Patrick Callaghan - Nico Oud - Johan Håkon Bjørngaard
Henk Nijman - Tom Palmstierna - Joy Duxbury

Proceedings of the 9th European Congress on

VIOLENCE IN CLINICAL PSYCHIATRY

KAVANAH

Violence in Clinical Psychiatry

Prof. Patrick Callaghan
Mr. Nico Oud, MNSc
Prof. Johan Håkon Bjørngaard
Prof. Henk Nijman
Prof. Tom Palmstierna
Prof. Joy Duxbury

Editors

Violence in Clinical Psychiatry

Proceedings of the
9th European Congress on
Violence in Clinical Psychiatry

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Preface

Welcome to 'Wonderful Copenhagen'. Denmark's vibrant, friendly, multicultural capital hosts the 9th European Congress in Violence in Clinical Psychiatry. This year's event is co-organised with the European Network for Training in the Management of Aggression (ENTMA08) and the European Violence in Psychiatry Research Group (EVIPRG); it is also a World Psychiatric Association (WPA) co-sponsored meeting.

This year's Congress theme: 'Advancing Knowledge; transforming practice' showcases the potential of research, education and practice innovations to transform the delivery and organisation of psychiatric services to prevent, minimise and better manage violence in clinical psychiatry. We are delighted to have attracted a host of international scholars, academics, clinicians, managers, policy makers, those using psychiatric services, and delegates.

Contemporary evidence-based health and social care prioritises the judicious use of best available evidence, ethical care, shared decision-making with service users and their representative agents, emphasises human aspects of care with strong service user choice and preferences based upon sound interpersonal skills. This is evident in the quality of presentations at this year's Congress. They provide an invaluable resource to commissioners of mental health and intellectual disability services, educators, and those shaping national and international policies in violence in clinical psychiatry.

As usual the Congress takes an interdisciplinary approach encompassing a range of themes relevant to violence research, education and practice. As usual the Congress focusses on clinically relevant and practically useful interdisciplinary scientific and practical knowledge with regard to interventions aimed at treating and reducing violent behaviour of psychiatric patients, forensic patients and challenging behaviour in persons with intellectually disability. For the first time we will discuss through a "meeting of minds" debate with service users how we can close the gap between the rhetoric of evidence and the reality of everyday practice.

Once again we welcome some of the leading international scholars who are at the forefront of thinking on violence in clinical psychiatry and beyond. Risk assessment and prediction of violence remains a popular, yet challenging field of research. Dr Jay P Singh will examine international perspectives and share evidence on the current state of the art in this area. Dr Singh (and other's) recent work has challenged the scientific reliance of ROC curve analysis and the AUC as the standard techniques to establish reliable predictors of violence and anti-social behaviour.

The clinical outcome of risk assessment and prediction sometimes leads to involuntary detention for those deemed at risk to themselves or others. Dr Soren Bredkjaer, Deputy Director of Psychiatry in the Zealand region of Denmark will discuss his national work addressing involuntary hospitalisation and treatment.

A practising clinical psychologist and academic professor in the North of England, Professor John Taylor is a familiar presence at the Congress. This year we are delighted he will present his recent advances using cognitive behavioural interventions in treating anger and aggression in people with intellectual disabilities.

Towards the end of the last century, the American novelist Tom Wolfe predicted the 21st Century would be the century of cognition. Increasingly the Congress has welcomed the contribution of neuroscience to how neuro-cognitive systems influence violence and aggression. The task this year falls to Dr James Blair, Chief of the Unit on Affective cognitive Neuroscience at the US National Institute of Mental Health. He will examine the neuro-biology of antisocial behaviour/psychopathy in relation to violence.

Ultimately, the primary purpose of violence research, education and practice in clinical psychiatry is the improvement of care and treatment to people using psychiatric services. Dr Julie Repper, Director of Improving Recovery through Organisational Change (ImRoC) in the UK is an international expert on recovery-focussed mental health practice, a leading mental health researcher, and a long-time user of mental health services. Dr Repper will provide a challenging and thought provoking service user perspective on violence and mental health. She will also contribute to the Congress' 'meeting of the minds' debate.

Two presentations come from the Congress' co-organisers. In the first, Dr Tillman Steinert a renowned researcher into violence in clinical psychiatry and a long standing member of EVIPRG will present the latest research on violence in clinical psychiatry. In the second, Dr Brodie Patterson, Chair of ENTMA08 will present recent advances into education and training in the management of violence.

In addition to the outstanding keynote papers the Congress offers a rich selection of concurrent sessions, symposia, poster presentations as well as a stimulating debate from presenters in all continents. What better setting than Northern Europe's premier capital for three days debating contemporary issues in research, education and practice about violence in clinical psychiatry. En varm velkomst til alle!

Professor Dr. Patrick Callaghan,
School of Health Sciences, University of Nottingham, UK

Supporting Organisations

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

- ENTMA[08]
- 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
- St. Olavs Hospital, Trondheim University Hospital
- The University of Nottingham
- The Mandt System
- The Psycho-Fysical Consultants
- Kudding & Partners B.V.
- Friends Hospital
- National Institute for the Prevention of Workplace Violence, Inc

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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 endeavors to do justice to all submitters and to the Congress participants, who are entitled to receive state of the art knowledge at the Congress.

In total we did receive 290 abstracts from 43 different countries worldwide, of which 44 (16%) were rejected, 30 (11%) were withdrawn mainly due to financial reasons or not getting funding in time, and 38 (14%) were not included in the program and the proceedings due to not registering after all or not paying the fees in time. Together with the special workshops and the keynotes in total 190 presentations from 30 different countries worldwide were presented.

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M.H. Knotter[1,2], G.J.J.M. Stams[2], X.M.H. Moonen[2,3], & I.B. Wissink[2.]
1. De Twentse ZorgCentra, Den Alerdinck 2, 7608 CM Almelo, The Netherlands
2. University of Amsterdam, Nieuwe Prinsengracht 130, 1018 VZ Amsterdam, The
   Netherlands
3. Hogeschool Zuyd, Nieuw Eyckholt 300, 6419 DJ Heerlen, The Netherlands.

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Janne Virta (Finland)

Diene Monique Carlos, Maria das Graças Bomfim Carvalho Ferriani,
Elisabete Matallo Marchesini de Pádua, Lygia Maria Pereira da Silva &
Michelly Rodrigues Esteves (Brazil)

Michael Bruenger (Germany)

Maria Teresa Ferreira Côrtes (Brazil)

Sun Mi Cho, Yun Mi Shin, Eun Ha Jung (Korea)

Maria Gutierrez-Cobo, Rosario Cabello & Pablo Fernandez-Berrocal (Spain)

Bung Nyun Kim & Soon-Beom Hong (South Korea)

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Restraint Reduction. Remembering but not repeating.

Keynote speech

Dr. Brody Paterson (UK)

"Progress, far from consisting in change, depends on retentiveness. When change is absolute there remains no being to improve and no direction is set for possible improvement: and when experience is not retained, as among savages, infancy is perpetual. Those who cannot remember the past are condemned to repeat it." [1]

Introduction

The use of restraint whether in the form of seclusion, mechanical restraint or physical holding has been the subject of debate for much longer than many practitioners realise. A truly exhaustive overview of the diversity of that debate is beyond the scope of this discussion that must of necessity be selective. The aim of this presentation will essentially be to summarise what as Santayana observed we should remember from our past both historical and somewhat more recent in order to ensure we make real progress as opposed to delivering mere change.

The early years of this century have seen the re-emergence of a restraint reduction movement in services for people with mental health needs. Such initiatives are in historical terms very far from new and have featured in many calls to reform the treatment of those experiencing mental distress over epochs. Soranus of Ephesus[2] a Greek physician who practiced in the town of the same name some 2000 years ago disagreed with punishment as a means of treatment but accepted that on occasion restraint was necessary stressed that servants who restrained must use their hands and not clubs. Persian physicians such as Rhazes (865-925), a senior doctor in Baghdad the location of the first known mental health ward advocated talking therapies and rejected the use starvation, flogging and fetters.

Ascribing the origins of restraint reduction to later developments in the works of Pinel in France, Tuke and Connolly (an Irishman) in the UK would therefore be a mistake. Such initiatives were driven by ideological, philosophical and religious belief systems that viewed approaches based on punishment as counterproductive and restraints as something to be avoided wherever possible. Tuke a quaker rejected the dominant discourse that "fear (is) the most effectual principle to reduce the insane to orderly conduct" in favour of "A system which, by limiting the power of the attendant" made it in "his interest to obtain the good opinion of those under his care". Connolly (1856) one of the foremost UK critics of mechanical restraint was however less concerned regarding the ethical principles involved than with the difficulties be encountered in preventing its misuse. As Bowers writing somewhat more recently (2005) notes restraint is not intrinsically a punitive intervention but it can be used in a punitive way. Exposes of poor practice involving allegations of the over use of restraint may therefore shock but should never surprise us. The potential for corrupted cultures of care to develop which are characterised by the misuse of physical intervention is a product of processes so powerful that services must continually guard against them.

Recent debates between supposed and actual advocates of restraint elimination and those who are fundamentally arguing that its ethical justification lies in its ultimate necessity to ensure safety for both service users and staff echo essentially echo versions of an argument recorded over centuries. Calls made by some to completely eliminate their use entirely have evoked dissent and reminders that mental health practitioners must sometimes face and manage grave risks. Current debates regarding the desirability of eliminating prone restraint physical intervention procedure once common in the UK have trod much the same ground as those advocating the elimination of mechanical restraint in the 19th century. It may seem tempting therefore to agree with the observation of the anonymous author of Ecclesiastes that there is after all nothing new under the sun.

Nothing however could be further from the truth in that whilst such arguments may in some respects be unoriginal in tenor this does not render them unimportant quite the contrary. They remain as vital as ever they were and the nature of the current debate is different in several key respects from those which have preceded it. This generation have rediscovered restraint reduction in an era in which the bio-chemical discourses that have dominated psychiatry for some decades have been challenged by the narratives of recovery and increasingly of trauma. They have rediscovered restraint reduction in an era of evidence based practice and with access to computing power unimaginable to our predecessors. They have rediscovered restraint reduction in an era where service user voices must be heard in the planning and delivery of services that are subject to levels of audit and demands for accountability almost unimaginable to previous generations.

This context has allowed many of the tenets of the pro restraint camp to be robustly tested. One consequence has been that the old shibboleth that has underpinning the use of restrictive interventions over the many centuries i.e. safety has been undermined by a series of research studies. These have revealed an astonishing variation in the nature and frequency of the use of restrictive interventions used. They also uncovered that the use of restrictive interventions has sometimes posed severe and even even fatal risk to consumers and practitioners.[3] Faced with such findings practitioners, researchers and policy makers across the globe have increasingly become engaged with the question of how to deliver safe and therapeutic services in which restrictive interventions are minimised. A consensus has emerged suggesting that it is only through deep change informed by root cause analyses that restraint reduction can be delivered. Multiple reviews of successful initiatives have suggested they must be systemic, multidimensional and whole organisational[4]. A series of complex interventions have now been developed, tested and disseminated that have delivered reduction.[5,6] Multiple studies have confirmed that services can often significantly reduce the frequency and level of restrictiveness of their interventions without compromising staff safety. The root causes of the corrupted cultures that can develop within mental settings can be identified and addressed.[7]

Significant challenges remain amongst which is how do we ensure that the insights generated by such research become sufficiently embedded in mainstream thinking to resist what will be inevitable regression to the mean. A tendency in this instance inevitably fostered by the discourses that spur the overuse of restraint which will never truly go away.[8] We may though be forgiven for celebrating practicing at a time when we can at least aspire towards proving that old radical Thomas Szasz wrong. Those familiar with his oeuvre will remember his famous or perhaps infamous observation that non-coercive psychiatry was an oxymoron, a conceptual impossibility.[9] We may never be able to completely eliminate the use of restrictive interventions but the ambition to do so has already taken some services on a quite incredible journey in which some old and unspoken assumptions have been foregrounded and challenged. We have on the very long journey the discussion presented here has touched upon sometimes forgotten that control where it may be necessary must rest, as it should in a family, in demonstrating that the person receives more help, more compassion, more love, more understanding and more encouragement then he will encounter elsewhere.[10] This above all is something we must strive not only to remember but to consistently deliver.

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Reduction of restraint use in Denmark – what have we learned?

Keynote speech

Søren Bredkjær (Denmark)
Medical Director, Psychiatry in Region Zealand

Abstract

Restraint and seclusion have been used in many countries and across service sectors for centuries. Restraint use in the treatment of mental illness has long been a controversial practice in Denmark. Regulatory agencies, licensing organizations and professional and advocacy groups have called for reduction of restraint use. With the recent and increasing recognition of the harm associated with these procedures, efforts have been made to reduce and prevent restraint use.

In the last ten year, projects (The National Breakthrough Series Collaborative) in psychiatric departments in Denmark have reduced and prevented restraint use by implementing the breakthrough method. There has been a lot of success for each of the projects but the results have not been implemented at a national level and the figures for restraint on a national level have not changed in the last decade.

In 2014, the Danish Ministry of Health made a partnership with each of the five regions responsible for all the psychiatric departments in Denmark to reduce the use of restraint with 50 % before 2020. The National Board of Health has established a task force that has standardized ways to define, register, measure, follow, and supervise restraint and violence so it is possible to make the inter-facility and inter-regional comparisons. The National Board of Health now publicly reports restraint rate, average duration, and frequency by facility and region every sixth month.

The regions are implementing the best practices to reduce restraint from the National Breakthrough Series Collaborative and elements from the Sixth Core Strategies in reducing and preventing the use of restraint. Leadership commitment is essential to begin and sustain this work of reducing and preventing restraint.

Coercive Treatment in Psychiatry: Ethical Aspects

Keynote speech

Prof. Tilman Steinert (Germany)

Introduction

Should a person not have the right to refuse treatment, and the right to keep one's illness? This is obviously the case in somatic diseases such as cancer, coronary heart disease or diabetes. Nobody would be forced to accept a diabetes diet, drugs for increased blood pressure or chemotherapy or even surgery for cancer, even if there is a considerable risk of deterioration of health status or even death. Most people will intuitively judge this attitude as ethically appropriate. But why should a person with schizophrenia or mania then be forced to take medication against his or her will? Is there any difference? We come closer to an understanding if we consider a patient with post-operative delirium after surgery. The 85-year-old women with acute inflammation of the gall bladder has consented to cholecystectomy after comprehensive information. But in a delirious state after the operation she wants to remove infusions with antibiotics (which she calls poison) and go home, saying she has to go to work and she supposes to be in a "madhouse" with bad people around her. Most people will intuitively feel that it would not be fair to let this patient go home as this would have a deleterious outcome. The key aspect of this scenario is that this patient is suffering from a somatic disease, but also from a mental state (delirium) which impairs her ability to make reasonable decisions. This increases the liability of carers - health care staff in the present case - to take responsibility for her. An ethical framework is required to achieve a sound theoretical reasoning for such cases.

Principle-based ethics

According to principle-based ethics (Beauchamp and Childress 2009, there are four fundamental ethical principles in medicine: respect for the patient's autonomy, beneficence, non-maleficence, and justice. Essentially, coercive treatment is a severe violation of patient's autonomy. Furthermore, coercive treatment can impose harm on the patient due to short-term and long-term medication side effects and psychological distress. On the other hand, withholding treatment can cause deterioration of mental health and social exclusion up to involuntary detention in case of severe behaviour disorders in consequences of untreated mental illness. Withholding treatment for the most seriously ill (who lack insight into illness and into treatment) would be a violation against the principle of justice. These considerations show that the adoption of principle-based ethics to the case of coercive treatment is in most cases not a solution but a first approach to a reasonable discussion.

Insight and capacity to consent

Balancing the four principles of medical ethics, there is only one good reason to justify violations of patient's autonomy: a weakening of this autonomy through severe illness. Severe mental disorders such as psychoses and organic brain disorders can impair insight and capacity to consent. The concept of capacity to consent is different from legal capacity. It is always related to a concrete situation. Patients need to understand relevant information, need to be able to relate that information to their personal situation, and need to be able to make a balanced decision. If a patient does not understand that he suffers from psychosis but understands that he suffers from pneumonia, he may be able to consent to therapy with antibiotics but not to therapy with antipsychotics. In this case it might be justified to transfer the decision on antipsychotic treatment to someone else (a relative, a guardian, a judge or combinations of these) according to a defined and fair procedure. However, it would not be justified that the decision lies on the doctor alone, except for cases of emergency.

Is untreated psychosis a danger to one's health?

Psychiatrists certainly would answer this question with "yes", but why? Results on the level of brain structure are inconclusive in this regard. However, mental disorders frequently manifest themselves as behavioral disorders. Behaviour driven by psychotic experience can be so strange and dangerous that it frequently leads to social exclusion – from involuntary detention in a psychiatric hospital up to seclusion, restraint, and detention in forensic psychiatry. Loss of social inclusion really is a severe damage of psycho-social health.

If coercion is necessary, should coercive treatment or other coercive measures be preferred from an ethical point of view?

This question is very important and it has been answered in opposing directions in different countries. In some countries, most clearly in the Netherlands, the position has been held that treatment is more invasive and a greater violation of patient's autonomy than 'pure' freedom-restrictive measures such as detention, seclusion, and restraint (Steinert et al. 2014). However, the consequence was an excessive use of seclusion which has then led to reconsiderations of such policies resulting in less restrictions to involuntary medication. In other countries, most clearly in the UK, the position has been held that coercive treatment is just treatment in the patient's best interest so that the aspect of coercion in treatment received rather little attention in research and practice. In recent years, there has been some empirical research on the use of different coercive interventions and patients' views on them. One definite answer is that not all patients need and prefer the same, as in all other areas (Veitkamp et al. 2008, Georgieva et al. 2012, Steinert et al. 2013). Concerning the use of different coercive interventions and successful strategies to avoid or replace them, ethical positions need to be supported by the findings of empirical research.

Conflict with the UN position on human rights

The ideas outlined so far are well accepted among ethicists and psychiatrists and find themselves more or less in the legislations of many developed countries. However, in 2013, a special report to the Human Rights Council of the United Nations (UN 2013) caused considerable concerns among psychiatrists. In this report, all coercive treatment and use of coercive measures in mentally ill people is called ill-treatment and even torture. The idea of lack of capacity and treatment in the patient's best interest is explicitly addressed as not justified in this report. It relates to the UN Convention of Rights of Persons with Disabilities which does not include any concept such as lack of capacity.

Danger to others: additional ethical conflicts

Coercive treatment may be justified if it is carried out in order to improve the patient's health or to avoid harm from her or him. In many cases, and in most cases of psychotic disorders, dangerous behaviour is due to the disorder. If so, treatment of the disorder is appropriate to improve also the dangerous behaviour. In these cases, coercive treatment might be justified under several conditions, because it is also in the patient's best interest. In some cases, however, medication is not in the interest of the patient but only or primarily in the interest of others. This applies if psychoactive drugs are used against a patient's will primarily for the purpose of controlling aggressive or other undesired behaviour and not for the treatment of an underlying mental disorder. No drugs are approved for this purpose, their application would be off-label anyway. Such kind of application of drugs cannot be called 'treatment' because it is not in the patient's interest. It should be considered as unethical. A subsequent question is whether mental health professional should be obliged to care for dangerous people who do not profit from treatment which can be offered by mental health services.

Ethical concern in involuntary outpatient treatment

In the countries where it is in use, involuntary outpatient treatment has been introduced primarily to ascertain antipsychotic maintenance therapy, preferably with depot antipsychotics, for people with poor insight into illness and treatment and frequent relapses. Under antipsychotic treatment, most of these individuals recover and regain capacity to consent. But, if they have capacity, it cannot be ethically justified to use coercion to apply the next depot medication. This could cause serious concern not only for people with mental illness but for civil rights in general. Where does it happen elsewhere in democratic societies that people who have not committed a crime are forced to undergo a medicalised dangerousness management against their will?

Conclusion

Mental health professionals and policy makers who are concerned with aspects of coercive treatment need continuous ethical reflections based on philosophy as well as research evidence.

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Correspondence

Prof. Dr. med. Tilman Steinert
Centres for Psychiatry Suedwuerttemberg
Ulm University, Clinic for Psychiatry and Psychotherapy I
Medical Director
Director of Education and Research
Weingartshofer Straße 2
88214 Ravensburg
tilman.steinert@zfp-zentrum.de

International Perspectives on Violence Risk Assessment

Keynote speech

Jay P. Singh, PhD

Keywords: violence, risk assessment, forensic, crime, innovation

Over the past 30 years, the development of structured instruments to aid in the evaluation of violence (including sexual violence) risk has become a cottage industry. There are now literally hundreds of available risk assessment tools and a large research literature suggesting their superior reliability and predictive validity over unstructured clinical judgments (Singh, Serper, Reinharth, & Fazel, 2011). With over 40 systematic reviews and meta-analyses on the topic (Singh & Fazel, 2010), and an average of 17 new risk assessment articles being published each month (Global Institute of Forensic Research, 2014), it is important to take a step back from this fast-moving train and examine possibilities for research innovation. The present article provides an overview of five opportunities for innovation in risk assessment research.

Recommendation 1:

Move beyond the idiographic vs. nomothetic controversy and start focusing on the nomothetic vs. nomothetic controversy

Over the past seven years, much research and commentary has focused on the issue of whether actuarial risk assessment tools can reliably apply group-based estimates of recidivism risk to individuals (e.g., Cooke & Michie, 2010; DeMatteo, Batastini, Foster, & Hunt, 2010; Hart, Michie, & Cooke, 2007; Scurich, Monahan, & John, 2012). This has come to be known as the "idiographic versus nomothetic" controversy. What seems to have been forgotten is that there is only a need for research in this area if practitioners are actually assigning group-based probabilities to individuals (e.g., "Mr. X has a Y% probability of recidivating in Z years"). But only a minority of practitioners are doing so. Indeed, according to recent survey evidence (Singh, 2013b), a large majority of clinicians communicate risk in a categorical (e.g., "Mr. X is at low/moderate/high risk") or dichotomous manner (e.g., "Mr. X is dangerous").

Abandoning actuarial risk assessment tools based solely on the argument that group-based estimates are not applicable to individuals is a slippery slope. By this logic, most research findings should be disregarded, as the preponderance of scientific investigations attempt to make conclusions about individuals based on group-level findings. Consider the public health problems that would result from disregarding widely-used medical screening tests such as mammograms or prostatic-specific antigen tests due to their use of normative cut-off thresholds to inform decisions about individuals.

In the end, what is worrying in the actuarial risk assessment literature is not so much that group-based estimates cannot be applied to individuals, but rather that group-based estimates appear to not be applicable to groups. Two meta-analyses in the past year have found that rates of recidivism in groups judged to be at "high risk" by both sex offender (Singh, Fazel, Gueorguieva, & Buchanan, 2013) and violence risk assessment tools (Singh, Fazel, Gueorguieva, & Buchanan, 2014) vary so much that practitioners simply cannot assume manual-based probabilistic estimates of recidivism risk to be true. These large reviews found that sexual recidivism rates in "high risk" groups were higher in younger samples assessed by actuarial instruments when conviction was the study outcome, and violent recidivism rates in "high risk" groups were higher in samples with fewer men where an SPJ tool had been administered to a population with overall higher recidivism rate. And recent primary research has confirmed that even when replication studies match the sample and design characteristics of normative investigations closely and follow manual-based protocols exactly, group-based recidivism rates still do not hold (Rossegger, Endrass, Gerth, Urbaniok, & Singh, 2014; Rossegger, Gerth, Singh, & Endrass, 2013).

This nomothetic versus nomothetic quandary is more concerning than the idiographic versus nomothetic debate, as a main benefit of actuarial instruments over alternative risk assessment approaches is the production of probabilistic estimates of group-based recidivism. And if these estimates do not hold for

different risk groups or risk scores (cf. Helmus, Thornton, Hanson, Babchishin, & Harris, 2012), then it could be argued that the actuarial approach has a difficult road ahead in forensic mental health.

Recommendation 2: Move beyond discrimination validity

In the context of structured risk assessment, predictive validity refers to the ability of an instrument to predict the likelihood of an adverse outcome (Singh & Petrila, 2013). This form of construct validity can be divided into two equally important components: discrimination and calibration (for a primer see Singh, 2013a). Consistent with a diagnostic approach, discrimination refers to the ability to retrospectively detect whether recidivists were judged to have been at higher risk than non-recidivists. Consistent with a prognostic approach, calibration refers to the ability to prospectively predict whether individuals judged to be at higher risk are more likely to recidivate. Given that risk assessment in practice relies inherently upon conditions of uncertainty, the calibration component of predictive validity is perhaps more relevant. But calibration performance indicators are reported in less than a third of risk assessment predictive validity studies, with the general reasoning being that discrimination indicators are less influenced by outcome prevalence rates and, hence, easier to compare across studies (Singh, Desmarais, & Van Dorn, 2013). This said, both discrimination and calibration validity should arguably be established before implementing an instrument in practice.

As Bayesian thought is currently in vogue in the field (e.g., Harris & Rice, 2013; Beauregard & Mieczkowski, 2009; Wollert, 2006), it may be that the time has come to explore advancing the statistical methodology used in the field to take into consideration the issue of outcome prevalence rather than to systematically sweep this issue under the proverbial rug. For example, instead of providing readers with receiver operating characteristic (ROC) curves, predictiveness curves could be constructed (Pepe et al., 2008). Rather than publishing areas under the ROC curve (AUC), probabilistic AUCs could be reported (Shiu & Gatsonis, 2008). Should researchers wish to combine both discrimination and calibration in a single performance indicator, the Brier score and its various decompositions could be calculated (Rufibach, 2010).

Recommendation 3:

Move beyond using comparisons against chance

Risk assessment researchers have a number of statistical methods at their disposal when measuring predictive validity. Many of these methodologies – including correlation, regression, and ROC curve analysis – incorporate null hypothesis significance testing (NHST). NHST is a statistical method by which the likelihood of a research hypothesis being "true" is evaluated (Carver, 1978). The conventional null hypothesis in the behavioral sciences is chance. However, there are no practitioners whose alternative to using a risk assessment tool is simply flipping a coin (and if there are, please alert me so malpractice charges can be brought forth). As a field, we cannot be content to rely on methods of statistical testing that lack practical meaning.

The ideal comparison against which to compare the performance of risk assessment tools would be unstructured clinical judgments. However, to recommend that case-control study designs be used when clinical guidelines suggest that structured assessments are preferable to unstructured evaluations would be unethical. An alternative would be to use routinely available pieces of information that would likely drive unstructured clinical judgments as a proxy. Recent research has shown that simple models composed of just three pieces of routinely available information (age, sex, and criminal history) produce rates of discrimination validity similar to widely used risk assessment scales (Fries, Rossegger, Endrass, & Singh, 2013; Buchanan & Leese, 2006; Fazel, Singh, Doll, & Grann, 2012). This transition would mean that the p-values produced by commonly used statistical packages, which assume a null hypothesis of chance, would no longer be reported. Rather, predictive validity estimates produced by tools versus routinely available demographic information would be compared using established statistical tests such as the Steiger (1980) z-test or the Pearson-Filon (1898) z-test for differences in correlations, the Breslow-Day (1987) $\chi2$ test for differences in odds ratios, or the DeLong-DeLong-Clarke-Pearson (1988) $\chi2$ test for differences in AUCs. In interpreting the findings of these tests of differences, it should be remembered that statistical significance – no matter how it is calculated – does not necessarily mean practical importance, and smaller p-values do not necessarily mean stronger relationships (Glinger, Leech, & Morgan, 2002).

Recommendation 4:

Move beyond using rules-of-thumb to justify claims of predictive validity

There is little question that the AUC is the most commonly used performance indicator in predictive validity studies of risk assessment tools. In their systematic review of predictive validity methodology, Singh, Desmarais, and Van Dorn (2013) found that AUCs were frequently labelled as small, moderate, or large in terms of their magnitude. The usefulness of such rules-of-thumb is predicated upon there being some agreement in the field as to what ranges of AUCs constitute small, moderate, and large effect sizes. But there is no such agreement. Both the Singh review and an overview by Mossman (2013) – the clinical researcher who introduced the field to ROC curve analysis in the 1990s – have concluded that there is too much variability in rules-of-thumb for them to be practically useful. Rather than relying on rules-of-thumb, AUCs should be interpreted for readers using a standardized definition (e.g., "The probability that a randomly selected recidivist had a higher risk classification than a randomly selected non-recidivist was X%"). Surprisingly, such a straightforward interpretation is provided in a minority of studies. Also, it is important to note that risk assessment tools that perform well at identifying recidivists but poorly at identifying non-recidivists can produce the same AUCs as tools that perform well at identifying non-recidivists but poorly at identifying recidivists (cf. Singh, Grann, Lichtenstein, Långström, & Fazel, 2012). Hence, statements that an instrument should be used in practice solely because the AUCs it produces are comparable with those of other instruments should be read with due caution.

Recommendation 5:

Move beyond assuming incidents of recidivism occurred after index offenses

The use of criminal registers to detect incidents of recidivism is commonplace in predictive validity studies of risk assessment tools (Singh, Grann, & Fazel, 2011). Though much has been written on the potential drawbacks of relying solely on register-based outcomes like charges or convictions (e.g., Davies, Clarke, & Duggan, 2004; Monahan et al., 2001), comparatively little attention has been paid to the closely related issue of pseudo-recidivism. Pseudo-recidivism refers to new charges or convictions handed down after an index offense precipitated by incidents occurring before that index offense (Quinsey, Harris, Rice, & Cormier, 2006).

Consider the following situation: Mr. X is charged with threatening to his father-in-law with a knife and is released on bail. The next day he gets into an argument at a local bar, a confrontation that ends in Mr. X murdering the bartender. He is summarily convicted of second-degree murder and incarcerated in the state penitentiary. Upon admission to the facility, a risk assessment tool is administered with hopes of establishing the likelihood of future harmful behavior. Six months later, Mr. X goes to court to face the charge of threatening his father-in-law and is convicted. Is this new conviction an act of recidivism? No – the new conviction was for an incident that occurred before the index offense. But if researchers interested in the predictive validity of the administered risk assessment tool rely solely upon conviction outcomes without cross-referencing date-of-offense information, then their findings concerning the utility of the tool will be biased. It is important to control for this issue of pseudo-recidivism to ensure that outcomes rates are as accurate as possible.

Concluding Remarks

The most important aspect of risk assessment research can be summed up in a single word: transparency. Consumers of research – be they other researchers, practitioners, or policymakers – need to know exactly how an instrument was tested and on whom in order to judge whether findings are applicable to their particular context. Consensus-based guidelines for what should be routinely reported in risk assessment research have recently been established (Singh, Yang, Mulvey, & the RAGEE Group, 2015), offering a promising way forward. With high hopes for the field, what must be advocated when it comes to structured risk assessment is neither nihilistic cynicism nor unfettered optimism, but rather objective and respectful scientific caution. Risk assessment tools are not panaceas, but they do represent a significant improvement in psychometric performance over unstructured approaches.

Conflicts of interest

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Correspondence

Global Institute of Forensic Research
11700 Plaza America Drive
Suite 810
Reston, VA 20190, USA
jaysingh@gifrinc.com

Coercion in Psychiatry: A User Perspective

Keynote speech

Julie Repper RGN RMN Ba(Hons) MPhil PhD

Abstract

Violence in Clinical Psychiatry has long focused on why, how, when and how often patients are violent towards staff. Whilst this has often been done sympathetically in order to improve the experience of patients and thereby reduce the likelihood of them being violent, neither the violence perpetrated by psychiatry (Clarke, 1964) nor the perspectives of people who use services have been explored in such detail. It is only when both sides of this story are fully understood that both can be brought together to coproduce more harmonious, less restrictive, recovery focused services.

I have used acute psychiatric services on and off for nearly 40 years and so I am aware of how it feels to be rendered powerless and voiceless by people who don't appear to hear my distress, who don't seem to try to understand what I am saying, who offer glib responses when faced with my desperation, who effectively minimise my despair and who label it rather than listening. Such utter powerlessness – an absolute conviction that I can't cope, am not being heard, am unable change things - is unbearable and so it inevitably turns into that seering high pitched pain that can only be relieved by doing something that makes a difference, that stops the burning pain. This might be harming oneself or it might result in someone or something else. For me, and others like me, it is called coping with an unbearable situation. For you this is Violence in Clinical Psychiatry.

In this paper I want to go beyond my own experiences to describe the feelings, beliefs, and explanations for violence that have been narrated by people who use mental health services. I will then draw on recent research and practice based evidence about coproduction, shared decision making, joint crisis plans, negotiated safety plans and collaborative care planning to propose processes that bring together the experiences, roles, relationships and skills of both people who use services and people who staff those services in order to find solutions and negotiate agreements that reduce violence and promote recovery.

Correspondence

Julie Repper
Julie.Repper@nottshc.nhs.uk

Understanding and Treating Anger and Aggression in Adults with Intellectual and Developmental Disabilities

Keynote speech

Prof. John L. Taylor, Northumbria University and Northumberland, Tyne & Wear NHS Trust, UK.

Introduction

During 2013-2014 there were 30,574 admissions to NHS facilities (including high security hospitals) in England under the Mental Health Act (MHA) 1983 (Health & Social Care Information Centre, 2014). Of the 29,116 detentions under civil sections of the act during this period 2.5% were categorised as having an intellectual disability (ID). However of the 1,317 criminal detentions under court and prison disposals during the corresponding period, just over 6% were categorised having an ID. Assuming a normal distribution, the proportion of people in the general population with IQ scores under 70 is approximately 2.5%. Thus it appears that more than double the expected number of people with ID are being detained in NHS facilities under criminal sections of the MHA 1983. However, the evidence that people with ID commit more crime than others is highly equivocal.

It is not clear whether people with ID commit more crime than those without ID or, in fact, whether the nature and frequency of offending by people with ID differs from that committed by offenders in the general population. A policy of deinstitutionalisation has been implemented across the western world since the mid-1970s and has had a significant effected on services for people with ID who offend or engage in offending-type behaviour. For example, most large hospital facilities for people with ID in the UK would have had wards dealing with patients exhibiting this type of behaviour. Such people are now more likely to be living in community settings where their offending and offending-type behaviour is more visible and subject to scrutiny by the criminal justice system.

Prevalence and Impact of Anger and Aggression

In the Northgate, Cambridge and Abertay Pathways (NCAP) project O'Brien et al. (2010) reported on the offence characteristics of 477 adults with ID referred to ID services in three regions of the UK during a 12-month period because of antisocial or offending behaviour. They found that aggression (physical and verbal) accounted for over 80% of the antisocial and offending behaviour referred. Research on several continents has found high rates of aggression amongst people with ID – with much higher rates for those living in institutional and secure forensic facilities than for those residing in community settings (see Table 1). The impact of aggression is significant in a number of ways for people with ID and those who provide support and services to them. Aggression has been shown to be the main reason for individuals in this client group to be prescribed antipsychotic and behavioural control drugs (Aman et al., 1987), despite there being little or no evidence for their efficacy (e.g. Brylweski & Duggan, 1999; Tyrer et al, 2008); and it is the primary reason for people with ID to be admitted or re-admitted to institutional settings (Lakin et al., 1983).

While it is neither necessary nor sufficient for aggression to occur, anger has been shown to be strongly associated with and predictive of violence in men with ID and offending histories (Novaco & Taylor, 2004). Thus anger has become a legitimate therapeutic target. The treatment of anger and aggression using cognitive-behavioural interventions has been extensively evaluated with a range of clinical populations (see Taylor & Novaco, 2005 for a review). One potential advantage of cognitive behavioural anger treatment over interventions based on applied behaviour analysis, is that self-actualisation through the promotion of portable and internalised control of behaviour is intrinsic to the skills training components of these approaches (Taylor, 2002). Further, there is evidence from studies in non-disability fields that for a range of psychological problems the effects of cognitive-behavioural treatments are maintained and increase over time compared to control conditions (Taylor & Novaco, 2005).

Cognitive Behavioural Anger Treatment

Willner (2007) reviewed nine controlled studies involving people with ID that compared cognitive behavioural treatment for anger control problems with wait-list control conditions. Most of these

interventions were based on the treatment approach developed by Novaco (1975) that incorporates Meichenbaum's (1985) stress inoculation paradigm. All of these studies reported significant improvements on outcome measures for those in treatment conditions that were maintained at 3 to 12-month follow-up. Nicoll et al. (2013) systematically reviewed 12 studies of cognitive behavioural treatment for anger in adults with ID published between 1999 and 2011. Nine studies were included in a meta-analysis that yielded a large uncontrolled effect size (average ES = 0.84).

Taylor and colleagues have evaluated individual cognitive-behavioural anger treatment with detained male patients with mild-borderline ID and significant histories of violence in a linked series of studies (Taylor et al., 2005; Taylor et al., 2002; Taylor et al., 2004). The 18-session treatment package included a six-session broadly psycho-educational and motivational preparatory phase; followed by a 12-session treatment phase based an individual formulation of each participant's anger problems and needs, following the classical cognitive-behavioural stages of cognitive preparation, skills acquisition, skills rehearsal and then practice in vivo. These studies showed significant improvements on self-reported measures of anger disposition, reactivity and imaginal provocation following intervention in the treatment groups compared with scores for the control groups, and these differences were maintained for up to four-months following treatment. Figure 1 shows the effects of anger treatment over a routine care control group on the Novaco Anger Scale (Novaco, 2003), a reliable and valid self-report measure of anger disposition, as reported by Taylor et al. (2005).

Reductions in Aggressive and Violent Behaviour

The impact of these anger interventions on aggressive behaviour, including physical violence, has been investigated empirically on only a few occasions. Allan et al. (2001) and Lindsay et al. (2003) reported reductions in violence following a group intervention in case series of 6 women and 6 men respectively with violence convictions living in the community. In a larger study involving 47 people with ID and histories of aggression, Lindsay et al. (2004) showed that following a community group anger intervention 14% of participants had been aggressive during follow-up, compared with 45% of people in a control condition.

Taylor et al. (in press) described an evaluation of the impact of the cognitive behavioural anger treatment described earlier (e.g. Taylor et al., 2005) on aggressive and violent behaviour by offenders with ID living in secure forensic hospital settings. Incident data were collected retrospectively from hospital case notes over a 24-month period. The data collected were organised into four assessment intervals: Time 1 = 7-12 months pre-treatment; Time 2 = 0-6 months pre-treatment; Time 3 = 0-6 months post-treatment; and Time 4 = 7-12 months post-treatment. The participants in this study were 44 men and 6 women referred by their clinical teams for anger treatment on the basis of their histories of aggression and/or current presentation. The total number of aggressive incidents fell from 856 in the12-months before treatment to 561 in the 12-month period following. This represents a reduction after treatment of 34.5%. The total number of physical attacks against staff and patients fell from 319 in the12-months before treatment (Time 1 = 128; Time 2 = 191) to 153 in the 12-month period following treatment (Time 3 = 93; Time 4 = 60). This represents a reduction after treatment of 55.9%. The reductions in the mean number of physical attacks from Time 2 pre-treatment to Time 3 and Time 4 post-treatment were statistically significant.

Importantly, in an extension of this study, Novaco and Taylor (2015) demonstrated that the reduction in physical assaults was associated with measured reductions in anger over the course of treatment as indexed by several anger measures validated for use with this population.

Conclusions

Aggression and violence by people with ID is a significant problem for patients, staff and service-providers, and is amplified in inpatient secure services. Antipsychotic medication is the most common treatment for aggression in people with ID despite the absence of an adequate evidence base with this population (e.g. Tsiouris, 2010; Tyrer et al., 2008). The evidence base for cognitive behavioural anger treatment for people with ID has been growing steadily over the last two decades.

These interventions can be effective in the treatment of offenders with ID and histories of aggression and violence in terms of improvements on self-report and informant anger dependent measures. However, there has been little evidence available to show that treatment gains on measures anger disposition, reactivity and control are associated with reductions in aggressive and violent behaviour. The results of recent research shows that incidents of aggressive behaviour directed at others, including physical assaults, reduce significantly for detained patients with ID in the 12-month period following delivery of a

case-formulated, individual cognitive behavioural anger intervention compared with the 12-month period prior to treatment commencing.

Further, the reduction in physical assaults was associated with measured reduction in anger over the course of treatment, indexed by multiple self-rated anger psychometric scales with validated use for this patient population. Importantly, reduction in patient anger over the course of treatment as rated by staff in their ward observations was also significantly associated with the decline in assaults from pre-treatment to post-treatment. Overall, the results provide support for the rationale that case-formulated cognitive behavioural anger treatment has clinical value in reducing patient violence.

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Table 1: Studies of Prevalence of Aggression amongst People with ID

	N	Location	Prevalence (%)		
			Community	Institution	Forensic
Tyrer et al. (2006)	3065	England	16	-	-
Taylor et al. (2004)	782	England	12	-	-
Hill & Bruininks (1984)	2491	USA	16	37	-
Harris (1993)	1362	England	11	38	-
Sigafoos et al. (1994)	2412	Australia	10	35	-
Smith et al. (1996)	2202	England	-	40	-
Novaco & Taylor (2004) †	129	England	-		47
McMillan et al. (2004) †	124	England	-	-	47
Note. †These studies involved detained inpatients with offending histories. The prevalence concerns physical assaults post-admission.					

Figure 1. Mean Novaco Anger Scale Total scores over Time. ANCOVA (WAIS-R IQ as covariate) F(1,33) = 4.74. p < .05, r = .35
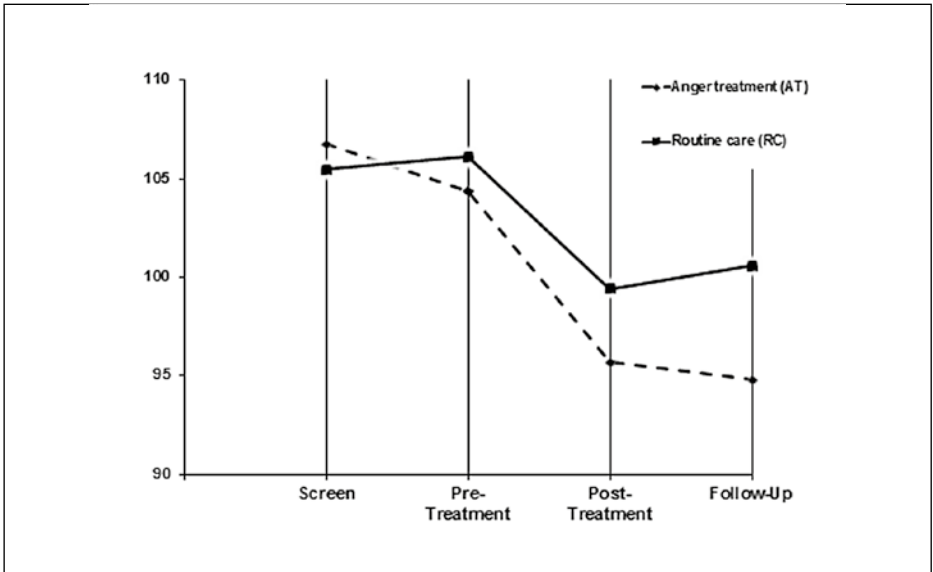
Figure 2. Total Physical Attacks Over 24 Months. ANOVA (log10), F(1,49) = 11.23, p = .002, r = 0.43.
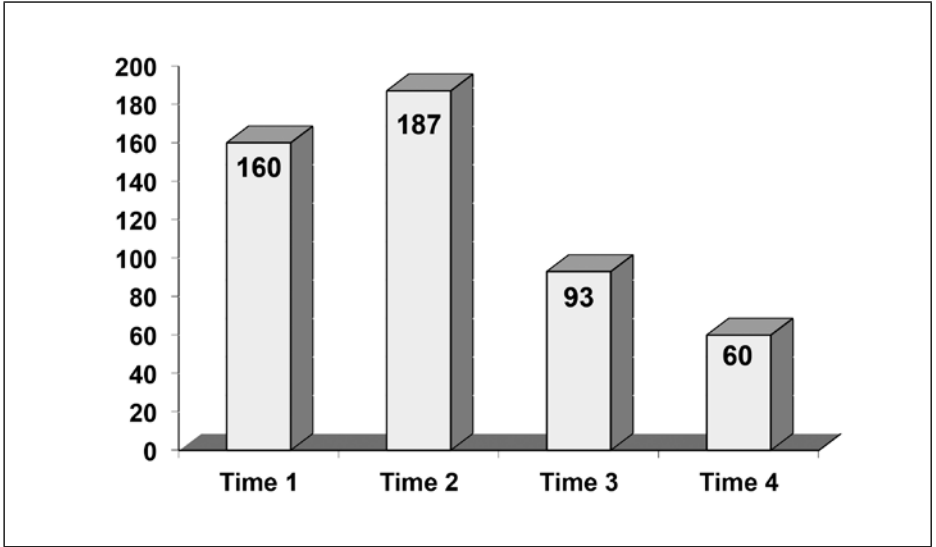
Correspondence

Professor John L. Taylor
Northumbria University
Room H018, Coach Lane Campus-East
Benton, Newcastle upon Tyne, NE7 7XA, UK,
john.taylor@ntw.nhs.uk

A cognitive neuroscience approach to violence

Keynote speech

James Blair (USA)

The cognitive neuroscience approach with respect to psychiatry involves considering not only which neural regions are dysfunctional in a patient population but also what functional impairments are consequences of this neural dysfunction. This paper takes the cognitive neuroscience approach to the study of violence. The first thing to note is that violence/aggression is not a homogeneous behavior. A distinction can be drawn between instrumental and reactive aggression. Instrumental aggression is aggression committed to achieve a goal; e.g., acquiring another individual's money. As such, instrumental aggression is like any other form of instrumental behavior. What is interesting is that few individuals typically use instrumental aggression to achieve their goals. This relates to a desire to avoid the negative consequences of engaging in instrumental aggression. Importantly, the distress of another individual is a particularly salient negative consequence of instrumental aggression. The amygdala is a core component of a circuit that orchestrates responding to the distress of others. The level of a patient's dysfunction in their amygdala responsiveness to the distress of others predicts their level of instrumental aggression. It also predicts their level of callous-unemotional traits (reduced guilt and empathy), the core emotional component of psychopathy.

Reactive aggression is aggression committed in response to threat, social provocation and frustration. Considerable work with animals has identified a circuit that includes the amygdala, hypothalamus and periaqueductal gray and which organizes the response to threat. Distal threats induce freezing but as they grow closer they induce flight and, if very close, fighting. Work with animals indicates that the greater the activity of the amygdala, hypothalamus and periaqueductal gray, the greater the likelihood that reactive aggression will be displayed. Recent fMRI work has shown that this network shows a response to threat, social provocation and frustration in humans also. Importantly, individuals who selectively show an increased risk for reactive aggression show heighted responsiveness of this circuitry to threat and social provocation relative to healthy individuals.

Aggression, including even reactive aggression, is typically a chosen behavior. Human reactive aggression paradigms such as the Taylor Aggression Paradigm involve participants choosing a response to provocation. Reinforcement-based decision-making, choosing actions based on the rewards and punishments associated with them, involves a series of neural regions including ventromedial frontal cortex, dorsomedial frontal cortex and anterior insula cortex. Ventromedial frontal cortex is particularly responsive to the reinforcement associated with an action. This region shows increased responding when a participant is choosing a behavior as a function of the reward associated with that choice. Deficient responding within this region should be associated with poorer response choices. These will include poorer modulation of aggressive responses. In line with this, recent fMRI work reveals that patients showing heightened levels of aggression show reduced modulated ventromedial frontal cortex activity when retaliating to another individual's social provocation. Notably, the level of failure in modulation predicts the level of reactive aggression shown by the individual in the community.

Dorsomedial frontal and anterior insula cortices are particularly important when choosing to avoid particular behavioral choices. Importantly, they show increases in activity as a function of the poverty of the choice. The more a behavioral choice is associated with punishment, the greater the activity in these regions should a healthy individual make that choice. However, recent fMRI work reveals that patients showing heightened levels of aggression show reduced modulation of dorsomedial frontal and anterior insula cortices as a function of anticipated punishment in decision-making paradigms. Moreover, this work reveals that the greater this impairment, the greater the levels of antisocial behavior symptoms shown by the patients.

In summary, the proposed paper will consider four core neuro-cognitive systems involved in emotional responding and reinforcement-based decision-making and show how these, when dysfunctional, increase the risk for aggression and antisocial behavior.

Chapter 2 – Special Debate: "Meetings of the Minds"

Meeting of the minds: closing the gap between violence research, education and practice

In debate with service users form the UK and Denmark

Violence in clinical psychiatry remains a major health care issue in many parts of the world. Research and education on the prevention, minimisation and management of violence in this setting is extensive and ongoing. In line with most research and educational initiatives, it remains a formidable challenge to translate these activities into better care for people using psychiatric services. This session will debate how we close the gap between violence research and education, and clinical practice.

Co-production is a method, approach and philosophy to deliver health and social scare services that uses an egalitarian and reciprocal approach between people delivering services and those receiving them. It has been shown to produce better and sustained outcomes for service users. It can be summed up by the phrase 'nothing about you, without you'. Using this approach, academics, clinicians and service users will debate with conference delegates what value violence research and education has for improving the experience of people using mental health services where violence is present.

Topics that we will explore during this session include the role and presence of mental health service users working collaboratively with violence researchers and educators in the design and delivery of research and education, the possibilities and pitfalls in working with service users in violence research and education, the issues and concerns that service users have with violence research and education, and how researchers and educators address these and whether discourses around violence research and education disempowers service users and impedes the translation of research and educator into better services.

Presenters

Professor Patrick Callaghan, UK - Moderator
Dr Julie Repper, UK – Discussant
Odile Poulsen, Denmark – Discussant

Chapter 3 – Epidemiology and nature of violence

Patient and Visitor Violence in a South Indian hospital

Background

Patient and visitor violence (PVV) towards staff is common across health settings. It is has negative effects on staff and treatment provision. There is very little data from the developing world.

Aims

We examined the prevalence of PVV in India in a government run hospital and a Missionary hospital in South India and made comparisons with existing data.

Methods

We administered an abbreviated version of the Survey of Violence Experienced by Staff (SOVES-A) in English in Mysore on medical and psychiatric wards in two different hospitals that serve an underprivileged area.

Results

249 staff participated. 16% of staff in psychiatric wards was subjected to some form of PVV in the past 4 weeks which is lower than in the developed world. Fifty-seven percent of staff on medical wards experienced PVV which is similar to the developed world. Patients and Visitors were almost equal sources of this violence. Verbal abuse was more common than threats and physical assaults. Training in aggression management may be a protective factor.

Conclusion

PVV is a significant problem in India, especially on medical wards. Aggression management training may be a way to reduce the prevalence of PVV. PVV on psychiatric wards may be reduced because of the fact that a relative is routinely present at all times when a patient gets admitted to a psychiatric unit.

Educational Goals

- Expand knowledge of prevalence of violence in hospital settings outside Europe
- Compare PVV data

Correspondence

Mr. Peter Lepping
BCULHB, Centre for Mental Health and Society (Bangor University) and Mysore MC&RI
Ffordd Croesnewydd
LL13 7TD Wrexham, Wales (UK)
peter.lepping@wales.nhs.uk

The Nature of Violence: Strategies for Violence Prevention

Sylvia McKnight (USA)

Abstract

Violence in healthcare facilities is a prominent global concern. To prevent violence it is necessary to have an organized plan of action against violence. It is vital to learn where violence originates and then to develop an organized interventional plan to prevent violence. This article analyzes the origins (causes and risk factors) of violence and delineates the process and development of an evidence based violence prevention plan designed to negate violence risk factors and prevent violence in mental health facilities. Specific techniques are presented for prevention and de-escalation of aggression to prevent violence. Strategies are determined for development and implementation of effective violence prevention plan utilizing holistic evidence based interventions to prevent/reduce violence in mental health facilities for a safe and therapeutic environment for everyone. Implications for practice are strategies for best practice in safety and violence prevention. Environmental, patient and caregiver interventions for prevention of aggression and violence in mental health facilities is delineated as well as psychosocial management of aggressive behavior for safety in the healthcare environment. An effective violence prevention educational plan is presented for holistic applications for decreasing violence in psychiatric facilities promoting mental health, wellness and recovery.

Introduction

Violence is a prominent global healthcare concern. Violence permeates every aspect of our culture, including mental health care organizations (Liss & McCaskell, 1994; Cole, 2005). Every year one in four mental health nurses suffers a disabling injury from patient violence (Simon & Tardiff, 2008; Findorff et al, 2004;Franz et al, 2010). An essential safety strategy for violence prevention is the development and implementation of an organized violence prevention plan for mental health care facilities. A violence prevention plan decreases violence and assists to maintain a safe and therapeutic environment for everyone. This article describes the process of the development of an evidence based violence prevention plan with interventional strategies effective to prevent/reduce violence in mental health facilities. The violence prevention plan developed is based on violence origins (causes) and prevention of violence, focusing interventional strategies to prevent the phenomenon of violence promoting safety, health, wellness and optimal recovery outcomes.

Background

To prevent violence it is necessary to learn where violence originates (Demeo,1991; Pinker, 2011; Copeland-Linder, Lambert, & Lalongo, 2013;Sapolsky, 2007; Littrell & Littrell,1998).Violence is defined as an outburst of physical force that abuses, injures or harms another individual or object (Sunderland, 1997). Appropriate organized healthcare response to the phenomenon of violence requires recognition that violence originates from multiple causes. There is robust evidence that origins of violence is associated with patient risk factors, environmental risk factors, caregiver (nursing and mental health staff) risk factors and that in most cases violence is predictable (Distasio, 1994).

Method

The process of developing an evidence based violence prevention plan begins with researching the violence risk groups of patient, environment and caregiver for risk factors associated with violence as well as researching effective strategies to negate each violence risk factor and prevent violence (Bowers et al, 2009). Extensive research was completed utilizing multiple data bases such as PubMed and CINAHL from years 1989 to 2014. The research identified definitive risks for violence (Findorff et al, 2003). After each group's risk factors is identified then strategies and an interventional plan is developed from best practice to reduce/eliminate each risk for violence.

Patient violence risk factors

Literature review on patient risk factors for violence indicates there are primary groups that are associated with increased risk of violence. The first high risk group for violence are those individuals with a diagnosis of psychosis such as schizophrenia or bipolar disorder (Hodgins, 2008). The second high risk group is organic patients with neurological or medical disorders such as brain injury, dementia, organic brain syndrome, alcohol or drug intoxication, infections, delirium or degenerative diseases of brain. The last high risk group for violence is personality disorders such as borderline personality disorders known for poor impulse control (Umhau, Trandem, Shah, & George, 2012). Mental instability increases the risk of directed violence toward others. Indicators for primary motivation for violence include 1) disordered impulse control, 2) psycopathy and 3) symptoms of psychosis (Simon & Tardiff, 2008). The presence of delusions or command hallucinations with violent content is an indicator of greatly increased risk of violence in that individual.

Environmental violence risk factors

Environmental risk factors may contribute substantially to the risk of violence. Research suggests that environmental factors such as levels of stimulation can affect the risk for violence. Environmental factors of excessive external stimuli such as noise or physical activity is associated with violent behavior. An environment that is devoid of therapeutic groups and activities contributes to boredom and also increases risk of violence. Changing environments such as during renovation may increase risk of violence (Chou, Kaas, & Richie, 1996). A major contributing environmental factor is lack of unit structure and a predictable schedule. The most common times for inpatient violence are at meal times when patients have eating utensils and during shift change (Johnson & Delaney, 2007; Lehmann, McCormick, & Kizer, 1999).

Caregiver violence risk factors

Evidence based research on caregiver violence risk factors indicates caregiver characteristics greatly contribute to the risk factors for inpatient violence. The educational level of the caregiver staff impacts risk of encountering violence. Staff members that attend education on violence prevention reduce their risk of becoming a victim of violence (Chou, Lu, & Mao, 2002). Caregivers work experience and attitude effect the risk of a violent encounter staff (Simon & Tardiff, 2008; Lanza, 1991).

Analysis

The violence prevention plan is developed in a three domain framework of patient, environment and caregiver. The violence risk factors were delineated and separated by each domain. After the risk factors were divided the violence prevention interventional strategies were also separated by patient, environment and caregiver. Each risk factor was then paired with the most effective interventions to negate each violence risk factor. The educational interventions were then structured into an interventional framework that formed the violence prevention educational plan. The completed violence prevention plan is listed in figure 4. The interventional plan is implemented as an organized structured plan to reduce inpatient violence.

Patient factors admission risk assessment for safety

To address patient risk factors for violence it is necessary to understand that violence is a common reason for psychiatric evaluation and admission to a mental health facility. Over 10% - 40% of mental health admissions are to address aggression and violence issues (Swanson, 1994; Singh, Fazel, Gueorguieva & Buchanan, 2014). Research indicates violence prevention begins the first day a patient is admitted with an effective risk assessment (American Psychiatric Association (APA), 2008; Gately, & Stabb, 2005; Haggard-Grann, Hallqvist, Langstrom, & Moller, 2006). Strong clinical admission assessment is one of the most vital interventions to prevent healthcare violence (Singh, Fazel, Gueorguieva, Buchanan, 2014). It is imperative that an efficient violence prevention plan include a risk assessment on admission as a critical part of a comprehensive mental health assessment. Violence prevention includes professionals routinely assess, document and monitor dynamic risk factors for violence (Singh et al, 2012; McKnight, 2011). An admission risk assessment based on Joint Commission recommendations is listed in Figure 1. Risk assessments increase staff awareness and safety to anticipate and potentially prevent aggression and violence (Hamrin et al, 2009; Johnson & Delaney, 2007). It is important to include risk factors for assault and violence in the initial evaluation of the patient and ongoing (Abderhalden et al, 2008). Vital assessment also includes identifying the situations which trigger a patient's violent response. The admission assessment on violence triggers is seen in Figure 2. The assessment assists in identifying precursors to violence that may be diminished or eliminated from the environment to prevent episodes of violence or self harm until the patient becomes emotional stable (Chabora, Judge-Gorney, & Grogan, 2003).

Figure 1 – Admission Risk Assessment

Danger to Self or Others: ☐ Yes
☐ No

☐ Homicidal Thoughts _____
☐ Homicidal Plan _____
☐ Homicidal Intent _____
☐ Homicidal Means _____

☐ Suicidal Thoughts _____
☐ Suicidal Plan _____
☐ Suicidal Intent _____
☐ Suicidal Means _____

Figure 2 – Admission Assessment of Violence Triggers

Do any of the following render you emotionally upset, stressed or agitated/violent?

☐ Touch
☐ Shouting/Loud Noise
☐ Physical Force
☐ Restraints
☐ Derogatory Name Calling
☐ Television
☐ Uniforms
☐ People Crying
☐ People Angry
☐ Isolation
☐ Threats
☐ Other _____

A de-escalation assessment is an important part of an admission assessment to prevent violence. An example of a de-escalation assessment is seen in Figure 3. The purpose of the de-escalation assessment is to obtain information on personal preferences of interventions that are effective in calming the individual to prevent harming behaviors. It is important to integrate all the assessment factors into the treatment plan.

