior managers, all the clinical disciplines and the patients, work in partnership together.

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Aggressive Behaviour Management training in a High Secure Mental Health Facility

Paper

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Background

The Park, Centre for Mental Health, is Queensland's tertiary mental health facility, incorporating the state's only High Secure inpatient forensic mental health unit. The West Moreton Hospital and Health Service (WMHHS) Aggressive Behaviour Management (ABM) training unit is located at The Park. All clinical staff were required to complete 5 day ABM training with annual 2 day refresher training, as per Queensland Health ABM training guidelines. The initial course and the annual refresher were carried out in the ABM training centre. The training area has a classroom and a matted training area.

The High Secure Inpatient Services (HSIS) has five units servicing both male and female inpatients.

In January 2012 a 9 bed high acuity assessment and treatment unit – Kuranda – was opened within the High Secure Inpatient Service (HSIS). This unit is a specialised environment enabling patients with treatment resistant behaviours to access an appropriate level of care. Some of these patients have been unable to be transferred from the prison system to access effective therapeutic inpatient mental health treatment due to the risks associated with dangerous and aggressive behaviours, and some have been managed within HSIS by long term seclusion and mechanical restraints.

Identified issues

The problem was identified as:
The current model of delivery of ABM training was not adequate for the forensic High Secure units.
Staff did not feel confident in the level and retention of skills attained in ABM training. This was confirmed with the review of ABM training conducted by the District's School of Education and Research Unit.

Releasing staff off line to attend the annual refresher training was difficult for line managers – there were multiple staff who had not attended an annual 2 day refresher, or who were over the 12 month time frame. There was also a population of staff unable to complete the training due to physical constraints.

Method

An analysis of occupational violence workplace incident data from The Park was undertaken, by OHS from 2010 to July 2012. Number of events compared to incident forms lodged was considered, as an indication of the seriousness of an event. Data on patients involved in repeated incidents, in collaboration with the Patient Safety Unit, was also considered.

Occupational Violence Risk assessments were revisited, and the findings of the report on ABM training at the Park compiled by the Education and Research Unit were also reviewed.

Aggression incidents in the HSIS and Medium Secure units are often unpredictable, with no time for clinical intervention or to enact de-escalation ABM techniques – for example staff being king hit. Forensic patients in mental health facilities also demonstrate predatory and aggressive behaviours learned in the prison system – for example stealing sharp implements, such as pens and attempting to stab other patients or staff.

The aggressive events, occurring in HSIS, very often require physical takedown and seclusion of the patients.

Based on this information, the likelihood of patient aggression incidents occurring in the HSIS is therefore assessed as likely to almost certain, with the consequences being moderate, providing a risk rating of Very High.

In all cases of patient aggression a clinical review and/or Human Error and Patient Safety (HEAPs) analysis is conducted, to identify possible reasons for the event, evaluating clinical and other controls. HEAPs analyses include Occupational Health and Safety (OHS) input. OHS also conducted concurrent investigations into the incidents to identify non clinical factors contributing to the incident.

ABM training was consistently identified as an administrative control. It was determined that the ABM training model was not meeting the needs of the forensic service.

Consultation process

The management of aggressive behaviours is a particular challenge for any organisation each with idiosyncrasies and mental health has been identified as an area of practice that is considered a high risk of encountering aggression. The secure mental health setting presents as an area that encounters an increased risk of aggression due to the restrictions put in place to care for an individual with a mental illness.

Training staff to deal with aggression in such a high risk area, has presented some unique challenges. Initially staff completed their basic course, as identified by an Occupational Violence Risk Assessment (OVRA), which incorporates a training needs analysis. After completion of the basic course staff are required to attend an annual refresher course.

The ABM training courses are conducted in a designated training area which is set up with matted walls and floor and limited in the number of participants as per safety guidelines set out by Queensland Health. The proposal was discussed and feedback sought at local management committees, union consultative forums, and staff meetings. The district OHS committee with executive sponsorship supported the proposal.

Results

There was an indentified need to change in the model of delivery of ABM training within HSIS at The Park, as outlined below.

1. On site workplace training model
An ABM training area was set up in August 2010, with matting inside the HSIS campus, in the admissions transport bay. Regular (weekly) training/tutorial and in house assessment sessions are now run within the actual HSIS campus.

Benefits:
•   Enables staff to recreate different scenarios based on incidents that have occurred, and to simulate actual patient aggression behaviours that they are familiar with, and to practice effective ABM techniques as a working team.
•   Enables practicing of specialist PPE techniques for use in planned interventions, and application and removal of restraints techniques. These techniques are required only by staff working in these areas.
•   Staff do not have to leave the HSIS precinct, allowing them to respond to duress alarm if needed.
•   Enables in house assessments to be conducted by the trainers to assess each individual staff member's skill retention and application.
•   Enables more intensive instructor /participant time to maximise the abilities and confidence of staff with physical limitations

2. Introduction of Personal Protective Equipment
Soft shields were implemented across the HSIS and Medium Secure Units, with procedures, documentation (including post deployment review of soft shields) and training developed, based on the local physical environment.

Specialist PPE gear consisting of helmets and face shields, limb and body protection has been introduced, only for use in planned interventions within the Kuranda High Acuity unit. There was extensive research by the ABM Nurse Educator/Coordinator and senior clinicians, also extensive consultation prior to implementing the appropriate personal protective equipment.

•   The equipment is available as a last resort for clinically indicated planned interventions when it is assessed by the clinical team that the intervention is likely to require this level of protection to minimise the risk of harm to staff and patient.
•   The ABM team regularly train and check staff's competency in using the PP&E allocated.

Overall Benefit/Effects

ABM training compliance improved – Kuranda staff have 100% compliance with training whilst in the High Secure Inpatient Service campus ABM training data reflects a 90% plus compliance.

Significant reduction in staffing costs due to reduction in time off line to attend training.

HSIS occupational violence related injuries costs and days lost statistics
2010 $447,053 days lost 854
2011 $180,645 days lost 519
2012 $1,143 days lost 1 (until July 2012)

Conclusion.

This year we are expanding the workplace training model to other high risk areas within the district. This mode of training has proven to be the most effective way of delivering the course content to the staff.

During training the emphasis on verbal de-escalation is reinforced continually. Whilst we do train in physical techniques to restrain an individual we actively promote that this as a last option.

The usefulness/effectiveness of on site training cannot be denied. The future expansion of the training model is well underway with applications designed to suit various other health settings in our health service.

The ABM team has had major support from the senior management of the West Moreton Hospital and Health Service in Queensland and staff at The Park Centre for Mental Health. This alone has allowed us to think outside the square and move ahead with planning more innovative training for staff. The balance is always to maintain the integrity of the ABM course content and effective contextualised delivery of that content to the staff.

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A study into the attitudes towards violence and aggression a high security hospital

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Introduction

This paper presents a qualitative research project conducted within a high secure hospital to ascertain staff and patient views on how aggression and violence is managed and the subsequent impact on all parties.

Both the National Institute for Mental Health in England (NIMHE, 2004) and the National Institute of Clinical Excellence (NICE, 2005) have emphasised the need to take account of contextual factors when considering the cause and management of aggression. Whilst patient variables (internal) are important within psychiatry, the environment or setting (including culture), relational issues (including gender) and staff attitude are equally important (Jansen et al., 2006). Duxbury & Whittington (2005) found that poor communication contributed to the development of patient aggression, whereby restrictions and environmental factors are fundamental to relational issues.

There is currently very little research conducted in High Secure Services (HSS) that focuses on the management of violence and aggression (MVA). Uppal & McMurran 2009 report on the frequency and nature of incidents of violence, self-harm and security; Ireland (2006) considers bullying within this context rather than the staff and patients attitudes towards violence and aggression. However, these studies do not focus specifically on the attitudes of staff and patients to violence and aggression.
To date, it has been assumed that research conducted into violence and aggression in secure services is transferable across all secure settings. As there are only three high security hospitals across England and Wales, accessibility and concerns about the 'over-researched' client group has often inhibited such research. However, this research collaboration between academics at the University of Central Lancashire (UK) and clinicians with a high secure hospital has made this unique study possible.

McKeown, M. & Stowell-Smith, M. (2006) speak about the construction of difference between staff and patients who exist in conditions of high security and suggest that we separate ourselves from those with psychopathic personalities to cope with the work, but acknowledge that this creates its own difficulties within the establishment of the therapeutic relationship. More recently, Canadian authors, Jacob, Gagnon and Holmes (2009) stated that "Forensic psychiatric nurses work with individuals who may evoke feelings of empathy as well as feelings of disgust, repulsion, and fear." (2009: 153), they attribute these emotions to the fear of caring for individuals who are viewed as 'monsters' and so, in the face of abjection, create a context that constructs a sense of difference and 'otherness' between themselves and the patients. They suggest that developing greater understanding, and thus a better attitude towards the client group, would allow forensic mental health nurses to engage in a reflective process regarding their professional practice and, as a result, improve the provision of nursing care. Such commentary is valuable, but is based upon observation and experience rather than research.

The aims of the research

The project aims to identify nursing staff and patients attitudes to the management of violence and aggression.

Thus two key aims were established for this qualitative study:

- To compare attitudes between nursing staff and patients as a medium for identifying possible convergent views that can impede the development of non-physical interventions, and similarities that can promote positive interventions.
- To utilise findings within the development of future training in non-physical approaches to the recognition, prevention and therapeutic management of aggression.

The context of the research

The research took place at one of the three high secure facilities in England and Wales which provides care for 215 adult males detained under the Mental Health Act (MHA 1983). Here, patients present a level of danger to others which is both grave and immediate (Campbell, 2005), staff attempt to balance care and containment for patients whose average length of stay is 6.25 years. Furthermore, the average length of service for nursing staff is higher than average at18 years for qualified staff and 15 years for nursing assistants.

Participants

Eight male patients and ten members of staff were interviewed, (seven male and 3 female.)
Whilst this may seem unequal it is reflective of the High Secure Services work force of which male staff are approximately 2:1. Interviews were conducted within a three month time-frame.

Research design and method

Semi-structured interviews were employed within a constructivist approach as identified by Guba & Lincoln (2005) who view constructivism as one of the main paradigms of contemporary qualitative research. A constructivist approach purports that … knowledge is established through the meanings attached to the phenomenon studied (Krauss, 2005:759). The data was then analysed using thematic analysis as outlined by Braun and Clarke (2006) .

Ethical considerations

Ethical approval was obtained from the hospital research and development committee, an NHS regional ethics committee and a University ethics committee. The patients' care team
provided advice regarding participant suitability and all names were removed to ensure anonymity.

Findings

There were similarities between the emergent themes across both staff and patient
interviews. The establishment, relationships, gender, the construction of difference,
medication, environmental stimuli and identity were all central themes from both data sets.

Establishment:
Many of the patients referred to a sense of 'order' and routine that created a predictable and
yet constraining view of the service and their immediate environment and how that was managed:
You don't have the ability to walk away [05P] *and being locked up* [02 Patient]

Most staff agreed that the environment created its own difficulties in terms of present
aggression.

Relationships:
Therapeutic relationships were valued by both staff and patient, but for some patients, the power imbalance was notable. Approachability, a sense of being able to trust the staff, staff availability and their receptiveness to the patient's need to talk was seen as important and diffusing:
Some of the other patients hold onto issues because they don't know how to talk
...and all of a sudden they start kicking off and shouting...[13 Patient]

The immediacy of the connection and the right attitude was most readily identified by the staff as important in managing violence and aggression (MVA):
A good attitude will always reduce the chance of aggression [167 Staff]

But, unfortunately, some of the aggression was directly related to staff attitudes:
I think a lot of aggression around here can be caused by staff attitude, staff problems, how they try to resolve it and the situation, dependant on what the situation may be. [17 Patient]

Gender:
The patient population is all male so commentary related to the dynamics created by females within the workforce. All interviews revealed a belief that female workers had a positive impact in reducing aggression:

the female approach has a massive calming influence ... she goes to talk to him, she spends hours with him and it has the desired effect. Now if I was going to do that he would be climbing the walls. There are less incidents with females on the wards. [101 Staff]

Construction of difference:

The patient interviews clearly identified a belief that it was 'them and us' and that a lack of interest in the patients created a division between staff and patients:
There has always been a them and us situation-'them' being the staff and 'us' being the patients [10P]

Staff disagreed with this, except in the resolution of such a construction:
I think treating them as normal as possible and not trying to maximise the idea of patient and staff. [61 Staff]

Medication:
In terms of aggression management, Medication could be seen as both positive and negative.
...some people have medication because they are aggressive and if they didn't have that then they are violent.[32 Patient]
There are also patients that the medication makes them very tired and when you are tired your temper can be shorter so there is that aspect of it.[190 Staff]

Identity:
The 'patient' identity, (as opposed to 'prisoner') was important, some of the patients used the word 'patient', but many used the term *'prisoner'*. A similar example was given with regard to being unable to make choices and many patients believed that they were being treated like children which created frustration. One patient referred to his peer group as a 'nursery':
this gets more like a nursery as time goes on [10 Patient]

Environmental stimuli:
Boredom was clearly identified as a reason for violence and aggression occurring to the extent that some patients actually generated hostile and provocative situations to provide a more stimulating environment for themselves:
I get bored very easily and I start messing around and doing things to wind staff up ...laugh at them and spar...Well, there are a few patients who, I don't know if boundaries is the right word but, they go around bugging staff and getting in staff's personal space. [02 Patient]

Active sessions were seen as useful in reducing aggression:
Activities can de-stress, can remove aggression, especially if it is sports activities, it can channel aggression though sport activities. [101 Staff]

Discussion

It is evident that the staff experience great difficulty in managing patients who often have an extensive criminal and violent history, a personality disorder and are subject to compulsory detention . This study resonates with a similar Australian study conducted by Meehan, McIntosh and Bergen (2006) which focussed solely on patients in a high secure forensic setting and concluded that boredom and medication were significant factors in the management of aggression. Meehan and colleagues also identified that the negative and oppressive culture of the organisation was highly restrictive and contributed to the tensions which increased both violence and self-harm. However, until this point, no UK study had been conducted to ascertain if these findings could be applied to our population.
Aspects of the care and treatment such as the 'structured day', fixed medication and meal times and fixed staff shift patterns reinforce this closed system may be perpetuating institutionalisation and the creation of the 'them and us' culture.

By raising awareness of the variables that influence attitudes towards the management of aggression and perceived helpful practice, this study highlights issues which influence aggression as well as practices that patients find helpful. The use of a strengths based approach promotes positive and safe responses to patients presenting with dangerous behaviour. Hence the following practice recommendations have been made:

• MVA staff representation at patient forum groups,
• Integration of MVA trained staff into service management groups,

- Recognition of the uniqueness of the High Secure population and the culture of the organisation,
- Additional training into relational security,
- The consideration of the pursuit of positive and safe responses to dangerous patients,
- Regular clinical supervision for all staff which considers attitude as well as knowledge and skill,
- Provision of meaningful activity rather than 'occupation' for patients,
- Facilitate patient involvement in developing respectful and inclusive practices.

Limitations of the study

This study was conducted in one of the three hospitals of high security in the country.
Ideally, this study would be replicated in the other two hospitals to determine if these findings are transferable, or unique to this service. The uniqueness of the HSS coupled with the specific history of the hospital may have affected the nature of the findings.

Conclusion

The findings suggest that the culture and context of the high secure setting has a significant impact on the perceptions and attitudes of both staff and patients. It may seem inevitable that a detained group of people will seek to make their needs using violent and aggressive means, so it is imperative that the patient's voice is heard in a calm, dignified and respectful way. The impact of managing violence and aggression also takes its toll on staff and so clinical supervision and peer support is vital.
Although the patients in this study have stated a preference for the title 'patient' we recognise that 'service-user involvement' can be one way forward in addressing the perceived inequalities that divide staff and patients and create a culture of 'them and us'. The establishment and maintenance of a trusting and therapeutic relationship is pivotal to this.

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Involuntary hospitalization for offenders with mental disorders in Japan

Paper

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Background

Both community-based care and specialized treatment for offenders with mental disorders are global trends [1]. However, dealing with patients who commit less serious crimes and have less intrusive behaviors is controversial.

Japan had no specific legal provisions for offenders with mental disorders for many years [2]. Such offenders weretreated under the Mental Health and Welfare (MHW) Law. According to the MHW law, patients with mental disorders who are potentially dangerous and capable of harming themselves or others arehospitalized under the prefectural government order. This system of official involuntary hospitalization is completely detached from the criminal justice system [3]. Therefore, some lawyers have claimed that the human rights of these patients arenotassured. Meanwhile, some psychiatrists suggested the need of special hospitals with a secure structure and adequate staff to provide appropriate care to offenders with mental disorders [4].

To solve these problems, the Japanese forensic mental health system underwent reform that coincided with enforcement of the Act on Medical Care and Treatment for the Persons Who Had Caused Serious Cases under the Condition of Insanity: the Medical Treatment and Supervision (MTS) Act in 2005 [5]. Under this new scheme, a person who commits a serious criminal offense while in a state of insanity or with diminished responsibility will be supervised in a judicial administrative frame. The court orders them to undergo specialized medical services at an appropriate hospital. In addition, a rehabilitation coordinator who belongs to a probation office supervises them. Since the MTS act was first enforced 8 years ago, several papers have been published regarding the outcome of this new system [6].

On the other hand, a conventional scheme of official involuntary hospitalization under the MHW law has remained almost unchanged. Currently, offenders diagnosed with a mental disorder who commit less serious crimes under the influence of mental disorders and who have a necessity for immediate medical care are subjected to official involuntary hospitalization.

In contrast to the MTS act, Japan has no system in place that monitors patients who are hospitalized based on the MHW law. Although a few surveys have been performed [7], the outcome of these patients has not been adequately examined. We believe it is necessary to consider using a conventional scheme that is suitable for the post-MTS act era.

This research aimed to examine the current situation of mental health care of offenders with mental disorders in Japan. Therefore, we administered a questionnaire survey on the patients assigned to official involuntary hospitalization based on the MLW law in the Chiba prefecture.

Material and methods

We attempted to examine all cases of official involuntary admission based on the MLW law in the Chiba prefecture from Oct 2009 to Sep 2010. We sent the questionnaire to all mental hospitals admitting patients of official involuntary hospitalization in Chiba prefecture. We asked mental health practitioners working at these institutes to provide inputs regarding patients assigned under official involuntary hospitalization. Each questionnaire included the following data regarding the patient: age, sex, therapeutic history, criminal history, content of the crime, psychiatric diagnosis, term of the hospitalization, treatment after the completion of the official involuntary hospitalization, situation at their home, and so on. We also collected

the practitioners opinions regarding the difficulties related to the treatment of such patients and the social resources required. We then drew the survival curve of the completed cases to allow comparisons with previous data. The data was analyzed using PASW Statistic 18 (R).

Ethical issues

We did not gather personal information regarding the patients. We reported the contents of this survey to the Ethical Council of the Graduate School of Medicine at Chiba University in advance, and the council declared that the survey did not pose any ethical problems (Dec 1, 2010). We registered this survey on the Clinical Trials Registry (CTR) of the University Hospital Medical Information Network (UMIN, Tokyo, Japan) with the unique trial number UMIN000004768.

Results

We received responses from 27 hospitals, 9 of which did not have any suitable cases. A total of 206 cases were included in the responses, of which 143 were males and 63 were females. The mean age for the patients was 43.6 years. Only one-fourth of the patients were therapy naïve. One-hundred and five patients had prior history of hospitalization; 43 of these 105 patients had been previously hospitalized under official involuntary hospitalization.

History of prior imprisonment was noted in 25 patients and 24 patients were previously arrested. No prior criminal history was noted in 141 patients. The category of crimes committed by these patients were as follows: murder, 2; attempted murder, 2; arson or attempted arson, 9; robbery or attempted robbery, 1; sexual offense or attempted sexual offenses, 2; injury to death, 1; injury, 38; assault, 59; coercion, 22; theft, 12; property damage 52; fraud, 5; and attempted suicide, 29.

The most frequent diagnosis was schizophrenia, but in some cases, these diagnoses were changed at discharge. The mean term of official involuntary hospitalization was 48 days. Almost half of the patients remained hospitalized even after the official involuntary hospitalization order was completed. More than half of the patients were supposed to go home after their discharge.

According to respondents, the necessity for official involuntary hospitalization was appropriately assessed. Reasons for difficulties pertaining to the case management were various. Many cases could not be followed up after discharge or after changing hospitals. Some practitioners suggested the need for a new tracking system similar to that used for the MTS act to follow patients who tend to withdraw from medical treatment.

Discussion

We conducted a questionnaire survey to collect data regarding cases of official involuntary hospitalization based on the MHW law in the Chiba prefecture. A total of 27 hospitals responded to the survey. There were 35 hospitals that admitted patients of official involuntary hospitalization in the Chiba prefecture in 2010; 6 were official hospitals and 29 were private hospitals [8]. Thus, the response rate was 77.1%. In total 206 cases were collected. According to an official report [9], there were 269 cases of official involuntary hospitalization in the Chiba prefecture in 2010. Thus, we collected 76.6% of all cases targeted.

The male/female ratio of the patients was higher than that in general population [8]. This may have been because of the characteristic of official involuntary hospitalization as an administrative disposition for offenders with mental disorders.

The one-third of the cases was continuing to get some mental health services at the occurrence of the crime. They seem not to be able to control their mental status with usual care. Among them, 43 cases had a prior history of official involuntary hospitalization. These cases were deemed as habitual offenders with mental disorders. The mean term of official involuntary hospitalization for patients with history of hospitalization is significantly longer than those without a history of hospitalizations (65.7 days vs. 47.0 days, unpaired t-test, t = -2.12, Df = 129, P = 0.036). Thus, previous inpatient care might not prevent future official involuntary hospitalizations and may suggest a risk factor for delaying discharge.

In this survey, three-fourths of the cases had no previous history of criminal behaviors. However, the number of patient with history of previous official involuntary hospitalizations was significantly higher in patients with a criminal history (0.81 times vs. 0.26 times, unpaired t-test, t = -3.08, Df = 187, P = 0.0024). Patients with prior history of hospitalizations tended to have longer hospital stays. Three-fourths

of patients had no history of prior arrests. However, patients who were hospitalized repeatedly showed a higher tendency of violence.

A total of 55 patients committed serious offences. The reason why they were not alleged to the indication of the MTS act is unknown. Another research suggests that the relationship between the police and the prosecutor in dealing with such cases is not adequately distinguished [7]. It is also possible that the police could not investigate the case because of the severely hampered mental status of the offenders.

Sixty percent of the patients were diagnosed with schizophrenia in an assessment before hospitalization; however, some of the diagnoses were changed because it is difficult to give a precise diagnosis at an initial assessment of the patient with limited information. Therefore, a diagnosis change is unavoidable in some cases.

Eight percent of the patients were discharged from the official involuntary hospitalization because of improvement in mental status within 3 months. Compared with the data collected in 2002 (before the enforcement of the MTS act), the survival curve for official involuntary hospitalization has sharply decreased. The total number of cases of official involuntary hospitalization also decreased. A main reason is that the patients who committed serious crimes have been dealt under a scheme of the MTS act.

Most offenders with mental disorders want to go home after their mental status has improved. This tendency is the same as in the patients under a scheme of the MTS act [6]. However, these offenders are not readily accepted by their family or the community. Some patients remain hospitalized even after the completion of the official involuntary hospitalization. Social resources, such as group homes, must be utilized more flexibly to improve the community-based care for patients with mental disorders.

The respondents indicated a need for a system that monitors discharged patients. It is difficult for practitioners to have the patients return to the hospital when he or she intends to quit the treatment. If left without treatment, the high recurrence of mental disorders might possibly occur.

Previously, we investigated the difficulties within conventional mental health settings using a questionnaire that surveyed mental health practitioners working at mental hospitals. We assessed their response regarding five factors in treating offenders with mental disorders, such as "electro convulsive therapy", "long acting injection of antipsychotic drugs", "use of clozapine", "confrontation of the offense that the patient committed", and "home nursing before discharge". As a result, it was determined that there were some common difficulties between specific treatment of forensic mental health and general treatment for offenders with mental disorders [10].

Conclusion

In Japan, offenders with mental disorders are often treated through a conventional mental health care system. After enforcement of the MTS act, the system of official involuntary hospitalization in the MHW law has become more functional. Continuous and efficacious support for risky patients is still required not only in forensic mental health but also in community-based care.

Acknowledgements

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A Survey of Staff and Patient Attitudes towards Aggression in a United Kingdom High Secure Hospital

Paper

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Background

Professional opinion worldwide is that the use of controlling strategies for responding to aggression and violence in mental health care settings should be reduced in favour of greater employment of interpersonal approaches (Huckshorn, 2007; Jonker et al, 2008). Understanding the attitudes of staff regarding aggression management is one step towards achieving this aim. At the same time, users of mental health in-patient services will have their own attitudes about aggression and appreciating their perspectives is also vital for determining appropriate strategies. This paper reports on a survey of attitudes towards aggression and its management held by staff and patients in a high secure hospital for adults with mental health problems in the United Kingdom.

Mason et al (2008) suggest that violence and aggression are less of a problem in secure mental health services than is popularly thought, owing perhaps to the greater preparedness of staff for managing aggressive incidents. At the same time, a recent audit of violent incidents in a forensic mental health service (Green et al, 2008) found that 130 incidents occurred during a 12-month period. Interestingly, while 40% of these incidents were classified as moderate (the victim being struck, but not injured) and only 15% as serious (causing bruising, lacerations or damage to property), 'Control and Restraint' (C&R) was used as a management approach for over 52% of all incidents. A survey of incidents involving aggression (verbal aggression, physical violence and self harm) in one UK high secure hospital reported 0.89 incidents per patient per month, though a small number of patients accounted for a high proportion of incidents (Uppal & McMullan, 2009). There is a clear tension for staff in high secure mental health services between promoting patients' recovery and human rights and managing risk and security (Timmons, 2010). Again the attitudes and beliefs of staff may play a major role in determining the social climate of the hospital (Howells et al, 2009).

Patients have their own attitudes about aggressive behaviour, not least because they will frequently be the victims of aggression as well as the perpetrators (Uppal & McMullan, 2009). The few previous studies that have sought the views of patients about these questions have found discrepancies between their views and those of professionals. Qualitative research by Hinsby & Baker (2004) with patients and staff in a medium secure unit indicated that patients put more emphasis on external and situational causative factors for aggression than did staff. Patients felt they could control their violent impulses, but sometimes reacted to environmental stressors. These findings support the survey results of Duxbury & Whittington (2005) who ascertained the views of patients in acute psychiatric in-patient units. A broader comparison of staff and patients' perceptions of social climate within a high secure hospital found that staff regarded the climate as being more therapeutic and positive than did patients (Howells et al, 2009).

Aim of Study
- To ascertain and compare the beliefs of staff and patients in a high secure hospital as to the causes of, and best means of responding to, aggressive and violent incidents.

Methods

Design
All participants completed an adapted version of the Management of Aggression and Violence Attitude Scale (MAVAS). MAVAS contains 13 statements about causes of aggression and violence, relating to:
- The internal model, in which aggression and violence are seen as being due largely to factors within the aggressive person, such as mental illness or personality,
- The external model: in which aggression and violence are seen as being mainly caused by factors in the person's physical or social environment, such as the physical layout of the ward, or the way the ward is governed by the staff,

- The situational/interactional model: in which factors in the immediate situation, such as the interaction between the patient and others, especially staff members, are seen as the most significant issues to be addressed.

MAVAS also includes 14 statements relating to different approaches to aggression management. The development and psychometric testing of the MAVAS have been described elsewhere (Duxbury, 2003).

The MAVAS was adapted for the purpose of this study by replacing the usual visual analogue scale with a five-point Likert scale (5= Strongly agree; 1 = Strongly disagree). In addition, participants were asked to record their agreement or otherwise with three additional statements that reflected particular concerns within the hospital that was the study setting. The version used in this study is referred to as MAVAS-Likert (abbreviated to MAVAS-L).

Setting
The study took place in one of three high secure hospitals serving England and Wales. The hospital provides in-patient care and treatment for men, who are deemed to be a grave danger to themselves and / or others, in conditions of maximum security.

Participants
Staff: All qualified nurses, unqualified care staff and other direct care personnel were invited to participate in the study.
Patients: Consultant Psychiatrists were approached to ascertain if patients' current mental state was conducive to completing the MAVAS-L. If it was felt that it was suitable, the investigator asked patients if they were interested in taking part in the study.

Ethical Considerations
Ethical approval was obtained from the hospital research and development committee and an NHS regional ethics committee. University ethics approval was also secured. Participants were given written information about the study, and the voluntary nature of participation. Consent of staff was assumed if they returned the completed MAVAS-L. Written consent was obtained from patients.

Data Analysis
Analysis was carried out on a question-by-question basis. Descriptive comparisons were made.

Results

A total of 109 questionnaires were returned from staff out of 301 distributed, a response rate of 36%. A total of 26 questionnaires were returned from patients out of 97 initially approached, a response rate of 27%. There was considerable concordance between staff and patients in their responses to MAVAS-L overall. While there were significant differences in the median responses of the two groups to eleven out of thirty statements, in seven cases the difference was one of degree only. The groups parted company in their responses to just four statements, and gave opposing views to only two statements.

Staff and Patients' Views regarding the Causes of Patient Aggression & Violence

Internal Model
Both groups agreed that "there appear to be types of patient who are aggressive" and that "patients who are aggressive should try to control their feelings", patients significantly more so than staff. Staff agreed that "patients are aggressive because they are ill" while patients were unsure, but the difference between the groups was not significant. Patients agreed that that "aggressive patients will calm down automatically when left alone" while staff disagreed. Both groups disagreed that "it is difficult to prevent patients from becoming aggressive" and that "patients from particular ethnic minority groups are more likely to become aggressive".

External Model
Both groups agreed that "restrictive environments can cause aggression". Patients agreed with the statement "if the physical environment were different, patients would be less aggressive", while staff were unsure. Staff disagreed with the statement "patients are aggressive because of the environment they are in" while patients were unsure, but the difference between the groups was not significant.

Situational/Interactional Model
Both groups agreed that "poor communication between staff and patients leads to patient aggression", that "improved one to one relationships between staff and patients can reduce the incidence of aggression"

and that "it is largely situations that can contribute towards the expression of aggression by patients"; in the latter case patients were significantly more likely to agree than staff. Both groups disagreed with the statement "patients commonly become aggressive because staff do not listen to them". Patients agreed that "other people make patients aggressive" and "differences in cultural beliefs between patients and staff may lead to aggression" while staff were unsure. In neither case was the difference between the groups statistically significant.

Staff and Patients' Views regarding the Management of Aggression & Violence

General
Both groups agreed that "different approaches are used on this ward to manage aggression" and that "having both male and female staff on a shift is important in the management of aggression". Patients agreed with the statement "patient aggression could be handled more effectively on this ward", while staff disagreed.

Use of Medication
Both groups agreed quite strongly that "medication is a valuable approach for treating aggressive and violent behaviour". Patients agreed that "prescribed medication should be used more frequently for aggressive patients", while staff were less supportive of this statement. Staff tended to agree that "prescribed medication can sometimes lead to aggression" while patients were less convinced. The difference between the two groups however was not significant.

Use of Seclusion
Both groups disagreed that "the practice of secluding violent patients should be discontinued", staff significantly more so than patients. Both groups disagreed that "seclusion is sometimes used more than necessary". Patients agreed that "when a patient is violent seclusion is one of the most effective approaches" while staff neither agreed or disagreed, but the difference was not significant.

Use of Restraint
Both groups agreed with the statement "patients who are violent are restrained for their own safety", patients more so than staff. Both groups disagreed that "physical restraint is sometimes used more than necessary", staff more so than patients.

Use of Non-Physical Methods
There was near complete agreement between staff and patients in their responses to these statements. Both groups agreed that "negotiation could be used more effectively when managing aggression and violence", that "expressions of aggression do not always require staff intervention" and "the use of de-escalation is successful in preventing violence" (staff significantly more than patients). Both groups were unsure when responding to the statement "alternatives to the use of containment and tranquilisation to manage patient violence could be used more frequently".

Discussion

An important finding from this study is the overall concordance of views expressed by staff and patients. The degree of agreement between staff and patients is in contrast to the study carried out by Duxbury & Whittington (2005) in an acute in-patient unit, in which staff and patients' views were opposed on 14 out of 27 statements.

Staff and patients displayed mixed, but often similar views regarding the causes of aggression and violence. When considering strategies for managing aggression, it was striking that patients were broadly as approving of physical or controlling strategies as were staff. It was also the case that the majority of participants were inclined to support non-physical methods of aggression management such as negotiation and de-escalation, but it was notable that both groups were unsure whether alternatives to containment and tranquilisation should be used more frequently.

Questions were put to both staff and patients regarding ethnicity and the need for female staff members in an all-male patient environment. Neither staff nor patients highlighted ethnicity or culture as being significant factors in aggression management, though it should be noted that the large majority of both staff and patient respondents were white. Both staff and patients agreed that availability of female staff is important for aggression management, despite the hospital admitting only male patients. Staff took an eclectic view of aggression management, embracing both physical and non-physical methods, but physical management strategies such as medication, seclusion and restraint were all regarded as valuable. Our findings reflect the tension noted between the imperatives of promoting recovery in high secure settings along with maintaining safety and security (Timmons, 2010).

The views of patients tended to match those of the staff who were not only caring for them, but maintaining them in custody. Their support for medication, seclusion and restraint was striking. Our study showed some parallels with the findings of Meehan et al (2006), whose patient group supported the use of controlling strategies to prevent some patients harming others. We might tentatively relate these findings to the fact that patients in high secure hospitals can be as likely as staff to be victims of aggression (Uppal & McMullan, 2009). Bullying between patients is not uncommon in high secure settings (Ireland, 2005) and it has been observed that violence among patients in such settings may be used to establish a "pecking order" and territorial boundaries (Love & Hunter, 1999). The stressful nature of living within a high secure setting may therefore lead some patients to regard control of their more aggressive or dominant peers as being important for their quality of life.

Conclusion

The results of our survey have shown that staff in a high secure hospital regard patient aggression and violence as having a range of causes. They also reflect an eclectic view of aggression management, seeing the value of non-physical strategies while also being in favour of the use of medication, seclusion and restraint to respond to aggressive incidents. Our findings also suggest that in this setting the views of patients are remarkably consistent with those of staff, with patients being as much in favour of controlling strategies. This leads to an ethical dilemma in that there is general disapproval of controlling methods of aggression management as set out in the literature (Huckshorn, 2007; Jonkers, 2008). The complexities of meeting best practice guidelines for aggression management in high secure settings are highlighted by our study.

Please note that a fuller version of this paper has been published (Pulsford et al, 2013).

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Frequency of relapse in challenging behaviour in forensic patients. Special care unit vs. traditional care unit

Paper

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Keywords: Forensic, coercion, re-admittance, GAF, SOAS, BVC

Introduction and/or background

The medium secure forensic psychiatric unit R8 wasa special project unit.
The aim of the unit was:
• Reduction in length of admission for forensic psychiatric patients
• Reduction in aggressive behaviour through focus on the patients cognitive deficits
• Impede absconding
• Reduce recidivism to illness
• Reduce recidivism to crime

The project ran from 1/10-09 to 31/3-12, the aim was primarily to receive, diagnose and treat patients referred from jails for psychiatric treatment but also to receive particularly patients with high flight risk and extrovert reaction pattern. Resources where allocated to intensify the treatment process and also there was a focus of early onset treatment.

The aim of this retrospective comparison study is to determine whether treatment within a ward with a focused aim of rapid onset of diagnostics and treatment with high levels of staff on hand (n=37) and high levels of physical (n=2) and other activities (n=2) have an impact on the frequency of aggressive events by inpatients and whether it has a prophylactic effect on patients disease recurrence, their potential relapse to legal violations, substance abuse and other challenging behavior. Also, the study sought to determine if it leads to fewer readmissions to psychiatric hospitals.

Method

Two groups of patients (n=60) were randomly selected. Group 1 (n=30) from intervention unit and group 2 (n=30) from the other forensic units at the same psychiatric hospital. Inclusion criteria in the study were as follows: admitted for a minimum of 21 days, male, admitted and discharged from unit during the investigation period.

Information on aggressive behaviour was derived from SOAS-R and BVC database, Information on use of coercive measures such as mechanical restraints, medication and seclusion were drawn from the national database and coercion protocols at the hospital. Information on readmittance will come from national patient database.

Results are pending as the study is in progress. Initial figures show lower frequency and intensity of aggression and use of coercive measures in intervention unit than non-intervention units.

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Patient involvement in planning for the prevention and management of aggression and violence: an audit study

Paper

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Background

The prevention and management of aggression and violence (PMAV) is a very important issue in mental health services for both staff and patients. In forensic settings, where rates of aggression are highest (1), there is added urgency to find solutions. Patient involvement in contingency planning this has been highlighted in National Institute of Clinical Excellence (NICE) (2) guidance as a vital part of the process. St Andrew's PMAV policy (CRM26) states 'Service users should be involved in the development of the PMAV Risk Assessment, initially and at Care Plan reviews', and further stipulates that all service users must have a PMAV care plan within seven days of admission, therefore completion rates should be 100%. The purpose of the care plan is threefold: firstly to prevent incidents of aggression through identification of potential triggers, and early intervention; secondly to identify de-escalation strategies when violence is imminent; and thirdly, to plan for safely managing violence when physical interventions are necessary. Prevention can be conceptualised as comprising three tiers: primary, secondary and tertiary. Primary prevention relates to those actions which take place before violence has occurred, with the aim of stopping its occurrence. Secondary prevention comprises the actions that are taken to prevent imminent violence. Finally, tertiary prevention describes the interventions that take place whilst violence is occurring and, following the event, the actions that are used to minimise the harm to the individuals involved (3). These tiers are all covered in the PMAV care plan.

Aim and objectives

The current study describes an audit of the secondary prevention measures (i.e., documented de-escalation strategies) identified in individual patients' care plans. De-escalation is the use of skills and techniques to reduce or stop an escalating situation or incident (4). The specific objectives of the study were:
- To identify the extent to which patients are involved in the content of their PMAV care plan.
- To describe early intervention and de-escalation methods documented in care plans.
- To ascertain the extent to which the de-escalation methods described in the care plan are recorded as having been attempted in the event of an incident.

Methods

Setting

The study was conducted at St Andrew's Healthcare, Northampton, an independent sector hospital providing accommodation for inpatients with a wide variety of mental health problems, mostly in conditions of low and medium security. Admissions usually come from other hospitals and are referred because of the specialist or complex nature of their mental health problems or because of difficulties in managing their challenging behaviour. Almost all are referred and funded by the NHS. The majority of patients are detained under the Mental Health Act (MHA) of England and Wales 1983, amended in 2007.

Participants

All patients in men's and women's mental health care pathways who were involved in an aggressive incident between 1st May 2012 and 31st October 2012 were included in the audit. For the purpose of the study aggressive incidents were operationally defined as those flagged in the event-reporting form as: abuse/aggression – verbal; abuse/aggression – physical; abuse – sexual; property damage; or self harm and suicide.

Procedure

Each patient's PMAV care plan was scrutinized to gather information about their level of involvement and agreement in its development. Information was taken from three sections of the care plan: 'Early

Intervention Strategies', 'Preferred De-escalation Methods' and 'Staff De-escalation Strategies or Interventions'. The content of the care plan was examined to ascertain which early intervention and de-escalation strategies were documented. In order to examine whether the care plan was adhered to in practice we examined reports of incidents in the electronic patient record. A maximum of ten incidents per patient was included in the audit. The data was collected using a specially designed audit form. A brief description of the incident was recorded and a decision about whether the care plan was adhered to was made. Care plans were recorded as 'adhered to' when de-escalation strategies identified in the care plan were documented in the event report. Thus, if restraint (not a de-escalation strategy) had been recorded in the care plan, and had been documented as having occurred during the incident, then this would not have been recorded as 'adhered to'. If moving the patient to a low stimulus environment (de-escalation strategy) had been recorded in the care plan and had been documented as having occurred during the incident, this would have been marked 'adhered to'.

Analysis
Thematic analysis of information gathered from the PMAV care plans was conducted to identify de-escalation strategies that were employed. Descriptive statistics were used to explore care plan adherence.

Results

We examined 539 incidents involving 147 (52% male) patients. The mean number of incidents per patient was 3.6. The mean age of patients was 37.4 years (range 18-76 years). Of the 539 incidents, there was no PMAV care plan for 151 involving 49 patients, giving a compliance rate of 72%. One hundred and twenty one unique care plans were included in the audit.

Two care plan items required documentation of the patient's contribution to, and agreement with the care plan. The results for these sections of the care plan are shown in Figure 1.

Figure 1: Contribution to/agreement with care plan
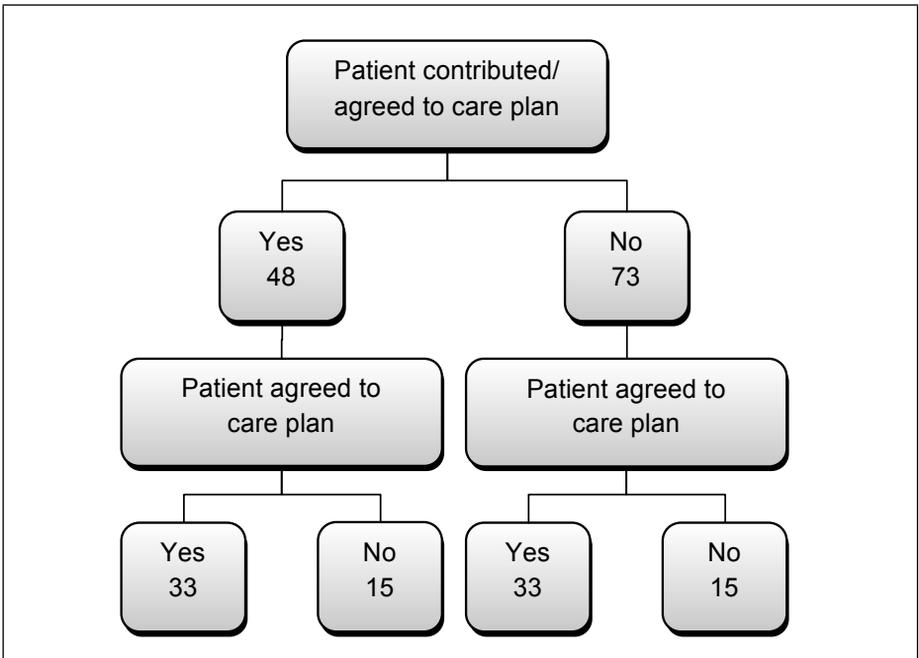
Thematic analysis s identified five categories of de-escalation interventions in PMAV care plans: staff interventions, interactions/communication, space/quiet, activities and patient strategies/skills. A sixth category, coercive strategies, consisting of seclusion, restraint and pro re nata (PRN) medication, was also documented. The three most documented interventions were offering to talk to the patient (commonly

referred to as a '1:1') (76% of care plans), low stimulus environment (68%) and PRN medication (54%). These were documented between two and three times more often than the next commonest/most frequent intervention, de-escalation techniques (unspecified) (22%).

Early intervention/de-escalation elements of the care plan had been documented in 41% of incidents (n=220) and were not in 20% (n=108). Where there was no opportunity for staff intervention, e.g. where a patient hit a member of staff then walked away with no escalation, or where a patient reported an incident rather than being witnessed by staff, this was recorded as 'No escalation, no de-escalation' and occurred in 9% of incidents (n=48).

Discussion

Compliance rates of completion of the care plans fell short of the 100% rate set out in the PMAV policy with 28% of all patients involved in an incident not having a care plan at the time of the incident. There could be a number of reasons for this; lack of time for completion of paperwork is often cited by clinical staff (5), and this care plan may be perceived as a low priority. The care plans appeared to be overcomplicated and confusing in part e.g. 48 care plans documenting that the patient contributed to and agreed to the care plan but, of those, 15 documenting that the patient did not agree to the care plan. Similarly there appeared to be confusion about the difference between the three audited sections of the care plan, with some having information cut and pasted between the sections and others documenting what appeared to be staff strategies in the section for preferred patient interventions. These factors may reduce staff motivation in completing the care plans.

Of the 121 unique care plans included in this audit only 48 (40%) documented that the patient had contributed. This appears to be a low figure when considering the NICE (2005) guidance stating that patients should be involved in planning for the management of aggression, and local policy, which states that patients should be involved. Although it may be useful to have documentation about the management of aggression from a staff perspective, various studies have demonstrated that patient involvement in this is one element that can reduce aggressive incidents (6, 7).

De-escalation is one of the key staff interventions for preventing imminent inpatient aggression and violence (4), and de-escalation techniques formed the largest category within the theme of staff interventions. Unfortunately, the lack of consensus within the literature, training programmes or amongst inpatient staff as to what de-escalation techniques consist of (8), means that documenting 'de-escalation techniques' does not give a clear indication of the actual actions that staff should take. Nearly all of the staff behaviours identified in the care plans are present in literature on de-escalation and conflict management. Being aware of one's own tone of voice and body language are both indicated as part of verbal de-escalation, as are remaining calm and being non-confrontational (8). Not doing anything to exacerbate the situation, i.e. ensuring that requests are responded to in a timely manner and staff being consistent, is identified in conflict resolution (9).

Staff-patient interactions are often central to inpatient violence and aggression, being found to be the factor that precipitates the highest number of violent and aggressive incidents (10). It is hardly surprising that a major factor in the cause of aggression is also perceived to play a vital role in its prevention and management. Offering the patient a 1:1 was the most documented intervention.

Staff-patient interactions are central to two of the three basic components of a de-escalation model described by Dix and Page (11) being communication skills and problem-solving tactics. The importance of both verbal and non-verbal communication skills are stressed in this model, and are identified as key components of de-escalation in studies (4, 8, 12). Various specific verbal instructions were given in the care plans, including instructions to use clear language and give clear explanations. Ensuring that there is no miscommunication is identified as part of de-escalation (11).

Problem-solving was identified in a small number of the care plans, with directions to explore solutions or frustrations with the patient, and to offer solutions in the case of one patient. Problem-solving skills have been identified by the Health and Safety Executive (13) as key elements of good PMAV training. It appears incongruent that problem solving is such an important feature of de-escalation, but was identified in few care plans; this could be a reflection of the training staff had received, suggesting that there may be a lack of emphasis on problem-solving. Alternatively, it could be that nurses view problem-solving as an integral part of the process of de-escalation, which therefore does not need to be documented separately. Containment measures can be described as those measures that are used to prevent or reduce imminent harm, when verbal and/or de-escalatory measures have failed (14). The PMAV care plan contains separate sections for physical interventions, medication and seclusion, therefore, none of these interventions should have been documented within the de-escalation sections of the care plan. Despite this, containment measures were documented 141 times in the care plans. PRN medication was the third most documented intervention overall, although the route was often not documented.

Where an incident escalated and a care plan was in place, the care plan was adhered to in twice as many incidents as when the care plan was not adhered to. This is in part likely to be due to an awareness by staff of the patient's care plan. It could also be because much of the content of the care plans is de-escalation strategies that would be used frequently by staff anyway.

An action plan will be developed in conjunction with key stakeholders to identify changes that can be made with the aim of improving the compliance rate of completion of care plans. Much of the de-escalation efforts documented in care plans is reflected in the literature on de-escalation, but the inclusion of containment measures as de-escalation interventions is of some concern. There is little empirical research available on de-escalation; the literature is characterised by a lack of shared understanding, reflected in the lack of agreed definitions, making it difficult for clinical staff to develop successful practical solutions to this serious problem in secure in-patient settings.

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What are we doing to de-escalate? Inpatient staff views on de-escalation

Paper

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Background

De-escalation is one of the key nursing interventions in the prevention of inpatient violence and aggression; this may be of particular importance in secure services where the incidence of violence and aggression is higher. Despite this, there does not appear to be a clear consensus in the literature on the specific actions inpatient staff take when de-escalating, and it is not known what actions inpatient staff take which they would describe as de-escalation.

Aims

To discover how staff define de-escalation. To identify the actions inpatient staff believe they take when de-escalating violent or aggressive situations/patients. To compare what staff document as de-escalation in patient records with the actions they describe as de-escalation.

Methods

Cross-sectional free-text survey of inpatient staff working within mental health care pathways in secure services in one charitable trust. This survey will be posted on the intranet of the charitable trust and staff attending annual training will also be approached for participation.

Results

Content analysis of the responses will be undertaken to identify themes within the data. Some possible themes could be: verbal communication, non-verbal communication, maintaining a safe environment and the timing of intervention.

Conclusions

The findings will be discussed in relation to current literature on de-escalation, and will be compared to the results of an audit investigating de-escalation strategies documented in prevention and management of aggression and violence care plans. In theory there should little difference between the results of this study and of the audit, but in reality it is likely that what staff think (this study) and what is documented (audit) are very different.

Educational Goals

1. To gain insight into what inpatient staff believe they are doing to de-escalate situations/patients.
2. To use this research as a starting point for future research and to guide the development of training in the prevention of violence and aggression.

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Disciplinary infractions in three Flemish forensic institutions: prevalence and judicial reaction

Paper

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Introduction

Under Belgian law, internment is a safety measure imposed by a judge on an offender if the latter is found not guilty by reason of insanity. The purpose of this safety measure is to prevent further harm to society and provide treatment for the mentally ill offender [1,2]. A special commission, the 'Commission of the Protection of Society' (CPS), is responsible for the execution of the internment, and decides amongst others in which type of setting the mentally ill offender will be treated. Both inpatient and outpatient treatment and support settings can be regarded eligible according to the specific situation and individual characteristics of the mentally ill offender. In Flanders (the Flemish speaking part of Belgium), internees are subdivided depending on their treatment needs (low, medium and high care), risk of recidivism (low, medium and high risk) and security level (low, medium and high security) [3]. Since high security forensic beds aren't available yet in Flanders and the amount of medium security treatment beds, implemented in three general psychiatric hospitals since 2001, is insufficient in proportion to the demand for these treatment beds, many Flemish internees (599 in June 2008 [3]) still remain in prison without adequate treatment.

Within a medium security treatment setting, the internee is 'on parole' under the authority of the CPS. As soon as the security level has diminished, the offender will either be referred to a low security (inpatient) facility or be released into the community with outpatient care. If the treatment is not successful in reducing the security level, the mentally ill offender can be readmitted to prison since high security facilities are lacking.

Empirical data about the prevalence of disciplinary infractions including aggressive behavior in the three Flemish medium security units are missing. This information might however be warranted since many regular psychiatric institutions are reluctant to admit and treat mentally ill offenders arguing that the risk of institutional violence and/or misconduct is too high.

Aggression can take many forms, from verbal aggression to (attempted) manslaughter. All of these forms can cause physical and psychological problems in the victims.
As has been shown in previous international research, the most common victims of violence by medium security forensic psychiatric patients are employees of the facility; other patients or unknown persons are victimized to a lesser extent [4,5].

In general, most violent incidents in psychiatric institutions are never brought to court [6].
Therefore, the aim of the current study is to investigate the prevalence and the nature of, and the judicial reaction to disciplinary infractions in the three medium security forensic psychiatric units in Flanders.

Methods

The study sample consists of internees admitted, under the authority of the CPS of the judicial jurisdiction of Ghent, to one of the three medium security wards from 2001 till 2010.
Judicial files of the latter CPSwere analyzed retrospectively, since incidents occurring during treatment should be reported to the CPS. All incidents registered in these judicial files were clustered into two broad categories: non crime-related incidents (treatment compliance issues and breach of judicial conditions including absconding from (un)supervised leave or escape) and crime related incidents (which could be

subject for prosecution). The latter category was further divided into five categories: violent (both verbal and non-verbal), sexual, drug related, property and other (e.g. destruction) offences. Incident reports to the CPS can consist of one or more separate incidents which occurred at the same time or in the same period. Official recidivism data (new convictions) were collected from the Central Criminal Records of the Justice Department.

Besides the analysis of the nature and frequency of the incidents, the victim characteristics as well as how the judicial system responded to these incidents were studied.
SAS Version 9.3 was used for the descriptive statistics and statistical analyses [7].The association between categorical variables was tested using Fisher's Exact test with a 5% significance level [8].

Results

Sample description
The study sample consists of 203 internees, mainly males (92.6%) born in Belgium (92%). The median age at admission to the medium security unit was 35 years and the mean duration of stay in this unit was 1.7 years (SD 1.3 year; range 8 – 2,729 days). Most participants (82.5%) had previously been admitted to general psychiatric wards and were previously convicted and/or interned (85.7%). Most common index offences were violent offences (58.6%) and property offences (49.7%).
The most common diagnoses according to the Diagnostic and Statistical Manual of mental disorders (DSM) [9] were: personality disorder (62.6%), substance use disorder (46.3%), psychotic disorder (46.3%) and intellectual disability (22.7%).

Prevalence and nature of incidents
In some cases more than one incident was reported to the CPS at the same time, resulting in a total of 236 incident reports (and 331 incidents) during the stay in a medium security ward.

The 331 incidents that were registered during medium security treatment were caused by more than half of the population (n = 108; 53.2%). Most of these incidents (62.6%) concerned non crime related incidents such as problems with (treatment) compliance (n=71) or breach of judicial condition(s) (n=135). The latter mainly consisted of absconding (n= 122), which lasted on average 6.4 days, but was terminated in 71.2% of the cases within two days.

In addition, a total of 123 crime related incidents were registered, caused by one third of the study sample (n=63; 31%). The following nonviolent crime related incidents were registered (n=60): property offences without violence such as theft, fraud and arson in an uninhabited property (n=17), non violent sexual offenses (n=1), drug related offenses such as using or selling drugs (n=34) and other offenses such as damaging property (n=8). Violent crime related incidents (n=63) were found in a minority of the population (n=36; 17.7%) and included verbal aggression such as threats and stalking (n=29), property offenses with violence (n=3), other violent offences such as battery (n=28), arson in an occupied property (n=1) and attempted manslaughter (n=2). Five violent incidents were considered serious as these resulted in documented victim injury. A summary of the incidents is provided in table 1.

Table 1. Nature of incidents

	Incidents (n=331)	Amount missing
		0,6%
Non crimerelated incidents		
Breach of conditions	135 (41%)	
Compliance	71 (21.6%)	
Crimerelated incidents		
Violent incidents	63 (19.1%)	
Drug related incidents	34 (10.3%)	
Property offenses	17 (5.2%)	
Other offenses	8 (2.4%)	
Sexual incidents	1 (0.3%)	

Victim description
Among the 236 reports made to the CPS, direct victims – that is victims being either assaulted or seriously threatened – were present in 48 cases (20.3%). In total 64 victims were identified. None of the victims were minors. In only 39.12% of the cases, data regarding sex of the victims were available. In these cases males

(n=20) were more prevalent than females (n=5). In most of the cases (93.3%) the internee knew the victim. The majority of victims were nurses (45%) and patients (28.3%), followed by family members (11.7%). In the minority of cases, friends (6.7%) or others (1.7%) were victimized (table 2).

Table 2. Relationship patient - victim

	Victims total (n=64)	Amount missing	Victims violence (n=26)	Victims verbal violence (n=29)	Victims violent property offense (n=3)	Victims attempted manslaughter (n=2)
		6.2%				
Nurses	27 (45%)		11	16	0	0
Other patient	17 (28.3%)		11	5	0	1
Family	7 (11.7%)		2	3	2	0
Other	4 (6.7%)		0	4	0	0
Friend	1 (1.7%)		1	0	0	0
No relationship	4 (6,7%)		1	1	1	1

Judicial reaction
In almost half of the 236 reports (44.9%) the judicial system decided to readmit the internee to prison, with no further judicial processing. Only rarely other – usually more strict – conditions were imposed by the CPS (e.g. strict interdiction to drink alcohol). In more than half of the cases (53.8 %) the treatment continued without any formal judicial reaction. In these cases it is however possible that the internee was cautioned by the chairman at the hearing of the CPS. Table 3 shows the exact nature of the reports according to the nature of the most serious incident in the report. Most common reasons for readmission to prison were 1) breach of condition, 2) violent offense and en 3) noncompliance with treatment.

There was no statistically significant association between readmission to prison and the nature of the reports (p=0,377).Moreover, no significant association is to be found when the incidents involving verbal aggression are not taken into account(p=0,161).

Table 3. CBM decision after report

	Reports total (n=236)	Report violence (n=47)	Report sexual (n=1)	Report drugs (n=31)	Report property (n=13)	Report other (n=6)	Report compliance (n=28)	Report breach of condition (n=108)
Incarceration	106(44.9%)	28(59.6%)	0	11(35.5%)	9(69.2%)	3(50%)	16(57.1%)	37(34.3%)
Adjustment conditions	3(1.3%)	1(2.1%)	0	0	0	1(16.7%)	1(3.6%)	0
File report	127(53.8%)	18(38.3%)	1(100%)	20(64.5%)	4(30.8%)	2(33.3%)	11(39.3%)	71(65.7%)

Although the internment measure is executed under the authority of the CPS any offense can theoretically be referred to court. Formal court procedures were completed in two cases. One internee got a new internment measure because of battery with victim injury and another patient got a TBS measure in the Netherlands after trying to strangle an unknown victim.

Discussion

One third of the study sample committed crime-related incidents (such as drug use, theft or violence) during an admission in a medium security ward. Violent incidents occurred in only 17.7% of the studied internees, and were in almost half of the cases verbal in nature. Victims of violence were mainly (male) nurses or patients, which is in line with previous studies [4,5]. The occurrence of severe physical aggression (with documented victim injury or sick leave due to the aggression) was rare (n=5). There was no violent sexual offense. Considering that more than half of the internees had a history of violent offenses (n=119; 58.6%), the prevalence of violent incidents during medium security admission can be regarded as rather low. The low prevalence rate of institutional violence can indicate a good risk management on medium security forensic psychiatric units. Although we had access to all of the registered incidents, the low base rate could also be explained by the underreporting of some (characteristics of) incidents by the hospital ('dark number'). Especially verbal aggression, although it can induce fear and psychological harm on personnel, might be underreported [4]. It is however unlikely that other, more severe forms of aggression, are not reported. The low base rate of sexual offenses – one hands-off sexual offense - is due to population bias since internees with primary sexual offenses and/or paraphilia were excluded from admission.

In only two cases the internee was formally accused and convicted for the committed crime related incident. Both crimes occurred after absconding. The majority of the incidents were not reported to police services by the hospital. As has been shown in previous research, the decision to report an incident to police services can be influenced by different factors, including the influence of the institute's policy and the attitude of colleagues [6]. Unfortunately the current study did not investigate this topic further. What is clear, however, is that Flemish medium security units do not have protocols on this matter. The low base rate of new convictions confirms other research studies which have shown that, even when incidents are reported to the police, they are rarely referred to court [6].

In the specific case of internment, the lack of prosecution may be due to the mandatory supervision of the CPS, which allows the prosecutor to incarcerate the internee within a rather flexible procedure thus avoiding a new trial.

The registered incidents - both crime related and non crime related - were associated with serious consequences for the internee since in almost half of the cases, the treatment was interrupted and the internee was readmitted to prison for breach of condition. It seems that prosecutors – rather than starting a new procedure – prefer to adopt a more pragmatic strategy.
There was no correlation between the nature of the incident and the risk of being sent to prison.

In conclusion, the data in this study highlight several topics:
1. Although there were some major incidents, the overall base rate of aggressive incidents during medium security forensic psychiatric treatment is low.
2. Crime-related incidents during medium security treatment are rarely prosecuted.
3. The base rate of readmission to prison – and therefore treatment drop out – as a result of (non) crime-related incidents is high.
4. At this moment no clear policy regarding the reporting of incidents - particularly those of an aggressive nature –during the treatment of medium security forensic psychiatric patients exists in Flanders.

Acknowledgements

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Working in forensic mental health

Paper

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Introduction

The everyday working life of mental health clinicians can be very challenging. This paper will report on the experiences and attitudes of Forensic Mental Health (FMH) clinicians in one setting in Australia. It will report on the attitudes, values, beliefs and the clinical context of the clinicians who work directly in treating forensic patients i.e. people who have killed and who have experienced a mental illness. FMH clinicians feel unsupported, and unprepared for the work that they are required to do. Some FMH clinicians describe that they feel thwarted in their efforts to do a good job. They describe being frustration in their roles in that they feel unable to provide the level of care and treatment that they would like to provide. They felt unsupported in making their own transition to working with forensic patients and the response that was generated when trying to develop a therapeutic relationship with this group of people. While some of these obstacles were attributed to forces outside the forensic institution others, they felt, were ingrained in the culture and leadership of the institution. They felt powerless in their ability to confront these barriers. While FMH is an under researched area as a whole, the practice of clinicians who work in FMH has received even less attention.

Method

This study forms part of a larger study that examined the preparation undertaken in Australia by forensic patients who were making the transition to community living. As a result of the paucity of information in this area a qualitative method was chosen to obtain thick rich description of the experiences (Stebbins, 2001; Tong, Sainsbury, & Craig, 2007). Purposive sampling was used to collect data from 3 groups of participants; the forensic patients (20 participants), the forensic mental health clinicians (26 participants from all disciples and represented both inpatient and community based staff) and finally the clinical leaders. Focus groups were chosen to elicit the views of clinicians. Focus groups are "carefully planned discussions that take advantage of group dynamics for accessing rich information in an efficient manner" (Polit & Beck, 2004, p. 342). These were followed up with in-depth individual interviews with participants who had something particular that they wanted to elaborate on and were not able to fully discuss in the focus group setting. Individual interviews were used for both the forensic patients and the clinical leaders. The forensic patients were mostly interviewed 4 times each while the leaders were interviewed once each.

Ethics

Ethics approval was given by the Department of human services in Victoria, Australia and the University of Melbourne human research ethics committee.

Discussion

The paper will discuss one of the themes to emerge from the findings - working in forensic mental health and will be taken from the all 3 groups of participants; the forensic patients, FMH clinicians and the leaders. It will look specifically at the subthemes of
- orientation and adjustment to FMH,
- training in FMH,
- vicarious traumatisation,
- clinical debriefing and clinical supervision for staff,
- therapeutic relationship.

Orientation and adjustment to FMH
Findings demonstrate that some forensic clinicians find it difficult to adjust to the environment in which they work. They report feeling frustrated in the roles and feel unsupported in making the transition to FMH. They identified two sets of obstacles i.e. those outside the organisation and those within the organisation. The external obstacles were recognized as issues such as stigma of FMH impacting negatively on their

professional reputation. While some of the internal obstacles were the culture and leadership of the institution. They expressed that they had little if any relevant orientation or support when starting in FMH. It was the patient's offence that made forensic psychiatry unique and clinicians were required to develop skills (being either personal qualities or professional competence) to deal with this. They felt powerless in their ability to confront these barriers. The leadership group did not see it as an organisation's responsibility to assist clinicians in developing the skills to work in forensic mental health. One leader described that some clinicians avoided developing meaningful relationships with forensic patients and proposed that this may be because it taps into the clinician's own insecurities about their own behaviour. One FMH clinician commented that

 "I think if you have the community view of the patients as the monster then you are going to be frightened because they are mysterious" and *" how different am I from him?"* . .