Figure 3 – De-escalation Assessment

Do any of the following activities assist you to calm when under stress?

☐ Watching TV
☐ Going for a Walk
☐ Deep Breathing Exercises
☐ Working with Puzzles/Games
☐ Time Alone/Quiet Time
☐ Physical Activity
☐ Medication
☐ Speaking to Family, Friends or Staff
☐ Reading a Book, Bible or Magazine
☐ Taking a Nap
☐ Music
☐ Warm Blanket
☐ Other _____

Caregiver Factors De-escalation Training for Violence Prevention

Evidence based research indicates that early intervention and de-escalation training of mental health staff greatly reduces the risk of violence (Chabora, Judge-Gorney, & Grogam, 2003; United States Department of Health and Human Services, 2007). Figure 3 lists therapeutic de-escalation techniques to reduce/ eliminate agitated states and prevent risks for violence. Adequate acuity based staffing is important as staff need to be available to intervene at the first sign of agitation to prevent violence (Biancosino et al, 2009). Focus on elements of treatment plan to prevent violence, eg. de-escalation, prn medication, special observation one-to-one, and coping skills development (Timko et al, 2012). If these least restrictive alternatives fail the last resort for violence prevention is seclusion or application of a physical restraint per hospital policy.

Caregiver factors minimizing personal risk

The literature review indicates that staff education and training in interpersonal skills is effective for improving safety and violence prevention. Education and training programs in communication skills of empathy, listening, and low expressed emotion to role model calmness greatly reduces the risk of patient violence (Rice, Harris, Varney, Quinsey, 1989). Provide staff with clinical supervision to review interactions with patients such as debriefing to review techniques to prevent future violence.
As a professional interacting with patients daily it is important to implement strategies to decrease personal risk for encountering violent behavior. For safety utilize nonthreatening body language. Respect the patient's personal space when interacting (Umhau et al; Sifford-Snellgrove, Beck, Green, & McSweeney, 2012). Choosing to leave the door open while conversing is important for personal safety. Remember to never become isolated with an agitated person.

Environmental factors changing healthcare culture

Research suggests that hospital environments affect patient behavior in either a positive or negative manner. Promoting a healing environment with therapeutic activities will benefit in reducing episodes of violence. It is important to reduce and mitigate risk during times of transition. It is vital staff be available for therapeutic intervention and de-escalation even during shift change (Hamrin, Lennaco & Olsen, 2009). Create comforting and calming physical environments (Felgen, 2004). Encourage staff to increase time staff spend on the unit observing, assessing and interacting with patients to encourage therapeutic rapport and prevent violence.

Environmental factors improving milieu structure

Environmental interventions for violence prevention include a unit culture that provides meaningful and predictable unit activities. Unit activities and groups with structure and schedules posted and given to patients as well as consistency in rules and staff roles is beneficial (Adamson, Vincent & Cundiff, 2009). Promote peer advocates as mentors and facilitators of patient centered care (Henry, Miller-Johnson, Simon, & Schoeny, 2006). Plan a conflict resolution group to voice and air issues before open conflict erupts. Introduce an anger management group to assist in self control of aggressive impulsive behavior. An exercise group is beneficial to release endorphins which are the bodies natural calming hormones to restore homeostasis.

Environmental factors safety in milieu control

The hazardous item search is important to maintain a safe therapeutic milieu for everyone (Damon, Matthew, Sheehan, Uebelacker, 2012). All patients and belongings are searched for hazardous items when entering a mental health unit (Rice, Harris, Varney, Quinsey, 1989). A very careful head to toe body pat search and a metal detector scan is completed for prevention of dangerous items entering the secure unit.

Environmental factors psychosocial management of aggression

One of the most vital interventions for management of aggression to prevent violence is direct communication between patient, provider and staff (APA, American Psychiatric Nurses Association and National Association of Psychiatric Health Systems, 2007). To facilitate communication minimize any sensory deficits by providing eyeglasses and a hearing aid (Sifford-Snellgrove, Beck, Green & McSweeney, 2012; Negley & Manley,1990). Emphasize patient strengths and the hope of recovery. Offer creative treatment combinations to promote holistic healing and violence prevention.

Figure 4 Violence Prevention Plan

Violence prevention plan		
Violence Risk Domains	Violence Prevention Interventions & Strategies	Rationale
Patient Factors	- Risk assessment on admission - Mental Health Assessment (hx violence, substance/ETOH abuse, psychosis)	- Helps nurse/provider identify triggers for aggression, factors that can mitigate or reduce risk of anger and physical aggression especially with early intervention
	- Early intervention and de-escalation	- Early intervention with de-escalation techniques greatly improves chances of successful de-escalation
	- Patient education (group therapy, recovery groups, psycho-education, activity therapy, cognitive behavioral therapy, anger management, conflict resolution group, community groups, coping with symptoms groups, medication groups, and stress management groups) for coping skills development	- Patient education to develop coping skills, learn systemic and effective approaches to dealing with and mastering tough life situations/problems.
	- Peer mentors for support	- Peer mentors for social support and as positive role models of recovery
	- Provide patient with other outlets for stress and anxiety (exercise, listening to music, talking to a friend or staff member, attending support groups, participating in sports)	- Alternative means of channeling aggression and angry feelings can assist to decrease anxiety and stress and allow for calming
	- Direct communication with caregivers and provider	- Clear lines communication to establish trust & rapport, verbalization of feelings may assist to resolve issues.
	- Decrease environmental stimulation	- Stimulating environment may increase levels of anxiety
	- PRN (when needed) medication	- Medications reduce immediate aggression and anxiety to prevent escalation to violence
	- Special observation one-to-one	- Patients at high risk for violence require close observation to prevent harm to self or others
	- When interpersonal and pharmacologic interventions fail last resort is seclusion and restraint	- Hospital protocols are clear & well written on when to implement as a last resort when least restrictive measures have failed to ensure safety of patient and others
Environmental Factors	- Create caring and healing, calm therapeutic environments - Ward design for optimal observation - Mitigate risks during times of transition - Educational posters on unit teaching healthy appropriate behavior - Stagger shifts so they overlap to maximize staff availability - Staff dining with patients during meal time to develop rapport and observing for safety - Provide group & activity schedules - Hazardous item search - Decrease/prevent long lines - Control access to entrances and exits - Therapeutic music and television - Implement group therapy, psycho- education groups, recovery groups, activity therapy and exercise groups - Provide predictable, safe, orderly & respectful environment - Activities & groups during days, evenings, weekends and during shift changes	- Environments with a calm safe therapeutic environment, safe staffing levels, meaningful activities and group therapy decrease harmful stimuli and promote optimal recovery outcomes.
	- Keep environmental stimulation to a minimum (e.g., lower lights, decrease noise, calm milieu or take patient to a another area	- Increased stimulation increases patients anxiety level which leads to increased agitation and aggression risks

Caregiver Factors	- Caregiver Mental Health Learning Needs Assessment to identify educational gaps for education and competency development - De-escalation & Violence prevention training - Crisis Intervention Training - Management of aggressive behavior - Conflict resolution training - CPI (crisis prevention institute) or PMDB (prevention & management of disruptive behavior) training - Therapeutic & Interpersonal Communication skill development - Intervene early and de-escalate	- Education & training in early therapeutic intervention, risks, communication skills and techniques of de-escalation as well as violence prevention reduces risks of encountering violence.
	- Offer availability to talk - Encourage verbalization of issues and precipitating events	- Verbalization of feelings in a non threatening environment can diffuse an agitated state
	- Introduce yourself - Call patient by his/her proper name and Mr. or Mrs. - Develop listening skills - Acknowledge, validate & encourage individual to discuss feelings - Show respect in words and interactions	- Develops therapeutic rapport and shows respect which reduces risk of aggression
	- Remain calm, non-confrontational & never shout - Role model calmness - Nonthreatening body language	- Calm matter of fact approach can help interrupt cycle of violence
	- Debrief	- Discussing events can lead to better understanding and decreases emotional impact as well as may prevent future aggressive or violent acts
	- Increase time observing and assessing patients in milieu	- Early intervention may prevent aggressive response to command hallucinations or delusions
	- Maintain reliability and consistency &-Adequate personal space	- Essential for developing trust and therapeutic rapport
	- Minimize personal risk (open door, short hair, post earrings, avoid objects around neck)	- Know well the units safety precautions for staff as well as patient safety to prevent injury
	- Acuity based staffing	- Providing adequate staff availability for observation, monitoring and early intervention with de-escalation decreases risk of violence.

Discussion

The violence prevention plan suggested in Figure 4 addresses the critical areas of violence origins for effective strategies to prevent violence in mental health facilities for safe holistic care. A violence prevention plan addressing the holistic risk factor domains of patient, caregiver, and environment are effective as an organized method to reduce/prevent healthcare violence. The violence prevention plan suggested is comprehensive and therapeutic, educating and implementing best practice in violence prevention for a safe healthcare environment.

The disadvantage of the violence prevention plan is it implements comprehensive change. The complete implementation of the plan takes several months of tiered education and training in violence techniques as well as environmental changes. The plan introduces effective patient assessment as well as staff and patient education. Environmental changes are extensive to create a caring and healing environment for recovery oriented care. The nursing and mental health staff education suggested for violence prevention is in-depth and requires educational time off the units for training.

The major advantage of the violence prevention plan is it empowers holistic applications for safety. Healthcare violence has more than one point of origin. Holistic applications utilizing the framework of patient, environment and caregiver comprehensively addresses the multiple origins of violence for effective interventions and strategies to prevent/reduce violence in mental health facilities.

Conclusion

Violence in mental health facilities is preventable with early assessment and interventional strategies for safety. Violence prevention plans targeting the causes of inpatient violence will greatly improve safety

for all individuals in the therapeutic mental health care environment. Safety is improved with holistic application of interventions focused on the patient, caregiver and environment risk factors to prevent violence. Holistic applications for violence prevention will greatly benefit everyone and is truly the future of safe mental health care. Implementation of a violence prevention plan will improve care and provide a safe therapeutic mental health environment. Research is needed into advanced application of violence prevention plans into all healthcare environments. The violence prevention plan is versatile, improves safety, and can provide optimal recovery outcomes, improving the lives of vulnerable populations promoting health, wellness, and recovery.

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Educational Goals

- Develop and Implement evidence based strategies for violence prevention
- Implement therapeutic violence prevention principles for healthcare facilities

Correspondence

Ms. Sylvia McKnight
University of Alabama
P. O. Box 371
76643 Hewitt, Texas
USA
Smcknight541@gmail.com

From Psychomotor Therapy for Psychiatric Patients to Suicide Prevention through Adapted Physical Activity and Sports Participation

Paper

Herman Van Coppenolle, Svetlana Belousova & Ejgil Jespersen (Belgium)

Keywords: psychomotor therapy, suicide prevention, adapted physical activity, sports participation

Abstract

We started-up psycho-motor therapy in Europe in 1965 and promoted it world-wide through European and Erasmus Mundus Master courses for 600 international students in Adapted Physical Activity. In this way we had good therapeutical results with psychotic, depressive and anorexia nervosa patients.

However we wanted to use Adapted Physical Activity and Sports Participation not only as Therapy but also as life-saving suicide prevention tool. Literature research showed indeed the protective value against Suicide of Adapted Physical Activity and Sports Participation. Participation in Exercise and Sports resulted in more physical self-esteem, better social relations and less suicidal ideation

Starting from these hopeful research data we can assume that an individualized sports program could have a protective and Suicide prevention effect. We are now researching this in the University of Southern Denmark in Odense and in the University of St. Petersburg in Russia. If we are able to demonstrate this preventive effect we will have contributed to reduce one of the most important international problems in many countries: suicide.

Educational Goals

- Demonstrate the positive effect on reducing the number of suicides though Adapted Physician Activity and Sports Participation

Correspondence

Mr. Herman Van Coppenolle
Faculty of Kinesiology and Rehabilitation Sciences KU Leuven
Beekstraat
3070 Kortenberg
Belgium
herman.vancoppenolle@faber.kuleuven.be

Prevalence and risk factors of violence by psychiatric acute inpatients: A systematic review and meta-analysis

Paper

Giovanni de Girolamo, Laura Iozzino, Clarissa Ferrari, Matthew Large & Olav Nielssen (Italy)

Background

Physical violence in acute psychiatric wards is a major problem, not only because of the potential for injury to patients and staff, but also because of the counter therapeutic effects of both violence and measures to prevent violence.

However there is wide variation in the reported rates of violence in mental health care settings, which might be due to real differences in the rates of violence between wards, differences in the definition of violence, differences in the duration of measurement and methods of data collection, and variations in the level of under-reporting of aggressive incidents by mental health care workers

Aims

The aims of this study was to use systematic meta-analysis in order to estimate the pooled rate of violence, in terms of period prevalence, in acute psychiatric wards, and to examine the characteristics of the participants, and aspects of the studies themselves that might explain the variation in the reported rates of violence (moderators)..

Methods

Studies were identified by searching the electronic databases Cumulative Index to Nursing and Allied Health Literature (CINAHL), Scopus and Pubmed. Queries were limited to articles published in all languages between January 1995 and December 2014 and reporting data on violence in acute psychiatric wards of general or psychiatric hospital in the 31 countries classified as "high-income countries" by the World Bank.

Results

Of the 23,972 inpatients described in 35 studies, the pooled proportion of patients who committed at least one act of violence was 17% (95% confidence interval (CI) 14-20%). Studies with higher proportions of male patients, involuntary patients, patients with schizophrenia and a history of alcohol use disorder reported higher rates of inpatient violence.

Conclusion

The findings of this study suggest that as many as 1 in 5 patients admitted to acute psychiatric units commit an act of violence. Factors associated with levels of violence in psychiatric units are similar to factors that are associated with violence among individual patients (male gender, diagnosis of schizophrenia, and substance use and lifetime history of violence). Establishing the risk factors for violence in acute psychiatric inpatients may enable researchers and clinicians to devise strategies to prevent and manage violence in psychiatric wards.

Educational Goals

1. To present rates of violence in different mental health care settings;
2. To examine the characteristics of the participants, and aspects of the studies themselves that might explain the variation in the reported rates of violence

Correspondence

Mr. Giovanni de Girolamo
IRCCS St John of God
Pilastroni, 4
25125 Brescia
Italy
gdegirolamo@fatebenefratelli.it

Observational study of aggression and violence and its subsequent coercive measures on Indian psychiatric wards

Paper

Bevinahalli N Raveesh, Tom Palmstierna, Vijay Danivas, Shivanna Punitharani, Kundapur S Ashwini, Handithavalli Gowrishree & Peter Lepping (India)

Keywords: aggression, coercion, India

Background

Recent studies have shown that patient and visitor violence on staff may be less common in India than in Europe or the US. However, all these studies used retrospective recall by staff to calculate prevalence data, but there is no data from direct observations on wards, neither from India nor from other countries. Indian hospital wards, including psychiatric wards, usually require a relative to be with the patient at all times. There is also a high likelihood of security staff being present on psychiatric wards. This mixture of multiple possible actors and victims of aggression and violence on psychiatric wards increases the possible interactions as compared to European wards where most violence and victimization concern patients and staff only. To study and compare differences of violence, victimization and coercion in such different contexts could reveal more substantial knowledge about the nature and reasons for violence and coercion in acute psychiatric disorders.

Method

We performed an observational study of all aggression and violence and its subsequent coercive measures that can be observed on the two psychiatric wards in Mysore Psychiatric Hospital. The two wards both have 10 beds in one unisex dormitory each. There are two nurses on duty during the day and one during the night plus a doctor, security and auxiliary staff. We have identified three psychologists who will register any episode of aggression during the days and duty doctors during the nights for a four week period. They use the internationally recognized instrument SOAS-R to register violent incidents. We have amended the SOAS-R for the Indian context (SOAS-RI) to include relatives and security staff as potential actors or victims of violence as well as performers of coercive measures. The reports on violence and coercion are performed according to the SOAS-RI by direct observation of trained the psychologists present on the ward for observation, thus reviving a tradition of violence observation from the 1980-ies which has not been in use for long, but probably could provide a more "observer-neutral" observation than the traditional reports from the SOAS-R. We will analyze the data using a scoring procedure of the SOAS-R extended to this context.

Results

In a small pilot we have identified three serious incidents in a 45 minute period during the day. Patients, staff and relatives were involved in these incidents. We will present the complete findings in this presentation with comparisons to western psychiatric institutional context.

Conclusion

The data will be the first ever comprehensive data set that will give us realistic 24-hour observational data about patient and visitor violence on an Indian psychiatric ward and the responses that staff and others gave to these incidents which could provide knowledge on how aversive behavior is generated and managed in different contexts of institutional psychiatric

Educational Goals

- Indicate prevalence of aggression on Indian psychiatric wards
- Analysis of aggression with more than 2 potential actors

Correspondence

Mr. BN Raveesh
Mysore Medical College and Research Institute
Irwin Road
570001 Mysore
India
raveesh6@yahoo.com

Aggressive behavior in autism spectrum disorders preschool children with or without Attention-Deficit/Hyperactivity Disorder

Paper

Chen Chen, Jianjun Ou & Weixiong Cai (China)

Keywords: Aggressive behavior, autism spectrum disorders, Attention Deficit/Hyperactivity Disorder

Objective

Aggressive behavior is a commonly co-occurring problem with autism spectrum disorders (ASD) and Attention-Deficit/Hyperactivity Disorder (ADHD). Therefore, we designed this study to investigate the pattern of aggression in children with only ASD and ASD comorbid with ADHD, and explore whether aggressive behavior is associated with the severity of sleep problems and autism symptoms.

Methods

Three hundred and seventy five ASD children, 129 ASD children comorbid with attention-deficit (ASD+AD), 75 ASD children combined with attention-deficit and hyperactivity disorder (ASD+ADHD), and 428 control children, age 4-6 years, were recruited in this study. Modified Overt Aggression Scale (IBR-MOAS) was used to measure the pattern of aggression. This scale includes five domains: verbal aggression toward others (VAO), verbal aggression toward self (VAS), physical aggression against other people (PAP), physical aggression against objects (PAO) and physical aggression against self (PAS). Children's Sleep Habits Questionnaire (CSHQ) and Social Responsiveness Scale (SRS) were used to measure the severity of sleep problems and autism symptoms, respectively.

Results

The total scores of IBR-MOAS were significantly different among four groups after controlling for gender of children and parental education level . The total and all sub scores, except PAO, of IBR-MOAS in ASD+ADHD group were significantly higher than other groups (all, $p<0.05$).

Conclusion

The pattern of aggressive behavior in children with only ASD and ASD co-morbid with ADHD was different. ASD children had more self-injurious behavior than normal children. However, when ASD comorbid with ADHD, children would not only had worse autism symptoms, but also had more aggression against themselves and others. Aggressive behavior positively associated with the severity of sleep problems and autism symptoms.

Correspondence

Ms. Chen Chen
Institute of Forensic Science, Ministry of Justice, P.R.China
GuangFu West Road 1347#
200063 Shanghai
China
chenchen15601@163.com

Which are the clinical characteristics of psychiatric patients with an history of violence behavior? An in-depth assessment of a prospective cohort in Italy

Paper

Giovanni DeGirolamo, Valentina Candini, Viola Bulgari, Laura Iozzino, Chiara Buizza, Clarissa Ferrari, Paolo Maggi, De Francesco & Giuseppe Rossi (Italy)

Keywords: Violence, recidivism risk, psychiatry

Introduction

In Italy, a recent law has decided to shut down all Forensic Mental Hospitals, and forensic patients will have to be cared for by ordinary Departments of Mental Health: for this reason it is important to assess in great details their clinical characteristics and to see to which extent they are associated with a higher risk of recidivism.

Aims

The aim of the study is to assess a sample of patients living in 23 Residential Facilities (RFs) with a history of violent behavior against people, and to compare their clinical characteristics with those of never-violent residents. Innovative elements of the evaluation, hypothesized as potential discriminating variables for the act of violent behavior, are the dimensions of metacognition, deficits of executive functions and skills of emotion recognition.

Methods

We compared two groups of patients with a primary psychiatric diagnosis: the 'violent' group consisted of patients who had ever committed at least one severe violent act against people, while the 'never-violent' group included patients who have never displayed physical violence against people, matched by age, sex, and diagnosis. Each patient underwent a very detailed assessment at baseline (average time of assessment: 8 hours), and was followed-up for one year to monitor aggressive and violent behavior.

Assessment instruments included: SCID I e II, BPRS, SLOF, Brown-Goodwin Lifetime History of Aggression (BGQ), Insight Scale, Buss Durkee Hostility Inventory (BDHI), State-Trait Anger Expression Inventory 2 (STAXI-2), Barratt Impulsiveness Scale 11 (BIS-11), Millon Clinical Multiaxial Inventory–III (MCMI-III), Wisconsin Card Sorting Test (WCST), Iowa Gambling Task (IGT), Brief Assessment of Cognition in Schizophrenia (BACS) and Facially Expressed Emotion Labeling (FEEL).

Results

The study involved 142 patients: 81 violent and 61 never-violent. We will report data about the scoring and the clinical profiles of the two groups of patients as they emerge from the complex set of assessment instruments.

Conclusion

This is the first prospective study ever done in Italy to assess in great detail and follow-up a cohort of previously violent and never violent patients. Our result shed light on several clinical, neuropsychological and metacognitive variables associated with a higher risk of aggressive and violent behavior.

Educational Goals

- Add depth information about psycho-social characteristics of patients with and history of violence treated at Italian residential facilities.

- Add new information about predictors of violence recidivism risk in patients with an history of violent behaviors treated at Italian residential facilities.

Correspondence

Mr. Giovanni DeGirolamo
IRCCS St John of God Fatebenefratelli, Brescia, Italy
Via Pilastroni 4
25125 Brescia (BS)
Italy
gdegirolamo@fatebenefratelli.it

The half halfway: reduction of seclusion in Dutch psychiatry between 2007 and 2013

Paper

Eric Noorthoorn, Yolande Voskes, Wim Janssen, Niels Mulder, R. van de Sande, A. Smit, Henk Nijman, A. Hoogendoorn, A. Bousardt & Guy Widdershoven (Netherlands)

Keywords: Epidemiology of coercion, nationwide study, predictors of coercion

Background

From 2007 to 2013 an increasing number of Mental Health institutes in the Netherlands recorded their coercive measures in a Nationwide database (1, 2). Since 2007 a growing number of provided data was obligatory form 2012 onwards for all psychiatric hospitals and wards. (3,4). In 2014, according to the Dutch Healthcare Authority, 87 institutions used the Argus dataset and submitted data.

Aim

The current study firstly investigated trends in coercive through a number of years. In data of 2012 we investigated which patient and ward characteristics determined risk to be secluded. The following research questions are addressed in the presentation:
1. What are the trends in seclusion numbers and duration between 2008 and 2012?
2. To what extent is seclusion determined by patient, ward and hospital characteristics?

Methods

In the Trend study the number and duration of coercive measures was calculated using the number of admissions as an offset for number of seclusions, restraints as well as applications of enforced medication. Also, duration of the admissions was used as offset for the duration of the seclusions and restraints. These offset variables were applied to correct for differences between hospitals participating in the study. The relationship between patient and ward characteristics with seclusion was investigated by means of a multilevel logistic regression.

Results

Institutes with an active participation in reduction efforts for more than four years showed a reduction of 45%. Institutes with a shorter time frame showed a reduction between 13 en 17 %. We may estimate a decrease of approximately 50% in both numbers of patients exposed as well as in the duration of interventions (Table 1).

Table 1. Trends in seclusion for 2008-2012 at an intervention level

Year	Institutions recording in Argus	Wards (N)	Seclusions	Patients	% of seclusions per total no. of admitted patients	Hours, mean and median '08		Decrease for the period of recording in % of hrs. per admission hrs.				
								'09	'10	'11	'12	
'08	8	68	3685	1338	11.8	128	92	45%				
'09	6	198	4750	2322	10.8	71	43		17%			
'10	14	227	5525	2722	10.2	70	38			17%		
'11	13	375	7476	3743	8.5	62	35				13.5 %	
'12	22	570	9469	7198	6.5	58	17					

Table 2. Patient characteristics and seclusion risk in 2012

	Analysis: patient level			Multi-level analysis: seclusion hrs. compared to admission hrs., adjusted for exposure (admission duration)	
				Multivariant	
	No seclusion	Seclusion	Significance difference	EX (B)	95% CI EX(B)
N=	38519 (91 %)	3687 (9%)			
Personal characteristics					
Age < 35 years	31%	42%	++	1.87	1.61 – 2.16
Male	53%	63%	++	0.73	0.63 – 0.85
Partner	15%	10%	++		
Ethnic minority	13%	18%	++		
Diagnosis					
Adjustment disorder	20%	10%	++	0.79	0.63 – 0.99
Anxiety disorder	4%	2%	+		
Depressive disorder	14%	6%	++	0.51	0.38 – 0.69
Bipolar disorder	5%	10%	++	1.64	1.29 – 2.09
Psychotic disorder	10%	18%	+	1.18	0.97 – 1.43
Schizophrenia	12%	16%	+		
Organic disorder	5%	2%	++		
Substance abuse	22%	26%	-		
Personality disorder	27%	27%	-		
Ward type					
Admission	87%	13%	++	2.16	1.64 – 2.86
Transmural	91%	9%	-		
Child and adolescent	95%	5%	+	0.46	0.26 – 0.81
Long-term	97%	3%	+	0.32	0.17 – 0.62
Specialist	96%	4%	++	0.49	0.33 – 0.73
Elderly	97%	3%	++	0.53	0.34 – 0.84
Forensic	87%	13%	+	2.24	1.51 – 3.32
Institution characteristics					
Urban service area	89%	11%	++		
Rural service area	92%	8%			
Large, integrated institution	91%	9%	-		
Medium institution	93%	7%	+	0.63	0.47 – 0.85
Small institution	89%	11%	++		

*++ P < 0.001 + P < 0.05 ** The analysis was performed in 91972 admissions over 70664 different patients in 1484 wards
*** Column percentages representing % patients with a characteristic in not secluded patients and secluded patients
**** Row percentages representing % patients either or not secluded and secluded in a certain ward type

The multilevel analyses showed higher odds ratio's to be secluded in patients with a psychotic disorder, a bipolar disorder or schizophrenia (table 2) . Younger age, male sex and stay at a admission ward, a long stay ward, a forensic ward or a youth ward were associated with an increased seclusion risk. At hospital level urban location of the hospital as well as a smaller size of the hospital were associated to an increased seclusion risk. The final model showed a McFadden's r^2 of 0,25 which implies a fair figure of 25% explained variance (5).

Discussion

Between 2008 and 2012, institutions registering in Argus showed a decrease up to 45 % in the rate of seclusion per 1000 admission hours. The percentage of patients exposed to seclusion decreased by 41%, from 11.8% in 2008 to 6.5% in 2012. The mean and per seclusion decreased by more than 50%;, the median duration even more. A study in 2002 showed 15.7% of the patients were secluded (6). Several observations can be made from our findings. Hospitals engaged in reduction efforts for more years showed more effect than hospitals participating shorter. A reduction in seclusion came together with a decrease in other interventions except forced medication. A study in one of the institutes showed this increase in forced medication meant the total amount of coercion decreased importantly anyway(7). In another presentation we will show these data.

Many factors influence this comparison. First, hospitals vary in size and ward types, as well as urban or rural location. Second, the patient compilation between hospitals may be substantially different. Therefore we preformed the multi-level analysis, which showed a younger age, male gender, having a bipolar, or a psychotic disorder and being admitted to either admission, long stay, child psychiatry or forensic wards, as well as being admitted to a smaller institute, are associated with a relatively higher rate of seclusion. Hospitals where many of these characteristics are prevalent may show higher seclusion rates than others. In the future we need to correct for these differences, especially because in an international perspective differences between hospitals seem to be larger than differences between countries.

Conclusion

This study showed half of the hospitals seem to have reached some effect, while the others did not show any effect. In futures studies we need to develop correction factors when comparing hospitals to one another, as patient as well as hospital compilation seem to determine many of the differences.

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Educational Goals

• Law, clinical practice of coercion, how to reduce the use of coercion in daily practice

Correspondence

Mr. Eric Noorthoorn
Altrecht Aventurijn and GGnet mental health institute
Vordensestraat 12
7231 PA Warnsveld
The Netherlands
e.noorthoorn@ggnet.nl

Violent Recidivism of Mentally Ill Offenders: A Long-term Follow-Up Study

Paper

Susanne Bengtson & Jens Lund (Denmark)

Keywords: Recidivism risk, violence, mentally ill offenders, follow-up study, long-term follow-up

Background

Violent recidivism risk is a priority issue for clinicians working within psychiatry. The objective is to reduce patients' risk of violence. Although a number of studies have followed mentally disordered offenders, only few studies have compared the relative violence risk of severe mentally ill and their non-mentally ill counterparts.

Objective

This study aimed to determine the rate of violent recidivism after discharge in a sample of violent individuals referred for a pre-trial forensic psychiatric evaluation and compare relative recidivism risk among severe mentally ill and non-mentally ill, respectively.

Method

The case sample (violent offenders) was recruited from a cohort consisting of individuals referred for a pre-trial forensic psychiatric evaluation at the Department of Forensic Psychiatry, Ministry of Justice, or the Department of Forensic Psychiatry, Aarhus University Hospital, Denmark, between 1978 and 1992 (n = 1184). Socio-demographic and clinical data was collected from clinical case material and linked to national registers to determine recidivism risk of subjects.

Results

One third of the violent offenders had a severe mental illness (ICD-10, F0, F2 or F3). During follow-up 46% of the case sample re-offended to violence (including sexual offences) and 77% to any crime. Relative risk of severe mentally ill and their non-mentally ill counterparts will be published at the conference.

Conclusions

Almost half of the followed case sample re-offended violently. The high recidivism reflects a long follow-up time. Still, the findings reveal that violent offense recidivism remains a problem over a significant part of a violent offender's life.

Educational Goals

1. Knowledge concerning long-term violent recidivism risk among mentally ill
2. Knowledge concerning risk of severe mentally ill relative to non-mentally ill counterparts

Correspondence

Ms. Susanne Bengtson
Department of Forensic Psychiatry, Aarhus University Hospital, Risskov
Skovagervej 2
8240 Risskov
Denmark
susanne.bengtson@ps.rm.dk

Predictors of violence among German forensic in-patients

Jan Querengässer, Sebastian Harttung, Jan Bulla, Klaus Hoffmann, Thomas Ross (Germany)

Introduction and background

Societies attach great importance to violence committed by mentally ill people. Health professionals are encouraged to predict and prevent violent acts committed in the community. During inpatient treatment, violence against other patients and staff in psychiatric hospitals is considered a significant problem (Woods & Ashley, 2007). In-patient violence is closely linked to coercive measures and has a number of legal, ethical and medical implications. Many violent attacks are associated with (re-) traumatization and counteract the hospitals' obligation to protect both the patients' and the staff's well-being. Though, identifying patients at risk for violence is important in order to take appropriate means to minimize the risk for clinic staff and other patients.

Consequently, a large number of research projects on inpatient violence has been conducted during the past thirty years. But study aims, designs and samples results are rather heterogeneous (Cornaggia et al., 2011). The focus may lay on patient–related, staff-related, and unit-related variables, or on interactions between patients and staff (Johnson, 2004). The present study focuses on patient-related factors, because they are suitable to predict the risk of violence *before* treatment has taken place.

The purpose of this study is to identify patient-related risk factors for prediction of future violent behavior among forensic in-patients.

Hypothesis: Patient related risk factors are suitable to predict violent behavior among forensic inpatients.

Methods

Sample

Regardless of their length of stay, 1433 patients (incl. 160 female patients) according to section 63 of the German penal code (or respective process regulations) have been treated between 2009 and 2013 in the six forensic hospitals of the German federal state of Baden-Württemberg. 231 patients (16.1%) had committed one or more violent assaults against staff or other patients during this five year period. 99 patients committed one assault during their stay (this figure equals 42.9 % of the subsample), 106 patients between two and ten (45.9%), and 24 patients between 11 and 50 assaults (10.4%). Two patients committed over 50 assaults during their long-stay treatment.

The data base relies upon a delimited time period, but only a few patients started *and* terminated treatment during this period. Hence, the non-violent comparison group comprised 340 patients, whose entire treatment started and ended without *any* reported violent assault over the five year period.

Data collection and analysis

A computer-based forensic documentation tool including legal, psychiatric, actuarial, and clinical outcome data was developed. A Likert-type response format was used throughout the documentation sheet, and all items were entered into a glossary. The final documentation tool contained 140 entries for 34 variables. These variables included personal variables, clinical assessment data and legal criminal data. Two variables served as basis to define the subsamples: "violent assaults against staff" and "violent assaults against other patients".

Reliability checks were performed for all entries following a data assessment protocol. The data were entered into the electronic system by trained psychologists and psychiatrists only. All of the entries were supervised by the patient's principal therapist. Completed data sheets were then reviewed by the clinics´ chief medical officers.

In a first step the two subgroups (patients with vs. without any reported violent assault) were compared on all historic variables included in the documentation system. T-tests for continuous data and Chi-squared statistics for categorical or nominal data were used and effect sizes were calculated (Cramer's V or Cohen's d).

In a second step the authors performed logistic regression analyses on the variables that discriminated between the two groups (see below: *Results, Step 1*). Three different logistic regression models (enter,

stepwise forward and stepwise backward) were computed and compared to each other on various measures indicating effectiveness and goodness of fit. The best-fitting model was chosen for a detailed report.

Results

Step 1
Table 1 and 2 show 16 variables (out of approx. 60) indicating a significant and at least moderate difference (i.e. effect sizes V or d > .2) between violence and comparison group.

Table 1: Continuous variables indicating differences between violence and comparison group

| | groups | | | | | | | | | |
| | violence | | | comparison | | | Significance level | | | |
Continuous variables	n[1]	Mean	(SD)	n[2]	Mean	(SD)	t	df[3]	p	d[4]
Total work time until admission	225	54.3	90.2	306	129.9	139.4	7.57	521.2	.000	.67
Duration of sentence (concurrent sentence)*	231	11.4	25.7	340	5.71	18.4	-2.90	386.9	.004	-.25
Total no. of comorbid diagnoses	231	2.6	2.45	340	1.52	1.91	-5,71	412.2	.000	-.49
No. of comorbid personality disorder diagnoses	231	.19	.42	340	.09	.30	-3.31	389.1	.001	-.28
No. of comorbid psychotic diagnoses	231	.11	.32	340	.03	.19	-3.59	337.6	.000	-.31
No. of comorbid retardation diagnoses	231	.27	.53	340	.05	.24	-5.95	293.9	.000	-.51
No. of comorbid somatic diagnoses	231	1.3	1.97	340	.78	1.46	-3.60	395.2	.000	-.31
No. of prior admissions to psychiatric hospital	231	4.6	3.81	335	3.12	3.81	-4.71	478.4	.000	-.40
Age at admission to a forensic psychiatric hospital in the actual legal proceeding	231	32.1	12.2	339	42.1	14.7	8.78	547.6	.000	.75

Notes: [1] difference to 231 due to missing data; [2] difference to 340 due to missing data; [3] adjusted for unequal variances; [4] effect size

Table 2: Continuous variables indicating differences between violence and comparison group

| group: | violence | | comparison | | | | | |
| Variable | n = 231 | | n = 340 | | | | | |
specification	n1	%	n2	%	Chi[2]	df	p	Effect Size V
Family status at admission	228		325		33.39	3	.000	.25
single	196	86%	209	64%				
married	9	4%	48	15%				
divorced	20	9%	60	18%				
widowed	3	1%	8	2%				
Social life situation at time of offence	231		338		49.57	6	.000	.30
lives on his own	57	25%	130	38%				
with significant other	14	6%	61	18%				
with parents	51	22%	57	17%				
assisted living	14	6%	13	4%				
institution	55	24%	30	9%				
other	35	15%	36	11%				
homeless	5	2%	11	3%				

Grade of formal schooling	223		301		42.29	5	.000	.28
none	70	31%	45	15%				
special school	32	14%	16	5%				
elementary school	72	32%	138	46%				
junior high school	28	13%	52	17%				
college entrance qualification	2	1%	14	5%				
university entrance qualification	19	9%	36	12%				
Any professional qualification at admission?	226		310		-a		.000	.26
Yes	59	26%	160	52%				
No	167	74%	150	48%				
Working activity before first diagnosis of mental illness?	213		282		-a		.000	.34
Yes	114	54%	238	84%				
No	99	46%	114	40%				
Type of offence (main offence)	231		340		29.04	10	.001	.23
killing of a person	10	4%	12	4%				
attempted killing	23	10%	50	15%				
violent physical assault	109	47%	104	31%				
sexual offence	15	6%	16	5%				
sexual offence against minors	16	7%	17	5%				
other violent offence	19	8%	45	13%				
theft	6	3%	18	5%				
arson	28	12%	53	16%				
traffic offence	0	0%	2	1%				
drug offence	0	0%	4	1%				
other offence	5	2%	19	6%				
Diagnostic Group	231		338		41.07	10	.000	.27
paranoid schizophrenia	67	29%	135	40%				
other psychotic disorders	39	17%	59	17%				
Cluster A personality disorders	0	0%	2	1%				
Cluster B personality disorders	19	8%	17	5%				
sexual preference disorders	6	3%	5	1%				
other pesonality disorders	20	9%	28	8%				
mild mental retardation	19	8%	10	3%				
severe mental retardation, organic disorders (dementia etc.)	34	15%	16	5%				
alcohol-related disorders	4	2%	21	6%				
other substance-related disorders	2	1%	9	3%				
others	21	9%	36	11%				

Notes: [1] difference to 231 due to missings, [2] differences to 340 due to missings, [a] Fisher's exact test

Step 2
Three logistic regression models were calculated. The enter-model included all 16 variables and classified 80.1% of all patients correctly (violence group: 81.3%; comparison group: 79.2%). The correct classification rate dropped slightly to 77.9% (violence group: 78.3%; comparison group: 77.6%) in a stepwise forward model that terminated the iteration process after 9 variables. The best classification emerged from a backward stepwise model: Having removed the 5 least significant variables, the remaining 11 (see table 3) provided correct classification of 80.4% (violence group: 80.8%; comparison group: 80.0%).

Table 3: Variables in the equation, step 6 (final step) of the resulting backward-stepwise regression model

Variable (reference specification for categorical variables)			Significance level			
specification	b	SE	Wald	df	p	Exp (b)1
Grade of formal schooling (university entrance qualification)			10.5	5	.06	
none	-.56	.49	1.31	1	.25	.57
special school	.53	.69	.59	1	.44	1.69
elementary school	-.75	.43	3.10	1	.08	.47
junior high school	-.13	.46	.08	1	.78	.88
college entrance qualification	-1.83	1.05	3.04	1	.08	.16
Type of offence / main offence (violent physical assault)*			31.5	9	.00	
killing of a person	-.34	.63	.30	1	.58	.71
attempted killing*	-.78	.41	3.51	1	.06	.46
sexual offence	-.88	.58	2.34	1	.13	.41
sexual offence against. Minors	-.85	.65	1.70	1	.19	.43
other violent offence*	-1.36	.42	10.4	1	.00	.26
theft*	-1.92	.61	9.94	1	.00	.15
arson*	-1.74	.41	17.6	1	.00	.18
traffic offence	-21.3					
other offence*	-2.71	.83	10.6	1	.00	.07
Diagnostic Group (other psychotic disorders)			15.4	10	.12	
paranoid schizophrenia	-.41	.36	1.30	1	.25	.66
Cluster A personality disorders	-20.2					
Cluster B personality disorders	-.67	.54	1.53	1	.22	.51
sexual preference disorders	-.42	1.05	.16	1	.69	.66
other pesonality disorders	-.26	.52	.25	1	.61	.77
mild mental retardation	.07	.68	.01	1	.91	1.08
severe mental retardation, organic disorders (dementia etc.)*	1.92	.71	7.36	1	.01	6.86
alcohol-related disorders	-.90	.81	1.23	1	.27	.41
other substance-related disorders	-.47	1.00	.23	1	.63	.62
others	-.08	.52	.02	1	.88	.92
Total work time until admission*	-.81	.32	6.49	1	.01	.45
Duration of sentence (concurrent sentence)*	.01	.01	4.76	1	.03	1.01
No. of comorbid personality disorder diagnoses*	.84	.36	5.50	1	.02	2.31
Number of comorbid psychotic diagnoses*	1.42	.49	8.40	1	.00	4.13
Number of comorbid retardation diagnoses*	.90	.43	4.35	1	.04	2.46
No. of comorbid somatic diagnoses*	.18	.08	5.16	1	.02	1.20
Number of prior admissions to psychiatric hospital*	.09	.04	5.93	1	.01	1.09
Age at admission to forensic psychiatry in the actual legal proceeding*	-.07	.01	32.4	1	.00	.93
Constant*	3.36	.70	21.0	1	.00	28.7

Notes: [1] Exp (b) > 1 increases the probability to be identified as a violent patient and vice versa, *indicates significant factors

For further model specifications see table 4. Nagelkerke's R² may be interpreted as the amount of explained variance and the Area under the Curve (AUC) serves to estimate the discriminative power. Both indicators support strongly our hypothesis that person-related risk factors are suitable to predict violent behavior among forensic inpatients.

Table 4: Summary of step 6 (final step) of the resulting backward-stepwise regression model

Omnibus model test			Model Summary			Goodness of fit, Hosmer & Lemeshow Test			ROC-Analysis		
Chi²	df	p	-2 Log likeli-hood	Cox & Snell R²	Nagel-kerke R²	Chi²	df	p	AUC	SE	p
206.30	32	.000	416.80	.37	.49	13.80	8	.087	.857	.017	.000

Discussion

Our findings revealed several biographical risk factors for in-patient violence on forensic wards: violent physical assaults as main offence prior to treatment, a low level of schooling, severe mental retardation or organic disorders as main psychiatric diagnosis, comorbid psychotic and personality disorders, mental retardation and, to a lesser extent, somatic secondary diagnoses; the amount of time spent in a regular work environment until admission, the number of prior admissions to psychiatric facilities and young age at admission to forensic psychiatry in the actual legal proceeding. However, it remains unclear if these factors can be generalized on forensic psychiatric patients outside Germany.

The risk factors we identified predict future violent inpatient behavior to a notable degree. Retrospectively, 11 core variables served to classify 4 out of 5 patients correctly into the groups and explained half of the variance. The results could be used to inform existing screening tools for violence on forensic wards. Taking into account the information included in court files and psychiatric reports, it may be possible to estimate a patient's risk for violence during treatment at the very moment of his referral– or even before.

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Educational Goals

1. To become aware of specific risk-factors for violence in forensic in-patient treatment.
2. To identify risk levels for violence in newly admitted patient groups.

Correspondence

Mr. Jan Querengässer
Reichenau Centre for psychiatry
Feursteinstraße 55
78479 Reichenau
Germany
j.querengaesser@zfp-reichenau.de

Transforming clinical practice in the management of acute behavioral disturbance in an Acute Psychiatric Unit

Paper

Vincent Drinkwater (Australia)

Keywords: Acute, behavioral, disturbance, psychiatric, rapid tranquillization, sedation, assessment tools, practice, protocols, guidelines

Abstract

- Development of a Local Health District approved Clinical Guideline for the Management of Acute Behavioral Disturbance;

- Publication of a prospective study of high dose sedation for rapid tranquilization of acute behavioral disturbance in an acute mental health unit;

- Publication of a Randomized Controlled Trial – The 'HORD' study comparing the effectiveness of medications used in Rapid Tranquillization (Parenteral Sedation) for the treatment of Acute Behavioral Disturbance;

Transforming Practice

- A significant change in practice has occurred for both nursing and medical staff in relation to the management and care of Acute Behavioral Disturbance;

- Implementation of the Sedation Assessment Tool (SAT) to ensure regular observation and recording of vital signs for patients who require Parenteral sedation;

Educational Goals

- To develop and implement a Clinical Guideline for the Management of Acute Behavioral disturbance which had practical utility and application in a high risk environment;
- To implement the Sedation Assessment Tool (SAT) to provide the clinical team with an objective measure of:
  - the patients level of agitation and aggression;
  - effectiveness of the medication;
  - patients vital signs following sedation;
- To prove that using a single optimal dose of a sedating agent demonstrated a reduction in adverse events in this patient group;

Correspondence

Mr. Vincent Drinkwater
Hunter New England Mental Health Service
34 Veda Street Hamilton
2303 Newcastle
Australia
vincent.drinkwater@hnehealth.nsw.gov.au

Use of restraint and open-area seclusion in Norwegian mental health services for adults

Background

Norway does not have an electronic report system for national restraint data. The Centre for Research and Education in Forensic Psychiatry at Oslo University Hospital was asked by the Health Authorities to collect and analyze the use of restraint and/open-area seclusion («skjerming») in mental health services for adults in 2009 and in 2012.

Method

Data was extracted from anonymous copies of all routinely handwritten restraint/open-area seclusion protocols. Data were coded into a data form specially designed for this purpose and analyzed with SPSS, Version 18.0.

Results

Number of patients subjected to restraint and open-area seclusion increased by 7% from 2009 to 2012. There was no change in the number of patients with decision on pharmacological restraint from 2009 to 2012. Patients on mechanical restraints increased by 3.9%, patients in isolation increased by 26.3%, patients with physical restraint increased 30.5% and patients in open area seclusion increase by 15% from 2009 to 2012.

The number of episodes with restraint and open-area seclusion rose by 5.4% from 2009 to 2011, the number on pharmacotherapy and restraint decreased by 28.8%, mechanical restraint decreased by 13.2%, isolation increased by 112.3%, phys. restraint increased by 36.7 % and open- area seclusion increased by 23.4%.

The relative number of men increased for all types of restraint and open-area seclusion. The number of female patients who received decisions on isolation, physical restraint and open-area seclusion increased.

Discussion and recommendations:

- Development of a common electronic report system including all institutions in mental health services for both adults and adolescents is called upon.
- In future mapping of restraint from different mental health institutions, data from each institutions should be corrected for number of admissions, number of treated patients and size of catchment area. This would make comparison more reliable.
- Codes for different types of wards (forensic, acute, long-term-treatment etc.) must be synchronized with the ongoing organizational changes of mental health services.
- Additional requirements for documentation of the use of phys. restraint should be developed to obtain:
  - Information about patients position during the restraint episode (e.g. how many persons are involved, gender, in which position patient is held).
  - How long phys. restraint should last before a decision on phys. restraint is to be taken.
- To conduct forced treatment (either medication or food) staff sometimes actually ad up the level of enforcements by holding the patients either by using their own phys. force or strapping the patient to a bed. Due to Norwegian Mental Health Care Act and Mental Health Care Act Regulations, IS-9/2012 (page 64), such interventions are regarded as restraint and therefore a decision to use restraint should be made and documented. This is not always the case since practice varies due to different perceptions among clinicians whether these interventions are considered as restraints or as 'necessary" parts of forced treatment. In order to ensure uniform practice this clarification in the law should be made known among clinicians.

Correspondence

Ms. Maria Knutzen
Centre for Research and Education in Forensic Psychiatry, Oslo University Hospital, Norway
Sognsvannveien 21
0372 Oslo
Norway
uxmakn@ous-hf.no

Aggression towards staff: trends from an intensive treatment program in the Netherlands

Poster

Nienke Kool & Tony Bloemendaal (Netherlands)

Keywords: Aggression, staff, trends, Netherlands

Introduction

Some patients with severe psychiatric disorders are extremely difficult to treat because of their disruptive relationships with treatment staff. Most of these patients are admitted against their will and many have multiple and complex problems like severe self-harming and suicidal behavior, threatening or actual aggression, and disruptive psychotic behaviors. In the Netherlands, such patients can be referred to special centers for intensive treatment (CIT). Staff working in these CIT's is confronted with aggression on a daily basis. As a result, guiding and investment in staff is a necessary and essential part of the treatment program: they must be patient and persistent, but also able to cope with the aggressive and other emotionally disturbing experiences with patients.

Method

For this study, we collected data from 2003 till 2014 about: verbal aggression, threatening with aggression, physical aggression towards others, physical aggression towards objects, self-harm, sexual intimidation. These data were collected using a specially developed form on which the nursing staff registered the number of (above named) incidents twice daily.. The study took place on a closed ward where a maximum of seventeen patients are treated. The staff consists of about 30 mental health nurses.

Findings

From 2003 to 2014 the total number of aggression incidents increased by 230% from 3331 to 7670. All types of aggression increased in this period, but especially verbal aggression (285%), threatening with aggression (155%), physical aggression towards others (152%) and physical aggression towards objects (230%) increased strongly.

Conclusion

Staff working in a specialized, intensive treatment program in the Netherlands, where patients are treated with disruptive relationships with treatment staff due to severe psychiatric disorders, are confronted on a daily basis with aggression incidents. Guiding and investment in staff is a necessary condition for the treatment of these patients. Especially at this time of financial difficulties it is important not to cut on essential conditions for staff: education, super- and intervision and specialized care after extreme incidents.

Educational Goals

- To gain insight in trends in aggression towards staff in a specialized treatment program
- To gain insight in essential conditions for treatment of patients with severe psychiatric disorders who are extremely difficult to treat because of their disruptive relationships with treatment staff.

Correspondence

Ms. Nienke Kool
Palier
Fenny ten Boschstraat 23
2553PT The Hague
The Netherlands
n.kool@palier.nl

Factors associated to repetitively assaultive psychiatric inpatients.

Poster

Didier Camus, Valérie Moulin, & Mehdi Gholam Rezae (Switzerland)

Keywords: Repetitively violent patient, Violence, Contextual factors, Risk assessment, SOAS-R

Abstract

Research conducted on violence in psychiatric settings has shown that there are some differences between violent psychiatric inpatients and others. A recent review and meta-analysis published by Dack (2013) shows that different factors were significantly associated to inpatient aggressions : being younger, male, admitted involuntarily, not married, a diagnostic of schizophrenia, a great number of previous admissions, a history of violence, a history of self-destructive behavior and a history of substance abuse.

In the group of violent patients, it's well known that a small number of patients are responsible for a high percentage of violent acts during their hospitalization. These patients are named "repetitively violent patients", "chronically assaultive inpatients" or "repeatedly assaultive patients" .(Flannery, 2002; Lussier, 2010 ; Abderhalden, 2007 ; Grassi, 2006 ; Barlow, 2000; Grenier Brin, 2013 ; Dack , 2013). However, reports on the prevalence violent patients are rather heterogeneous (Grassi: 40.6%; Jones M.K: 43%; Lussier: 10% of patients responsible for more than 60% of the incidents; Barlow : 42% of patients responsible for 71% of the incidents ; Abderhalden: 2% of patients responsible for 51% of the violent incidents).

This heterogeneity can be explained by several potential factors: methodological and contextual differences among studies, patient populations and studied violence types or even the definition used to characterize a repetitively violent patient (Grassi, 2006; Abderhalden 2007; Cornaggia 2011; Lussier, 2010). In this study, we chose a common definition to describe a repetitively patient: 3 or more violent incidents during one hospitalization.

Furthermore, while environmental and situational contexts to commit a violent act are studied in the literature on violent behavior in the general population (Gendreau, 1996, Andrew § Bonta, 2007; Douglas, Skeem, 2005, Elbogen, 2009. Fazel, 2010), various studies report a lack of accomplished works on institutional and situational factors, and their association with individual characteristics in psychiatric institutions (Shepherd 1999; Flannery, 2002; Flannery and al 2003; Steinert 2002; Gadon et al 2006; Dack, 2013).

The aim of the current study is to evaluate the importance of individual, institutional and situational factors which might influence the repetition of physical violence.

The study was performed in an adult psychiatric service (7 wards, 95 beds and 12 seclusion rooms) in the Psychiatric Department of the Lausanne University Hospital (DP-CHUV), Switzerland. Data on violent incidents were collected during five years (2009-2013) with the SOAS-R (Nijman, 1999). Context of the incidents were analyzed with the three items (provocation, means used and target of the incident). Some other variables were also collected, as the time and place of the incident.

Some institutional information on all patients admitted in the hospital during the study period were also extracted from the hospital database (including age, gender, type of admission, principal psychiatric diagnosis, number of incidents per patient, number of hospitalizations by patient etc.).

Educational Goals

Describing:
1. The characteristics of repetitively violent patients
2. Their differences with no repetitively violent patients
3. The contextual factors influencing violent incidents, can help staffs to better prevent and manage risk of violent behavior in clinical settings

Correspondence

Mr. Didier Camus
Psychiatric Department of the Lausanne University Hospital /DP-CHUV)
Site de Cery
1008 Prilly s/Lausanne
Switzerland
didier.camus@chuv.ch

Violence, crime, sexual behaviors and use of crack cocaine in a Brazilian inpatient sample

Poster

Sandra Cristina Pillon, Alessandra Diehl, Manoel Antônio dos Santos, G Hussein Rassool & Ronaldo Laranjeira (Brazil)

Keywords: crack-cocaine, violence, sexual behavior, crime

Abstract

The aim of the present study was to evaluate violence, crime and sexual behavior among patients with substance-related disorder admitted to a specialized inpatient care unit.

Methods

This was a cross-sectional study using a questionnaire about socio-demographic data and drug of choice (DOC), questions about sexual behavior, and instruments to evaluate dependence severity (SADD, DAST, FTND), level of impulsivity (BIS-11), and a screening sex addiction scale.

Results

The sample consisted of 587 adult subjects, 82.3% men, 66.4% had cocaine (sniffed and smoked) as their DOC; 24.4% had an arrest history; 26.8% had committed crimes; 19.3% was engaged in violent situations and 12.2% of patients were involved in drug trafficking.

Conclusion

In this sample, crime was associated strongly with various sexual behaviors and the severity of substance dependence

Educational Goals

1. Learn how to work with preventive issues of violence involving drug use in inpatient units.
2. Understand the process of teaching about the issues of violence and drug use, to work with graduate students in nursing

Correspondence

Ms. Sandra Cristina Pillon
Department of Psychiatric Nursing and Human Science
Av Bandeirantes, 3900
14040-902 Ribeirão Preto, SP
Brazil
pillon@eerp.usp.br

Factors influencing the Advance directive among psychiatric inpatients from India: A prospective study

Paper

Guru S Gowda, Eric Noorthoorn, Channaveerachari NaveenKumar, Philip Sharath,
Raveesh Benvinahalli Nanjegowda, Peter Lepping & Suresh Bada Math (India)

Keywords: Advanced directives, patients' perspective, coercion, intensive care psychiatry, developed countries

Background

Psychiatric Advance Directives (PADs) is a document of patient's treatment preferences and, if desired, a surrogate decision maker during loss of capacity. Even in India, the Mental Health Care Bill (MHCB) –2013 advocates it. However, we have little evidence on patient perspectives and factors contributing to a better appreciation of PAD.

Methodology

This a hospital based prospective follow up study. Two hundred patients were assessed within three days of admission. 182 subjects were re-assessed at the time or within 3 days of discharge for their perspective on PADs.

Results

At Discharge, out of 182 patients, 67% welcome the need for PADs and as many as 95% made their own. 80% patients wished to be treated as advised by their doctor or psychiatrist within a Mental Health Establishment or General Hospital Psychiatric Unit and 57% prepared Outpatient Care. 50-55% of the patients wished not to be treated with ECT, Faith Healers, and psychosurgery. Few patients rejected injections (13.79%) and medicine (2.3%). Patients with absent insight, high scores on Clinical Global Impression - S, & General improvement, opted out ECT, in patient care and medication, results were statistically significant. In linear regression, analysis shows that low Socio economic status, not willing to stay; and patients tat underwent ECT showed an inverse relation to the appreciation of PADs. On the other hand patients with several severe mental illnesses, such as schizophrenia, bipolar disorder and alcohol and drug abuse showed a positive appreciation of PADs, possibly due to some experience with previous hospital admissions.

Conclusion

A majority of patients welcomed need for PADs and wanted to continue treatment in the future. Most opted treatment as advised by doctor/psychiatrist and in/out patient treatment under GHPU / MHE. Absent insight, having current mental illness and incomplete recovery may influence consistent PADs Statements like opting out treatment options like ECT, Injection, Inpatient care, and medicine. Therefore, clinicians must look in to all of the above along with assessing for capacity for PADs. They have to keep in mind the patients' disorder and state of mind may be related to their willingness to formulate PAD's and collaborate with treatment teams.

Educational Goals

- The presentation provides insight in consequences of Mental Health law in developing countries
- Also we compare what we may learn in western society form choices made in developing countries

Correspondence

Mr. Guru S Gowda
Department of Psychiatry, National Institute of Mental Health and Neuro Sciences (NIMHANS)
Hosur Road, Lakkasandra, Bengaluru, Karnataka
560029 Bangalore
India
drgsgowda@gmail.com

Chapter 4 – Role of Post-Traumatic Stress Disorder (PTSD) & violence

The effect of trauma focused treatment on violent risk: the integration of theoretical perspectives and clinical practice

Workshop

Ellen van den Broek & Renate Reker (Netherlands)

Keywords: Trauma focused treatment, Risk, Resilience, Protective factors, RNR, HCR-20:V3, SAPROF.

Abstract

Research indicates that programs that fulfill the principles of the Risk-Need-Responsivity model (Andrews & Bonta, 2010) are most effective at reducing criminal recidivism (Andrews, 2012). Within the RNR model the Need Principle states that management efforts should target dynamic risk factors deemed important for lowering the risk for a specific patient, also called criminogenic needs. Eight major risk/need factors can be distinguished, the so called "Central Eight".

As trauma, according to Andrews and Bonta, is not one of these major risk factors, the question can be posed if the value of trauma focused treatment in forensic mental health services is being overestimated. Since longstanding clinical experience with severely traumatized forensic psychiatric patients suggests otherwise, an integration of clinical practice, theoretical perspectives and empirical knowledge on risk and protective factors seems needed. This symposium provides an exploration of this topic in order to achieve such an integration.

In the first part of the presentation state of the art theories and developments in the area of violence risk assessment and risk management are presented. The RNR model, HCR-20V3 and SAPROF will briefly be introduced. Subsequently, the possible value of trauma focused treatment will be discussed in the light of the RNR model and what is currently known about risk and protective factors. Several patients displaying serious aggressive behavior are presented. Being in outpatient care (Forensic ACT) for several years now and having reached a situation of relative stability and safety, trauma focused treatment is used to reduce the PTSS symptoms the patients developed from the severe traumatic events in the past.

After presenting the case studies the presumed effects of trauma focused treatment on diminishing the risk of violent behavior are discussed with the audience. The RNR model, HCR-20V3 and SAPROF are thereby used in an attempt to bridge the gap between clinical practice, theoretical perspectives and empirical findings on this topic. The main question posed in this discussion is if and how the positive experiences in clinical practice with treatment of trauma in forensic populations can be explained by or integrated into the presented theoretical models and tools. The audience is invited to participate in this discussion.