Training in Forensic mental health

For clinicians the adjustment to working with forensic patients instilled a sense of horror and the fear (Jacob et al. 2011). Several clinicians described that knowing the details of the crime committed by some forensic patients had caused them to be fearful of their own safety. They reported that they felt they lacked the competence to counsel the forensic patient if the issue of their crime was raised by the patient. As one FMH clinician described;

"It was part of the culture not to talk about it" and *"sometimes we don't deal with the offence...you are told not to talk about it".*

The clinicians also spoke about this theme in an emotive way. The explanations offered as a reason for issues being overlooked during psychiatric treatment were the delicate nature of the topic, the fear of recreating the psychological environment of the crime and the fear that clinicians lacked the skills to deal with the patient's behaviour. For some clinicians the fear had the ability to affect their role as therapeutic agents. One FMH clinician articulated that

"Staff feel unskilled themselves in dealing with the issues".

At the same time they came to realise that forensic patients were people who were not unlike themselves and then realised that they were therefore capable of killing just like the forensic patients.

There is ....someone that you work with that has done even the worst things that you begin to realise that they are not that different from yourself.

While it has been recognised (Aiyegbusi, 2009; Cashin, et al., 2010; Holmes et al., 2006; Jacob. & Holmes 2011; Jacob et al., 2009; Jacob et al. 2011) that the crime does effect the nature of the therapeutic relationship. However, there has been no acknowledgment or guidance offered to clinicians to assist them to cope with their own response to the forensic patients' past history of violence.

Vicarious traumatisation

The history of the patients' crime had a significant impact on the development of an ongoing therapeutic relationship between clinician and forensic patient. It has been pointed out by a number of clinicians that knowledge of the crime committed by the patient provides some abject images in their minds. "There are some of our people who...make the hairs on the back of your neck stand on end".

Some of the patient's history provides not only a threat but a thrill, being both disgusting and fascinating (Holmes et al., 2006). Some individuals instigate greater emotional responses than others and are medically and socially described as being at risk (Holmes et al., 2006). A small number of the clinicians interviewed described how they feared the shock of hearing the details of the crime.

So [the forensic patient] starts to describe oh there was blood all over the floor…. And I am building this picture and I went home and suddenly I have got this damn picture in my head and it is too bloody awful ……I was moping around feeling like shit. The image was really affecting me. What am I going to do with it?

In particular the quality and process of developing a therapeutic relationship with someone who stimulated fear in the clinician, provides one of the most striking themes in this aspect of the data. Understandably, different forensic patients generated various levels of fear in the clinician, according to their own assessment of the patient's dangerousness. It was suggested, by one leader, that informal professional networks need to divert their attention and become supportive of clinicians and that this was not responsibility of the employing agency. However, several participants believed that clinicians were not prepared to discuss the impact interaction with forensic patients had on them.

At times some clinicians have found it too threatening to discuss their own responses to a patient's crime with their peers. Some of the most confronting issues were the phases clinicians went through when working with people who had committed murder. In particular, there was no support for people who were trying to manage their own fear while trying to be therapeutic.

Clinicians described that being seen as capable took precedence over their fear of the forensic patients and their crimes. As a means of addressing this situation, Elder, Evans and Nizette (2008) purport that for mental health nurses to have therapeutic alliances with forensic patients they must explore their own feelings, thoughts and actions and develop self-awareness. According to Holmes et al., (2006) nurses may feel the need to separate themselves both emotionally and in concrete ways such as having less face to face contact with patients in order to maintain their own subjectivity and integrity and to not lose the comfort of having a clean and an ordered self-image as a nurse.

Clinical debriefing and clinical supervision for staff.
It was put emphatically that forensic psychiatry needs to begin to train clinicians in managing vicarious traumatisation.
I wonder too if there's an element of personal, emotional, psychological safety. When you go home at the end of the day not having these images for ourselves, because if, you know, if we know the exact detail about it all, we've got to deal with that as well which is pretty shitty.

Effective supervision by someone with expertise in the area can assist clinicians to deal with situations where vicarious traumatisation may occur. Martin and Street (2003) emphasise that an integral role of the mental health nurse is to establish a meaningful therapeutic relationship with the patient. In order to achieve this they aver that mental health nurses must acknowledge and accept the effect of the patient's offence on themselves and their ability to be therapeutic. Thorpe et al. (2009) identify similar issues and recommend the use of clinical coaching as a method of addressing them. In the current culture of the institution did not support such practices.

As stated by Aiyegbusi (2009) it is the clinician's task to assist the forensic patient to recover their lives. Such a task requires a skilled and supported environment that encourages and teaches clinicians how to achieve excellence in their work. Without systematic support systems being in place, clinicians are unlikely to gain the competence or confidence in such work. They will continue to create a non-therapeutic distance from forensic patients as a defence against their own anxiety and stress (Cashin, Newman, Eason, Thorpe, & O'Discoll, 2010; Dale et al., 1995; Holmes et al., 2006; Jacob et al., 2009) and protection from violence (Fisher, 1995) and to manage their own feelings while trying to provide a caring environment (Dhondea, 1995; Weikopf, 2005).

Therapeutic relationship
Clinicians described that the lengthy period of engagement has been one of the factors that makes engagement difficult. It is because of the length of the engagement that according to the clinicians the status of both the clinician and forensic patient equalises and the clinician no longer has a guaranteed position of power over the patient. The details of the crime at times caused the clinician to maintain a personal level of caution with the forensic patient that they felt hindered the development of a close therapeutic alliance. Clinicians felt some patients only ever received superficial attention from clinicians and that clinicians avoided any meaningful interactions in an attempt to protect themselves from having disturbing images of the crime recurring. There was also the fear that getting to know the forensic patient at a deeper and personal level may result in a heightened sense of fear. As a means of avoiding further frightening self-awareness and therefore threats to the clinicians understanding of themselves Holmes et al. (2006) propose that clinicians may not engage in the therapeutic relationship.

Final remarks

The data reveals that while some FMH clinicians feel that there was a very strong and positive aspect to the therapeutic relationship within forensic settings there is evidence to contradict this. The population of forensic patients themselves feel that there is a strong bond between themselves that has a similar quality to those held with the clinician. It was pointed out that under these circumstances some of the expected aspects of the professional therapeutic relationship, e.g. Confidentiality, are difficult to maintain. Clinicians described the need to maintain a positive view of the patient's future. It was described that even when the clinicians were aware that a particular forensic patient under their management is unlikely to obtain what might be considered a normal lifestyle or reach the goals that they set for themselves that the clinician must not allow their personal thoughts and feelings to be detected by the patient. Most clinicians spoke of a lack of service support and the fear of unleashing the patient's psychosis. They felt that these two issues significantly influenced their approach to their work. They reported that there was little assistance given to making the transition to working in a forensic environment and found that they were concerned at revealing their own response to forensic patient because they feared being seen as unsuitable for the role.

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Strengthening of mental health services in Egypt, but did we learn something?

Poster

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Background

Collaboration between Egypt and Finland in the field of mental health started in January 2002. The implementation of the program continued in 2010 with three years training in mental health rehabilitation and forensic psychiatric nursing. The overall objective of the project was to improve the quality of life and health of people suffering from severe mental health disorders and to develop nursing skills in these fields in Egypt.

Methods

The training seminars and workshops were arranged in the framework of the project for improving the skills of personnel working with mentally ill people. The seminars and workshops were targeted at personnel working in mental health rehabilitation and in forensic psychiatry. The seminars were planned so that the training and the materials were easily adopted and disseminated. During the study visits the participants visited mental health hospitals in Finland. In each training seminar there were around 25 participants: doctors, psychologists, social workers and nurses. The presentations were mostly modelled after the Current Finnish Care guidelines for schizophrenia, which recommend long lasting and confidential therapeutic relationships and realistic care plans for patients.
Some of the core issues in forensic nursing in Finland were taught: How to make an individual care plan? How to pay attention to safety and security matters in daily nursing? How to manage violent situations? What is a therapeutic nurse-patient relationship? The patients' human rights were an important issue as well.

Results

This kind of cooperation is bilateral and both parties learn always something from each others. The main conclusions drawn from three years of training seminars, taking into account some cultural differences/challenges between the Egyptian and the Finnish system (i.e. family involvement, size of the units and religion), were that the patients and the potential problem situations were more alike than different. During the workshops participants were able to relate their practise to the issues discussed. They were interested in therapeutic nurse-patient relationships. A method with a heavy reliance solely on the forensic nurse would not however be the most appropriate method due to the personnel resources (1 nurse to 10 patients). That is why the training focused more on multi-professional teamwork, forming of potential risk scenarios, treatment targeting and challenges in communicating information between staff members (groups).

The main challenge in the treatment of forensic patients in both Egypt and Finland is uncontrolled violence connected to psychotic symptoms. The patients' inability to easily trust anyone and their poor social skills make the treatment challenging in both countries. One of the purposes of the project was to motivate the nurses to form closer and more structured co-operation with their patients. We recommend that the modified theory of working as a personal nurse would be added to nursing education and supervision.

Educational Goals

To improve the quality of life and health of people suffering from severe mental health disorders and to develop nursing skills in the Forensic nursing in Egypt.

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Handling relations towards legal instances in forensic psychiatric ward regarding intramural violence

Poster

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Abstract

Hegoa is a forensic psychiatric ward in the Centre Hospitalier Jean-Titeca, Brussels. Our intent is to rehabilitate psychotic subjects who have been found "not guilty by reason of insanity". In Belgium, these subjects are placed in a psychiatric ward of a prison. Our project intents to help these individuals out of prison back to society through a 1.5-year psychiatric hospitalization. The way we understand the historicity of this medical and legal status is through a relational break forcing the individual to "offend" in order to restore his or her sense of security. At a certain point, the individual with his psychotic structure is incapable of accommodating himself within legal boundaries and this coerces the subject into (often violent) offends. Our aim is to restore psychological and interpersonal functioning and balance through our multidisciplinary team. Our team is composed of psychiatrists, individual and family psychologists/ psychotherapists, a criminolo gist, psychiatric nurses, an occupational therapist, a social worker, and a physiotherapist. Each patient is followed by one member of each discipline throughout his stay.

The addition of a specific legal restraint/framework to the treatment/rehabilitation of psychotic subjects appends complexity to the already known challenges. Although our approach is tailored according to Belgian legal system, many common challenges in handling violence with this forensic group will emerge with other legal systems.

- As a multidisciplinary team, we have to report to legal instances while maintaining a therapeutic stance towards our patients. Although we are not mandated for our expertise, our decisions, appreciations and broader questioning in our reporting clearly affects the individual's course of life. How and what to report?
- If a violent outbreak occurs, we have the possibility to exclude patients for our treatment program back to a psychiatric ward in prison. When to decide when we have reached the limits of our therapeutic potency? What to do when therapeutic prospects have run out and containment succumbs?
- Assessment procedures, we all have them, but how effective are they in predicting violent outburst in this specific forensic population? Unlike character disturbances like psychopathy, the dangerousness of a psychotic patient is highly correlated with his clinical state.
- …

Educational Goals

- Psychotherapeutic contributions

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No Show for treatment in forensic outpatients with ADHD

Poster

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Background

Although no show is an important issue in today's health care services, limited information exists on disorder or behavioral specific patterns of no show. Therefore, we examined the distribution of the no show in a forensic ADHD population and features that were associated with no show rates.

Methods

134 male patients who were diagnosed with ADHD and had a presence of aggressive and/or delinquent behavior were included in this study. ADHD was diagnosed through psychiatric examination (with DSM-IV classification) and a Dutch semi-structured interview called the Diagnostic Interview for Adults with ADHD (DIVA). Patient features were derived from chart review.

Results

Over the period of September 2011 until September 2012, patients had an average of 37 (SD 27.1) appointments, with an average of 18% (SD 13.3) no shows (corresponds approximately with 7 appointments per patient). A multivariate linear regression showed that not showing up on the first appointment (B=.-10.68, 95%CI [-19.97 - 1.26], p=0.044) and being in treatment as part of a penalty by the justice department (B=10.01, 95%CI [-1.95-21.53], p=.045) were associated with a higher percentage of no show in the future. Type of delinquent behavior, comorbid psychiatric disorders and substance abuse seemed not to be associated with no show.

Conclusions

The findings of the current study showed that patients not showing up on their first appointment and patients being mandatory in treatment were associated with higher no show percentages. This study showed that no show is a large problem in a forensic ADHD population, especially in patients in whom intrinsic motivation for treatment is less (the mandatory treatment).

Educational Goals

Exploration of no show in ADHD patients.

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choice and full citizenship were central concepts. People with learning disabilities increasingly participate in society: they live in ordinary houses (community care) and work in ordinary settings (supported employment).

This development fits into the quality of life paradigm. To support people to have a good life became the key concept. This resulted in the citizenship paradigm in which support has to be reconstructed from the needs of the client.

Caregivers from DFP and the Rotonde reflected upon these different paradigms. We concluded that elements of each paradigm are necessary to provide good treatment and care. People with an intellectual disability differ on certain points from people without these disabilities and there has to be a focus on the disability in order to be able to support people. But there has also to be a focus on possibilities and on the quality of life.

We combined these different ways of thinking and developed one vision, based on evidence based practice. This means that treatment and care has to be based on scientific knowledge, clinical expertise and on the values and needs of the patients.

The RAK

The RAK is the Dutch abbreviation for Regional Forensic Circuit. The RAK is a collaboration of the Division of Forensic Psychiatric care and the Rotonde. The patients have a mild intellectual disability (IQ: 55-85) and exhibit serious challenging and often offending behaviour. There is often a combination with a psychiatric disorder and addiction.

The team consists of caregivers of both organizations. The DFP brings in knowledge and expertise on forensic psychiatry, the Rotonde on intellectual disabilities. The caregivers work according to the vision we developed together.

We work in a network structure. This means that we try to create a continuity of care around the patient, in which different organizations and disciplines cooperate and the patient is central. We try to give care and treatment, which is adapted to the needs of the patient in the different phases of treatment.

The goals of the RAK are:
- reduction of recidivism
- treatment of the psychiatric disorder
- treatment of the addiction
- improvement of the quality of life
- reintegration into society

We try to achieve these goals by offering a continuity of care in a network structure. We will illustrate this with a case study.

Conclusion

Through the collaboration of the DFP and the Rotonde we are able to meet the complex needs of this specific group of patients. We combine the knowledge and expertise of both organizations and work according to one vision. We think this is a promising development in the care for intellectually disabled people with forensic psychiatric problems.

choice and participation are important aspects of "community care". The essence of "community care" is that people with intellectual disabilities live their own lives in society, just as people without intellectual disabilities (Plemper en Van Vliet 2002: 14-15). Where it is needed they are compensated for their disability by professional support, so they can participate fully in the existing structures of society in all areas such as training, labour, housing and social contacts.

In the mental health sector, the image of people with a psychiatric disorder is subject to change, just like in the mental disability sector. The leading paradigms within mental health care are nowadays: rehabilitation and recovery. Rehabilitation as a form of professional care is focused on the support of people in their adaptation and recovery process. Recovery has two aspects: personal recovery and social recovery. Social recovery covers the (re-) fulfilling of social roles and reintegration into employment or other activities. Important parts of this concept are social participation and citizenship.

To bring the different paradigm, prevailing in both organizations together, a vision and mission were developed, based on a common language.

Vision
The DFP and the Rotonde want their clients to integrate in society as far as possible. People with forensic psychiatric problems and an intellectual disability (mental retardation) have the right to participate in the society.

Mission
Persons with intellectual disability and forensic problems are diagnosed and treated, by integration of knowledge to lift severe disruption in functioning on personal and society level.

With our vision and mission in mind, we started to look at our clients in a different way. It became possible that a client from the Rotonde could benefit from the care which was offered within the DFP and the other way around. Clients could also benefit from care from both organizations simultaneously. In recent years, we started to realize that several things are important to cure and care. isk assessment provides reliable predictions for the risk of violent behavior in this population (Van den Berg & De Vogel, 2011). One of the things we discovered is the importance of early alert of risk behavior of people with intellectual disabilities, forensic and psychiatric problems. Until the cooperation between both organizations was realized, early alert of risk behavior occurred separately. Nowadays, early alert can be a shared task. In the future we want to achieve a more systematic form of early alert. At this moment, a pilot is due to start to test an instrument on early alert (Kaal, H.L.).

Currently, we are paying a great deal of attention to the IQ of a client, in conjunction with the social emotional development and social independence. The personality structure and the intellectual disability risk assessment is also taken into account. The program consists of diagnostics on social emotional development (http://www.seo-r.nl/) and risk assessment with intellectual disabled forensic psychiatric patients.

The above mentioned four pillars are the basis in the consultations that we have jointly every six weeks. Here, clients with forensic, psychiatric problems and intellectual disability can be discussed. Caregivers can give each other advice on how to treat or guide a client. They also can ask each other for extra diagnostic support and in some cases clients were transferred to one of the two participating organizations because there the treatment or the therapeutic climate is more in line with the clients' needs.

Cooperation in specific interventions is also a part of this program. Interventions include aggression regulation, preventing sexual offences and structuring daily life. We are also starting cooperation in a forensic assertive community treatment team to provide interventions and consultation in complex situations with our target population. We will show the preliminary results we achieved in meeting their complex needs.

Conclusion

First, we will present how our program of diagnostics on social emotional development and risk assessment contributes to a successful treatment and rehabilitation. Then we will ask the participants to assess in a case

study and discuss the interventions we provide in our program. We will end our workshop with some do's and don'ts in the treatment of this vulnerable group of clients.

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The relation between staff attitude towards aggression of clients with intellectual disabilities and the applied interventions in different working contexts

Paper

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Introduction

There are many reasons why aggressive behaviour of individuals with intellectual disabilities (ID) constitutes a significant clinical concern. First of all, the level of aggression shown by individuals with ID is high (Cooper, Smiley, Jackson et al., 2009; Drieschner, Marrozos & Regenboog, 2013; Emerson, Robertson, Gregory et al., 2001; Kozak, Kersten, Schillmöller & Nienhaus, 2013; Lundqvist, 2013; Tenneij & Koot, 2008). Second, aggressive behaviour is likely to persist over time (Green, O'Reilly, Itchon & Sigafoos, 2005; Totsika, Toogood, Hastings, & Lewis, 2008). And, finally, the behaviour poses significant challenges for interventions (Grey & Hastings, 2005). Following this, Heyvaert et al., (2012) conducted a multilevel meta-analysis of single-case and small-n research on interventions aimed at reducing challenging behaviours (CB) in persons with ID. They found that interventions for CB in persons with ID on average turn out to be significantly less effective for participants with outwardly directed aggression as CB-type, than for participants without outwardly directed aggression as CB-type. Their results are consistent with results from Harvey et al (2009), who found that individuals with ID with disruptive and aggressive behaviour generally responded least well to behaviour change efforts.

Aggressive behaviour of individuals with ID has a range of associated negative outcomes, including risks for themself and others (such as other clients and staff members), increased staff stress (Bromley & Emerson, 1995; Jenkins, Rose, & Lovell, 1997), the use of restrictive practices, such as physical and chemical restraint or seclusion (Emerson, Kiernan, Alborz et al., 2000; Sturmey, 2009), and the increased risk of placement breakdown (Broadhurst & Mansell, 2007). Therefore, it is important to investigate how aggressive behaviour of clients with ID can be treated. Staff members play a significant role in the treatment of aggression because of their daily contact with clients with ID.

The title of this paper refers to the important but also difficult job of staff members who work with clients with ID who exhibit severe aggressive behaviour. To prevent harm to themselves, to other clients or to colleagues, staff members may perceive they have no alternative than to use restrictive interventions in order to create a save environment. Unfortunately, these restrictive interventions can be counterproductive in the long term, especially when no efforts are made to provide a functional analysis and treatment of the aggressive behaviour (Hastings & Remington, 1994). Besides, the use of restrictive practices causes clients to feel unsafe.. It causes frustration, anger, stress and anxiety by clients with ID and also causes staff to experience negative feelings (Fish & Culshaw, 2005; Hawkins, Allen, & Jenkins, 2005). To strengthen the quality of positive contact between care workers and clients with ID and to reduce the rate of aggression, it is therefore important to develop effective, less intrusive behavioural interventions. Positive behavioural interventions that identify the function of aggression and then teach the individual functionally equivalent adaptive skills are considered as the most effective interventions (Didden, Korzilius, van Oorsouw & Sturmey, 2006; Grey & Hastings, 2005; Harvey et al., 2009; Heyvaert et al., 2012). However, these interventions require a range of complex skills. Further research is recommended to obtain more knowledge about the effectiveness of staff training, so that staff are qualified to "treat" aggressive behaviour rather than to "restrict" it. But before that, more information is needed about the complexity of the dynamic interaction process between staff members and clients in different working contexts (depending on the specific team and client group) in order to develop effective training programmes for staff.

Research project: "Attitude and behavioural interventions of staff responding to aggression in people with intellectual disabilities; A socio-ecological approach (University of Amsterdam, PhD)"

This project will examine which factors (individual and contextual) are related to the way staff members behave when they encounter aggression from their clients with ID. The project provides more information about the effectiveness of staff training.

Staff's attitudes and reactions towards aggressive behaviour of clients with intellectual disabilities: A multi-level study

In a first study of Knotter et al., (2013) the relation between staff's positive and negative attitudes towards aggression (Jansen, 2005) and their interventions in response to aggressive behaviour of clients with ID were investigated, taking into account several individual staff characteristics, client characteristics, and team variables. The study sample comprised 121 supporting staff members (N = 121; 20 teams), working in an institution for clients with intellectual disabilities in the Netherlands. Multilevel analyses (individual and contextual level) were performed to examine the relations between all studied variables (background characteristics of the individual staff members and their teams; gender, age, years of work experience, position and education, the frequency and form of aggression of clients with an intellectual disability; verbal or physical, staff members' attitudes towards aggression) and the types of behavioural interventions they used (providing personal space and behavioural boundary-setting, restricting freedom and coercive measures).

Results

The results showed that a negative attitude towards aggression of the direct support team as a whole proved to be strongly related to the use of coercive measures. To reduce the use of coercive measures, interventions could therefore be directed towards influencing the attitude of direct support teams, instead of individual staff members.

Team climate and attitude towards external professionals
With a second study the associations between team climate (Anderson & West, 1998) and attitude towards external professionals (Rose, Ahuja & Jones, 2006) on one hand, and attitude towards aggression (Jansen, 2005) of a team on the other hand. The first research question was whether there is a relation between a negative team climate and the team's negative attitude towards aggression of clients with ID? Another research question was whether there is a relationship between a negative attitude towards aggression of a team as whole and the team's negative attitude towards external professionals?

Four hundred and sixty-eight staff members (N= 468; 69 teams) from 7 Dutch organizations for people with intellectual disabilities participated in this study. The climate of a team was measured with the Team Climate Inventory (TCI; Anderson & West, 1998; Dutch translation) and comprised four factors: participative safety, support for innovation, shared vision and task orientation. The attitude towards external professionals was measured with The Care Staff Attitude Questionnaire (Rose et al., 2006; Dutch translation). The results of this study will be presented at the conference.

Meta-analysis of staff training
The third study is a meta-analysis of the effects of staff training and management strategies that may affect the attitude and behaviour of teams working with clients with ID who behave aggressively. The meta-analysis will summarize the magnitude of effects (training effects) across all eligible intervention studies with an experimental or quasi-experimental design. At this moment, 20 studies (1994-2013) are included. Variables like the study design (post-test, follow up, intensity and quality), theoretical construct of the intervention, and the focus of the training (for instance: on attribution, knowledge or skills) that may account for variation in the training effects are examined as moderators of the effect size. The study is still running and the results will be presented at the conference as well.

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Institutional aggression in intellectually disabled (ID) offenders – An analysis of 5 specialized forensic ID projects

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Introduction

'Challenging behavior', including aggression, in people with intellectual disabilities (ID) is often the only way to express themselves or have their needs met [1]. According to a large-scale research within the health sector in England, psychiatric units and especially ID services, are amongst the most violent type of workspace [2]. Depending on the setting and definition of aggression, international studies show that up to 27% of people with ID demonstrate some form of aggressive behavior. Within residential settings, this is even 2 to 3 times higher [3-5]. Although there is a considerable amount of offenders with ID (OID) in residential forensic settings and prisons in Flanders [6-8], exact data about the prevalence of institutional aggressive behavior are lacking.

Aggression can take many forms, from verbal aggression to (attempted) manslaughter. All of these types can cause physical and psychological problems for the victims, as well as reduced quality of care [9-11]. Furthermore, the financial cost for the institution due to sickness absence in staff cannot be underestimated [3]. To minimize and manage aggressive behavior, it is essential to gain insight into potential risk factors. However, studies that have investigated risk factor for violent behavior in OID focus mainly on future behavior outside of the clinic. Scarce research about factors associated with inpatient aggression shows that aggressive patients tend to be male [3] and between age 20 and 35 [12]. Findings concerning the presence of psychopathology or severity of intellectual disability are somewhat equivocal [5, 13, 14].

The aim of the study was to investigate the nature, frequency and management of institutional violent behavior on five specialized units for offenders with intellectual disabilities. Aggressive patients were compared to non-aggressive patients to infer risk factors for inpatient aggression. To the best of our knowledge, this is the first study of its kind in Flanders.

Methods

During six months, ranging from October 2010 to April 2012, aggressive incidents were registered in five Flemish forensic ID projects, located in forensic units and prisons. In total, 60 OID's participated. Eight clients were excluded from the analyses due to leave or (long-term) transfer from the ward, resulting in a final sample of 52. Participants had often previously been in contact with judicial authorities during childhood or adolescence (29.1%) or adulthood (48.3%) because of criminal behavior. The index offense was in half of the cases (58.3%) a sexual crime, most frequently sexual hands on offenses against minors (88.6%). Other offenses were (non-sexual) violent offences (35%) and property offenses (26.7%). The mean IQ, albeit assessed with different IQ tests, was 57 (SD = 9.13; range = 35 – 79). Based on a clinical diagnosis according to the Diagnostic and Statistical Manual of mental disorders (DSM) [15, 16], 3.3% had a borderline, 53.3% a mild, 40% a moderate and 1.7% a severe intellectual disability. One person (1.7%) wasn't diagnosed with intellectual disability, but did however function on a subaverage intellectual level together with an autism spectrum disorder. Based on the Psychopathy Checklist – Revised (PCL-R) [17], an instrument to measure psychopathic traits, nobody could be diagnosed as a psychopath. The mean PCL-score was 15 (range 3.2 – 29.5).

Aggressive incidents were recorded using the Staff Observation Aggression Scale – Revised (SOAS-R, version ID services) [18]. The SOAS-R is an aggression registration instrument that evaluates the nature, severity and frequency of (verbally) aggressive incidents. By indicating the cause of the aggression, the means used by the patient, the target of aggression, the consequences of the aggression and the measures to prevent further escalation, a severity score is obtained ranging from 0 to 22. In addition, there is also room for indicating the time, location and subjective severity of the aggression. The SOAS(-R) seems to be a reliable and valid instrument to systematically register institutional aggression [19-21]. Aggressive patients

were compared to non-aggressive patients with regard to age at time of research, previous psychiatric hospitalization, index offence, criminal history, IQ, diagnoses and score on the PCL-R [17]. Depending on the type of variable, chi-square tests, Fisher's exact tests, t-tests or Mann Whitney U-tests were used.

Results

Description incidents
A total of 68 incidents were registered, caused by a minority of the patients (n = 19; 36.5%; see table 1). Most of these patients (n = 18; 94.7%) were involved in two or more incidents.

Table 1. Number of incidents per setting

Unit	Setting	Number of patients	Incidents	Incidents per bed per year	Aggressive clients (%)
Amanis	Hospital	12	13	2.2	4 (33.3)
Limes	Hospital	9	21	4.7	4 (44.4)
Itinera	Hospital	8	9	2.3	3 (37.5)
A.B.A.G.G.	Prison	15	11	1.5	3 (20.0)
Ontgrendeld	Prison	8	14	3.5	5 (62.5)

In the majority of cases patients were verbally aggressive (86.8%). Half of the cases (55.9%) involved verbal aggression alone. One third of the aggressive patients (n = 6; 31.6%) was involved in physical aggression towards others. The severity of aggressive incidents ranged from 0 to 18 points, with a mean severity score of 9.4 (SD = 4.28). The mean severity of aggression was similar in both settings, being 9.3 for the prison projects and 9.4 for the residential projects, U = 531.50, z = -.08, p = .94. There were physical consequences in only 4.4% of the incidents, resulting in pain (1.5%) or visible injuries (2.9%). In half of the cases (48.5%) there were psychological consequences in that the victim felt threatened as a result of the aggression. Although the person completing the SOAS indicated a rather low (subjective) severity score of 4.4 out of 10, 75% of the incidents was followed by restrictive measures like seclusion or isolation. The results of the SOAS-R coding are presented in table 2.
Most of the incidents took place in the morning (37.7%) and in the afternoon (45.3%). There seemed to be an equal distribution through the week, with only a minority of the incidents occurring during the weekends (12%). Incidents occurred mainly in the common rooms of the unit (69%).

Table 2. Descriptives SOAS-R (%)

Provocation		Means		Victim		Consequences		Measures	
No understandable provocation	11.8	Verbal aggression	86.8	Nothing/nobody	2.9	None	38.2	None	1.5
Other patient(s)	17.6	Chair(s)	4.4	Object(s)	23.5	Damaged, not replaced	4.4	Talk to patient	35.3
Request to do chores	20.6	Glass(ware)	4.4	Other patient(s)	22.1	Damaged, replaced	8.8	Calmly brought away	4.4
Patient denied something	29.4	Other objects	8.8	Patient self	4.4	Felt threatened	48.5	Contact ended	19.1
Help with ADL	5.9	Hand (hitting, punching,…)*	32.4	Staff member(s)	66.2	Pain < 10 min	1.5	Oral medication	1.5
Physical proximity	1.5	Hand (physical sexual harassment)	0	Other person(s)	1.5	Pain > 10 min	0	Parenteral medication	0
Unexpected situation	2.9	Foot (kicking)	10.3			Visible injury	2.9	Held with force	5.9
Change of activity	2.9	Teeth (biting)	0			Need for treatment	0	Being sent to room/ cell	29.4
Alcohol/drugs	0	Knife	0			Need for treatment by a physician	0	Seclusion (locked door)	16.2
Staff requiring patient to take medication	1.5	Strangulation	1.5			Other	1.5	Isolation (locked door)	29.4
Receiving bad news	5.9	Other	0					Physical restraints	0
Other provocations	13.2							Other measures	10.3

* This included hitting with doors (Nijman, personal communication).

Characteristics aggressive patients

Aggressive patients were compared to patients who weren't involved in an aggressive incident during the registration period. Even though aggressive patients were on average older at the time of the study (M = 43.16, SD = 9.12) than the non-aggressive patients (M = 40.85, SD = 12.67), this difference was not significant, U = 280.00, z = -.64, p = .52. Aggressive patients also were not more often convicted or interned than non-aggressive patients, χ^2 (1) = 2.73, p = .10. There was no difference in IQ score between patients who were involved in an incident (M = 55.89, SD = 9.62) and those that were not (M = 57.18, SD = 8.93), U = 295.50, p = .73. Furthermore, there appeared no significant differences in type of psychiatric disorders. There appeared to be an association between previous psychiatric hospitalization and involvement in an aggressive incident. Out of the 18 people who were aggressive, 16 (88.9%) were previously hospitalized, χ^2 (1) = 6.57, p = .01. Patients who were aggressive also had a higher PCL-R total score (M = 17.77, SD = 6.68), and thus had more psychopathic traits than non-aggressive patients (M = 14.00, SD = 5.29), t (50) = -2.24, p = .03.