Educational Goals

- Learn about the RNR model, risk factors (HCR-20V3) and protective factors (SAPROF)
- Learn about clinical experiences concerning the effects of trauma focused treatment on violent behaviour
- Learn about the integration of theory and clinical practice

Correspondence

Ms Ellen Van den Broek
Van der Hoeven Kliniek
Willem Dreeslaan 2
3515 GB Utrecht
The Netherlands
evandenbroek@hoevenkliniek.nl

The Need for Specialized Support Services for Nurse Victims of Physical Assault by Psychiatric Patients

Paper

Lois Biggin Moylan, Marybeth McManus & Meritta Cullinan (USA)

Keywords: Psychiatric Nurses, Assault, Post-traumatic Stress Disorder, Support Groups

Background

Over the last fifty years, many advances have been made in the field of psychiatry, including increased understanding of neurology, the pathophysiology of psychiatric illness and the development of more effective pharmacological agents. In spite of this progress made in the care of psychiatric patients, the rate of assault within acute care settings continues to be far too frequent (Lanza, Zeiss, & Rierdan, 2006; Slovenko, 2006). Some authors report increases in the incidence of violence in acute care psychiatry (Duxbury & Wittington, 2005; Paterson & Duxbury, 2007; Tucker, 2003). The issue of violence directed at health care workers is a global concern and has been identified as such in studies done in Japan (Inoue et al., 2006), South Africa (Bimenyimama et al. , 2009), Israel (Yarovitsky & Tabak, 2009), the U.K. and throughout Europe (Duxbury et al., 2008). These studies identify the alarming rate of violence against health care workers; and, among these, nurses are the most frequently assaulted (Moylan & Cullinan, 2011).

The effect that assault has on nurses can be devastating. In a the qualitative segment of a study that the authors of this paper conductedin six different acute care psychiatric settings, with 110 nurse participants, the responses to the assaults reported included flashbacks, nightmares, feelings of guilt and shame, feeling blamed by managers and/or colleagues, generalized feelings of fear, anxiety, anger, and hyper-vigilance, and fear when subsequently exposed to aggressive situations. Some nurses even reported feelings of pity for the patient who had assaulted them. In many cases, those feelings were ongoing, and the nurses believed that the assault had impacted both their professional and personal lives. Many of these responses are consistent with symptoms of post-traumatic stress disorder (PTSD) (American Psychiatric Association, 2000). These findings are also consistent with those reported by Jacobowitz (2013) in a review of the literature that looked at multiple prior studies related to PTSD in psychiatric nurses and other mental health care providers. The responses of the nurses in the study done by the authors of the present paper and reported in the article by Moylan and Cullinan (2011) are also consistent with the findings of Needham, I., Abderhalden, C., Halfens, R., Fischer, J., and Dassen, T. (2005) reported in a comprehensive review of the literature. An additional consequence experienced by nurses who had been seriously injured identified in the study (Moylan & Cullinan, 2011), which was not identified in any of the other related literature, was a significant negative financial impact. One nurse in this study reported losing her house while several others identified a considerable decrease in their financial status due to an inability to work because of serious disabilities related to their injuries.

Yet, in spite of the serious effects identified by the nurses in this study, many nurses who had been physically assaulted by psychiatric patients believed that the services offered to them by their institutions were minimal and inadequate. This was reported for both the physical care given, and, to an even greater degree, the psychosocial support offered. This was especially evident in those nurses who had been seriously injured. Jacobowitz (2013) identified critical incident debriefing (CID) as the most common method of intervention provided to psychiatric nurses who have experienced violence in the workplace. Although this may be a supportive early intervention, it does not address the long-term effects described in the literature and found in the study done by the authors of this paper (Moylan & Cullinan, 2011).

After completion of that study done in 2011, the principal investigator (Moylan) was contacted by subject participants requesting that more effective measures be taken to address the needs of nurses who have been assaulted by patients. The psychosocial support services rendered by their institutions ran the gamut from none to one debriefing session and, for a very few, several short-term sessions with a counselor who was not specifically qualified in this area. A few nurses reported that they attended, on their own, a support group and, there they were questioned by other group members about their competency relating to their approach to the patient who perpetrated the assault. These nurses reported feeling blamed and stated that

they felt re-traumatized by the experience in the support group. In speaking with these nurses, it became evident that the assaulted nurses needed a supportive approach that gave consideration specifically to their role functions and professional expectations as care-providers in acute care settings.

In an effort to address the concerns of these nurses, a follow-up quantitative study is currently underway to investigate nurses' interest in having support groups available that addressed the specific needs related to assault by a patient and to triangulate the findings from the original study. The present paper focuses on the segment of the study related to the need for support groups for nurses who have experienced assault in the performance of their professional duties.

Methodology

A questionnaire was developed with items reflecting the responses reported in the prior qualitative study. This consisted of 14 "yes" or "no" questions such as "Did you report the assault" and a 20 item 4 point Likert scale, ranging from "not at all" to "strongly" in response to statements such as "I felt blamed by my colleagues". An optional section was added where participants could provide a qualitative narrative related to their assault experience, if they so desired. Additionally, demographic data was collected which included a history of assault. Consent forms were included. An invitation to participate in the study was provided in a cover letter that included a description of the study.

After obtaining IRB approval from Molloy College, the questionnaires were distributed in the following manner:
1. After receiving permission from the American Psychiatric Nurses Association (APNA), the forms were posted electronically on the APNA discussion forum using Snap survey software.
2. A large Health Care System with multiple psychiatric settings was approached and asked to participate in the study. Contact was made with the Chief Nursing Officer, Associate Executive Director of Patient Care Services who facilitated the complex process of obtaining approval and who subsequently managed the conduction of the study. Within this large Health Care System, this individual became the internal Principal Investigator for this segment of the study. That process is described below:

Once IRB approval was obtained, the internal Principal Investigator (internal PI) of the study reached out to the Chief Nursing Officers (CNOs) at five behavioral health sites to gain their support. Four of the sites were single behavioral health units within three community hospitals and one tertiary facility, and one site was a free-standing 222 bed behavioral health hospital. The CNOs were asked to forward an email from the internal PI to all behavioral health nurses in their hospitals, with their personal endorsement of the study.

The email from the internal PI described the project as a follow-up to a previously conducted study entitled, "Nurses' Perceptions of an Assault Experience in Acute Care Psychiatry: Supplemental Qualitative Findings from a Multisite, Multiphase, Mixed Methodology Study of Violence in Psychiatry." Findings from the initial qualitative segment needed to be validated and, if supported, would be used to design a support program for nurses who have been assaulted and injured in the course of their professional practice. The email also delineated the data collection process which entailed an electronic research packet including a cover letter describing the study, a survey questionnaire with a Likert scale component, and a demographic data form to be emailed to psychiatric nurses. Information for an ethical informed consent was provided in the cover letter. The internal PI pointed out that nursing research that directly affects psychiatric specialty practice is essential to the future of the profession, and that the nurses' participation was sought to assure the study's success.

Molloy College's Community Research Institute conducted a statistical power analysis and determined that a sample size of 128 was needed in order to identify a moderate effect size at p= .05, for those calculations requiring the use of inferential statistics. The initial survey did not collect that number of participants, so a request was made to the IRB to extend the study to five other behavioral health units within community hospitals. The process was then repeated by the internal PI in terms of obtaining on-site nurse executive support and sending a detailed email to all psychiatric nurses.

At the present time, data collection is continuing. Currently, 52 nurse participants who met the inclusion criteria of having experienced assault have responded. Thirteen of these are from the national APNA group and 39 are from the participating multi-site health care system. Preliminary findings are reported below:

Study Findings

Thirteen nurses from the aggregate groups reported one incidence of assault; thirty-three reported two or more assaults and six did not answer this question. Only 17% of the nurses stated that they reported all assault occurrences. Fifty-three percent reported at least one of the assaults they had experienced. Of those nurses who answered this question, reasons selected for not reporting assaults (from a list of choices provided) were "most nurses don't bother to report assault" (42%); they "did not want to make a big deal" about the assault (75%); "it is too much trouble" (42%); and "my competency may be questioned" (8%). Others wrote in the following reasons for not reporting: "no serious injury occurred" (n=2); "assault is a norm" (n=1); and "it's the hospital culture" (n=1) under the choice "other". The data indicate that a significant number of assaults go unreported.

In response to the "yes" or "no" questions, of those responding, 30% reported having flashbacks, and 30% had dreams about the assault. When asked about the type of support that was offered by the organization, 10% reported that a formal program was provided and 30% reported that they received informal support. Three further "yes" or "no" questions assessed the interest of the nurses in pursuing further avenues of support specific to their assault experience. Seventy-six percent wanted more information about such groups if these were available; 44% reported that they might be interested in attending these groups; and 41% reported that they would be interested in attending these support groups.

Findings from the other segment of the study related to responses to workplace assault in acute care psychiatry showed that the vast majority of nurses were disturbed by recurring thoughts of the assault, felt fear while at work, experienced feelings of generalized anger, and felt a sense of lack of control. Many of the nurses reported feelings of guilt, shame, sleep disturbance, a decrease in job satisfaction, as well as experiencing a negative impact on their practice. A majority of nurses reported the belief that assault is to be expected and many believed that assault is to be accepted in an acute care psychiatric setting.

Discussion of Findings

The above findings show that many assault incidences experienced by nurses in acute care psychiatry go unreported. Consequently, any formal support program for those nurses is lacking. Even when officially reported, only a small percentage of nurses (10%) are provided with a formal program by their employing institution. Findings from the study show that nurses' responses to patient assault are consistent with the symptoms associated with post-traumatic stress disorder. Many nurses in the study wished to pursue further avenues of support. Forty-four percent reported that they might be interested in attending a support group, and 41% would be interested in attending a support group for nurses who had been assaulted by patients. When considering frequency of assault (Lanza, Zeiss, & Rierdan, 2006; Slovenko, 2006) and severity of injury (Moylan & Cullinan, 2011) of nurses in acute care psychiatry, the percentages of nurse desiring post assault supportive services in this study potentially represent a vast number of nurses.

Conclusion

This study supports the need for support groups specifically tailored to the needs of psychiatric nurses who have experienced assault. After completion of the current study, the principal investigator (Moylan) will constitute a team of experts consisting of psychiatric nurses, professionals with experience in post-traumatic stress disorder, and specialists in group dynamics and information technology who will develop a program to meet the specific needs of nurses who wish avail themselves of these services. Several options for the delivery of services will be considered, such as nationally available on-line groups and local in-person meetings. A grant will be sought to support this project.

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Educational Goals

- The learner will identify the effect that assault by a patient has on the assaulted nurse.
- The learner will recognize the need for the availability of a specialized support program for nurses who have been assaulted in the performance of professional duties.

Correspondence

Ms. Lois Biggin Moylan
Molloy College
132 Westminster Rd.
11552 West Hempstead, New York
U. S. A.
Lmoylan@molloy.edu

Chapter 5 – Trauma informed care & practice

Dream experiences in patients who experienced the comatose state: a clinical-qualitative approach

Poster

Tatiane Maria Angelo Catharini, Thiago Calderan & Mário Eduardo Costa Pereira (Brazil)

Keywords: dream; coma; Qualitative Research; psychoanalysis

Introduction

The dream is important for the psychological recovery and for fixing the affective character of memories. The induced coma consists of sedation unstable patient to decreased mental and physical stress. There are few studies on the relationship between coma and dreams.

The objectives of this study are:

1. To analyze and understand the subjective meanings of dream experiences during and after the comatose state and
2. Investigate the mental functioning during and after the coma.

Methodology

We carried out a qualitative study of semi-structured interviews with 8 patients who experienced coma, at the Clinical Hospital of the University of Campinas.

Results

The study is still in progress, we have significant results. Data were analyzed for the formation of thematic groups and from the perspective of psychopathology and psychoanalysis. The main reported dream content was related to the desire to return to everyday life, religion and the hospital environment. There were no reported dreams related to the trauma scene. Dreams were associated with feelings of relief and anguish. There was a report of dream experience during the coma period, referring to the sequelae of trauma, of which the patient had not been informed. Changing the perception of reality, time and space has proved to be highly stressful factor, while the dialogue and narration of the disease proved to be beneficial and reassuring.

Discussion

Most of the dreams of patients reflect your deepest desires, which influences with the psycho-emotional state. Although forgetfulness occur with defensive characteristics in order of Freud, through forgetfulness, it is common that patients associate dreams to your wishes. Therefore, we question the appearance, after the coma experience, a new way of preparation of unconscious desires. The patients' absence of relieving the trauma from nightmares points to a peculiar pattern of development of post-traumatic stress disorder in these cases. Put the subject as narrator of the disease and the traumatic experience itself allows a biopsychosocial management to patients and to promote a more individualized care, promoting better clinical outcome of post-comatose.

Conclusion

Reported dream contents reveal the wishes of patients, the absence of dreams related to trauma scenes point to a different perspective of posttraumatic stress disorder at post-coma and the reports reveal the peculiarities of psychic functioning of these patients.

Educational Goals

1. Create new hypotheses and concepts on the patient's mental functioning who experienced coma
2. Recognize and recalling knowledge about interpretation of dreams, psychoanalysis and post-traumatic stress disorder

Correspondence

Ms. Tatiane Maria Angelo Catharini
Universidade Estadual de Campinas, Faculade de Ciências Médicas
Tessália Vieira de Camargo, 126
13083887 Campinas
Brasil
tcatharini@yahoo.com.br

Witnessing violence: What are the experiences of psychiatric nurses?

Paper

Dave Jeffery (UK) (Member of ENTMA)

Background

Violence against healthcare staff is a global concern. In the UK psychiatric nurses are ten times more likely to be assaulted at work than their general nurse colleagues. Research into the effects of violence on those psychiatric nurses who have been assaulted is gradually improving. However the evidence base for the effects violence incurs on those staff who bear witness to it is remarkably poor. The emergence and recognition of the vicarious impact of violence and subsequent trauma over the past fifteen years demonstrates the urgent need for evidence which explores the impact such facets have on personal issues and professional practice.

Methods

Semi-structured interviews were undertaken to collect the experiences of a purposive sample of 10 psychiatric nurses who had witnessed an incident of violence in the previous six months. Grounded theory (Strauss and Corbin, 1998) was used to analyze the narrative data via an iterative and systematic process of open, line by line, axial and selective coding in order to generate themes and theoretical constructs related to witnessing violence.

Results

Participants interviewed experienced similar emotional consequences as those who were assaulted. Anger, fear and guilt were primary factors. The experience of witnessing violence left participants seeking resolution on personal and professional conflict. The themes of wanting holistic control, feeling responsible, making the right decisions, dealing with feelings and wanting cohesive support were found to be fundamental to the participants' experience. In the absence of support staff was drawn towards informal forums which reinforced the viewpoint that management and the wider organization were uncaring. Further research into psychiatric nurses' lived experience of debriefs and support in the workplace is needed.

Educational Goals

Participants will:
- Have an understanding of the five key themes the study identified in relation to the lived experience of witnessing violence
- Have an understanding of the identified gaps in knowledge and the implications of the study for policy and practice

Correspondence

Mr. Dave Jeffery
Birmingham and Solihull Mental Health Foundation Trust
4 Foxes Close
Blackwell Bromsgrove
UK
davebjeffery@btinternet.com

Trauma Informed Teamwork: Understanding the Dynamics of the Trauma Histories of Caregivers

Workshop

Bob Bowen (USA)

Keywords: trauma, caregiver, secondary trauma

Introduction

Much has been written about the broad subject of trauma, the creation of trauma informed service systems, and the effect of trauma on both individuals served and staff. The focus has been primarily on the trauma histories of individuals served and how that history translates into behavioral challenges. That importance is real and not to be diminished in any way. It is also important to understand the trauma histories of staff and how their behavior has been affected by their own trauma histories.

In human service systems, there is usually a team of people responsible for the design, coordination, implementation, evaluation, and modification of plans for individuals. It is this team that must be informed of the effect of trauma on team members. Research from Canada (Maunder et al, 2010) and the United States (SAMHSA, 2014) reveal higher rates of trauma than among the general population. Psychologists have significantly higher rates of sexual abuse in childhood than among the general population. (Pope & Feldman-Summers, 1992) While Secondary Traumatic Stress is a very real issue that must be dealt with, the traumatic stress resulting from exposure to Adverse Childhood Experiences, similar to the experiences of individuals served, must be recognized by the Trauma Informed Team.

Trauma Informed Teamwork provides a framework for team members to self-disclose and discuss the effects of trauma on their lives within the boundaries of employment law. Employers are prohibited from using medical information regarding staff in the employment relationship. However, there must be a process to address the interactions between staff and individuals served when both have histories of trauma which may interact in negative ways for both parties. The four step process for overcoming cultural trauma developed by Dr. Maria Yellow Horse Brave Heart (Brave Heart, 2011) and the "4 R model" (SAMHSA, 2014) have been adapted for use in addressing individual histories of trauma and transcending that trauma. Trauma Informed Teamwork takes these steps and provides a voluntary series of steps which staff can take to 1) confront their trauma, 2) understand the neurobiological and behavioral effects of that trauma, 3) release the pain, and then 4) transcend the trauma.

Each step is guided by members of the team using a self-directed approach to teamwork, with access to relevant professionals as needed. The increased awareness of trauma among staff provides for a way to address those times when the trauma histories of individuals served and the trauma histories of staff intersect and interact. Without this awareness, staff may inadvertently re-traumatize individuals served, and/or be re-traumatized themselves. It must be reiterated that this process is entirely voluntary. If even one member of the team is hesitant or refuses to participate, it is an indicator that the team is not ready to move on. In this case, supports through the policies, procedures, and protocols of the organization for all staff should be implemented.

Step one: Confront the Trauma

Following is the ACE questionnaire. Team members would take this quiz, and share the responses:

Prior to your 18th birthday:
1. Did a parent or other adult in the household often or very often… Swear at you, insult you, put you down, or humiliate you? or Act in a way that made you afraid that you might be physically hurt?
   No___If Yes, enter 1 __
2. Did a parent or other adult in the household often or very often… Push, grab, slap, or throw something at you? or Ever hit you so hard that you had marks or were injured?
   No___If Yes, enter 1 __
3. Did an adult or person at least 5 years older than you ever… Touch or fondle you or have you touch their body in a sexual way? or Attempt or actually have oral, anal, or vaginal intercourse with you?
   No___If Yes, enter 1 __

4. Did you often or very often feel that … No one in your family loved you or thought you were important or special? or Your family didn't look out for each other, feel close to each other, or support each other?
   No___If Yes, enter 1 __
5. Did you often or very often feel that … You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? or Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   No___If Yes, enter 1 __
6. Was a biological parent ever lost to you through divorce, abandonment, or other reason ?
   No___If Yes, enter 1 __
7. Was your mother or stepmother:
   Often or very often pushed, grabbed, slapped, or had something thrown at her? or Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? or Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
   No___If Yes, enter 1 __
8. Did you live with anyone who was a problem drinker or alcoholic, or who used street drugs?
   No___If Yes, enter 1 __
9. Was a household member depressed or mentally ill, or did a household member attempt suicide?   No___If Yes, enter 1 __
10. Did a household member go to prison?
    No___If Yes, enter 1 __
Now add up your "Yes" answers: _ This is your ACE Score

The national data in the United States and subsequent studies in different states showed remarkable consistency. A study done in Washington state (Anda, 2012) showed that of 30 students, 10 students had more than 4 ACE's. Extrapolating this data forward, it would not be unusual to have one third of the staff in a human service organization to have 4 or more adverse childhood experiences

Being aware of one's own trauma history is important in understanding how caregivers respond, or sometimes react, to the behaviors of individuals served. The more people understand their own history, the more control they will have over their own future. When caregivers and recipients of care both have trauma histories, the interaction between them can quickly become counterproductive for everyone.

Step Two: Understand the Trauma

The information available to understand the neurobiological impact of trauma on children (Perry 2004, Van der Kolk, 2007) and how these traumatic experiences affect adult behavior (Briere 2002) can readily be applied to caregivers, as well as people receiving care. The Neurosequential Model of Therapeutics (Perry, 2006) can be used to understand and respond to adult behavior just as effectively as that of children.

Self-awareness of trauma history is central to the process of self-disclosure of trauma history. In Trauma Informed Teamwork, some participants may not be aware of their own trauma histories, and this is not the venue to address such concerns. Rather, each person who is aware of their own trauma history and feels comfortable with their teammates can disclose how their trauma histories affect them. In my work I self-disclose that I am a survivor of trauma, and that it has affected my abilities to be aware of emotions and my comfort (or rather discomfort) with conflict. Being aware of this makes it easier for colleagues to use cognitive rather than affective language in our interactions.

One of the tools used to understand how to better support people who have escalated is included below:

Crisis Cycle Phase	What I can do for myself to feel safe	What others can do to help me feel safe
Baseline		
Stimulus or Trigger		
Escalation		
Crisis — Out of Control		
De-escalation		
Stabilization		
Post-Crisis Drain		

By identifying what caregiver's needs, it becomes easier for them to understand what individuals served need. The human experience of and response to stress and traumatic events appears to be universal, and is not bound by culture or diagnosis.

Step Three: Release the Pain

This step will have less importance within the team of individuals working together. Releasing the trauma means forgiving those who perpetrated the abuse or neglect, and not holding on to the pain. There may be cases where staff to staff relationships were retraumatizing experiences for individuals, and in this case specific conflict management strategies should be followed.

Team members must always be aware of the potential for re-traumatization in their work with individuals served. The focus to date has been how staff actions re-traumatize those receiving services. There must also be an awareness of how the behaviors of individuals served can re-traumatize staff. Unlike staff, however, consumers or clients are not responsible to manage themselves to the same degree as staff are. The assumption is that staff have a "normal" range of responses to situations and that they can readily monitor their own behavior and choose their actions.

The Mandt System® (Mandt and Bowen, 2014) teaches a phrase to all participants: "affirm your feelings, choose your behaviors." By releasing the pain, releasing the grip trauma has it is easier to affirm the feelings inside of survivors of trauma. After doing so, people can now choose how they will respond instead of reacting to their own emotional responses such as fear, frustration, anxiety and tension.

Step Four: Transcend the Trauma

It is in this fourth step that survivors of trauma begin to thrive. To transcend the trauma, it is vital that people have safe relationships with others. There will be times when the stress of human service work becomes so great that re-traumatization occurs. When this happens, people with trauma histories must be able to rely on others for psychological and emotional safety.
Physical safety is important, and most regulations dealing with staff safety in the workplace focus on physical safety. Of equal, and perhaps more importance, is emotional and psychological safety. When people feel safe, they are able to tolerate more stress in their lives.

Survivors of trauma are often asked: "have you gotten over it?" The answer most survivors give is that one does not "get over" trauma, one "gets through" trauma. Having connections with others who can walk through the process of healing is critical to getting through the trauma. Teamwork, when it is characterized by words such as "dignity" and "patience" and "fairness" and "forgiveness" is much more effective than when characterized by the negative counterparts of these words.
Trauma Informed Teamwork must extend everything we know about the trauma of individuals served to the traumatic experiences of the servants. Only when the elements of healing provided to clients are also provided to staff can we move forward.

In this interactive workshop, participants will participate in some of the activities used to increase awareness of trauma histories of staff, understand the neurobiological effect of trauma in an individualized format, discuss how that pain can be released and the experience of trauma can be transcended. It is only when staff can transcend their own trauma, if present, that they can pass healing on to others in their therapeutic relationships.

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Educational Goals

At the completion of this workshop, participants will have:
1. Described the process of traumatization among staff
2. Assessed the possible presence of trauma in their own lives
3. Integrated the knowledge of trauma into a process of support for themselves and individuals served

Correspondence

Mr. Bob Bowen
(Adjunct Assistant Professor of Psychiatry, University of Rochester, Rochester, NY)
The Mandt System, Inc.
PO Box 831790
75083 Richardson
USA
bob.bowen@mandtsystem.com

Chapter 6 – Assessment of risk, prevention & protective factors

Violence and aggression against staff in mental health work: Consequences and effective management

Abstract/introduction

This paper examines the consequences of violence from mental health service users/patients on workers, service users themselves, and others in their formal and informal networks, and addresses how best to respond to workers and service users after such incidents. It also examines how best to involve service users and staff in systems to identify triggers, and ways forward in individual situations and in systems approaches in mental health settings.

Main paper

This presentation is based on analysis of the evidence arising from a review of the research and wider literature concerning the effects of violence and aggression in mental health work, and findings from a study of risk assessment tools in England that examines how well service users are included in such risk assessments, and how they might better be included (e.g. Littlechild and Hawley, 2009). The presentation will set out the key features from our knowledge of the areas covered, and how we might analyse these in order to produce best practice in policy guidance and direct work with patients, including those from the UK's National Institute for Health and Care Excellence (NIHCE) Guideline Development Group's systematic review on *'Violence and Aggression: The short-term management of violent and physically threatening behaviour in mental health, health and community settings'* (NIHCE, 2015), in order to involve all those involved in an incident, and the effects on them.

The effects of aggression and violence on staff

Harris and Leather (2012) found in their research that as exposure to service user violence increases, so does reporting of stress symptoms, reduction of job satisfaction, and fear/feeling vulnerable as a consequence of exposure to such behaviour.

Holmes et al (2012:3) conclude that the consequences of workplace violence in the health care sector are far–reaching, including absenteeism, injury, high staff turnover, lower quality of service, and decreased satisfaction at work. In addition, the service user and the service user's network, e.g. partners, family members or the wider patient group may be affected (Holmes et al., 2012), and that the relationships between these different actors can also be affected.

Staff may become wary and distrustful of the perpetrators, and/or come to generalize their distrust and attitudes onto other service users, with similar issues being present for the other parties involved. The individualised experiences and effects on staff- their emotional and physical effects, effects on their professional and/or personal life, effects on respondents' subsequent work- and the individualised experiences of and effects on service users/patients (Holmes et al, 2012) -and others involved- need to be taken into account in policies and procedures in providing support for staff and clients/patients, as examined in this presentation.

NIHCE guidelines

NIHCE is the organisation tasked by the UK government to develop quality standards and performance metrics for those providing and commissioning health, public health and social care services and to provide informational services for commissioners, practitioners and managers across the spectrum of health and social care. Since 1999, it has provided the UK National Health Service (NHS) (and since2013 for social care), and those who rely on it for their care, with advice on effective, good value healthcare, based on evidence-based guidance and advice. NIHCE's role is to improve outcomes for people using the NHS and other public health and social care services.

The NIHCE guideline referred to in this presentation was published in May 2015 and covers the short-term management of violence and physically threatening behaviour in mental health, health and community settings. This includes inpatient psychiatric care, emergency and urgent care, secondary mental health care (such as care provided by assertive community teams, community mental health teams, early intervention teams and crisis resolution and home treatment teams), community healthcare, primary care, social care and care provided in people's homes (NICE 2015).

Definitions and incidence

NIHCE defines the area as follows: *"Violence and aggression refer to a range of behaviours or actions that can result in harm, hurt or injury to another person, regardless of whether the violence or aggression is physically or verbally expressed, physical harm is sustained or the intention is clear".* (NIHCE 2015).

Violence and aggression were found by NIHCE to be relatively common and serious occurrences in health and social care settings. Between 2013 and 2014 there were 68,683 assaults reported against NHS staff in England: the highest rate was in mental health and learning disability settings, and of these, most frequently in inpatient psychiatric units (NIHCE 2015).

The NICE guideline found that *"the manifestations of violence and aggression depends on a combination of intrinsic factors, such as personality characteristics and intense mental distress, and extrinsic factors, such as the attitudes and behaviours of surrounding staff and service users, the physical setting and any restrictions that limit the service user's freedom",* and that the impact of violence and aggression is significant and multi-facetted, *"adversely affect*(ing) *the health and safety of the service user, other service users in the vicinity, carers and staff"* (NIHCE, 2015).

A key element for the purposes of this paper is that the NIHCE guidance expects that there is dialogue with service users about the reviews of and interventions to deal with this matter, and their preferences about this for them, to help them to reach fully informed decisions about these plans. This paper proposes that this should not only be a key feature/goal of any effective set of responses to violence and aggression, but also that any policies/procedures need to take into account what might prevent such effective processes taking place, and how to facilitate this aim of including service users and carers fully in the aftermath of and forward planning for such aggression and violence.

The guideline in section 1.1, recommends that to improve the service user experience/inclusion, staff and agencies should:
• work in partnership with service users and their carers
• adopt approaches to care that respect service users' independence, choice and human rights, and as part of this, if willing and capable, that service users and carers are involved in decision-making whenever possible.

In addition, service users and carers should be involved in adjustments to services that might include providing a particular type of support, modifying the way services are delivered or the approach to interactions with the service user, or making changes to facilities. These deliberations and decisions should then be recorded, as agreed between the service user, carer, where appropriate, and staff in the service users care plans and care notes.

The guideline recommends that:

"The results from such reviews with the service user and carer where appropriate, should lead to a risk assessment and risk management plan, which may need to be shared with other agencies. This should be reviewed regularly to look at changes and updates on this the circumstances of the client, the carer and the agency.", which should evaluate the physical and emotional impact on everyone involved, including witnesses; help service users and staff to identify what led to the incident and what could have been done differently (this could be done by way of a critical incident analysis, for example). Such

reviews/assessments should determine whether alternatives, including less restrictive interventions, were discussed; determine whether service delivery issues make it difficult to avoid the same course of actions in future; potentially recommend changes to the service's philosophy, policies, care environment, treatment approaches, staff education and training; and try to avoid a similar incident happening in future. It is recommended that a service user experience monitoring unit or equivalent service user group should be involved in carrying out such reviews, and give a report to the agency/setting that is based on a formal external post-incident review.

Research exploring risk assessment and risk-management from the perspective of how much service users perceived themselves to pose a risk to others provides some valuable insights into issues concerning risk assessments for mental health service users (Langan, 2000; Langan and Lindow, 2004). One of the most effective forms of risk assessment was found to be to get to know the service user over time and to engage with them; this was likely to give a far more balanced assessment (Littlechild, 2009).

The guideline places a high emphasis on restrictive interventions, and recommends that where these take place, post incident actions should address environmental factors likely to increase or decrease the need for restrictive interventions, and involve and empower service users and their carers, and use crisis and risk management plans and strategies to reduce such interventions, that should include post-incident debrief and review. The guideline does not address so fully other incidents of aggression and violence, which do not result in restrictive interventions; this paper sets out the need for these processes be put into place for these other types of incidents as well.

The learning from such processes should not only be for individual service users, but also for the organisation as a whole, by way of having service user-led review bodies which report directly to the Board of the organisation. The guidance states that health and social care provider organisations should develop a service user experience monitoring unit- as mentioned above-, or equivalent service user group, led by service users and including staff, to report and analyse data on violence and aggression and the use of restrictive interventions.

The guideline also notes the important fact that it is not just service users and potentially carers and staff that are affected by such incidents, and recommends that any other service users who may have seen or heard the incident are given the opportunity to discuss it so that they can understand what has happened, and be involved in plans to decrease risks.

These recommendations about service user involvement at a high level are welcome, but we do need to take into account our knowledge of the difficulties of including them in currently formulated risk assessment and risk management plans. Findings of a research study into risk assessment tools used within NHS Mental Health Trusts in England provide evidence of the wide variability in the content of such tools (Hawley et al., 2006). Eighty-three Trusts- all of those in England- were contacted, and 53 (64%) provided returns.

A content analysis of the areas covered in the Risk Assessment Tools was undertaken, and it was clear from the forms which were examined how service users and/or carers were involved in their risk assessments, if at all; there may still be much work to be done to include people within their own risk assessments, and risk management plans. There was no indication in the forms of how, or if, service users and/or carers contributed to the risk assessment (Littlechild, 2009).

Conclusion

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

As an overarching model of how to include service users and carers in such ways as deemed valuable in the guidance could be coproduction with service users, carers and staff.

Co-production

In looking at how services can move towards co-production of risk assessments and risk management strategies, both individually and for the setting and the agency, rather than merely just taking into account

the views of service users about their services, and bearing in mind the key issues from the work of Langan and Littlechild and Hawley set out above, Arnstein's ladder of participation is of note (Arnstein, 1969).

The bottom rungs of the ladder- the least desirable for co-production- are 1) manipulation and (2) therapy. These two rungs describe levels of "non-participation" - these approaches do not enable people to participate in planning or conducting programmes, but emphasise power-holders "educating" or "curing" the service user.

Rungs 3- informing- and 4 - consultation - progress to levels of "tokenism" that allow the service user to hear and to have a voice. When they are proffered by power holders as the total extent of participation, service users may indeed hear and be heard, but they lack the power to ensure that their views will be heeded by the powerful.

Further up the ladder are levels of citizen power with increasing degrees of decision-making effect. Clients can enter into a partnership – level 6 – that enables them to negotiate and engage in trade-offs with traditional power holders. At the topmost rungs of the ladder, we come to (7) delegated power and (8) client control, which are considered to be the most inclusive and empowering, and therefore effective and desirable for co-production. The same points can be made about staff involvement in these matters.

In order to effectively introduce the positive elements of the guideline from NIHCE, taking account of the research into the lack of inclusion of service users and carers in risk assessment and risk management procedures, and ideas how this might be more effective, it is suggested that the idea of coproduction based upon Arnstein's model may be a key feature of the strategy implementation of those recommendations

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Correspondence

Professor Brian Littlechild PhD, Dr Honoris Causa (University of Ostrava), BA, MA, CQSW, RSW, FRSA, FHEA, AUH
Department of Nursing (Children's, Learning Disabilities and Mental Health) and Social Work,
School of Health and Social Work,
University of Hertfordshire,
College Lane,
Hatfield,
Hertfordshire,
AL10 9AB, UK
b.littlechild@herts.ac.uk

From scale to scenario: Old method but new development in risk assessment research?

Paper

Stål Bjørkly (Norway)

Keywords: Research, violence, risk assessment, risk scenarios

Abstract

Risk assessment of violence is a clinical and research task engaged in worldwide. This is exemplified by translations of the most commonly-used risk assessment tools into a multitude of languages, and a substantial number of publications from countries outside the tools' country of origin. Generally, the tools are also used across treatment units with the assumption that these contexts are equal provided that the units serve the same function (e.g. forensic psychiatry or acute psychiatry). Although many studies have been published examining the predictive validity of risk assessment tools in different countries, little guidance exists on practical considerations when conducting such research.

The principal aim of this presentation is to explore some methodological considerations unique to carrying out assessment research with emphasis on contextual factors. More specifically, scenario-based risk assessment will be discussed. This facet of risk assessment has a central role in the seven step model of the HCR-20V3 and it has been used for over 50 years for instance in the field of economics and in the military.

The core of a risk scenario lies in the answer to: What might a person do in a given context in the future? The strength of this approach concerning risk assessment research is that the inclusion of risk management strategies and other contextual factors is a basic premise for its use. Contextual factors cover a wide range of aspects that may have an impact on the accuracy of risk assessments. For example, there is good evidence that contextual changes, such as moving back to a violence-prone neighborhood, losing a job, or becoming divorced, may be significant risk factors for violence. Housing, employment, finances, leisure activities, professional and private network, and neighborhood, may facilitate or protect against relapse into violence. Scenario-based risk assessment research may want to compare the type and quality of the future contextual conditions that was predicted to enhance/mitigate risk of violence with the type and quality of the contextual conditions the sample actually lived in during follow-up.

Two tentative research models for scenario-based risk assessment will be discussed: (1) The ideal model that measures prospectively the frequency and severity of exposure to the components of the risk scenario, and (2) The feasibility model that measures retrospectively to what extent the components of the risk scenario actually precipitated violence recidivism. The models will be analyzed according to criteria of internal and external validity. Suggestions for future research will be discussed.

Educational Goals

- The significance of monitoring contextual factors and risk management strategies in risk assessment
- The idea of using risk scenario ratings as an alternative to sum scores and final risk judgments in risk assessment research

Correspondence

Mr. Stål Bjørkly
Molde University College and Oslo University Hospital
P.O.Box 2110
6402 Molde
Norway
stal.bjorkly@himolde.no

Reducing violence by implementing BVC and SOAS-R in forensic clinical practice

Poster

Johan Christian Clasen, Liselotte Mattison, Kelly Nielsen, Katrine Christiansen & Liselotte Pedersen (Denmark)

Keywords: BVC, SOAS-R, Violence, Risk assessment, preventive measures

Background

Inpatient aggression is generally prevalent on forensic psychiatric wards; hence, risk assessment in order to prevent violence is a priority. In order to optimize the day-to-day violence risk assessments (using the Brøset Violence Checklist; BVC) and the registration of incidents of aggressive/violent behavior (using the Staff Observation Aggression Scale – Revised; SOAS-R) the Department of Forensic Psychiatry has implemented an electronic registration and analysis system (Re-Act) encompassing BVC and SOAS-R. The overall aim is to improve systematic short-term violence risk assessment and reduce incidents of violence towards patients and staff.

Aim

The aim of this study is to describe the process of implementing the Re-Act registration system to optimize documentation and analyses of BVC assessments and SOAS-R registrations. Furthermore, the aim is to investigate whether the systematic documentation and analyses of BVC assessments and SOAS-R registrations will reduce the number and severity of violent incidents.

Method

The study took place at two forensic psychiatric units at the Department of Forensic Psychiatry, Region Zealand, Denmark. Both units had some experience in using paper versions of BVC and SOAS-R prior to the implementation of the Re-Act registration and analyses system. Re-Act was implemented by a local interdisciplinary team during autumn 2014. This team was responsible for the initial staff training, continuous training and clinical case meetings as well as for focusing on using the systematic documentation and analyses in relevant settings, e.g. treatment meetings and shift hand-over etc. Data will be collected for at period of 1 year and will include the actual implementation process and the completed BVC and SOAS-R registrations in the Re-Act system.

Results and conclusions

Data on registrations of aggressive/violent incidents will be presented, for example the nature of violent incidents, where and when the violence take place, and to what extent it is possible to detect patterns in the way violence is performed across patients and units. Furthermore, data on aggressive/violent incidents will be presented in relation to BVC violence risk assessments scores and implemented preventive measures. It will be discussed in what way a systematic registration system encompassing BVC and SOAS-R are useful in clinical practice. Including, whether a reduction in violence is detectable, to what extent other outcomes such as a reduction in the use of restrictive practices and staff related incidents are detectable, and whether generated data are put in use to inform daily patient treatment.

Educational Goals

1. Implementation of systematic registration in clinical practice
2. Assessing and reducing violence in clinical practice

Correspondence

Mr. Johan Christian Clasen
Department of Forensic Psychiatry, Region Zealand
Annebergparken 62
4500 Nykøbing Sj.
Denmark
jocc@regionsjaelland.dk

The use of the HCR-20 in Forensic Medium Security Units in Flanders: Clinical value?

Paper

Inge Jeandarme, Claudia Pouls, Jan De Laender, T.I. Oei & Stefan Bogaerts (Belgium)

Abstract

Structured risk assessment has become part of routine practice in forensic settings. However, little attention has been paid to the clinical applicability of existing tools. The present research focused on the performance of the Historical Clinical Risk Management-20 (HCR-20) – one of the most commonly used structured instruments – in the daily practice of three medium security units in Flanders.

During medium security treatment, the HCR-20 was administered at least once for slightly more than half of the patients, of which 168 within one year after admission and 105 within one year before discharge. Areas under the curve (AUCs) for the prediction of recidivism during and after medium security treatment were non-significant, except for general recidivism during treatment. Further analyses showed that the HCR-20 was mainly of interest in identifying low-risk individuals. As most performance indicators may vary depending on base rate, population, time at risk and outcome, results can't be generalized. Further research measuring different aspects of predictive validity is therefore recommended.

Educational Goals

• Understand the use of risk assessment tools

Correspondence

Ms. Inge Jeandarme
OPZC Rekem
Runkelenstraat 12 A
Zoutleeuw
Belgium
ingeborg.jeandarme@telenet.be

Brøset Violence Checklist: Risk Assessment of Violence in Psychiatric Care – From Evidence to Everyday Practice

Poster

Dorte Graulund Olsen & Sabina Renee Beldring (Denmark)

Keywords: BVC, Risk Assessment, Violence, Coercion, Psychiatric care, Care strategy, Implementation

Background

This poster presents results of an implementation process of Brøset Violence Checklist (BVC) in everyday practice.

Aim

The aim of this study was to evaluate the use of BVC from two perspectives: Nurses and patients in order to determine if the risk assessment tool prevented violence and coercion.

Method

The study was carried out in two psychiatric care units in Denmark. The sample consisted of 23 patients and 45 caregivers (including 13 nurses).

A number of data was collected using the following methods:

- Qualitative and quantitative questionnaire given to the caregivers
- Audit of patient records (n10)
- Focus group interview with three nurses
- Semi structured interviews with two inpatients.

Results

The questionnaire showed that 50 % of the caregivers found BVC meaningless; 87% did not believe that a rating ≥2 equals a higher risk of violence. Forty-three percent stated that they can assess the risk of violence without the BVC.

The audit showed deficient documentation; 58% of documentation of initiated interventions as a result of the BVC-rating and 79% of documentation of the effect was inadequate in the patient records.

The nurses stated that BVC is not an integrated part of everyday practice, and have a wish of becoming more harmonized in rating.

The inpatients requested collaboration when caregivers intervene.

Conclusion

The caregivers expressed uncertainty about how and when to use BVC and with whom. The nurses indicated that they do intervene despite lack of documentation. The inpatients were not aware that the care strategies, giving in escalated situations, were influenced by the caregiver's knowledge about BVC. They seek individual, cooperative care.

Implication for practice: First, an evaluation of the implementation strategy is needed to ensure that the BVC is properly used in everyday practice. Second, there is a need for more knowledge and experience about BVC. We recommend training in teams, peer-to-peer training and educational ratings in groups in order to compare outcomes.

Furthermore, with the implementation of SOAS-R (to document aggression and violence), it seems possible to acquire statistics about individual patient violence as well as violence in the unit as a whole. Such statistics may show a coherence between violence, BVC and the effect of the interventions; hence giving the caregivers a greater purpose for using the BVC.

Last, we recommend that patients are involved in BVC-ratings and that interventions are made in collaboration with them.

Educational Goals

1. To understand how patients and mental health workers comprehend BVC
2. To understand how BVC can be implemented in the everyday practice

Correspondence

Ms. Dorte Graulund Olsen
Psykiatrien Syd, Region Sjælland
Færgegaardsvej 15
4760
Vordingborg
Denmark
dgol@regionsjaelland.dk

Violent Behavior and risk of recidivism of violence among patients living in psychiatric residential facilities

Paper

Giovanni de Girolamo (Italy)

Keywords: Risk of violence, recidivism, mental health, cohort prospective study

Introduction

Persons with mental disorders and a history of violence are often seen as a difficult-to-manage segment of the population. This group is also characterized by a high risk of recidivism, and poor compliance with community and aftercare programs. In Italy, the research on this topic is very limited: no data exist on their socio-demographic and clinical profiles of patients who have acted violent behavior.

Aims

The first aim of the study is to investigate a sample of patients living in Residential Facilities (RFs) with a history of violent behavior against people and to compare their characteristics with those of never-violent residents. Innovative elements of the evaluation, as potential discriminating variables for the act of violent behavior, are the dimensions of metacognition, deficits of executive functions and skills of emotion recognition. The second aim is to compare the frequency and severity of aggressive and violent behavior in the last two years through a bimonthly monitoring done with the Modified Overt Aggression Scale (MOAS) in these two groups; and, finally to assess the predictors of aggressive behavior.

Methods

The aim of this cohort prospective study was to compare two groups of patients with a primary psychiatric diagnosis, matched by sex, diagnosis and age, staying in one of the 23 medium-long term RFs of St John of God Order's during an index period. The 'violent' group consisted of patients who have committed at least one violent act against people (before entering the study), while the 'never-violent' group only included patients who have never committed physical violence against people. Socio-demographic and treatment-related information, included in a 'Patient Schedule', were gathered. Moreover, a large set of standardized instruments were administered to assess clinical and psychosocial functioning, aggressive behavior, impulsivity, metacognition, emotion recognition, cognitive functioning, and personality traits. In order to monitor the risk of recidivism during the 1-year follow-up we used the MOAS, which was administered twice a month.

Results

The study involved 142 patients: 81 violent and 61 never-violent. The data are currently being processed and will be presented at the meeting.

Conclusion

To date very little is known about if, and how, RFs can meet the everyday needs of patients with a history of violent behavior. As stressed by many authors, more investigations aimed at evaluating risk of reoffending in this group of patients are needed. Our study, conducted in the specific setting of RFs, is a strong contribution in this area.

Educational Goals

1. To better predict risk of violence
2. To better manage patients with history of violence living in residential facilities

Correspondence

Mr. Giovanni de Girolamo
IRCCS St John of God
Pilastroni, 4
25125
Brescia
Italy
gdegirolamo@fatebenefratelli.it

What is the evidence for factors protective against violence in an intellectually disabled population?

Paper

Juliet Hounsome & Richard Whittington (UK)

Keywords: Violence, Intellectually disabled, protective factors, scoping review

Abstract

Factors underlying violent behavior are wide and the interplay between these factors is extremely complex. Factors may operate both negatively and positively, with protective factors thought to be variables that reduce the effect of risk factors or influence the outcome independently. Though there is an increasing amount of research into this area, the research into the role of risk and protective factors for people with an intellectual disability (ID) is limited.

One assessment tool designed to assess the factors protective against violence, the Structured Assessment of Protective Factors for violence risk (SAPROF) is currently being used in clinical practice but there has been some query as to the generalizability of it to an ID population. As a team we are developing an additional manual for the SAPROF to be used in this population (SAPROF-ID). To ensure that any changes are evidence based we are attempting to identify any relevant research in the field. A systematic review of protective factors for violence by adults with an ID conducted earlier in 2015 found very limited evidence therefore we propose to conduct a scoping review to widen the search.

Scoping reviews enable researchers to rapidly identify and map the literature relevant to a particular clinical area or research question. In scoping reviews the search strategy is a key focus and can be iterative in nature. Relevant papers identified can then be used to identify additional search terms and the search strategy expanded and rerun. This iterative process is ideally suited for this study where it is possible that research has been conducted on protective factors but they have not been identified as such.

An iterative search for relevant studies (including grey literature) will be conducted using nine electronic databases. The search strategy will be developed using key words identified from a variety of sources. These sources will include client focus groups, discussion with clinical experts and data mining of key papers identified in recently conducted systematic reviews of risk assessment tools, risk factors and protective factors. Predefined inclusion criteria will be applied by one reviewer using an inclusive approach, to titles and abstracts of identified papers then full papers, decisions will be checked by a second reviewer.

Data from papers meeting the inclusion criteria will be extracted into a Microsoft Access database by one researcher and cross checked by a second reviewer. Variables will be limited but include; definition of outcomes, country & setting of studies, number of participants, list of factors measured and author conclusions. The results will be summarized and similar factors grouped and discussed. The results will be used to identify evidence based protective factors to be considered in the development of a SAPROF-ID additional manual. The resulting interrogable database will also serve as a valuable resource of references for the justification of changes to the current SAPROF in relation to an ID population. Results of the scoping review will be presented on the day.

Educational Goals

- Participants will be able to describe the methods used in a scoping review.
- Participants will be able to summarize the evidence base for factors protective against violence for people with an intellectually disabled population

Correspondence

Ms. Juliet Hounsome
University of Liverpool
14 East street
L22 8QR Waterloo
United Kingdom
julieth@liv.ac.uk

Protective factors for violence risk in boys and girls: the SAPROF – Youth Version

Paper

Michiel de Vries Robbé & Vivienne de Vogel (Netherlands)

Keywords: Risk assessment, Protective factors, Juvenile, Violence risk, SAPROF, SAPROF - Youth Version

Background

Protective factors are important in the prevention of violence risk. As juveniles still have the potential for positive change, assessment and treatment should also focus on the development of strengths. Accurate assessment of protective factors related to violence risk is essential in order to effectively focus treatment on the development of protective factors and to evaluate treatment progress. Commonly used tools such as the SAVRY include a limited number of protective factors, while especially with youth the development of personal and situational strengths may have a substantial impact. In response to the international implementation of the SAPROF for adult offenders, mental health care professionals working in juvenile offender treatment requested the development of a SAPROF - Youth Version (SAPROF-YV).

Aims

Following literature searches and pilot studies, the SAPROF-YV was designed and published in Dutch in 2014, and translated into English and Spanish in 2015. The SAPROF-YV is an SPJ risk assessment tool containing 16 dynamic protective factors derived from empirical studies and clinical experience. All factors are dynamic and offer potential to serve as positive treatment goals for juveniles in clinical and outpatient forensic psychiatry. The tool is intended to be used in addition to predominantly risk focused tools, such as the SAVRY, in order to offer more balance in the risk assessment approach. The present study concerns a first validation of the SAPROF-YV in an outpatient forensic psychiatric juvenile sample.

Method

The SAPROF-YV and SAVRY were retrospectively assessed for 300 adolescents who had taken part in outpatient treatment following violent offending. Recidivism data were collected with a follow-up time of three years after treatment. The sample consisted of 4 groups: boys 12-17, girls 12-17, young adult men 18-23 and young adult women 18-23.

Results

Interrater reliability, predictive validity for community violent recidivism and concurrent validity between the tools were analyzed.

Conclusions

The SAPROF-Youth Version demonstrates to be a promising new tool for the assessment of protective factors for violence risk in juveniles and young adults. In this presentation the tool will be introduced and results on the interrater reliability, predictive validity and concurrent validity for boys and girls in different age groups treated in an outpatient setting will be presented.

Educational Goals

- Learn about the value of protective factors for violence risk in juveniles
- Learn about research results for boys and girls with the SAPROF - Youth Version

Correspondence

Mr. Michiel de Vries Robbé
Van der Hoeven Kliniek, De Forensische Zorgspecialisten
Willem Dreeslaan 2
3515 GB Utrecht
The Netherlands
mdevriesrobbe@hoevenkliniek.nl

Anger, Violent Fantasies, and Violent Behavior among Discharged Psychiatric Patients

Paper

Raymond W. Novaco, University of California, USA
Michael Russell, Pennsylvania State University, USA
John Monahan, University of Virginia, USA

Abstract

Anger has had insufficient priority in the forensic field, but substantial research finds anger to have dynamic bearing on violence risk and involvement in multiple psychiatric disorders. The violent behavior of psychiatric patients before, during, and after hospitalization is associated with anger, controlling for other background factors and disorders. The pathways by which anger is linked to violence remain to be disentangled. As recurrent anger is accompanied by rumination and anger often springs from grievances derived from unresolved conflicts, imagined violence or violent fantasy is a potential pathway.

The interrelationship between anger, violent fantasies, and violent behaviour was examined in present study analyses conducted on the MacArthur Violence Risk data set (Monahan et al. 2001), which involved civil commitment patients in three US metropolitan areas, who were assessed during hospitalization and on community follow-ups.

Recent studies with that data set have shown anger, assessed by the Novaco Anger Scale (NAS) in hospital, to be significantly related to other-directed and self-directed violence in the community, controlling for many covariates (e.g., Sadeh & McNeil, 2014; Swogger et al, 2012). Previous research (Grisso et al. 2000) has shown that NAS scores are highly related to imagined violence in hospital. The present study concerned 1136 patients assessed in hospital and at 10-weeks and 20-weeks regarding anger (NAS) and violent fantasies (Grisso, Schedule of Imagined Violence, SIV). Violent behavior data were obtained for those two community follow-ups.

Cross-lagged panel analyses found anger in hospital to be predictive of violent fantasies (SIV) at 10-weeks (controlling for SIV in hospital); imagined violence in hospital was predictive of anger (NAS) at 10 weeks (controlling for NAS in hospital); and anger at 10 weeks was predictive of violent fantasies at 20 weeks (controlling for their previous assessments). With the repeated measures data, multi-level models (individual and aggregate) were run to further examine interrelationships of anger, violent fantasies, and violent behavior.

We found that patients show significantly more anger ($M = 94.3$) when they report violent fantasies compared to themselves when they report no violent fantasies ($M = 88.2$). The relationship between violent fantasies and anger over time is significantly stronger ($p = .02$) for some patients than for others, and it is particular so for patients who engage in violent behavior. Our findings have important implications for violence risk assessment and for targeting anger treatment with regard to ruminative processes and the development of violence scripts.

Educational Goals

- Learning about anger assessment with an extensively validated psychometric instrument
- Learning how imagined violence can be assessed with psychiatric patients and it relationship to violent behavior
- Learning how anger and imagined violence are reciprocally influenced and of their dynamic relationship to violent behavior

Correspondence

Mr Raymond Novaco
University of California, Irvine
Department of Psychology and Social Behavior
92697-7085 Irvine, CA
USA
E-mail :rwnovaco@uci.edu

Anger, violent images and physical aggression among male forensic inpatients

Paper

Stine Bjerrum Moeller, University of Copenhagen
Matthias Gondan, Department of Psychology, University of Copenhagen
Raymond W. Novaco, University of California, Irvine

Abstract

The interrelationship between anger, imagining violence, and violent behavior is an important subject for psychiatric patients and for those in correctional detainment for many reasons. Violent fantasies are judged by clinicians in acute, chronic, and forensic types of hospitalization to be strong indicators of violence risk (Elbogen, Mercado, Scalora, & Tomkins, 2002).

In pursuing the anger topic, we build on the recent work of Moeller, Novaco, Heinola, & Hougard (2015), which developed and validated the Danish translation of the Novaco Anger Scale with clinical and non-clinical populations. One of the Moeller et al. validation studies tested whether the Danish NAS was predictive of the aggressive behavior of hospitalized forensic patients and found it to be so, retrospectively and prospectively. We here investigate how imagining violence may be related to anger and aggression, examining whether the associations may be intensified in conjunction with PTSD intrusion symptoms.

Violent Images, Anger, and Aggressive Behavior

Exposure to violence prompts the production of aggressive scripts and anger schemas. The person acquires a repertoire of aggressive behaviors, which is then readily accessed in responding to social problem situations. The assessment of imagined violence among psychiatric patients was initiated by Grisso et al. (2000) with the construction of Grisso's Schedule for Imagined Violence (SIV) that was used in the landmark MacArthur project on violence and mental disorder (cf. Monahan et al., 2001). Grisso and colleagues found that patients who reported imagined violence (SIV positive) while in the hospital were significantly more likely to be violent compared to those who were SIV negative, during a 20-week post-discharge period. They also found that being SIV positive in hospital was significantly related to anger in hospital (assessed by the instrument used in the present study), and the F-ratios for the anger indices were substantial larger than those for the impulsivity and for psychopathy measures (cf. their Table 6). The MacArthur project involved a large sample in three US metropolitan areas; however, the participants were civil commitment patients. Thus, we here seek to extend the inquiry to forensic patients, albeit a relatively small sample, and examine their physically aggressive behavior in hospital, where continued treatment is available prior to discharge.

Violence victimization and violent images

Violent images are rooted in violence experience, whether real or vicarious. Violence victimization has high prevalence among forensic populations in prisons (e.g., Wolff, Shi, & Siegel, 2009) and in hospitals (e.g., Novaco & Taylor, 2008), as well as psychiatric patients in general (e.g., Fortugno et al., 2013; Sturup, Monahan, & Kristianson, 2013), and having a history of violence victimization is associated with violent behavior post-discharge (e.g., Hiday, Swanson, Swartz, Borum, & Wagner, 2001; Silver, Piquero, Jennings, Piquero, & Leiber, 2011). Hospitalized patients, particularly those in forensic facilities generally have an ample supply of personal memories of violence experiences, often traumatic, with which to craft images of violence enactments. McHugh, Forbes, Bates, Hopwood, & Craemer (2012) argued that visual imagery is crucial to the involvement of anger in posttraumatic stress disorder (PTSD), highlighting the primacy of intrusions. In arguing for the importance of assessing PTSD symptoms among forensic inpatients,Spitzer, Dudeck, Liss, Orlob, Gillner & Freyberger (2001) found that 64% of the patients had at least one traumatic experience, and, 56% met lifetime criteria for PTSD, and 15% met criteria for PTSD at the time of assessment.

Study Hypotheses

The present study involves male inpatients at a high security psychiatric hospital in Denmark. Our main hypotheses are: (1) Patients who imagine violence, compared to those who do not, will be higher in psychological distress (anger and symptoms of PTSD, depression, anxiety, and psychosis); (2) Patients

who imagine violence, compared to those who do not, will be higher in physical aggression (staff recorded); (3) The association of imagined violence with both anger and aggressive behaviour will be intensified by intrusion symptoms.

Method

Participants
The study was conducted at the 80 beds forensic psychiatric unit of the Mental Health Centre Sct. Hans in Denmark. Of 88 available male forensic inpatients, 54 (61%) volunteered to participate.

Measures
Novaco Anger Scale (NAS; Novaco, 2003). The NAS is a 60-item scale constructed to measure anger disposition. The Cognitive, Arousal and Behavioral subscales are each comprised of 16 items. The sum of these 48 items forms the NAS Total score. There is a separate 12-item Anger Regulation subscale. The reliability and validity of the NAS Danish has been established (Moeller et al., 2015).

Hospital Anxiety and Depression Scale (HADS; Zigmond & Snaith, 1983). This instrument is a 14-item self-report questionnaire measuring anxiety and depression.

Staff Observation Aggression Scale–Revised (SOAS-R; Nijman, Palmstierna, Almvik, & Stolker, 2005). This is a form used to register aggressive incidents on wards. Verbal incidents were excluded. The total number of physical incidents retrospective to hospital admission was recorded. For prospective analyses, total number of physical incidents was registered for 5 months or up to the patient's release from hospital. During the period from being admitted to the hospital and the test date, 41% of the patients had had at least one aggressive incident, and 33% of the patients had a least one aggressive incident from the test date to the end of the observation period.

Schedule of Imagined Violence (SIV; Grisso et al., 2000). This is a semi-structured interview that assesses whether the respondent has had daydreams or thoughts about physically hurting or injuring some other person.

PTSD symptoms. Bliese and collegues (2008) identified a 4-item subset of the Posttraumatic Stress Disorder Check List-Civilian Version (PCL-C; Weathers, Litz, Herman, Huska, & Keane, 1993) as having high discriminative value as a screen for PTSD diagnosis. We used Item 1 ("Repeated disturbing memories, thoughts, or images of the traumatic experience") to index the presence of intrusions.
Psychotic symptoms. Hallucinations and delusions (persecutory and non-persecutory), and paranoid delusions were recorded as variables from the daily hospital case records.

Results

Psychological distress
The first hypothesis stating that patients who imagine violence, compared to those who do not, will be higher in psychological distress (anger and symptoms of PTSD, depression, anxiety, and psychosis), was confirmed. Patients reporting violent images were significantly more angry on all subscales of the NAS; NAS total, $t(51.8) = -4.739$ ($p < .001$) (CI = -27.2 to -11.0); NAS arousal, $t(51.7) = -4.206$ ($p < .001$) (CI = -9.06 to -3.21); NAS behavioral, $t(48.4) = -3.407$ ($p = .001$) (CI = -9.58 to -2.47); NAS cognitive, $t(47.9) = -5.314$ ($p < .001$) (CI = -9.62 to -4.34). On the regulation subscale the expected reversed effect, although not significant, was found: NAS regulation, $t(50.6) = 1.835$ ($p = .072$) (CI = -0.208 to 4.64). Patients who imagine violence experienced significantly more PTSD symptoms ($t(51.3) = -2.383$ ($p = .021$) (CI = -4.80 to -0.411)), particularly symptoms of intrusions ($t(51.7) = -2.715$ ($p = .009$) (CI = -1.76 to -0.263)), they were significantly more anxious ($t(47.2) = -2.239$ ($p = .030$) (CI = -5.62 to -0.301)) and depressed ($t(48.9) = -2.165$ ($p = .035$) (CI = -4.95 to -0.184)), and they suffered more from delusional symptoms = 6.263, $p = .012$)) and symptoms of paranoia = 12.244, $p < .001$)) than patients not reporting having violent images within the last two months. Only regarding hallucinations, patients with violent images did not have significantly more hallucinations compared with patients without violent images = 2.425, $p = .119$)).

Physical aggression
Regarding the second hypothesis stating that patients who imagine violence, compared to those who do not, will be higher in physical aggression (staff recorded), we did not obtain a significant result and the hypothesis was not confirmed. However, we did see a trend in the expected direction approaching significance with patients with violent images being more engaged in violence, both retrospectively (risk

ratio = 0.86, p = .585) and prospectively (risk ratio = 0.62, p = .082). The presence of violent images increased the risk of behaving aggressively in the follow up period

The role of intrusion symptoms

Regarding the third hypothesis stating that the association of imagined violence with both anger and aggressive behavior will be intensified by intrusion symptoms, we did not confirm our hypothesis. The interaction is far from significant, for retrospective (risk ratio = 1.19, p = .552) and for prospective (risk ratio = 1.83, p = .138) physical aggression, which suggests that both violent images and intrusions contribute independently to anger.

Discussion

This study supported prior research demonstrating that forensic inpatients have high levels of psychopathology, including psychological distress and PTSD symptoms. These findings emphasize the importance of assessing and providing treatment in order to meet these patients` clinical needs. The finding that increased psychological distress is related to violent images also calls attention to these patients´ clinical needs. This is emphasized by the approaching significant association between violent images and physical aggression. The previous studies investigating the link between violent images and physical aggression has found a significant association in the community, and not at a closed forensic ward. The lacking significance may thus indicate that this association is stronger in the community than at a secured ward. Furthermore the proposed interaction where the co-occurrence of intrusions and violent images should produce and increased effect on physical aggression than that of each of the variables was not confirmed. This could be explained by an already very high effect of each of these variables. The limitations of this study are foremost the small sample size and the relative crude assessment of PTSD and violent images. In conclusion, the clinical implication of this study is that we need to pay even more attention to the clinical needs of forensic inpatients in order to reduce the risk of aggression.

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Educational Goals

1. knowledge about the importance of focusing on dynamic risk factors to prevent future aggression
2. increased understanding about key dynamic variables such as anger, violent images, psychotic symptoms, and intrusions

Authors note

Correspondence

Stine Bjerrum Moeller
Psychiatric Research Unit, Mental Health Centre North Zealand
Dyrehavevej 48
DK-3400 Hilleroed
Denmark
Stine.Bjerrum.Moeller@regionh.dk

Young nurses and experiences of aggression: a qualitative content analysis

Introduction

Nursing staff all over the world is affected by patient and visitor aggression during daily work (Jackson, Clare & Mannix, 2002). The effects from aggression can be physically and psychologically damaging (Rippon, 2000). Most studies on patient and visitor violence have been conducted in either mental health or emergency care settings (Estryn-Behar, van der Heijden, Camerino, Fry, Le Nezet, Conway et al., 2008). However, in the general hospital setting, healthcare professionals encounter aggression from patients as well as from visitors. The study of Hahn, Müller, Hantikainen, Kok, Dassen and Halfens (2012) indicated that almost 85% of Swiss health care professionals working in a general hospital had experienced aggression by patients or visitors during their career. Young nurses are increasingly affected by aggression and this can lead to their premature departure from the profession. Nevertheless, little knowledge exists regarding their experiences with aggression. Therefore, this study focuses on the experiences of young nurses in regards to patient and visitor violence in Swiss hospitals, in order to describe their experiences with patient and visitor aggression.

Method

In this qualitative pilot study a descriptive design was used. The convenience sample included 13 registered nurses between 23 and 28 years of age, working in different settings in general hospitals. The face-to-face interviews lasted 20 to 50 minutes and were conducted in a location (at home, at the workplace, in a quiet restaurant) chosen by the participants. Data was collected utilizing a semi-structured interview. All sessions were audio-recorded. The collected data was transcribed and analysed using content analysis according to Mayring (2010). In a first step, the coding process was conducted by one of the authors of this study. In a second step, the codes were discussed in the research team and the main categories were developed by all of the team members.

Findings

12 females and 1 male who were employed in medical, surgical, emergency or private wards, and who had an average age of 25.2 years and 2.6 years (1/2 year to 6 years) of work experience, were interviewed. The data from the interviews can be described in the following five main categories: prototype of aggressive situations, burden triggered by patient and visitor aggression, processing of experienced aggression, the attitude relating to patient and visitor aggression and the explanatory models of how young nurses explore the patient and visitor violence.

Scenarios of aggressive situations
Arising from the experiences of the young nurses, five scenarios of aggressive situations were synthesized: The first scenario is centred on an 80 year old woman with dementia who is experiencing postoperative delirium after undergoing cardiac surgery. She becomes physically and verbally aggressive. The second scenario concerns a 35-year old man with chronic alcohol abuse, who is verbally aggressive in the emergency department and also later on in the surgical ward. The third scenario focuses on a 50-year old woman who has no cognitive impairment but is verbally aggressive towards the night shift nurse. The fourth scenario concerns an 80 year old man in a postoperative delirium who does not understand the language of the nurses and is verbally and physically aggressive. The fifth scenario focuses on a mother of a patient in the surgical ward. She disagrees with the wound care management provided by the nurses and becomes verbally aggressive.

Burden
The described burden of young nurses is divided into negative feelings after having experienced aggression, the suppression of one's own aggressive feelings, the direct and indirect aggression and the additional burden caused by suboptimal organizational structures.

Negative feelings
If the young nurses experienced aggression from a cognitively impaired patient, feelings such as anxiety, strain, uncertainty, helplessness and powerlessness were described. One nurse stated: "It was a difficult situation for me. I would have liked to have done something good for the patient and to have helped him, but I could not do anything. Only anger and aggression came back. I did not know what he wanted, or how to deal with this situation. It was a very difficult situation for me." (TN1, 52). Additionally, some nurses felt emotionally hurt or that they had been treated unfairly.

Suppression of one's own aggressive feelings
Several nurses described feelings of pressure to act in a professional manner and to not react with aggressive feelings towards the patient during the aggressive incident. One nurse described her feelings as follows: "If you get verbally attacked in this way, it is hard to stay calm. You then became a little angry as well, because you know that you did not do anything in bad faith, and that you have done nothing wrong. I see it as a form of injustice." (TN11, 61).

Additionally, some young nurses described feeling more offended when experiencing aggression from cognitively intact patients. One nurse stated the following: "I feel angrier if a cognitively intact patient is verbally assaulting me (...) you then feel the need to give back. Of course you don't do that, but in the moment, the feeling is there (…)" (TN13, 122-126).

Some nurses also had negative feelings towards their health care institution, because they felt that the patient and visitor aggression was due to lack of personnel resources.

Direct and indirect aggression
Aggression from cognitively impaired patients was described as less straining for young nurses. They believed that the reason for this aggression was connected to the patients' diseases. Therefore, the source of the aggressive reaction seemed clear. This was described by one nurse as: "If I know the patient is in a delirium, it doesn't majorly affect me, because the main reason for the aggression is understandable to me." (TN12, 43).

Verbal aggression from cognitively intact patients was described as being especially violating. The nurses perceived verbal aggression from cognitively intact patients as being more personally violating, more straining and they felt more offended than when it occurred with cognitively impaired patients. A young nurse described it as follows: "If someone cognitively intact is attacking me, then I recognize that it is the will of that person to hurt me." (TN13, 108).

Other nurses described physical patient aggression as being more straining, because a "personal barrier" had been overstepped.

Suboptimal organizational structures
The participating young nurses described patients' demands and needs as being high. Additionally, if a health care institution had a negative reputation, the nursing staff felt that they then received a lot of verbal complaints during their shift. Some of the nurses felt unable to properly care for people with dementia or patient in a postoperative delirium due to constant understaffing and a high patient turnover.

Processing of experienced aggression
Immediate cognitive processing of the experienced aggressive incident seems important for young nurses. Additionally, discussing the aggression within the team was considered to be crucial for young nurses. This is especially important in regards to continuing to work as a nurse. A young nurse described this as follows: "you talk about the situation and I think that this simply helps to let off steam (...) I think it is helpful to discuss such situations within the nursing team." (TN7, 81)." The young nurses described the discussion of an aggressive incident in the nursing team as giving a feeling of not being alone with their experiences in their daily work. However, several nurses reiterated that very few of the patient and visitor aggression incidents were discussed in the team.

Attitude
Young nurses believe that patient and visitor aggression is part of the job. They feel that aggression is an inevitable event belonging to the nursing profession. Nevertheless, some nurses described themselves

as not tolerating every kind of aggression at work and were willing to defend themselves against patient and visitor aggression. Several of these young nurses stated that it is not possible to prevent many of the aggressive incidents, but they should be reduced to a minimum by using adequate de-escalation strategies.

Explanatory models
In the interviews, the young nurses were asked about their explanations regarding why they experienced more patient and visitor aggression than older nurses. Some of the younger nurses assumed that older nurses may have better de-escalation strategies. In addition, they attributed experiencing more aggression to their novice professional status, less life experience, their personal characteristics, along with their lack of authority as a young person. One young nurse stated the reason as being: "because the patients may feel that younger nurses are less competent" (TN13, 156).

Discussion and Conclusion

In the findings, five scenarios of aggressive situations of patients with dementia, chronic alcohol abuse, as well as with cognitively intact patients or their relatives were synthesized. In studies of Zernike and Sharpe (1998), Winstanley and Whittington (2004), and Lin and Liu (2005), several of these patients' conditions were also described as being diagnoses which led to increased aggressive incidents in general hospitals.

In addition to their feelings of powerlessness, uncertainty, anxiety, strain or helplessness, several young nurses recognized their own aggressive feelings towards patients during the aggressive incidents, and suppressed these feelings in order to act in a professional manner. Grywa (2006) described that aggression can easily lead to an aggressive backlash and also that permanent suppression of negative emotions can be physically and psychologically damaging (e.g. depression) (Deffenbacher, Oetting, Lynch, & Morris, 1996). Therefore, it seems to be important to provide an opportunity for young nurses to discuss aggressive incidents and support them in coping with own aggressive feelings in a positive way.

In particular, young nurses described feeling violated when experiencing verbal aggression from cognitively intact patients. These results are similar to the study from Richter (2012), in which participants' experienced verbal aggression as being more harmful and straining because it was perceived as being targeted towards the personality and skills of a person. This is particularly applicable if the experienced aggression is perceived as being wilfully inflicted (Lundström, Saveman, Eisenmann & Aström, 2007). Thus, the burden and consequences of stress experienced by young nurses due to verbal aggression from cognitively intact patients, needs to be given more acknowledgement in nursing practice.

The importance of exchanging and discussing aggressive incidents in nursing teams in order to improve coping with such hurtful situations is also described in the study of Lundström et al. (2007) and Farell, Bobrowski and Bobrowski (2006). Nevertheless, effective follow-up care after an aggressive incident cannot be guaranteed if it is provided unsystematically and only in the nursing team. Institutionalized after incidence support and debriefing from experts is needed. Additionally, in order to reduce the occurrence of verbally aggressive incidents from cognitively intact patients, preventive measures tailored towards meeting the needs of these patients and discovering their reasons for verbal aggression are necessary.

Young nurses explained their higher risk for experiencing patient and visitor aggression as being due to their limited professional and life experience. Several studies revealed that young nurses are more often afflicted by patient and visitor aggression than their more experienced colleagues (Ayranci, Yenilmez, Balci & Kaptanoglu, 2006; Hahn, 2012). Using their professional skills and intuition, older nurses seems to be able to avoid patient aggression or have learned to more effectively de-escalate aggressive incidents (Ducan, Hyndman, Estabrooks, Hesketh, Humphrey, Wong et al., 2001). Therefore, it seems necessary to protect young nurses via provision of adequate training and development of skills, in order to prevent and de-escalate aggressive interactions. On the other hand, systematic reflection of this challenging situation and the exchange of experience can help to improve early recognition of possible dangerous situations in practice.

Few hospitals have clear organizational strategies to prevent and reduce workplace aggression effectively, especial verbally aggression. Therefore, a clear institutional strategy which considers aggression in the workplace is needed in order to effectively address aggression. Additional research focusing on young nurses is important in order to improve effective and ongoing institutional strategies for managing patient and visitor aggression.

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Educational Goals

- Participants will gain insight into the emotional world of young nurses experiencing patient and visitor aggression in general hospitals.
- Participants will have the opportunity to reflect on their attitude regarding verbal aggression and to gain an understanding of how important support is for young staff in order to prevent and manage verbal patient aggression.

Correspondence

Ms. Karin A. Peter
Applied Research & Development in Nursing
Murtenstrasse 10
CH-3008 Bern
Switzerland
karin.peter@bfh.ch

Introduction of a Conducted Electrical Weapon to Control Violence in a Hospital Setting

Paper

Jeffrey Ho (USA)

Abstract

Health care settings, including mental health care environments, are experiencing increased amounts of violent activity that are challenging to the health care security profession. There is difficulty in addressing this issue completely. Some of this difficulty is because of factors that include inexperienced and untrained clinicians and administrators that are often the decision-makers in the health care setting. This talk discusses how one acute care hospital and mental health facility have utilized conducted electrical weapons to control and prevent violent activity in combination with a well-trained security force. This talk will outline the background of the problem and discusses the challenges we encountered in implementing this technology as well as the benefits we have discovered along the way since deployment. This talk will be beneficial to any health care provider, security person, or administrator that is interested in enhancing or improving their current health care security use of force model to further counter the increasing violent activity in their respective health care setting.

Educational Goals

1. The learner will be able to comprehend the various factors that allow healthcare and mental health facilities to be ripe for violence and will understand how to deal with many of the hurdles that exist in changing the culture of these areas to become unacceptable places of violence.
2. The learner will be able to understand how to apply a novel technology as a possible solution to dealing with violent events and incorporating this technology into a prevention plan.

Correspondence

Mr Jeffrey Ho
Hennepin County Medical Center
701 Park Avenue South
55415
Minneapolis
United States
jeffrey.ho@hcmed.org

Gender-Responsiveness in Corrections: Estimating Female Inmate Misconduct Risk Using the Personality Assessment Inventory (PAI)

Paper

Jonathan Sorensen, Megan Davidson & Thomas Reidy (USA)

Keywords: Personality assessment inventory; Inmate misconduct; Gender-responsiveness; Risk assessment; prison classification

Abstract

Proper inmate classification is critical to correctional management and institutional security. While many instruments have been developed to assist with inmate classification and assessment, most of these tools have not been validated using samples of female inmates although distinct gender differences have been identified in the inmate population in terms of adaptation and misconduct.

The Personality Assessment Inventory (PAI) is a multiscale measure of psychopathology that is being increasingly utilized in the correctional setting to assist with the inmate classification process. The current study contributes to the dearth of literature surrounding gender-responsive inmate classification by utilizing a sample of 2,000 female inmates to examine the incremental and predictive validity of the PAI in association with general and assaultive disciplinary infractions. Findings from this study reveal that the PAI scales presenting the strongest relationship to general and assaultive disciplinary infractions among this female sample included Aggression (AGG), Antisocial Features (ANT), Paranoia (PAR), and Violence Potential Index (VPI). Moreover, findings derived from this study suggest that certain PAI measures, specifically ARD-T, ALC/DRG, and the mental health scales may be useful gender-responsive scales to be incorporated into the female inmate classification process.

Educational Goals

1. Explain gender-responsiveness principle in relation to risk assessment in a forensic application.
2. Interpret incremental validity as it relates to risk assessment in a forensic application.

Correspondence

Mr. Jonathan Sorensen
East Carolina University
238 Rivers Building
27858 Greenville
USA
sorensenj@ecu.edu

Coercion decisions: Event sequences of aggression, seclusion and enforced medication in a sample of admission and specialized treatment wards for adults and the elderly

Paper

Marlies Snelleman-Van der Plas, Peter Lepping, Lia Verlinde, Willem Snelleman, Adriaan Hoogendoorn, Henk van den Berg & Eric Noorthoorn (Netherlands)

Keywords: Aggression, seclusion and event sequences

Background

In the Netherlands seclusion prevails as a coercive measure of first choice. Over the past years, several seclusion reduction efforts were implemented over a large number of hospitals. Risk assessment was seen as an important way to prevent coercion as a whole (van der Sande et al, 2011). Dutch law only allows coercive measures in case of imminent danger. Over the past years, seclusion as first choice seems to be gradually replaced by medication. , From a scientific rather than a legal point of view, seclusion has no therapeutic effect while medication does (Verlinde et al, 2014). In this study we investigated event sequences of aggression followed or preceded either by seclusion, mechanical restraint or enforced intramuscular medication. We were interested in whether aggression was preceded or followed by seclusion, by mechanical restraint or by enforced intramuscular medication in which patients and i ward types.

Methods and Materials

Aggression was measured with the SOAS-R (Nijman, 1996). We performed a timelag-analyse on coercive measures using the Argus coercive measures rating scale in the year 2014 for all patients in 25 wards in a two Mental Health Trusts with a catchment area of 1,000,000 inhabitants. Furthermore, a multi-level poisson regression was performed relating the occurrence of the number of aggression incidents and the number of coercive measures to patient characteristics.

Results

2148 patients were included in a preliminary sample over 2014 of which 9% were either secluded, received enforced medication or underwent mechanical restraint. 62 % of the measures started with seclusion, 27% with enforced medication, while 11% started with mechanical restraint. Aggression occurred in 30% of the measures in the same day, and in 52% in a time span of three days before or after the coercive measure. Importantly, one third of the aggression occurred after a measure started, not before. 97 % of patients subjected to coercive measures at some point during their hospitalization showed aggression as measured by the SOAS-R.

Discussion and conclusions

These preliminary findings showed most patients subjected to coercive measures were aggressive. Aggression, however, occurred not necessarily imminently before the coercive measure, with a substantial number of aggressive incidents occurring after the measure. In the presentation we will discuss the clinical implications of the several time sequences and the characteristics of the patients several sequence patterns occurred in.

Educational Goals

Participants learn about the
1. The precursors and consequences of aggression
2. The daily practice clinical implications of the findings, which has bearing on how to deal with aggression in admission ward care.

Correspondence

Ms. Marlies Snelleman - Van der Plas
GGnet
Vordensestraat 12
7231 PA Warnsveld
The Netherlands
marliessnelleman@gmail.com

Coercion decisions, event sequences of aggression, seclusion and enforced medication before and after a policy change

Paper

Lia Verlinde, Eric Noorthoorn, Willem Snelleman, Marlies Snelleman-Van der Plas, Henk van den Berg & Peter Lepping (Netherlands)

Keywords: seclusion, mental health law, decision process

Background

In the Netherlands, seclusion remains the measure of first choice (Steinert et al, 2014, Noorthoorn et al, 2015) when dealing with aggressive patients. Recent studies in Dutch samples show that seclusion duration as well as total coercive measures decrease when enforced medication is applied as a measure of first choice in dealing with aggression (Georgieva et al, 2012, Verlinde et al, 2014, Noorthoorn et al, 2015). Taking the view that medication has an evidence based effect, whilst seclusion or restraints are primarily containment measures with no proven effect; the current study investigated sequences of decision-making on coercive measures either before or after the occurrence of aggression over a 7-year period. Half way, the policy of the hospital changed from seclusion as first choice to enforced medication as measure of first choice, in line with international consensus (Steinert & Lepping, 2009).

Aim

To investigate the sequence of aggression and the initiation of seclusion, mechanical restraint or enforced medication after a policy change where enforced medication became the measure of first choice. We examined whether the policy change would have an impact on the frequency and duration of seclusion and various other coercive measures,

Methods & materials

Aggression was measured with the SOAS-R (Nijman, 1996). We performed a time lag-analysis on coercive measures using the Argus coercive measures rating scale including seclusion, mechanical restraint and enforced medication on all patients during 2007- 2009 as well as during 2011- 2013 after the policy change.

Results

2728 patients were included in the study. 547 were secluded, restrained or underwent enforced medication. Mechanical restraint occurred in different patients compared to seclusion or enforced medication: almost exclusively the elderly. Mechanical restraint reduced from 16773 in 2007 to nil in 2013. Most change in the use of mechanical restraint was brought about in the years 2011 and 2012, following current developments in geriatric care.

Of the patients confronted with seclusion or enforced medication 350 (68%) were subject to only seclusion, and 7% underwent enforced medication as a single measure. 25% underwent both measures. Between 2007 and 2009, 97% of the combined measures started with seclusion and in 18 % of those, enforced medication was administered. After the policy change, which favored enforced medication; the findings show seclusion remained the first coercive measure in 65 % of patients. In 35% enforced medication was the first measure. Aggression decreased by 23%.

The number of occasions patients were secluded decreased from 1040 to 526 (RRR=-50%), the number of seclusion days decreased from 11689 to 3260 (RRR=-72%).

Conclusions

These figures support changes in line with international consensus on oercive measures. Seclusion frequency and duration decreased significantly. The total amount of coercive measures also decreased,

a relative but not absolute increase in aggression could be observed. In the presentation we show several event sequence changes before and after policy change and discuss clinical implications of a change in law.

Educational Goals

• In this presentation participants will learn several aspects of law in psychiatry and consequences on decision making processes after aggression occurred.

Correspondence

Ms. Lia Verlinde
Mediant Geestelijke Gezondheidszorg
Broekheurnerring 1050
7546 TA Enschede
The Netherlands
aa.verlinde@mediant.nl

Interventions in a Finnish psychiatric admission ward after the assessment of violence risk

Paper

Jenni Kaunomäki, Markus Jokela, Raija Kontio, Tero Laiho, Eila Sailas & Nina Lindberg (Finland)

Keywords: violence risk, assessment, intervention, coercive methods, non-coercive methods

Background

The Dynamic Appraisal of Situational Aggression (DASA) is a 7-item rating scale used to predict imminent aggression in psychiatric inward patients. DASA measures the presence of seven behaviors that predict the probability of violence within 24 hours. The purpose of this research was to validate the sensitivity of DASA in a Finnish psychiatric inpatient population, examine the interventions that were applied after identifying high-risk patients, and finally study which interventions were the most effective in decreasing the DASA score.

Methods

The data were collected in a naturalistic setting during a six-month period in an acute psychiatric admission ward (n=300 patients admitted to the ward). Interventions were clustered into four groups by frequency of use: (1) interventions restricted by Finnish mental health act, (2) PRN-medication, (3) discussion with nurse, and (4) other interventions. In the analysis we formed two logistic regression models: one to study every intervention group's separate association with the total DASA score the next day, and another to study the associations when adjusted for the use of multiple interventions.

Results

DASA scores were high (≥ 4) in 61 % of the incidents where a patient had been restrained, secluded and/or given forced medication. In 16 % of the incidents patient had been rated as non-violent (DASA = 0), although the patient had been restricted, secluded and/or given forced medication. The most frequently used interventions for high-risk patients (DASA score ≥ 4) were PRN-medication (33.5 % of all interventions), seclusion (15.8 %) and focused discussion with nurse (10.8 %). Interventions regulated by the Finnish mental health act (seclusion, mechanical restraint, involuntary intramuscular medication, restriction of freedom of movement, physical restraint, and restriction of communication), PRN-medication, and discussion with nurse were not associated with DASA score the next day. Only the category of "other interventions" (e.g. discussion with a relative or daily activities) were associated with lower DASA score the next day when examined separately (B = -0.70 ; CI: -1.24,-0.16; p = .01) or when adjusted for the use of other concurrent interventions (B = -1.07; CI: -1.17, -0.05; p = .032).

Conclusion

DASA is an effective method to predict imminent aggression in Finnish psychiatric population. Although there remains unpredictable violence that is not predicted by DASA scores, on average, psychiatric staff uses restrictive and coercive methods, but we observed DASA scores to decrease only in individuals who received non-coercive interventions, such as discussion with relatives. Randomized controlled trials are needed to test the relative effectiveness of different intervention methods.

Educational Goals

- The participant is expected to notice the effectiveness of non-coercive interventions on inpatient violence risk.
- The participant will familiarize himself with the key points of 'the Dynamic Appraisal of Situational Aggression' (DASA) violence risk assessment method.

Correspondence

Ms. Jenni Kaunomäki
Helsingin Yliopisto
Vellamonkatu 16-18 B 23
00550 Helsinki
Finland
jenni.kaunomaki@helsinki.fi

Response Crisis Intervention Model for Conflict Management: Fidelity Scale in Psychiatric Care

Paper

Remko den Dulk, Eva Heijkants, Ishany Balder, Antonia Bauer, Eva Hoogstins, Steven Nooter, Loubna Ouifak. & Elizabeth Wiese (Netherlands)

Introduction

Conflict management training has become an essential tool for handling physical and psychological violence in psychiatric organizations, especially as conflicts between clients, and staff and clients has increased (Morrison & Love, 2003). Conflict management's primary goal is the prevention of increased tension or arising issues leading to unsafe situations (Hallett, Huber & Dickens, 2014). With the high frequency of conflicts in psychiatric care, guidelines have been designed aimed at reducing violence escalation, maintaining or exerting control over psychologically or physically harmful situations, in a non-confrontational way (Windcaller, 2010). With these guidelines, the use of restraint and seclusion can be diminished drastically.

Studies have pointed that clinicians tend to use their clinical judgment and intuition when predicting aggressive behavior in patients, without a solid theoretical basis (Needham, Abderhalden, Halfens, Dassen, Haug, & Fischer, 2004). Hence providing a checklist in order to organize potentially aggressive patients into "high risk" and "low risk" may aid staff members in their judgement of situations and of patients at risk. Methods to prevent impulsive reactions from both clients and staff members are included in response protocol to support the maintenance of a calm reaction allowing for non-physical management to occur (Richter & Whittington, 2006).

One structured method for conflict management in psychiatry is the Response Crisis Intervention Model (RCIM), which focuses on preventing aggressive behavior, improving its control and building interactive ways in which staff members play the main role in managing conflicts (Windcaller, 2010). The use of the RCIM provides a structure for staff members to follow in order to restore safety, as well as proposes a variety of techniques in which safety strategies can be applied to control conflicts and aggressive situations.

In this research, in order to investigate the application of the RCIM in a psychiatric setting, a fidelity scale was applied. Fidelity is defined as the extent to which delivery of an intervention adheres to the protocol or program model originally developed (Mowbray, Holter, Teague & Bybee, 2003). Fidelity scales have become a necessary component of research for measuring quality of treatment effectiveness, being a supervising aid in order to monitor staff for quality and performance (Mowbray et al., 2003). The implementation of fidelity scales has been found to be an effective method to improve clients' outcomes (Mowbray et al., 2003). This research, aimed at measuring the application of the RCIM in a mental health organization, in Zeeland, at the southwest of the Netherlands. The investigation followed the method and used the same instrument of a previous study conducted by Wiese and colleagues (2013) and results were compared to see if improvements had been made in the implementation of the RCIM. In this study, the overriding research questions were: To what extent is the RCIM applied correctly in the mental health care organization? How the application of the RCIM has improved in comparison to the results of previous investigation? Which improvements could still be develop in the RCIM application? How can the research protocol be improved?

Method

The research was conducted in one ward of a mental health organization in Zeeland, in the Netherlands. The investigation included interviewing staff and clients, based on the already implemented fidelity scale, and results were compared to previous investigation by Wiese and colleagues (2013).

Three pairs of interviewers conducted a total of 19 interviews with: 2 team leader/response coaches, 7 clients and 10 other staff members; 7 clients' files were also examined. Informed consent was signed by staff and by the clients' parents, as the clients' average age was between 12 and 18 years old. Before

starting the interviews, each pair of interviewers familiarized themselves with the RCIM fidelity scale provided by the organization. The interviews were held in Dutch. The fidelity scale aimed to measure: *Implementation and Organization, Training of Teams, Work Consultation* (communication), *Evaluation* (communication), *Intervision* (team communication), *Consultation with Client, Trainer/coach, Team Leader, Clients,* and *Implementation in the Workspace*. The scores were measured through a 5 point Likert scale with 1 signifying poor fidelity, while 5 signified excellent fidelity, with the exception of dimension 10. Dimension 10 is a checklist used to measure if and to what extent the RCIM is used in the workplace: the interviewee is asked to recall a recent unsafe situation, with the availability for the interviewer to score "Yes" or "No" in relation to the specifically recalled situation.

The analysis of the data was carried out using Excel and SPSS. Excel was mainly used to calculate the mean fidelity scores for each dimension, as well as the overall fidelity score. In order to compare the overall model of fidelity score with those of the wards that were examined by the previous study by Wiese and cols. (2013), one-way ANOVA was carried out. The F-score was reported and the related p-values were tested against a .05 α-level. The main assumptions of ANOVA are the independence of observations and absence of outliers as well as an approximately normal distribution of the dependent variable.

Results

Quantitative and qualitative analyses of the results obtained from the interviews were conducted, using the model provided by the organization. The analyses were based on the mean scores on the Likert scale for each separate item, and on the model fidelity and fidelity scores of each dimension. The mean scores can be found below on Table 1.

Table 1: Fidelity scores per dimension

	Dimension	Fidelity Score
1	Implementation and organization	4
2	Schooling teams	4
3	Communication	4
4	Evaluation	4
5	Peer Reviews (intervision)	3
6	Client Meeting	4
7	Trainer/Coach	3
8	Manager and/or trainer/coach	4
9	Clients	2
10	Implementation in the workplace	4
11	Files	2
Model Fidelity Response Protocol	38/11=3.5	

Moderate to High Fidelity

As can be seen in the Table 1, the dimensions 1, 2, 3, 4, 6, 8, and 10 showed relatively high value on the fidelity scales. This means that the implementation of these dimensions has been successful in this specific ward.

Dimension 5, *Intervision*, was found to have a mean of 3, with the data presenting a lower score for evaluations of conflict being discussed in the intervision, while discussion on safety and RCIM scored higher. Dimension 7, *Trainer/coach*, had a mean of 3 yet it must be taken into consideration that only 2 trainers/coaches were interviewed hence differences in responses from each interviewee had a larger impacted on the overall mean. It was found that differences concerning the consultation of a manager by the RCIM trainers had low score as it only occurred on a monthly basis. Furthermore during these consultations it was indicated that the RCIM was only mentioned in quarter to half of the meetings. These two aspects have been seen to require improvement, while the overall evaluation of the basic courses and the refresher courses had a good rating.

The *Clients*' results, dimension 9, suggested necessary improvement. This is due to the lack of RCIM training available to these clients, and the overall low participation of clients in the RCIM training. As the

first item of this section in the interview was consistently score between 4 and 5, an indication for future plans of client inclusion of an action plan in regards to a safety plan or a crisis relapse intervention plan. Finally, Dimension 11, *Client's file,* had a low mean score of 2. This could be explained due to the lack of incidents with the files presented, as 3 clients did not have a history of incidents, and there were low scores on items regarding whether elements of the RCIM were included in the report of incidents. Safety is part of the client files, yet down not have a specific subsection reserved specifically for the topic. Due to a large variation of results in regards to repetitive behavior, difficulties in the application of the fidelity scale in this section may be a large contributor to the results. The overall result of the RCIM in this specific ward was 3.5, being a moderate to high fidelity score.

Comparison of fidelity scale results and those obtained in previous research

Once results were obtained, the model fidelity of ward 1, Amares, was compared to the model fidelity scores obtained by the wards that were investigated by Wiese and colleagues (2013) (Figure 1). There was no significant difference between the mean fidelity scores of the ward that was examined in the current research and the previous study done by Wiese and colleagues, as can be seen on Table 2 and Figure 1.

Table 2: Differences between mean fidelity scores comparing present and previous research.

Anova					
Mean Fidelity	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	5.891	4	1.473	1.278	.291
Within Groups	57.636	50	1.153		
Total	63.527	54			

Figure 1: Model of fidelity scores comparing present research at Amares and previous research at other wards of the same organization.
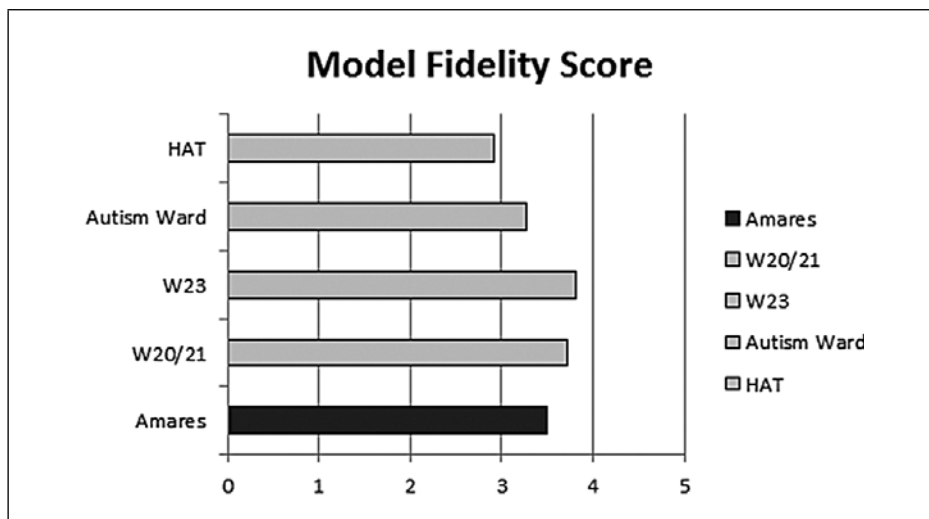
Although none of these differences was statistically significant, Amares scored higher than both the Autism and HAT ward in the overall model fidelity score (Wiese et al., 2013). Due to limited data no in-depth comparison between subgroups could be made.

When assessing the individual results, *Implementation* and *Organization* were found to be scored higher than the average of the 2013's research by Wiese and colleagues. *Schooling Teams* was scored slightly lower in comparison, although not by a large extent. The availability of RCIM trainers has improved, while in 2013 2 certified trainers were not always available to provide trainings, in this study it indicated

to have improved, no longer posing an issue. Due the only having two respondents for the *Trainer/coach* section, validity issues were raised while the fidelity score were found to be moderate.

Notable differences compared to the previous study are needed to be taken into consideration. The study conducted by Wiese and colleagues (2014) considered 5 wards, hence interviews were split differently between each group of interviewers. Furthermore, this study did not compare the fidelity scale to the COMPaZ (In Dutch: Cultuur Onderzoek onder Medewerkers over Patientveiligheid in Ziekenhuizen), which is used to measure patient safety culture in health institutes. Hence a lack of information limits this research from pinpointing the source of effective or ineffective implementation of the response training. All in all, the difference of results between the two studies was not found to be drastic, yet improvement in specific sections are still apparent.

Conclusion

Some limitations were found when conducting this research. Firstly, interviews were conducted in Dutch while two members of the research group were not fluent in Dutch, what may eventually have caused discomfort. In addition, the research team lacked practical experience in psychiatric care, what brought concern from staff about their competence to interpret data. Hence, the inherent problems stemming from how the fidelity scale was structured exacerbated the language and experience-based problems throughout the procedure. External validity was threatened due to the limited interviews conducted (n=19), hence conclusions drawn from the fidelity of the RCIM may not be representative to all individuals present in the mental health care organization. The sample of clients (n=7) was limited to the ones that received approval from their parents or legal guardians, in the form of a signed consent form. Situations occurred in which the clients with a history of aggressive behavior did not return the consent form and were therefore excluded from the research, while those with the consent form who did not have a history of aggressive or violent behavior were included, which may have led to sampling bias.

The fidelity scale itself was found to cause limitations. This was due to the questions presented to clients being mostly focused on the description of a situation; the required answers on the scoring sheet were highly specific on the RCIM's jargon. Furthermore, questions concerning 'safety' could be perceived ambiguously, as it could be interpreted differently due to not having its own sub-heading. Some questions were directed more specifically to certain team members and not well adjusted to other interviewees.

Section 10 of the fidelity scale required good interpretational skills of the interviewer, as the detailed description of the client's or staff members memory of a conflict situation was used to answer highly specific questions. Finally, the fidelity scale is directed at the interviewee's knowledge on the ward, for example the inclusion of clients in RCIM training, rather than accurate data presented by the ward itself. This did not pose an issue during the investigation, as none of the clients had participated in the specific training, yet it may cause future problems when using the fidelity scale with clients that had followed the training.

In conclusion, conflict management is a crucial aspect of psychiatric care in mental health care organizations. The RCIM has been successfully applied internationally by mental healthcare organizations in modern psychiatric care as it encompasses an approach focused on de-escalation and safety; research indicates higher levels of client-satisfaction and cost-efficiency associated with organizations utilizing the model. Training staff in the RCIM protocol is therefore crucial for the mental healthcare organizations. While there are few notable differences in the results of the present research compared to previous research (Wiese et al., 2014), there were however, no drastic changes. Furthermore, although improvement is necessary on some areas, the results of the fidelity scale are generally positive and indicate that the mental healthcare organization applied well the RCIM within ward 1, Amares, to a large extent. On a more general note, due to lacking data specifically for the Amares in the previous study of 2013, the scores obtained by means of the fidelity scale in this study may not be directly comparable.

To aid future research, suggestions have been made to revise the fidelity instrument used by the organization to conduct the interview and collect data. All in all, the mental healthcare organization can optimize safety culture further by polishing the implementation of the RCIM.

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Educational Goals / Learning objectives:

- To improve the awareness in relation to their practice in conflict management in psychiatric care;
- To bring broader knowledge and reflection in relation to a specific method of conflict management in psychiatry;
- To improve the knowledge of the research method using fidelity scale in psychiatry.

Correspondence

Ms. Elizabeth Wiese
University College Roosevelt / Utrecht University
Lange Noordstraat 1
4331 CB Middelburg
The Netherlands
e.wiese@ucr.nl

Staff's attitudes towards aggression in psychiatry

Milou M. H. Mik, Ingrid L. Malan, Erik J. E. Janssen, Bas E. A. M. Kooiman, Roos E. D. X. Middelkoop, Stefanie Poelman, Jeppe de Lange & Elizabeth Wiese (Netherlands)

Introduction

Aggression is a prominent problem in mental healthcare organizations, especially in in-patient facilities, as there are indications that nurses are exposed to approximately three times more violence in the workplace than other professionals (Martin, Gray, & Adam, 2007). Patients' aggressive behavior can be directed towards staff, other patients, property or materials, affecting individuals, groups, organizations, and properties. Psychiatric patients' behavior can be hurtful, either as a means of being destructive or offensive, as a form of communication, with the purpose of being intrusive, or as self-protection. Aggressive behavior affects the safety of the clinical environment, having severe consequences for the physical, psychological, and social well-being of all persons directly or indirectly involved (Needham, Abderhalden, Halfens, Dassen, Haug, & Fischer, 2005; Martin et al., 2007).

The aim of this study was to identify how the personnel within an in-patient mental health care organization in the South West of the Netherlands understands and interprets patients' aggressive behavior. The main research questions included: What characterizes the attitudes towards aggression of mental health care professionals working in a psychiatric hospital setting in the Netherlands? To what extent do gender, age, profession, experience in psychiatry, the work in a specific type of ward and number of encounters with patients' aggression influence the professionals' attitudes towards aggression?

The organization investigated deals with a wide range of mental health disorders, causing aggression to be ever-present in their daily care. This has led the organization to adopt the Response Crisis Intervention Model for Conflict Management (Windcaller, 2010) as a form of training for the staff and as a preventive strategy. The aim of employing this training is for health care workers to adopt effective deterrent approaches to deal with aggression at the workplace, with a focus on diminishing forceful treatment and general aggression throughout the organization.

In this study, the Attitudes Towards Aggression Scale – ATAS (Jansen, Middel, & Dassen, 2005) was used to measure the perceptions of staff members towards aggression. As was found by Wiese and cols. (2014), the ATAS has showed to be the most reliable scale for assessing attitudes towards aggression in that mental health care organization, due to its clear assessment items and its availability in Dutch. The ATAS has notably been utilized in several other studies worldwide, being validated in English, German, and Dutch.

Method

The sample utilized included employees that work in in-patient wards within the given organization. Four wards and two sheltered livings facilities were selected by the organization to be investigated, resulting in a total sample of 61 employees. The sample included nurses, attendants, psychologists, psychiatrists, social workers, general practitioners, and activity attendants. The participants were selected by means of purposive sampling with the inclusion criterion being that the employee should come into contact with clients on a daily basis. For this project, a cross-sectional survey sample approach was used. Data was obtained through the use of an online questionnaire. The distribution of the online questionnaires to the participants was mediated through the team leaders of the wards and sheltered livings via email and phone call reminders.

In the survey the ATAS (Jansen, 2005) was used to assess employees' attitudes towards aggression. The ATAS distinguishes five different types of attitudes, measured by several subscales (1) the *offensive attitude* views aggression as insulting, hurtful, unpleasant and unacceptable behavior including verbal aggression; (2) the *communicative attitude* views aggression as a means of communicating any feelings or cognitions; (3) the *destructive attitude* describes aggression mostly as an indication of the threat or actual act of physical harm or violence; the (4) *protective attitude* views aggression as the shielding or defending of physical and emotion space; and (5) the *intrusive attitude*, covered by three items, where aggression is perceived as the expression of the intention to damage or injure others.

Besides the ATAS (Jansen, 2005), eight questions addressing background information of the health care organization employees were included. These questions regarded their gender, age, work department, work status (either fulltime or part-time), educational level, department-specific work experience, number of aggressive encounters, and whether they had received the Response Training for Conflict Management (Windcaller, 2010).

Results

Overall comparison between the domains
The results indicated significant differences among most subscales of aggression, when comparisons were made between regarding aggression as: offensive (Mean = 3,52) compared to communicative (Mean = 2,62), offensive compared to protective (Mean = 2,71), offensive compared to intrusive (Mean = 2,76), destructive (Mean = 3,52) compared to communicative, destructive compared to protective, and destructive compared to intrusive. Aggression, considered as protective, communicative and intrusive, were also found to largely overlap and correlate.

Comparison between age groups
There were significant differences in aggression identification across four different age-groups; being for the offensive domain, the destructive domain, the intrusive domain and the total score. Employees who were older than 50 years of age as well as those with ages between 30 and 50 years and others with age between 20 and 30 years, all viewed aggression as most offensive and less as communicative, while those under age 20 years considered aggression as also most offensive but as less intrusive. The extent to which aggression was regarded as intrusive was highest for employees older than 50 years of age and lowest for employees younger than 20 years. Results indicated that, in general, the participants older than 50 presented a significantly higher average for the offensive, destructive, intrusive domains and the total score than the other age groups.

The results indicate that independent of the age group, the participants tended to agree most with the statements related to aggression being offensive and destructive and least with the statement related to aggression being communicative and intrusive.

Comparison between educational level WO and HBO
For all aggression identification types, except as communicative behaviour, it was found that employees' education level had no significant influence on the way by which they perceived the aggressive behaviour expressed by clients. For communicative behaviour, WO Dutch education (WO is Wetenschappelijk Onderwijs, in Dutch, which is scientific university education) scored significantly higher than the HBO education group (HBO is Hoger Beroeps Onderwijs, in Dutch, which is university for applied science education), however, due to the limited size of the WO group, this result has to be taken with caution.

Comparison of having done or not the response training for conflict management
Even though the sample size was too small to draw valid conclusions about this comparison, it is interesting to note that there was a significant difference on the destructive domain.

Comparison of the high and low frequency of aggressive encounters
There was only a significant difference on the communicative domain when comparing staff members with high versus low frequency of aggressive encounters. For the participants who, on average, encounter aggression on higher frequency, the lowest score was for the communicative domain with a significant difference when comparing with staff members that have low frequency of aggressive encounters which attributed a higher score for the communicative domain.

Comparisons across gender, work department such as wards and sheltered livings, work experience, work status as full-time and part-time, and when employee last received the Response Training for Conflict Management, did not indicate any significant results on employees' attitudes towards aggression. This points that, overall, these different groups agreed most with the statement related to aggression being offensive and destructive and least with statement related to aggression being communicative and intrusive.

Discussion

When comparing the findings of this research with other studies, there are several similarities and contrasts. Jonker, Goossens, Steenhuis, and Oud (2008) concluded that through higher levels of self-efficacy, older nurses were better able to deal with aggressive behavior. These findings lead one to believe that this might have influences on their interpretations of the aggression, specifically, that the older employees might view aggressive behavior as more communicative. However, this research showed that mental health staff

members above the age of 50 have interpreted aggressive behavior as more offensive, and destructive, compared to the young employees.

The results indicating that aggression is interpreted as more communicative by employees with a higher education level – WO in the Dutch system – corresponds with the findings of a study done by Ferns and Meerabeau (2008) and Myers, Kriebel, Karasek, Punnett and Wegman (2005). Nevertheless, two other studies, conducted by Zeller, Dassen, Kok, Needham and Halfens (2012) and Magnavita and Heponiemi (2011) presented contradicting results. According to their research, having experienced more aggression was associated with the higher educational level could have numbed the extent to which aggression is considered to be communicative behavior by staff members. However, it could be that the intensity of training can differ per country, making the comparison between different studies more complex.

Finally, the results of this study coincided with findings from Hahn, Needham, Abderhalden, Duxbury, and Halfens (2006) and Needham and colleagues (2005) where both showed that response-like trainings for conflict management might help employees to cope with aggression. It was interesting to find in this study that it did not have a significant influence on the perception of aggression by the employees.

This research provides valuable insights into different attitudes towards aggression in the specific mental health care facility in the South West of the Netherlands. There are, however, some limitations to this study that need to be taken into account. Firstly, it must be noted that the sample that was used was not randomly selected from the target population, nor randomly assigned to the different independent variables, limiting the study's internal and external validity. In addition, the sample size was small, which lowers reliability. Additionally, the ATAS (Jansen et al., 2005) was developed among and for psychiatric nurses in institutional psychiatry. In this study, employees who do not exclusively fall into the category of psychiatric nurses also completed the questionnaires.

Conclusion

The aim of this research was to identify the interpretations of clients' aggressive behavior by the personnel (n=61) within an in-patient mental healthcare organization in the Netherlands. The ATAS (Jansen et al., 2005) was used for the research, which also investigated to what extent do gender, age, working in a particular department, experience in that specific department, educational level, work status, receiving Response Training for Conflict Management, and amounts of encounters with aggressive behavior have an influence on the employee's attitude towards aggression.

The participants of this study tended to agree most with statements of the ATAS (Jansen et al., 2005) indicating that aggression was considered as offensive or destructive, and least with the statement that aggression is communicative, intrusive or protective. This was not only the trend for the entire sample, but also for all the different groups that were compared in relation to; gender, age groups, work departments, wards and sheltered livings, educational level, work related experience, work status, the frequency of aggressive encounters, and finally, whether or not they did the Response Training for Conflict Management and when was it done.

The results of this study indicated that in this mental health care organization, there were significant differences between the attitudes towards some of the domains of aggression as measured by the ATAS (Jansen et al., 2005) between age groups, educational level, how often the employees encounter aggressive behavior, and whether or not the employees have received Response Training for Conflict Management. However, no significant difference was found between gender, department, work status, and at what point in time the employees have received the Response Training for Conflict Management. To conclude, the results indicated that, in general, staff members considered aggressive behavior most as offensive and destructive and less as communicative, intrusive and protective.

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Educational Goals / Learning objectives:

- To improve the awareness in relation to their own attitudes towards aggression as well as the attitudes of other staff members in psychiatric care;
- To bring broader knowledge and reflection in relation to different aspects involved in attitudes towards aggression in psychiatry;
- To improve the knowledge of the differences between sub-groups in relation to attitudes towards aggression in psychiatry;

Correspondence

Ms. Elizabeth Wiese
University College Roosevelt/ Utrecht University
Lange Noordstraat 1
4331 CB Middelburg
The Netherlands
e.wiese@ucr.nl

Experiences with the Response Crisis Intervention Model for Conflict Management: The Safety Team

Paper

Kyra L. J. Smeets, Nicole Ligthart, Ien Albers, Ibtissam Benali, Dorien de Hoop, Victoria O'Callaghan, Lisa Rückwardt, Toon van Meel & Elizabeth Wiese (Netherlands)

Introduction

Mental Health care organizations have developed policies and strategies in how to deal with aggressive behavior, a frequent problem in clinical settings. Constantly facing threats to their safety often has adverse effects on staff members' job motivation and satisfaction (Lynch, Plant & Ryan, 2005). In order to cope with these threats staff members until recently had the tendency to manage aggressive situations by using coercive interventions (Foster, Bowers & Nijman (2007), such as restraint and seclusion of clients (Benedictis de et al., 2011). Seclusion, however, is one of the most controversial procedures in clinical settings (Huckshorn, 2006), as research has indicated that it does not bring treatment benefits and can be harmful and sometimes traumatic for the client as well as staff (Larue, Dumais, Boyer, Goulet, Bonin, & Baba, 2013). As restraint and seclusion are still debated topics in psychiatry, other methods should replace these invasive procedures. Therefore, the development, training and application of non-invasive methods for conflict management turned into paramount necessity in psychiatric organizations as staff members need to react adequately in aggressive situations, maintaining a safe environment, and avoiding disruptive actions.

One of the alternative methods used to regain and maintain safety in incidents of aggression is the Response Crisis Intervention Model for Conflict Management - RCIM, developed originally in the United States of America, by Windcaller (2010). The main focus of this research is to investigate the experiences of staff members of the Safety Team in relation to this specific approach in managing aggression and conflicts in psychiatric wards.

The main aim of RCIM is to establish and maintain the safety of the scene, more specifically the safety of all partners of the situation in psychiatric care. An important aspect of this approach is early intervention of potentially aggressive behaviour to prevent a more serious outburst. The goal is not to get to know all the details of the conflict, but to de-escalate the scene in order to create a safe environment and help the client regain enough self-control to act reasonably and responsibly (Windcaller, 2010). At the same time RCIM offers staff members a means to remain confident and to keep self-control.

In restoring safety, the RCIM-protocol (Response Training, 2015) is central to the role of the Safety Team in psychiatric organizations. The Response Training of the RCIM-protocol "teaches and promotes the concept that crisis equals opportunity. A crisis can, therefore, "provide staff with an opportunity for learning pro-active conflict management skills" (p. 1). The RCIM-protocol highlights a specific procedure that the Safety Team must adhere to, which enables its participants to "examine and define their position as professionals, authority figures, and role models" (p. 1). The Safety Team is trained on safety management, knowing what interventions have to be used, as well as which techniques have to be applied to enable them to respond to incidents in a calm and clear-headed manner (Response Training, 2015). The RCIM procedure implies that the Safety Team asks the ward staff to explain what has happened, and what they expect the Safety Team to do. Once the Safety Team arrives at the scene, their main task is to establish safety.

At the mental health care organisation selected for this study, each Safety Team consists of 5 designated staff members, with shifts of 5 hours long. In total, 100 staff members have been trained specifically to work in Safety Teams. Additionally, the Safety Teams rotate in order to enable all staff members to work together. There are two situations in which the Safety Team may be called in: one is a precautionary measure when staff members of a particular ward anticipate that an aggressive incident may occur. The second situation is one of immediate danger when an alarm button is pressed. The number of Safety Team members that actually go to the scene of (possible) aggression varies, depending on the perceived danger of the situation by staff. For this research the key question was: What effect does the application

of the Response Crisis Intervention Model for Conflict Management have on staff members and on people involved in the situation in relation to their sense of safety?

Method

The research procedure included recent episodes of aggressive behavior involving members of the Safety Team who were interviewed afterwards. For this study seven members of the Safety Team from a mental health care organization in the Southwest of the Netherlands were individually interviewed.

A semi-structured interview, consisting of 19 guiding questions, was developed for this qualitative research. The face-to-face qualitative interviews were conducted by pairs of Clinical Psychology students from University College Roosevelt, the honors College of Utrecht University, in the Netherlands. Before starting the interview, participants read and signed the informed consent for research, after which they filled in their personal data. The interview started with an introduction about the topics, followed by general questions regarding aggression in psychiatry, the RCIM training, experiences with aggression and the Safety Team. At the end of the interview, the participants could give comments.

All interviews were recorded and transcribed. The QDA Miner Lite v1.4.1 by Provalis Research was used to anonymize, thematize, and code transcripts in order to prepare them for analysis. After that preparation the data were submitted to qualitative analysis in terms of categories of concepts.

The following themes were established for analysis: demographics, aggression, feellings of safety, before and after RCIM, training, composition of the Safety Team, dynamics of the Safety Team, aftercare and recommendations. To these themes a set of code words was assigned to be used in the analysis. Of all the words in the transcripts the dominating code words indicating the most important themes were *applicability* (12.5%), *working together* (8.8%) and *changes in method* (12%) respectively (the total coverage of these three code words was 33.3%).

Sample demographics

The participants, two men and five women, were in the age range from 31 to 57. Two participants had their first RCIM training in 2009, two participants in 2011, two participants in 2012, and one participant in 2014. RCIM was first introduced in 2009. The last RCIM training took place in January 2015. All participants did this last training.

Results

Aggression: For many participants, aggression is a broad concept which clients express both verbally and non-verbally: they can scream, use swear words, walk away angrily, show angry face expressions, kick, curse, try to hit, and throw objects. It can be a threatening and scary experience feeling that someone is capable of doing harm, reducing participants' safety feelings. Staff members feel that a situation may be threatening and unsafe by listening to the client's tone of voice. As a result they may think that holding clients physically is necessary. At the same time, staff members feel a certain tension themselves. Even when staff members do not know a client, they may have a certain feeling of awareness that they are not safe.

Awareness of safety: Most participants indicated that staff members have become more aware of safety and dangers during crises after the RCIM training, which has taught them to think about their own safety first before thinking about the client's safety. The RCIM training taught them to focus on safety (during crises) and not on the causes of the aggression.

Negative feelings about safety: Participants indicated that RCIM does not always work in all situations and that there are clients with whom this method does not result in satisfactory results. Sometimes they feel unsafe for different reasons, and may not feel capable of dealing with a crisis: this could be due to lack of experience or to the composition of the Safety Teams. They mostly do not feel safe when the Safety Team only consists of women or when they do not know the other members of the Team.

Before and after RCIM: Participants stated that many of them had aggression training, called CFB, before the implementation of the RCIM training. However, that former training aimed at treating aggression during an attack, mainly focusing on self-defence, rather than prevention, taking into account only physical aggression. When the client became aggressive, medication and separation rooms were used to reduce it. Since the RCIM training started, these methods have been less used or excluded all together. Staff members indicated that they were capable of handling aggression (before RCIM), but that they have grown in dealing with aggression because of the new training. They also pointed out that some members

of the Safety Team were rather reluctant to participate in the RCIM training at first, which caused some irritation among staff members. Nowadays the willingness to participate in the RCIM training is much higher. Participants referred that situations of aggression used to be very chaotic, unorganized and heavy, indicating that the RICM training created a good organization of teams that needs to respond to situations of aggression, as a result of which clients are treated better.

Training: Participants mentioned that the most important point they have learned during the training was to take time to decide what to do, to divide tasks, and particularly to take time during their action, in order to try to create a safe environment. The training's most important aspect is to learn not to enhance the client's feelings of aggression by speaking about the subject that actually raised the aggression. RCIM training is well applicable because staff members have been taught to talk to clients, rather than forcing them physically. Additionally, the effects of that training could be further enhanced if the training were to be done more often since the staff members will be then more experienced. Besides, some of the clients may know about the training, but they have not been trained themselves. Before the introduction of the RCIM training, it was customary to keep the aggressive client secluded to ensure safety. During the training staff has learned how to stay calm and to prevent unfair treatment of clients. The training practices, include speaking techniques to prevent aggression and techniques how to hold the client in a firm grip in order to handle the client's aggression. Finally, the RCIM training has also taught staff members to place their own safety first.

Composition of the Safety Team: All participants explained that they did not voluntarily choose to work for the Safety Team. Besides, the composition of the Safety Teams needs some change. Some participants suggested forming a Safety Team consisting of a fixed group of staff members, so other staff members do not need to leave their clients to work for the Team, as this is often not beneficial. Nevertheless, it is crucial for all staff members to do the RCIM training. Another suggestion was to appoint a special coordinator of all Safety Teams who should have an overall view on the functioning of the Teams. Changing the composition of the Safety Teams may have positive and negative aspects. If there is only one fixed group of staff members that works for one Safety Team, there may be a problem if some team members are suddenly not able to work for the team. On the other hand, the fixed members of a Safety Team will become very experienced in dealing with crises. Besides, staff members in a vulnerable condition – physically or psychologically – should not work for the Safety Teams. On the other hand it was suggested that male staff members should participate in every Safety Team. Another recommendation made was to let staff members choose for themselves if they want to work for the Safety Team or not.

Dynamics of the Safety Team: There are different indications about how well the staff members in the Safety Teams know each other. This could depend on the number of years a staff member has worked for the organization and how often a staff member has actually worked for the Safety Teams. They often know some other members of the Safety Teams, but not everyone. The members of the Safety Team mostly work well together, but not always. Most participants believed that this problem is caused by the composition of the Teams. It was indicated that members do not work well together, when they did not apply for a position in the Safety Team voluntarily. Others indicated that the composition of the Safety Teams changes too often, making it difficult for staff to learn to work well together. Some members who had worked for the Safety Team for a longer time have developed their own techniques of dealing with aggressive behaviour, which deviate from RCIM-guidelines. Consequently, it is more likely that these members will not cooperate well with the other members of the Team. Furthermore, members may think differently about how safe a situation actually is. Members will cooperate better in the Safety Team when they get to know one another well and when the composition of the Safety Teams changes less often. The cooperation between members also depends on the kind of incident that they have to deal with.

Aftercare: Several participants referred to the care provided after an incident had happened as it is customary to hold evaluation consultations. The reports of these evaluations are read by the coordinator of the Safety Team. There were positive indications about the aftercare provided. It is the task of the staff members of the ward to talk to the clients about the causes of the incident. Safety Team members can fill out evaluation forms, which are discussed with the coordinator and team coaches. It is very important to talk about the incidents and the way the Safety Teams deal with the situation and the ones involved.

Recommendations about the training and the Safety Team: The participants gave some recommendations to improve the RCIM training: it should be given more often and focus also on situations for which RCIM is insufficiently effective. The effectiveness of the RCIM could also be improved by practicing RCIM with different staff members. All participants suggested to create one Safety Team composed of a fixed group of staff members. Apart from the fact that almost all participants preferred a fixed group of staff members working for the Safety Team, there were also other recommendations concerning its composition. Participants indicated that Safety Teams will function better if staff members can choose

for themselves whether they prefer working for the team. If people choose to be on the team voluntarily, they will be more motivated in dealing with crises. Some participants suggested to have more male staff members in the Safety Team, because they feel less safe when there are no male members in their team. It was also suggested that there should be an operational Safety Team during the night.