Discussion

A minority of the patients was involved in aggressive incidents, mostly verbal aggression. The occurrence of severe physical aggression (with physical consequences) was rare. Nevertheless, almost 50% of the victims felt threatened during the incident, which poses the risk of psychological harm and burnout. It is therefore suggested that all types of violence need to be systematically reported through accident forms. Only this way, a global picture arises that highlights problem areas which then can be addressed through preventive actions. The SOAS-R could be a useful tool for this matter for a number of reasons. First, different types of aggression are included, ranging from less severe types of aggression, like verbal aggression, to aggression that can be life threatening like strangulation. Furthermore, the SOAS is a quick and easy to score instrument, which makes it easy to implement in daily practice. Last, the instrument gives insight into different aspects of institutional aggression, such as the type op provocation. This information may be helpful in determining strategies to reduce risk of violence, which in turn could to lead to a better staff well-being. Because it's an incident-base scale however, the reliability of the assessments relies upon the preparedness of the staff to document all incidents. According to Nijman [22], measuring violent incidents is not only important for preventive and management purposes. The frequency and nature is also indicative for future violent behavior in that previous behavior is the best predictor for future behavior [22, 23].

When looking at the characteristics, only previous psychiatric hospitalization and psychopathy score were related to the occurrence of aggression. Other characteristics like diagnosis showed no association. It has been suggested by Davis [24] that perhaps the stage of the illness or the type of symptoms is a more useful predictor for aggression than does the presence of a psychiatric disorder. Our knowledge about risk factors for institutional aggression in OID is limited, and national large-scale research is therefore recommended. There are however a few methodological difficulties related to this study. For instance, although staff was instructed on the scoring of the SOAS and it was stressed that every incident needed to be registered, it is possible that the number of incidents is underreported. A reason for this could be that patients remain in the projects for a rather long period. Staff are thus well-known with the patient and may be tolerant to a number of incidents. Furthermore, IQ was measured by means of different instruments.

This study shows that severe (physical) aggressive behavior remains the exception in forensic ID projects in Flanders. Given the possible psychological consequences, it is therefore important to systematically register all institutional incidents in order to prevent and manage it. The present findings suggest that the SOAS-R could be a useful tool for this matter.

Acknowledgements

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A community groups approach to managing interpersonal violence in an intellectual disabilities service

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Introduction

This paper describes a ward-based intervention that has been implemented at Calderstones Partnership NHS Foundation Trust. The trust provides services to adults with intellectual disabilities who are detained in conditions of medium or low security or within high support services. Historically, high levels of interpersonal violence were present in the environment. The clients in this service also present with a plethora of other difficulties that challenge staff, including inappropriate sexual behaviour, self injurious behaviour, verbal hostility, bullying, attempts to engage in psychological coercion and difficulties engaging in conventional forms of therapeutic work. A review of the evidence base proved largely fruitless in terms of identifying effective treatment interventions for people dually diagnosed with intellectual disability and personality disorder. However, evidence from research with people diagnosed with personality disorder indicates that 'community' based approaches are promising (Ministry of Justice [MoJ], 2011). Community based approaches draw on theories of group processes, including, all members of the community working together, curiosity about the behaviour of oneself and others, continual feedback and sharing authority amongst the group. Within such approaches 'the community' is considered to be the primary mechanism of change. The community functions to help individuals gain insight into how their behaviour impacts on them and other group members. Contact with other secure intellectual disability services indicated that methods of this type are gaining increasing prominence in personality disorder/intellectual disability provision (Taylor, 2011).

Method

The clients were 12 men aged 21-52 who resided on a ward designated for the treatment and care of individuals with a dual diagnosis of intellectual disability and personality disorder. The men had committed a variety of offences including assault, sexual assault and arson. All the men lived in shared flats within the ward environment. To prepare for the implementation of community meetings members of the psychology service delivered training sessions with the ward staff team, briefing sessions with the clients and staff support sessions were also implemented on a weekly basis. Community meetings were held weekly, facilitated by members of the psychology service alongside members of the ward staff team. At the meetings the agenda was set by a list of items to be discussed, which had been recorded over the previous week by clients and staff members. Clients and staff were encouraged to use the 'agenda book' to write down anything they had been affected by, positively or negatively, over the course of the last week. During the meeting a chairperson went through the items of the agenda, facilitated discussion amongst the group and attempted to find resolutions to the problems raised. The outcome measures were the episodes of aggression (verbal, physical, damage to property) recorded on the electronic patient record system. The measures were taken a year before the meetings and a year after the meetings had been implemented.

Results

In the twelve months prior to the intervention, the men were involved in a total of 185 episodes of aggression. Of these, 149 took place within the ward environment, and 36 elsewhere. In the first twelve months since the intervention commenced, the men have been involved in 148 episodes of aggression, 135 in the ward environment and 13 in other locations. This represents an overall reduction of 20% in the number of episodes of aggression in the first year of this intervention. Informal analysis of the content of the discussion at community meetings, via contemporaneous notes, suggests that the men increased their skills of negotiation, compromise and perspective taking, and had applied these skills within the ward environment.

Of the sample, there were two men where the level of aggression remained unchanged, and there was one man who displayed an increased level of aggression over the time period.

Conclusion

Whilst several factors will have contributed to the reduction in violence and aggression shown by these men, the results suggest that the use of structured community meetings can play an important role in the proactive management of violence in men with intellectual disabilities. The results also suggest that the skills learned may generalise beyond the setting in which they were acquired.

For some the use of community meetings appeared to lead to a genuine change in their aggressive behaviour, however for a small subset of the sample the intervention did not appear to make a difference to their aggressive behaviour, and one individual recorded an increased amount of aggressive behaviour over the time period. Anecdotally, it seems that unlike other members of the community, these men struggled to use the meetings to reflect on their behaviour and consequently felt attacked by the process. They also seemed to have difficulties with distress tolerance and therefore struggled to manage the process of receiving feedback from others regarding their behaviour. Further research is needed to tease out the factors that are likely to lead to the positive uptake of this approach for some clients and not others.

Reflections on the meetings revealed that waiting a week to discuss issues could lead to issues being forgotten about or missed, particularly positive events. Following discussions with clients and staff members, the intention is to start having meetings on a daily basis to assist with the process of considering all events that happen over the course of a day.

Educational goals

1. Increasing awareness of contemporary practice in working with forensic populations of men with intellectual disabilities
2. Increasing awareness of interventions that could be employed in many group residential settings.

Acknowledgements

We would like to extend our thanks to staff members and clients for embracing this approach and all working together as part of a community.

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Risk factors for inpatient aggression by adults with intellectual disabilities and severe challenging behaviour: a long-term prospective study

Paper

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Introduction

Aggressive behaviour by adults with intellectual disability (ID) has been a long recognized problem(Matson & Gorman-Smith, 1986). It constitutes a risk factor for staff burnout (Howard, Rose & Levenson, 2009), and strains relationships with caregivers (Jahoda & Wanless, 2005). Moreover, aggression is the primary reason for admission to restrictive residential settings and a barrier to resocialisation after hospitalization (Cowly et al., ., 2005; Tenneij, et al.,, 2009). This explains why aggression by people with ID is consistently found to be more prevalent in residential than community settings (Crocker et al., 2006; Tyrer et alp, et al., 2006).

Prevalence rates for aggressive behaviour differ considerably, at least partly due to methodological inconsistencies (Crocker, et al., 2006). For example, in similar residential treatment facilities for people with mild or borderline ID and severe challenging behaviour, the prevalence of aggression per patient per week varied between 0.15 for "outwardly directed" aggression (Tenneij and Koot, 2008), 0.60 for physical aggression and aggression towards objects (Reed et al., , 2004), and 0.27 for physical aggression plus aggression towards objects and 0.61 for verbal aggression (Drieschner, Marrozos, and Regenboog, 2013). Several studies indicated that aggressive behaviour by individuals with ID is a persistent rather than transient phenomenon. Of individuals who exhibited physical attacks, more than 80% continued to do so five respectively eight years later (Kiernan & Albortz, 1996; Nottestad & Linaker, 2002), and 70% even eleven years later (Totsika et al., , 2008). However, when aggression is the reason for referral to a treatment facility, it is expected the treatment will reduce the amount and/or severity of aggression, in order to enable discharge to a less restrictive living environments.

There is little agreement concerning characteristics of individuals who exhibit a lot of aggression. For example, gender, age, level of ID were found to be related to aggression in some but not all studies (for an overview see Drieschner et al., 2013). There is more agreement concerning the role of psychopathology. Positive relationships with aggression were found for psychotic disorders (Linaker, 1994; Tsiouris et al., 2011), autism (McClintock et al., 2003, Tsiouris et al., 2011; Tyrer et al., 2006), personality disorders (Linaker, 1994; Tsiouris et al., 2011), impulse control disorders, and mood disorders (Tsiouris et al., 2011). Especially interesting from a clinical point of view are dynamic risk factors, which may constitute targets for treatment, such as deficits social skills and coping skills deficits, problem recognition, lack of impulse control, and hostile attributional bias. However, there is little knowledge about the relationship between these variablese and inpatient aggression in the ID field.

The aims of this study are to identify (a) patient-related risk factors for various types of inpatient aggression, and (b) dynamic variables associated with reduction of aggressive behaviour.

Method

Setting
The study was conducted in a Dutch residential treatment facility for about 180 adults with mild or borderline intellectual disability and severe problem behaviour with about 180 beds (about half forensic). The treatment approach is multimodal, including manualized cognitive-behavioural programmes, art-, drama-, and psychomotorical therapy, occupational therapy, skills trainings, and pharmacotherapy. There are specialized treatment trajectories for patients with the primary problem in the areas of aggression

and violence, substance abuse, sexual behaviour, and high vulnerability to psychosis or psychological decompensation. The median treatment duration is about 5 years for court-mandated patients and 2.8 years for the other patients

Measures
Extended Modified Overt Aggression Scale (MOAS+). Aggressive behaviour wasrecorded with an adapted version of the Modified Overt Aggression Scale (MOAS; Kay, Wolkenfeld & Murrill, 1988). After each shift the ward staff records the incidents by each patients by placing tally marks on a MOAS+ week-form. Five types of incidents are distinguished (verbal aggression, aggression towards objects, physical aggression, autoaggression and sexual aggression), each with four levels of severity (mild, moderate, strong, and severe). High inter-rater reliabilities were found for the original MOAS score (Kay et al., 1988; r = .85–.94) as well as adapted MOAS versions with frequency scoring systems (Cohen et al., 2010; r = .70–.83). Detail about the MOAS+, including the issues of underreporting and imputation of missing values, can be found in Drieschner, Marrozos and Regenboog (2013).

Dynamic Risk Outcome Scales (DROS). The DROS (Drieschner & Hesper, 2008) is a therapist-rating instrument which contains 43 five-point items for dynamic risk factors of serious externalizing problem behaviour in people with ID. The DROS scales are labelled 'Problem recognition', 'Antisocial attitudes', 'Attitude towards the treatment', 'Treatment engagement', 'Realistic plans', 'Coping skills', 'Social skills', 'Self-care', 'Impulsivity', 'Hostility', 'Sexual deviancy', 'Proclivity for substance abuse', 'Psychotic symptoms and vulnerability' and 'Social network'. Cronbach's alpha values were .93 for the total score between .55 and .91 (mean .79) for the separate scales. The 6-months test-retest correlation was .79 for the total score and between .69 and .86 (mean .75) for the scales. The validity of the scales was supported by correlations between .52 and .77 with scales of overlapping content of the Dutch HKT-30.

DSM-IV diagnoses are generated by psychiatrists based on clinical observation. IQ was assessed with the Wechsler Adult Intelligence Scale III (81%) or the Groningen Intelligence Test 2.

Procedure
All data were collected in the context of structural periodic outcome measurement (routine outcome monitoring). Administration of the DROS took place three months after admission and then six-monthly by the responsible psychologist of the ward. The MOAS+ was scored throughout the entire admission period by the ward staff. Stable patient characteristics (see Table 1) were assessed within three months after admission by psychologists, psychiatrists, admission officers, and social workers.

Data analysis
First, the prevalence of the various kinds of aggression is computed. This is accomplished in two ways, as the average number of incidents per patient per week and as the percentage of patients who cause at least one incident in six months. Second, Spearman correlations are established between stable patient characteristics (e.g. gender, age, IQ, DSM-IV classification) and initial DROS scores (obtained three months after admission), at the one hand, and MOAS+ aggression incidents after month three, at the other hand. In the following steps, the focus is on longitudinal change of aggression during the treatment. In the third step, changes in the number of MOAS+ incidents and changes across consecutive (six-monthly) DROS scores are analyzed. Fourth, Spearman correlations are computed for the relationship between, at the one hand, stable patient characteristics and initial DROS scores, and at the other hand, longitudinal change of number of MOAS+ incidents. For this purpose, the number of incidents of each patient were averaged over periods of six months, and change was computed as the difference of the number of incidents in the first six months compared to those in the second, third, fourth, etc. six-months periods. Finally, the Spearman correlations are computed for the association between change of the number of MOAS+ incidents and simultaneous change of DROS scores.

Results

Sample characteristics
Of 243 individuals who were admitted since june 2007, 144 were followed for 18 months or longer by May 2012. Characteristics of this study population (N= 144) are summarized in Table 1. As can be seen, aggression and violence is by far the most common reason for admission. A third of the patients (32.6%) were discharged during the study period. The average time in treatment, either at discharge or at the end of the study period was 147 (range 78 to 256).

Table 1: Sample characteristics

Gender (% male)	90.1 %
Age (mean/sd)	33.6 / 11.3
IQ (mean/sd) [1]	69.7 / 9.1
Treatment on the basis of criminal law	60.1%
Reason for admission	
Aggression or violence	73.7 %
Sexual problem behaviour	28.9 %
Other externalizing problem behaviour	21.9 %
Psychopathology (DSM-IV)1	
Psychotic disorder	26.5 %
Attention deficit or disruptive behaviour disorder	27.2 %
Substance-related disorder	39.0 %
Pervasive developmental disorder	19.9 %
Personality disorder (cluster B)	25.7 %

[1] all other DSM IV disorders < 10%

Prevalence and Predictors of Aggression
As shown in Table 2, there was about one aggressive incident per patient per week, of which almost two thirds were verbal aggression. Although physical aggression causing injury in relatively rare, 0.01 incidents per patient per week implies that an average eight-bed ward suffers such an event every 2-3 months. Most patients exhibit aggression at least once in six months. Almost one of ten patients cause substantial destruction of property (destroying objects, smashing windows, setting fire), and 5% are violent causing injury to staff or other patients.

Table 2: Incident-based and patient-based prevalence of aggressive incidents

MOAS severity level	Number of incidents per patient per week	% of patients with [3]1 incident per 6 months
Verbal aggression		
Mild/Moderate	0.53	74.8 %
Strong/Extreme	0.14	38.4 %
Aggression towards objects		
Mild/Moderate	0.22	46.7 %
Strong/Extreme	0.04	9.1 %
Physical aggression		
Mild/Moderate	0.08	21.1 %
Strong /Extreme	0.01	5.0 %
Any externalizing aggression		
	1.02	81.2 %

Only few stable patient characteristics significantly predicted aggression during the treatment. Surprisingly, females an non-offenders caused more incidents of al types than males and criminal justice patients (factor 1.5 – 2.2). As expected, those admitted because of aggression exhibited more aggression than those with other reasons for admission (factor 1.9 – 2.4). Of all DSM-IV diagnoses, only the categories ADHD/ Disruptive behaviour disorders and Substance-related disorders were associated with amount of aggression (factors 2.0 – 2.6 and -1.5 – -1.6, respectively). All other categories, including psychotic disorder, pervasive developmental disorder and personality disorder were unrelated to aggression. Younger age was associated with more aggression of all types (rho = - 31 – -.37). Initial DROS scores moderately predicted aggression later in the treatment. The highest correlations were found for the scales Coping Skills Deficits (r = .35 - .44), Impulsiveness (r = .31 - .44), Social Skills Deficits (r = .31 - .43), Hostility (r = .32 - .37) and low Treatment Engagement (r = .31 - .35).

Course of Aggression During the Treatment
As shown in Figure 1, the average number of aggressive incidents per patient per week decreased during the treatment, especially in the first year. However, this did not apply for all patients. Only 29% showed a

clear downward trend, while 21% showed a constant level of aggression and 7% even an increase of the number of incidents. A pattern of ecreased relapses was found for 7% and the remaining 36% caused very few incidents from the start of the treatment such that a significant reduction was impossible.

At the same time, the six-monthly DROS scores indicate average improvement. The total score, an aggregate of all DROS scales, improves by about a half standard deviation after one year, one standard deviation after two, and slightly more after three years. Again, not all patients improve. After one year, 17% improve reliably (two times the standard errors of change measurement), and another 24% show likely improvement (one standard error). The corresponding figures after two years are 31% and 23%, respectively, and after three years 36% and 21%, respectively. Less than 3% show reliable or likely change of DROS total scores indicating exacerbation of problems.

Figure 1: Average number of aggressive incidents per patient per week during three years after admission
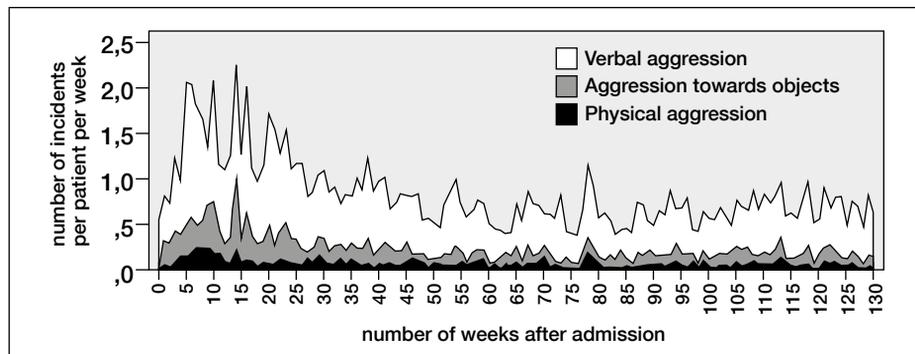
Predictors of change in aggression during the treatment

Change of the number of aggression incidents was not significantly correlated with any of the stable patient variables, including DSM-IV disorders, gender, and IQ. DROS scores after three months of treatment showed a week but statistically significant negative association with change of the amount of aggression during the treatment. The correlations ranged from r = -.24 for aggression change from the first to the second half year of treatment to r = -.30 for change between the first and the sixth half year. Thus, more reduction of aggression was found in patients with higher levels of dynamic risk factors at the start of the treatment. This is not surprising because these dynamic risk factors are the main targets of the treatments. The DROS scale for Social Skills was the best predictor of reduction of the number of the three types of aggressive incidents (r = -.26 – –.43).

As expected, change of the amount of aggression was associated with change of dynamic risk factors for aggression. There were weak to moderate correlations between change in the number of MOAS+ incidents (first half year of the treatment compared to the second, third, fourth, fifth and sixth half year) and change of DROS scores in the same time-intervals (administration after 3 months compared to administrations after 9, 15, 21, 27, and 33 months). For the DROS total score (aggregate of all scales), these correlations were in the range of r=.18 – .50, with increasing correlations the longer the time interval gets. All DROS scales contributed to these correlations, except the scales Proclivity for Substance Abuse and Psychotic Symptoms and Vulnerability.

Conclusion

Incidents of aggression by patients in a treatment facility for individuals with mild ID and challenging behaviour are daily events on an average eight-bed ward. Although most aggression is verbal, a typical ward is weekly confronted with more severe aggression and every 2-3 months with aggression which causes injury in the victim. Although most patients exhibit aggression at times, there are large differences across patients (For more detail concerning the distribution of aggressive incidents over patient, refer to Drieschner et al., 2013). Surprisingly female patients caused more incidents than males, which also applied to physical aggression. Most DSM-IV diagnoses were unrelated to aggression, with the exception of attention deficit or disruptive behaviour disorder. (more aggression) and substance abuse disorder (less aggression). Younger patients tend to cause more incidents.

The treatment was found to be effective in reducing the number of aggressive incidents for about half of the aggressive patients, while the other half showed a constant level, an unstable pattern, and, in a few cases, even an increase of aggressiveness. We found no stable characteristics which would predict decrease of aggressiveness. However, dynamic variables, which can constitute treatment targets, did predict decrease of number of incidents. The more coping skills deficits, impulsiveness, social skills deficits, hostility, and lack of treatment engagement at the start of the treatment, the more likely the patient was to become less aggressive during the course of the treatment. This suggests that decrease of aggressiveness may be achieved by improvements in these problem areas. This is supported by the finding that change of the number of aggressive incidents was correlated with simultaneous change on these problem areas (and problems, such as coping skill deficits, problem recognition and antisocial attitudes). These correlations became stronger, the longer the patient was in treatment. This is an interesting finding which may reflect that aggression earlier in treatment depends more on situational or environmental factors which. Therefore treatment progress in terms of improvement on the various problem areas has a stronger effect on aggressive behaviour later in the treatment.

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Personality Assessment in Offenders with Intellectual Disabilities: Associations with Personality Disorder, Clinical Engagement and Aggression

Symposium

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Background

The measurement of personality traits can provide a clearer understanding of a person's psychopathology and associated clinical needs. However, research into the relationship between personality, personality disorder (PD) and clinical presentation is limited, particularly in intellectual disability (ID) populations. Furthermore, reliable assessment within clinical contexts often relies on traditional diagnostic measures of PD which are lengthy and are usually dependent on self-report, which can be problematic in ID populations. The current study aims to investigate the clinical utility of brief informant-based and self-report measures of personality and PD in offenders with ID and there associations with clinical engagement and aggressive behaviour.

Objectives

- To explore associations between personality traits and PD characteristics, clinical presentation, and clinical engagement in a sample of offenders with ID; and
- To investigate the predictive validity of short PD screening instrument in relation full diagnostic assessment of PD.

Method

Approximately 110 male and female offenders at a specialist forensic ID inpatient facility (Northgate Hospital) were invited to participate, and complete a self-report PD screening assessment. Measures of personality, PD, and clinical presentation were also completed with nursing staff, and file information was collected for various measures of psychopathology, behaviour, and risk.
Correlational and regression analyses were used to explore relationships between personality traits, PD, clinical presentation, and clinical engagement. The extent to which PD screening measures predict behaviour, clinical engagement and PD diagnosis were assessed using ROC analyses.

Results

Initial study findings indicate that a brief PD screening instrument is predictive of full diagnostic assessment of Dissocial and Emotionally Unstable personality disorder. Characteristics of these disorders are highly associated with previous and current aggressive behaviour, and inversely associated with indicators of clinical engagement. The implications of these findings for future research and practice are discussed.

Educational Goals

1. To inform the audience of the literature concerning PD and PD assessment concerning offenders with ID.
2. To dissemiante the results of an empirical study concerning the associations between PD, clinical engagement and challenging behaviour.

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Intellectual Disability, Alcohol Misuse and Risk for Violence

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Poster

Background

Alcohol misuse has special relevance for offenders with intellectual disability (ID), particularly violent offenders. Offence–focussed programmes that ignore alcohol misuse and the individual formulation of associated risk may be misdirected.

Aims

To review and integrate the theory and best available evidence in order to develop and pilot a psychosocial programme for identified at-risk detained patients with ID during the pre-discharge phase of their treatment.

Method

A novel programme was delivered that is group-delivered but individually formulated. It comprised weekly in vivo exposure over 12 weeks, with group members attending a series of public bars in the town adjacent to the hospital where they are detained. They also attended a reflective group the following day to consider internal events, as experienced; and external events, as observed. These were linked to past histories and to future concerns, tasks and challenges. Social learning, cognitive behavioural and contingency management approaches all played a role in the intervention.

Results

A single case study approach was used to evaluate the emerging data from the pilot programme. The findings are outlined with descriptive statistics of participants and presented in terms of individual single case data, formulation of risk and care planning recommendations. Preliminary results are encouraging.

Conclusions

It has been possible to develop structured clinical judgements for long-term detained offenders with ID who have alcohol-related risk for violence, using an in vivo graded exposure intervention programme to facilitate their discharge from hospital and community rehabilitation.

Educational Goals

1. To inform participants about the literature concerning and the links between alcohol misuse and offending by people with ID.
2. To describe a novel approach to working with offenders with ID on the risks linked to their alcohol misuse.

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Anger Treatment Gains and Violence Reductions

Symposium

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Abstract

Anger is a dynamic risk factor for violence, and it constitutes an important forensic mental health treatment need. Hospital patient anger is predictive of violence prior to, during, and after hospitalization. Nine meta-analyses of anger treatment have found medium to strong effect size results for anger criterion measures, but very few studies have examined whether anger treatment is effective in reducing violent behavior. The present study evaluated whether reductions in physically assaultive behavior in hospital occurred in conjunction with CBT anger treatment and whether such lowered violence was a function of the reductions in anger that occurred in that treatment.

An established anger treatment protocol was applied to male and female forensic hospital patients having intellectual disabilities. Differences between the number of physical assaults in hospital 12 months before and 12 months after anger treatment were tested using generalized estimating equations, controlling for background variables and IQ. Significant reduction in physical assaults occurred in conjunction with anger treatment. The magnitude of the reduction in violence that occurred at post-treatment was associated with the degree to which anger, assessed on multiple psychometric measures, was reduced from pre- to post-treatment.

These results buttress the value of anger treatment for psychiatric patients having violence histories, not only for those with intellectual disabilities but also for forensic patients in general. As assaultive behavior by hospitalized patients is costly and impairs the therapeutic milieu, there are also benefits for hospital management.

Educational Goals

1. Dissemination of clinical knowledge about the delivery of anger treatment to a forensic hospital population.
2. Information about anger assessment methods and analyses of assaultive behavior data.

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Bridging the gap between assessment and treatment of people with learning disabilities who offend

Poster

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Abstract

We will present our work in the National unit of Mandatory care in Norway for people with intellectual/ learning disabilities. Traditionally there is a gap between risk assessment, psycological treatment and millieu therapy.We have developed a cognitve treatment program - KAOS- for adressing risk factors and protective factors assessed with the risk assessment instrument ARMIDILO.

Educational Goals

To give an overview of a new method of treatment in connection to risk assessment

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The effectiveness of risk assessment tools for adults with intellectual disabilities: A systematic review

Paper

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Background

Whilst much research has been conducted into the design and validity of risk assessment tools to assess risk of violence in a general adult population, it is unclear how much of this research is generalisable to a population of adults with an intellectual disability (ID). Whilst much of the literature from other populations is likely to be applicable, distinct characteristics of an ID population mean that certain aspects may differ.

Aims

To identify, and assess the effectiveness of, risk assessment tools for predicting violent behaviour in an ID population

Methods

A systematic review was conducted using broad search strategies to interrogate two electronic databases (Medline and Psycinfo). Predefined inclusion criteria were then applied, firstly to the titles and abstracts, then to full papers identified as potentially relevant. Data were then extracted from relevant papers into piloted data extraction forms.

Results

Nineteen studies assessing the predictive validity of risk assessment tools for predicting violence in adults with an ID were identified. Studies were primarily conducted in the UK (n=15) and the earliest study was published in 1997. The studies included a total of 1,702 individuals who were primarily young male offenders. A total of 28 different tools were assessed across the studies with 16 studies testing more than one tool. Of the 28 tools assessed, only two were designed specifically for use in an ID population. Seven of the tools, including one designed for use in an ID population, were assessed by more than one study. Area under the curve (AUC) analysis was used in eight studies, which assessed 11 tools. AUC values ranged between 0.47 and 0.86 generally indicating good predictive validity.

Conclusions

Research into the risk assessment of violence in individuals with an ID is an emergent and under-researched area in comparison to the non-ID population,. Few tools have been designed specifically for use in this population. However, this review indicates that those designed to assess risk in a non-ID population generally indicate good predictive validity when applied to an ID population, suggesting that many of the components of risk assessment are transferrable to an ID population.

Educational Goals

1. Identify risk assessment tools that have been tested in an adult ID population
2. Assess the effectiveness of the identified tools in predicting violence

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Mandatory care for people with a mental retardation

Poster

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Trondheim, Norway

Abstract

Norway implemented a new penal code for people with a mental retardation in 2002. Accordingly, persons with IQ below 55 are considered by the courts as "not guilty because of high degree of mental deficiency". These persons can be sentenced to "mandatory care" to the National unit, if the crime is serious AND considered by the courts as liable to a new serious crime AND it is considered by the court that the society needs protection by the individual. The National unit can also be ordered by the courts to implement remand custody on suspicion of high degree of mental retardation if the alleged crime is serious.

Educational goals

1. To learn about the legal system for people with a mental retardation in Norway.
2. To learn about the National unit for mandatory care.

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Evaluation of Electrical Aversion Therapy (EAT) for aggressive and sexual inappropriate behaviour after acquired brain injury: Two Single Case Design studies

Paper

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Keywords: neurobehavioural, neuropsychiatric, aggression, sexual inappropriate behaviour

Introduction

Brain injury can lead to deficits in different areas of functioning; such as physical, cognitive, emotional, behavioural and social functioning.[1] Especially severe behavioural consequences like aggression and inappropriate sexual behaviour, can have a negative impact on the patient's life and social reintegration.[2] [3] [4]

As to aggression, the impact on patients and caregivers is severe and it can be pervasive and difficult to treat.[5] Tateno et al. (2003)[6] report that 33% of patients with traumatic brain injury present with aggressive behaviour up to 6 months post injury. Britton (1998)[7] shows that aggressive behaviour also occurs later post injury. Aggression is more frequent if neurocognitive impairments, premorbid aggression and drug- dependency are involved. ([8], [6], [9], [10]) Antecedent control procedures and contingent reinforcement procedures are effective as a non-pharmacological treatment of aggression in the post acute phase. ([11], [12], [13], [14], [15]) Many pharmacological interventions are used, though evidence is lacking. ([16] [17]

As to inappropriate sexual behaviour, Simpson et al.[18] reported in a retrospective study, a prevalence of 6.5% inappropriate sexual behaviour in patients with acquired brain injury. Bezeau et al.[19] showed that 70% of professionals working with patients with traumatic brain injury reported sexual touching as a common problem where 20% reported sexual force as commonly used by their patients. In this paper we use the definition proffered by Johnson et al.[22] based on a detailed literature review: "a verbal or physical act of an explicit, or perceived, sexual nature, which is unacceptable within the social context in which it is carried out".

Several forms of behavioural treatment have been suggested for the management of inappropriate sexual behaviour. Bezeau et al.[19] provide an overview of behavioural approaches. Some case studies [21] [23] report positive effects of pharmacological treatment.

The aim of these case studies was to evaluate the effectiveness of EAT in the management of aggression and inappropriate sexual behaviour after severe brain injury in a Single-Case (Experimental) Design (SCED).

Methods

Study design
In Case Q an ABBA, single–case experimental design was used. In a five-week baseline phase (A1), frequency of target behaviour (i.e. sexual inappropriate behaviour as defined by Johnson) was recorded daily. Supervision by the mother and medication did not change during this phase. In phase B1 (13 months), EAT was applied daily. The number of delivered electrical pulses was recorded daily, which was considered to be equal to the occurrence of the target behaviour. The intervention continued and after a measurement interval of 10 months, in phase B2 (3 months) again there were daily recordings of the number of pulses. And finally in phase A2 (2 months), the withdrawal phase, target behaviour frequency was recorded daily once again. The total amounted to over 500 measurements performed by the mother.

The study of Case X was naturalistic and a single case AB design was used. During the baseline phase (A), three weeks, aggressive behaviour was measured as a function of the restraint on the patient needed

to safely see to his daily needs, clean him, feed him and apply physical therapy to prevent secondary complications. And as a function of the time spent out of bed daily, and the amount of nurses needed to take care of him. The EAT intervention was then applied and the number of pulses needed was measured on a daily basis (except for the weekend) during the treatment phase (B). At follow-up, three months later, the amount of restraint needed was established, the time spent out of bed and the number of nurses needed to take care of him.

Case history

Q is a 40-year old male who sustained a severe traumatic brain injury in a road
traffic accident when he was 14 years old. His initial Glasgow Coma Scale score was 5/15 with 3 months of coma with a posttraumatic amnesic period of 6 months. Computed tomography scans showed a base of skull fracture and a brainstem lesion. After two years he was discharged from rehabilitation to live with his mother. Cognitive impairments were severe. There were behavioural problems such as aggressiveness and inappropriate sexual behaviour. Before injury he was reported to have a normal development with normal school attendance. Post injury he was able to attend social activities without getting into trouble when closely supervised by his mother.