Conclusion

As aggressive behaviour is a recurring everyday reality in psychiatric clinical settings, it is vital that staff members are well prepared in order to be able to respond adequately to critical situations. By focusing on prevention and de-escalation of the scene, RCIM showed to be appropriate in giving support to staff members to be better prepared to deal with aggressive incidents. Working with a well-structured Safety Team not only helps staff to cope with aggression more effectively, but also results in a better treatment of patients.

Research indicated that staff overall perception was that their sense of safety has improved since the introduction of RCIM as intervention model. As result of the RCIM training, they became more aware of safety as the prime target in cases of aggression. This awareness has enhanced their feeling of being in control of possible threats, which is a prerequisite for feeling safe. Additionally, operating with a more structured Safety Team and applying RCIM techniques in every day practice, have enabled them to gain control of incidents of aggression more confidently. Nevertheless, situations might be so complex that eventually staff may experience insufficient control, leaving them with feelings of insecurity. For that reason safety should be a constant issue on the agenda of every mental health organisation.

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• To improve the awareness in relation to their own attitudes towards aggression as well as the attitudes of other staff members in psychiatric care;
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Correspondence

Ms. Elizabeth Wiese
University College Roosevelt / Utrecht University
Lange Noordstraat 1
4331 CB Middelburg
The Netherlands
e.wiese@ucr.nl

Presenting GRIP®: a Grouped Risk-assessment Instrument for Psychiatry, for aggression, suicide and fire setting

Workshop

Cornelis Baas & Carla De Bruyn (Netherlands)

Background

Prevention of aggression, suicide and fire setting in clinical psychiatry is of obvious importance but only limited progress has been made in the development of tools for risk assessment. The consequences of aggression and suicide have been an area of interest for some time, but the consequences of fire-setting are often ignored, in spite of an estimated 6 deaths annually from deliberately caused fires in clinical psychiatry in the Netherlands.

Aims

The development of a risk assessment tool for aggression, suicide and fire setting in clinical psychiatry that is useful in terms of validity as well as practicality.

Methods

Literature on risk determinants for aggression, suicide and fire setting was identified, studied and analyzed and interviews with specialists in the field were conducted. Based on these interviews, studies on the implementation of risk assessment instruments in clinical psychiatry were included. A risk assessment instrument reflecting the findings was proposed.

Results

Only a few risk assessment instruments for aggression have been validated for clinical psychiatry, and no reliable risk assessment tools for suicide and fire setting were identified. The tools that are available for clinical psychiatry often fail to be used properly because of time constraints or a perceived lack of utility. Tools validated for forensic psychiatry have outcome measures of long term recidivism that are not meaningful for the prevention of risk behavior on psychiatric wards. Risk determinants for aggression, suicide and fire setting appear to have common aspects that can be used to create groups of determinants that are easily recognized by trained psychiatric staff.

Conclusions

It is possible to design a risk assessment instrument for aggression, suicide and fire setting in clinical psychiatry that reflects current knowledge about risk determinants for these three forms of risk behavior and that illustrates the difference between modifiable and non-modifiable risk determinants and that is accepted as useful and practical by psychiatric nurses.

Educational goals

- After this workshop, participants have increased awareness of the importance of explicit risk analysis for aggression, suicide and fire setting in clinical psychiatry and of the main determinants for such risk behavior. Also, they can distinguish between modifiable and non-modifiable risk determinants and can integrate the results of explicit risk analysis in their structured professional opinion and therapeutic strategies.

Correspondence

Mr. Cornelis Baas
Lentis Groningen
van Spilbergenstraat 38
8023XM Zwolle
The Netherlands
cees.baas@mac.com

Understanding antisocial behaviors: Antisocial personality traits involving sensation seeking and callousness

Poster

Saima Eman (UK)

Keywords: Empathy subtypes, Sensation seeking, Callous and Unemotional traits, Physically aggressive, Non-aggressive behaviors

Background

This study considers empathy, sensation seeking, and callous and unemotional (CU) personality traits as various forms of emotions in association with antisocial behaviors (ASB).

Aim

It examines subtypes of empathy (i.e. emotional reactivity, cognitive empathy and social skills), main and subtypes of sensation seeking (disinhibition, thrill and adventure seeking and experience seeking) and CU traits (callous, uncaring and unemotional) in various regression models predicting physically aggressive (actual or threatened aggression against living things) and non-aggressive (actual or threatened aggression against others possessions) subtypes of ASB.

Method

An online self-report survey was administered to N=433, predominantly female volunteer students from University of Sheffield, UK, aged 25 years and below. The measures were modified Emotional Quotient-15, Brief Sensation Seeking Scale-8, The Inventory of Callous and Unemotional traits -24 (Youth version) and the Antisocial Behavior Measure-17.

Results

Emotional reactivity predicted both ASB subtypes. Both emotional reactivity and sensation seeking became significant predictors when sensation seeking was added. Both CU traits and sensation seeking became significant predictors when CU traits were added. Stepwise regression revealed "disinhibition" and "callousness" as significant predictors of non-aggressive behaviors; while "thrill and adventure seeking" and "callousness" as significant predictors of physically aggressive behaviors.

Conclusion

Different personality traits differentially predict ASB subtypes amongst university students, indicating the normal functioning of different emotions to predict ASB subtypes. Furthermore, empathy does not predict ASB when CU traits and sensation seeking are included as predictors. Future research might consider other personality traits such as sadism or affective dissonance as predictors of ASB subtypes, which are closely linked to sensation seeking and CU traits.

Correspondence

Ms. Saima Eman
University of Sheffield
Western Bank
S10 2TP Sheffield
United Kingdom
saima.eman@sheffield.ac.uk

Validation of the Novaco Anger Scale – Provocation Inventory (Danish) with Non-Clinical, Clinical, and Offender Samples

Paper

Stine Bjerrum Moeller[1], Raymond W. Novaco[2],
Vivian Heinola-Nielsen[3], Tine Wøbbe[3], and Helle Hougaard[4]
[1]Psychiatric Center Capital Region, North of Zealand, Denmark
[2]University of California, Irvine, USA
[3]Psychiatric Center Capital Region, Sct. Hans, Denmark
[4]Psychiatric Center Capital Region, Ballerup, Denmark

Keywords: Novaco Anger Scale and Provocation Inventory; anger assessment; aggression; hospital violence.

Validation of the Novaco Anger Scale – Provocation Inventory (Danish) with Non-Clinical, Clinical, and Offender Samples
As treatment for anger problems should be grounded in assessment of deficits in anger control, validation of the assessment procedures is an important clinical research agenda
The NAS and PI (Novaco, 1994) were developed for use with mentally disordered populations, and they were validated in the landmark MacArthur study on violence and mental disorder (Monahan et al., 2001). The present study concerns the Danish translation of the NAS and PI, testing their psychometric properties with non-clinical, prisoner, general psychiatric, and forensic samples.

Anger, Violence, and Clinical Care Needs
The prevalence of anger as a salient problem across clinical and forensic populations is now widely recognized (e.g Skeem et al., 2006; Swogger et al., 2012). Anger is not only an important clinical need, it also bears on the therapeutic milieu and on the well-being of clinical and custodial staff. To assess anger for treatment, to formulate anger treatment, and to evaluate treatment programs for problematic anger, it is essential to have reliable and valid psychometric instruments. However, no such anger assessment measures are available in Danish. As a consequence, studies of anger as a clinical problem in Denmark have been limited, and the current clinical practice for anger assessment, to the extent that it exists at all, is not based on a differentiated assessment of the anger construct.

Problems of Anger and Aggression in Danish Populations
As in other countries, anger and aggressive behavior are clinically significant ward atmosphere variables in psychiatric hospitals in Denmark, being more prevalent on locked units and generally detracting from the satisfaction of both patients and staff (Middelboe, Schjødt, Byrsting, & Gjerris, 2001; Schjødt, Middelboe, Mortensen, & Gjerris, 2003). The prevalence of physical attacks on human service staff by clients in Denmark is evidenced in a study by Pedersen, Ramussen, & Elsass (2012) which reported that 37% of the patients at a Danish forensic hospital had one or more aggressive incidents during hospitalization.

A Danish-Norwegian study (Bak, Zoffmann, Sestoft, Almvik, & Brandt-Christensen, 2014) on reducing mechanical restraint, missed the potential role of patients' anger as an activator of behaviors that result in episodes of mechanical restraint, and thus missed anger treatment as a potential remedy. This neglect or oversight is perhaps due to the absence of a valid Danish language psychometric instrument for anger.

The prison and probation service has implemented anger management programs, however, inmates are selected for treatment based only on their index crime -- not on their clinical needs or the assessment of anger -- and clinical evaluation of efficacy has typically been absent. General psychiatry and psychiatric wards in Denmark have no scientific clinical practice with regard to anger, despite the fact that the political system in Denmark is very concerned with the use of restraint.

Given this established relevance of anger in Denmark, in clinical and non-clinical populations, the present study sought to translate the NAS and evaluate its validity with diverse samples.

Current Study Objectives
The main goal of the present study was to develop NAS-PI-2003-D and to test its psychometric properties. We tested the retrospective and prospective validity of the Danish NAS regarding forensic inpatients' (males) physically aggressive behavior in hospital.

Method

Participants
Participants were drawn from non-clinical, clinical, and correctional settings, each of which had variations within that type of setting. The non-clinical sample was comprised of ($N = 477$), 167 males (35%) and 306 (64%) females, the clinical sample was comprised of 87 males (35%) and 159 (64%) females, and the offenders sample was comprised of male inmates at 5 different prisons in Denmark ($N = 167$; 61% of whom were convicted of a violent crime) and of male forensic patients at a forensic hospital ($N = 64$; 92% of whom were convicted of a violent crime), ten of these being outpatients

Measures
Novaco Anger Scale (NAS; Novaco, 2003): The NAS is a 60-item scale constructed to measure anger disposition. Its items were generated from a theoretical framework. The Cognitive, Arousal and Behavioral subscales are each comprised of 16 items. The sum of these 48 items forms the NAS Total score. There is also a separate 12-item Anger Regulation subscale. All items are rated on a 3-point scale of 1 = "never true"; 2 = "sometimes true"; and 3 = "always true". The validity of the NAS has been established by independent investigators (e.g., Baker et al., 2008; Hornsveld et al., 2011; Jones, Thomas-Peter, & Trout, 1999), including the prediction of violent behavior by psychiatric patients (Monahan et al., 2001; Swogger et al., 2012).

Provocation Inventory (PI; Novaco, 2003): The PI is a 25-item self-report instrument measuring anger intensity. The instrument describes situations that could potentially elicit anger, and the respondent rates anger intensity on a 4-point scale. The stability and validity of the PI has been supported in a variety of samples, including prisoners (Baker et al., 2008; Jones et al., 1999; Mills, Kroner, & Forth, 1998).

S*tate-Trait Anger Expression Inventory* (STAXI-2; Spielberger, 1999). The STAXI-2 is a 57-item scale constructed to measure anger experiences, anger disposition, and anger expression. The scale consists of 6 subscales measuring State Anger, Trait Anger, and the components of Anger Expression (Anger Out, Anger In, and Anger Control).

Hospital Anxiety and Depression Scale (HADS; Zigmond & Snaith, 1983). This instrument is a 14-item self-report questionnaire measuring anxiety and depression.

Staff Observation Aggression Scale – Revised (SOAS-R; Nijman et al., 1999) is a form used to register aggressive incidents on wards. Verbal incidents were excluded. During the period from being admitted to the hospital and the test date, 44% of the patients had had at least one aggressive incident, and 36% of the patients had at least one aggressive incident from the test date to the end of the observation period.

Results

Internal reliability was excellent overall for total score and subscale indices for the NAS and PI. The test-retest evaluation, conducted with a subsample ($N = 57$) of the clinical outpatients, found strong reliability coefficients for the NAS-PI. Overall, the NAS-PI reliability coefficients are comparable to those given in the instrument's manual (Novaco, 2003).

Discrimination of Clinical and Non-Clinical Samples
The NAS and PI discriminated between non-clinical and clinical populations, Cohen's *d* coefficients were computed on the magnitude of the effect size. The clinical patients and forensic patients, respectively, had significantly higher scores than did the non-clinical participants on NAS and PI and each of its subscales with effect sizes ranging from, $d = 0.50$ to 1.55. Thus, for each of these comparisons, the effect size is large and is in the expected direction. The NAS and PI also differentiated between the clinical and forensic patients, the scores of the clinical patients were significantly lower on all NAS measures, except the Arousal subscale ($d = 0.10$), effect sizes ranging from, $d = 0.45$ to 0.60.

Concurrent Validity
The concurrent validity of the Danish NAS and PI was addressed by their correlations (Pearson) with the STAXI-2 in the clinical sample. Results showed the expected high correlations with the STAXI-2 across all NAS-PI indices, with the highest correlation being between NAS Total and Trait Anger.

Confirmatory factor analyses

The factor structure of the Danish translation of the NAS-PI was tested by running a Confirmatory Factor Analyses on the combined sample. The model fit tests for the NAS were $\chi 2$ (1704) = 6362.48, $p < .0001$, CFI = .688, RMSEA = .059, indicating a model fit on only one of the indices. The model fit tests for the PI were $\chi 2$ (275) = 1374.17, $p < .0001$, CFI = .844, RMSEA = .070, indicating approximate model fit on only one index.

Predictive validity

With regard to the retrospective aggression, higher scores on NAS are associated with more aggressive incidents (risk ratio = 1.039, 95% CI 1.01 to 1.07, $p = .008$). In other words, a 10 units NAS increase by 47% increase in aggressive incidents. Regarding future aggression, higher NAS scores also go along with more aggressive incidents (risk ratio = 1.037, 95% CI 1.02 to 1.06, $p = .000$). A 10 units NAS increase by 44% increase in aggressive incidents.

Discussion

The results across the set of studies provide support for the reliability (internal and test-retest), concurrent validity, discriminant validity, and predictive validity of the Danish NAS-PI. However, the tests of the NAS and PI factor structure were generally not supportive, as acceptable model fit was found only for the RMSEA index. Those results for the confirmatory factor analysis are comparable to that obtained by Hornsveld et al. (2011) for the Dutch translation of the NAS-PI. That non-fitting may be due either to language translation, cultural differences, or instrument limitations.

The correlations with the STAXI are supportive of concurrent validity. Discriminative validity for the Danish NAS and PI in differentiating the non-clinical, clinical and forensic samples was substantiated.

The Danish NAS and PI scores are generally comparable to those reported in published studies involving the instrument translations into Swedish (Lindqvist et al., 2005), and Dutch (Hornsveld et al., 2011) with non-clinical, clinical, or offender/forensic samples. The high level of anger reported by the participants in the forensic hospital and prison samples give credence to the merit of inquiring about anger among such populations and to including anger as a dynamic variable (cf. Douglas & Skeem, 2005) when conducting research on aggression with offender populations. This has been lacking in Denmark, partly due to the absence of assessment tools.

Regarding predictive validity NAS Total was predictive of violent behaviour which has importance because anger is a viable treatment target. The latter point has been established by numerous meta-analyses. Our findings support the NAS-PI as a suitable instrument for selection of candidates for "anger management" interventions in Denmark and for the evaluation of such programs. That the NAS and PI scores for the offender samples are in the clinical range is indicative of those respondents being anger treatment candidates.

The present study has several limitations. First, the non-clinical sample has limited representativeness, as it was comprised of a convenience aggregate of university students, political party members, and private company employees. The forensic sample was small with only 54 inpatients and 10 outpatients. In adding to research on anger, we also hope to stimulate psychotherapy outcome studies aimed at decreasing anger dysregulation.

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Correspondence

Stine Bjerrum Møller, Ph.D.
Psychiatric Research Unit
Mental Health Centre North Zealand
University of Copenhagen
Dyrehavevej 48, DK-3400 Hillerød
Denmark
Stine.Bjerrum.Moeller@regionh.dk

Validity and Reliability of the Chinese Version on Perception of Aggression Scale (POAS) in health care workers

Poster

Wai Kit Wong & Wai Tong Chien (China)

Keywords: Patient aggression, psychiatric nurses, psychometric testing, Chinese

Background

Patients' aggression and violent behaviors towards health care workers are common phenomena in health care settings. Self-report questionnaires are one of the commonest methods or tools to measure staff attitude such as those toward aggressive behaviors however, no validated Chinese measurement tool is available for assessing the staff attitudes, which is considered an important and predictive factor for aggression.

Purpose

The aim of this study was to evaluate the validity and reliability of the Chinese version of the 12-item Perception of Aggression Scale.

Methods and Results

The psychometric properties of Chinese version of the 12-item Perception of Aggression Scale (POAS) were evaluated in terms of three phases:

In Phase I, 12-item POAS was translated and back-translated by two bilingual research assistants. Then the content validity testing was examined by a panel of 10 experts. The item-level content validity index (CVI) for the Chinese version ranged from .86 to 1.00, and the scale-level CVI was 0.9, indicating universal agreement.

In Phase II, a convenience sample of 36 bilingual psychiatric nursing staffs participated in checking the equivalence between translated Chinese and original English version using weighted kappas. Six items had a kappa >0.61, and the remaining six items had a kappa between 0.48 and 0.55, representing moderate agreement.

In Phase III, a convenience sample of 249 nursing students was recruited for construct validity test by using factor analysis (principal component analysis). Principal components analysis revealed the presence of three components with eigen values exceeding 1, explaining 37.3%, 16.4% and 10.3% of the variance respectively. An inspection of the Scree plot revealed a clear break after the second component. It was decided to retain two components for further investigation. The first factor treated aggression as dysfunctional and the second as functional. The coefficient of internal consistency of the scale was 0.826 for factor 1 and 0.804 for factor 2. Then half of them, 126 nursing students participated in test-retest reliability test. The test-retest reliability coefficients for the Chinese version over a 14-day interval were .73, indicating moderate reliability.

Conclusion

The findings indicate that the Chinese version of Perception of Aggression Scale is a valid and reliable tool to examine psychiatric nurses' perceptions of aggressive behavior among patients. It is recommended this Chinese version to be tested in diverse samples of health professionals before its use in clinical practice.

Educational Goals

1. Discuss the validity and reliability of the Chinese version on Perception of Aggression Scale (POAS).
2. Apply Chinese version POAS in clinical practice.

Correspondence

Mr. Wai Kit Wong
The Hong Kong Polytechnic University
Hung Hom, kowloon
852 Hing Kong
China
wai.kit.wong@polyu.edu.hk

Predictive validity of lipids for violence after discharge from an acute psychiatric ward

Poster

Bjørn Magne S Eriksen, Stål Bjørkly, Ann Paerden & John Olav Roaldset (Norway)

Keywords: lipids, cholesterol, violence risk assessment, acute psychiatry, biological risk markers

Abstract

Lipids (total-cholesterol, low density lipoprotein, LDL, and high density lipoprotein, HDL) are among the most studied biological markers of aggression, and several studies have found associations between low levels of serum cholesterol and aggressive behavior. Serum lipids as possible risk markers of violence might be especially interesting in acute psychiatric settings where the patients turnover is high, as taking a blood sample require little time and effort and is often routine procedure at admission.

The objective of this prospective observational study was to investigate serum lipids as risk markers of violence the first year after discharge from the Acute psychiatric ward at Oslo University Hospital, Norway. The target population was all patients admitted during one year, from 21st of March 2012.

A total of 528 patients were included. Baseline measures were serum total-cholesterol and HDL recorded from results of routine blood tests on admission. Clinical and demographic data were gathered from hospital records. Outcome measure was episodes of violence and threats during the first year after discharge, at intervals of 3, 6, 9 and 12 months, for the proportion of the patients were such information was available. The sources for information were: 1: follow up by the patient's therapist at the district psychiatric wards, 2: readmissions in the acute ward, 3: hospital records and 4: police records. The study was approved by the Regional committee for medical research ethics without informed consent, but with the right to decline participation.

According to preliminary results, 180 patients (34%) completed at least one of the 3, 6, 9 and 12 months measures and were included, and 348 patients (66%) were lost during follow-up. 62 of the included patients (34%) were registered with violence or threats at least one time within the first year after discharge. Further details and preliminary findings of the predictive value of total cholesterol and HDL for one-year violence will be presented.

Educational Goals

1. Describe the frequency and types of violence after discharge from acute psychiatry.
2. Discuss the potential of serum lipids as possible biological markers for violence.

Correspondence

Mr. Bjørn Magne S. Eriksen
Oslo University Hospital, Acute Psychiatric Ward
Smedgata 34
0651 Oslo
Norway
b.m.s.eriksen@medisin.uio.no

Nurses' perception of factors contributing to patient aggression – findings from Slovak mental health clinical areas

Poster

Martina Lepiešová, Jana Nemcová, Martina Tomagová, Ivana Bóriková, Juraj Čáp & Catarína Žiakováína (Slovakia)

Background

Patient aggression becomes an integral part of nurses' everyday lives. While obtaining data on extent of the problem it is recommended to focus on nurses' perception of this phenomenon including its causative and underlying factors. The highest prevalence of patient aggression in broader study in Slovak hospitals (n = 1220 nurses) was reported by mental health nurses (n = 221), thus we are focused on this subsample.

Aims

Patient aggression is multifactorial as for its causes and factors it is conditioned by. In literary sources they are variously categorized, reflected and interpreted. The aim of study was to measure mental health nurses' perception of the risk level of various factors in terms of their potential to increase the risk of patient aggression; to compare mental health nurses' perspectives to those from other workplaces; and to compare two groups of mental health nurses subdivided by the fact, whether they had undergone any special training/education focused on patient aggression.

Methods

FAPAS (Factors Affecting Patient Aggression Scale) scale of own construction with confirmed construct validity and reliability (Cronbach's alpha 0.915) was used to collect data. Based on factor analysis FAPAS is structured into 7 subscales/the groups of risk factors, from FAP1 to FAP7. Items are evaluated by 5-point scale from 1-the least impact on the risk of aggression to 5-the greatest impact on the risk of aggression. Higher score indicates rating the factor/the group of factors as more risky for patient aggression against nurses.

Results

By mental health nurses of our sample, the highest risk of patient aggression was assigned to the patient's factors (FAP4; 3.89±0.71), then specific factors of workplace (FAP6; 3.08±0.92), nurse's factors (FAP3; 3.04±0.79), situations of patient's emotional overload (FAP2; 3.02±0.79), factors of work shift organization (FAP7; 2.85±1.10), factors of physical environment (FAP1; 2.72±1.02), and finally, factors related to the issue of gender (FAP5; 2.22±0.92) were reflected as the least risky. While comparing two groups based on specific education undergone, the mean scores of subscales varied, but only in case of subscale FAP7 it differed significantly. As for different types of workplaces/clinical disciplines the nurses work in, the mean scores of all subscales differed significantly with the exception of FAP4 subscale.

Conclusion

Apart from internal factors of aggression (FAP4), mental health nurses of our sample reflected the significance of situational and external factors (FAP6, FAP2, FAP7, FAP1 and FAP5) and articulated the likelihood of their own contribution to increased risk of aggression (FAP3). Patient aggression affects nurses' health and safety, job satisfaction and consequently the quality of nursing care provided thus study results could be helpful for hospital management to make decisions on further evaluation and improvement of various factors contributing to patient aggression. The findings of the study have to be addressed in future approach.

Educational Goals

- To gain understanding about the FAPAS (Factors Affecting Patient Aggression Scale) and the findings from Slovak mental health clinical areas obtained with its use;
- To gain understanding of how various groups of patient aggression contributing factors are viewed by Slovak mental health nurses in terms of their potential to increase the risk of aggression;

Correspondence

Ms. Martina Lepiešová
Institute of Nursing, Jessenius Faculty of Medicine in Martin, Comenius University in Bratislava
Malá hora 5
036 01 Martin
Slovakia
lepiesova@jfmed.uniba.sk

A review of the relationship between Emotional Intelligence and psychopathic traits: is the EI construct a mediator between aggression and psychopathy?

Poster

Maria Gutierrez-Cobo, Rosario Cabello & Pablo Fernandez-Berrocal (Spain)

Keywords: Psychopathy, Emotional Intelligence, aggression, protective factor

Background

In spite of their normal intelligence, individuals with psychopathic traits are usually characterized as having numerous troubles with social and emotional facets in their daily. These deficits that make complicated their adaptation could be related with deficiencies in their Emotional Intelligence (EI) or their ability to perceive, use, understand and regulate emotions.

Aims

The aim of the present study is to review the existing evidence of the relationships between EI and the population with psychopathy traits for a better understanding of the emotional problems of these individuals and looking for evidence of EI as a possible mediator between psychopathy and the aggressive behavior.

Methods

Scopus and Medline were searched for finding relevant articles in Spanish and English. Articles with psychopathic trait populations of all ages assessed through different scales were accepted when they were measured together with a self-report or an ability EI test.

Results

These studies provide some evidences that participants with psychopathic traits have lower EI than control participants in almost all the articles found. Specifically, it seems that the secondary psychopathy and their impulsivity trait are the most related aspect of these construct with EI. Besides, the gender and age variables seem to play some roles in the link between EI and psychopathy. For its parts, some studies show evidence of the positive relationship between psychopathy and aggressive behavior as in a negative relation between EI and antisocial conduct. However, none of the reviewed articles stablish EI as a mediator variable.

Conclusions

The results obtained from the review could be of special importance for future treatment of psychopathic population as well as for the prevention of a possible disruptive behavior in their adolescence or adulthood. Given that a deficit in EI is achieved for psychopath, an EI intervention could act as a protective factor by reducing their emotional and social shortages or prevent them if the training is implemented in an early period of their life and, therefore, improving their inappropriate behavior. Nonetheless, future research is necessary for a better understanding of the role of EI as a mediator between psychopathy and aggression.

Educational Goals

A systematic knowledge of some possible emotional deficit related to psychopathic traits population.
The participants will learn more about the emotional intelligence construct and its potential benefit as a new training.

Correspondence

Ms. Maria J. Gutierrez-Cobo
Department of Basic Psychology, Faculty of Psychology
Bulevar de Louis Pasteur, 25
29010 Malaga
Spain
mjgc@uma.es

Developing a psychiatric intensive care unit and effects observed on the incidence of violence

Poster

Halldora Jonsdottir, Eyrun Thorstensen & Bryndis Berg (Iceland)

Keywords: violence, security, severe mental disorders, PICU

Introduction

The acute psychiatric wards at Landspitali University Hospital were operated in the same manner for years. The security issues were many and difficult incidents with violence were common. Experience from other countries has shown that violence in psychiatric wards decreases with more space in the inpatient wards. In 2013 a psychiatric intensive care unit (PICU) was opened. The aim of the PICU is to treat acutely ill patients who are seriously behaviorally disturbed and unpredictable and need extra support in secure surroundings. The unit is spacious and easily overviewed. It has 10 patient rooms, with men and women in different corridors.

Methods

One of the acute units underwent extensive changes with focus on space and security. We counted serious incidents before and after the changes were introduced. Staff satisfaction was measured.

Results

Before opening the PICU the average number of serious incidents in the acute units was 12 per month. In 2014 the average was 7 incidents a month. 71% of the staff reported increased satisfaction in their work.

Discussion: We have seen a reduction in violence after opening a PICU and our conclusion is that security has increased for patients and staff. Our goal is to reduce violence further and in doing so the focus will be on teamwork and specializing of staff in caring for the severely ill and in methods for reducing violence.

Educational Goals

• Development of safer wards

Correspondence

Ms. Halldora Jonsdottir
Psychiatrist, Landspitali University Hospital
Hringbraut
101 Reykjavik
Iceland
Tel: +354 8245359
Fax: +354 5434816
halldjon@landspitali.is

Reducing aggression among chronic psychiatric inpatients through nutritional supplementation

Poster

A. Schat, A.A.M. Hubers, J.M. Geleijnse, O. van de Rest, W.B. van den Hout, J.P.A.M Bogers, C. Mouton, A.M. van Hemert & E.J. Giltay (Netherlands)

Keywords: Aggression reduction, nutrition, psychiatric inpatient

Abstract

Aggressive incidents frequently occur among long-term psychiatric inpatients (n=11000 in the Netherlands). These incidents include verbal aggression, physical aggression towards persons, physical aggression towards objects, and self-harm and suicide attempts. Aggression has serious consequences as incidents may be traumatic and cause stress in caregivers and patients. Consequences can also be expressed in terms of costs: employee-costs of time spent regulating and restraining aggressive patients; (coerced) medication; medical emergency unit visits; involvement of police, physicians and guards; consultation; transport; reporting and transfer of information between health professionals; but also of compensation claims; lost workdays and sick leave; rehabilitation and educational programs. Finally, aggression is one reason these patients remain admitted involuntarily.(1)

Several studies have demonstrated anti-aggressive effects of vitamins, minerals and essential Omega -3 (n-3) fatty acids (FA). In four randomized controlled trials (RCTs), daily administration of multivitamins and (n-3) fatty acids (eicosapentaenoic acid and docosahexaenoic acid) reduced the number of (violent and nonviolent) offences, antisocial behavior, and agitation in juvenile delinquents (2), frequently disciplined schoolchildren (3), and in young adult prisoners.(4),(5) Finally, a pilot study with 12 treatment resistant schizophrenia patients demonstrated reduced agitation (measured by prescribed anxiolytics) and psychopathology and increased functioning upon n-3FA supplementation. (6)

We propose a study to conduct a study to test the effectiveness and cost-effectiveness of multivitamin-, mineral- and essential n-3 fatty acids (n-3FA) supplementation versus placebo to reduce aggressive incidents in chronic psychiatric inpatients. We hypothesize that supplementation reduces aggression and thereby costs of care while increasing quality of life.

The study is designed as a double-blind, randomized, placebo-controlled multicenter trial. We aim to include a total of 200 patients who have been hospitalized for ≥1 year in one of 10 involved institutions for long-term psychiatric care. Patients who are randomized to the intervention will receive daily supplementation of vitamins (B1, B2, B3, B5, B6, B11, B12, C, D, E, Beta Carotene), minerals (Calcium, Iodine, Copper, Magnesium, Selenium, Iron, Zinc, Potassium, Chrome, Manganese) and n-3 FA (EPA, DHA), that will be taken through Orthica Soft Multi and Orthica Fish EPA Forte supplements; controls will receive placebo.

The main outcome measure in this study will be the number and severity of aggressive incidents. Secondary outcomes are costs of time spent on incidents by staff, additional costs related to aggression incidents, nutritional status, aggression scales, and quality of life.

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Educational Goals

- Describing the effect of nutrition in aggression reduction
- Gaining insight in the implementation of a nutritional intervention in psychiatric inpatient care

Correspondence

Ms. A. Schat
Leiden University Medical Center
Albinusdreef 2
2333 ZA Leiden
The Netherlands
Tel: +31 71-5262552
a.schat@lumc.nl

Incidences of violence in psychiatric inpatient care as described by staff

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

Background

Violence in psychiatric inpatient care is a serious problem for patient and staff security. In order to create safe ward environments it is essential to learn from patients' and professionals' experiences of violent incidents and their value preferences with regard to such incidents.

Aim

The aim of the study was to examine experiences of staff, working in psychiatric inpatient care, of violent incidences.

Method

The study was performed using the Critical Incidence Technique at 8 general, forensic, and addictive psychiatric inpatient clinics in Sweden. All categories of staff working with patients at these units received a questionnaire on work environment and health (QPS Nordic). As an addition to the questionnaire, respondents were asked to describe two incidents of violence they had experienced in the last two years. Open ended follow up questions were asked concerning e.g. what happened before and after the incident and possible factors explaining the incident. Data was analyzed by using qualitative content analysis with an inductive approach.

In all, questionnaires were distributed to 1069 individuals, of which 445 responded. Descriptions of 273 critical incidents were reported in 198 questionnaires.

Results

Different kinds of violent incidents were reported: physical, verbal, threats, and sexual assaults. Most common were violence from patients targeted at staff, but also violence between patients and from relatives, and in a few cases from staff, were reported. Two main reported causes of the incidents were found:
- The patient's illness or behavior (majority).
- Staff behavior or organizational shortcomings.

Similarly, two main categories of suggestions for preventing these incidents were found:
- Material solutions and removal or medication of patients (majority)
- Reflections upon staff behavior (ethical issues, attitudes and emotions) in encounters with patients.

No question was asked about leadership, but lack of support from managers in handling violent incidents was described as a problem in the material.

Conclusion

A distinct leadership is called for and staff experiences should be taken into account to prevent and handle violent incidences in psychiatric inpatient care. Patient experiences of violent incidences should be investigated.

Educational Goals

Learning objectives for readers of the poster:
- Reflect upon essential values in treatment of patients and handling of violent incidences in psychiatric inpatient care.

- Discuss the role of leadership in preventing and handling violence, supporting victims and learning from experiences of critical incidents.

Correspondence

Mr. Lars Kjellin
University Health Care Research Center, Faculty of Medicine and Health, Örebro University, Sweden
P.O. Box 1613
SE-701 16 Örebro
Sweden
lars.kjellin@regionorebrolan.se

Violence prevention and organizational values: Views from management and staff in three types of psychiatric inpatient care

Poster

Ulrika Hylén, Karin Engström, Veikko Pelto-Piri, Lars Kjellin & Lars-Erik Warg (Sweden)

Background

The implementation of programs and policies to improve the care environment and prevent violence is common and important in health services. Prior research on violence prevention and risk assessment has often focused on evidence-based knowledge. It is, however, our assumption that prevention of violence is not only a question of evidence, but also a question of values. This research project strives to investigate how management and staff, in practice, balance the need for security against the values of health promotion and quality patient meetings.

Aim

The aim of the study was to explore the views of ward managers and staff members regarding prevention of violence and important values in patient meetings, as well as their views on whether the organization supports or impedes the care and treatment of patients.

Method

A case study design with multiple cases was used. Purposive sampling was applied to ensure three types of psychiatric inpatient units were included: addiction, forensic, and general psychiatric care. Semi structured interviews were conducted with 3 ward managers and 16 staff members, the latter in focus group settings. The material was analyzed using qualitative content analysis with an inductive approach.

Results

Preliminary results show three different approaches to working with violence prevention and organizational values.

1. Working with structure, creating policies, developing written routines and educating staff members in both ethics and how to deal with violence. Education was compulsory. Staff and managers alike gave credence to education and routines.

2. Process-oriented working strategies. Policies and written routines were not emphasised. Instead, staff and the manager learned from experience and from each other.

3. Staff works autonomously from the management. The management wanted to introduce new ways of working such as new policies and education, but staff members chose independently what to use.

In the first two cases the staff and the management had shared values, but in the third case there was a discrepancy in values between management and staff. In all interviews, the staff expressed an ambition to deliver good care, to be present in the ward and work closely with patients.

Conclusion

This study shows that there are different ways to prepare for new programs and policies in psychiatric inpatient care. In order to be successful when implementing new working methods, the management has to be aware of how the working group is functioning.

Shared values, trust and confidence between staff and management seem to be important for a successful process of implementation. Ward managers play a key role in creating and maintaining these shared values

and implementing new ways of working. In addition, this study indicates that the ambition to deliver good care may be a general shared value.

Educational Goals

- Discuss ways of implementing prevention programs in psychiatric inpatient care, taking the ward culture into account
- Reflect upon the importance of, and how to achieve, shared values between management and staff in preventing and handling violent incidents.

Correspondence

Ms. Ulrika Hylén
University Health Care Research Center, Faculty of Medicine and Health, Örebro University, Sweden
P.O. Box 1613
SE-701 16 Örebro
Sweden
ulrika.hylen@regionorebrolan.se

Risk predictions of physical aggression in acute psychiatric wards: accuracy, determination and suggested control interventions

Poster

Suna Uysa & Hulya Bilgin (Turkey)

Abstract

Nurses working in acute psychiatric wards are the ones who encounter, contact and communicate with patient firstly in the hospital (Björkdahl and et al. 2006, Doyle ve Dolan 2002). Therefore, accurate aggression risk prediction made by nurses using strong predictors is a protective and preventive factor (Kettles and Woods 2009).

This descriptive and cross-sectional study was conducted to make risk prediction of physical aggression, to define the accuracy and the features used in determination of the predictions and control interventions suggested for patients being treated in acute psychiatric wards.

The sample of the study consisted of 252 patients admitted in female and male wards during May&June 2012. In data collection, Risk Assessment Form for Patient Physical Aggression was used prepared in the basis on the literature and expert view.

In the data analysis, descriptive statistics (percentage and frequency distribution, average) and chi-square test were used.

The risk of physical aggression was predicted being low for more than half of the patients (%61,9;n=156). The ward characteristics had a higher utilization in prediction of aggression risk ("locked door" (n=95;%37,7), 'crowded' (n=61;%24,2), "lack of activity" (n=50;%19,8), "lack of staff" (n=48;%19,0). In accordance with risk predictions, communication with patient and observation were ranked as the first two interventions. The rate of patient who exhibited physical aggressive behaviour during the hospitalization was 15,5% (n=39). The rate of specified at risk for patients was higher in risk predictions of physical aggression (χ^2 = 35.072, p = 0.000). Furthermore, the likelihood of the patient not becoming violent rather than the likelihood of the patient becoming violent was more predicted correctly (specificity 76%, sensitivity 72%, negative predictive value 94%, positive predictive value 35%).

Accurate risk prediction of aggression was made by nurses working in acute psychiatric wards successfully. The ward characteristics had a higher utilization in prediction of aggression risk, thus, it is likely that nurses assess patients within their environment. To choose the non-coercive method is considered to exhibit a positive attitude in aggression management.

Educational Goals

1. To emphasize the importance of accurate risk estimation and make decision in aggression management in acute psychiatric wards
2. To present the nurses' roles and their tendencies to predict the risk of physical aggression for acute inpatients

Correspondence

Ms. Suna Uysal
PhD Student, Msc, Ward Manager and Psychiatric Nurse, Department of Psychiatry, Bakýrkoy Prof. Dr.
Mazhar Osman Research and Training Hospital for Psychiatry, Istanbul
Zuhuratbaba
34000 Istanbul
Turkey
sunauysl@hotmail.com

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

How a 24/7 Single point of entry service (SPOE) can increase access to Mental Health Services (MHS)

Paper

Ian McLauchlan (New Zealand)

Keywords: mental health, access, crisis line

Abstract

In order to make access to mental health services easier (MHS) for the population of the Wellington region a new service was established to act as a Single Point of Entry (SPOE). One of the aims of making access to MHS easier was to have people seen and treated before they became acutely unwell to the point of requiring compulsory assessment and treatment. A 24 hour crisis line was established alongside a referral management system for all referrals to MHS. This includes the Crisis Assessment & Treatment Team (CATT), all Child & Adolescent & Adult services, A & D services plus specialty services, such as Transcultural (Maori & Pasifika), Early Intervention Service and Maternal MHS. Te Haika is also the access point for people to apply for compulsory assessment and treatment under the Mental Health Act for friends and relatives. The name of the service is Te Haika which translates in Maori (indigenous people of NZ) as The Anchor. Since Te Haika has been operating, wait times are down and access rates are up. Feedback from consumers and their families/whanau has been positive.

Educational Goals

1. Attendees to understand how 24/7 crisis lines operate and how clinicians triage for risk.
2. For attendees to understand how easier access to assessment and treatment can reduce need for compulsion and thereby the risk of violence.

Correspondence

Mr. Ian McLauchlan
Capital & Coast District Health Board
Ambulance Drive
5024 Porirua
New Zealand
ian.mclauchlan@ccdhb.org.nz

No coercion without care!

Workshop

Minco Ruiter & Petra Schaftenaar (Netherlands)

Abstract

No Coercion without Care! That´s more easily said than done. It seems a paradox: coercion and care. And so it can feel to the patient as well: 'what do you mean care'? I feel punished! Despite all the efforts the (Forensic) Mental Health Field has made in the last decade to diminish the use of coercion and seclusion, it is still very difficult to change the focus on the question why coercion and seclusion is being used. Somehow we all are 'held hostage' in dealing with the disruptive behavior of the patient, while in crisis. And when only the disruptive or aggressive behavior is the focus, we can't find another solution than to use coercion or to seclude. When seclusion is used as the 'solution', even subconsciously, the patient will experience that he is the 'problem', the perpetrator, and that HE has to change. But at the same time, he feels completely the opposite: he feels a victim of the whole situation, he feels being abandoned, which can bring different kinds of negative feelings and no real solution at all. This process can happen after a (potential) aggressive incident, but also with a suicidal patient. There are a lot of suicidal patients being partly secluded because of their self-injury behavior.

So, in order to change our way of dealing with challenging behavior in crisis, we have to find another focus and another way of thinking as well. Therefore, at Inforsa, with our partly forensic and partly very high and intensive care clinics, we find our inspiration both from current studies, such as a 'the elements of a positive living climate' and theories on de-escalation as well as from internal analyses of our own practice.

We have learned from studies that a positive living climate, with much positive attention, responsiveness, a supportive atmosphere, perspective giving, less repressive and trust giving, really can make the difference. And that's what we also experience on the wards: when you methodically focus more on the positive behavior and on the relationship with the patients, the mutual understanding and trust will grow and the possibility of changing perspectives will be much easier.

We also learned from internal analyses and our own experiences. We learned, for example, that even in crisis, there are always some people who are able to make contact. They can de-escalate, where others fail. A focus on the relationship is therefore the key. They are able to connect more to the inner world of the patient. In our practice based way of intervening, we put energy into that, we try to find those care workers who have that 'click', we try to find ways to be available again for the patient, unconditionally, with time, patience, empathy, sincerity and a care based attitude.

This does not mean that coercion or seclusion does not occur anymore, it does. But it altered our methodical focus. Seclusion means disconnecting the relationship. So the focus must lie on reconnecting again. Our practice based focus in care, also during coercion, is now relational.

At Inforsa, we have two special trained and selected teams to do so, and/or to support the teams on the ward. And in this way, we can say: no coercion without care

Educational Goals

1. One can learn the necessities and possibilities of connecting and reconnecting
2. One can learn in which way relational care can bring solutions in troubled therapeutic relationships during coercion

Correspondence

Mr. Minco Ruiter
Inforsa, Arkin
Duivendrechtsekade 55
1096 AH Amsterdam
The Netherlands
minco.ruiter@inforsa.nl

Safety in MIND': Cross-organizational training to improve patient safety in crisis and restraint

Workshop

Natalie Hammond, Karen Wright & Ivan McGlen (UK)

Keywords: Cross-sector training, communication, collaboration, patient safety, crisis, restraint, Crisis Resource Management, place of safety detention.

Abstract

Within the UK, Emergency service personnel are often the first point of contact for a person suffering mental health crisis. Every year, some 11,000 people are taken to a 'Place of Safety' under the Mental Health Act. Within such situations, mental health, police and ambulance personnel converge, often with a lack of explicit understanding of each other's operational roles and priorities. Areas of working relationships that have immense patient safety concerns relate to the joint management of aggressive and violent behavior, especially in regard to deaths in restraint. Within such situations, 1 in every 2 deaths occurred whilst the individual was either detained under the Mental Health Act or in police custody (Independent Advisory Panel, 2010). Responding to the needs of the person experiencing mental health crisis and restraint therefore transcends professional boundaries. When expecting often disparate organizations to respond safely and appropriately to the person's (often complex) needs, a bridging program is required to facilitate a consensual and coordinated response.

The 'Safety in MIND' project, launched on 1 October 2014 across Greater London, seeks to provide this. Produced in partnership with South London and Maudsley NHS Foundation Trust, Metropolitan Police, University of Central Lancashire, and London Ambulance Service, 'Safety in MIND' (https://www.youtube.com/watch?v=E_CXyAhHQMo) is a cross-organizational training package which, used in conjunction with the ABCDE (Appearance and Atmosphere, Behavior, Communication, Danger & Environment) training program (Wright & McGlen, 2008), seeks to improve collaboration and minimize risk to the person in crisis and restraint when attended by police officers, ambulance crews, or mental health practitioners in relation to 5 domains:

- Cross-sector Communication:
- Cross- sector Roles & Responsibilities:
- Cross-sector understanding of Risks in Restraint:
- Cross-Sector Management of Medical Emergency:
- Cross- sector Crisis Resource Management:

Following its launch in October 2014, 40,000 Metropolitan Police Officers, London Ambulance Service and mental health personnel across Greater London will undergo training in 'Safety in MIND'.

Key contributors to this project include Lord Victor Adebowale, Professor Emeritus James Reason, Professor Hugh Montgomery, Professor Len Bowers, President Elect World Psychiatric Association Dinesh Bhugra, Metropolitan Police Commander Christine Jones, Nash Momori, Vice Chair Recovery College – expert through experience and Medical Director London Ambulance Service Dr Fionna Moore. This initiative was underpinned by the ABCDE training program, developed by Principal Lecturer Dr Karen Wright & Senior Lecturer Ivan McGlen, University of Central Lancashire.

Educational Goals

1. To improve cross-sector communication and response during restraint.
2. To illustrate the value of the 'Safety in Mind' project as a mechanism to improve collaboration and minimize risk to the person in crisis and restraint when attended by police officers, ambulance crews, or mental health practitioners.

Correspondence

Ms. Natalie Hammond
Director of Nursing & Quality - North Essex Partnership University Foundation Trust
Trust HQ, Stapleford House, 103 Stapleford Close
CM2 0QX Chelmsford
Essex (UK)
natalie.hammond@nepft.nhs.uk

Treatment of heavily disruptive patients: A Dutch model for complex care

Paper

Elvira van Wirdum & Martijn Helmerhorst (Netherlands)

Keywords: Disruption, aggression, untreatable clinical care, relational care

Introduction

Mental healthcare doesn't provide solutions and 'answers' for every service-user or patient. In clinical care, there will always be patients who are described as 'untreatable' and extremely difficult.

These patients show extremely disruptive behaviour like auto mutilation, aggression and are often difficult to engage in treatment. They tend to exhaust mental healthcare and community teams.

The policy focus in Dutch healthcare is outpatient treatment. By reducing clinical facilities, mental healthcare is to become less expensive. This results in problems, especially for patients who are depending on long term care. With the current emphasis in Dutch healthcare on results and effectiveness, organizations are likely to change admission criteria and patients with non-curable problems will be more inclined to drop out of treatment.

The Dutch clinics for intensive treatment offer treatment to this group of patients are unable to live on their own, suffer from severe disorders, are in constant need of care and can become so violent, that no-one wants to come near them. These patients need something special.

Article

The KIBs (kliniek voor intensieve behandeling/clinic for intensive treatment) were established in the eighties of the last century. They offer specialized treatment to clients who were considered untreatable and unmanageable in regular mental health care, as a result of their disturbed and aggressive behaviour. At that time treatment was focussed on control through a system of reward and punishment.

Since then, the clinics for intensive treatment have become established. At the moment there are seven KIBs, each with an individual expertise (children and adolescents, forensic clients, addiction, intellectual disability) but also with a strong communal and shared expertise. In order to increase collaboration between KIBs, and, as such, be of greater service to other mental health services, the KIBs organised themselves in a national cooperative body, KIB Nederland. This enables them to offer and share their expertise with referring organisations who struggle with the treatment of patients with severe and complex problems.

Patients are referred when they show severe behavioural problems and the relationship between patient and healthcare professionals are seriously disrupted. Severe aggression, acting out, suicidality, auto mutilation and manipulative behaviour are common problems.

The clinics of intensive treatment distinguish themselves by approaching problems in a different way. The disruptive behaviour is the main focus of the treatment, regardless of other problems or disorders. The clinics search for alternative hypothesis of the problematic behaviour. By reinforcing the patients' competences, providing structure and safety, and collaborating with patient and the primary responsible health care institution, these clinics manage to recover and restore the treatment relationship. Treatment goals are to diminish the disruptive behaviour, stimulate collaboration and responsibility and raise self-esteem and self-reliance.

Method

More often than not, referring teams have tried everything in terms of medication and standard treatment programs. Since that has clearly not lead to a decrease in problematic behaviour, something else is needed.

Not the crisis, but the individual disruption is the central point of attention. We try to break the impasse through a personal based approach. Treatment is aimed at breaking the negative spiral of acting-out

behaviour and resulting attempts to control this. We focus on underlying causes that cause and maintain the problem behaviour. The here and now, is what is important.

The client needs to regain control over his or her own life. Working on enhancement of competences and offering structure and safety are central elements in the treatment method.

This is achieved by:
1. Offering new perspective;
2. Relational approach;
3. Offering a healing and supportive therapeutic environment;
4. Searching for a new approach of the problematic behaviour.

Treatment components

The KIBs offer individual, person-centred care. During their stay in the KIB the patient follows an intensive and individual treatment program. This program consists of several components that together form an integrated whole. The KIBs offer a wide choice of creative therapies, vocational and day time activities that are supporting the individual goals of the patient. Treatment is aimed at controlling the symptoms as well as improving functioning of the patient.

Examples of treatment goals are:
- Increasing self-reliance;
- strengthen self-esteem;
- better emotion regulation and impulse control;
- learning to take responsibility for one's own behaviour / behaviour control;
- dealing with social rules;
- working with others;
- finding an satisfying and adequate daily routine.

In the past years the KIBs have become specialists in decreasing involuntary and coerced intervention, stabilizing the condition and working on creating an opening for treatment, time out, crisis interventions and diagnostics.

In addition the KIBs place strong emphasis on consulting and advising referring teams and organisations, both (and preferable) to try to prevent admission to the clinic as to provide helpful back up after the KIB treatment .

Conclusion and/or discussion

In the last 25 years the KIBs have established themselves as specialists in the treatment of patients who are characterized by very difficult and often severely disruptive behaviour. The field of mental health care, however, is ever changing and developing and constant attention needs to be given to maintaining a high standard of care and keeping up with developments in research and treatment.

Other factors that have to be taken into account are the social, political and economic developments in the greater society which influence not only funding but also, for instance, attitudes of the general public and policy makers towards our patients.

To consolidate our position KIB Nederland is currently working on a description of our specialism, our expertise, our treatment programs and the evidence and reasoning behind these. This will help our referring partners, policymakers, funding organisations, and others that are involved with these patients to understand what is that we offer, why we offer this and sustain the KIBS for the future.

Acknowledgements

References

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Educational Goals

1. After attending this presentation, participants know how Dutch mental healthcare is organized to help patients with severe disruptive problems.
2. After attending this presentation, participants learned how relational care can contribute to care with extremely disruptive patients.

Correspondence

Elvira van Wirdum
KIB Inforsa
Vlaardingenlaan 5
1059 GL Amsterdam
The Netherlands
Elvira.van.wirdum@inforsa.nl

Reducing the use of restrictive practices in Forensic Psychiatry – a case study illustration

Poster

Liselotte Mattison, Kelly Nielsen & Katrine Christiansen (Denmark)

Keywords: Reducing restrictive practices, case study, intervention strategies, forensic psychiatry

Background

The use of restrictive practices in psychiatric settings is of great concern in Denmark. The Danish government has a goal of reducing the use of restrictive practices by 50% before 2020. In spite of several efforts over many years, it has not been possible to show a continuous reduction in the use of restrictive practices, including the use of physical restraint. Hence, a recent national project across Denmark has been carried out over a three year period (2012-2015).

Aim

The aim of this study is to illustrate to what degree a single case study analyses may contribute to developing new or alternative practices in the effort to reduce the use of restrictive practices.

Method

Case study methodology was used. A case study is a way to empirically examine a phenomenon as it occurs as well as its related contextual conditions. The case study is a triangulated research strategy using multiple sources of data.

The study was conducted in a closed forensic psychiatric ward with 10 patients, of whom most have long-term admissions. The majority of patients are diagnosed within the schizophrenia spectrum disorder and all have committed a serious violent crime. The case study is based on one patient admission and the data are collected from start of admission in November 2013 through July 2015. A range of data is collected; including, risk assessments using Brøset Violence Checklist (BVC), registration of aggression and violence (SOAS-R), use of coercive measures, level of observation, use of medication, activity program and other clinical information extracted from file material such as long-term and acute intervention strategies in relation to aggressive behavior patterns.

Results and Conclusions

Results from the different data sources throughout the data collection will be presented. The patient's aggressive behaviour pattern and staff's use of restrictive practices are presented on a timeline and analysed in relation to the range of data sources. Implications for intervention practices will be discussed.

Educational Goals

1. Intervention strategies alternative to restrictive practices
2. Exemplifying a method to analyzing own clinical practice

Correspondence

Ms. Liselotte Mattison
Department of Forensic Psychiatry, Region Zealand
Annebergparken 30
4500 Nykøbing Sj.
Denmark
lima@regionsjaelland.dk

Professional behavior and attitudes to 'get in control'

Workshop

Sophie de Valk & Petra Schaftenaar (Netherlands)

Keywords: aggression, punishment, attitudes, professional behavior, group climate

Background

Aggression of clients in clinical psychiatry has a great impact on professional behaviour, because group workers often fear getting hurt and experience loss of control. To get in control again, group workers sometimes think that punishment is a solution.

Aims

(I) To investigate whether punishment is effective in clinical psychiatry, and if so, in what circumstances.
(II) To provide alternatives to punishment when dealing with aggression.
(III) To investigate which attitudes of group workers are relevant in whether or not a group worker will use punishment?

Methods

(I)+(II) Scientific evidence for the effectiveness of punishment in secure institutions was systematically reviewed using the databases Academic Search Premier, CINAHL, ERIC, PubMed and PsycInfo.

(III) To investigate the attitudes of future group workers in relation to aggression, an experimental design study is performed at the moment (February 2015): A group of 120 Social Work students are at random divided over three conditions. They all watched a short movie: one aggressive movie, one caring movie or one neutral movie. Aggressive attitudes are measured directly afterwards with the BDHI-D (Lange et al., 1995) and punitive attitudes with the new Punitive Attitudes Questionnaire (De Valk, in preparation).

Results

(I) The literature review showed that punishment is often a result of professional helplessness in the face of escalating aggressive situations. Only if group climate reflects trust and cooperation, punishment can occasionally be effective. When punishment is used for revenge or repression, coercive cycles of interaction between group workers and clients have a detrimental effect on group climate.

(II) To support group workers dealing with aggression several methods have been designed and implemented: Non-Violent Resistance (Omer, 2004), De-escalation supporters (Ruiter, 2013) and TOP-training (Boekee & Aseib, 2011). The first practice-based results are encouraging.

(III) The results of (III) will be presented during the workshop. It was hypothesized that students who watch the aggressive movie show more aggressive attitudes and consequently more punitive attitudes.

Conclusions

Group workers are responsible for creating an open group climate and have the difficult task to combine flexibility (e.g. therapeutic responsiveness) and control to maintain structure and safety at the living group. Experienced trust, regular contact and cooperation have been shown to improve mutual communication between group workers and patients. As a result, group workers feel more in control and display increased flexibility in their professional behaviour, which positively affects group climate.

Educational Goals

1. After attending this workshop, participants will have learned how to 'get into control' in a caring and safe way

2. After attending this workshop, participants will have experienced the way professional behaviour is affected by attitudes

Correspondence

Ms. Sophie de Valk
University of Applied Sciences Leiden
Zernikedreef 11
2333 CK Leiden
The Netherlands
valk.de.s@hsleiden.nl

Music listening as anxiety management in intensive psychiatry

Paper

Helle Nystrup Lund & Lars Rye Bertelsen (Denmark)

Keywords: Music, anxiety, force, intensive, psychiatry,

Abstract

In the spring of 2015 specially designed Music equipment was installed in 10 patient rooms in 2 units for intensive psychiatry at Aalborg University Hospital. This initiative is part of a national campaign aiming to reduce the use of force in psychiatry.

Several pilot studies in psychiatric hospitals in Denmark has documented positive effect reducing anxiety in patients using a music pillow with selected music for relaxation (Egelund, 2005 and Schou, 2007, Hannibal, Lund, Bonde, 2013).

The presenters will give an introduction to the equipment and the music intervention including audio examples of music for music listening, present new software for Ipad developed by music therapists – the "music star" as a new method to select music and discuss its status and outcomes.

2 presenters

Helle Nystrup Lund has a MA in music therapy from Aalborg University in 1995/2003. Since 2003 she has worked as a clinical Music Therapist Aalborg University Hospital. Cognitive Therapist since 2012. Her main experience is in adult psychiatry. Lund has published work on music listening groups, song writing and on music pillows in psychiatry. She also works as a professional jazz pianist and composer.

Lars Rye Bertelsen has a MA in music therapy from Aalborg University in 1997/2003. He is since 2011 employed as a clinical Music Therapist at Aalborg University Hospital. He has worked in private practise with various client groups since 1987 and is also GIM fellow (FAMI). Bertelsen is also a professional freelance drummer and singer.

Educational Goals

1. Learning objectives in cognitive and affective domains when presenting clinical perspectives on music listening and playing music examples (audio recordings).
2. Learning objective in the cognitive domain regarding presentation of music equipment.

Correspondence

Ms. Helle Nystrup Lund
Aalborg University Hospital - Psychiatry
Mølleparkvej 10
9000
Aalborg
Denmark
hnl@rn.dk

The Forensic Clinical Specialist Initiative: transforming practice by enhancing skills in risk minimization

Background

The Forensic Clinical Specialist (FCS) program is a government initiative in Victoria, Australia in which expert allied health clinicians enhance the service capacity of public mental health services. It was introduced in 2010.

Aims

The FCS initiative has been introduced to achieve skill enhancement and improved practice standards in the mental health workforce. It aims to assist the general mental health workforce to better assess, treat and manage people with forensic difficulties and offending behaviors.

Methods

FCS positions have been placed in ten locations, within existing public mental health services, across Victoria. Forensicare, a specialist forensic mental health agency provides training, support and supervision to the FCS clinicians. The FCS role includes specialist assessment and management recommendations as well as the fostering of improved collaboration and referral pathways between justice, clinical and community services. It also provides education and training to build capacity in the workforce to support forensic clients. The FCS also contributes to the improvement of organizational policies and procedures in provision of service to these consumers.

Results

Evaluation has shown that FCS enhanced services have adopted more systematic and evidence based approaches to risk identification, assessment and management. It has generated better informed risk management policies in the relevant mental health providers. This has resulted in a 26% reduction in referrals to Forensicare for the FCS enhanced services, while there has been a 30% increase state-wide from non FCS services.

Evaluation has also revealed a change in beliefs and attitudes among staff toward these consumers. In particular, there is a greater acceptance that these consumers are part of the target client group. More effective inter service communication around risk has been demonstrated, and referral pathways between the justice system and area mental health services have been strengthened.

Conclusions

The FCS initiative has thus far been successful in fostering improved service provision to forensic clients in the public mental health system in Victoria, reduced demand on the specialist forensic mental health agency and enabled a cultural shift in staff working with this group of people.

Educational Goals

- Audience members will learn about an example of transformative practice.
- Audience members will consider the benefits such an initiative might bring to their own clients and workplaces.

Correspondence

Mr. Patrick Seal
Victorian Institute of Forensic Mental Health (Eastern Health)
Murnong Community Mental Health Clinic, Bona Street
3135 East Ringwood, Victoria
Australia
patrick.seal@easternhealth.org.au

De-escalation processes in mental health settings – a co-operative inquiry project

Lene Lauge Berring, Liselotte Pedersen & Niels Buus (Denmark)

Keywords: De-escalation, Co-operative inquiry, restrictive practices, user-involvement

Background

It is a challenge to identify effective and safe tools to manage violence in mental health settings and at the same time reduce the use of coercive measures and restrictive practices.

Aim

The overall aim of the study was to investigate whether de-escalation can prevent and reduce coercive measures and restrictive practices in mental health settings. Based on qualitative research methods, we wanted to identify, describe and assess verbal and nonverbal de-escalating methods. De-escalation is an interactive process through which the patient is directed to a calmer personal space and which supports the aggressive patient's self-control.

Method

The project was carried out at one acute admission ward in the Zealand Region of Denmark. The ward had a long history of executing very strict treatment regimes, i.e.: excessive behavioral control and the use of M/R.

The design was a co-operative inquiry based on a constructivist approach. Service users and mental health workers were involved as co-researchers. They actively participated in deciding on the themes for inquiry and actions for implementation, which strengthened their sense of ownership of the project and the de-escalating methods.

The research methods used were ethnographic with participant observation and interviews, field-notes, focus groups, dialogical meetings and collection of clinical progress notes.

The interpretation of the present study was based on the theoretical framework of Symbolic Interactionism.

During the process, evaluation was done with the following data: BVC (Brøset Violence Checklist), SOAS-R (Staff Observation Aggression Scale) and registered coercion.

Results

Preliminary results revealed a certain pattern of how participants (patients and staff) make sense of aggressive incidents and of de-escalation. Furthermore, the use of co-operative inquiry achieved learning amongst people in and around the research process.

Preliminary Conclusion

Co-operative inquiry was well suited in order to identify, describe and assess de-escalations processes in mental health settings. Involving clinicians and service users as co-researcher to achieve learning in practice and helped developing people's reflections and capacity for reflection, which should influence their actions in aggressive situations. Participants' contribution to this practical research helped bridging the gap between theory and practice. In a broader perspective, the results of this study may contribute to increased knowledge of the effect of de-escalation processes in mental health.

Educational Goals

- To be aware of how learning can be achieved in research processes by involving people in a co-operative inquiry
- To understand how the co-operative inquiry method influences restrictive practices

Correspondence

Ms. Lene Lauge Berring
Region Zealand. Department of Psychiatry, Research Unit
Toftebakken 9
4000 Roskilde
Denmark
Tel: +45 28562921
lelb@regionsjaelland.dk

Implementation of a Crisis Intervention Model in a psychiatric clinic: The Response Method as an answer to reduce restraint and seclusion at Emergis Zeeland over seven years

Paper

Loubna Ouifak (Netherlands)

Keywords: Response Crisis Intervention Model, decreasing use of restraint and seclusion, implementing the Response Method during 7 years, implementing new model, Experiences of the co-workers difficulties, Self-Control

Abstract

In 2007 it appeared that the Netherlands was the European leader in the use of restraints and seclusion. The rate of seclusion and restraint use were so high that the national government gave priority and monies to decrease the rates of use of seclusion and restraint. Emergis choose the Response Crisis Intervention Model by A. Windcaller and implemented it in the whole organization. With leadership and supervision of A. Windcaller started a long-term collaboration and can we look back on seven years of experience.

In this article we describe the difficulties of implementing the Response Method and the successes we experienced along the way.

Method

The implementation of the Response Model and the experiences are described in this article. Experiences of the co-workers with the Response Method can be translated in the study of Aggression and Resilience of the Internet Spiegel and also measured in audits by the use of the Fidelity Scale.

The assignment was how to implement and secure the Response Method in times of economic changes.

Results

Since November 2008 the Response Method became part of the way we manage crisis and changed the attitude towards using restraint and seclusion.

Response Crisis Intervention Model requires using the Response Protocol to help change the culture of using restraint and seclusion.

Clients are responsible for their recovery and every crisis is an opportunity to change. Maintaining, and if need be regaining Self Control is the goal.

Conclusion

The experiences by implementing and securing a Crisis Intervention Model in a clinic are not obvious. Changing attitudes demands a long-term and resolute approach that includes constant self-reflection and continually increasing the skill of the workers through staff development. Implementation of a new model proved to be efficient by connecting to the recovery oriented organizational culture.

Investing in a sustainable implementation of the Response Model fits the current organizational culture and vision of an institute is the aim.

Educational Goals

- Sharing experiences about how to implement a model that aims change of attitude of co- workers
- Difficulties and how to overcome them
- Learning from successes

Correspondence

Ms. Loubna Ouifak
Emergis, Goes Zeeland
De Jongestraat 3
4531 GL Terneuzen
Netherlands
ouifak@emergis.nl

Violence and Restraint reduction SPSP–Mental Health/East London Foundation NHS Trust: Culture, Attitude, Data

Workshop

Johnathan MacLennan, Andy Cruikshank & David Hall (UK)

Abstract

SPSP-MH is part of the Scottish Patient Safety Program (SPSP). The SPSP-MH is a four year program (2012–2016) with an overall aim of Reducing the harm experienced by individuals in receipt of care from mental health services.

SPSP-MH has five work streams, to develop, spread, consolidate and support existing good practice around improvement and harm reduction. These work streams are: Communication at transitions, Leadership and culture, Restraint and seclusion, Risk assessment and safety planning,

Safer medicines management

ELFT aspires to provide care of the highest quality, in collaboration with those who use our services. ELFT is an organization that embraces continuous improvement and learning. Achieving this will mean having to think differently, be innovative, and give everyone, at every level, the skills they need to lead change. It will not be easy to build this culture, but focusing on what matters most to our service users and staff, and improving access to evidence-based care will make services more effective, give more power to staff and improve patient experience and outcomes.

Both the Scottish Patient Safety Program for Mental Health and East London Foundation NHS Trust have stated aims to reduce levels of violence and levels of restraint using quality improvement methodology. Violence and restraint are common phenomenon within our services but how it affects the system and those within it is not well understood and there are no standard operational processes to reliably reduce or eliminate it.

Both programs have at their core the systematic and sustained reduction of harm caused by violence and restraint and also those who witness the same.

There are over 60 wards in Scotland regularly reporting rates of restraint and there is a national aggregated data set with a current median value rate of 7 per 1000 bed days. A number of areas have rates lower than 2 per 1000 bed days and are developing evidence to suggest links between process and outcome.

Across ELFT wards using the violence reduction care bundle there has been a reduction of at least 50% in rates of violence. The reaction to and anticipation of violence highlighted the need for proactive intervention for higher risk patients which included the use of medication and faster transition from standard acute to intensive care. A crucial adjunct to this has been the sensitivity of staff to their patients' needs and the reduction of commonplace minor frustrations and delays associated with hospital care.

In the interactive workshop the presenters will demonstrate that there are a number of interdependent factors that have contributed to violence and restraint reductions in their respective areas. Delegates will be asked to discuss debate and consider the following potential key elements that contribute to reduced levels of both:

- The use of data to measure, monitor and suggest improvement/deterioration
- Patient carer and staff feedback
- Debrief following restraint/violent incidents
- The balance of theory and practical teaching in management of aggression
- The attitudinal and cultural elements of staff and services

Educational Goals

1. Understand the key components of an improvement program that are applicable to a mental health setting and in particular violence and restraint reduction. This will include the importance of collaboration with patients, carers and staff teams.
2. Be aware of the challenges and how to address these using improvement methodologies in mental health settings.
3. Know of results achieved across two collaboratives across a range of work streams. This will include sharing of change packages and measurement strategies.
4. Be able to connect to a wider network of professionals seeking improvement in mental healthcare and reduction in harm caused by violence and restraint so as to support attendees in their next steps.

Correspondence

Mr. Johnathan MacLennan
Healthcare Improvement Scotland
1 South Gyle Crescent
EH12 9EB Edinburgh
Scotland (UK)
Tel: +44 131 623 4299
Johnathan.maclennan1@nhs.net

Client participation 3.0

Paper

Mauro Vittali & Renske De Jong (Netherlands)

Keywords: Domesticity, trust, predictability, autonomy and participation

Abstract

"Think, Live, Do, Pursue together with courage and trust, balance and creativity "

This is our motto since the opening of the LIZ, a clinic for long-term intensive care that houses 44 complex psychiatric clients that have seen it all. Clients with a severe (multiple) psychiatric disorders in many cases in combination with a criminal record, aggression, addictions, behavioral problems and in some cases intellectual disability. All of them have been admitted to clinics for most of their lives. As a "last resort", the LIZ is asked to try new methods, see the problems from a different perspective in order to get the clients ready for less intensive care. We have five years to reach that goal.

The motto still stands today and all that we do in the treatment of our clients is based on the words above. Our focus is quality of life. Giving perspective to clients that have none (or very little) and breaking the circle of constant failure, (severe) aggression and exhaustion in treatment. The LIZ is a new chance of finding a way to a better life. Feeling save, domesticity, trust, predictability, autonomy and participation are keywords that give the treatment a greater chance of success and is the base of every person needed to develop.

For this abstract we will be focusing on real participation

On the LIZ we have a one on one team, de-escalation supporter and many other interventions to prevent or de-escalate aggression as soon as possible. But it's not about that one intervention or method, although important, secondary, it's the basic attitude towards your clients. Do you take them seriously as a human, do you listen without seeing them immediately as a patient with a problem and is your contact more than just functional. That's the LIZ's answer when it comes to reducing (aggression) incidents and prevent coercion and compulsion (such as solitary confinement).

Each (clinical) institution has a board with client representatives who consult and advise directors and management, and every ward has meetings once a week for the clients. Asking for an opinion isn't that difficult you would say. Because everyone knows that client participation is important, that it's vital for good care to listen, but most institutions are not going further than the board, ward meetings or for example a client satisfaction survey.

The LIZ goes a number of steps further than that. By truly seeing the qualities of the client, by actually using that quality, involve clients in their treatment and making policy decisions together. We let them take part in projects as an equal partner, we let clients give tours to external contacts, let them participate in audits and attend at job interviews with potential new employees.

Participation 3.0 LIZ style

Educational Goals

1. Knowledge: Describes how real client participation (3.0) contributes to a climate with fewer aggression incidents.
2. Application: Describes what is necessary to increase real client participation effectively.

Correspondence

Mr. Mauro Vittali
Inforsa
Duivendrechtsekade 55
1096AH Amsterdam
Netherlands
mauro.vittali@inforsa.nl

Creating safety: Client centered care or unit centered care?

Paper

Isabelle Jarrin, Anne Marie Brown, Annette McDougall, Andrea Rosner & Bonita Fanzega (Canada)

Keywords: Prevention, seclusion, client-centered care

Background

Acute mental health units strive for ways to create safe environments to facilitate patient's recovery. Seclusion and restraint have been recognized as unsafe practices for both patients and staff and there is nearly universal acceptance that reducing these practices must occur in mental health.

Aims

The Six Core Strategies initiative aims to work proactively with the individual client to increase the staff's understanding of the individual's specific needs of and how the treatment team can best work with the client to facilitate recovery. This approach requires acceptance of behaviours that may previously have resulted in seclusion or restraint episodes. Instead, the aim is to continue to dialogue with the patient, using principles of trauma informed care, to help identify potential triggers and interventions that can assist the client to remain in control and continue to be an active participate in their recovery.

Methods

Introducing new initiatives can often create challenges. In recognition of this fact opportunities for staff to question the seclusion reduction initiative and alternative methods to seek direct -service providers experiences have occurred. These opportunities prompted questions and observations worthy of further exploration.

Results

Staff recognizes the need to identify and address the individual's needs however; they have shared their concerns that individual behavior can be traumatic to others on the unit. In an effort to de-escalate and work together with a client to address their triggers, staff worry about the recovery and well-being of others clients. Observing a seclusion event has been identified as traumatic however staff have openly questioned, whether observing ongoing unsuccessful de-escalation attempts may also be traumatizing.

Conclusion

Direct service providers responsible for implementing program changes often cannot predict or are not asked about the potential impact of new practices. One strategy to acknowledge this reality is ongoing open and transparent dialogue between leadership and staff to identify issues related to the change and explore solutions to ensure safe care for all clients.

Educational Goals

1. Incorporate clinician feedback into evidence-based practices
2. Evaluate ethical aspects of evidence-based practices

Correspondence

Ms Isabelle Jarrin
Winnipeg Regional Health Authority
PX246-771 Bannatyne Avenue
R3E 3N4
Winnipeg
Canada
ijarrin@mts.net

Emotion Regulation through Sensory – Gardening: Managing Aggression of Adult Psychiatric Patients in an Inpatient Unit

Poster

Susan Rappaport, Leilanie Marie Ayala, Aimee Levine-Dickman, Nancy Wicks, Era Hawk, Curtis Boelke, Anna Kurtz & Jennifer Alcaide (USA)

Keywords: sensory-garden, adult, inpatient psychiatry unit

Background

"Recovery" refers to the lived or real experiences of persons as they accept and overcome the challenges of their disabilities (Deegan, 2009). The hospital inpatient staff is dedicated to implementing therapeutic group activities to promote patients' recovery from their illnesses in addition to decreasing the number of patient and staff injuries, assaults and the use of seclusion and restraints in the acute adult inpatient unit.

Aim

After conducting a literature review, the multidisciplinary team proposed the development of a sensory garden to engage hospitalized patients in a meaningful activity with the goal of decreasing patients' level of anxiety and improving their moods. Several studies have shown promising psychosocial benefits of gardening to those living with schizophrenia, depression, mood & anxiety disorders; as well as those recovering from addictions (Annerstedt & Wahrborg, P., 2011).

It has shown to decrease agitation among patients w ith dementia (Wear et al, 1024); decrease depressive symptoms (Gonzales& Kirkevold, 2011) and stress levels for individuals with psychiatric illnesses. The current inpatient program includes "Deck Time" when patients are able to go to the outdoor area attached to the inpatient unit with staff supervision. Unfortunately, at present, there is only limited scenery and visual stimulation on the deck, as well as limited structured group activities.

Method

Patients will participate in preparing the garden beds, planting and caring for the plants. Patients not wanting or able to garden will be encouraged to sit outside and create watercolors of the garden. Whether gardening or painting, these activities will employ the use of their five senses in ways that help with emotion regulation. After participating in the gardening activity, patients will be encouraged to share their thoughts and feelings about their experiences and will evaluate whether gardening helps foster a sense of purpose a nd hope; allays anxiety and improves their moods.

Results

This presentation will describe the project development process, and patients' feedback regarding mood improvement, and changes in their level of anxiety using a validated tool. The nursing staffs' assessment of the unit acuity , the number of seclusion and restraint episodes, PRN medications given and assault episodes (NDNQI) pre and post implementation of the program will be used to evaluate effectiveness of the program.

Educational Goals

1. The participants will identify how gardening can help decrease the episodes of aggression in an inpatient adult psychiatric setting.
2. The participants will describe how the process of gardening was implemented in an acute care psychiatric setting.

Correspondence

Ms. Susan Rappaport
UCLA health system – Resnick neuropsychiatric hospital
150 UCLA medical plaza
90095 Los Angeles
USA
srappaport@mednet.ucla.edu

Restraint Reduction – What Works? – A review of the Literature and Research Relating to the use of Restrictive Practices in Healthcare settings and how these might be implemented in practice

Paper

Christopher Stirling & Colin Dale (UK)

Abstract

This presentation will present the findings of an international study which:
- reviewed the literature relating to restrictive practices and in particular how these might be reduced
- Identified relevant research in relation to the use of de-escalation techniques in order to avoid the use of physical restraint.
- highlighted common themes and key learning points, which can be shared
- utilized the findings from the restraint reduction literature review to construct a checklist, based upon the available international evidence, which allows services to determine the extent to which this is evident in their practice

The review was focused upon: Educational settings, child and adolescent units, inpatient units; mental health units and wards; residential care; high security hospitals; psychiatric units or wards.
The period of the review was between 2004 and 2014 in order to ensure that the results would be current.

The countries/ continents covered are based on relevance to settings within England and Wales: USA, Canada, UK, Republic of Ireland, Europe, Australia and New Zealand.

The study found that there was wide international evidence base to draw upon. Nine previous relevant literature reviews were found and synthesized

Literature reviews show successful reduction programs include strong leadership from local management; external restraint review committees or post-incident debriefing and analysis and staff training and program changes at a local level.

Multimodal programs have the most reliable and significant results.

Behavioral and cognitive-behavioral programs appear to be useful in child and adolescent services.

In learning disability sectors management of maladaptive behavior may be an important factor in reducing restraint use. This goal could be achieved either by changing the target behavior itself, or by effective staff training.

In mental health care, successful programs included trauma-informed care training, changes to the physical characteristics of the therapeutic environment, and involvement of service users in treatment planning.

Flexibility and responsiveness for clinicians and managers was seen to be essential.

Overcoming barriers and staff resistance is needed for implementation of effective restraint reduction strategies.

The findings from the literature review on restraint reduction were analyzed to consider how they might contribute to a checklist for services. The findings were re-worded (where necessary) in such a way to make them measurable.

It was noted that there was a plethora of policy documents available in the health, education and social services sector and this were developed into a separate checklist for services to evaluate policy compliance.

The evidence based checklist was developed separately to the policy checklist and was peer reviewed for its relevance and findings

Three NHS Trusts are keen to pilot the Checklists and pilot work will commence in March 2015.

Completion of the pilot work is anticipated for Summer 2015 and findings will be available for the conference.

Educational Goals

- Following attendance at this presentation delegates will be able to:
- Describe the most effective means by which restraint can be reduced by services
- Utilize a restraint checklist which has proven efficacy in reducing the use of restraint in services

Correspondence

Mr. Christopher Stirling
Crisis Prevention Institute Europe
15-17 Britannia Road
M33 2AA Manchester
UK
cstirling@CrisisPrevention.com

Sensory rooms in acute psychiatric care: primary and secondary violence prevention

Paper

Anna Björkdahl (Sweden)

Abstract

The use of sensory rooms first developed about 50 years ago mainly to offer demand free sensory stimulation to persons with severe neurological multi handicap and learning disabilities. The aim was to enrich their sensory input and stimulate brain functioning. Since then, sensory rooms have been introduced in many different health care environments such as dementia care, brain injury rehabilitation and to some extent in psychiatric care.

The environment of sensory rooms stimulates sight, smell, hearing, touch and taste, and may include items such as lights, pictures, painted walls, aromatic oils, music player, video, weighted blanket, comfortable furniture and cushions. The aim of sensory rooms today is to offer patients a place to relax, ease distress and to perform and develop 'self-soothing' routines. Patients are encouraged to make individual choices of what sensory input they wish to use during their stay in the room.

We conducted a clinical development project between 2012 and 2014, where sensory rooms of equal type and design were introduced and developed on ten different psychiatric inpatient wards in Stockholm, Sweden. The sensory rooms were accessible for patients 24 hours a day and always used on a voluntary basis. The patient could choose to stay in the room on their own or be accompanied by a nurse. The aim of this project was i) to describe patients' experiences of using the room, ii) to evaluate if the rooms could represent an increased risk for patient safety, iii)to describe the experiences of staff working with sensory rooms and iv) to survey quantitative data on the use of the rooms. For data collection, we used individual interviews, questionnaires, sensory room charts, staff group meetings and a blog.

We found that the rooms were frequently used by both male and female patients representing many different and often acute mental health conditions. Approximately 10 000 visits were made by patients during the project. None of these visits included any type of severe negative incident, such as self-harm, suicidal behavior, violence or vandalism. A majority of patients experienced enhanced well-being and calm. Many were surprised by the positive effects on anxiety, sleep problems and agitation. Similarly, staff experienced the rooms as something positive for patients but also for the whole ward atmosphere. They described that by encouraging patients to use the room, they could promote patients' emotional self-care and learn to become less controlling, and the room was found to often defuse aggressive situations.

Educational Goals

- Describe patients' and staff experiences of sensory rooms in acute psychiatry.
- Discuss how sensory rooms can be implemented in psychiatric inpatient care.

Correspondence

Dr Anna Björkdahl
Centre of Psychiatric Research and Education
Norra Stationsgatan 69, plan 7
SE11364 Stockholm
Sweden
anna.bjorkdahl@sll.se

Implementing the Six Core Strategies (6CS) to reduce physical restraint in the UK: The 'REsTRAIN YOURSELF' project

Paper

Joy Duxbury, Fiona Jones, John Baker, Mick McKeown, Richard Whittington, Gill Thomson, Paul Greenwood & Soo Downe (UK)

Abstract

Physical restraint is a coercive intervention used to prevent individuals in mental health services from harming themselves or others. It is only meant to be used as a 'last resort'. Nonetheless, it continues to be used routinely in mental health services. A number of adverse effects have been reported as a result of the use of restraint, ranging from patient and staff discomfort to injuries resulting in death.

Empirical evidence from the UK and North America clearly demonstrates that rate variation in restraint and seclusion is largely influenced by environmental, or contextual, factors. Unclear policy and guidelines, overcrowding, poor ward design, low or inflexible staff numbers, inexperienced staff, poor staff retention, poor information sharing and service user acuity have all been implicated. Unsurprisingly, a number of studies have also shown that various staff characteristics are linked to the development of aggression and violence in mental health patients, including negative interactional styles, provocative, authoritarian behavior and poor communication skills. Hence, a substantial body of evidence indicates that many seclusion and restraint episodes may be preventable if these contextual factors are addressed.

Using an overarching multi-method evaluative design we examined the impact and process of implementing a restraint minimization approach adapted from the Six Core Strategies called REsTRAIN YOURSELF (RY) (Lebel et al 2014) across 8 inpatient mental health units in the North West of England using a range of data collection methods.

The objectives of the evaluation were to:
1. Prepare for the tailoring and implementation of RY
2. Undertake pre-tests to form a diagnostic and contextual analysis of the current baseline for change
3. Evaluate the process, outcomes, and sustainability of the practice change using post tests and realist evaluation

Within this design there were three phases of activity: The first phase was preparatory and involved workshops and a train the trainer program. A pre-post quasi–experimental method was used in phase 2 and realist evaluation for the third phase of the project. Multi-methods including a range of survey measures, interviews, focus groups (with patients, staff, trainers) and rapid ethnography were employed. We are in the process of phase three but will be in a position to report upon some early findings on the efficacy of the intervention and relationship between intervention components and outcomes; whether strategies were implemented as planned; expected or unexpected outcomes and facilitators and barriers to the implementation process.

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Educational Goals

For participants 2 intended learning outcomes are to:
- Gain an understanding of implementing a dedicated minimisation approach to restraint reduction in inpatient mental health settings
- Learn lessons from the process and outcomes of implementation in this area of practice

Correspondence

Ms. Joy Duxbury
University of Central Lancashire
Adelphi Street
PR12HE Preston
United Kingdom
JDuxbury@uclan.ac.uk

Normalizing the Environment: The Appearance of the Emergency Department Safe Rooms

Michael Polacek & Dana Hart (USA)

Introduction

For children, adolescents and adults experiencing severe psychiatric/mental health (PMH) and substance toxicity crisis, the emergency department (ED) provides a safe social, emotional, and physical environment that protects both patient and staff while ensuring crisis stabilization. Environmental factors such as unit atmosphere and physical appearance (McAndrew, Chambers, Nolan, Thomas, & Watts, 2013) can impact mood while playing a pivotal role in the optimal delivery and outcomes of care (O'Connor et al., 2012). Using passive interventions in care environments such as color (Liu, Ji, Chen, & Ye, 2014) and ambient light to reduce anxiety and agitation can invite engagement by sending a message of care and patient centeredness (Karlin, & Zeiss, 2006). This paper aims to describe how an interdisciplinary team of clinicians in the ED improved the appearance of their PMH treatment area and to determine if appearance influenced the stabilization of patients in crisis.

Background

During a "Walk in My Shoes" event in April 2014, one of the executive participants observed that the area used to care for PMH patients appeared to be more like a correctional facility than a place of healing and caring. The lead author was invited to collaborate with an ED workgroup led by the second author and ED Tech Greg Hauth to explore ways to make the rooms appear less correctional in appearance. Frequent complaints from patients, their friends and family and staff had identified that the entire area used to care for PMH patients was untherapeutic and "felt like a jail." This project took place in a 60-bed ED located within a Magnet® designated not-for-profit Level II Trauma Center with 458 acute care beds situated in the Pacific Northwest region of the United States and one of the busiest on the West Coast. Patients varied from children and adolescents to all ages of adults suffering from many forms of PMH conditions including alcohol and substance toxicity.

An area in the back of the ED was specifically designed to serve this population and was separated from the general ED by double, unlocked doors and continually staffed by an ED Tech or ED Registered Nurse. Within this area were three secure rooms with electronic locking doors, cameras, speaker system, a soft chair and specially designed bed attached to the floor that enables physical restraints. Together with the ED physician assigned to this area, the care team included the ED Tech, RN, Mental Health Evaluators along with the ED pharmacist and hospital security.

Original Design Characteristics

This ED facility was constructed in 2009 and used seclusion design features that would ensure the physical safety of both staff and violent patients. These rooms are commonly known as seclusion rooms because their design supports "involuntary confinement of a client alone in a room, which the client is prevented from leaving" (Knox, & Holloman, 2012, p.35-36). When a physician determines that the patient is unable to be safe from harm to self or others or is gravely disabled, they have the option to order a legal hold that permits the confinement of patients to a locked seclusion room. Walls were covered with a white impact resistant surface that gave some protection for the prevention of injuries related to head banging or striking with a body part while being easily cleanable. The heavy steel doors were painted dark grey to match organizational color branding, simplify repainting and were locked using a powerful magnet system. Windows were made of industrial grade safety glass. Inside each room there was a security camera, intercom and a bed that was molded in hard plastic and attached to the floor.

The design and décor prudently focused upon creating a space of physical safety and confinement. Persons admitted to these rooms were physically safe and secure; however, because of the correctional appearance, they were not emotionally or psychologically safe (Eris, & Kulac, 2014). There are broad guidelines for the design of these rooms that consider both physical and psychological safety (Department of Veterans

Affairs, 2014) (British Ministry of Health, 2012) (Shepley, & Pasha, 2013), such as avoiding white walls and the use of soft, comforting colors. However, the walls and ceiling in these rooms were bright white, doors and door/window frames were painted with a dark grey. The flooring was a soft tan with a type of flowing stipe feature to give the room some sense of normalcy.

Methods and Results

This quasi-experiment compared the length of stay (LOS) and utilization of security staff before and after making design changes to the ED safe rooms. Due to the complex requirements of collecting human subject data, the team decided not to collect input from participants. The null hypothesis selected was that the color of doors and quality of light would have no influence on LOS or utilization of security. Two primary interventions were covering the lights with faux skylights (photographic film over the light covers, and painting doors and door/windows frames a softer tone of slate blue. A secondary intervention was to change room labels from "psychiatric" or "P" to "safe" and "S" rooms. Comparison data were collected six months before and then collected for three months after implementation of these three interventions. These data were (a) mean LOS; (b.) number of security visits; and (c) total security staff hours expended. These data were compiled from all patients admitted into the ED safe rooms without regard of age or chief concern/diagnosis. Security utilization data only included response to actual or potential for violence.

The shaded months in the table below report on data after the interventions.

	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
Room Visits	140	151	141	170	133	110	136	109	136	162	153	140
LOS (hours)	7.5	8.4	8.4	8.3	9.0	10.4	8.7	9.2	8.3	7.3	7.3	8.0
Security visits	271	291	329	346	349	353	343	346	342	392	386	356
Security hours	94	109	128	129	137	125	133	114	130	140	139	143

Study Results

The average LOS decreased over 8% from 8.7 to 8.0 while the monthly mean visits to the ED safe rooms increased over 10% from 136 to 152. Security response increased over 12% from 330 to 378 while the average monthly security man-hours increased over 13 % from 122 to 140.

Variables that were unaccounted for include an inability to determine if one or two security staff were available for response, some events may have required a significantly more number of security staff response and other indeterminable variation in acuity needs.

Discussion

The data indicates that despite more patients visiting these ED safe rooms, they attained crisis stabilization more rapidly after the lighting was improved and the doors were painted a calmer color. On the other hand, more and longer security visits may have contributed to reducing the LOS. Although this study is unable to determine causal association, reducing the LOS was an important outcome of this project. In addition to examining a longer study duration, future studies include examining any change in rate of injuries and exploring the experiences of patients, their friends and family and staff. There is little question that the appearance of a care environment influences the customer's perception of being treated as a person. Both the psychosocial and physical environment are chief contributors to the engagement of both patients and nurses (Delaney & Johnson, 2014). Patient and staff engagement is a pillar of safe environments (Polacek et al, 2015) and nursing performance (Pelletier & Stichler, 2013). Engaged patients collaborate with care resulting in swifter stabilization. Utilizing passive and inexpensive interventions in ED safe room design may help to reduce the trauma associated with PMH crisis and improve outcomes for very little cost. Humanizing this environment takes on even more importance when considering that all ages and conditions are treated in the same place.

Conclusion

More research specific to the ED is needed to explore patient experiences. Active collaboration between facilities and clinical leadership while designing and planning ED environments to provide both physical and psychological safety. To sum up this project, one staff member said it best, "At the very least, our customers will see that we are doing *something* to show that we care about them as persons and fellow humans." Making every effort to humanize the environment of care is imperative—not optional.

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Educational Goals

- Participants will consider the benefits of inexpensive and passive interventions to improve quality of care.
- Participants will recognize the value in how the environment contributes to patient experience

Correspondence

Mr. Michael Polacek
Salem Health
890 Oak St SE
97309 Salem, OR
United States of America
michael.polacek@salemhealth.org

High and Intensive Care in Psychiatry: a validity study of the HIC-monitor

Paper

Laura van Melle, Yolande Voskes, Eric Noorthoorn, Roland van de Sande, Yolanda Nijssen, Niels Mulder & Guy Widdershoven (Netherlands)

Keywords: high and intensive care, high and intensive care monitor, quality of care, instrument development, implementation

Abstract

High and Intensive Care (HIC) is an acute admission ward for patients in severe mental crisis. The ambulatory care is no longer adequate and a closed admission setting is needed to provide necessary care. The HIC-model represents a new vision on mental health care and aims at improving the quality of care as well as reducing seclusion.

In order to measure the implementation of professional, organizational and architectural features of the HIC-model, the HIC-monitor has been developed. The HIC-monitor consists of 65 items divided over thirteen dimensions: team structure, team processes, diagnostics, treatment and treatment interventions, monitoring, professionalization, the Psychiatric Hospitals Compulsory Admissions Act (BOPZ), Electronic Patient Record, environmental design, safety and evaluation and feedback on coercive measures. The current set of items originated from experiences, scientific research and expert consensus and asks for further empirical evidence.

The aim of this study is to evaluate the applicability, validity and inter-rater reliability of the HIC-monitor, an instrument designed to improve model fidelity and to measure the implementation of HIC.

This mixed-method study was conducted in 38 inpatient adult psychiatric care units in the Netherlands. These wards were all implementing HIC. Over the period of one year, audits took place at these units by a team of 26 auditors. During an audit, two auditors independently assessed whether the unit met the HIC-standards by scoring the HIC-monitor.

This resulted in a total of 76 audit reports . In dialogue sessions at the wards and in reflection meetings with the auditors, feedback was collected on the HIC-model and on the HIC-monitor. Moreover, professionals were interviewed about the implementation process of the HIC- model. At this moment we are in the phase of analysis. In this session, initial results from the analysis of the validity and reliability of the HIC-monitor and the implementation process will be discussed.

Educational Goals

1. To learn about the HIC monitor
2. Analyzing the validity and reliability of the HIC-monitor using mixed-method data
3. Describe the implementation of the HIC- model by using the HIC- monitor

Correspondence

Ms. Laura van Melle
VU university medical center
Kerdijkhof 40
1067MN Amsterdam
The Netherlands
a.vanmelle@vumc.nl

High and Intensive Care: a new vision on mental health care in Dutch psychiatry

Paper

Yolande Voskes, Laura van Melle, Tom van Mierlo, Frits Bovenberg & Niels Mulder (Netherlands

Keywords: High and Intensive Care, reduction of seclusion, recovery

Abstract

In recent years, mental healthcare institutions in the Netherlands started projects to reduce seclusion. The projects have resulted in improvements in mental health care and in the decline of both the number and duration of seclusions. However, psychiatric patients are still secluded. To achieve further reduction of seclusion as well as to reduce the number of beds in mental health care institutions, a group of professionals started the development of High and Intensive Care (HIC) in mental health care.

Previous research on the reduction of seclusion in the Netherlands, evidence based practices, experience based practices and consensus meetings with all stakeholders (patients, peer providers, family, nurses, psychiatrists, managers and researchers) were the basis of this new vision on mental health care in the Netherlands. In this new vision, the ambulatory care plays a leading role during admission. Admission is seen as a temporary interruption of outpatient treatment.

On the HIC, aspects of recovery based care and the medical model are integrated. The starting point for HIC is the improvement of the autonomy of patients in order to facilitate recovery, at least to a level at where the patient can resume everyday life outside the HIC. At a HIC ward, a combination is made of an high care unit (HC) and an intensive care unit (IC) to provide stepped care. A patient in crisis is initially admitted at the High Care unit.

Restoring and maintaining contact and a preventive way of working are central elements of the HC. The IC is a physical space within the whole of the HIC. If the care of the HC is insufficient, a transfer to the IC is possible. The IC consists of several Intensive Care Units (ICUs).Transfer to the IC should be avoided.

The motto is: 'The best IC is an empty IC". The IC consists of one or more 'secure rooms'. The secure room is a closed room and is therefore seen as a coercive measure. The secure room is the very last step and is only used in case of emergencies. In this session the model of HIC and the developments in the Netherlands are presented.

Educational Goals

1. To describe the concept of High and Intensive Care in psychiatry
2. To improve the quality of care in mental health care institutions
3. To reduce seclusion in mental health care institutions

Correspondence

Ms. Yolande Voskes
VU University medical centre
Van der Boechorstsraat 7
1081 BT Amsterdam
the Netherlands
y.voskes@gmail.com

Extreme Coercion and recovery journeys in a high secure hospital: stories of recalcitrance, resistance and cooperation

Paper

Mick McKeown, Mark Chandley, Fiona Jones, Karen Wright, Joy Duxbury & Paul Foy (UK)

Background

This paper reports on the findings of two inter-linked qualitative research studies undertaken within a high secure mental health hospital in England (UK). The first study explored service user and staff views and sense-making of the policy of recovery. The second inquired into service user and staff experiences of extreme coercive measures, such as extreme forms of restraint and long-term seclusion or segregation. Only a handful of published papers exist on the topic of recovery in wider forensic care environments, with some discussion of notions of personal 'redemption' (see Allen 2010, Ayres et al. 2014, Chandley & Rouski 2014, Drennan & Aldred 2012, Ferrito et al. 2012, Livingston et al. 2012, Mezey et al. 2010, Pouncey & Lukens 2010, Turton et al. 2011).

Aims

The studies respectively aimed to explore (i) diverse viewpoints as to how people make sense of recovery and experiences of recovery oriented assessment and treatment initiatives within the hospital (ii) experiences of extreme coercive measures within the high secure context and contemplation of possible alternatives.

Methods

In the first study 30 staff and 25 service users participated, and in the second study 20 staff and 20 service users. Both studies involved either semi-structured interviews or focus groups. All data was subject to thematic analysis.

Findings

Identified themes include: Study (i): different understandings of recovery; the importance of meaningful occupation; staff-service user relationships; recovery journeys and dialogue with the past; and recovery as personal responsibility. Study (ii): good and bad coercion; cooperation, resistance and recalcitrance; and alternatives to coercion.

Discussion

Critical social theory is drawn upon to illuminate understanding of coercive practices, existing alongside attempts to implement recovery oriented services, within the high secure context. The research findings suggest that cooperation is largely framed by services in terms of acceptance of, and compliance with, a bio-medical model. The impact of the secure environment, whilst ever-present, is not an absolute constraint on the realization of recovery objectives. Findings framing understandings of recovery in terms of individual journeying were evident for patients and staff. Reflections involve a sense of both looking back, into personal histories and the chequered history of the institution, and looking forward, often, but not exclusively, with the sort of hope implied in standard definitions of recovery. The availability of extreme coercive measures raises some seemingly paradoxical understandings from both service user and staff perspectives.

Conclusions

An interesting avenue for future research is further exploration of the meaningfulness of recalcitrance in this environment, and whether different understandings of cooperation will become increasingly evident

with the adoption of more sophisticated thinking and practice related to recovery, including alternatives to extreme coercion or potential consensus upon its legitimacy under certain circumstances.

Educational Goals

1. Attendees will be able to demonstrate enhanced appreciation and understanding of the inter-relationships between policies framed by recovery and the use of extreme coercive practices
2. Attendees will have the opportunity to engage in critical discussion of the circumstances under which extreme coercion is legitimated and possible alternatives.

Correspondence

Mr. Mick McKeown
University of Central Lancashire
School of Nursing
PR1 2HE Preston
UK
mmckeown@uclan.ac.uk

Co-productivity – a cross agency partnership for education and skills acquisition: the TEAM course ('Teaching Effective Aggression Management')

Poster

Karen Wright, Iain Harbison & Tiffany Sinclair (UK)

Abstract

Maintaining contemporary knowledge, expertise and skill is a moving target, by definition. Here in Lancashire, England we have developed a program of study which tries to meet national directives, moves with the changing needs of service and enables attendees to gain an academic award.

The Graduate Certificate: Teaching Effective Aggression Management is a course that was developed with services users, clinicians and educators to provide compassionate approaches.

We have created an honest and transparent environment that has eroded the 'restraint is a dirty secret' myth. We found that involving service users to discuss their experiences and interventions that contributed to their recovery, we were able to shine a light on practices good and bad and also challenge paternalistic attitudes.

Educators, healthcare professionals and service users work together in both teaching and assessing the students.

This course has just celebrated its tenth anniversary , but we're not standing still. Every year we consider aspects that shift with changing policy and directives. Additionally we have shifted the focus away from restraint and onto environmental and interpersonal aspects. Hence attempting to establish safe places, humane relationships and compassionate and recovery focussed care.

Educational Goals

1. Demonstration of an academic pathway for healthcare professionals to gains skills and expertise in reducing restrictive practice.
2. Promotion of a compassionate response to the distressed.

Correspondence

Ms,. Karen Wright
University of Central Lancashire, School of Health
R347 Brook Building
PR1 2HE PRESTON
UK
kmwright1@uclan.ac.uk

Can implementing a Quiet Room reduce the use of mechanical restraints?

Poster

Stella Bonde, Lena Rasmussen & Lene Lauge Berring (Denmark)

Keywords: Quiet room, de-escalation, restraint, violence, action research, psychiatric intensive care unit

Background

In order to reduce the use of mechanical restraints, this project aimed to implement a Quiet Room in a Psychiatric Intensive Care Unit (PICU). Previous studies has demonstrated that quiet rooms, such as comfort rooms (Cf. Cummings, Grandfield and Coldwell, 2010) and sensory rooms(Cf. Bjôrkdahl 2015), contributed to higher patient satisfaction and lower rates of violence, seclusion and restraints. This poster describes the preliminary results and the implementations process.

Aim

The study aim was to 1) reduce the use of coercive measures such as mechanical restraints, 2) redirect agitated, threatening and violent patients toward a calmer personal space, and 3) offer the patients a quiet, clean and relaxing room in the unit where they were able to relax in a 'staff and co-patient free zone'.

Method

A quiet room was implemented at a Psychiatric Intensive Care Unit. The room was designed with relaxing furniture's such as a comfortable chair, a 'special calming down chair', quiet music and nice pictures on the wall. All staff in the unit was taught how and when to utilize the quiet room and all patients entering the unit were introduced to the room. The room should be utilized when patients show signs of distress, anger or agitated behavior. In such situations the nurse enters into a dialogue with the patient and offers the quiet room. Furthermore, patients themselves may request to use the quiet room. Study data was collected since September 2014 until September 2015. Data consists of questionnaires with structured and semi-structured questions answered by patients and staff after each use of the room. Further, the use of coercive measures was registered throughout the data collection.

Preliminary Results

Until now the room was used 150 times for at mean period of 1 hour. 66 different patients used the room between 1 and 5 times. Staff and patients report that coercive measures were avoided, however, we were not able to identify any changes within the registered use of mechanical restraints. Generally, patients experienced great benefits and reported that they appreciated the opportunity to withdraw to a room, which were not their ordinary patient room.

Preliminary Conclusion

Staff and patients were appreciating the implementation of a quiet room. The concept has been adjusted toward the users' expectations and we have initiated a longer trial in order to follow the effect on mechanical restraints over a longer period of time.

Educational Goals

- To understand the implementations process by being aware of the opportunities and challenges within the system
- To take note on the difficulties in monitoring effect of altered caring-approaches such as a quiet room

Correspondence

Ms. Stella Bonde
Region Zeeland Psykiatrien Vest
Ingemannsvej 18, V1
4200 Slagelse
Denmark
smhn@regionsjaelland.dk

1on1-support to reduce seclusion and to improve care

Poster

Petra Schaftenaar & Minco Ruiter (Netherlands)

Keywords: 1on1-support, seclusion, innovative care, research

Background

The reduction of coercion, restraint and seclusion is an important goal in the Dutch mental health care since the beginning of the 00's. Alternatives are tested and best practices were developed, supported by scientific research. At Inforsa, specific interventions were developed to contribute to this improvement. This poster will show the results of a study on the effect and experiences of 1on1-support.

Theoretical framework

The use of coercion is a very disruptive and undesirable part of psychiatric treatment that needs to be avoided. Coercion and seclusion are final points in treatment, which need to be deployed very carefully. In clinical psychiatry, aggression is a common problem and an indicator for the use of seclusion. Seclusion is often employed where safety is a problem, due to behavior of patients.

Previous research shows that interaction between staff and patients is related to aggression incidents. We also know that communication (problems) (lack of) reflexivity and organizational culture are important factors in making decision to seclude. What we do and the way we do it, can escalate or de-escalate situations. That makes aggression interactive and the restoration of conflict situations relational. The relationship between caregiver and patient is important, because the quality of life depends on this relation-ship, even more in situations of seclusion. Staff needs to be de-escalating, with an attitude of care and compassion. They must be sensitive for the experiences and needs of the patient during the seclusion.

1on1-support is given in situations of (or to prevent) seclusion.

The present study

This research was conducted to explore the value and meaning of the given 1on1-support, as narrated by patients, staff, the 1on1-teams and managers. Focus groups and interviews were conducted. Purposeful sampling has taken place. Data was analyzed by two researchers, using thematic analyses and sensitizing concepts.

Informed consent was given by all participants in the study

Results

Results can be divided in two parts:
1. What is it that 1on1 does and how is it experienced?
2. How does 1on1-support contribute?
Both of these results are depicted in models at the poster.

Conclusion

On-on-support contributes in direct relation with patients by the way they work: there's space, time, creativity and the possibility of giving voice. Parts of these results are related to not being part of the treatment team. 1on1-supporters also coach the treatment teams. It brings reflexivity and deliberation in complex care situations and it improves the connection between patient and staff.

Educational Goals

• To show how innovative concepts can contribute to deliver better care in complex situations.

Correspondence

Ms. Petra Schaftenaar
Inforsa
Duivendrechtsekade 55
1096 AH Amsterdam
The Netherlands
p.schaftenaar@ziggo.nl

Setting the stage for a new approach to coercive interventions in Belgian Mental Health Care

Poster

Frieda Matthys, Chris Bervoets (Belgium)

Keywords: coercion, definition of coercive measures, recommendations for control and restraint

Background

Coercive interventions are common in mental healthcare and involve acting against an individual's autonomy. Generalization of the results of research on coercive interventions remains largely impossible due to differences between countries with regard to mental health care organization, cultural and ethical views on coercion and incomplete data registration.

Aims

1. To provide a clinical definition and framework for coercive measures and to describe good medical practices in coercion;
2. To describe recommendations for service providers in order to substantiate these good medical practices.

Method

A working group within the Superior Health Council of Belgium reviewed the existing literature on epidemiology of coercive interventions, seclusion and restraint, involuntary admission and coercive medication. The relation between conflict and containment, from the caregiver's and the patient's point of view, together with an introduction into setup and the results of the "Safewards" trial was commented on by the research group, in debate with our working group. All information was compiled in a recommendation. In order to create a widely supported advice, this recommendation was also sent out to stakeholders amending the text proposal.

Result

We argue that there should be a prima facie ban on coercion in mental healthcare. The use of coercive practices needs to be justified in the context of an additional medical prescription for the treatment of a specific symptom. This implies the use of an evidence based strategy and the accordance with quality standards. Moreover, if a coercive intervention is deemed necessary, it should only be carried out in a psychiatric intensive care unit2 by specifically trained staff. In order to achieve the highest clinical quality standards, future research of the highest methodological standards should be set up to compare the effectiveness and safety of coercive measures for the aforementioned symptom control with the best pharmacological and psychotherapeutic standards. If a coercive measure fails to be proved at least as effective as other less coercive strategies it should be abandoned from using it.

Conclusion

The use of this guidance has the potential to lessen the prevalence and extent of coercion in mental healthcare by eliminating all coercion that is not a responsive decision to the acute symptoms of the patient.

Educational Goals

1. Generalizability of a definition of coercion
2. Coercion as a medical prescription

Correspondence

Ms. Frieda Matthys
Vrije Universiteit Brussel (VUB)
Laarbeeklaan 103
1090 Brussel
Belgium
frieda.matthys@vub.ac.be

Introducing the Safewards-model in adolescent psychiatry of HUH in Finland

Background

In adolescent psychiatric wards conflicts and containments following them are a risk of serious harm both to adolescents and staff. The Safewards–model delineates comprehensive implications on methods for reducing risk and coercion in psychiatric wards by depicting six domains of originating factors. Finding ways to enhance adolescents' choices, freedom and control over their circumstances might help reduce conflict with the staff. The Safewards model has not been included in adolescent psychiatric care in Finland. More research is required in order to confirm this model, especially in adolescent psychiatry.

Aims

The overall aim of this study is to examine the suitability of the Safewards model to the inpatient care of adolescent psychiatry in HUH (Helsinki University Hospital) in Finland. The aim of the study is also to develop quality of care in adolescent psychiatric wards by decreasing conflicts and restraints and increasing patient-centered care.

Methods

The data will be collected from six adolescent wards before and after the introduction of the Safewards-model. The study consists of six sub-phases: HaiPro–notifications of adolescents, HUS-Risks – notifications of staff, restraint and holding amounts of adolescents, features of adolescents, configuration and amount of staff, and climate of adolescent psychiatric wards. The climate of the wards will be collected by the EssenCES questionnaire (adolescents and staff), other data will be collected from existing official reports of the wards and patients. The data before introduction of the model will be collected during summer and autumn in 2015. The introduction of the model will be done in autumn 2015 and the data after introduction of the model will be collected during 2016.

Results

The data will be analyzed by statistical methods. The implementation process of Safewards-model, the study scheme, monitoring the introducing and preliminary findings of the data will be presented.

Conclusions

The background of the implementation process and the baseline data of the study will be assembled to the presentation. Also the experiences of preparation and evaluation work of the model will be assembled.

Educational Goals

1. Discuss Safewards-model implementation in adolescent psychiatric wards
2. Analyse the clinical picture in adolescent psychiatric wards before the Safewards-model implementation using baseline data

Correspondence

Ms. Anja Hottinen
Helsinki University Hospital, Department of Psychiatry
PL 590
00029 HUS
Finland
anja.hottinen@hus.fi

A participatory approach to develop tools for post-seclusion and/or restraint review.

Poster

Marie-Hélène Goulet, Caroline Larue (Canada)

Keywords: review; seclusion; restraint; model; debriefing; clinical psychiatry

Background

After an aggressive behavior leading to seclusion and/or restraint, an intervention should be conducted with the patient and the health care team to ensure continuity of care and promote the reduction of aggression on acute wards. Few models of post-seclusion and/or restraint review exists. Therefore Needham & Sands (2010) recommend to develop a model that clearly lays out the conditions of a systematic intervention.

Aims

The poster's objective is to present two intervention tools of a post-seclusion and/or restraint review model involving both patients and health care providers in psychiatric settings.

Methods

As part of a case study (Stake, 2005) designed to develop, implement and evaluate the post-seclusion and/or restraint review, the development phase prioritized a participatory approach in order to meet as accurately as possible the clinical needs. A committee of experts was formed consisting of a researcher, managers, nurses and a patient partner (n = 8). The selection of participants was made by a convenience sampling. From the literature review on different models of post-seclusion review conducted by the researcher, the expert committee has chosen to adapt the model proposed by Huckshorn (2004, 2005) to his practice setting, a first-episode psychosis unit.

Results

Two intervention tools have been developed. The first tool, Review with the patient, aims to come back with the patient about his experience of seclusion or restraint so that he can express himself freely and collaborates to the adjustment of the treatment plan. The themes addressed are: the triggers, the feelings experienced, the elements perceived as obstacles or facilitators, the perception of intimacy and dignity, and what the patient and the team could have done differently. The second tool, Review as a team, aims to improve the quality of care surrounding a seclusion or restraint episode through learning obtained from a rigorous analysis of the event. It consists of 24 questions designed to analyze: the environment, the triggers, the identification of behavioral change, the interventions attempted, the exact reason for the decision, the application of the protocol, the duration of measurement control, and the learning related to the treatment plan and the practice. The terms of each intervention will also be discussed.

Conclusions

In addition to improving the patient and health care team experience when seclusion and/or restraint is involved, this kind of review will also help to continually enhance the quality and safety of patient care when managing aggressive behavior. Moreover, the effects of post-seclusion and/or restraint review on patients and stakeholders should be rigorously assessed.

Educational Goals

1. Participants will have an understanding of the need for post-seclusion and/or restraint review.
2. Participants will know a model that will assist them in their clinical interventions with the patient and as a team.

Correpondence

Ms. Marie-Hélène Goulet
Université de Montréal
2375, chemin de la Côte Ste-Catherine
h3t1a8 Montreal
Canada
marie-helene.goulet@umontreal.ca

A sensory based approach to preventing violence in a closed ward – Project 'New Paths'

Poster

Roland Westerlund, Katarina Nenadovic, Karen Jurlander & Annick Francoise Parnas (Denmark)

Keywords: Psychiatry, closed ward, mechanical restraint, arousal, aggression, violence, sensory room, comfort room, sensory integration, prevention, multidisciplinary, psychiatric care

Abstract

This poster describes some of the therapeutic efforts that are being carried out in order to reduce – and ultimately abolish – the use of mechanical restraint in a closed ward. The overall goal is to improve the quality of treatment. The project 'New Paths' ('Nye veje') takes place at the Copenhagen University Hospital, Psychiatric Centre Hvidovre, and is a part of a larger national project funded by the Danish Health and Medicines Authorities.

The poster presentation emphasizes the sensory based approaches, such as the specially design 'sensory rooms', also known as 'comfort rooms'. The theory behind can be summed up as sensory integration; psychiatric patients in the acute phases of their disorder may suffer from confusion, anxiety, psychosis, and an experience of stimuli overload – the threshold for aggressive and violent behavior decreases. Some patients find it helpful to be guided through steps of sensory integration.
We will illustrate how this can be implemented; how the sensory integration approach is being used by the multidisciplinary staff, how the sensory room is designed, the impact on patients' arousal etc.

Finally, we will share some comments/feed-back from a patient perspective.

Educational Goals

- Describe theoretically how sensory integration can be an important factor in reducing mechanical restraint in psychiatric care.
- Illustrate how this approach can be implemented in in a closed ward.

Correspondence

Mr. Roland Westerlund
Copenhagen University Hospital, Psychiatric Centre Hvidovre
Brøndbyøstervej 160
2650 Brøndby
Denmark
roland.jannik.westerlund@regionh.dk

Chapter 8 – Neurobiological approaches and pharmacological therapies

Efficacy and safety of Medical Cannabis Oil (MCO) in aggression and agitation due to Alzheimer's dementia: an open label, add on, pilot study

Paper

*Assaf Shelef[1], Yoram Barak[1], Uri Berger[2], Diana Paleacu[1], Shelly Tadger[1], Igor Plopsky[1]
and Yehuda Baruch[3,4]*
[1] Abarbanel Mental Health Center, Bat-Yam,Israel and Sackler Faculty of medicine, Tel-Aviv University, Tel-Aviv,Israel
[2] Department of Psychology, Bar-Ilan University, Ramat-Gan , Israel
[3] OneWorldCannabis Ltd.
[4] Gertner institute for epidemiology and health Policy research

Keywords :Aggression, Alzheimer, cannabis, marijuana

Introduction

Marijuana is being used medicinally for a variety of indications. The cannabis plant contains numerous cannabinoids, which are responsible for its physiological and psychoactive effects. The main psychoactive cannabinoid delta-9-tetrahydrocannabinol (THC) could be a potential therapeutic treatment option for Alzheimer's disease through multiple functions and pathways.

Aim:To measure the efficacy and safety of medical cannabis oil (MCO) which contains delta-9-tetrahydrocannabinol (THC) extract as an add on to the current medications regime, in relieving behavioral and psychological symptoms of dementia (BPSD) of patients with Alzheimer Dementia.

Methods

This study was an open label, prospective, small pilot trial. 11 patients with BPSD were given MCO with THC extract as an add-on to their current medications.

Results

MMSE showed modest positive change. CGI – severity score and NPI showed significant decrease from baseline over two weeks' time.

Conclusion

This study shows that adding THC extract to the current pharmacotherapy of dementia patients with BPSD is safe and efficacious. Cannabis can be a new, safe and more effective treatment for dementia and its associated symptoms.

Introduction

During the moderate and late stages of dementia, patients experience behavioral and psychological symptoms of dementia (BPSD), such as agitation, psychosis, and aggression.

Marijuana (Cannabis sativa) is being used medicinally for variety of indications (1,2). The cannabis plant contains numerous cannabinoids, which are responsible for its physiological and psychoactive effects. The first cannabinoids to be identified were the main psychoactive compound delta-9-tetrahydrocannabinol (THC) and the nonpsychoactive compound cannabidiol (CBD), a cannabinoid with strong anti-inflammatory characteristics, although there are thought to be various other cannabinoids.

Cannabinoids act primarily through CB1 receptors (which are common in the brain, particularly in the hippocampus, basal ganglia and cerebellum) and CB2 (peripheral tissues, especially on white blood cells). Following the discovery of an endogenous cannabinoid system and the identification of specific cannabinoid receptors in the brain, an effort has been made to investigate weather medical cannabis is efficient therapy in various neurodegenerative diseases.

Cannabinoid system has the potential to regulate neurodegenerative processes such as neuroinflammation and excessive glutamate production (3,4). Recent studies have shown that cannabinoids may have more specific effects in interrupting the pathological process in Alzheimer's disease (5,6) . Lately Cao et al, found that THC directly interacts with amyloid-beta peptide, thereby inhibiting its aggregation (7). Furthermore, THC was effective in cellular mechanisms in low concentrations.

Endogenous cannabinoid system is connected in the CNS to regulating psychomotor system, mood, sleep-wake cycle and eating behavior. All of these functions are injured in progressive dementia.

Two small open trials have shown efficacy of Dronabinol (synthetic THC) in the treatment of Behavioral and Psychological Symptoms of Dementia (BPSD).These studies demonstrated improvement in anorexia, sleep-wake cycle and agitation(8,9). Antipsychotic medications are extensively used to treat BPSD but have only little efficacy and severe side effects (10).

In addition cholinesterase inhibitor drugs, are in current usage to treat BPSD IN Alzheimer's dementia, but can only modestly improve cognitive symptoms, activities of daily living and behavior and they only act to delay an inevitable decline by around 9 to 12 months (11).

THC could be a potential therapeutic treatment option for Alzheimer's disease through multiple functions and pathways .Cannabis can be a new, safe and more effective treatment for dementia and its associated symptoms.

There is currently no solid clinical evidence to prove that cannabinoids - whether natural or synthetic - can effectively treat Alzheimer dementia.

Methods

Participants

Eleven consecutive inpatients at our geriatric psychiatry ward and outpatient clinic who had been diagnosed with Alzheimer's dementia accompanied by BPSD were included in this pilot open-label trial. The patients were recruited during 18 months period from February 2013 to July 2014. Patient diagnosis was given by a senior psychiatrist in accordance with the DSM4 criteria.

The study was conducted in accordance with the declaration of Helsinki and approved by the ethics committee (Internal Review Board) of Abarbanel Mental Health Center and The Israel Ministry of Health. Patients' guardians provided informed consent. Patients without a Guardian were evaluated for informed consent by independent senior psychiatrist which was not a part of the research group.

Materials

The term medical marijuana is ambiguous in that it can refer to 2 of the 3 forms in which cannabinoids occur. These include (a)endocannabinoids, arachidonic acid derivatives such as anandamide produced in human tissue (b) phytocannabinoids, the hundreds of compounds in the Cannabis Sativa plant, including the 2 most medically relevant ones, THC and cannabidiol (CBD) and (c) synthetic cannabinoids, laboratory-produced products of THC and cannabidiol that form the foundation of the pharmaceutical industry in cannabinoid-related products(12). For purposes of this study, medical marijuana will be synonymous with botanical cannabis, the second option.

Medical Cannabis Oil (MCO) is a form of botanical cannabis. In our study it contained extract obtained from the Cannabis plant with THC as the main cannabinoid..

MCO is a potent cannabis product because of its level of psychoactive compound per its volume, which can vary depending on the plant's psychoactive compounds.

MCO was obtained from "Canabliss" company, a licensed medical cannabis manufacturer by the Israeli Ministry of Health. Canabliss made a THC extract from Cannabis flowers and leaves to prepare one potency of oil of 1.65%.

Study protocol

Senior psychiatrist obtained full medical and psychiatric history. This study was a prospective trial in which participants were assigned to a treatment for a 4 weeks period.

After baseline assessments, patients received MCO which contained 2.5 mg of THC twice a day, every morning and evening for 4 weeks. The dosage was increased as clinically needed to 5 mg THC two times a day or 7.5 mg THC two times a day. The minimal dose had been given to all 10 participants and only 3 subjects' dose was elevated during the study.

Cannabinoid profile

Chemical analysis of the cannabinoid content of the MCO by Panaxia LTD laboratories by was undertaken using high performance liquid chromatography (HPLC)(13) showed very low levels of other phytocannabinoids, particularly cannabidiol (CBD)% of 0.05, cannabigerol (CBG), cannabichromene (CBC)% of 0.05, cannabinol (CBN)% of 0.17 , tetrahydrocannabivarin (THC-V)% of 0.02, and Tetrahydrocannabinolic acid (THC-A)% <0.01

Outcome measures

Physical and neuropsychiatric outcome measures were obtained at baseline, and at 2 & 4 weeks. Participants weight, glucose level, and both systolic and diastolic blood pressure were assesed. Adverse effects were recorded during the study period.