The behavioural problems were foremost. Impact on family and caregivers, and social functioning in general was profound and the behaviour caused him to be admitted to a mental health institution, for 3 years, where he often was sedated and put into seclusion. Several pharmacological were tried without effect. The mother took him home, against medical advice. He was weaned of medication without medical supervision. Professional support was minimal for about 9 years. 15 years post trauma, following a sexual incident with his niece, Q was referred to our outpatient neuropsychiatric clinic. Again pharmacological and other treatment were ineffective. No other therapeutic options were available. This justified the exploration of the EAT option.

X is a 41-year-old male who sustained severe brain damage due to a subarachnoid haemorrhage from an aneurism of the posterior communicating artery. After coiling of the aneurism there were arterial spasms and hydrocephalus. In the acute phase there was a Glasgow Coma Scale of E1M1V1. Eight months post injury there was a persistent confusional state, Rancho Los Amigos scale IV: confused-agitated. (Ranchos IV) As he passed from Ranchos III to IV he developed severe aggressive outbursts, injuring the nursing staff. He was then transferred to our brain injury rehabilitation unit specialised in the management of challenging behaviour.

Pre injury X was functioning normally in his family as a father and spouse and in his work. During adolescence, he had psychiatric treatment for aggressive behaviour. When X came to our facility he needed five points fixation during daily care. In between a single bond was enough to prevent him coming out of bed, which was judged to be unsafe. We tried to manage his behaviour by creating a stimuli free environment. Medication was tried without a direct effect, though due to sedation the aggression was less destructive. But secondary complications of sedation occurred. Three nurses were needed to nurse him safely. He remained under five-point fixation during care. In between a single bond was enough. Transferral to a nursing home was not possible under the circumstances. His wife was very concerned and contemplated applying for euthanasia. EAT was suggested.

Measurements

Case Q:
Target behaviour: Based on the definition of Johnson et al.[22] Knight et al.[20] developed The St Andrew's Sexual Behaviour Assessment (SASBA) In this study items from this classification were used to determine the target behaviour of Q.

Case X:
Target behaviour: Any sign of physical aggression like beating, kicking, pinching, biting or spitting would lead to a pulse from the apparatus. And trying to remove the electrode or receiver. In the treatment phase (B) the number of pulses needed during morning care session, physical therapy and during breakfast was recorded. Treatment continued after registration ended.

Outcome measure
No baseline measurement of aggressive incidents was performed. From the notes we recorded the amount of fixation needed, the number of nurses needed for care and the time out of bed was established creating a baseline (A) At the end of the registration the amount of fixation, the number of nurses needed for care and the time out of bed was established again.

Intervention

EAT is the immediate application of an aversive electrical stimulus following un- called-for behaviour, with the aim of reducing this behaviour. EAT is based on the two-factor procedure theory of Mowrer.[25] Through parallel processes of operant and classical conditioning, there will be a reduction or suppression of the target behaviour by evoking avoidance conditioning. EAT is mostly applied in intellectually disabled or autistic individuals who show severe self-injuring behaviour[24] and in some cases of aggressive behaviour[26] and vomiting.[26] Van Oorsouw et al.[28] however failed to find negative side effects in a study with 9 participants. Moreover, Matson and Taras[29] reviewed 56 applied studies and reported that 96% of the side effects were positive (i.e., increased social behaviour, increased activity levels, increased eye contact). No side effects were observed with Q and X. The EAT device consisted of an electrode applied to Q's right thy and to X's right arm, a receiver attached to their belt and connected to the electrode. A transmitter (remote controlled shocker, type HSP, Schoutissen Electronics, The Netherlands) was carried by the mother in case Q and one of the nurses, in Case X, during the daily care sessions. The Dutch health authorities have approved the apparatus.

Procedure

In *Case Q* target behaviour was determined together with the mother. Subsequently the mother underwent instruction and in vivo training in the use of the EAT device. Then Q and his mother both gave their consent for treatment fully informed. The EAT device was installed after the baseline phase. The mother applied continuous supervision when Q was not at home. In the treatment phase he was attached to the EAT device, when amongst people. As soon as Q displayed the target behaviour his mother would administer a pulse of about 40 mA and applied by alternating current of 30 Hz during less than one second.

In *Case X* EAT was explained and ethical issues were discussed in the team and with his wife. Target behaviour was determined and the nurses underwent instruction and in vivo training in the use of the EAT device. Then the wife gave her consent for treatment fully informed. The staff was able to commit themselves to this kind of treatment. In the treatment phase X was attached to the EAT device, during daily care sessions, during meals and during physical therapy sessions. If X displayed target behaviour a pulse would be given, the same as in Case Q. Frequency of pulses was recorded during weekdays only because of staffing difficulties.

Analyses

In *Case Q* the number of target behaviours per day was presented graphically and visual analysis was conducted. Next, descriptive analyses were performed to summarize the raw data. T-tests were used to test the differences between the 4 phases of the experimental design. Alpha was set at 0.05. SPSS 15.0 for Windows was used.

In *Case X* the number of pulses per activity was represented graphically and visual analyses was conducted. Next, descriptive analyses were performed to summarize the rough data. The Wilcoxon signed-rank test was used to test statistically, the difference between the first half of the registration and the second half. SPSS 19.0 for Windows was used.

Results

Case Q:

In phase A1, 34 recordings were conducted with a mean target behaviour of 12.18 (2.49) per day.
In phase B1 the target behaviour was reduced dramatically to a mean of 3.15 (3.19) per day (n=409 recordings). This reduction further increased in the second treatment phase B2 to a mean of 0.47 (0.70) target behaviours per day (n=68). In the withdrawal phase A2 there was a non-significant increase in target behaviour (mean 1.35 (1.56); n=40). In table 1 the mean (sd) number of target behaviours per day are shown per period. The differences between the baseline phase (A1) and all other phases are significant (p<0.001). There was no significant difference between the treatment phase and withdrawal. Thus the treatment effect was sustained 2 months after withdrawal.

Case X:
Target behaviour
The amount of pulses during morning care sessions decreased from max.nine per session to max.two at the end of registration. Total registration time 341 days. A reduction of EAT-pulses per meal during breakfast from max. five initially to zero was achieved. Total registration time 180 days. Pulses per session during physical therapy decreased from max. three initially to zero. Total registration time 320 days.

Statistics

1. During morning care, pulse count per day was significantly lower in period 2 (mean 0.21) than in period 1 (mean 0.54), z = -2.186, p < 0.05.
2. During physical therapy pulse count per session was significantly lower in period 2 (mean 0.07) than in period 1 (mean 0.19), z=-2.223, p< 0.05.
3. During breakfast pulse count per session was significantly lower in period 2 (mean 0.00) than in period 1 (mean 0.10), z=-2.585, p< 0.01.

Outcome measurement

At baseline 3 nurses were needed during care sessions including 5 points fixation. X took his meals in bed under close supervision. X was only out of bed going to the toilet or shower and during physical therapy. Transferral to a regular nursing home was not possible due to aggression. After registration ended, only one nurse was needed for the actual care. No fixation during care sessions. X was out of bed from 9 am to 1.30 pm. The rest of the day he spent in bed because he was worn out. Sedatives could be reduced. We were able to transfer him to a regular nursing home with this regime, without relapse.

Discussion

Case Q and **Case X** are the first studies on EAT in inappropriate sexual behaviour and aggression after brain injury. In both cases the intervention was shown to be effective. The design in Case Q was stronger than in Case X. Ethical considerations were discussed throughout the process. We only proposed this potentially controversial intervention, because there were no other options after all available interventions had been tried. The impact of the behaviour of Q on his mother and family and of X on his wife and the nursing staff was profound. The ethical consideration in this case is analogous to compassive treatments of cancer, when every other intervention failed to show effect.

Based on the results of these Single Case Design studies, EAT could be considered in brain injured patients with severe aggressive and/or inappropriate sexual behaviour resistant to other behavioural and pharmacological treatments.

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Chapter 19 – Training and education of interdisciplinary staff

Violence against Children: Raising Awareness amongst Arab women Students

Introduction

This presentation is based on the learning process of the course "Violence against Children" given for fourth year Arab female students living in the north of Israel at Sakhnin college for teachers' education in the department of preschool education during the academic year 2012/2013. Throughout my career I have worded as a social worker, a certified family therapist, an expert in family issues and have managed the first Arabic center for preventing domestic violence in Israel. As a lecturer at Sakhnin College, I taught the course "Violence against children" last academic year. . The course syllable included both theoretical contents on violence and personal and professional development of the students themselves in that they had the opportunity to observe internal cognitive and emotional processes so that they would be able to handle the phenomenon of violence.

It is known that the child's first years are critical in shaping his/her future life. During these years, his personality is shaped and constructed. Consequently, the preschool education department at Sakhnin College highly considers this period of the child's life and has prepared a specific varied curriculum that consists of very significant courses related to this age period. The teaching program for kindergarten teachers at the college aspires to prepare teachers and educators for a multicultural society, to enrich them with academic knowledge in the field, in general educational realms in addition to evaluation and methodology, and to equip them with the knowledge of child's characteristics from birth to the age of six. The students in the department are also aware and have reflective thinking over the personal processes they go through as well as over the educational processes that occur in the kindergarten both at a personal level and in the group as a whole.

Increasing kindergarten teachers' Awareness of violence in preschool years

Violence against children is an emotionally loaded issue in that it evokes worries and anger in the general public. It sometimes demands the invasion into the private family life. When some doubt emerges concerning child abuse, we all feel responsible for that child's fate and act out to save him. I believe that we as educators should be aware of what is happening around us and to fulfill our duties in designing activities to prevent violence against children and at the same time to help these children when necessary. I suggest an intervention program that aims at decreasing and even eliminating violence against children.The program includes increasing the teacher's awareness towards her own perspectives concerning children's aggression in kindergarten and towards desirable methods to deal with aggression. It is very vital for the kindergarten teacher to be well informed of the phenomenon which requires her to learn about the causes of this phenomenon, its development and effects. This learning process exposes the teacher to various recommended methods into how to deal with behavioral violent problems. It is strongly recommended for teachers in general, but for kindergarten teachers in particular, to be updated with the latest findings and information in the literature on violence. Teachers should also realize that violent behavior reflects social, emotional, environmental and developmental difficulties among children. In addition, it is essential to qualify teachers to identify the reasons for anger burst, causes of violent behavior and to train them in applying possible intervention principles.

Since the kindergarten teacher constitutes a significant figure for children, she can have a tremendous effect on their behavior and on the general atmosphere of the kindergarten management. As a result, increasing her awareness and developing her personal understanding constitute the first step in preventive treatment of violence. A calm and attentive teacher who sets clear limits and is consistent in her expectations of the children creates the right conditions to cope with emotional storming.

According to previous research, it was found out that only a quarter of Israeli educators received qualification in how to deal and cope with violence in their teacher training programs; only a third of the educators and half of the principals participated in interdisciplinary courses in the issue of school violence. (Astor, Benbenishty, & Khoury-Kasbri,2002).

The Arab community in Israel

The Arab community in Israel is considered a national minority characterized by being a conservative patriarchal society in all its sectors: Christians and Muslims that include Bedouins and Druze. This community refuses to reveal occurrences of domestic violence. The status of women and children in the Arabic society is low. It is not acceptable socially to interfere with the education and behavior of the father in the family, the intervention of the authorities is conceived as an offence to the family dignity. In addition, the commitment of the individual and the family to the tribal community requires that they preserve its honor. (Haj-Yahia, 2000, 2002), (Haj-Yahia & Sadan, 2008)

The sample

The sample consisted of interviews with 10 4th year students in their last year of studies at the early age department at the college. All of them are in their early 20s, married with children. They are mothers raising and educating children on their own. They had no specific previous knowledge in the issue of violence against children. They were teacher students who faced cases of violence against children either at home or in class as they were teaching. Through this course, those students learned about violence against children, its types and legislations concerning it. They also went through a personal experience through simulations to check their beliefs and feelings, renewed their behaviors and raised their awareness of the subject.

A summary of the students' experiences in learning the course

Student 1:
"By the name of the course, I understood that it included rough topics that we had to deal with. Honestly, I wasn't willing to take the course especially that it was given in the first semester. I was hesitant concerning the continuation of my studies this year because of my children especially on Sundays. I remember the hardest day I had when we watched a short movie which showed a teacher harshly hitting a child who was begging her to stop. The pain I felt that day was the hardest I had in my life. I remember arriving home on that day, hugging my children as if I was holding them for the first time in my life. I was worried about them. I cannot go on writing right now. This reminds me of difficult moments." [1]

1. That student later confessed that she herself had been a victim of psychological violence and neglect by the large family especially her grandmother because of her dark skin in comparison to her light skinned sisters. She also said that she had never forgiven her grandmother. Due to this course, she considered going for a therapy and initiated a discussion with her parents, specifically her mother whom she told how much she needed someone to support her as she was mistreated by the others.

Student 2:
" […] Today, I think about every verbal or physical behavior before doing it. I think whether my behavior is violent or not and if there is a little doubt that it is, I immediately stop. Despite the stress I deal with in my life, I avoid using physical or emotional force which I did not know that it is violence before the course. I also learned about new types of violence that our society does not regard as violent acts like verbal abuse, child neglect, and starvation of children or not providing enough food or clothing. I have changed a lot of things in my behavior as a result of the course. Today there is no occurrence of violence in my behavior since I think before doing anything."

Student 3:
"I hadn't had enough knowledge on the topic before taking the course. I felt trauma during the sessions of the course especially when the lecturer told us bout different cases of child abuse that I did not believe would exist. After each session I felt depressed as if I experienced the abuse myself. I gained lot of knowledge throughout the course which was one of the most significant courses I have ever had. I learned that each child constitutes a whole world by himself; he feels thinks and is shy. I learned the child's rights

and my duties towards him as his teacher and as a human being. A new thing that I learned was that even if we hurt a child while playing with him, it is considered violence. I remember this every time I play with my daughter. I remember everything we learned in the course since I am a mother for 3 kids. My behavior and my interaction with children and adults have changed after taking the course. I am more cautious with them. I observe children around me to understand them more. […] There are parents who treat their children as their property and do whatever they want with them."

Student 4:
I think [the course] is the most effective course we have ever learned throughout our studies. It helps us both at personal and practical levels. I hear a lot about child abuse in our society but do not know how to deal with it. […] I learned my rights and duties as a citizen and a teacher concerning child abuse. As a kindergarten teacher, I have learned how sensitive this age is and that children at this age need an understanding and loving relationship. I have also understood that I play a role in saving children if I observe them and check their situation deeply. […] Personally, I went into a change during the course. I gained information on the topic. As a mother of a 3 year old child, I now consider each and every word I say to her since I care a lot about her psychological health as her physical one. We should initiate social and educational activities to help abused children. As a kindergarten teacher, I can play a very significant role since the child spends most of his time with me in the kindergarten and it is my duty to report any violent occurrence so that we do not lose him."

Student 5:
" I used to consider the topic a secondary issue that we should not give much importance especially if violence is used within a family to forbid improper behavior of children. The course clarified the issue for me and deepened my insight that a child can be abused by relatives who are supposed to provide him love and protection.."

Student 6:
"The course added a lot to my previous little knowledge of the topic. I personally do not tolerate a person who does not smile to a child how I can tolerate a person who hurts him. Children are God's love and should be treated tenderly. As an educator, I changed a lot during the course. […] As educators, we should also be updated with information on the subject. […] The phenomenon is spreading; thus, we should do our utmost to prevent it through intervention programs and social activities that enable us to notice changes in the behavior of the abused child."

Student 7:
"Before starting the course, I thought it would consist of theories like other courses on how to cope with violence. But the variation it included, the way the material was conveyed, the articles, the films and the discussions on the topic provided a lot of knowledge to my professional qualification. Today, I am able to recognize an abused child, know laws in the subject and ways to protect this child. "

Student 8:
"The learning experience accompanied with the unique teaching style of the lecturer made the course a different one. The lecturer used alternative teaching methods like dialogues, discussions and case studies. Each student had the opportunity to express her opinion freely. Although the films with real stories were hard to watch, I liked the way the lecturer discussed them with us and listened to our debate and conversations."

Student 9:
" I […] thought that today's parents and teachers do not use violent methods with children as they used to in the past. However, the course with the cases it presented increased my curiosity in the subject and in ways to deal with it as an educator. I have realized that every violent act is considered violence no matter how simple it is and that it has serious long term implications. […] I wonder why there are no centers for raising public awareness on the topic so that an abused child can be recognized by parents and teachers. I also came to realize that there are different types of violence and that it is not only physical. Yelling at and scorning of a child are also considered violence. Violence can be verbal and sexual. We also learned about laws for helpless people, what to do, who to turn to and what punishment one may get if he does not report a violent act he has witnessed. We also learned to be empathetic with children and how to approach them since a child can express abuse through various ways in his behavior, drawings, introversion and physical signs. I tried to change the way I talk with my kids at home, to hold discussions with them without using any violent acts. […] I include children but at the same time I set limits and is assertive in dealing with them. I encourage positive behavior, support children and remind them that they can always be better. Violence is not a method of education. Every person should take part in workshops on the subject so that he can raise a child in the right way."

Summary and Conclusions:

I accompanied my students in their journey to a new land they had never visited before. A new horizon has been opened for them to glance and perceive a new scope by not only relying on theories but through personal human experiences of mothers and teachers to be. My aim was to raise students' awareness, to stimulate their thoughts, to understand their feelings and to bring a change into their behaviors.

I support and call for interaction of experts and professionals in the field to decreases levels of violence against children as it has become an international annoying and critical problem. Finally, I truly believe that if we do not aspire to achieve a solution to the problem we may become part of it.

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Integration of the Audio-Visual Moylan Assessment of Progressive Aggression Tool (MAPAT) in a USA State Wide Training Program of Mental Health Workers

Paper

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Keywords: Training, Psychiatry, Violence, Nurses, Assault, Mental Health

Introduction/Background

Aggressive and violent behavior toward health care workers in psychiatric hospital settings is a long recognized occupational hazard with significant psychological, physical and economic costs (U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Hunter. Carmel 1992). Numerous professional publications highlight the problem and emphasize the need for formalized staff training (one of many clinical and occupational approaches) to reduce the risk of violence and the related rate and severity of staff injuries (Infantino and Musingo 1985; Lehman, Medilla and Clark1983, Carmel and Hunter 1990, American Psychiatric Association Task Force on Clinician Safety (Task Force Report 33, Beech and Leather 2006).

Training programs are widely used and options include private (e.g. Non-violent Crisis Intervention, Crisis Prevention Institute) and public sector developed (States of NY, CT, et al) programs. In the United States, staff that work in psychiatric hospital settings, where restraints and seclusion are used, must meet the training requirements set forth by regulatory and accrediting bodies [Center for Medicare/Medicaid Services CFR Part 482 (CMS), The Joint Commission (TJC)]. Hospital policies and state laws (e.g., Connecticut General Statute 814e, Sec 46-154) typically include training requirements. The requirements include who should be trained (direct care staff that work in settings where restraints and seclusion are used), at what intervals (orientation and subsequent periodic reviews) and what the content must include. Competence in the theoretical knowledge as well as physical skill knowledge are commonly used measures.

Training Content

The content of most training programs includes information on early identification of escalating behavior and therapeutic verbal and non-physical interventions to prevent dangerous behavior from escalating to violence; and should violence occur, physically restrictive interventions to ensure the immediate physical safety of the staff, others, and importantly, the patient. The physical interventions used are typically based on martial arts techniques. In addition to the training requirements identified by the regulatory and accrediting bodies, a number of professional publications representing healthcare organizations (e.g., American Psychiatric Association, American Psychiatric Nurses Association) advocacy organizations (e.g., National Alliance on Mental Illness) have published position papers on the use of restraint and seclusion. National government agencies (e.g.Substance Abuse and Mental Health Services Administration) and professional organization (e.g., National Association of Psychiatric Health Systems) have also played significant roles (over the past 13 years) in informing the content to include best practices (Learning from Each Other, Roadmap to Seclusion and Restraint Free Mental Health Services) for training in reducing the use of restraints and seclusion. While the safety of staff and others is addressed by these, the training requirements focus primarily on patient safety related to the use of restraints and seclusion. Content that is focused on reducing related staff injury rates and severity is not nationally regulated, however it also serves to inform training program content e.g., (OSHA: Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers – OSHA 3148-01R, 2004).

Over the past 30 years, much has changed and been learned about preventing and managing violence and the dangers of restraint and seclusion use. The widely published report "Deadly Restraints" (Weiss et al 1998) highlighted the dangers and played a significant role in educating the public about them. More effective psychotropic medications, therapies (e.g., Behavioral Therapies and Interventions) and a greater understanding of the effects of trauma have resulted in numerous evidence based practices to prevent and

manage violence. These, as well as advances in the risk assessment field as well as philosophical shifts (e.g., a greater focus on recovery, person centered treatment) have significantly changed clinical practice.

This paper/presentation will focus on a training effort by the United States, State of Connecticut's Department of Mental Health and Addiction Services (DMHAS) Using the Audio-Visual Moylan Assessment of Progressive Aggression Tool (MAPAT) to enhance its training design.

The United States, State of Connecticut's Department of Mental Health and Addiction Services (DMHAS) is the state agency (mandated by CT state law) that serves adults (18 years of age and older) with psychiatric and/or substance use disorders who lack the financial means to obtain these services. Approximately 2600 direct care staff provides services in both in-patient and out-patient settings at seven state operated facilities located throughout the state. These include psychiatrists, medical doctors, psychologists, nurses, social workers, therapists from various disciplines and assistants to the professional staff. Four of the facilities provide hospital level inpatient care and are staffed by approximately 1600 professional and paraprofessional mental health staff. In 1994, after eight years of using a private vendor company's training program to prevent and manage violent patient behavior, DMHAS hired two registered nurses to assess the safety and safety training needs of its employees. The assessment findings resulted in the recommendation 1) to develop a centralized Safety Education and Training Unit (established in the Office of the Commissioner, Division of Safety Services') and 2) to self develop a training program (Collaborative Safety Strategies Training Program- initially entitled the Behavioral Management Strategies Training Program). The establishment of the centralized Safety Education and Training Unit (SETU) ensured that training content and instruction were standardized as well as being cost efficient. The training assessment involved an extensive literature review; an assessment of several training programs available at that time and a statewide assessment of training needs.

The key assessment findings that led to the decision to self develop the training included the need for a greater focus on clinical prevention and management of violence, e.g.: risk assessment, special populations and cultural diversity, the need for content and skill training on the risks of restraint use and how to apply mechanical restraints and a greater focus on preventing and responding to violence when working in the outpatient and homecare settings. The Department's decision was based on the belief that its clinical and training resources could develop training that would have greater clinical content and would provide greater flexibility in making revisions in an efficient and cost effective manner. The benefits of self developed training have been largely realized in light of the many previously noted changes. The Safety Education and Training Unit is responsible for conducting Collaborative Safety Strategies Training for all newly hired and existing professional and paraprofessional direct care staff. Training for newly hired employees is conducted at a central location and annual review training is conducted on-site at the seven facilities. The CSS (Collaborative Safety Strategies) New Employee Training Program teaches direct care staff how to prevent and manage the risks associated with dangerous and/or violent patient behavior using a variety of therapeutic interventions and should they fail or be determined to be ineffective; how to intervene, including the use of physical and mechanical restraints or seclusion to protect the patient and others from harm and to reduce the rate and severity of injuries.

Training is provided in 3 formats:
- CSS New Employee 3 day training program (newly hired staff)
- CSS Annual In-patient Review five hour class (existing staff)
- CSS Annual Outpatient Review five hour class (existing staff)

The training meets the training requirements set forth by regulatory, licensing and accrediting bodies previously noted. More importantly, the content is grounded in the best clinical and safety training practices. Concepts that promote recovery, recognize the role of other factors (e.g. trauma) that contribute to violence, and a focus on prevention and the use of least restrictive interventions underlie the content.

The Collaborative Safety Strategies Annual Inpatient Review Training Program (CSS IR)

The CSS IR is taught to existing staff who work in four DMHAS in-patient settings. It consists of seven Modules that cover six overarching learning objectives. To successfully complete the course, staff must demonstrate knowledge by achieving a written test score of at least 80; actively participating in learning activities and accurately demonstrating the ability to perform physical skills as follows:

1. Create and maintain safe and therapeutic environments of care that are grounded in understanding the underlying causes of anger and related dangerous and violent behavior.
2. Use risk management strategies to prevent dangerous behavior from escalating to violence.

3. Use verbal and non verbal communication with co-workers and patients in non-emergency and emergency situations to reduce the risks to staff, patients and others who are associated with dangerous and violent behavior.
4. Use a variety of safety strategies in escalating and crisis situations to reduce the risk of physically, medically and emotionally traumatizing effects resulting from dangerous and violent behavior and the use of Restraint/Seclusion.
5. Correctly use all of the CSS physical techniques in emergency situations and should they fail to be executed correctly, take immediate corrective action to reduce the rate and severity of injuries to staff, patients and others.
6. Use mechanical restraints and seclusion per DMHAS Restraint and Seclusion Policy's and manufacturer's instructions to prevent use related physical injury or death.

The seven modules include:

Module One: Introduction and Overview
The objectives and completion requirements are reviewed. A contextual framework is provided that addresses workplace violence and national injury rates for staff as well as DMHAS data regarding the use of restraints and seclusion.

Module Two: Creating Safe and Therapeutic Environments
Staff learns how to create and maintain safe and therapeutic environments of care that are grounded in understanding the underlying causes of anger and related dangerous and violent behavior. Two integrated models for understanding violence: the Cycle of Dangerous Behavior and phases of a Crisis are reviewed. Staff learn that unmet needs typically trigger anger (pre-crisis phase) that can escalate (escalation phase) to dangerous and violent behavior (Crisis phase) that eventually subsides (post crisis phase). There is a focus on creating a culture of safety and the aspects of safety (Sanctuary as a Safety Culture) are discussed. Staff are encouraged to explore their interactional style for resolving conflicts and the role it plays in provoking or de-escalating violent behavior.

Module Three: Physical Techniques (Protective Skills)
Physical skills to protect against being grabbed (e.g., hair, wrists), strikes and chokes are taught using physical demonstration. Staff practices the skills and must provide an accurate return demonstration. A number of scenarios are practiced so that staff has the opportunity to dynamically use the skills.

Module Four: Risk Management
The hallmark of the CSS Annual Inpatient Review is its focus on risk management.
Staff learns how to identify the major clinical, situational and environmental risk factors that increase the risk for violence, with a focus on triggering situations and situational awareness. Risk and protective factors are addressed that serve to inform critical thinking and decision making to determine interventions that have the greatest potential to succeed. The DMHAS Policy and philosophy for preventing and managing dangerous behavior are reviewed.

Module Five: Strategies for Enhancing Safety and Interrupting the Cycle
The focus of this Module is on early intervention. Staff learns the key elements of non-emergency and emergency planning for patients at risk for violent behavior and that pre-planning is essential. They learn that the 3 W's (Sculli, Sine 2011) are an efficient and effective way to communicate in emerging behavioral emergencies. A number of verbal intervention skills are taught including using Conflict Resolution to resolve conflicts early; how to set limits effectively (recognizing that limit setting is often a trigger) and how to verbally de-escalate a patient who is escalating. They also learn that there are some patients for whom verbal interventions don't work and/or are contraindicated and less –not more- interpersonal stimulation may help. This is all taught within the context that diagnosis, age, developmental considerations, gender issues, ethnicity and history of trauma may affect the way a patient reacts to physical contact, thus early verbal and non-physical intervention is critical.

Module Six: Managing a Code involving the use of Restraints (Physical and Mechanical) and Seclusion
The focus of this module is on managing an emergency code using a variety of physically restrictive interventions (Escorts, Assists and Takedown) and seclusion along the continuum of least to most restrictive. Since most injuries occur during the process of containing violent behavior (Carmel & Hunter, 1989), there is a major focus on using the Team Approach during physical interventions and the roles of both the Team Leader and members in preventing the rate and severity of injuries. Restraint and seclusion application and discontinuation of mechanical restraints is practiced with a focus on their risks and how to manage them using the A-E assessment (Hollins, 2010).

Module Seven: Safety Strategies for Escalating and Crisis Situations
The focus of this module is on critical thinking and decision making skills in escalating and crisis situations to reduce the risk of physically, medically and emotionally traumatizing effects resulting from dangerous and violent behavior and the use of restraints and seclusion. Staff learns how to provide intensive care for the patient in restraints as well as for the staff who were involved in the crisis, and the importance of post crisis debriefing activities for staff, the involved patient and others who witnessed it, in order to reduce the associated medical, physical and emotional risks.

Training Design

Adult learning principles serve as the foundation for course design. The CSS IR design uses a mix of lecture, facilitated discussions, written and oral learning activities, overheads and physical skill training. In its early years, the CSS IR used role plays with the instructors playing the roles patients. Recommendations for training programs encourage a focus on core principles that can be applied to specific situations (Johnson, 2010). Case studies provide an excellent opportunity for staff to accomplish this. They provide the opportunity for staff to actively practice critical thinking and decision making skills in the classroom setting. In 2012, the CSS Annual Inpatient Review Training Program was revised. One of the revision goals was to increase learning opportunities to practice and master clinical risk assessment, critical thinking, and decision making skills. Over recent years, CSS had increasingly used simulated role play scenarios for this purpose. Simulated role plays were eliminated in 2011 as they were often met with resistance by employees that felt they were contrived. thus they were ineffective. Instead, case studies with a photo (retrieved from Clip Art) to depict the patient are now presented and followed by a facilitated discussion that involves active questioning about the case to provide the opportunity for staff to practice and master risk assessment, critical thinking and decision making skills. Classroom participation significantly increased following the visual depiction of the patient with staff commenting that it appeared more realistic. This led the SETU to explore making a video scenario and had the internal resources to accomplish it.

In March 2012, Sharon Ciarlo, as part of the literature review, read the article entitled, Frequency of assault and severity of injury of psychiatric nurses in relation to the nurses' decision to restrain (Moylan, Cullinan 2011) and learned of the Moylan Assessment of Progressive Aggression Tool (MAPAT). Permission to use the MAPAT in CSS Training was obtained. In September 2012, the MAPAT videotape was implemented into the Collaborative Safety Strategies Annual In-patient Review (CSS-IR) Training. Prior to implementation, the nine Safety Education Instructors conducting the training were trained in its use. The MAPAT is an instrument that has been in use for the purposes of training and evaluation in relation to decision making by psychiatric nurses in situations of patient aggression. It has also been used in research studies to identify nurses' decision to restrain aggressive patients and what factors or characteristics may influence the decision to restrain. The instrument was developed based on a thirty year literature review from the disciplines of psychology, medicine, nursing, law enforcement and governmental sources related to the trajectory of escalating aggression (Byrnes, 2003; Kay, Wolkenfeld, & Murrill, 1988; Lange, 1966; Metropolitan Nashville Police Department. 1999; Navis, 1987; Phillips & Nasr, 1983; Pisarcik, 1981; Silver & Yudofsky,1987; Yudofsky et al., 1986).These sources supported that the vast majority of aggressive behavior (but not all) follows a predictable pattern which includes behavioral and verbal indicators that occur during the various phases of the aggression cycle. This literature also discusses how individual characteristic such as psychosis, substance abuse, emotional instability, and impulsive behavior can trigger aggressive episodes. Additionally, situational and environmental factors were identified which contribute to aggression.