The primary efficacy parameters were the change in NPI scale.

The NPI scale assesses the frequency and severity of the behavioral symptoms in patients with dementia. The scores are given on the basis of an interview with the caregiver. It contains 12 sub fields, with a total score ranging from 0 to 144. Higher scores reflect greater symptoms.

NPI scale the Mini-Mental State Examination Apart from the (MMSE) and the CGI severity (CGI-S) and improvement (CGI-I) were assessed during each time point.

Statistical analysis

Due to the small sample size, all analyses were made with non-parametric tests. Fridman's analysis of variance was used for the comparison of each variable change in time (k-related samples; baseline, 2 weeks, 4 weeks). The Wilcoxon signed-rank test was used for the comparison of 2 related samples (i.e., time comparisons). All analysis was conducted with the SPSS v20 (IBM SPSS Statistics for Windows, Version 20.0. Armonk, NY: IBM Corp.).

Results

Out of eleven patients with Alzheimer dementia diagnosis, ten patients completed the four weeks trial. One patient stopped receiving MCO after three days (see, adverse events section).

Out of ten patients, 5 were females. The mean age was 73.2, SD=8.59 years. Illness duration was on average 3.9 years (SD = 3.47).

Education was 12.1 years, SD=4.38.

Six patients were born in Israel the rest immigrated at various ages from the former USSR, Morocco, and Turkey.

Patients were referred to hospitalization with severe agitation (n=7) and aggressive behavior (n=3).

Eight patients out of the ten patients that completed the study received antipsychotic medications: Risperidone (5 patients), and Olanzapine (2 patients), Clozapine(1 patitient), 2 patients did not recieve any antipsychotics.

Adverse events

Only 3 patients out 11 patients who started the trial, had adverse events. One patient stopped receiving MCO after three days due to dysphagia which was probably not connected to MCO. This patient was admitted due to agitation with severe side effects of high dosage long acting antipsychotic medication (long acting risperidone) that probably caused him the dysphagia. Although during the hours after he received MCO the dysphagia did not worsen we decided to stop the MCO. The patient was dyspneic and

referred to general hospital and was admitted there for two days due to aspiration pneumonia and then recovered.

Another patient had recurrent fallings prior to admission and during the month which he received the MCO fell and broke pelvic bone (Ramus Pubis bone), a simple fracture with no observable impairment. This patient continued the trial because we thought his fall was not connected to the MCO.

One patient had been more confused with MCO dosage of THC -10 mg/day. We decreased the MCO dosage to 5 mg/day and the patient confusion improved.

Physiological measures.

No significant results were obtained for weight ($\chi^2(2)=1.46$, $p=.48$), glucose level ($\chi^2(2)=0$, $p=1$), and both systolic ($\chi^2(2)=4.15$, $p=.13$) and diastolic blood pressure ($\chi^2(2)=2.57$, $p=.28$). However, a trend ($p<0.1$) was obtained for a decrease between the baseline and week 4, in both systolic ($W(10) = 8.5$, $Z = -1.66$, $p = .097$) and diastolic ($W(9) = 8.4$, $Z = -1.72$, $p = .084$) blood pressure (table 1).

Neuropsychiatric measures

The MMSE have shown a modest trend of change with time ($\chi^2(2)=4.95$, $p=.08$), which originates from a significant increase in MMSE score between weeks 2 and 4 ($W(5) = 15$, $Z = 2.04$, $p<.05$). (Table 1).

CGI-Severity score has shown a significant change with time (Table 1) ($\chi^2(2)=4.95$, $p=.08$), which originated from a decrease from baseline within two weeks ($W(7) = 0$, $Z = -2.53$, $p<.05$), and four weeks ($W(7) = 0$, $Z = -2.26$, $p<.05$). A similar decrease was not observed between the second week and the fourth week ($W(0) = 15$, $Z = 0$, $p=1$).

CGI-Improvement measures of change were compared to a no change score of 4 (indicating no change in CGI). Both CGI change after two weeks ($D(9)=3.09$, $p<.001$), and CGI change after 4 weeks ($D(9)=2.77$, $p<.001$) were found to be significantly different from a state of no change (table 1).

Each NPI sub-scale was analyzed separately (table 2). Significant decreases were observed in symptoms of Delusions (baseline to four weeks), Agitation/Aggression (baseline to two and four weeks), Apathy/Indifference (Baseline to two weeks), Irritability/Labiality (baseline to two and four weeks), Aberrant motor behavior (baseline to two and four weeks), Sleep and night time behavior disorders (baseline to four weeks), Caregiver distress (baseline to two and four weeks), and the NPI total score (baseline to two and four weeks). Although only the mentioned above sub-scales were significantly affected by cannabis administration, a trend was noted in all NPI subscales (figure 1).

Discussion

There is no FDA-approved treatments for BPSD, but antipsychotics are frequently prescribed off-label, antipsychotics yield only modest improvements in BPSD and have been shown to increase death in elderly patients with dementia. There are/reports of increased mortality, cerebrovascular events, and cardiovascular effects in elderly patients which encouraged the FDA to issue a black box warning for these agents.

Various studies, including CATIE-AD compared placebo to Olanzapine, Quetiapine and risperidone in study periods of up to 12 weeks in the treatment of BPSD in dementia (15-16).In this study a significant total NPI decrease of 7 to 17.7 points was noticed, while in our open label study the decrease in total NPI score was more pronounced with 31.6 points decrease at 4 weeks of treatment. The adverse effect rate was relatively low and most probably not related to the MCO treatment.

Conclusions

MCO appears to be a safe and effective treatment for BPSD although more research, especially to the potential of CBD (the non-psychoactive cannabinoid) is warranted.

Table 1. Change in physiological measures and clinical measures(MMSE and CGI).

	Time (weeks)				Change in weeks (Wilcoxon's test)		
	0	2	4	Friedman's test	0 to 2	2 to 4	0 to 4
Weight(Kg)	66.57 (14.02)	67.31 (12.76)	67.64 (11.92)	1.46	0.42	1.18	0.94
Glucose(mg%)	114.9 (27.61)	110.0 (21.29)	117.8 (23.41)	0.00	-0.05	0.46	-0.25
Systolic BP	151.6 (23.19)	142.0 (23.05)	139.4 (17.87)	4.16	-2.19*	-0.31	-1.66
Diastolic BP	82.9 (9.31)	79.4 (7.98)	75.1 (8.37)	2.58	-1.42	-1.22	-1.72
MMSE	10.30 (9.38)	10.00 (8.89)	11.00 (8.67)	4.95	-0.41	2.04*	0.89
CGI-Severity	6.5 (.52)	5.7 (.48)	5.7 (.48)	14.00**	-2.53*	0.00	-2.53*
CGI-Improvement		2.3 (0.67)	2.2 (0.78)				
Note:*p<.05 , **p<0.01 ,***p<0.001							

Table 2. Change in NPI scales.

	Time (weeks)				Change in weeks (Wilcoxon's test)		
	0	2	4	Friedman's test	0 to 2	2 to 4	0 to 4
Delusions	3.3 (3.94)	0.6 (1.26)	0.2 (0.42)	8.38*	-1.82	-1.34	-2.03
Hallucinations	1.7 (3.83)	0.5 (1.26)	0.3 (0.48)	0.67	-1.00	-0.45	-1.07
Agitation/Aggression	8.6 (3.77)	2.9 (2.18)	2.6 (2.11)	13.86**	-2.53*	-.68	-2.52*
Depression/ Dysphoria	1.9 (4.01)	0.1 (0.31)	0.3 (0.67)	3.50	-1.61	1.00	-1.10
Anxiety	2.4 (4.19)	0.5 (1.26)	0.1 (0.31)	5.63	-1.60	-1.34	-1.63
Elation/Euphoria	1.8 (3.82)	0.8 (1.31)	0.7 (1.33)	2.00	-.82	-1.00	-1.34
Apathy/Indifference	3.7 (4.32)	1.0 (1.33)	1.4 (2.01)	6.91*	-2.21*	.38	-1.79
Disinhibition	5.3 (3.49)	2.0 (2.00)	1.6 (1.95)	12.97**	-2.52*	-.74	-2.37*
Irritability/ Lability	5.9 (3.54)	2.0 (1.76)	1.7 (1.63)	12.87**	-2.52*	-.55	-2.52*
Aberrant motor behavior	4.6 (4.71)	2.1 (2.42)	1.9 (1.96)	6.42*	-2.03*	-.48	-1.99*
Sleep and night time behavior disorders	3.8 (3.70)	1.8 (2.74)	0.9 (1.66)	6.12*	-1.46	-1.34	-2.02*
Appetite and eating changes	1.4 (2.50)	0.6 (1.34)	0.8 (1.93)	.80	-1.07	1.00	-.82
Care giver distress	20.7 (5.92)	10.5 (6.02)	9.4 (5.85)	13.87**	-2.52*	-1.02	-2.67**
NPI total	44.4 (23.31)	14.9 (8.77)	12.8 (9.99)	14.81**	-2.52*	-1.58	-2.67**
Note. *p<.05, **p<.01							

Table 3. NPI difference score comparison between cannabis and other medications during 4 weeks period.

Study	Medication	NPI scale	Dosage	Original effect	Cannabis effect	K-S test
De Deyn et al. (2004)	Olanzapine	total	1.0 mg	-14.80 (16.20)	-31.60 (22.25)	1.56*
			2.5 mg	-15.70 (14.90)		1.59*
			5.0 mg	-16.30 (17.00)		1.47*
			7.5 mg	-17.70 (15.70)		1.47*
	Placebo		NA			1.43*
Sultzer et al. (2008)	Olanzapine		2.5,5 mg	-7.00 (18.1)0		1.71**
	Quetiapine		25, 50 mg	-7.30 (20.2)0		1.63*
	Risperidone		0.5, 1 mg	-11.60 (15.4)0		1.69**
	Placebo		NA	-4.20 (20.00)		1.70**
Schneider et al. (2006)	Olanzapine		3.2-5.5 mg	-14.00 (18.70)		1.48*
	Quetiapine		34.1–56.5 mg	-16.60 (18.3)		1.40*
	Risperidone		0.7-1.0 mg	-16.40 (15.00)		1.56*
	Placebo		NA	-9.00 (20.6)		1.57*
Breder, Swanink, and Marcus (2004)	Aripiprazole		NA	-15.87 (19.84)		1.37*
Streim (2004)	Aripiprazole		NA	-16.43 (21.95)		1.27
De Deyn et al. (2003)	Aripiprazole		NA	-11.20 (23.65)		1.40*

Note. *p<.05, **p<.01

Figure 1-NPI subscales
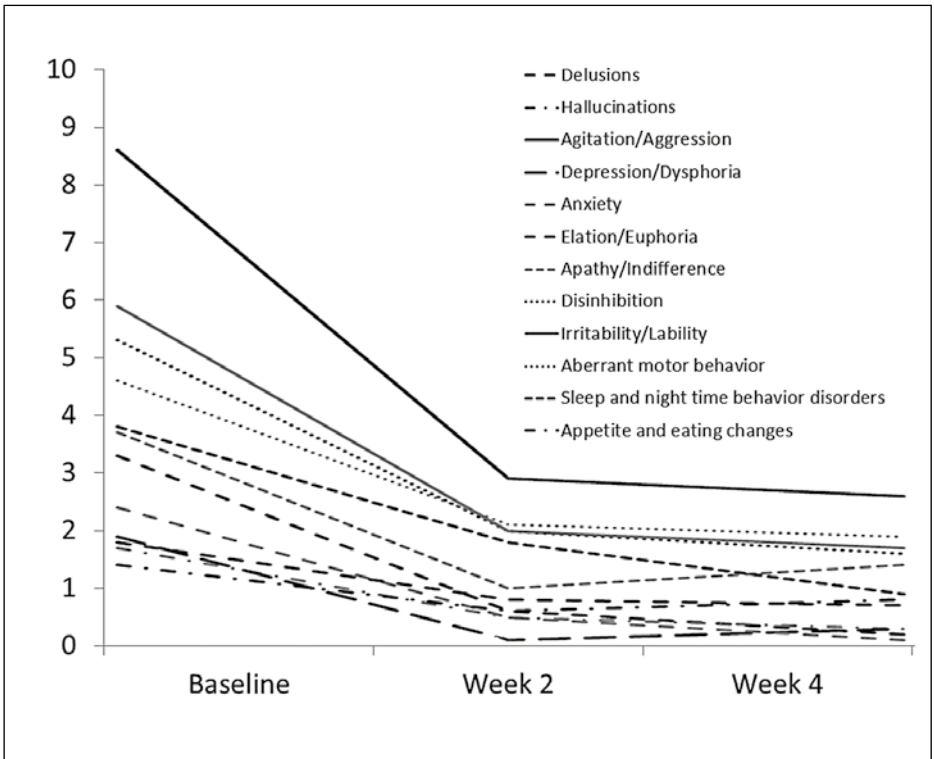
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Educational Goals

1. measuring aggression in Alzheimer is very important for safety and wellbeing of care givers and patients
2. use of cannabis for medical purposes is a growing domain and this is a presentation of how to study potential uses and outcomes

Correspondence

Mr. Yehuda Baruch
10 Pikus st. Gedera
Israel.
yehuda.baruch@owcpharma.com

Chapter 9 – Application of new technology (media – social networks – information technology – e-learning – virtual environment)

Using Technology to Prevent Coercive Practices in Inpatient Mental Health Setting: A Canadian Specialty Mental Health Setting Lens

Workshop

Ian Dawe, Sanaz Riahi, Philip Klassen & Ilan Fischler (Canada)

Keywords: Technology, Predictive analytics, Restraint and Seclusion, Violence

Background

Ontario Shores Centre for Mental Health Sciences (Ontario Shores) has embarked on a journey to partner with patients towards Recovery and is actively continuing to further advance and integrate Recovery within clinical practice. This places great importance on preventing the use of restraint and seclusion within the inpatient mental health setting.

Ontario Shores was recently awarded the HIMSS Analytics Stage 7 Award, becoming the first hospital in Canada and the first behavioral hospital anywhere in the world to achieve this feat. The award recognizes the Organization's advanced abilities in electronically sharing clinical information, supporting the widespread and comprehensive use of health and wellness information by consumers and hospitals, and its use of data warehousing and mining techniques to capture and analyze care data to perfect, advance and institute organization-wide operational, financial and quality improvements.

Aims

This paper demonstrates the Organization's attempts to leverage the use of these advanced technologies to promote proactive, evidence-based care in the prevention of coercive practices.

Method

A strategic approach has been undertaken to develop and implement technology-based strategies, such as clinical practice guidelines and decision supports and rules within the electronic medical record to promote preventative interventions for the use of restraint and seclusion. Additionally, Recovery Rounds, a quality improvement strategy has been created which is enabled by technology and addresses the real-time prevention of restraint and seclusion on a daily basis by senior leaders and peer support specialists within the organization.

Using the embedded electronic decision support aids in the Electronic Medical Record (EMR), Ontario Shores has supported the adoption of these strategies by the physician group and has allowed for each provider to monitor their performance with regard to adherence to established guidelines. Indeed, the ability to utilize the data from the EMR in order to benchmark their performance has allowed physicians to engage in meaningful discussions around patient care and improve their performance. The physicians at Ontario Shores have enthusiastically committed to ongoing quality improvements by using clinical

scorecards to highlight challenging clinical scenarios and drive peer review processes to further develop peer lead quality improvement opportunities.

This strategy is consistent with the Institute for Health Care Improvement framework of using data to shine light, not heat on individual performance.

Results

The use of technology to advance the prevention of restraint and seclusion and resulted in the following:

- Enhance data integrity
- Downward trending of incidents of restraint and seclusion
- Downward trending of total hours of restraint and seclusion
- Significant savings in staffing costs
- Positive outcomes as a result of Recovery Rounds

Conclusion

Ontario Shores has achieved significant positive outcomes in supporting clinicians to best practices in the prevention of coercive practices through the use of technology.

Educational Goals

At the Conclusion of this presentation the learner will:

1. Describe the strategic and tactical steps required to implement a comprehensive technical decision support system in a mental health care setting,
2. Discuss the clinician engagement strategies needed to keep staff members engaged in a technological solution to violence in the healthcare setting,
3. Apply ideas regarding the use of technology in situations to prevent coercive practices in their own practice environment using what has been learned.

Correspondence

Mr. Ian Dawe
Ontario Shores Centre for Mental Health Sciences
700 Gordon Street
L1N 5S9 Whitby
Canada
dawei@ontarioshores.ca

Co-Creating new tools for good practices in recovery and high secure healing environments.

Paper

Erik Kuijpers & Alwin Verdonk (Netherlands)

Keywords: Healing Environment, Co-Creation, New Solutions, Perception-oriented care, Ownership for the service-user, Technology based on recovery, High Secure

Introduction

The world of health care is changing from caregiver organisations to caretaker organisations. Recovery concepts, together with Peer support Knowledge are rapidly spread nowadays. Hospital based treatment changes in Community based treatments. In the future hospitalization is only a 'crisis management tool' in a community based treatment concept.
In an attempt to understand needs and requirements of the crisis unit of the future we want to share some insides found during different Co-creation pilots in the Eindhoven region. From new care concepts to co-creation to healing environment we show the listeners, how technology can play a supportive role in this transition.

Main Paper

In a period of transition there is a need for new care concepts and tools. We will especially focus on the world of crisis care, with high risks on seclusion and restraint. In the Eindhoven region there was an approach to create new concepts and tools, in which we tried to create a creative environment by organizing different pilot studies with both caregivers, caretakers, managers, researchers and technicians.

First let's give words to the transition:

Hospital based medical treatment concepts in modern Dutch psychiatry lose their dominant position. In an attempt to give more ownership to the caretaker, recovery orientated and community based treatment becomes popular. In this way, the new reality is that, caretakers can more and more choose what concept is the best fit for his or her treatment. This ability to choose is already common in other parts of society.

Transition
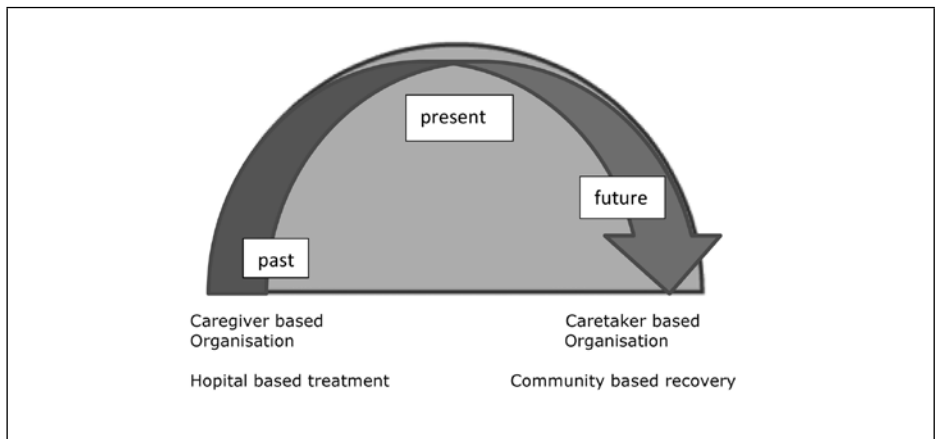
In crisis care there is a high risk on conflicts between caregivers and caretakers. (Self)Control and ownership are important theme's in these conflicts. Let's take a closer look on the subject of aggression.

Aggression in psychiatry can be seen as a last stage of a process of losing control. Fear, anxiety and other unbearable, sometimes unconscious emotions can disturb the internal emotional balance. In an attempt to cope with these emotions a person has several strategies according to the context and social cultural situation. The ability to choose the socially correct coping strategy stands in our culture equal to the stage of being a grown-up and psychological healthy.

People in crisis fall back on basic coping strategies and lose the ability to choose. That's a problem for their feeling of control in life and often leads to exhausting, psychiatric symptoms and feeling of powerlessness. But on the contrary this basic coping strategy can be a key to early warning symptoms and crisis support.

Good practice teaches us that recovery can be seen as the process of learning how to regain self-control in someone's own life. Crisis care can be seen as supporting a person to find its own solutions, based on knowledge, awareness and responsibility on his/her own coping style. Of course this care context is temporally placed in a square of safety depending on the severity of the crisis.

So good crisis care is *perception-orientated* and starts with human support, focused on finding his/her *own solution*, followed by *balanced decision making*, all performed in a *healing environment* with *access to different tools and solutions*.

Here an example of a co-creating project. First we describe the old situation, than the headlines of the project and after that the new situation:

Old situation

Caregiver (Erik Kuijpers):

Within the traditional hospital care situation there were little possibilities to de-escalate.

Almost all discussion was made by the staff, little together with the caretaker.

In the ward there was apart from the sleeping aria a kitchen and two living rooms, some were in the back there were two isolation cells.

Technical support contained a staff alarm and an intercom with the isolation cell.

Caretaker (Alwin Verdonk):

Lots of different approaches from caregivers, but little real contact during de-escalation

Lots of decisions were made without me

The old buildings were depressing

I have experience with isolation cells.

Technical support in this cell was a simple radio and an intercom.

The headlines of the Co-creation Project:

The main challenge was to let all (3) perspectives work together Without judgement!!!
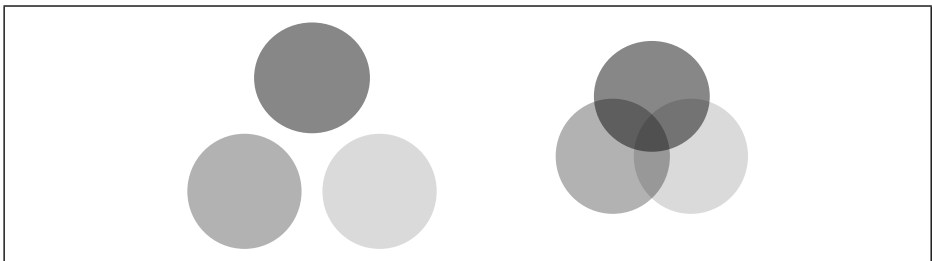
Goals of change:

From aggression to preventive de-escalation
From Conflicts to joined decision making
From powerlessness to new solutions
From outside domination to autonomy

We started with listening without judgement to all the stories and experiences around seclusion ad restrained.
We hat brainstorm session, listened to dream needs and wishes.

In the end we created new possibilities in care, building and technology. We organised a pilot study for the first effect.
The evaluation gave positive feedback to all perspectives involved.

New situation

Caregiver (Erik Kuijpers):

The care concepts provides different step in individual de-escalation support.

The overall line (frame) is decided by the staff.

Within this frame individual and personal approaches can be made.

The new building contains two parts a ward and a unit for special care.

Technical support is possible with the communication wall with light solutions and video calling.

Caretaker (Alwin Verdonk):

Care taker feel more supported, more individual and personal care.

Almost everything is decided together with the caretaker, there are much less conflicts.

The bedroom has a private zone which is well respected by the caregivers.

The communication wall gives lots of new possibilities, it reduces stress.

Conclusion

In an attempt to create new possibilities and tools in crisis care co-creation can be a productive way to find new care concepts in an healing environment supported by new technologies. Co-creation with the end-user (caretakers and caregivers) shows respect to the main transition in the world of modern psychiatry.
The ownership, empowerment by both the caregiver as the caretaker grew by this project. The overall feelings of powerlessness reduced.

Discussion:

During the end of this session we want to show the participants some good examples of new technological tools based on co-creation, caretaker ownership and personalized solutions; maybe the beginning of re-creating the current standards of crisis care.

- A wristband device to measure stress levels to give feedback and learn more awareness to the end-user. https://www.empatica.com/
- A touch screen based on safety glass. To provide end-users in severe crisis access to applications like a video calling, personal photos, relax themes and control of their environment. http://recornect.com/
- A safety window which can be opened anytime by the end-user provide fresh air. http://www.britplas. com/mental-health/safevent-window/

Acknowledgements

References

Investigating the effect of different type of visual content on psychiatric patients during a stressful episode, *Joyce de Laat, HTI TU/e identity number 0633008*

Educational Goals

- In this oral paper we want to show that new co-creation based and recovery supporting solutions are already existing, even in High secure buildings and that in the nearby future more screen, sensor and healing environment based (technical) support is coming up. One of the presenters (Alwin Verdonk) is a very experienced Peer support worker.

Correspondence

Mr. Erik Kuijpers
Recornect
Science Park Eindhoven 5008C
5692EA SON EN BREUGEL
The Netherlands
erik.kuijpers@recornect.com

Quantifying Violent Episodes on Psychiatric In-Patient Units: How to Collect and Analyze High Frequency Problem Behaviors for Clinical Interventions by Leveraging Electronic Medical Records

Poster

John Boronow, Barbara Charen, Jaqueline Williams-Porter, Christopher Borleis, Annie Verghese & Josh Nohe (USA)

Keywords: violence; electronic medical records; lean

Background

Measuring clinical phenomena quantitatively is the foundation for any evidence based treatment programming and effectiveness research. Our hospital was challenged by an upsurge in violent behaviors. We needed to be able to report on violent episodes in real time, and to respond quickly with both programmatic and individualized interventions. Our data collection had historically relied on paper incident reports which were incomplete, private in distribution, and late.

Aim

To develop a clinical behavior inventory for inpatient psychiatric units using an electronic medical record (EMR), that would provide a reliable way for clinical staff to record violent and other disturbed behaviors in real time, and generate analyzable data with which to assess subsequent interventions.

Method

Building on pre-existing functionality in our EMR called 'Significant Events', we developed an inventory of typical inpatient behaviors, based on an intensive review with nursing leadership of the kinds of behaviors that were being recorded by narrative in the EMR. A total of 19 clinical 'Significant Events' types were defined. Within each type, additional specific behaviors and events were defined, with the option of adding narrative detail. Training materials for clinician users were built directly into the EMR data entry process, enabling users to review which categories best suited the event being documented, and also prompting users to complete paper incident reports on high risk cases. User adoption was encouraged by displaying the Significant Events in clinician documentation, thus addressing objections about duplicate work. Finally, reports were developed which provided daily auto-printed summaries of aggressive behaviors and emergency interventions for unit leadership to monitor. These reports also enable long term trending analysis.

Around the same time, a "Lean" violence prevention workgroup developed a set of novel programmatic interventions targeting a variety of clinical treatment processes. These were piloted on our Psychotic Disorders Unit, which treats the most aggressive patients. The new Significant Events reporting capability enabled us to assess the impact of these interventions.

Results

The Significant Events reports have indeed greatly increased the reporting of all episodes of aggressive behavior. The annual number of assaults reported by the paper incident reporting method on this unit increased nearly 400%, from 26 to 129. The availability of real time aggression data has enabled unit leadership to focus rapidly on problem areas, using the Lean improvement strategies. ER visits from aggression have ceased for the past 5 months, and the number of serious assaults was significantly reduced by 69%, from 1.6/month to .5/month (p = .01).

Conclusions

Measuring clinical aggression can be efficiently integrated into daily clinical practice using EMR technology to promote long term clinical problem solving and enable future reliable quantitative study of best practices in the management of aggressive behaviors. Such measures can be extended to a wide variety of other disturbed target behaviors in inpatient psychiatric settings.

Educational Goals

1. Describe a process for collecting structured psychiatric behavioral data through routine clinical documentation using an electronic medical record.
2. Discuss how the availability of structured behavioral observations can both facilitate and quantify the outcomes of a successful lean strategy of violence mitigation interventions.

Correspondence

Mr. John Boronow
Sheppard Pratt Health System
6501 N. Charles St.
21285-6815 Towson, MD
U.S.A.
jboronow@sheppardpratt.org

Chapter 10 – Advances in psychological therapies

Violence Reduction with Equine-Assisted Group Psychotherapy – A controlled study in long term psychiatric inpatients

Paper

Jeffry Nurenberg & Steven Schleifer (USA)

Keywords: animal assisted therapy, equine assisted therapy, horses, dogs, inpatient violence

Introduction

Interactions with animals have been employed clinically in many settings, with benefits described for psychiatric and other medical patients in affective symptoms and interpersonal interactions. More formal animal assisted psychotherapy (AAT) is being used increasingly and may be especially helpful for patients with verbal and cognitive limitations and those with impulsive, including violent, behavior. There have been few systematic studies of AAT (1,2), with some evidence that AAT can reduce symptoms such as anxiety and depression and enhance self-esteem and socialization in psychiatric patients (3,4,5,6).

While dogs have become increasingly common therapy assistants, benefits for both aggressive and regressed behavior, which are important clinical concerns in psychiatric inpatients, may be especially pronounced with larger animals such as horses. This may result from interacting with more imposing animals. Moreover, feasibility may be enhanced by the ready adaptability of horses to group exercises. Nevertheless, equine-assisted therapies are costly and labor intensive, underscoring the need for studies of the efficacy of equine programs (7,8). We introduced equine-assisted psychotherapy (EAP) at our 500 bed State psychiatric hospital in 2009 and found considerable enthusiasm among patients and staff for the program. We undertook the present randomized control study comparing EAP as well as more traditional canine assisted psychotherapy (CAP) with both an active control intervention (enhanced social skills psychotherapy, SSP) and regular hospital care (RHC). The project confirmed the feasibility of animal assisted interventions with a severely affected chronic patient population and investigated the comparative efficacy of the several interventions in reducing violence and associated symptoms (9).

Methods and Results

90 long term hospitalized patients, most with recent in-hospital violent behavior, were enrolled, with signed informed consent obtained. Participants were randomized to one of four intervention groups: 10 weekly 40-60 minute active group therapy sessions in one of the intervention modalities (EAP, CAP, SSP) or continued regular hospital care (RHC). EAP followed the model of EAGALA (Equine Assisted Growth and Learning Association; Santaquin, UT) (10). Two EAGALA certified equine therapists worked with 2-3 therapy horses tested and credentialed as suitable for direct patient contact in clinical environments by Delta Society/Pet Partners (Bellevue, WA). Sessions were conducted in an area adjacent to the hospital with a specially designed corral. Interventions included scripted, increasingly complex ground exercises involving group interactions among patients, horses, and the equine therapists (there was no riding). For CAP, 3 certified therapist-dog teams (St. Hubert's Animal Welfare Center, Madison, NJ) participated. CAP sessions were intended to be comparable to EAP in structure, novelty and environmental change from the main hospital. The active control group (SSP) employed social skills exercises similar to those in the hospital's general program but, as with CAP, were conducted in an appropriately configured cottage outside in the main hospital. SSP was included to control for therapeutic factors unrelated to animal interactions, including leaving the hospital building, visiting a novel setting, and added staff attention.

Data from hospital records contrasted the two months preceding intake with the 3 months post-intake. Clinical interview measures were also obtained from staff at intake and at three months post-intake. Nonviolent incidents were quantified as a nonspecific comparison variable. Other outcomes included the frequency of the patient requiring 1:1 clinical observation or seclusion/restraint (the latter very infrequent). Staff-assessed measures included verbal and physical aggression assessed with the Overt Aggression Scale (OAS) (11). Clinical/demographic characteristics considered potential covariates included age, sex, chart-derived psychiatric and medical diagnoses, hospitalization duration, legal status, and number of intervention sessions attended. Staff pre-study impressions of the potential efficacy of AAT were also obtained.

Participants' mean age was 44, 37% were female, 76% had chart diagnoses of schizophrenia or schizoaffective disorder, and the mean duration of hospitalization was 5.4 years. All interventions were well tolerated. Significant effects were found among the intervention groups with respect to the number of violence-related incident reports filed for each patient by clinical staff during the three months following study intake compared with the number filed for the patient during the two months pre-intake (ANOVA: $F=3.00$, $p=.035$). Post-hoc tests showed specific benefits for EAP ($p<.05$). Similar AAT effects were found in relation to the need for close (1:1) clinical observation, with post-hoc tests here suggesting benefits for CAP ($p=.058$) as well as EAP ($p=.082$). Secondary aggression-related measures also suggested improvement with AAT: OAS group differences were found for aggression against objects and persons ($F=2.71$, $p=.05$; $F=2.66$, $p=.053$, respectively), with EAP participants having decreased aggression vs increased or unchanged levels for other groups. Group differences were also observed in relation to the need for 1:1 staff: patient observation, often a consequence of aggressive behavior ($F=2.70$, $p=.051$), post-hoc tests suggesting benefits vs RHC for canine ($p=.058$) as well as equine therapy ($p=.082$). In contrast to violence-related effects, non-violent incidents showed no differences pre- vs post-intervention ($F=0.29$, $p>.1$), further suggesting that the violence effects did not reflect nonspecific hospital phenomena. While most of the covariates tested, including general measures of clinical symptomatology, did not account for the AAT effects on violent behavior, pre-randomization staff expectations of AAT benefits (on a 4-point scale: very helpful, somewhat helpful, little or no help, may be detrimental) were associated with AAT effects on violence ($F=6.99$, $p=.01$). Thus, among patients eventually assigned to equine assisted psychotherapy (EAP), violent incidents appeared unchanged among patients for whom staff had lesser AAT expectations, while patients for whom staff predicted AAT would be "very helpful" showed a large decrease in incidents.

Discussion

The study provides evidence that AAT, and perhaps especially EAP, is an effective therapeutic modality for long term psychiatric patients at risk for violence. To our knowledge, this is the first controlled study of AAT and violent behavior in long term psychiatric patients. It provides some of the first empirical data to support the increasing use of equine related treatments for psychiatric disorders, the paucity of which has been a focus of recent criticism (2).

Our findings showed that EAP was associated with reduced violence for at least several months following treatment initiation, with the need for 1:1 clinical observation reduced by both canine and equine therapies. It is noteworthy that the weekly interventions of less than an hour on at most ten occasions (for some, considerably fewer—the median AAT sessions attended was 7) had a detectable effect on a serious and at times intractable dimension of behavior. The three month outcome data suggest that EAP benefits extend at least several weeks beyond the equine contact; the extent to which benefits persist thereafter requires study. Statistical consideration of the effects of variable attendance showed no evidence that the number of sessions attended predicted outcomes, suggesting that fewer than ten EAP sessions may be sufficient. This could increase feasibility considering the costs of EAP, the modest number of patients who can be accommodated per session, and the brief duration of most psychiatric hospitalizations. Our findings further suggest that EAP may be beneficial for a broad range of extended-hospitalization psychiatric patients, with no evidence of specificity in relation to age, sex, ethnicity, chart diagnosis, symptom severity, legal status, attitudes toward animals, or length of hospitalization.

Unique effects with therapy horses, vs the more frequently utilized therapy dogs, may be accounted for by a variety of factors (12, 13). These include effects of interacting with physically imposing animals that appear quite capable of causing harm, but do not. Equine interactions may model nonviolent behavioral strategies, resulting in greater patient tolerance for provocative interpersonal stimuli. Non-predatory equines, which are prey animals, may have a therapeutic advantage for some patients, such as those with a history of interpersonal trauma, compared with more predatory species such as canines and humans. Preliminary clinical observations with trauma patients suggest that the horses are often used to model aggressive and abusive interactions. Interacting with horses was described by some patients as transformative experiences

and, in some cases; EAP sessions were associated with immediate and dramatic improvements in patient social behaviors on their clinical units.

Equine assisted group therapy following standard therapeutic approaches, such as recommended by EAGALA (10), is resource intensive. It requires construction and maintenance of the physical environment, attention to risk reduction and patient and animal safety, identifying and accessing appropriate therapy horses and equine therapists, and integrating (weather-dependent) AAT sessions with other ongoing hospital programs. As the therapeutic mechanisms of EAP effects require further investigation, it is important to avoid premature generalizations from the current observations to other animal assisted interventions such as unstructured exposure to pets or visiting animals, therapeutic riding, or structured one-on-one AAT. Replications using similar and disparate intervention models and populations are essential.

The challenges that need to be addressed prior to initiating equine therapy programs may seem daunting, but can be readily addressed in many settings. Among these is the identification of suitable (usually outdoor) space. In the absence of proprietary space, even urban centers may have public parks and open spaces that can be engaged for such typically well received programs. Programmatic organization can vary widely. One approach utilizes a fully integrated equine therapy group who arrive on the scene with horses, equine therapists and the necessary portable hardware. The group sets up the space, conducts the entire encounter, and restores the site to its prior state at the conclusion of the session. Another approach, used in our program, is to rely upon trained staff and available resources within the sponsoring organization, supplemented by specialized outside staff. Other successful approaches have involved local police equine squads. In sum, the requirements of equine associated psychotherapies have been addressed in a wide range of settings and new programs are likely to find existing models that can be adapted to their resources and needs.

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Educational Goals

1. The participants will be able to identify patients who can benefit from equine assisted therapy
2. The participants will be able to address impediments to the use of equine assisted therapy in inpatient and outpatient settings
3. The participants will be able to address symptomatically violent patients with a new form of therapy

Correspondence

Mr. Steven J. Schleifer
Department of Psychiatry
Rutgers New Jersey Medical School
Newark, NJ 07103
USA
schleife@rutgers.edu

Self-wise, Other-wise, Streetwise (SOS) training: a novel intervention to reduce victimization in psychiatric patients with substance use disorders: a randomized controlled trial

Paper

Marleen M de Waal[1,2], Martijn J Kikkert[1], Matthijs Blankers[1,3], Jack JM Dekker[1,4], Anna E Goudriaan[1,2]
1) Department of Research, Arkin Mental Health Care, Klaprozenweg 111, 1033 NN Amsterdam, The Netherlands
2) Academic Medical Center, Department of Psychiatry, Amsterdam Institute for Addiction Research, University of Amsterdam, Amsterdam, The Netherlands
3) Trimbos Institute, Da Costakade 45, 3521 VS Utrecht, The Netherlands
4) Vrije Universiteit Amsterdam, Department of Clinical Psychology, Amsterdam, The Netherlands

Introduction

Psychiatric patients are more often victims of crime than perpetrators [1-3]. A rapidly growing amount of research shows that psychiatric patients are more likely to be victimized than other community members [2-4]. Especially prone to victimization are patients with co-occurring psychiatric and substance use disorders [2,5]. Victimization is associated with more severe symptomatology, more substance abuse and homelessness [6-10]. We developed a group-based intervention, the Self-wise, Other-wise, Streetwise (SOS) training, that aims to reduce victimization in patients with dual diagnosis. Since no evidence-based interventions to diminish victimization are available so far, the SOS-training is based on research on risk factors for victimization, evidence based interventions in other target groups that focus on diminishing these risk factors and the experience of mental health care professionals and patients.

Method

The SOS-training is being implemented in a randomized controlled trial, to investigate the effectiveness. Overall, 250 patients of Arkin Mental Health Care in Amsterdam will be included. Participants are interviewed at baseline and 2, 8 and 14 months follow-up. The primary outcome measure is victimization measured with the Safety Monitor. The Safety Monitor assesses victimization of 11 different crimes, subdivided in violent crimes, property crimes and vandalism. Secondary outcome measures are: substance use, psychopathology, emotion dysregulation, interpersonal functioning and quality of life.

Results

Preliminary data on the year prevalence of victimization of patients with dual diagnosis will be presented. Moreover, the contents of the SOS-training as well as patient evaluations will be presented.

Discussion

The high prevalence of victimization shows the urgent need for interventions like the SOS-training. Although the effectiveness of the SOS-training is still being investigated in this randomized controlled trial, first reactions of patients and therapists are very promising.

Educational goals

Participants will be able to cite prevalence rates of different types of victimization of patients with dual diagnosis and comprehend why patients with dual diagnosis are vulnerable for victimization.
Participants will gain knowledge about potential mechanisms of action to diminish victimization of patients with dual diagnosis and get an impression of an intervention that can be widely implemented in mental health care in the future.

Acknowledgements

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Educational Goals

1. Participants will be able to cite prevalence rates of different types of victimization of patients with dual diagnosis and comprehend why patients with dual diagnosis are vulnerable for victimization.
2. Participants will gain knowledge about potential mechanisms of action to diminish victimization of patients with dual diagnosis and get an impression of an intervention that can be widely implemented in mental health care in the future.

Correspondence

Ms. Marleen de Waal
Arkin GGZ Amsterdam
Klaprozenweg 111
1033 NN Amsterdam
Netherlands
marleen.de.waal@arkin.nl

Victimization in depressed patients: Prevalence rates and the description of an intervention study

C. Christ, S.C. Meijwaard, M. Kikkert, D.J.F. van Schaik, R. Van, C.L.H. Bockting, J.J.M. Dekker & A.T.F. Beekman (Netherlands)

Background

Victimization in psychiatric patients
Psychiatric patients have a considerably high risk of being victim of a crime (Hiday et al., 2001; Silver et al., 2005). Even after controlling for demographic variables, prevalence rates were found to be 11 times higher in psychiatric patients than in the general population (Teplin, 2005). Victimization is a highly stressful experience that often impacts multiple domains of life, especially in the vulnerable population of psychiatric patients. Victimization can exacerbate existing symptoms, increase the likelihood of service use, hospitalization, relapse, remission and posttraumatic stress disorder and can substantially diminish quality of life (Teplin, 2005).

The majority of victimization research has focused on patients with severe mental illness (SMI) or substance use disorders (SUD). Comorbid depressive symptoms were identified as a risk factor for victimization in this group (e.g., Stevens et al., 2007). The few studies that specifically focused on depressed outpatients also demonstrated that depression is associated with victimization (Silver et al., 2005).

Risk factors for victimization
In psychiatric patients, previous victimization, symptom severity, alcohol and drug abuse, psychotic symptoms, and comorbid disorders such as depression and personality disorders have been identified as risk factors for victimization (e.g., Teasdale, 2009; Iverson et al., 2011; Cougle et al., 2009). In addition, emotion regulation (ER) is assumed to be an underlying mechanism in victimization (i.e., Marx et al., 2005). ER refers to "the processes responsible for monitoring, evaluating and modifying emotional reactions, especially their intensive and temporal features, to accomplish one's goals" (Thompson, 1994). Emotion dysregulation (ED) is considered to be a consequence of prior victimization and a unique predictor of future (re)victimization (Messman-Moore et al., 2013; Messman-Moore et al., 2015; Iverson et al., 2013; Walsh et al., 2012). The influence of ED on victimization seems highly relevant for patients with depression. In a recent study, ED has been identified as a risk factor and maintaining factor for depression as well (Radkovsky et al., 2014).

Victimization in depressed patients:

1. Prevalence study (Meijwaard et al., 2015)

Methods
Our research group conducted a cross-sectional study to determine 12-month violent and non-violent victimization prevalence rates in a sample of 300 outpatients with either a depressive disorder, a substance use disorder (SUD) or SMI. Prevalence rates were compared to those in the general population, consisting of 10.865 respondents living in the area of Amsterdam.

Results
Results confirmed that psychiatric outpatients are at increased risk of falling victim to both violent crimes (assault, sexual abuse or threat of violence) and non-violent crimes (property crimes; burglary, theft and pickpocketing). Prevalence rates for violent victimization were four times higher in psychiatric patients than in the general population. Prevalence rates in depressed patients or patients with SUD were higher on overall victimization (respectively 67% and 76%) than in patients with SMI (39%). More than a third of the depressive outpatients reported to have fallen victim to a violent crime in the past year. Depressed patients were 3.8 times more likely to be a victim of a violent crime in comparison to the general population (Meijwaard et al., 2015).

Discussion

Since there seems to be little attention for victimization in depressed outpatients in clinical settings, these results are striking. In addition, current victimization research seems to focus mainly on patients with SMI and/or SUD. As a result, existing knowledge regarding victimization in patients with a depression is minimal. In order to develop successful prevention programs, further research is necessary (Meijwaard et al., 2015).

2. Intervention study

Objective

Given the high risk for violent victimization and its severe impact, it is highly important to find a way to reduce victimization risk in this vulnerable group of depressed patients. No evidence-based anti-victimization interventions are yet available for this population. Because ER is suggested to be an underlying mechanism leading to (re)victimization and to play an important role in depression as well, a clinical intervention aimed at enhancing ER skills may decrease (re)victimization risk in depressive patients.

Methods

In an RCT, we will therefore examine the effectiveness of a blended version of the Emotion Regulation skills Training (ERT; Berking et al., 2013) added to treatment as usual (Cognitive-Behavioral Therapy; CBT) in reducing victimization risk and depressive symptoms. A sample of 150 participants with a Major Depressive Disorder will be recruited in multiple mental health care institutes in The Netherlands. Victimization will be assessed using a National Crime Victimization Survey (CBS, 2009) at 12, 24 and 36 months after baseline. Other secondary outcome measures will be assessed at these time points and during the treatment phase.

E-health intervention

The presentation will provide an overview and impression of our blended Emotion Regulation Training, which is a shortened and slightly adapted version of the Affect Regulation Training (Berking, 2007). Educational goals of the presentation

Participants will be able to cite prevalence rates of different types of victimization of patients with depression and comprehend why patients with depression are vulnerable for victimization.

Participants will gain knowledge about potential mechanisms of action to diminish victimization of patients with depression and get an impression of an online version of emotion regulation skills training that can be widely implemented in mental health care in the future.

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Educational Goals

1. Participants will be able to cite prevalence rates of different types of victimization of patients with depression and comprehend why patients with depression are vulnerable for victimization.
2. Participants will gain knowledge about potential mechanisms of action to diminish victimization of patients with depression and get an impression of an online version of emotion regulation skills training that can be widely implemented in mental health care in the future.

Correspondence

Ms. Carolien Christ
VU University Amsterdam and GGZ InGeest
A.J. Ernststraat 1187
1081 HL
Amsterdam
Netherlands
carolien.christ@arkin.nl

Anger Treatment for Forensic Patients: Stress Inoculation Module

Workshop

Raymond W. Novaco, University of California, USA
John L. Taylor, Northumberland, Tyne & Wear NHS Trust & University of Northumbria, UK

Keywords: anger, treatment, stress inoculation

Abstract

Dysregulated anger often drives violent behavior by psychiatric patients, before during, and after hospitalization. Anger 'dyscontrol' can have serious consequences for clients, their families, and for mental health care staff. The efficacy of CBT programmes for anger has been demonstrated across types of settings, institutions (forensic and non-forensic), and formats (individual and group). Beyond reduction in anger levels, our anger treatment program has produced substantial declines in assaultive behavior in a forensic hospital. A core component of our treatment approach is "stress inoculation", which involves graded exposure to simulated provocation, for which the client is guided to apply cognitive, arousal, and behavioral coping skills that have been acquired therapeutically.

In this interactive workshop, participants will learn how to use the stress inoculation paradigm as a component part of our CBT intervention, including for clients with limitations in cognitive abilities. Participants will practice developing clients' provocation hierarchies in analogues of clinical work (e.g., developing them from anger inventory assessment) and shown how to facilitate clients' use of therapist-guided anger control coping strategies for provocation experiences presented in imaginal mode.

Training modalities

Didactic and experiential

Workshop Leaders

Ray Novaco is Professor of Psychology and Social Behavior at the University of California, Irvine, USA. He is the foremost international authority on anger treatment research and pioneered the therapeutic approach that incorporates the stress inoculation paradigm. He has published extensively on anger, its treatment, and it relation to psychopathology.

John Taylor is Professor of Clinical Psychology at Northumbria University and Consultant Clinical Psychologist with Northumberland, Tyne & Wear NHS Trust, UK. He has conducted extensive clinical research on anger problems experienced by people with mild and borderline intellectual and developmental disabilities. He has Responsible Clinician status in the UK.

Key References

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Educational Goals / Learning objectives:

- Rapid familiarity with anger assessment instruments; focus on an anger inventory
- Learning provocation hierarchy construction, including incorporation of anger moderators
- Learning how the stress inoculation approach is conducted

Correspondence

Mr. Raymond Novaco
University of California, Irvine
Department of Psychology and Social Behavior
92697-7085 Irvine, CA
USA
rwnovaco@uci.edu

Anger Treatment Therapist Training Level Effects with Forensic Intellectual Disability Patients

Paper

John L. Taylor, Northumberland, Tyne & Wear NHS Trust & University of Northumbria, UK
Raymond W. Novaco, University of California, USA

Keywords: anger treatment, therapist level, treatment gains

Abstract

Among forensic populations, the unmet need for mental health care is greater than for the general population, and this is especially so for those with intellectual disabilities (ID). The present study concerns an enhancement in the provision of anger treatment delivered to that client population at a forensic hospital. The clinical research question was whether a CBT anger treatment, specialized for offenders with ID (Taylor & Novaco, 2005), can be efficaciously delivered by supervised trainee therapists. We examined whether trainee therapists can achieve clinical gains and compared their outcomes to those attained by experienced therapists using the same manual-based treatment protocol. Multiple patient-rated and staff-rated measures of anger and aggressive behaviour were used to evaluate treatment gains among 88 patients (55 treated by professionally qualified therapist and 33 by trainee therapists) who received an 18-session treatment.

Anger assessments occurred at 4 time points: baseline, pre-treatment, post-treatment, and 12-month follow-up. Repeated measures analyses revealed that trainee therapists indeed achieved significant declines in patient anger and aggressive behavior. However, treatment gains were significantly stronger for experienced therapists, especially for the STAXI anger control, NAS anger regulation, and staff-rated anger indices. Significant differences were found in patient characteristics, with more difficult patients having been assigned to the professionally qualified therapists.

Overall, the present study results extend our previous findings on the efficacy of CBT anger treatment with this client group, which has not only shown reduction in anger levels but also reductions in physical assaults. Our findings are good news for world-wide initiatives seeking to boost the delivery of psychological treatment for the mental health needs of forensic populations.

Educational Goals

Learning the components of CBT anger treatment as applied to clients with intellectual disabilities
Learning how trainee therapists were trained and supervised to deliver the anger treatment
Learning treatment evaluation methodology

Correspondence

Mr. Raymond Novaco
University of California, Irvine
Department of Psychology and Social Behavior
92697-7085 Irvine, CA
USA
rwnovaco@uci.edu

The Use of Cognitive Behavioral Therapy in Treating Patients with DSM–5 Intermittent Explosive Disorder

Poster

Michael McCloskey, Alexander Hamilton, Alexander Puhalla, Lauren Uyeji, Anne Knorr & Daniel Kulper (USA)

Abstract

Intermittent Explosive Disorder (IED) is a disabling psychiatric condition characterized by recurrent, problematic, impulsive aggressive outbursts. Despite this, there is currently no empirically supported treatment for IED. A 12-week cognitive behavioral therapy for IED reduced aggression and increased quality of life relative to supportive psychotherapy.

Aim

Intermittent Explosive Disorder (IED) is a disabling psychiatric condition characterized by recurrent, problematic, impulsive aggressive outbursts. Once thought to be rare, recent studies have shown IED to have a lifetime prevalence of 4-6 %. IED is also associated with severe psychological distress. Despite this, there is currently no empirically supported treatment for IED. We aimed to test the efficacy of 12-week cognitive behavioral therapy (CBT) for IED at reducing aggression and impulsivity and increasing quality of life.

Methods

Thirty-seven participants meeting DSM-V criteria for IED were randomized into either wait-list control (11 participants) or CBT (26 participants). All participants completed behavioral measures of aggression (Taylor Aggression Paradigm: TAP) and impulsivity (Immediate Memory Task: IMT) and a self-report quality of life (QOL) measure at two time-points: at baseline and 1-week post treatment/wait-list.

Results

Results of a one-way analysis of covariance (ANCOVA) with baseline performance as the covariate, showed that subjects in the CBT condition, compared to those in the wait list condition showed less aggression on the TAP at post treatment/wait-list, $F (1, 34) = 5.88$, $p < .05$. Likewise, ANCOVA analyses showed that participants in the CBT condition reported greater life satisfaction , and well-being at post treatment/wait-list. However, there was no effect of treatment on IMT commission errors ($F < 1$).

Discussion: These results support the efficacy of CBT in reducing aggression and improving life satisfaction among individuals with IED via mechanisms other than by reducing impulsivity.

Educational Goals

• Goal 1 - Learn the diagnostic criteria for DSM-5 IED.
• Goal 2 - Learn about current treatment for IED

Correspondence

Mr. Michael McCloskey
Temple University
1701 N 13th st
19122 Philadelphia
United States
mikemccloskey@temple.edu

Is It More Than Just the Play? The Influence of Therapeutic Catharsis-Seeking, Personality Differences, Self-Construal and Social Capital

Poster

Hye Rim Lee, Eui Jun Jeong & Ju Woo Kim (South Korea)

Abstract

Evidence of the effects of playing games on aggression has been mixed. Previous research has focused mainly on aggression in violent games. Therefore, we sought to extend on this research by examining the connections between therapeutic catharsis-seeking, personality traits, self-construal (independent and interdependent) and social capital (bonding and bridging) in games more generally.

Using data from a survey of 918 game players in South Korea, we conducted a regression analysis to see the associations of psychosocial factors with the degree of aggression.

Results showed that therapeutic catharsis seeking alleviated aggression, extraversion and neuroticism negatively affected aggression, whereas agreeableness enhanced the degree of aggression. Independent self-construal reduced the level of the players' aggression. Interestingly enough, the bonding social capital enhanced the level of the players' aggression, while individuals with bridging social capital did not show any significant effects. The important results as well as their implications for the players and further associated research are explored.

For two weeks, we conducted an online survey in which a total of 918 participants, ranging from 16 to 59 years of age, were randomly selected from South Korea for our final analysis. 532 (58%) of the respondents identified themselves as male and 386 (42%) as female. These participants voluntarily completed a questionnaire, and were informed before the study began that they had to either be currently active in a game or active within the previous six months. After finding variables significantly correlated with aggression, we used a regression analysis to examine how each variable affected it.

Educational Goals

To understand:
A. The Aggression Catharsis Perspective
B. Big 5 factor model
C. Self-Construal
D. Social Capital

Correspondence

Ms Hye Rim Lee
Konkuk University
20 Neung Dong-Ro, Gwang Jin-Gu,143-701,
ASI|KR|KS013|SEOUL
South Korea
Tel: +82-10-7220-4709
nevercry2100@gmail.com

Chapter 11 – Service users and family perspectives

"My daddy has an illness in his mind", Children as next of kin

Poster

Anne Kristine Bergem (Norway)

Keywords: Parenting, psychosis, children, next of child, risk factors, information, children's rights, health personnel, mental health, prevention

Abstract

In Norway, there are a large numbers of families with somatic disorders, mental disorders and/or drug problems. Children are affected by dealing with serious illness in the family. Moreover, children with mentally ill/drug dependent parents are at greater risk of developing mental disorders themselves.

In 2010, the Norwegian Government developed health personnel and specialist law provisions concerning the safeguarding of children as dependents were developed. (The law on Health Personnel § 10a and § 25 and Specialized Act § 3-7a and circular IS-5/2010; Children dependents.)

The background for this law is the adversity that children may suffer in connection with parental illness, injury or addiction.

The purpose and aim of the law is to prevent problems in children and parents through:
- ensuring risk children and youth early intervention
- putting children and parents better able to cope when parents experience mental illness, drug addiction or serious physical illness or injury

Children of parents with psychosis and violent behavior are at risk in at least three different ways when it comes to developing mental health problems themselves.

The first risk factor is the genetic predisposition these children inherit from their parent.

The second risk factor is the fact that parents with severe mental disorders will in periods of their lives be unable to take care of themselves or others. Children may experience neglect and/or abuse. The third risk factor is that it may difficult for the child to be next of kin to their severely ill parent.

The legislation in Norway mentioned above makes hospitals responsible for children as next- of-kins. In addition to this, all hospitals in Norway have to have health workers that are designated to work with children of adult patients.

The law states that children shall be identified and involved according to their age and how mature they are. They should receive information on their own terms.

None the less, many health workers find it difficult to address children, especially when it comes to mental health problems. It is difficult to explain psychiatric disorders to small children.

I have worked both in acute wards and in a forensic ward for several years. Even before the new legislation was introduced, I was concerned with the welfare and the situation around the children of the adult patients I met.

I experienced a lack of tools and knowledge in the field. As a result I decided to write a book about psychosis and violent behavior for health workers and other adults to use when talking to small children.

If I get the opportunity to present my work in the conference, I will translate my book into English, and read it out load to the audience whilst showing the illustrations on the screen. The book contains colorful images that will appeal to small children.

In addition to this I will inform the conderence of the National Competence Network for Children as Next of Kin in Norway:

National competence network for collecting, systematizing, and communicating knowledge about children who have parents with somatic, mental and/or drug-related disorders.

The Ministry of Health and Care Services has established a national competence network in order to improve the follow-up of children with somatically and mentally ill/drug dependent parents. (Sørlandet Hospital HF spearheads and coordinates the network, named BarnsBeste (Children's Best Interests).

BarnsBeste collects, systematizes, and communicates knowledge and methodology for the purpose of preventing and treating problems in children with parents who suffer from illness and/or drug problems.

The network helps institutions and services to more systematically identify and follow up on the children who need it. Another objective is to focus on the collection and communication of competence aimed at children with minority backgrounds.

BarnsBeste fascilitates the transfer of knowledge across professional communities, government agencies, treatment levels, universities, and colleges.

BarnBeste maintains contact between professional communities, government agencies, treatment levels, universities, and colleges in all parts of the country. We meet with people from these communities for brainstorming, conferences, and sharing experiences.

Objectives and responsibilities of BarnsBeste:
- To collect, systematize, and communicate knowledge and experience about children as next of kin from Norway and other countries.
- To collect, systematize, and communicate knowledge to services regarding constructive coordination measures.
- To facilitate national competence building through initiatives for research and professional development and through advice and guidance for central health authorities and the health service.
- To obtain and communicate knowledge about children as next of kin from ethnic minorities.
- Competence building which directly benefits children and youth should be prioritized.

Educational Goals

- Identify children of patients with severe mental disorders
- Give children an opportunity to talk about their experiences with a sick parent
- Give adults, both in mental health care, in community services and other important grownups a tool in communicating with children
- Give children a language to describe psychosis and their experiences related to a parents illness

Corespondence

Ms. Anne Kristine Bergem
The best for children - National Competence Network for Children as Next of Kin
Engelsrudlia 51
1385 Asker
Norway
akbergem@me.com

Subjective Perception of Coercion in Persons with Mental Disorder in India

Paper

Bevinahalli N Raveesh, Peter Lepping, Soumithra Pathare & Joske Bunders (India)

Keywords: Coercion, Subjective Perception

Introduction

Coercive practices are relatively common in mental healthcare, but coercion is ethically problematic because it involves acting against an individual's autonomy. Coercion is a subjective inner experience to a particular intervention that is against their will, either through force or by threat. Increasing patient autonomy and decreasing coercion are frequently cited goals in mental health care.

Objectives

To assess subjective perception of coercion in persons with mental disorder admitted on involuntary subjects. To correlate socio-demographic factors like age, gender, education, marital status, family size and income, distance of stay from the hospital, type and duration of mental illness and former coercive used with subjective perception.

Methods

The study was conducted after obtaining institutional ethical clearance at department of Psychiatry, Krishnarajendra Hospital attached to Mysore Medical College & Research Institute (MMCRI), Mysore. Subjects were administered MacArthur Admission Experience Interview questionnaire, a short form of 15 questions with true, false or do not know responses. Consent was taken and confidentiality was maintained.