Based on this information, an audio-visual depiction of a patient demonstrating the cycle of escalating aggression was made using professional actors. It is a 5 minute sequence with a time elapse recorded at the bottom of the screen. The behavior of the patient follows the trajectory described by Maier (1996 as cited in Moylan, 2009) and reflecting the concepts of the sources previously cited: beginning restlessness→ tensing of small muscles and pacing→ increased pacing and fisting of fingers→ verbalizations increasingly pressured→ tensing of facial muscles→ increase in voice volume and large muscle tensing→ generalized verbal threats→ specific threats of violence with discrete act of violence against property→ violence against persons. beginning restlessness→ tensing of small muscles and pacing→ increased pacing and fisting of fingers→ verbalizations increasingly pressured→ tensing of facial muscles→ increase in voice volume and large muscle tensing→ generalized verbal threats→ specific threats of violence with discrete act of violence against property→ violence against persons.

After the film was made, it was then submitted to a panel of 10 nurse experts who held Master's degrees and were Nurse Practitioners or Clinical Nurse Specialists in Psychiatry/ Mental health with a minimum of ten years of clinical practice. All ten of the nurses confirmed that the situation shown on the video was realistic and congruent with the cycle and patterns of aggressive behavior that they had witnessed multiple times throughout their careers establishing content validity. Additionally, it was submitted to 20

psychiatric staff nurses who agreed that the instrument appeared to be an accurate and realistic depiction of aggression as it occurs in the course of their practice. This supported face validity in that the instrument appears to portray what it is meant to portray. Although face validity has only superficial importance, it "should be included in every test for validity" (Treece & Treece, 1986, p. 265). Test-retest reliability was then established by 24graduate psychiatric/mental health nurses who were asked to identify at what point in the progression of aggression the patient was an immediate danger to himself or others. Analysis using a Pearson Product-moment correlation resulted in an "r" of .89, giving strong support for reliability. The reliability was retested using 15 staff nurses and an "r" of .88 was obtained. The findings in relation to both of the test-retest studies are congruent with a level of reliability acceptable for use (Carmines & Geller). The MAPAT is currently in use in several European countries and has been translated into Dutch. Testing done in 2012 by statistical and clinical experts from Kings College in England have confirmed the validity and reliability of the MAPAT.

The MAPAT is used at the end of the CSS-IR Risk Assessment module. This module teaches staff how to assess the risks of danger with a focus on situational risk assessment. It is played in its entirety and is followed by a facilitated discussion with key questions that include:

1. Were there things that you noticed about the situation immediately – specifically,
   a. Was there anything about the patient that was of concern? The focus here is on specific patient behaviors.
   b. Was there anything about the environment that was of concern? The focus here is on situational awareness, e.g., access to exit, items that could be dangerous, the fact that she was alone with him in a confined space.
2. What is the triggering event?
3. Were there other things that triggered him after she arrived? What were they?
4. What information is missing that would help you more thoroughly assess the risks and analyze the situation? We direct them to consider patient and staff risk and protective factors.

Discussion

The use of videos in training is an effective teaching and learning tool for case studies. Unlike a written scenario, where staff can read at their own pace, or re-read information to ensure that they haven't missed key information, videos more accurately replicate real situations when not all information is thoroughly processed. The MAPAT is proving to be an excellent tool because of its accuracy in depicting a patient demonstrating the cycle of escalating aggression. It is used to help staff practice risk assessment, critical thinking and decision making skills. The facilitated discussion is focused on the clinical behavior of the patient; the situational and environmental risk factors, as well as at what points could/should the Nurse have intervened and what interventions should she have taken. After viewing the MAPAT, the inaccuracy in processing all the information becomes evident during the facilitated discussion. This provides an opportunity for staff to identify how their individual assumptions and attitudes as well as their knowledge level can impact their ability to understand and interpret the information and ultimately use sound clinical judgment to determine what interventions to take. It also reinforces the importance of communicating clinical observations with other staff and engaging them in critical thinking and decision making about the risk for violence. The discussion about the nurse's actions, or lack thereof, is lively and provides the opportunity to reinforce how her lack of response contributed to the assault. It invariably raises the question about whether or not she was assessing the situation or whether or not her skills for intervening were appropriate in response to the behavior. While it is easy for staff to make judgments about what they saw and express their opinion on whether or not they would respond as the nurse did, it contributes to thoughtful individual reflection. Finally, the use of the MAPAT and related facilitated discussion provides the opportunity for making and defending clinical decisions. The accuracy of the video in depicting the cycle of escalating aggression including violent behavior provides an excellent opportunity for staff to practice and master the skills needed to reduce both the use of restraints and seclusion and the rate and severity of staff injuries.

Future training plans for its use include building a case study to accompany it as well as expand its use in the CSS New Employee Training Program. A current research study by the authors to evaluate the effectiveness of the MAPAT is in its preliminary phase. Data related to assault and injury rates and frequency of restraint and seclusion use will be examined.

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Violence in the health care setting: Empowering nursing students through the use of de-escalation training

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Background

The public is inundated daily with reported incidents of violence in their neighborhoods, their cities and town and around the world, both of an individual and group nature. Living with violence as an element in our environment has become the norm (Rippon, 2000). Research indicates violence is not only the norm in our environment, it now is the norm in healthcare work settings impacting healthcare workers, patients and their significant others. In 2009, there were 2,050 assaults and violent acts reported by nurses requiring an average of four days away from work. Of these nonfatal assaults, 89% were injuries inflicted by patients or residents, and 4% were inflicted by visitors or people other than patients. The reported injuries for these nurses requiring days away from work were as follows: 25% were hit, kicked or beaten, 6% were squeezed, pinched or scratched, and 2% were bitten (BLS, 2011). When healthcare workers are compared to the general public, healthcare workers are at 16 times higher risk for work place violence incidents (Anderson, 2006). Between 2003 and 2009, eight registered nurses were fatally injured at work, four died from gunshot wounds and four from other causes (BLS, 2011). All eight of these nurses were working in private healthcare facilities, not state or government facilities. The U.S. Occupational Safety and Health Administration (OSHA) and the National Institute for Occupational Safety and Health (NIOSH) define workplace violence as "violent acts (including physical assaults and threats of assault) directed towards persons at work or on duty" (NIOSH, 1996). Following September 11, 2001, OSHA and NIOSH (2002) revised the definition to read "violent acts include assaults, and threats of assaults directed towards persons at work or on duty. This includes terrorism." More recently, the American Association of Occupational Health Nurses (AAOHN) in collaboration with the Federal Bureau of Investigation (FBI) defined workplace violence as "any action that may threaten the safety of an employee, impact the employee's physical or psychological well-being , or cause damage to company property" (AAOHN, 2003). With this broader definition of workplace violence, the Bureau of Labor and Statistics reports (BLS, 2002) that healthcare workers lead the way with 45% of nonfatal injuries from violent acts against workers occurred in the healthcare environment.

In addition, lateral violence and bullying have been identified as two types of disruptive behaviors present in the work setting. Lateral violence in the healthcare setting is defined as nurse-to-nurse aggression. These behaviors may include backstabbing, verbal abuse, sabotage and withholding information. Bullying in the healthcare setting is defined as "insulting or malicious behavior or abuse of power causing an individual to feel threatened, humiliated or intimidated, causing the person to feel stressed and contributing to the loss of self-confidence" (Center for American Nurses, retrieved July 9, 2012). There are many reports of both the occurrence of lateral violence and bullying and the negative impact of these behaviors on patient outcomes, healthcare personnel and employers.

Nurses are the most common victims of workplace violence due to the high numbers of nurses on the frontlines of healthcare provision (Smith-Pittman & McCoy, 1999). Other workers vulnerable to workplace violence in the healthcare setting include therapists, independent practitioners, security guards, community mental health technicians, physician assistants and nurses' aides. Perpetrators of workplace violence are most commonly male and patients (Rosentha et al Rosenthal & Ackerman, 1992). Physicians may also be perpetrators (Manderino & Berkey, 1997), but threats of harm and actual physical assault by physicians appear uncommon. Nurses most commonly abuse other nurses (Anderson, 2002a, 2002b; Center for American Nurses, retrieved July 9, 2012).

The cause of workplace violence is neither simple nor one-dimensional. It is recognized that healthcare workers function under high levels of stress. Whether in hospitals, clinics or home environments, there are co-workers, patients, patient family members, visitors or intruders potentially contributing to violent

events in the healthcare environment. Other factors include the increased incidence of drug and alcohol use, weapons, poor coping skills, long wait times, unrealistic expectations of healthcare providers by patients and families, and compromised cognitive and social functioning skills of patients due to psychological changes such as dementia and psychosis. Other factors potentially impacting the increasing incidence of workplace violence include organizational structure deficits, omissions or limitations in the areas of policies, procedures, management and staffing. In combination, all of the above factors make detection and prevention difficult. Additionally, the links between stress, conflict and violence are known. However, organizations rarely prepare healthcare workers to recognize, prevent or manage potentially violent events. A comprehensive and multifaceted approach to workplace violence in the healthcare setting is essential. No plan to address workplace violence will be effective unless professional organizations, healthcare facilities and personnel along with communities support these efforts. Not only must healthcare organizations and facilities provide the means to create and maintain safe work environments for the provision of healthcare, healthcare personnel must also be able to recognize, prevent and/ or safely manage these events to decrease the effects of violence (Center for American Nurses, retrieved July 9, 2012). Therefore, it is proposed that nursing education must contribute to the creation of safe workplace environments by preparing future nurses to recognize, prevent and/ or manage violence in the workplace.

Throughout history, nurses have perceived violence as integral to the provision of healthcare to the acutely ill inpatient psychiatric patient (Cowman & Bowers, 2008). Many of these incidents were the result of patients being acutely ill and psychotic. However, education of direct care personnel in these settings in the assessment, prevention and management of violent events has been in existence for many years resulting in reductions of patient and staff injuries associated with workplace violence. Current standard practice requires all staff to receive training in de-escalation techniques and management of the violent person. However, this training has not consistently extended into other healthcare settings. Training and education are major elements in an effective organizational safety and security program.

Research on the need for and implementation of training programs to reduce workplace violence indicates an uneven and non-uniform implementation strategy. Anderson (2006) reports the implementation of an online training program on workplace violence as a means of addressing workplace violence for health workers at a small community hospital. The study implemented a three hour training program aimed at decreasing the incidents of violence with no significant differences. However, the need for training of personnel to address workplace violence is identified. Other research found de-escalation training improved nurses level of confidence (p=.007) in managing an aggressive or violent patient when compared to untrained nurses (Cahill, 2008). Nurses' communication skills were the core of the training program with emergency department nurses. However, no significant difference was found for changes in attitudes towards managing the aggressive or violent patient associated with training. The need for a zero tolerance policy for violence in the healthcare workplace is a common theme for writers. Gallant-Roman (2008) identified the necessary components provided to healthcare workers to identify, prevent and manage violence in the workplace. These include the empowerment of nurses to recognize and not accept violence as part of their professional practice. Clements et al (2005) speak to the need for corporate policy in the implementation of zero tolerance workplaces. However, the authors are focused on the effects of violence and the needed intervention post violent incident. The Journal of Hospital Home Health editorial (January, 2010) reiterates the need for organizational support and intervention through the use of policies and education and training with staff to create a "safe" work environment. Words alone will not create this environment, but action is needed by healthcare organizations to create a safe work environment. An approach of zero tolerance to violence by patients in the healthcare setting in Britain served to identify the need for an organized method of managing the violent clinic patient (Paniagua et al , 2009). Because of the implementation of zero tolerance, the identified violent patients were assigned to a separate clinic. The reported model of care is subject to the bias, abuse and miscommunication by staff as to whether the patient is perceived as a "victim" as when their behavior is a result of their health state or a "problem" when their behavior results in the inability of the provider to deliver care or violates the rights of others. For those providers in the clinic for violent patients, all staff is provided de-escalation training. The authors stress the need to better address the cause of violence as well as better prepared staff to identify and manage aggression and violence in the healthcare setting. Workplace violence has been found to include nursing students (Magnavita & Heponiemi, 2011). This study, though limited to Italy, described violent incidents experienced by student nurses and the negative impact of the experiences. Nurses reported more physical assaults and sexual harassment primarily from patients and patient's family. Nursing students reported higher incidents of verbal and physical assault from colleagues, staff, teachers, physicians and supervisors. The authors conclude that the relationship between workplace verbal violence and high levels of psychological problems, low perceived organizational justice, high job strain and low social support was stronger and more significant in nursing students when compared to nurses. The authors propose that along with organizational changes such as policies, improved staffing and non-tolerance of aggression or

violence, staff training to create and maintain a safe workplace is the best method to decrease incidents of workplace violence.

Method

Seventy eight traditional BSN students enrolled in the psychiatric mental health nursing course were provided a one day, six hour de-escalation training program by certified training staff employed at the local state mental health hospital. IRB approval was received and informed consent was provided by students participating in the training program. The evaluations (n=76) were anonymous and did not affect the student's grade or performance in the course. The didactic content included therapeutic communication techniques, stress and its effects, taking care of oneself, assessment of risk for violence, verbal de-escalation techniques and physical interventions. At the start of each session, a hardcopy of the slide show was provided to each student. The four hour didactic class time was followed by two hours of rehearsal or simulation with intervention techniques learned. No student refused to participate in the simulations. At the end of the class time, students were asked to participate in an evaluation of the de-escalation training session. The evaluation tool consisted of six open ended statements for students to complete. These statements were in the areas of identification of learning, the impact of their learning on their clinical practice, what made the learning effective and any further comments.

Results

Overall, the feedback from students was very positive. Participants found the presentation helpful, important, interactive and fun. One comment stated, "I really enjoyed and benefitted from this." Participants noted that the techniques taught in the presentation were very helpful to their practice, day-to-day encounters and also reported seeing the value in this training to go beyond the workplace. One participant commented "[De-escalation training] offers real life strategies that can be useful outside of the work environment." Participants reported learning new conflict management skills that would inform their practice going forward. Three themes emerged from the data. The first theme that emerged was the sense of empowerment. This theme emerged over and over across questions with statements such as "I am not a victim," and "I am more confident in dealing with conflict situations." Participants noted feeling more aware and more prepared to recognize and handle conflict. Second, participants reported learning new defensive techniques that will help them deal with conflict in a safe and effective manner that facilitates teamwork and protects both the patient as well as the caregiver (staff). Third, participants reported having learned new communication techniques that will help them keep and remain calm when dealing with conflict. Several terms were used including, "redirect," " neutralize," and "interact" to indicate a better understanding of how the two techniques (defensive and communication) can be used together to diffuse or address a conflict situation.

Discussion

With ever increasing incidents of workplace violence, it is critical that healthcare providers be prepared and able to manage the aggressive or violent situation or person. The healthcare organization intervenes through the development and implementation of "safe workplace" policies and procedures. Providers must be able to recognize, prevent and manage these risky situations and people with effective evidence-based strategies. The novice nurse entering the workforce can contribute to the creation and maintenance of a safe workplace by being knowledgeable and prepared. The experience of de-escalation training was perceived by nursing students as creating a sense of empowerment plus knowledge to better manage workplace violence in healthcare settings. The transfer of this perception to the utilization of these new skills and abilities in the workplace needs further research.

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"When experienced psychiatric nurses handle high risk of violence" – An elucidation of experienced psychiatric nurses' experience of nursing in dealing with a high risk of violence

Paper

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"When experienced psychiatric nurses handle high risk of violence" – An elucidation of experienced psychiatric nurses' experience of nursing in dealing with a high risk of violence.

Background

In Norway forensic psychiatry includes the use of milieu therapy and nurses have to be a guard and helper at the same time in practicing interdisciplinary milieu therapy.

Aim: To obtain detailed knowledge about interventions that can prevent violent outcomes in order to limit the need for the use of any coercive measures in the regional security departments, from experienced psychiatric nurses' perspectives. The following question is posed: What do nurses describe as important coping methods in dealing with patients where violence risk is considered high.

Litterature review

The primary grounding is taken from Peplau, Travelbee and Vatne. Research from closed psychiatric wards with violence and use of restraint is presented and used in this study.

Method

The study was conducted in three regional security wards in Norway using a qualitative design, with individual interviews of nine psychiatric nurses. They have an average of 12.8 years of experience in regional security wards. Data wereanalyzed based on Kvale's descriptions.

Results

Three key themes related to violence prevention interventions were identified 1) the environment's importance of the physical safety and structural arrangements must be good enough, and adapted to specific requirements. 2) The nurses' experience in facing a high risk describes the nurses' experiences of stress and challenges that they have experienced when they handled this risk, where the possibility of even being attacked themselves have been present. 3) Cooperation with colleagues has a central role in helping nurses deal with violence risk with minimal use of restraint.4) The interaction between nurses and patients is the fourth issue, and must be understood in the light of the surroundings, the experience and cooperation inside the nursing group.

Conclusion

To practice psychiatric nursing in an environmentally therapeutic form at the Regional psychiatric security wards, the nurses compensate for a high degree of control and using the guarding role. It requires interaction with a competent staff group. Individuals' inner confidence and personnel expectations are necessary. The nurses then create a safe environment for early intervention, and provide a protective effect that reduces coercion. Future challenges seem to be securing the staff, so that they dare to be with patients even when they are aggressive. Safety must be ensured by strategies that make staff staylongerin departments to achieve satisfactory experience, because experience provides safe and calm environment. The experience of a safe unit will secure respect and equality between staff and patients.

Educational Goals

Building and Keeping the expertise in the milieu-terapeutic staff.

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Change the patient or change the team? – Using Non-Violent Resistance (NVR) to change a team and decrease violence in inpatient settings

Workshop

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Abstract

Background
To successfully decrease violence in an inpatient setting a whole team change of vision is required. Training a team in NVR can decrease violence and promote interdisciplinary cohesion.

Aims of the Workshop
To explain the principles of NVR; Interactive experience of NVR through use of video training material.

Background

NVR is an active technique which views violence as an interaction. It is an illusion to think that we can control the behaviour of others, but we do have control over our own actions and behaviour. Control and restraint techniques do not decrease violence. Ignoring violence also does not work. However, teams can often become stuck in trying to maintain control – developing long lists of rules, for example or feeling helpless – not seeing an alternative to their own behaviour. The end result is a ward climate where small incidents can quickly escalate into aggressive ones requiring the use of seclusion or other control and restraint measures.

NVR helps teams adapt a new attitude focused on de-escalation. The power lies in deciding when to respond to a situation. Delaying a reaction does not mean ignoring unacceptable or dangerous behaviour but making a choice about when the best time to intervene is. Often in an inpatient setting the experience of the patient is a long list of rules, usually not written down, which change between staff members. The result is confusion and a collection of individuals working in the same setting though not necessarily as a team. NVR helps promote team cohesion through developing a whole team vision.

NVR is originally a method of socio-political conflict. In the last century major proponents include Gandhi and Martin Luther King. NVR was adapted by Haim Omer (1994) in Israel for use in family situations to help parents manage aggressive children. We have adapted these techniques for use in a ward setting. To use NVR successfully requires a major change in the team vision. It is important the whole team shares this vision – nurses, psychiatrist and other staff. NVR combines a clear way of interacting with a patient with specific interventions. The key principles of NVR are: 1) A team must take a stand against unacceptable behaviour; 2) preventing aggression is only possible when staff recognize their own role in escalation processes; 3) it is an illusion to think you can control other people; 4) Staff and parents need to resist unacceptable behaviour together, 5) Staff and patients need to work together, 6) respect for patients is crucial, NVR is a stand against aggressive behaviour, not the client showing aggressive behaviour; 7) NVR means to persevere; 8) NVR is a battle, but a non-violent one.

These beliefs are the basis for a NVR attitude, and the use of NVR communication and practical tools available for staff. NVR attitude and –communication include: non-verbal and verbal communication skills (looking at how we communicate and how this can lead to escalation of aggression), delayed response (strike when the iron is cold) to decrease the chance of escalation and reducing the amount of rules. Examples of the NVR tools are: (1) Reparation Act, working with a patient to repair the damage that has been done. (2) Announcement, a formal letter that informs patients about the staff' expectations, their will to resist particular behaviour and the teams plan to ask help from for example relatives. (3) Silent Message Sending (SMS) staff members enter a patient's room for fifteen minutes and ask the patient to come up with a solution, whereupon they will wait silently for a response. The SMS is always preceded by an Announcement.

NVR has been successful in decreasing the use of seclusion by over 50%, without an increase in aggression on the ward or increased use of other measure e.g. medication.

Workshop

The interactive workshop uses DVD material developed te help train teams in the principles of NVR. Through use of the DVD participants can learn about the principles and also about how to use the approach in clinical settings.

Conclusions

NVR brings about change in a team and decreases violence. In our ward settings violent incidents have decreased by 50%. Whilst currently being used in the child and adolescent psychiatric setting the principles are also applicable to adult psychiatric settings.

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The Experiences with Nurses Trainings Concerning Prevention of Violence in the Czech Republic in years 2010 – 2013

Paper

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Keywords: Violence, research, Czech Republic, communication, training, prevention.

Introduction

The Czech Republic (CR) has a problem with violence in the health care sector. CR lacks the support of government agencies, employers and research on the issue. Gradually, however, efforts are beginning to emerge, aiming to minimize violence in health care. In the CR, there were several project to minimise violence in health care. The experiences from projects point to deficiencies in staff training. It is important to educate empolyees and try to minimise violence in health care. The aim of this paper is to analyse the results from the implemented projects and training. The author wrote his dissertation work on this topic. He is a medical employee and communication lecturer. He prepares improvements for staff members in health care and their patiens in the CR on the basis of an analysis and comparison of the relevant projects.

Main paper

The research on violence is mostly focused on psychiatry hospitals and ICU's and these data are transferred to non-psychiatry wards automatically (general wards, non-intensive wards). Likewise, the preventive and strategic arrangements are transferred from the ICU and psychiatry wards to the general wards and non-intensive wards. But the general wards are specific in a different way. (1) The violence seen most often in the general wards is based on escalated negative emotions which get out of control. This type of violent behavior may be de-escalated by proper communication and specific approaches. The health care workers in the Czech Republic are not sufficiently trained and skilled in such approaches. This is due to the fact that the education in schools is not sufficient. (2) In the CR, there were three projects (2010 – 2013) for education and prevention of violence in the heatlth care area. The paper describes the results and experience from the communication training from these projects.

Methodology

1) Surveys in the Czech republic
2004 - 2010
In 2004, research was organised jointly by the Ministry of Health and Institute of Health Policy and Economics (IHPE). The research was to determine any facts concerning violence in the Czech health care system. The research was planned to continue to the year 2009, but the IHPE was closed down, and so the research took place for only two years. During those two years, an empirical quantitative study was carried out among 675 employees in the health care sector in the CR. (3) The study found out that violence in the healthcare system in the CR is a serious problem. Forty-twopercent of staff reported experience of verbal violence and 13 % had experience of physical violence. The incidence of physical violence was the highest hen compared with other countries (Thailand, Bulgaria, Brasil, Libanon, Portugal). The study obtained qualitative interview data from patients who fell victims of violence to the medical staff. E.g. patients who were coming for operations were attacked by medical staff via verbal violence (non-professional communication, arrogant behavior). (4) This fact was confirmed by means of another qualitative study in the 2006 which was aimed at violence in the emergency medical services in CR. Interviews were conducted with managers of emergency medical services in the CR. It was found thatthat verbal aggression is present in every third intervention; physical violence is present in 13 % of all interventions; and 15 % of violent incidents were due to the behavior of the staff of emergency medical services in the CR (when the staff provoke potentional aggressors to attack due to non-professional communication). (5) Within the above-mentioned time, no other studies about violence in the health care system in the CR were carried out. Unfortunatelly, these research undertakings failed to contain valid data and the numbers of respondents were too few.

We can determine general points in research from the years 2004 – 2010:

- violence is a serious problem in the healthcare system in the CR
- verbal violence prevails over physical violence
- absence of both central and local data on violence in health care
- the last surveys included few respondents
- violent incidents are partly caused by medical staff via their non-professional behaviour
- an absence of education in schools

2010 - 2013

The Czech-Moravian Confederation of Trade Unions started a project called Prevention of Violence in Health and Social Systems in the CR in 2010. It was a quantitative study covering 1500 empoyees. The study found that violence in the workplace was experienced by 31 % of employees (health and social system) in the past year. Physical violence was reported in 17 % of cases and psychical violence was admitted in 41 % (mobbing, sexual harrasment, bossing and racial harrasment). The numbers of violent verbal attacks was similar to the numbers of violence attacks shown in the projects in the year 2004. The incidence of physical violence was even higher. The changes were due to the approach of the management of hospitals and social areas – 60 % managers adopted the measures against the occurrence of violence at their premises (measures associated with the safety and occupational health screening and patient). Unfortunatelly, there were remained deficiencies in the work environment, human resources development, increasing staff numbers, or staff training in communication skills. Even though 6 years had passed from a similar project, the main problems remained the same: overworked staff, non-professional communication and lack of awareness. (6) Unlike in the first project in 2004, medical staff weren't educated practically. Generally, 1004 staff, so-called key people for violence in the health care, were educated. Every person was educated during five days: one day in the management of violence, two days in communication, and two days in the physical self-defence. In this project, an idea to create 14 violence prevention teams who should try to minimize violence in individual regions was deevloped. Unfortunatelly this activity currently works in only one region (Plzeň). As time went on, it was found that the education in this project was not effective. The selection of so-called key people did not have any criteria and the five educating days were not effective because many of the 1004 persons didn't understand the knowledge gained. The lecturers weren't experts. The lecturers were staff from a diferent workplace and department, minimum of them worked in the immediate contact with patients. Some education days were aimed to prevent violence a lot but some education days weren't aimed at violence at all. Despite the criticism, this project offered communication training for health care professionals throughout the country.. Most of the courses were unfortunatelly one-off, and if they are not repeated, the knowledge and training aren't beneficial for practice. In the years 2011 – 2013, another big educational project for medical staff in CR was conducted The organizer of the project was The Ministery of Health plus Aesculap Academy. The project was unique in its practical aproach. It was the only education project without quantitative research, but a great emphasis was placed on the quality and experience of the lecturers. One of the topics of education was the safety of staff members in the health care area. In total, 1948 staff members in health care were educated in 26 seminars and 9 conferences. In this project, a miniproject was included. 550 nurses from the hospital in the town of Jihlava were educated in the aproach and communication with aggressive patients or their relatives. (7) Currently, a reflexive survey is under way in order to find out whether or not the methods used for education of the above-mentioned 550 nurses were effective. The results will be part of the presentation in the congress in Ghent.

The development of violence prevention in the Czech Republic in the year 2010 – 2013 (based on the projects):
- The researchers are focused on a greater number of respondents
- The frequency of violent incidents stays the same
- Medical staff are not professional enough in communication
- Conferences and seminars are more focused on professionalism in communication
- There are more requirements for the quality of lecturers
- There is no existing general system of monitoring of violent incidents, the medical staff aren't motivated to report any possible incidents
- There is no relevant education at schools
- There is no continuous repetition of the knowledge and skills gained

2) The planned research

Currently, a minor project is running in CR which is focussed on Prague. Prague wasn't included in previous projects. The project is targeted at third party violence (TPV) (medical staff, patients and relations). The main coordinator of project is the Trade Union, and the project takes place with considerable support from Norway. The main aim of this project is to train 200 medical staff. These people should be educated to become lecturers and educate other people after the project has ended. The project should take place without deficiencies shown in previously projects. The project created a five member team of experts – a psychologist with experience in TPV, a lecturer in communication and researcher TPV in CR, a lecturer of selfdefence, and the trade union representatives. The psychogist and an expert in TPV are supervising the preparation of

training for 200 medical staff. The project started in September 2013 and will end in May 2014. The training will be organised aroundinteractive seminars. These seminars will prepare medical staff for managing violence incidents in future. The aim of the project is to train 200 medical staff who should be well-orientated to the problemof TPV and they should help to deal with violence incidents at their workplace.

Medical staff in the project will be trained during five days:
- Three days - communication – verbal selfdefence, viktimology, analysis of TPV incidents
- One day - management of TPV
- One day - physical selfdefence – defensive approach, light techniques

The preparation for this project have revealed several shortcomings that exist in the TPV in the Czech Republic:
- deficiency of experts and explorers in this field
- absence of an institution for TPV
- ignorance of procedures for dealing with TPV in departments
- low level of national monitoring of TPV
- measures for TPV are often only temporary

Another great benefit should be dissertation work on this topic. Since 2004, violence in health care in the CR occurs only in the context of short studies or final reports of the projects. Most of the reports is only for information purposes - the number of attacks and forms of attacks. The studies lack a detailed study of attacks, missing test cases and ways to solve them. There is an absence of reflexion about training days for TPV, many of them have a design such as a one day course. A major drawback is the establishment of a center for the capture of violent incidents - their subsequent analysis by experts and drawing of conclusions. These shortcomings will bet he focus of dissertations, which aim to create a manual for the management violence in the health sector in the CR. Based on the analysis of the foreign literature and practical experience of relevant experts, recommended procedures will be produced to monitor and minimize the problem. Also, we will develop effective research and how createeffective education for medicall staff aroud tis problem. We try currently to create a system for monitoring violence incidents in the Czech Republic. This is the focal point for our studie sof violence. We can then present examples from this system and propose solutions for preventing and managing violence.

Conclusion

Violence in the Czech republic is a serious problem. There aremany situations of non-professional behaviour on the part of medical In the Czech Republic there is an absence of effective education in approaches to aggressive patients and their relations. Professional staff lack a professional approach, management avoid solving violent situations, and the examples from other countries are rarely followed. The projects offered brought forward temporary solutions only and serve as a plaster on the wound rather than a cure. Research over the past 20 years has shown thepositive contribution of education and communication skills training for health professionals. The courses have measurable impact and nurses themselves considered them as beneficial. Acquired behavioural skills increase the patient's satisfaction with how the patients learn and understand health care. Any form of repression does not provide qualitative and expected changes, the only possible way to cope with violence is to seek practical training in communication with patients and colleagues. An essential part of such training must, however, provide feedback, medical personnel must be aware of how to "see" the patient.

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Using milieu therapy in a forensic psychiatric unit, experience and challenges

Poster

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Abstract

The Poster will present the conclusion from several small studies at a Regional Security Ward at Oslo University Hospital(RSA, Oslo).

Milieu therapy is an essential part of the therapy. The relationship between the patients and the staff should be characterised by helping more than controlling. This is a continuing challenge. The education of the staff, making them consider more therapeutic alternatives with less coercive measures is an important challenge too.

The poster will also present numbers and statistics from 2012.

The study is not finished yet, but I hope it will be possible to present more details later.

Educational Goals

Early interventions reduce use of mechanical retraint. Building daily relationships throughmilieu therapymakes it possible.

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Reducing aggression on a psychiatric unit through interdisciplinary staff education

Poster

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Background

Educating staff how to be sensitive to the nuances, shifting behaviors and moods of patients, and to be able to de-escalate in the very early stages violent behavior on a psychiatric unit.

Aims

There are many variables that influence how staff act, react and interact with the violent behavior that some psychiatric patients exhibit. There are also many reasons why the patients react and behave in a violent manner. The aim is to find methods to reduce the aggression and violent behavior of patients on a psychiatric unit, because aggression has a negative effect on patients and staff . By using different approaches to this serious problem, it is envisioned that a more positive outcome will ensue for everyone concerned.

Methods

The interdisciplinary staff needs to assess the patients behavior constantly and ensure that the patients are medicated accordingly. However, the most important approach to individuals with mental illness, who sometimes exhibit violent behavior, is through humane and compassionate treatment. Staff need to be educated on communication skills such as active and accurate listening to the patient. Staying in the 'now', the present moment while listening. Listening for facts and feelings. Staff should not jump to conclusions, not be authoritarian, nor be influenced by earlier reports from other staff members. Staff should offer alternative solutions to problems that patients may have. Being empathetic, and not showing fear of patient interaction decreases violent behavior.

Results

Statistical data will be gathered prior to educating the staff , and then after the methods have been implemented. Staff will demonstrate an attitude of respectful engagement with the patients. The key findings will indicate that there will be a significant decrease in the number of violent and aggressive outbursts by the patients on the unit due to the humane approach by the staff.

Conclusion

Violence on a psychiatric unit is a very traumatic experience both for the patients and the interdisciplinary staff. Violence can precipitate due to hostile and fearful stimulation between patients and staff. Being able to diffuse the violent behavior or respond to them more effectively, is the responsibility of the staff. They can accomplish this by being trained to be active listeners and not judgmental, and to have empathy and compassion for the violent patients.

Educational Goals

1. Educating staff to be compassionate and empathetic towards psychiatric patients.
2. Staff will be taught how to be active listeners and stay in the present with their patients.

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Implementation of violence risk assessment tool in clinical settings – experiences and observations

Poster

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Background

Despite the fast accumulation of research evidence favouring the use of structured violence risk assessment tools in clinical settings, the routine clinical use of these tools is still uncommon. As the implementation process of these tools seems not to be trouble-free, the implementation process needs to be further studied and discussed.

Aims

The aim of this study is to describe personnel's experiences on Dynamic Appraisal of Situational Aggression (DASA) after two months of daily clinical use and the concerns presented by personnel during DASA training sessions.

Methods

Six themed individual interviews were performed on one psychiatric admission ward, which had used DASA for two months. Interviews were analyzed using inductive content analysis. The concerns presented by personnel were collected from five training sessions that were kept separately for personnel of five different acute or forensic psychiatric wards. Data from training sessions was collected during fall/winter 2012; the individual interviews were conducted in February 2013.

Results

Data analysis is in process. The results of this study will be presented in congress.

Educational Goals

1. Issues that might prevent the implementation of clinical violence risk tools are presented
2. A successful adaptation process is presented

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Doing What We Know When We Know It: Translating Research into Practice

Workshop

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Keywords: Workplace Violence, translational science

The Problem

The gap between research and practice is estimated to be 17 years (Targonski, 2010). The effect of that gap is seen in the fact that workplace violence (WPV) has decreased in all work sectors in the US other than health care. (Janocha & Smith, 2010). Research into (WPV has been ongoing for over 20 years, yet the gap between what we know and what we do increases, as do the rates of WPV in the healthcare sector. This is despite years of conferences, articles, and initiatives. There have been over 400 articles published on workplace violence in the last 20 years, but by any measure the study of the topic has not increased the safety of people in the aggregate. Whilst there are indicators of success in individual organizations, the generalization of research into broad practice has not occurred.

The issue is not one of knowledge, it is one of translating knowledge into action. Unfortunately, the knowledge gained by psychiatrists is written in psychiatric English (or German or French or Arabic, etc.), while the knowledge gained by social workers is in social work English, etc. Each professional discipline has its' own way of discussing and discerning the issues at hand, resulting in a tower of Babel effect (Michalski & Privitera, 2011) Translating research into practice will require a level of professional cross-disciplinary cooperation heretofore seldom seen.

Successful researchers must master a language based on epidemiology, biostatistics, and a frame of reference that is vastly different from that of practitioners. (Jain, 2012) Practitioners in human services focus on the immediate needs of the individual and how to increase their safety. A research orientation studies those needs, often in settings that bear little resemblance to the real lives of people. Translating research into practice requires not only translating the language, but also the context in which behaviours occur.

Translational science refers to a highly collaborative process of the translation of basic research findings more rapidly and efficiently into practice. It is multidisciplinary by nature. Translational models in WPV then, would help translate a wealth of basic research in WPV in ways that would be more understandable and thereby more usable across a broad array of disciplines and professionals. The goal would be to help multiple disciplines and professions converge on common understandings in the complexity of violence and its causes, and eliminate the procedural and jargon differences that interfere with effective solutions.

Complicating the efforts of Translational Science are the many competing definitions and theories of WPV and its components. Even those who work or do research in the field struggle to understand the numerous issues. WPV, such as threats, assaults and homicide (macro-violence), may be low in number when considering a typical workday's events, but they have high impact on individuals and the healthcare system when they occur. Lower level violence (micro-violence), such as workplace incivility (WPI), unreasonable expectations, offensive actions or words, or the lack of action or words need to be better understood as possible antecedents of macro violence.

Violence from patients, visitors and family, staff styles of interaction as well as organizational contributions to violence (Bowie 2011) are often socially and politically delicate to discuss. This may be due to numerous competing interests, vantage points and agendas involved (Tabone et al, 2011). Staff may fear they will be blamed and lose their job and tend to under-report incidents. The risks they pose are real to staff, to other consumers, and sometimes to themselves.

The Context

The below graphic represents the experience of WPV and WPI in a human service context. The center circle must be understood to be bisected between individuals served and the staff providing those services, with

a further delineation of individual needs, trauma history, personal strengths and needs, etc. Organizational responses to the concerns have focused on managing the risk posed by people. However, the management of risk does not equate to an increase of safety. Again, if it did, there would have been a decrease, not an increase, in the number of injuries to workers in the health care sector.

WPV takes place, of course, in the workplace. The intra-personal, inter-personal, and organisational contexts of behaviour (Bowen et al, 2012) interact with each other to produce the context in which all behaviours occur. The set of behaviours called WPV are no different. Understanding this context gives us the ability to address not just the behaviour, but the various antecedents of the behaviours of WPV in order to create a meaningful and lasting solution.

The Answer

Translating research into practice requires the following:
A. Active leadership, not just passive support of leadership. Translating research into practice requires sustained change efforts over time.
B. A transdisciplinary (Direnfield, 2011, Bowen, 2011) rather than an interdisciplinary approach to services. Clinical leadership and administrative leadership must not only work together, but demonstrate and role model how to transcend the boundaries that are present in the health care sector
C. Affirmation of each discipline's approach to human behaviour. This affirmation does not necessarily equate to agreement, but does create the cultural context in which communication across traditional boundaries can occur.
D. Common definitions of target behaviours. Without a common definition, it is impossible to collect data.
E. An orientation to manage safety, not risk. When we focus on managing safety, we often lose sight of the opportunities that may be present. (Bowen et al, 2012)
F. Supporting direct support professionals as they translate research into practice.

Active Leadership

Leadership has been identified by many authors as critical to the reduction of restraint and seclusion in the health care sector. (Huckshorn, LeBel &Gold) This leadership must be able to transcend the transition between leaders. In 2011, a paper was presented in Prague (Vanderberg & Bowen, 2011) highlighting the lowered restraint rates and injuries among staff in a forensic treatment facility. Also lowered were rates of complaints from patients. Today, that same facility has significantly higher rates of restraint, as well as rates of injury to staff.

What changed was leadership in all of the departments of the organisation. This same process whereby progress is reversed is seen in many different settings. [Note: In the workshop there will be an activity to do here]

When leadership transitions, there must be a plan in place to transition the gains that were made. Accountability and support structures must become part of the Safety Management protocols of the organisation in order to facilitate continued growth in this area. The laws of entropy in physics also apply to human services in the opinion of the author. The natural state of human relationships is not positive and healthy, but rather destructive and sick. Studies by Bandura (1965) and Latham (2000) show that the rate of positive to negative behaviors is 1:6. Without sustained attention by leadership, success will turn to failure and the natural order of things will re-establish itself.

Transdisciplinary Teamwork

The four models of teamwork (Direnfield, 2009) range from unidisciplinary (I will do it myself) to transdisciplinary (let's share everything we know). In the face of complex problems that have proven to be resistant to traditional change efforts, a transdisciplinary approach is called for. (Hadorn & Hadorn, 2008). It is not natural for professional to trust each other, and this lack of trust is seen in the rates of horizontal violence in organisations

A transdisciplinary approach takes time, and is of greatest value when there is a high level of uncertainty regarding the behaviours of the individual, and when there is conflict between professionals regarding the etiology of the behaviour. There have been countless meetings in which I have listened to professionals argue if a behaviour was due to autism, or early childhood schizophrenia, etc. Hadorn & Hadorn go on to say that a "transdisciplinary approach to research can grasp complex systems issues, take into account diversity, link abstract and case or client specific knowledge, and develop knowledge and practices that promote the common good."

In human services, the common good is safety: emotional, psychological, and physical. (Bowen et al, 2011). Direnfield's model above recognizes that a transdisciplinary approach to the development of behaviour plans, treatment plans, etc. are better able to meet the complex needs of the individual, caregivers, family members, and the needs of society in this complex system we know as "human services."

Because other professionals are not only included, but valued, communication between team members can be improved, especially when there is conflict over diagnoses, treatment approaches, etc. By cross-training staff with knowledge from different disciplines, safety was increased in a forensic treatment center for residents and staff, complaints and grievances from residents were reduced by over two-thirds, and restraint usage was reduced to near zero. (Vanderberg & Bowen, 2011)

Affirmation of Each Discipline's Approach to Behaviour

Ask the question "what is behaviour?" at conferences and you will find significant differences. [Note: at the workshop, this will be another activity] Each discipline – nursing, psychology, psychiatry, neuroscience, security, legal, etc. – will have its own definition. There will be similarity in answering the question "what is behaviour?" and vast differences in understanding how that definition "comes to life" through the processes of motivation, intention, action, etc.

The Indian fable of the blind men and the elephant demonstrates the need for affirmation of different perspectives on behavior. Just as each person whose hand was on a different part of the elephant (trunk, leg, torso, ear) and felt a snake, tree, wall or large leaf, we will need to listen more than we talk as we are in meetings to discuss the behaviour of others.

Common Definitions

In order to measure, one needs common definitions. As a resident of the US, I am used to measuring inches and pounds. As I travel in the rest of the world, I have to translate the same distance into the different measurements of meters and kilograms. The mass remains the same, how we measure it changes.

Over the years of my own practice (35+ in human services) this has been the most difficult area on which to gain consensus. There are competing typologies of workplace violence (WHO, Cal-OSHA, Bowie, UIIPRC). This is where the "rubber meets the road" to use an American expression. If we cannot agree on definitions, we will have many more conferences on violence in clinical psychiatry with no decreases in violence.

It is not the intention of this article to propose a common definition. It is the suggestion of this article to challenge the health care sector to lead the difficult process of transcending disciplinary boundaries to craft a common set of definitions for the purpose of measurement and subsequent action.

Managing Safety

There are many different ways to understand and conceptualize the methodologies used to decrease risk. However, when the focus is on decreasing risk, we often lose sight of the concept of safety. Bridging the gap between managing risk and managing safety requires that we find ways to build a bridge between the regulatory and funding systems, and the service delivery systems so we can focus not on the risk to be avoided, but rather the opportunities that together we can gain. The New South Wales Council of Social Service states that risk management:

- Is a procedure to avoid any negative consequences and reduce potential .legal liability
- Seeks to address potential problem areas before they occur and creates a safer environment
- Is a process to test the effectiveness of measures to prevent events happening that may result in negative outcomes.

A graphic representation of this process is below:

STANDARD RISK MANAGEMENT PROCESS

Stakeholder Consultation / Communication	Establish Goals / Context	Monitor / Review
	Identify Risks	
	Analyse Risks — Likelihood — Consequence — Estimate Level of Risk	
	Evaluate the Risks	
	Treat Risks	

Source: Standards Australia and Standards New Zealand, AS/ NZS 4360:1999.
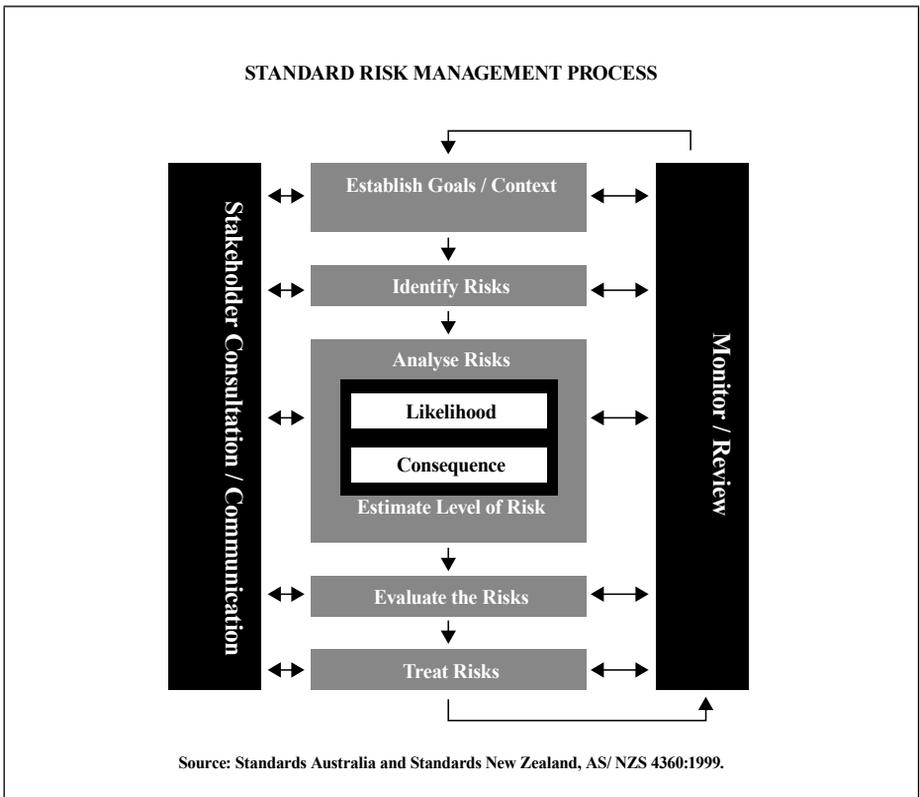
This model represents a standard of care in the industry of human services in New Zealand and Australia and, as such, is not subject to change. Rather than treat risks, our goal is to prepare for risks and identify ways in which we can work with people to manage safety as they live their lives.

Supporting Staff

When people are able to look back on the road called recovery and see the progress they have made, every single person has talked about a hero in their lives. This hero was always a direct support staff person. For staff to be able to be heroes, for staff to be able to give dignity and respect and autonomy and hope to others, they must have it within them. There is an axiom in psychology: you can only give what you have. In the book Patients Come Second (Spiegelman & Berrett, 2013) the authors clearly state that in order for patients in hospitals to receive health care that leads to healing, staff must come first, and patients come second. Supporting the staff, especially the direct support staff, is a pre-requisite to healing the individuals we serve, whatever that healing may be. If the staff do not feel supported, they will be less able, less empowered, to support the people they serve.

As we go through the process of supporting staff, the relative health or toxicity of the organization is the context in which all human services are provided and received. There has been a great deal of emphasis on the "bad apple," the employee who makes life difficult for others. The emphasis should be just as much, if not more, on the apple barrel (Bowie, 2011)

Conclusion

Seventeen years is far too long to wait for us to do what we know we should. The problem is complex, and more research is required in how to transfer knowledge from one discipline to another. Conferences and publications that are "open source" and that share knowledge freely with all people are a critical part of this process.

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Evaluation of changes in perceived self-efficacy in managing patient aggression after completing workplace prevention training

Paper

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Keywords: Self-efficacy, violence, management, psychiatry

Introduction

Since the 1980s, research efforts have led to a series of initiatives designed to prevent workplace violence. Unfortunately, it is difficult to judge how effective these initiatives are since few have been rigorously evaluated. Even though mental health workers are among the groups of workers most at-risk of physical violence, there is very little evidence-based strategies designed to prevent workplace violence in psychiatric institutions.

Omega is a training program designed in Canada that aims to develop in healthcare and social services workers skills and methods of intervention to ensure their safety and that of others in a situation of aggression (Robitaille, 2009). The main objective of Omega is to ensure both personnel and patients' safety, using several pedagogical approaches detailed in the training manual. It offers means to identify risk factors in the work environment, to classify aggressive behavior on an evaluation grid according to the level of dangerousness, and to select and apply, among different verbal, psychological, and physical techniques, the most appropriate according to the level of aggression expressed. The training also provides principles for protection and safe physical intervention and for teamwork, including effective communication in an objective of crisis resolution. Post-event analysis is intended to assess the modes of intervention chosen in crisis resolution and to ensure feedback and team monitoring following an intervention.

The main components of Omega are:
1. evaluation of the work situation (people, environment, equipment, task, time and work organization);
2. appreciation of the alert level (anticipate protection, observe physical, verbal and non-verbal parameters, and gauge reactions);
3. evaluation of the level of dangerousness (grid including a description of the level of aggression expressed and the appropriate intervention);
4. a pyramid of interventions for crisis pacification based on empathic listening;
5. physical techniques (including positioning for maintaining a safe distance and controlling the patient without physical contact, stances, blocks, and body hold releases);
6. and a post-event analysis procedure (to support the clinicians involved in the intervention and to review collectively the event and identify area for improvement to make the environment safer).

This program is currently implemented in several institutional settings at high-risk for violence such as hospitals and youth centers in Quebec and New Brunswick (Canada) and France.

Although Omega is used in several mental health institutions, its effects have only been partially empirically evaluated so far. Research data on participant satisfaction suggest that the program is very popular in workplaces where it is offered. An evaluation conducted with participants who received the training in a youth center in Montreal (Canada) indicates that they have acquired new knowledge and strengthened their adherence to the philosophy underlying the program (Groleau et al. 2008). However, changes in perceived self-efficacy in managing potentially aggressive patients have not been systematically studied.

The objective of the current study was to assess changes in perceived self-efficacy in managing patient aggression. A questionnaire designed to assess self-attributed clinician confidence in coping with patient aggression (Thackrey, 1987) was used. According to the author of this instrument, 'this domain was conceptualized as self-attributed ability, preparation, and comfort in safety and effectively intervening psychologically and physically with the aggressive patient for purposes of self-preservation and therapeutic intervention' (Thackrey, 1987, p. 58).

Methods

Eighty workers (45% females) of the emergency and intensive care units (45% nurses, 27.5% beneficiary attendants, 22.5% safety officers, 5% professionals and managers) from a psychiatric hospital in Montreal (Canada) were recruited. The average age of the participants was 45 years old. The majority (55%) worked full time and the overall sample had a mean of 20 years of experience.

Participants received the 4 days Omega training (28 hours) which involves raising awareness of the values and learning techniques of the program. We measured changes in perceived self-efficacy by comparing scores on the 10 items of the Confidence in coping with patient aggression instrument (CCPAI; Thackrey, 1987; alpha: .95) before (T0) and 3 months after (T1) training (response rate 90%).

Results

Results indicate positive significant changes for the overall score (for both men and women; t=-2.73, p=.009 and t=-3.81, p=.001 respectively). Significant effects were also observed for 9 of the 10 items (see Table 1).

Table 1. CCPAI Scores

		T0 Mean (SD)	T1 Mean (SD)	*t* tests
1.	How comfortable are you in working with an aggressive patient?	7.56 (2.15)	7.90 (1.84)	NS
2.	How good is your present level of training for handling psychological aggression?	7.29 (2.24)	8.44 (1.76)	-4.66 (p=.000)
3.	How able are you to intervene physically with an aggressive patient?	7.24 (2.81)	7.72 (2.51)	-2.55 (p=.013)
4.	How self-assured do you feel in the presence of an aggressive patient?	7.60 (2.26)	8.09 (2.07)	-2.66 (p=.010)
5.	How able are you to intervene psychologically with an aggressive patient?	7.95 (1.97)	8.71 (1.39)	-3.49 (p=.001)
6.	How good is your present level of training for handling physical aggression?	6.53 (2.65)	7.70 (2.17)	-4.58 (p=.000)
7.	How safe do you feel around an aggressive patient?	6.86 (2.36)	7.68 (2.17)	-3.81 (p=.000)
8.	How effective are the techniques that you know for dealing with aggression?	6.90 (2.37)	7.73 (2.10)	-3.52 (p=.001)
9.	How able are you to meet the needs of an aggressive patient?	7.18 (1.97)	8.16 (1.76)	-4.87 (p=.000)
10.	How able are you to protect yourself physically from an aggressive patient?	7.20 (2.66)	7.95 (2.35)	-2.88 (p=.005)

Conclusion

Workplace violence is been increasingly recognized as a work hazard (Occupational Safety and Health Administration, 2004) and staff training has been identified as an essential component of any violence prevention program (Anderson, 2002). In a review of the effectiveness of such programs with the staff of psychiatric hospitals, Livingston et al. (2010) found that employee training would reduce, at least in part, violent incidents and related injuries. In addition, it would substantially reduce the use of restraints and seclusion to manage aggressive patients.

Our findings suggest that staff perceive an increase in self-efficacy in managing potentially aggressive patients after completing the Omega training. These cognitive changes may lead to changes in practice in these workers' interventions responding to violence in the future. However, further investigation will be necessary to determine whether gains in confidence are maintained during a longer follow-up period and bring about new practices, and if similar results are observed in other settings. Positive results would be promising for this program that could prove to be cost effective for a variety of mental health institutions.

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Training in management of aggressive behaviour - strengths and difficulties

Symposium

Adriana Mihai, Julian Beezhold, Loredana Buftea, Jon Snorranson, Cristian Damsa
County Emergency Hospital, Targu Mures, Romania

Abstract

Training in management of aggressive behaviour is an important task in consolidating a team that works on a psychiatric ward. This assurse the confidence and protection of the team in applying the correct approach to a violent situation. Training programs vary across the Europe.

The experience in different European countries is varied and an exchange in knowledge between trainers is an important source of information and skills to improve training programs.

These symposia will offer different perspectives on training in Iceland, UK, France, Switzerland and Romania.

Each speaker will present their program and the impact on clinical practice. The understanding of interventions, similarities and differences will be shown underlying the strengths and difficulties in different programs.

Discussion will be organised for exchange opinion and clariying questions.

Educational Goals

Identifying the strengths and difficulties in different programs in Iceland, UK, France, Switzerland and Romania will help in improving training programs.

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Experience of staff using manual restraint techniques

Symposium

Jón Snorrason MSc., Guðmundur Sævar Sævarsson MSc., Hilmar Thor Bjarnason MSc.
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Introduction

Violence in health care settings is most frequent in psychiatry, accident and emergency wards and in geriatry (Nijman, Björkly, Palmstierna and Almvik, 2006; James, Madeley and Dove, 2006; Zeller, Dassen, Kok, Needham, Halfens, 2012). Of all staff members, nurses and nursing staff are most exposed to violence and aggressive behaviour (Lanza, 2006). Actions against violence in hospitals have advanced differently but there is a growing interest among them to manage violence in a professional and skillful way. Despite high percents of nursing staff that have been exposed to violence it is important to have in mind that most psychiatric patients in hospitals are not violent. Control & Restraint (C & R) has been defined "...as a set of formally taught techniques used to hold patients in an attempt to control and restrain potential or actual aggressive and/or violent behaviour in a ward situation" (Lee et al., 2003; p. 425). Training in C & R started in a psychiatric hospital in Iceland in 2000. It is a five days course and with requirement of one day refreshing course annually. A C & R team consists of four members, with the leader of the team supporting the patient´s head, two members supporting each arm and the fourth member supporting the legs if needed. The aim of the team is to help the patient to gain control of his behaviour that he has lost temporally for different reasons. In their training it is emphazised that manual restraint should only be used when it is appropriate and all measure should be taken not to have to use it. Research has shown that in a 20 bed ward 2 – 5 incidents occur on average where patients need to be manually restrained, most commonly in forensic wards (Stewart et al., 2009).

Aims

The study explores the experiences of of C & R teams of techniques used in manual restraint of physical violent patients in psychiatric hospital in Iceland.

Method

After an incidence when a C & R team has restrained a violent patient manually a questionaire is sent to the team with questions about different issues concerning the techniques used.

Results

The results will show . how long it took to de-escalate and restrain the patient; the restraint positions; how successful the team was; injuries of patients and staff members; which aspects of the techniques worked well and why; which aspects of the techniques did not work well and the reasons why; to what extent did the team members use techniques that they were taught during training etc.

Conclusion

Management of physical violence is a complicated and difficult task and can be dangerous both for staff members and patients. Researching techniques to manually restrain patients that are successful is complex and difficult to do due to ethical grounds. It is however important to hear the opinions and experiences of the staff that uses the techniques and in that way can be a step forward in it's development. It can also be argued that patients´ experience is also valuable information in this connection.

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Reducing violence in Acute Inpatient Psychiatry

Symposium

Julian Beezhold, Lisa Vescio
Milestones Hospital, Salhouse, Norfolk, United Kingdom

Keywords: Inpatient, in-patient, violence, reduction, controlled trial

Introduction

Violent incidents are a major issue for both patients and staff in inpatient psychiatric units. For patients they detract from or even destroy the therapeutic environment and can make admission a terrifying experience.

For staff they can seriously damage morale and make inpatient settings an undesirable workplace, leading in turn to problems with recruitment and retention. Many different approaches have been used to address this problem. In this presentation we will present work addressing separately both environmental and cultural factors that contribute to the incidence of violence. Results are also presented from a quasi-experimental controlled intervention to reduce violence.

Main Paper

This presentation describes two different interventions both aimed at reducing violence in inpatient wards with the aim of highlighting issues relevant to education and training.

The first intervention was the introduction of hospitalists (psychiatrists dedicated exclusively to inpatient work) into a system where psychiatrists conducted office-based practice with outpatients as well as delivering care to inpatients. Several other systems changes were made possible by this including daily reviews of each patient's treatment. A quasi-experimental controlled study of all admissions over an 8-year period (n= 5601) showed a 20% fall in violent incidents per admission in the intervention ward compared to no change in the control ward (p=0.02).

The second intervention describes the implementation of a new approach to the treatment of female patients with complex challenging mental disorders who had been referred to Milestones Hospital in Salhouse, Norfolk because they had failed to progress in acute / low secure / intensive care / medium secure units elsewhere. Almost all of these patients have an extensive history of violence against health service staff. The Milestones approach is based on high staffing numbers and the complete absence of the use of seclusion or physical restraints.

The presentation concludes by eliciting the principles and lessons learned that may be useful in educational interventions for mental health staff that aim to improve their ability to prevent and manage aggression.

Conclusion and Discussion

Violent incidents are not inevitable in acute inpatient settings. They are strongly influenced and moderated by both environmental and cultural factors.
Simple interventions are available that can help reduce violent incidents. These include an 'expectation' that patients will not be violent, systematic attempts to address trigger factors promptly, enough physical space and enough staff time.

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The training impact on management of agitation

Symposium

Cristian Damsa, Adriana Mihai
Geneva, Switzerland

Keywords: suicidal attempts, education, aggression

Abstract

There are many studies which show the short term impact of educational programs and their efficacy on management of aggressive behaviour.

The aim of this study was to evaluate the efficacy in the long term.

Material and methods

This observational study was done in the Emergency Department of the University Hospital of Geneva, Switzerland between January-March 2008, on 1258 patients, specifically evaluated for depression, anxiety, psychotic features, auto-aggressive behaviors and level of psychomotor agitation. The results will be correlated with different factors, which could influence the data: socio-demographic factors, diagnosis, staff characteristics.

Results

A preliminary study done in Geneva (Caihol et al., 2007) showed a significant reduction in violent behavior during 5 months in emergency psychiatry, after the introduction of a specific educational program, in 2008 the percent of violent behavior in this group of patients was significantly reduced by 2.45% (p Ł 0.0001).

Conclusion

The continual medical education of medical staff is reflected in the correct diagnosis and approach of psychomotor agitation of patients with suicidal attempts.

Educational Goals

The continual medical education of medical staff is reflected in correct diagnosis and approach of agitation of patients with suicidal attempts.

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Training in management of aggressive behaviour – experience in Romania

Symposium

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Targu Mures, Romania

Abstract

In Romania there is no formal training for medical staff working in psychiatric wards on the management of aggressive behavior.

The aim of this study is to evaluate the impact of training in management of aggressive behavior. This is a multicenter intervention study. We evaluated the number of admissions on closed wards, the non-voluntary admissions, the number of incidents and number of restraints, before and after interventions. 100 medical staff from 8 psychiatric wards with approximate 300 beds, which deserve the same region, were included in the study. They were divided into two groups A and B with or without training intervention. The medical staff did not have any previous training on this topic. During a regional project we invited trainers from abroad and trained four teams from four different psychiatric settings with the purpose to train the future trainers. We continued this training with nurses and doctors working in same settings. Our hypotheses are that this training will have an impact on reducing the incidence and severity of violence on psychiatric wards, increase the staff's confidence in managing the violence and confidence in team work, increasing the quality of care.

Preliminary data on results will be presented. We also propose to share in this presentation our experience of organizing training in Romania and the strengths and difficulties of training in the management of aggressive behavior.

Conclusions

The evaluation of training impact, of strengths and difficulties can improve future training programs to be more effective and produce better results.

Educational Goals

The strengths and difficulties of training in management of aggressive behavior and a project on how to measure the impact of training on clinical activities.

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Interaction Skills Training (IST): Improving the efficacy of interaction and cooperation under non-cooperative circumstances

Workshop

Jan Boogaarts & Bas van Raaij
Bureau de Mat, Haarlem, The Netherlands

Abstract

In The Netherlands a program called the Interaction Skills Training (IST) is developed and offered to healthcare professionals. Because of the broad interest in this program and the positive effects it has on healthcare professionals, participants of this workshop will be given an introduction of the training in which the significance of this program regarding efficacy of interaction and thereby ability of cooperation in non-cooperative circumstances is shown. The program aims at studying signs of cooperation and noncooperation and improvement of the quality of the working alliance between healthcare professionals and their clients. Cooperation where formerly the professional saw him/herself bound to using coercive measures. Or where the professional was becoming an opponent of the patient. The program offers participants the opportunity to reflect upon and gain insight into the effect of their behavior on cooperation and noncooperation. The introduction gives insight into several different styles of communication and several aspects of interaction, i.e. does the other person's behavior stem from "cannot" or "will not", and what is the difference between interventions based on influence compared to interventions based on power. The central question in the program is this: Is the effect that you get by what you say or do to the client also the effect that you want to achieve? And does this effect add to both short-term and long-term objectives of the professional and his client, or does it lead to barriers in the possibilities of client or professional to reach their treatment goals. In the program a model is used to show these aspects of the interaction. This model consists of a red-green mat (de Mat®) and a bag (de Tas®) by which interaction can easily be studied and behavior that affects cooperation or noncooperation can be made literally visible. The program follows the phases of contact between healthcare professionals and their clients and explores possibilities of cooperation in the meeting-phase, the phase of treatment and the phase of ending the working alliance. In the workshop an overview will be given as to what the program is and in which way it can contribute to improve the efficacy of interaction, improve cooperation, the reduction of seclusion and restraint and the prevention of aggression. Recently biological aspects were added to the program aiming to improve participants to understand more about "territorial" behavior.

In addition the interactive skills training program was subject of several scientific studies:
High and Intensive Care Veldnorm, GGZ Nederland, 2013
Best Practices rondom dwangreductie in de Geestelijke Gezondheidszorg, Voskes, Y., Theunissen, J., Widdershoven, G., 2011, VU Medisch Centrum, GGZ Nederland
Motivational interviewing and interaction skills training for parents to change cannabis use in young adults with recent-onset schizophrenia: a randomized controlled trial, Smeerdijk, M., Keet, R., e.a., 2011, Psychological Medicine, Cambridge Press.
Effective Interaction With Patients With Schizophrenia: Qualitative Evaluation of the Interaction Skills Training Program, Meijel, B. van, Meegens, Y. van, Perspectives in Psychiatric Care Vol. 45, No. 4, October 2009

- The Interaction Skills Training program is accredited by the Dutch Psychiatric Association (NVVP) with 19 points.
- The program is accredited by the association of nursing specialists with 19 points.
- The program is accredited by the Kwaliteitsregister Verpleegkundigen en Verzorgenden and the Stichting Register Vaktherapeutische beroepen.

The workshop aims to show and share with participants the method of the training to enable them to value and experience the training and the potential influence it can have on the prevention of aggression and cooperation between professionals and clients.

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Unclear & Present Danger – Synthetic Stimulants & Synthetic Marijuana

Poster

Susan Vickory, Rhonda Tierney
VA Boston Healthcare System, Boston, USA

Abstract

This is an educational poster on emerging drugs of abuse. They are known by their street names of 'Bath Salts' and 'Spice'. Historical data includes manufacture, marketing, and accessibility of toxic compounds that have caused an increase in violent behavior. Suicides, homicides, acute psychotic symptoms, cardiovascular and renal failure have been documented in previously healthy individuals using these substances.

Emphasis is on early recognition of the signs and symptoms by physicians and nurses working in Emergency Departments, Psychiatric Units, and in Medical Units. Although there is no antidote at this time, treatment is supportive and focused on providing a safe nonviolent environment for patients and staff.

Underground chemical labs are constantly changing names and compounds of these illicit substances to evade law enforcement.

Case reports and narrative accounts will be provided in handouts.

Educational Goals

Education of Clinical Staff about signs & symptoms to provide for a safe environment for patient & staff. Education of public about the risks of use.

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Implemention of SOAS-R and BVC in a new youth forensic emergency Unit

Poster

Elisabeth Myhre, Peter Jantzen
Child and Adolescent Psychiatry Capital Region of DK, Adolescent Forensic Unit, Copenhagen, Denmark

Abstract

The aim of the poster is to describe the Implementation of staff observation aggression scale (SOAS-R) and the Brøset violense checklist (BVC) in a newly open acute youth forensic Unit at Glostrup Psykiatrisk Center, Region Hovedstaden located in Copenhagen Denmark.

The poster Will give an oversight that include, training module, staff averseness and expected outcome during a period of 3 month introducing.

The aim is to reduce the use of mechanical restring and to see a decrease in recession.

Educational Goals

The aim of the project is to bring awareness to staff in understanding the effectives of risk assessment in reducing aggressive behavior.
Treating staff in using statistic from SOAS-R in planning care intervention to reduce aggressive behavior.

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Human Defence System (HDS) (Menselijk Verdedigingssysteem)(MVS)

Workshop

Edward Kudding & Hans Fleury
The Netherlands

Abstract

New developments regarding physical training for the management of aggressive and violent inpatient behaviour are based in America on the scientific principles of the Human Defence System (HDS). This approach is currently by far the most practical and realistic physical reaction as a human defence system after being confronted with aggressive and violent behaviour. It is based on scientific research on human behaviour, related to escalations of violence, fear and aggression.

One of the main principles of HDS is the perceived impact of sudden stress in the form of anxiety or fear. This increases the release of adrenaline and thus leads to various changes in mental and physical functioning and the ability to proper reasoning. It effects further in the worst case the ability to reason and correctly thinking at all. On the physical level, the psychomotor abilities are disturbed, and in the worst case, there are only reflex behaviours.

During the newly developed physical training in the management of aggressive and violent behaviour, the changes in human behaviour under the influence of adrenaline, are comprehensively analysed on the basis of video images of real violence including escalations. The insights obtained therefrom are conveniently integrated in the physical implementation of the physical management of aggression and violence.

The video and photos are also used to analyse the behaviour of an attacker. The trainee learns to recognize a potentially dangerous situation before and how to deal with it tactically.

HDS is distinguished from other similar training
- the HDS is not based on a martial arts;
- is not based on a variety of techniques difficult to learn;
- it is a scientific study of human movement in relation to aggression , stress and violence in threatening situations;
- develops how to act in spite of great anxiety and inability of sober thinking;
- provides a realistic understanding of all aspects of an escalation of violence, both psychological, emotionally and physically;
- starts from a realistic "unbalanced situation";
- is not age specific;
- some experience is not required.

What should therefore be taken into account more in the future?
- Experienced practitioners of martial arts under mild stress (heart rate up to 115 beats per minute without physical exertion) are capable of performing complex techniques. In aikido and jiu jitsu if the heart rate rises above 115 beats per minute, these complex techniques become impractical and can only be handled through a defense system based on natural reflexes.
- The lack of refresher trainings in practice can / may be for a large amount the reason why complex operations are quickly forgotten and no longer manageable.
- Training for employees who are confronted with aggression and violence in their work are only able to use those skills as long as the trained response is based on gross motor skills and taking account the Law of Hick.
- An automatic response to a specific threat can only occur if the has a skill training along with a specific level of threat.
- To condition a response or to make an automatic response should relate to a stimulus that triggers the response. If it is expected that this automatism occurs against a threat in the practice, these two are combined, and an early identification of a psychomotor program should be implemented. Linking the Flinch (first natural physical reaction after being confronted with a sudden stressful threatening

behaviour) and appropriately correctly handling of the situation. By integrating Flinch with the technique and tactics an adequately and efficiently handling can be stimulated and trained.

Integration of Flinch as technique and tactics :
- Keep the arms and hands in front of the body
- Use the hands, arms in the communication , appropriate to the situation
- Have nothing in your hands (you Flinch is less effective if you hold anything)
- A clear , open appearance from which the Flinch can be made easily
- Keep the feet and legs in a pace and alert stand. In approaching clients we use this basic stand, so that we always have the best safe physical stand. How can I surprise myself less ?
- Awareness of the situation (safety & security), be aware that you may be surprised
- To know, recognize and acknowledge the situation
- Recognize and acknowledge behaviour (blueprint)
- Proactive acting
- Forward thinking and acting

During the workshop some theoretical background will be given, but mostly the participants are invited to actively experience the principles of the HDS in the training and performance of a proper, safe and secure management of aggressive and violent behaviour.

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Announcement

The 9th European Congress on Violence in Clinical Psychiatry will be held in Copenhagen – Denmark from the 22nd till the 24th of October 2015.

Congress Venue & Hotel will be the Crown Plaza Copenhagen Towers (www.cpcopenhagen.dk/en)

Please reserve these dates in your diary.

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Addendum

The black box of aggression unraveled by means of The Early Recognition Method [ERM]

Pre-Congress Workshop

Frans Fluttert (The Netherlands), Gunnar Eidhammer (Norway), Stål Bjørkly (Norway)

Introduction

When forensic patients are convicted, the court assesses them as not fully accountable for the offence they committed due to their psychiatric disorder. For most of the forensic patients the core problem is to control their aggression (Daffern & Howells 2009, Vitacco et al. 2009). In forensic psychiatry the occurrence of aggressive incidents leads to threatening and sometimes even dangerous situations on the wards. Frequently restrictive measures are applied by nursing staff, e.g. seclusion, in order to control patients' aggressive behaviour and to avoid danger and harm. The core message is that aggression is not allowed, but generally not much effort is made to learn from previous events of aggression. However, this learning process is of utmost importance to enhance a better self -management of aggression by forensic patients. When patients are able to recognize and control the precursors of aggression, this could help them to carry out stabilizing actions in order to gain control over their behaviours and thus prevent aggressive incidents to occur. Additionally, when patients, while admitted at inpatient wards, succeed to manage their aggression, the transfer to the rehabilitation phase is more likely to become the next treatment step. Aggression management strategies are most likely to be successful when patients feel accepted and are treated as individuals with characteristics, which are valuable to acknowledge and to explore, even in case of aggression (Meehan, McIntosh & Bergen 2006). Patients' (self)-management of aggression, i.e. those activities which patients initiate to control their aggressive impulses, should be an important issue during treatment. The objective of this article is to explain the concept of the Early Recognition Method, how the ERM strategy could be applied, and more specific, how the Forensic Early Signs of Aggression Inventory could assist nurses and patient in detecting early warning signs.

The focus of ERM

Aggression often occurs in situations when patient's needs are not fully met and anger and frustration arises. Aggression and violent behaviours are complex phenomena, both defined as behaviours which are threatening or harmful to self, others or property. In forensic literature both terms are used, often as synonyms. There is no uniform definition of aggression or violence due to the complexity of these concepts (Abderhalden et al. 2008). The focus of ERM is to identify Early Warning Signs, which could be defined as perceptions, thoughts, and behaviours of the patient occurring prior to an incidence. Incidents could be violent acts, self harm and even psychotic episodes. The overarching aim of ERM is to prevent deteriorating behaviours in an early stage of onset.

In forensic care often incidents are linked to violence and aggression. Palmstierna & Wistedt (2000) explained that aggression could be described by its expressed behaviour and by its inner experienced emotions. However the conceptual problem with aggression is more semantically rooted. They propose the following dimensions in categorizing aggression: (1) inner experience versus outward behaviour, (2) aggressor's view versus observer's view, and (3) persistent state versus episodically occurrence. These dimensions might be helpful in both clinical practice and research to analyze the nature of concrete aggressive behaviours and the way it develops over time. We use the term aggression as defined by The categorization given by Palmstierna & Wistedt (2000) may be helpful in the further exploration of precursors of aggression in forensic patients.

The occurrence of aggression is associated with the complex interaction of both intrapersonal and interpersonal factors. Several intrapersonal factors are related to factors within the social context in which the patients functions, such as poverty, stressful life-events and victimization (Hiday 1997), (figure 1: Factors related to violence).

Figure 1: Factors related to violence

Figure 1: Factors related to violence
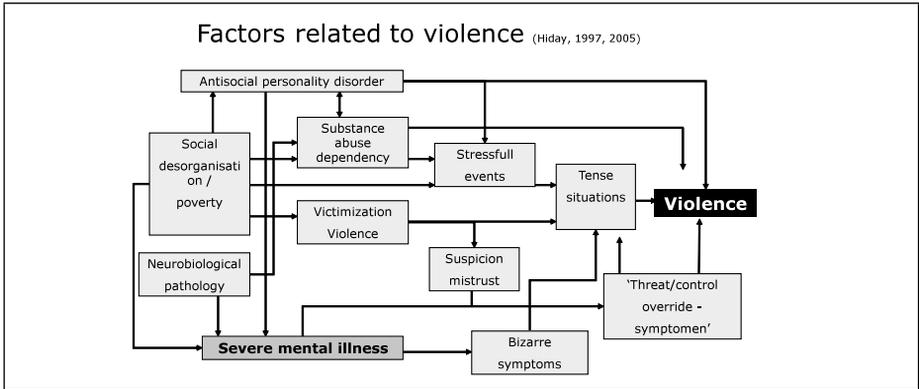
Risk management and self management

A profound insight into patient's vulnerability to cope with stressful situations (e.g., due to delusions), and into the developmental process of aggression, is essential in the dynamic interactional understanding of violence (Bjørkly 2006). So far, forensic researchers have mainly made efforts to identify precursors of inpatient aggression on the basis of clinically dynamic factors by means of risk assessment instruments (Almvik, Woods & Rasmussen 2000, Ogloff & Daffern 2006, McDermott et al. 2009, Dolan et al. 2008). By applying these instruments nurses can observe and record precursors of aggression by patients in daily ward situations and thereby gain knowledge of the likelihood of aggression by the individual patient. Despite these efforts, the onset of aggression and the escalation from mild forms of agitation into full-blown aggression remains unclear. An important limitation of using risk assessment instruments is that patients generally do not play an active role in these forms of risk management and hence their capacities of self-management to prevent aggression is not addressed. One would expect, that risk management strategies guiding the nurses in teaching patients these (self)-management skills constitute an important part of forensic mental health nursing working models, however, these strategies are currently hardly available (Bjørkly 2004, Fluttert et al. 2008). A step towards a better (self)-management of patients' aggression may be the development of strategies for a joint effort of mental health professionals and patients to (1) recognize the individual early warning signs of aggression in the first phase in which they occur, and by this (2) to execute preventive actions to minimize the risk of actual occurrence of aggression. Early warning signs of aggression can be defined as changes in individual, thoughts, perceptions, feelings and behaviours of the patient that precipitate aggressive behaviour (Fluttert et al. 2008, van Meijel et al. 2006). Early warning signs represent a continuum from the very early stage of deteriorating behaviour (e.g. increasing suspiciousness) until the phase of deterioration proximal to aggression (e.g. increasing anger). When early warning signs are recognized, intervention strategies can be applied to diffuse the threat of aggression and thereby to restore patient's equilibrium. Stabilizing interventions can be carried out by the patient himself, but also by others, e.g., nurses.

Work alliance between nurses and patients

On the interface of security and treatment professionals in forensic mental health care are confronted with two conflicting perspectives, namely the necessity of psychiatric treatment and care on the one hand, and the public outcry for more severe restrictions to prevent society from risk behaviour of the patient on the other hand. Nurses are members of a multidisciplinary treatment team in which therapeutic goals are set with emphasis on the management of violence and the path to future rehabilitation. At the same time these nurses fulfill a prominent role regarding safety; they prevent patients causing dangerous situations, e.g., threatening or abusing others (Caplan 1993, Martin 2001, Mason & Lovell 2008). Within this context of treatment and security, forensic mental health nurses in particular are confronted on a daily basis with mentally disturbed patients who are involuntary admitted to a place where they don't want to stay. These patients live in groups on forensic units in which many interactions between patients and nurses take place under sometime stressful conditions (Martin & Daffern 2006). Forensic patients must learn to cope with their own disturbing behaviours and with those of their fellow patients. One of the treatment goals is to develop the capacity to participate constructively in social interactions with fellow patients and with nurses, e.g., participating in ward meetings with other patients (Rask & Levander 2001). Nurses have to

manage the interactions within the therapeutic environment in order to create and maintain a safe living and learning environment for all patients. Nurses invest in building a therapeutic relationship with patients to work collaboratively on these goals and to tailor nursing care to the individual problems and needs of patients (Rask & Brunt 2006, Mason & Lovell 2008). In this process the occurrence of aggressive incidents causes threatening and sometimes even dangerous situations on the wards.

The ERM concept

The quality of the working alliance between nurses and patients is a major determinant of the successful application of risk management strategies in forensic care (Rask & Brunt 2006). Within a safe atmosphere, nurses encourage patients, in a systematic way, to discuss their perceptions and behaviours, which could be identified as precursors of aggression. Only then, when the patient experiences constructive interactions and communication with the professional, the likelihood increases that patients will participate actively and be motivated in risk management interventions, such as the Early Recognition Method [ERM]. Birchwood (2000) developed the early intervention model for patients with schizophrenia to detect their early signs of psychosis. Birchwood refers to this profile as a so-called 'relapse signature' (Birchwood 2000). It serves as a personalized signature to recognize the very specific development of psychosis in one patient. The early recognition of these signs offers possibilities for early interventions, finally aiming at the prevention of severe psychotic episodes. Based on this notion, van Meijel et al. (2006) developed for nursing practice 'The protocol for the application of the early recognition method in patients with schizophrenia'. This protocol was applied and studied in nursing practice on feasibility and effectiveness (van Meijel et al. 2006). Fluttert et al. (2002) modified this protocol in order to develop a risk management method for forensic mental health nurses aiming to prevent inpatient aggression in forensic patients with various diagnosis. To create an effective intervention for the prevention of severe incidents, the Early Recognition Method was developed and described in a previous study (Fluttert et al., 2002, 2010, 2011). Most characteristic of this risk management method is that the focus is on the early warning signs of aggression. With competent nursing attention, the signs can be detected during daily care. In addition, the method helps patient and nurse attune their perspectives on the risk of aggression and how to manage this risk with a particular patient. The concept of early recognition within a forensic context emphasizes the description and exploration of the early signs of deteriorating behaviour in situations associated with violent and aggressive patient behaviour with the patients themselves. These early signs can be defined as the subjective perceptions, thoughts, and behaviours of the patient occurring prior to the incidence of violent behaviour (see also Henrichs & Carpenter, 1985; van Meijel, van der Gaag, Kahn, & Grypdonck, 2003). The patient's objective behaviour is usually quite easy to grasp; that is, a shouting male patient clearly shows that he is angry. However, the source of the man's anger may be more difficult to grasp at times: Why is he shouting? Why is he so angry? What is going on in his mind? For the early detection of warning signs, considerable attention must be devoted to the recognition and exploration of the subjective factors underlying patient's aggression or the precursors to violence. Furthermore, the focus of early recognition training efforts is on the enhancement of patient's self-management skills and thereby their capacity to recognize the early stages of behavioural deterioration, as depicted in Figure 2.

Fig 2. The process of deteriorating behaviour.
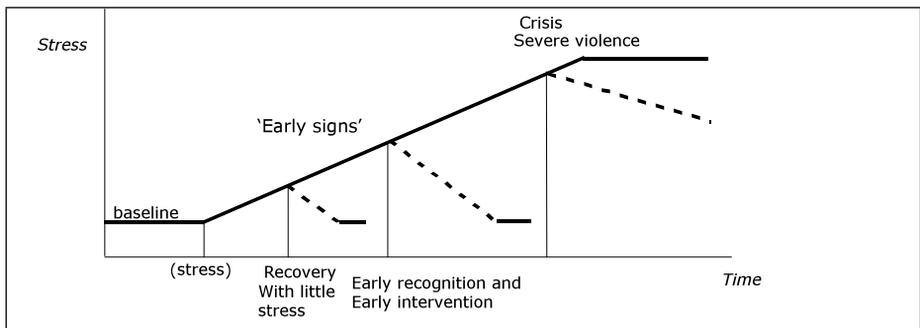
As can be seen from Figure 2, baseline involves behaviour that is constant, nonviolent, and fairly predictable. When patients experience limited stress, they are typically able to cope with setbacks or confrontations and contribute to efforts to help them maintain stability and thus recover. As the level of stress increases, however, further coping may only be possible with the support of others (e.g., professionals and members of the individual's social network), and intervention during this phase of behavioural deterioration

seems to be of vital importance for treatment. When early warning signs are recognized and intervention strategies can thus be applied to diffuse the threat of violence, a patient's equilibrium can also be restored and treatment resumed. When no intervention is possible or undertaken, crisis and violence are likely to emerge, and under such circumstances, a return to baseline may take considerable time and clinical effort. For forensic nursing care, thus, a focus on patient behaviour during the phase of early deterioration or early signs (see Figure 2) is an absolute necessity. Relatively "mild" incidences of aggression may characterize this phase, and the warning signs are often clearly detectable (Nijman & Palmstierna, 2002). Patient behaviour is not yet fully dominated by symptoms or stress, and patients can still participate in their recovery efforts to at least a certain extent and thereby return to baseline behaviour and stability with a minimum of effort.

The Black Box metaphor explaining ERM

The aviation metaphor of the "black box" can help us better understand the role of early recognition within the context of forensic care. Once upon a time, two glider planes collided at a height of 400 m. Both of the pilots reached the earth safely. Given the absence of a black box, however, the two pilots had to reconstruct the critical course of events leading up to the accident from their own memories and their own points of view. The focus of this "mental black box" was thus upon the reconstruction of those events leading up to the incident. The collision itself was so sudden and so inevitable at the moment just prior to occurrence that consideration of the total flight from start until collision was considered most informative. What was striking in the reconstructions of the course of events was that it was possible to point—after the fact—to some unusual maneuvers made during the *early stages* of the flights with a considerable probability of being related to the accident. In other words, when reconstructing and analyzing incidents, whether they be accidents in the air or occurrences of aggression, a focus on the behavioural antecedents and early warning signs seems to be more informative than a focus on the incident itself. From the perspective of prevention, it is necessary to understand at what point behaviour shifts from stable to disturbed, and thus, early warning signs occur. Inspection of the patient's mental black box allows us to create the conditions for effective interventions and thereby prevent incidents of severe aggression in the future.

The Early Recognition Method [ERM] strategy

In the protocol that we have developed, the Early Recognition Method has been described in detail (Figure 3). The protocol provides a clear structure for the four phases of early recognition: (1) Introduction, (2) Listing early warning signs, (3) Monitoring of behaviours and (4) Actions.

Figure 3: The ERM strategy
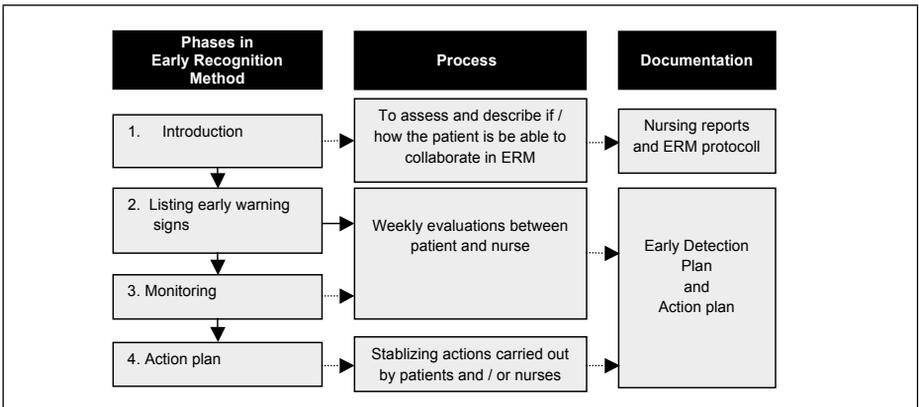
In more detail:
1. First is the introduction of the method to the patient(s) and an explanation of what is expected of the patient and the nurse. In three steps the collaboration is explored:
   a. Introduction of the plan with the patient
   b. Assessment of the characteristics of the patient and social network
   c. *Motivation / resistance / Insight into the illness / dangerousness / Influence personality disorder and symptoms*

2. Second, the nurse, patient, and members of the patient's social network are asked to list the main warning signs for the patient in question and to describe these within the early detection plan (which is a relapse prevention plan based on early signs). We try to find examples of formerly experiences of disturbing behaviour, which the patient can remember. Then we also ask a member of the social network, which early signs he or she fits, the best with the patient. Then the nurses, ask their selves the same question.

3. Third, patients learn to monitor their behaviour to recognize early warning signs. It is important to assess and describe in clear en simple words the degree in which certain behaviour is normal, out of line or severe outstanding. E.g. some patients are grown up under severe neglected conditions in which they are familiar with the whole day shouting and calling names. On the other hand are patients whom' shouting is outraging behaviour.

4. Fourth, preventive actions are outlined, and the patient is encouraged to carry out these actions when early warning signs are detected. In addition, in the protocol, how to anticipate and manage hostility or a lack of motivation on the part of the patient is also discussed.

In the 'Relapse prevention plan' five checklists (figure 4) are involved in which the early signs are described. Every subscription starts formulating; "I … [e.g.] speak fast and stuttering when feeling angry". The purpose is that the patient recognises his own behaviour in reading the checklist. At the top of the checklist data are determined on which the patient will read every item on the checklist. When he reads a subscription he asks himself whether this behaviour did occur the last week. If so he marks a cross under the data.

Figure 4: Checklist Early Detection Plan

This way the patient monitors his behaviour. When the patient marks more crosses in the upper part of the checklist, thus when his behaviour develops more disturbing, the patient looks at the action list which actions he can carry out to recover to more stable behaviour. The same applies to the nurses and the social network. Often appears that the patient marks quit different behaviour then the nurse marks on his checklist. These differences are important issues to find out why the patients perspective differences from e.g. the perspective of the nurse or psychiatrist. The purpose is not to judge but to let the patient discover how his behaviour alters in perspective of his environment.

Developing the Forensic Early Signs of Aggression Inventory [FESAI]

The Forensic Early Signs of Aggression Inventory [FESAI] was developed aiming to support patients and nurses to collaboratively assess early warning signs of aggression in a structured way (Fluttert et al. 2011,2013). A total of 167 Early Detection Plans were scrutinized. This resulted in a list of 3768 descriptions of early warning signs. After item reduction and categorizing the final version of the FESAI contained 45 items within 15 main categories among others: Change in daily activities, Social isolation, decreased social contact, Cognitive changes, Disinhibition and impulsivity, and Irrational ideas, perceptions. The FESAI is not aimed to be an exhaustive list and we cannot be sure about the completeness of the FESAI for all forensic patients in all different situations in which aggressive incidents occur. Therefore we added the extra category Other early warning signs to solve this problem. The inclusion of the warning sign items was based on the nurses' and patients' experience. In their view, changes in (several of the) early warning signs mentioned in the list are indicative of an increased risk of aggression.

Staff and patient can use the FESAI to discuss and identify the most relevant warning signs of aggression for the particular patient. When an aggressive incident has occurred or has been controlled, they can also use the FESAI to check afterwards whether all the relevant early signs of (imminent) aggression have been identified or whether there is a need to expand or reduce the survey of warning signs. By using the FESAI nurses and the patients may better be able to reconstruct the patient's process of escalation towards aggression. The FESAI-profile can be discussed with the individual patient from the angle of his or her treatment goals: how can the precursors of aggressive behavior be managed effectively in order to increase the chances of successful functioning within the clinical setting and to facilitate successful social rehabilitation in the future (Duxbury & Whittington 2005, Fluttert et al. 2008, Jonker et al. 2008). It is our experience that the use of the FESAI can assist nurses to manage disturbing behaviours of particular subgroups of patients, such as patients with antisocial personality disorder (Bulten et al. 2009, Koekkoek et al 2006, Goethals et al. 2007). By identifying specific early warning signs in these patients, education on nursing team level and nurses' early intervention concerning such high-risk groups may be improved (Jonker et al. 2008). Still, the development of the FESAI is at a very early stage. More research is needed to study the reliability and the predictive validity of the FESAI as a tool to monitor early warning signs for future violent behavior.

The ERM intervention Study

Since 2003, the Early Recognition Method has been used, with all of the 189 patients staying in the 16 wards of a forensic psychiatric hospital in The Netherlands. In a comprehensive nursing study, the effects of the method for patients, nurses, and the organization across a period of 30 months are being examined. The results show a significant decrease of incidents and a significant decrease of the severity of incidents among patients with Schizophrenia, patients with personality disorder and patients with substance abuse problems (Fluttert et al. 2010). The main purpose of this study was to explore the effects of using ERM with involuntarily admitted patients residing at a maximum security forensic hospital in the Netherlands. The hypothesis of this study was that patients who become actively involved in ERM will become less aggressive and therefore will undergo seclusion less often. The following research questions were leading: (1) What are the characteristics of patients who did become involved in ERM compared to those who didn't comply with the intervention?, and (2) Is the number of seclusions, as well as the severity of aggressive behaviour, reduced after the ERM intervention is applied? A delayed implementation of the ERM intervention was used. The 16 wards of the hospital participating in the study were allocated to three study groups. The intervention was initiated in all the wards at six month intervals over 30 months. Using a one-way case-crossover design, where cases were their own controls, the effects of ERM were assessed by comparing the number of incidents during 'Treatment As Usual' [TAU] with the period after ERM was implemented. The outcome measures were the number of seclusions and the severity of inpatient incidents, as rated retrospectively on the Staff Observation Aggression Scale – Revised. The number of seclusions in the TAU-condition was compared with those in the ERM-condition by means of a Chi square test. Within patients the number of seclusions and severity of incidents in TAU were compared to ERM by means of the Wilcoxon signed rank test. Additionally, an 'incident-severity-index' was created in order to compare TAU with ERM for the severity of incidents, also based on the retrospective ratings on the SOAS-R. Of a total of 189 male patients who were eligible to be included, 168 (88.9%) actually were involved in the intervention, whereas 21 patients (11.1%) persistently refused to be involved. These refusing patients scored significantly higher on psychopathy compared to the patients who did participate in the intervention. No significant difference, however, was found with regard to the prevalence of antisocial personality disorder in the two groups. A significant decrease in seclusions from 219 in TAU to 104 in ERM was found for the 168 patients that became involved in the intervention, [Chi-squared (1) = 22.82 p < 0.001]. The rates of seclusion per patient per month, as well as the mean severity of the incidents, in the 168 patients, decreased significantly when comparing TAU with ERM. Significant decreases in seclusions as well as in severity of incidents were found in the following patient subgroups: patients with schizophrenia, patients with anti-social personality disorder and patients with substance abuse. Patients convicted of sexual offences did not show significant improvement after participation in the intervention. As this study did not have a randomised controlled design the results clearly cannot be seen, however, as proof that the ERM intervention lead to the decrease in incidents. Random assignment of subjects, however, was not possible given the conditions under which the study had to take place. Nevertheless, the results suggest that ERM may be an innovative and promising risk management strategy for forensic psychiatric patients, but further controlled studies are needed.

Discussion

Forensic mental health nurses interact with patients on a daily basis, and play an important role in risk management and the prevention of aggression (Martin 2001, 2006, Mason 2009). The ultimately aim of ERM is participation of, and later on self management by, the patient in controlling his aggressive

impulses and behaviors. Drake & Deecan (2009) stresses the importance of involving psychiatric patients in decision making during treatment. When the patient is acknowledged as an autonomous adult who (to a certain extent) has the right to participate in decision-making, this may contribute to better compliance. It places the patient in the center of his own treatment and care process. Drake states that psychiatric patients are seldom incapable to decide about their own treatment. He objects to the so-called 'circular reasoning' in clinical practice: *"When the client is compliant, shared decision making is a virtue; when there is disagreement about treatment, the client "lacks insight" and shared decision making is a risk".* (Drake & Deecan, 2009, p. 1007). Shared decision making is also the aim in applying der Früherkennungsmethode: in all four phases of the der Früherkennungsmethode protocol nurses are guided to involve the patient actively in the risk management strategy, i.e. when introducing der Früherkennungsmethode, when drawing up the Early Detection Plan, when monitoring his behavior, and when describing actions. Nevertheless we are aware that, in particular in the start of treatment, forensic patients often lacks insight and motivation to participate in his treatment. Then shared decisions are hardly possible. However, from the angle of nursing care, efforts should be made to involve patients in risk management strategies and start dialogues regarding his behaviors, as is advocated in the der Früherkennungsmethode protocol.

The systematical approach of ERM, may contribute to nurses to interact as professionals in risk management. Mason (2009) studied nurses' roles within the context of binary themes, e.g., confidence versus fear, and success versus failure with regard to nurses' endeavors to contribute effectively to forensic care and treatment. One of the findings of that study is that forensic mental health nurses show little confidence in their ability to manage patients' dangerous behavior, while the fear they experience in their work is relatively high. In the hospital under study, before ERM was introduced, the response towards inpatient aggression was often of a restrictive nature by means of applying coercive measures such as seclusion. ERM was introduced in order to provide nurses structured approach in order to act more as professionals in risk management and deliberately start dialogues with their patients on hostile and aggressive behaviors. Also from the angle of prevention towards inpatient aggression, ERM may assist nurses in their endeavors to interact in advance of the occurrence of aggression.

More follow up research is necessary with regards to the psychometric characteristics of the Forensic Early Signs of Aggression Inventory [FESAI]. The FESAI has to be further validated with regard to, e.g., prospective research on the relation between items of the FESAI and occurrence of inpatient aggression, how the items could be interpreted with regard violent-distal versus violent-proximal behaviors and in if FESAI-items could be perceived only by the patient or also observed by nursing staff.

So far the Early Recognition Method is mainly discussed in relation to inpatient aggression, however, the main aim for treating forensic patients is the prevention of relapse into severe violence such was the case in patient' former offence. The context of an inpatient ward in a forensic psychiatric hospital is that of a rather controlled and safe environment. Stressful events on the wards may hardly mirror the severity and stress patients may have faced while committing the offences in society for which they were convicted. Future research should aim to enlighten if ERM could be modified in order to contribute to the management of early indicators of offence related behaviors.

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Acknowledgement

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"New horizons in interdisciplinary approaches"

The 8th European Congress on Violence in Clinical Psychiatry is taking place in the stimulating, idiosyncratic and authentic city of Ghent. People from all corners of the world will deliver papers, symposia and workshops, present posters and debate how 'new and interdisciplinary approaches' might transform the landscape of violence research, education and practice. The concerns the congress addresses will be of interest and significance to people providing, using, developing and commissioning mental health and intellectual disability services, as well as the people who shape policies.

The congress showcases scientific advances in violence prevention, reduction, risk and management and their application to specific populations and topics. Leading international scholars who are at the forefront of thinking on violence in clinical psychiatry, and beyond, spearhead what promises to be a lively three days of making discoveries about violence in clinical psychiatry, and making these discoveries matter to people's health and well being.

Prof. Patrick Callaghan
Mr. Nico Oud, MNSc
Prof. Johan Håkon Bjørngaard
Prof. Henk Nijman
Prof. Tom Palmstierna
Dr. Roger Almvik
Mr. Bart Thomas, MSc

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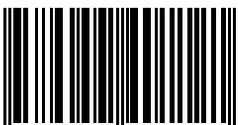
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