Results

The data was assessed using descriptive statistics and Chi- square test. Statistical significance was found in male, married and psychotic subjects, who felt they were forced and no chance was given to them. Subjects from nuclear family, with low income, depressives and from rural area reported that they were free and not threatened. Hindus and Christians, Alcohol dependents and psychosis subjects were angry. Muslims and female subjects felt relieved. Previously coerced subjects reported to be sad.

Conclusion

The issue of coercion remains controversial and challenging in psychiatric services. Coercive measures involve a conflict of medical-ethical principles. On the one hand there is the question of "doing good" or "avoiding harm", while on the other is the requirement to respect the autonomy of the patient as far as possible.

Educational Goals

- Cognitive Domain: To understand the subjective perception of coercion among persons with mental disorder
- Affective domain: To understand the emotional aspects of persons with mental disorder in family centered social system
- Psychomotor domain: To balance the ethical-legal-clinical aspects of coercion

Correspondence

Mr. Raveesh Bevinahalli Nanjegowda
Professor & Head, Dept of Psychiatry, Mysore Medical College & Research Institute
Irwin Road
570001 Mysore
India
Tel: +919980138016
raveesh6@yahoo.com

Risk, Gain, Liability and Hope: Integrating and Training Family Members in the Treatment Planning and Implementation Process When Aggression History is Present

Paper

Bob Bowen (USA)

Keywords: Restraint, Family Training, Consumer Involvement

Introduction

In the most recent study available from the United States, 78% of psychiatric patients wanted their families involved in the treatment planning and implementation process. Most reported that their families were involved to a minimal extent, with a desire for more involvement. (Cohen et al, 2013)

In a study done in the United Kingdom, 87.5% of family members indicated they had to use restraint on a family member, with 21% reporting frequent use. However, only 25% received any training in the use of restraint. Family members reported that while the physical stress of restraining a family member was intense, the emotional response was far worse. (Allen & Hawkins, 2004)

Staff receive a great deal of training in the prevention, and if needed, use of restraint, to varying degrees based on statutory requirements for training, available resources, and the need for such training in organization specific settings. Families of the individuals served in these settings rarely, if ever, get the same degree of training as staff. At a minimum, families should receive the same preventative training provided to staff.

Narrative

In 2008, Lisa Young approached The Mandt System, Inc. and asked for training to learn how to restrain her son. After interviewing her by phone and receiving supporting documentation, the decision was made to provide this training.

Lisa Young shared the following information regarding the impact of the training:

"We encountered a challenge three months after implementing the Mandt system. For the first time, I had to rely on my restraint training to see us through a very explosive episode. More importantly, I was unafraid! It was a short rage, lasting only 47 minutes. The hold was held for only 1 minute 32 seconds until he began to deescalate. He and I were both worn out at that point. Exhausted, he went to his room to rest. After a few minutes I checked on him. Although drowsy he sat up and really looked into my eyes. He then said, "Wow mom, you handled me!" Then he hugged me and spoke for the first time the words, "I love you," while keeping eye contact.

On that day my life dramatically changed. My son felt safe and secure in the fact that I could handle him, even when he couldn't handle himself. That was 605 days ago. Since then we have lived as a typical family, able to eat at restaurants, attend church, see movies in a theater and even go to crowded public places like the zoo and amusement parks." (Young, 2009, Personal Communication)

One of the concerns raised by many people is that if families are taught how to restrain their children, they will do so with more frequency. The case of Lisa Young and others proves otherwise. Her restraint of her son lasted approximately one and a half minutes, and for almost 2 years there was no need for restraint. Many human service organizations cannot say that!

After this experience, Lisa started an organization providing training to families. Prior to taking her own training initially, she was required to provide 3 references supporting her use of the techniques of restraint. This was done as staff are vetted with background checks, and a similar process should be undertaken with families.

No such safety net exists for family members. If a family member injures the individual served by the organization while they are on an approved home visit, the organization often fears it may be held accountable for the actions of the family at the same time they do not have the ability to monitor and supervise family actions with certainty to the same degree they do with the actions of staff.

A standard risk management model is presented for consideration:

Standard Risk Management Process

Source: Standards Australia and Standards New Zealand, AS/NZS 4360:1999
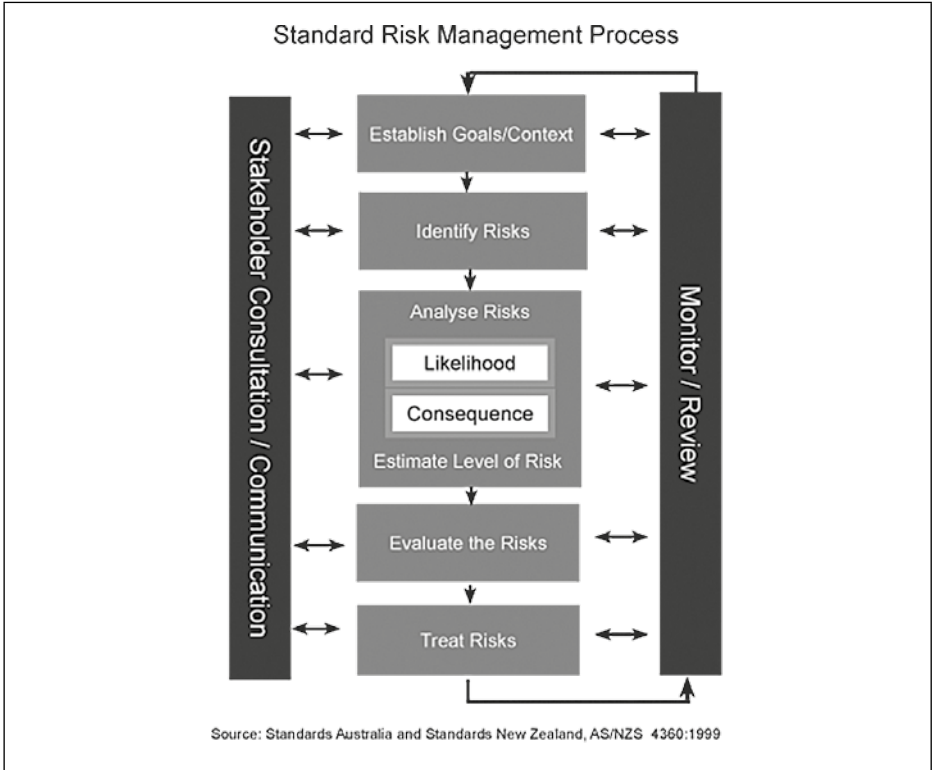
In this process there are 8 interrelated steps:

1. Establish goals and context. Earlier in this paper it was established that families need training in the prevention of aggression and, if needed, de-escalation tools to further prevent aggression. As a last resort, training in restraint would be needed.

2. The risks have been identified in many different studies as to the risks of doing restraint. Less well identified are the risks of not doing a restraint. Likewise, the benefits of restraint as a brief, behavioral interruption lasting less than 2 minutes have not been well documented.

3. The likelihood of injury to individuals served varies, with rates of 3.25% (Uppal, 2009) to 3.8% (CWLA, 2005) reported. In both studies, staff injuries were approximately twice as frequent, consistent with data from other studies. (Mohr, Pettit & Mohr, 2003). Family members are assumed to be susceptible to injury at the same or higher rates than staff.

4. The consequences of providing training versus not providing training have not been evaluated. In the opinion of the author, providing training has less overall risk than not providing training.

5. Evaluating the risks of not providing training includes having family members "invent" interventions. This occurs to staff who are untrained as well, when, due to their own fear, frustration, and other emotions they may be feelings, they react and physically intervene using either "street skills", previous training, or reflexive reactions. The risks of using an untested intervention versus an intervention that has been designed and evaluated for biomechanical safety are significant. (Mandt & Bowen, 2014)

6. In the model, the phrase "treat risks" as risk management is used. Rather than treat risk, human service providers teach new, replacement behaviors that provide safety. In this way, risk is mitigated by increasing safety. This use of a behavioral framework to address risk is sound and used by most vendors of training in the prevention and, if needed, use of restraint.

7. Stakeholder participation in this process is critical. In Dartmouth, Nova Scotia family members participated in training and felt empowered to respond to situations. (Fagan, 2015, Personal Communication).
8. Ongoing monitoring and review by outside entities is also a critical step in this process. Independent reviews of outcomes by case managers, funding entities or other commissioning bodies would provide external validation of what is, at this point, an internally driven process.

One concern often raised is liability. If a staff person is injured, or injures someone during the course of a physical intervention, there are well established risk management processes to follow during the initial period of employment before the staff are able to work independently. When the staff are deemed ready to work independently, they are covered by a combination of liability and risk management provisions commonly known as Occupational Health and Safety laws.

Family members, however, may be subject to allegations of abuse if their intervention results in injury to their child. This issue should be addressed by the regulatory bodies responsible to address abuse and neglect of children, as well as of adults who are living with family members.

There is certainly risk involved in training family members, and there are also rewards. There is certainly liability present, and there is hope that is present as well. The hope Lisa Young found can be provided to other families in other settings. Finding ways to balance these competing interests is the task of those involved in the funding, regulation, administration and provision of services to individuals affected by disabilities and mental health needs.

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Educational Goals

1. Identify the key factors in mitigating risk and liability in training family members in the prevention and, if needed, use of restraint.
2. Delineate a process to teach family members the prevention and, if needed, use of restraint

Correspondence

Mr. Bob Bowen
Senior Vice President for Product Development
The Mandt System, Inc.
PO Box 831790
75083 Richardson
USA
bob.bowen@mandtsystem.com

Self-determination and the use of coercion and restraint – People with intellectual disability

Abstract

Sometimes coercion is very apparent, at other times it is almost invisible and communicated to a lesser degree. It is important to identify and investigate the various relationships of power that influence consumers and patients under Norwegian law.

The research questions in this study are:
1. What do I decide, and what do others decide: The opinions of persons with intellectual disability and of others. This includes the significance of deciding for oneself over matters of identity, understanding of self, and quality of life, and for interaction with others based on the individual experiences of persons with intellectual disability.
2. How can one increase consciousness regarding constructive self-determination in persons with intellectual disability?
3. How can constructive self-determination in persons with intellectual disability contribute to reduction of use of coercion and restraint?

The project "Self-determination and the use of coercion and restraint" has its genesis in the intersection of the two central legal principles recorded in the preamble to Chapter 9 of the Health and Care Services Act; on the one hand, the right to self-determination, and on the other hand, the need to be able to prevent significant injury or damage. We know something about the extent to which persons with intellectual disability are subjected to the use of coercion and restraint, but there is still reason to believe that it is underreported and that the true extent is not known. In relevant public documents we read about an expectation that more knowledge about persons with challenging behavior and about other solutions than coercion, and more training in issuing orders in the care plan for use of coercion and restraint in accordance with law, will lead to less use of coercion and restraint. This expectation has not been met in terms of decreasing numbers of orders issued for the use of coercion and restraint or of decreasing numbers of persons with such orders.

Self-determination is one of the most important conditions for positive development and for one's own identity.

Research related to persons with intellectual disability, both internationally and nationally, has been based on studies of information given by staff, family, or from observations. The thoughts and voices of individual persons with intellectual disability have largely gone unheard and have not been focused upon. Research has a tendency to be "about" rather than "with".

This study takes a phenomenological approach to the exploration of a complex set of issues of which there are few descriptions and a dearth of research: the individual experiences of persons with intellectual disability. These experiences are important for many reasons, both for the individuals themselves and for the understanding they can contribute to service providers.

The overarching themes in this project are self-determination as a requisite condition and as a possibility in situations where coercion and restraint are used and where individuals' rights under the law are threatened. We carried out conversation-like interviews with individuals with intellectual disability. In total we interviewed 13 persons. Those who were invited to participate in the conversations/ interviews were all adults over 18 years of age who could give voluntary informed consent. We recruited individuals who have had or who have orders issued under Chapter 9 of the Health and Care Services Act, or under Chapter 4A of the former Social Services Act, which entail that coercion and restraint are used on a person in conjunction with care services provided by the municipality.

The basis for the respondents' experience with the topic at hand varies, with the exception that they all satisfy the study's design. Seven of the respondents have experience with having orders in their care plan that permit the use of coercion and restraint and that include the use of physical interventions. This may be understood as coercion and restraint in which municipal staff use physical interventions like holding, prone restraint and isolation to prevent significant injury or damage. The scope of the physical interventions varies also, both with respect to extent and severity. Six of the respondents have orders that permit the use of coercion and restraint with regard to the withholding of food and drink, except water.

All of the 13 persons we interviewed are in a situation where they are at the mercy of what the staff think and believe. Many of the informants have come to terms with this and can explain this in different ways, and they also appear to feel secure with their life situation. At the same time, they appear to lack important information that could make them capable to a greater degree of being a primary actor in their own lives. Others are more ambivalent and can be seen as opposing the staff. This opposition leads to conflicts and further restrictions on the part of the municipal staff. A final factor relating to our observations during the interviews with the respondents is that there are individual factors in each informant that play a deciding role with respect to what they manage to communicate and what they are in a position to understand. There can be great differences in communicating with a person who perhaps has a condition that might be classified as mild intellectual disability and communicating with a person who perhaps is on the border between mild and moderate intellectual disability.

The concept of self-determination is unknown to several of the informants, but the concept that they all understand is "deciding for oneself". They all report that they like to decide for themselves.
It appears that it is unclear for most all of the respondents with whom we have spoken that deciding for oneself is a legal right according to Norwegian law. Self-determination for those with whom we have spoken concerns three issues.
1. Everyone likes to decide.
2. Most of the areas where they make decisions have to do with other persons.
3. Staff have a veto in cases that are significant for the informants.

This study finds that respondents have rarely received information that was made accessible and understandable to them about the municipal staff's decisions on orders for use of coercion and restraint. There are exceptions; some of the respondents read through their orders after the care plan was already prepared. For the rest, it does not appear that this information has been shared. In all cases it appears that respondents have not participated in the drafting of the orders for use of coercion and restraint. Participation and the securing of this information is stipulated in three different sections of Chapter 9 of the Health and Care Services Act.

Those who are or who have been subject to physical interventions or restraints use similar types of descriptions to describe how they experience, or have experienced, the interventions. Words many of them used to describe coercive interventions were hurt, afraid, bad, and I hope it doesn't happen again. In relation to understanding why there were orders for coercion or why staff use physical interventions, levels of understanding were more divided. In our review of the material we see that five of the respondents are not able to communicate to us at they understand why staff used coercion. This is true both for those who experienced physical interventions and for those who have orders relating to the locking up of food. Some of the informants who have restrictions placed on their access to food say that it just has to be that way. For some, the reason for this is that they have an illness. Those who have a causal explanation appear calm in their recounting. Additionally, some of those who have experience with physical restraint have causal explanations; the staff use coercion with them so that they don't hurt themselves or others. Four of the respondents with whom we spoke had experiences related to dramatic life events that we understood to have been traumatic in nature. For example, one person had been raped, and several persons had been removed from their childhood homes against their will. Some also had experience with extreme use of physical coercion that had happened over the course of many years under municipal care.

Several of the turning points or life events, as the informants explained them, became the prelude to orders on the use of coercion and restraint.

When we address questions about alternatives to coercion and restraint, several of the respondents have ideas for alternatives or have a desire to find alternatives that are different to what we see in use today. A common denominator in this context is that the respondents express that they think it's nice that someone has come to talk about this topic.

NAKU recommends implementing the following initiatives:
1. Increase the focus on documentation with respect to sections § 9-1, § 9-3 and § 9-7 f in Chapter 9 of the Health and Care Services Act in the municipal decisions regarding use of coercion and restraint.
2. Tighten up and follow the requirements for education that are stipulated in the Health and Care Services Act. This, with regard to § 9-9 Requirements for implementation and evaluation.
3. Develop a net-based training module for staff to increase the focus on the tension inherent in the relationship between self-determination and use of coercion and restraint with persons who are intellectually disabled. Further on the contents of these training modules:
   a. Create training modules that contain ethical reflection, short technical texts that give clarity to questions of rights and understanding of the relationship between coercion and restraint and self-determination. The texts must be written in a way that makes them accessible to persons without formal education. This means that academic texts must be adjusted and the material re-written in a way that it is easily understood. Additionally, links should be provided to the original sources for those who wish to explore the subject matter more deeply. We recommend the use of updated research and the latest developments in the field, which are produced by NAKU and other central actors in the professional field. This approach should be used in all following points.
   b. The consequences of violations against individuals through the short- or long-term use of coercion and restraint should be addressed in a separate. The theoretical foundations and international research on the subject have earlier been described in two articles and a short instructional film created by NAKU; http://naku.no/node/1273. This was produced with the support of the Directorate for Children, Youth and Family Services in 2013. The title of the project was "Subproject I: Violations and offensive practices".
   c. The training should have a separate module for debriefing related to incidents of violations against individuals. Currently, routines for debriefing have been implemented as practice in the child protective services and in the mental health services, but are seldom used in conjunction with Chapter 9 in the Health and Care Services Act. Development of routines for debriefing will require a reworking of existing materials for use with other patient and user groups.
   d. The training should utilize films and should include practical advice about how to initiate and carry out conversations about coercion and restraint and self-determination. In addition, the films should be created in a way that supports reflection on both an individual level and in a staff group.
   e. Relevant material that can support the training can be provided through links in the materials.

Training materials should be available free of charge on the Internet and downloadable in PDF format.

Fulltext pdf in Norwegain, Summary in English: http://naku.no/sites/default/files/NAKU_tvang&makt_ferdig2_skjerm.pdf

Educational Goals

1. Describe how people with intellectually disability feel and think regarding coercion and restraint in Norway.
2. Analyze and describe prevalence of coercion and restraint in Norway.
3. Discuss implementing initiatives.

Correspondence

Mr. Kim Berge
The National Institute on Intellectual Disability and Community
Trollsvingen 21
7056 Ranheim
Norway
kim.berge@hist.no

Violence towards family caregivers by mentally ill relatives – results of a German online survey

Poster

Christian Zechert, Beate Lisofsky & Caroline Trautmann (Germany)

Keywords: Caregivers, family burden; online survey; prevention of aggression for families, domestic violence

Introduction

Families with severe mentally ill members have wide experiences with stressful situations and violence. Some families suffer from domestic violence over years. In opposite to clinical management these families lack professional trainings, clinical staff intervention, or any guide-lines for de-escalation. Instead, they use more or less successful individual coping strategies. There is little research on how clinical competences to manage patient violence could help in private situations within families.

Procedure/ Methods

An online qualitative data survey of the 'Bundesverband der Angehörigen psychisch Kranker' was carried out. The "Staff Observation Aggression Scale – revised" (SOAS-R) were used in a version that could be filled out by family members at home. 220 families took part in a pilot study and provided first data about aggression from the perspective of relatives of mental ill persons.

Results online survey: 88.2% (n=197) of the subjects experienced violence by a family member specifically, 43.7% by their partner or spouse, 29.1% by their son or daughter, 12.7% by a parent, 7% by their brother or sister, and 7.7% by a friend or other relative (see Fig.1). 55.9% of the family members lived together with the ill person and 59,0% had daily contact.

In 11.3% of the cases, violence happened only once, in 7.5% violence occurred rarely, in 22% sometimes, in 38.6% often and in 19.5% very often. Violence types were distributed as follows: 48.8% psychological violence 4.4% physical violence, 31.9% psychological and ph   ysical violence. 43.5% of the subjects reported incidences were the mentally ill relative announced suicide or self-injury. With regard to helpful strategies, 48.4% reported to use self-developed strategies, 29.7% reported that they don't have any strategy, 6.5% used professional support and 5.5% reported to be members of a self-help group.

Discussion/ Conclusion

More than 50% of relatives with the experience of aggression by the ill needs alike clinical staff attention, specialized training and research. The transfer of clinical de-escalation strategies, the follow-up care for injured and the inclusion of the knowledge and experience of these families helps to support a better aggression-management inside the families.

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Educational Goals

• Relatives with the experience of aggression by the ill need professional attention, training and research. The transfer of clinical de-escalation strategies, the follow-up care for injured family members and the inclusion of the knowledge and experience of these families helps to support a better aggression-management inside the families.

Correpondence

Mr. Christian Zechert
Bundesverband der Angehörigen psychisch Kranker e.V.
Oppelnerstraße 130
53119 Bonn
Germany
Tel: +49 157 75789447
zechert.bapk@psychiatrie.de

Chapter 12 – Race, gender, cross-cultural & ethnicity perspectives

Gender differences in victimization and the relation to personality disorders and MID: Results from a multicenter study in forensic psychiatry

Paper

Vivienne de Vogel & Anouk Bohle (Netherlands)

Keywords: gender, victimization, personality disorders, MID, forensic psychiatry

Introduction

One of the research topics that have gained interest over the years is that of trauma or victimization among forensic psychiatric patients. More knowledge on the topic of victimization in forensic patients is important because a history of victimization is associated with an increased vulnerability to stress and mental health problems (Anumba, Dematteo, & Heilbrun, 2012) and predictive of future violence to others (Douglas, Hart, Webster, & Belfrage, 2013) and of self-harm (Verona, Hicks, & Patrick, 2005). A history of abuse contributes to an intergenerational transfer of abuse as this is not only predictive of violence in general, but also of violence towards their own children (Temcheff et al., 2008). Furthermore, children who are abused by their parents become more vulnerable to victimization in other situations, for example being bullied at school (Finkelhor, Omrod, & Turner, 2007). Consequently, childhood victimization contributes to an intergenerational transfer of violence risk from parent to child and to the development of mental health problems (Pietrek et al., 2013).

In contrast to most research topics in forensic psychiatry that focus predominantly on males, studies on victimization have mainly focused on female populations (e.g., Anumba et al., 2012). While the majority of the studies on victimization tend to focus on women, other studies include both male and female patients without considering possible gender differences (e.g., Temcheff et al., 2008). Ultimately, only few studies have focused on gender differences regarding victimization in forensic psychiatric patients. In the present paper results will be presented from two studies. In the first study we examined gender differences in 218 female and 218 male forensic psychiatric patients with respect to their victimization histories. In the second study, the focus was on victimization histories in both female and male forensic psychiatric patients with mild intellectual disabilities (MID).

Method

In 2012, a retrospective multicentre study was conducted into gender differences in forensic psychiatric patients in The Netherlands. The major aim of this study was to gain more insight into gender differences in criminal and psychiatric characteristics of forensic patients, especially characteristics that may function as risk or protective factors for future violence. In a first phase of this study, 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 over 300 women who are - or have been admitted to five different forensic psychiatric facilities in the Netherlands between 1984 and 2014. Furthermore, several risk assessment tools like the HCR-20 and the *Female Additional Manual* (FAM; de Vogel et al., 2014) were coded. In a second phase of this study, the list and tools were also coded for male forensic psychiatric patients from the five facilities. The male patients were matched to the female patients based on year of birth and year of admission to the current or most recent institution.

The present paper describes results from two studies that were part of this ongoing research project. The aim of the first study was to examine gender differences in victimization both during childhood and adulthood

and the relation to personality disorders in 218 female and 218 matched male forensic psychiatric patients. These patients were all admitted with the so-called TBS-order, a court-ordered mandatory treatment. The second study focused on victimization histories specifically in forensic psychiatric patients with MID. Results were compared between 126 female forensic psychiatric patients with MID and 76 female patients without MID, as well as with 50 male forensic psychiatric patients with MID and 61 without MID.

Results

Study 1

Overall, it was found that the prevalence of victimization was higher among female patients than among male patients, both during childhood and adulthood. More detailed analyses showed no differences for emotional and physical abuse or neglect during childhood, but childhood sexual abuse was found to be more prevalent among women. Female patients with a history of emotional or sexual abuse were significantly more often diagnosed with Borderline Personality Disorder (BPD) than women without a history of abuse. Contrastingly, male patients with a history of physical abuse were significantly more often diagnosed with Antisocial Personality Disorder (APD) and had significantly higher scores on the PCL-R than male patients without childhood victimization.

Study 2

This study focused on forensic psychiatric patients with MID. Results indicated that in general women with MID had more disturbing histories than women without MID. Prevalence of victimization, especially emotional and sexual abuse, during both childhood and adulthood was higher in women with MID compared to those without MID. Though there was no difference in overall victimization during childhood, women with MID were more often the victim of sexual abuse than males with MID. During adulthood, victimization in women with MID was 3 times higher than in males with MID, and women with MID were more often the victim of sexual and physical abuse than males with MID. Compared to males with MID, women with MID had higher levels of victimization during both childhood and adulthood.

Conclusion

Overall, it is concluded that the prevalence of victimization is high, both in female and male forensic psychiatric patients. However, it seem that female forensic psychiatric patients, especially those with MID, have more complex histories of victimization. Although no differences could be detected in emotional and physical abuse during childhood, women more often experienced sexual victimization during childhood or a combination of emotional, physical and sexual abuse. In adulthood, women clearly experienced more victimization than men. This finding confirms what is generally believed and what has been found in previous studies, that women who offend more frequently have a severe history of victimization than male offenders (Siegel, 2000; Weizmann-Henelius et al., 2004). It should be noted, however, that possibly not all (sexual) victimization of the men was reported, registered or detected as male patients are sometimes believed to be more reluctant to reveal sexual victimization because of feelings of shame (Logan, 2008). Thus, the gender gap in history of (sexual) victimization may in fact be smaller than found in the present study. Furthermore, there seem to be differences with respect to the relation to psychopathology, as for women, victimization, especially sexual abuse was related to BPD. For men, victimization, especially physical abuse was related to APD and psychopathy. More research is definitely needed into this topic.

Finally, some suggestions will be provided with respect to gender-responsive treatment. Most importantly, gender-responsive treatment programs should address issues such as trauma and low self-esteem and target improving skills relating to coping, parenting and financial management. The majority of the women experienced (multiple) traumas in the past. It is important for them to learn how to cope with the consequences and how to prevent re-victimization, for instance by learning how to set boundaries. Especially in mixed treatment settings - but also in society - there are considerable risks of being victimized again considering the vulnerability of these traumatized women (Finkelhor, 2011).

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Educational Goals

- To learn more about victimization
- To learn more about differences between men and women with respect to victimization
- To learn more about the relationship between victimization and personality disorders

Correspondence

Ms. Vivienne de Vogel
Van der Hoeven Kliniek
P.O. Box 174
3500 DA Utrecht
The Netherlands
vdevogel@dfzs.nl

How Gender of Staff and Patient may Impact the Incidence and Management of Aggression in Forensic Psychiatric Units

Poster

Ms. Marie Gold (Canada)

Abstract

Gender issues related to aggression management in forensic psychiatry is a contentious issue. It has been demonstrated that an unsuitable gender staff profile and gender related clinician-patient pairing could result in negative outcomes as it pertains to violence and aggression.

There are significant gender differences in both psychiatric illnesses and criminal behavior. They are complex and multidimensional being influenced through biology (genes, hormones, anatomy) and psychosocial roles (history, experience, culture, societal roles). Sensible and specific service delivery to patients of both sexes requires more sophisticated grasp of gender issues.

A broad organizational approach is required for change which provides both structure and process to prevent incidence, and lead to better management of aggressive episodes. This includes gender specific practice and policy formulation, adjustments to the physical environment, staffing profiles, staff training, clinical approaches, routine organizational risk assessment, and continual monitoring.

Future research in gender issues from both male/female, and staff/patient perspectives must be conducted, analyzed and addressed. An understanding of gender issues may complement and enhance what otherwise would be inadequate psychiatry and psychological models.

Educational Goals

- Understand how gender may implicate the incidence and management of aggression and violence in forensic psychiatric inpatient units.
- Describe various strategies to apply towards gender related issues in order to reduce the incidence and better management of violence and aggression.

Correspondence

Ms. Marie Gold
St Josephs Hospital, McMaster University Hospital
100 West 5th Street
l8n3k7 Hamilton
Canada
mariechristinegold@hotmail.com

Chapter 13 – Ethical, human rights and legal perspectives

Decision-making capacity

Workshop

Peter Lepping & Bevinahalli N Raveesh (UK)

Keywords: Decision-making capacity, Ethical principles, Human rights

Abstract

Current capacity-based legislation and practice focuses primarily on patient autonomy as a primary value of ethical medicine. We argue that we currently overvalue autonomy to the detriment of other ethical principles such as beneficence, non-maleficence, justice and care ethics. This can have negative consequences for patients and their quality of life as well as service delivery. We argue that capacity is often over-estimated rather than under-estimated. A balanced ethical approach would consider the patient's right to treatment, their relationships and interactions with society and not solely the patient's right to liberty and autonomous decision-making. We give examples of the skewing of decision-making towards autonomy and the dangers it can pose. We also give alternatives and would like to invite the audience to discuss the best ways forward for psychiatry in the 21st century. We use the example of India to show different cultural approaches to autonomy, their dangers and their merits.

Educational Goals

- Address current legal priorities and whether they are fit for the 21st century.
- Discuss focus of care for patients and carers.
- Discuss differences amongst different cultures.

Correspondence

Mr. Peter Lepping
BCULHB, Centre for Mental Health and Society (Bangor University, UK) and Mysore MC&RI, India
Ffordd Croesnewydd
LL13 7TD Wrexham
Wales (UK)
peter.lepping@wales.nhs.uk

Prevalence of decision-making capacity in psychiatric patients compared to medical patients

Paper

Peter Lepping, Thushara Stanly & Jim Turner (UK)

Keywords: capacity, psychiatric settings, medical settings

Abstract

There is significant concern about patients' capacity to consent to admission and treatment in psychiatric and medical settings. Little is known about the prevalence of incapacity across specialties but decision-making capacity is likely to be overestimated by clinicians. The aim of this systematic review is to estimate the prevalence of incapacity to consent to treatment or admission in different psychiatric settings and compare it to medical settings. We conducted an electronic search following PRISMA principles and included 36 studies in psychiatric and 22 studies in medical settings. The 58 included studies revealed 70 data sets across all settings. For psychiatric settings the weighted average proportion of patients with incapacity was 45% (95%CI: 39%, 51%). For medical settings the weighted average proportion of patients with incapacity was 34% (95%CI: 25%, 44%). The two groups are not significantly different from each other in terms of the proportion of incapacity ($p = 0.92$). A considerable number of medical and psychiatric patients lack capacity to make treatment and assessment decisions. Clinicians should be more alert to the possibility that their patients may lack decision-making capacity. Health care professionals' assessment of capacity should be more frequent using the appropriate legal frameworks to act in the best interest of patients lacking capacity.

Educational Goals

- Increase awareness of lack of capacity in patients

Correspondence

Mr. Peter Lepping
BCULHB, North Wales, UK; Mysore Medical College and Research Institute, Mysore, India; Bangor University, Wales, UK
Croesnewydd Road
LL13 7TD Wrexham
Wales (UK)
peter.lepping@wales.nhs.uk

Coercive Measures in a High Secure Hospital: Attitudes and Experiences of Staff and Patients in England

Background

Violence in psychiatry, and the subsequent uses of coercive measures – restraint, seclusion, rapid tranquillization and segregation, has become increasingly prominent areas of study and debate over recent years. This paper reports on the findings of part of a doctoral study which examines the uses of coercive measures within a high secure hospital in England.

Aims

The study seeks to explore staff, patient and environmental influences on the uses of coercive measures, using a sequential mixed methods design. This paper reports on one stage of this study, notably, the findings from three questionnaires.

Methods

Standardized questionnaires were used to examine staff and patient attitudes and experiences across four specialized mental health wards within the hospital. The Attitudes Towards Aggression Scale (ATAS) was distributed to healthcare professionals, including nurses, nursing assistants, consultant psychiatrists, social workers and psychologists. In addition, the Attitudes Towards Containment Measures (ACMQ) and Essen Climate Evaluation Schema (EssenCES) were distributed to both healthcare professionals as well as patients. These findings were then analysed and compared using an iterative approach.

Results

Ward environment and philosophy were contributing factors towards differences in attitudes. Findings from this study revealed that staff rated the use of containment measures as being more acceptable than patients. Patients however, felt safer living in this environment than staff did working there. Those with the roles of containing are apparently more uncomfortable with this concept than those purported to being contained. Furthermore, discrepancies were found between staff and patient perceptions of the least restrictive methods of containment.

Conclusions

Findings from this study raise important ethical and moral questions surrounding the culture and philosophies within the high secure hospital environment. Staff frequently report tensions and conflicts within their roles as healthcare professionals, who are expected to care, manage and contain. Similarly, the term 'least restive method' appears problematic in light of differences between staff and patient perceptions. These findings raise further questions surrounding not only the tensions and conflicts of environment, ethos and role, but moreover, the support required by both staff and patients, either working or being accommodated in this environment.

Educational Goals

- Participants are invited to critically examine findings of three questionnaires; ATAS, ACMQ and EssenCES.
- Participants will be invited to explore, discuss and construct further questions as a result of these findings.

Correspondence

Ms. Ada Hui
University of Nottingham
Institute of Mental Health, Triumph Road
NG7 2TU Nottingham
England (UK)
ada.hui@nottingham.ac.uk

Coercive measures in cases of actual danger to others? Ethical aspects of the current German debate on coercion in psychiatry

Paper

Jakov Gather & Jochen Vollmann (Germany)

Keywords: coercion; psychiatry; danger to others; medical ethics

Abstract

The new legal regulation of coercive treatment has provoked an intensive and ongoing debate among German psychiatrists. Thereby, especially the question whether coercive measures in patients posing an acute danger to others can be ethically justified is discussed controversially.

In the first part of our ethical analysis, we discuss normative preconditions that have to be met, in order to justify coercive measures (such as involuntary hospitalization or medication) in patients who suffer from psychiatric disorders. Amongst others, we explain and discuss the concept of mental capacity and its relevance for the ethical debate on coercion in psychiatry.

In the second part, we analyze two recent ethical position statements, (1.) the one of the Central Ethics Committee of the German Medical Association (ZEKO) and (2.) the one of the German Association for Psychiatry, Psychotherapy and Psychosomatics (DGPPN). While ZEKO refuses involuntary medication for psychiatric patients who pose a danger to others and refers to coercive measures as being sufficient in such situations, DGPPN emphasizes the ethically unacceptable consequences of such a position, both for the patients and for the medical staff members, for example as severely agitated patients might undergo mechanical restraint during an acute psychotic episode without receiving symptomatic pharmacological treatment.

We conclude with a proposal for ethical criteria, which help identify the situations of acute danger to others in which different coercive measures can be considered ethically justified.

Educational Goals

- Ethical analysis of coercion in psychiatry and application of ethical knowledge in challenging situations in psychiatric care

Correspondence

Mr. Jakov Gather
Institute for Medical Ethics and History of Medicine, Ruhr-University Bochum
Malakowturm - Markstr. 258a
44799 Bochum
Germany
jakov.gather@rub.de

Children's rights versus parental rights in involuntary admission of minors to a psychiatric unit for children and adolescents in Germany – new developments in jurisdiction and legislation

Workshop

Michael Bruenger (Germany)

Keywords: legislation, jurisdiction, children's rights, parental rights, child custody, involuntary admissions of minors, fixation, family law, German national law, UN children's rights convention, complaint management for children and adolescents

Abstract

Recent legal developments and contentious jurisdiction in Germany in the field of family law reveal the need of a discussion on ethics and children's rights in the psychiatric field on an international scale.

In Germany a reinvigoration of parental rights is currently taking place by referring to natural law. However, is a person having the care and custody of a child in an identic legal position as the child's biological parents? While a strengthening of legal regulations has taken place in the field of legal custodians for adults in Germany, legislation and jurisdiction have left this question almost completely unanswered as far as minors are concerned.

Is it justifiable that biological parents can freely and autonomously decide on the continuous nightly fixation of their child while they are obliged to obtain approval from the family court for involuntary admission of their child to a locked psychiatric unit? How can children make use of their rights if they object to such measures?

Ways have to be identified to implement an efficient complaint management accessible and feasible even for minors.

Helpful arguments could rather derive from a discussion of the ethical aspects of children's rights than from discussion of national law. Therefore a debate on conflicting parental and children's rights beyond the national scale is highly encouraged. Which are the leading aspects in the ethical debate in other countries having ratified the UN children's rights convention?

Educational Goals

- Speaker and participants explore the differences in conflicting parental and children's rights on an international scale.
- Speakers and participants identify and gather ethical aspects of conflicting rights between children and parents on the topic of coercion and involuntary admission to psychiatry being discussed in their national contexts

Correspondence

Mr. Michael Bruenger
Pfalzinstitut Child & Adolescent Psychiatric Service - Pfalzklinikum
Weinstrasse 100
76889 Klingenmuenster
Germany
michael.bruenger@pfalzklinikum.de

Violence in media and aggressive behavior: the difficulties of establishing a debate

Poster

Maria Teresa Ferreira Côrtes (Brazil)

Keywords: Violence, violent media, violent media exposure and aggressive behavior

Abstract

Exposure to violence is a reality all over the world. It is difficult to assure if the human being is becoming more violent, but it is clear that the development of communication put us closer to violence demonstrations. That is the context in which the discussion about the relationship between media violence exposure and aggressive behavior appeared. We have the hypothesis that most of the authors used moralizing arguments to support their conclusions and that there is a general discomfort in not blaming violent media for violence that occurs in real life. The objective of this work is, therefore, to analyze the conclusions of articles about the relationship between aggressive behavior and violent content presented in media and analyze whether or not there is effectively a debate in literature about this theme.

Educational Goals

- Discuss the social discomfort in debating violence supposedly related to violent media
- Analyze the implications of social discomfort in debating violence supposedly related to violent media on scientific debate

Correspondence

Ms. Maria Teresa Ferreira Côrtes
Universidade Estadual de Campinas UNICAMP
Francisco de Campos Abreu, 860
13043710 Campinas
Brazil
mariateresaferreiracortes@gmail.com

Coercive measures in the treatment of drug-dependent patients

Introduction and background

The treatment of drug-dependent patients in Austria is a medical and ethical challenge for clinics staff, particularly on emergency and intensive care units. Criminal legal provisions, which in this context sometimes can be interpreted with different outcomes and often are difficult to assess for clinics staff, cause additional distress.

The study referred to in this paper, Medical activities at the interface between patient's autonomy and treatment mandate, supported by funds of the Oesterreichische Nationalbank, project number 15833, is conducted in order to establish the compatibility of current actions in the treatment of drug-dependent patients with criminal legal provisions. Actual situations in clinics are examined in respect of a potential link to criminal legal provisions; identified problems are evaluated and solutions on the dogmatic level as well as for practical purposes proffered. The interaction of legal, medical and ethical views taking the practical view into account will ultimately lead to more respect of the patient's will as well as legal security for clinics staff.

The methods applied are legal analysis and empirical research, particularly questionnaires and interviews with clinics staff.

As of now, final conclusion of this still running project cannot be drawn due to the empirical analysis not having been completed: the questionnaires have not yet been analysed. Interviews with practitioners, however, already allow for certain conclusions. Estimations resulting from these as well as evident tendencies have duly been taken into account for this paper.

Taking the example of a typical situation with a drug-dependent intoxicated patient on an emergency unit, the legal problems will subsequently be analysed.

Case example
Patient "A", intoxicated, is committed to the emergency unit. His consciousness is tarnished, but he is able to respond to questions. Health care personnel establish that patient A took heroin. Despite the need for treatment, explained to the patient by the attending physician, he refuses treatment and any other kind of help expresses his decision to go home.

The physician decides on the dispensation of an antidote, procedures the patient refuses. A staff member tries to inject the antidote himself, when the patient starts screaming and slashing about violently. Nurses fixate him on arms and legs and the physician inserts the needle to dispense the antidote.

From a criminal legal perspective, the patient's competency, his treatment refusal, the treatment and the fixations are of interest in such a situation, usually common with patients who refuse intervention. In the following, the focus will lie on the violent coercive measures exerted towards the patient particularly when commencing treatment.

Main paper

The term coercive measures, in this paper, encompasses two different meanings. On the one hand, all kinds of curative and other medical treatment without the patient's consent are comprised. On the other hand, coercive measures restraining the patient's freedom, such as fixations, are also covered. Legally speaking, the distinction is important for the different coercive measures have to be dealt with in different ways.

Coercive curative treatment
In Austria, the patient's will is protected by criminal law. If competent patients are treated without receiving adequate information and giving their consent, practitioners can be held culpable for so-called "unauthorised curative treatment"[1], even if the curative treatment is vital from the medical perspective. This applies to all patients who are competent.

For incompetent patients, a set of rules, some of them criminal legal, guarantees that necessary treatment is given. Emergencies are situations in which, compared to other situations, more patients are incompetent. Incompetent patients whose life and health are severely endangered have to be treated and can't legally refuse treatment in a state of incompetency. Underlying presumption is that the patient would have given his consent had he been able to. The only exception is if the patient's will refusing treatment is known.[2] A patient's will voiced before losing competency is legally binding, a situation which is not very likely with the patient group in focus.

The law, in specific acts, does provide for exceptions to this general rule: coercive curative treatment of competent patients can be legitimate under certain circumstances, e.g. in the interest of life and health of third parties, e.g. under the Tuberculosis Act,[3] none of which are applicable when dealing with the majority of drug-dependent patients taken to emergency or intensive care units. As a consequence, coercive treatment of drug-dependent, even intoxicated, patients is, the same as with any other patient group, prohibited by criminal law.

This short introduction into the criminal legal background of curative treatment shows that competency is an important factor.

The question important to practitioners in the introductory case is: Is patient A competent to refuse treatment in the first place?

From the legal perspective, competency is defined as the ability to comprehend reason for and consequences of the treatment and subsequently make an autonomous decision in accordance with this comprehension.[4] It is up to the physicians to decide if an individual patient is competent.[5] In practice, it is often difficult to establish an intoxicated patient's competency due to his clouded consciousness and/or agitated, aggressive or seemingly irresponsible behaviour; many cases are uncertain. Some patients might be disoriented, but still competent – and thus refuse treatment. Despite this practical difficulties, physicians have to make the decision, and patients have to be treated as either competent or incompetent.

For clinics staff, who have to make the decision establishing competency or the lack thereof conscious of the consequences, this might be difficult to understand, because it could mean that a competent patient who is in need of treatment but refuses it cannot – legally – be helped medically. Declaring patients incompetent or treating them against their will might seem tempting and convenient. Additionally, further progress of drug effect might be difficult to prognosticate due to e.g. unknown quantity or purity of the substance taken, a reason for practitioners to even more emphasise the need for treatment. Practitioners might find themselves in an area of conflict between their intention to help and the legal limits of such. At the same time, intoxicated persons are a complicated patient group not dealt with gladly. These factors, it becomes apparent in our empirical research so far, result in coercive treatment of intoxicated, yet competent patients.

In the exemplary case, patient A must be treated if he is incompetent, but most not be treated if he is competent to refuse the treatment.

Other coercive measures
As a side-effect of intoxication, patients often are generally non-compliant, irrespective of their competency or the severity of their current medical situation. Aggressive or agitated behaviour directed at others or themselves, just like patient A's, maybe with the intention of doing harm to themselves, occurs regularly. Practitioners are confronted with the question not only how to react, but also, and more specifically, if they should apply coercive measures, particularly physical or medical restraints.[6] Such fixations are, as could already be ascertained in the empirical research, applied regularly in dealing with intoxicated patients. As clear from the introduced case, fixating the patient might be necessary in order to enable treatment. Or they might seem necessary to restrain the agitated and aggressive patient endangering himself or others.

Again, criminal legal considerations have to be taken into account.
Coercive measures limiting personal freedom are not considered part of the medical treatment, but constitute a deprivation of liberty if not applied within the limits set by criminal law.[7] As is the case with coercive curative treatment, also coercive limitations of personal freedom, in hospitals, can be legal:

within the narrow confines of the Hospitalisation Act[8] and the Nursing Home Residence Act[9]. These exceptions are, however, explicitly not applicable for treating drug-dependent patients on emergency and intensive care units.[10] For justifying freedom-restraints, practitioners have to adhere to general criminal legal provisions, which again do not know specific rules designed for dealing with the special needs of intoxicated patients. Moreover, they are dogmatically meticulous and therefore even more difficult to comprehend for practitioners who are not jurists.

Competency also plays an important role for assessing fixations. Depending on the patient's capacity for decision making, different reactions to (auto-)aggressive behaviour are legal.

Competent patients usually are a difficult group when they refuse but are in need of treatment. The majority of problems with aggressive patients is related to either cases in which it is difficult to decide whether or not they are competent or with incompetent patients. As already mentioned above, a decision on competency has to be made.

In order for fixations of a competent patient to enable treatment to be legal, he or she would have to consent.

For our case, this means that patient A must not be fixated if he is competent, but instead be allowed to leave the hospital.

The legally far more complex rules concern incompetent patients.
The important distinction when assessing the lawfulness of fixations of incompetent patients is whether or not the coercive measures are necessary to enable curative treatment.

If the incompetent patient's freedom is restrained solely because he behaves aggressive towards staff, fixations are justified as self-defence. With patients who do not turn against other people, but "only" endanger themselves, whereby not only auto-aggressive behaviour, but also refusal of urgently needed treatment could be considered self-endangerment, presumed consent or the so-called justified emergency might serve as justifications of restraints. The emphasis lies on the subjunctive, since there exist diverging interpretations of the relevant legal provisions. It could also be argued that patients endangering themselves and only themselves with their aggressive behaviour cannot legally be restrained. For practitioners, of course, this is a suboptimal situation.

In the introduced case, the attending staff is, however, not confronted with these problems because A needs curative treatment.

Incompetent patients in need of curative treatment they refuse are also very common in practice. Fixations are necessary in order for the staff to be able to treat the patient. In situations like these, presumed consent could serve as a justification. Presumed consent works for legalising emergency treatment. If the thus justified treatment is only possible if the patient is fixated beforehand, it can be argued that the presumed consent includes the necessary fixations as well.

It could, however, also be argued that the coercive measures are indeed part of the treatment, in which case the rules on treatment would be applicable. To count coercive measures as part of treatment would indeed be excessive.

If incompetent patient A refuses curative treatment and fixations are only necessary in order to enable this treatment, restraints can be argued, but also the opinion that they would be illegal and thus a culpable deprivation of liberty can be held.

Without delving deeper into these mostly legal problems within the Austrian system, it becomes evident that the legal provisions can often be interpreted in different ways. Actions taken against the law, however, lead to culpability. The practical situation is all but easy. Neither necessary legal security of practitioners nor protection of patient autonomy can be provided.

Ethical approach
Applying ethical approaches, such as, for example, the principles of biomedical ethics by *Beauchamp and Childress*[11], could lead to a different assessment.

Treatment refusal of competent drug-dependent patients leads to a conflict between the principles beneficence, to which staff is obliged, and autonomy, to which the patient is entitled. Balancing these two principles results in the ethically motivated insight that curative treatment, which is beneficiary to the

patient, has to be given priority over respecting his autonomy – for the individual drug-dependent patient, the benefit of potentially life-saving treatment is high, whereas the disadvantage, i.e. losing his autonomy in this respect, is low, more so in comparison. Coercive curative treatment, therefore, can be ethically acceptable when dealing with this special group of patients even when they are competent. It could even be argued that in order to treat, and therefore comply with the principle of beneficence, fixations are ethically acceptable. This, however, might not comply with criminal legal provisions.

Conclusions

Interviews indicate that practitioners' awareness of the probably confusing legal situation and the consequences, particularly potential culpability, resulting thereof are to be doubted. Clinics staff tend to believe that coercive measures are always legally permitted. On at least one unit included in our research, patients are restrained and treated as a standard procedure, their competency denied on grounds of them being intoxicated. Paternalistic thinking opposing legal provisions seems to generally be prevalent in dealing with the patients often stigmatised as non-compliant and lacking health consciousness. For nursing staff, who usually has closest contact to the patients, this situation is likely the most distressing, for they might additionally find themselves in a conflict between physicians orders and the patient's will.

Solutions
Interviews have also shown that a differentiated approach is possible. On another emergency unit, the patient's will is adhered to more regularly even with patients whose consciousness is clouded but who are deemed competent nonetheless. On this particular unit, cooperation with police and police doctors leads to the competent patients' release from hospital if they refuse treatment, accompanied home by police officers if necessary. Additionally, emphasis is laid on letting the patient cool down instead of treating him immediately.

Cooperation with police, as far as police has respective capacities, would therefore be a solution for these difficult situation.

The fact that the law serves as a problematic factor in the practice of treating drug-dependent patients is unfortunate. Especially the law, provided the provisions are distinct and created with the needs of the practice in mind, could a priori prevent many problems from arising or at least help solving them. This way, sanctions would not even become relevant, a situation beneficent to patients and health-care personnel alike.

In order for practitioners to be able to adhere to respective provisions, it is necessary for them to be accessible. Legal advisors contactable also in emergencies should be considered. The consultation of psychiatric experts upon admission to the unit and during treatment and the implementation of medical-ethical and legal guidelines, also emphasising alternatives to coercive measures, which are universally applicable in emergency treatment of drug dependent patients can also help enhance patient's rights and practitioner's legal security.

Acknowledgements

Endnotes

1. Art 10 Austrian Criminal Code.
2. Art 110 para 2 Austrian Criminal Code
3. See Kletečka in Aigner/Kletečka/Kletečka-Pulker/Memmer, Handbuch Medizinrecht Kap. I.4.1.
4. See Triffterer in Triffterer, StGB Art 110 Rz 41.
5. See Kopetzki, Einleitung und Abbruch der medizinischen Behandlung beim einwilligungsunfähigen Patienten, iFamZ 2007, 197-204, 199.
6. See Herdega, Freiheitsbeschränkung, RdM 2012/2 (4); Zierl, Zustimmung und Erlöschen, ÖZPR 2012/146.
7. See Art 99 Austrian Criminal Code.
8. See Art 1 and 2 Hospitalisation Act.
9. See Art 4 to 7 Nursing Home Residence Act; Bürger, Patientenrechte, NÖ PPA, 03/13.

10 See Art 2 Hospitalisation Act.; Der präventive Freiheitsentzug darf nicht zur Erzwingung therapeutischer (wenn auch fürsorglicher) Ziele missbrauch werden, Halmich, Rechtsfragen, RdM 2013/79; Bürger, Patientenrechte, NÖ PPA, 03/13.; Weber, Rechtsprechungsübersicht, iFamZ 2012, 89.
11 See Beauchamp and Childress, Princples of Biomedical Ethics, OUP USA 2013.

Correspondence

Katrin Forstner / Mareike Wakolbinger / Karin Bruckmüller
Mail: forstner.katrin@gmx.at

Workplace Violence (WPV) – the Emergence and Jurisdiction of a Social Problem

Paper

Sofia Wikman (Sweden)

Background

Since perceptions and definitions of violence are context-dependent; the amount of attention society directs at a given social problem affects both how it is perceived and the extent to which it becomes visible in official statistics. But the way in which a problem is defined is also of significance in relation to the measures that are proposed as a means of coming to terms with it.

Aims

The objective is to analyze how the development of WPV as a social problem might be understood.

Methods

On the basis of a contextual constructivist approach, the extent of and trends in complex social problems are viewed as being linked to both actual changes in underlying conditions (the objective explanation) and shifts in perceptions of what the problem consists in and how it should be dealt with (the constructionist explanation). The study of these two explanations requires different types of data. The data employed in this project are drawn from nationally representative victim surveys, articles published in trade journals and occupational injury reports in Sweden.

Results

Defining WPV as a societal problem produces a situation where the problem must be resolved by means of legal strategies, which leads to the concealment of the underlying causes. Knowledge appears to exist at workplaces themselves, but these are not given the resources they need to resolve the problem. What we are failing to address are the underlying factors that serve to structure the framework in which these interactions take place.

Conclusion

Although more attention is now being focused on WPV, it appears to be a "top-down" perspective that is determining which measures should be introduced. Defining violence as a societal problem produces a situation where the problem must be resolved by means of legal strategies, which leads to the concealment of the underlying causes of the problem.

Although the objective of crime prevention today has considerable legitimacy and is furnished with relatively substantial resources, we are at risk of completely failing to prevent violence as a result of having an overly simplistic understanding of the problem. To the extent that we lack both an analysis of the negative effects of social change on the prevalence of WPV and any interest in using measures other than legal strategies focused on individuals, we risk finding ourselves in a situation where measures to combat WPV are restricted to a focus on personal interactions between staff and clients.

Educational Goals

1. Realize the way in which a problem is defined is also of significance in relation to the measures that are proposed as a means of coming to terms with it.
2. Be aware that legal strategies that focus on individuals may produce paradoxical results.

Correspondence

Ms. Sofia Wikman
Royal Institute of Technology (KTH), Department of Philosophy and the History of Technology,
Brinellvägen 38
100 44 Stockholm
Sweden
sofia.wikman@criminology.su.se

Getting it Right, Getting it Wrong: Ethical Tensions in Decisions Related to Seclusion Use

Paper

Isabelle Jarrin & Marie Edwards (Canada)

Keywords: clinical judgment, ethics, seclusion, mental health

Background

Decisions to seclude a patient on an in-patient mental health unit require an assessment of risk for harm to the patient or others while attending to the rights of the patient involved. A number of variables often need to be considered in these situations.

Aims

A qualitative study was carried out to explore the place of ethics in mental health nurses' judgments about the use of seclusion in in-patient mental health settings. This presentation will explore key findings related to the ethical tensions that may arise in these decisions.

Methods

In this interpretive descriptive study, nine registered psychiatric nurses and eight registered nurses participated in an individual, semi-structured interview related to their experiences of using seclusion in their practice. Data were analyzed using the thematic analysis approach described by Braun and Clarke.

Results

The clinical stories told by the nurses in this study highlighted the complexity of making judgments about how best to promote safety and prevent harm for patients and staff members in situations where seclusion use was contemplated. Ethical tensions in these situations were identified, including pressure from the team and patients to seclude, uncertainty about the risks in the situation, concerns that seclusion was being used as punishment, and concerns regarding "getting it wrong".

Nurses in this study reflected on the clinical judgment involved in balancing the preservation of the rights of the individual and the welfare of the patient with the safety and welfare of others, including other patients, visitors, and staff members. While these competing duties may be found to some degree in other areas of nursing and health care, the ethical conflicts experienced by nurses in this study have some unique characteristics. These characteristics have not been well described i n the literature and warrant further exploration. Christine Tanner outlined a Clinical Judgment Model, which she anticipated could be applied to clinical situations where conflicting values and competing interests were present. The model will be used to explore the study nurses' reflections on noticing, interpreting, and responding in the stories they told about seclusion use. Implications for practice, education, and research will be outlined.

Conclusions

The ethical tensions present in nurses' decisions to seclude patients have not been well explored to date. Tanner's Clinical Judgment Model provides a useful framework for exploring these tensions.

Educational Goals / Learning Outcomes

1. Describe ethical tensions encountered by nurses when using seclusion.
2. Utilize the Clinical Judgment Model in clinical care when using seclusion.

Correspondence

Ms Isabelle Jarrin
Winnipeg Regional Health Authority
PX246-771 Bannatyne Avenue
R3E 3N4
Winnipeg
Canada
ijarrin@mts.net

Legislation and coercive methods in Psychiatric Clinic in Romania – a five years follow-up study

Poster

Adriana Mihai, Paula Sarmasan, Alex Mihai, Elle Tifrea, Katalin Birtalan & Emese Muresan (Romania)

Keywords: coercive measures, compulsory admission, restraints, legislation

Abstract

The aim of this presentation is to evaluate the actual Romanian legislation on compulsory admission and coercive measures for psychiatric patients in Romania.

The material and Methods

We evaluated the actual legislation in Romanian concerning the psychiatric patients, legal procedure for non-voluntary admission and procedure for coercive measures. The second part was a prospective study which evaluated for 5 years the frequency of aggressive incidences onwards, coercive measures adopted and correlation with demographic items, psychiatric diagnosis, and length of hospitalization.

Results and discussions: The Mental Health Law, available since 2002, changed significantly the medical approach on aggressive situations, with large impact on respecting patients' rights. The total duration of each contention are maximum 4 hours, the average was 2.7 hours. The mechanical contention rate was 8.33%, no statistical differences were found between group of patients with psychosis and others. The coercive measures were needed more frequently for patients with personality disorders as co-morbidity. The numbers of non-voluntary admissions were also evaluated in the same period.

Conclusions

The existence of legislation protects patients' rights and reduced the number of coercive measures for patients with psychiatric disorder.

Educational Goals

- The Information about actual Mental Health legislation in Romania will be presented.
- The different coercive measures used in Psychiatric Clinic will be evaluated in a 5 years follow-up study.

Correspondence

Ms. Adriana Mihai
University of Medicine and Pharmacy Tg Mureș, IPPD
Gh Marinescu 38
540138 Tg Mures
Romania
dradrianamihai@yahoo.com

Judicial reactions on violence in clinical psychiatry

J.M. (Joke) Harte [a b] & M.E. (Mirjam) van Leeuwen [c]
[a] The Netherlands Institute for the Study of Crime and Law Enforcement (NSCR), Amsterdam, The Netherlands
[b] VU University, Department of Criminal Law and Criminology, Amsterdam, The Netherlands
[c] University of Applied Sciences Inholland, program Nursing, Amsterdam, The Netherlands

Background

Violence against health care workers is currently a subject of concern in clinical practice as well as in politics and society. In the Netherlands, the government started a program against violence towards public workers, such as emergency personnel, and the public prosecutor can file triple penalties for assailants of public officers (Harte, e.a., 2014). Especially mental health care professionals frequently encounter violence caused by patients that can be severe (Van Leeuwen & Harte, 2015; Foster, Bowers & Nijman, 2007; Nijman, Bowers, Oud & Jansen, 2005). Research shows that some subgroups of psychiatric patients have a greater tendency towards violence when compared with the general population (see e.g. Lamsma & Harte, 2015). Violent behavior caused by persons with a mental illness regularly leads to involuntary admission to a psychiatric hospital. This risk may remain during hospitalization, resulting in violent incidents in clinical practice.

Especially if aggression takes place inside psychiatric inpatient facilities, society seems less concerned and judicial authorities are reluctant to react. It is often thought that a psychiatric patient belongs in a psychiatric hospital, and not in jail, or people have the opinion that violence is an occupational hazard that comes with the job. As is regularly argued, the suspect is mentally ill and therefore not guilty by reason of insanity. A more practical argument that is often put forward is that aggressive psychiatric patients are already incarcerated and do not pose a danger to society. However, excluding them from punishment may promote stigmatization of psychiatric patients as irresponsible and unpredictable persons (Dinwiddie & Briska, 2004), and could give offenders the idea that they can get away with the violence.

This empirical study focusses on how judicial authorities respond to violent incidents against mental health workers that were reported to the police.

Methods

Within the context of a national study on violent incidents against care workers in psychiatry, Dutch mental health care professionals were asked to fill in an online questionnaire on their personal experience with violent physical incidents caused by patients in the past 5 years (Van Leeuwen & Harte, 2015). It appeared that 1534 mental health professionals were victims of a total of 2648 violent incidents. Over a quarter of the incidents (n=704) had been reported to the police. These respondents were asked about what the reasons were to report the incident to the police, what the reaction of the police was on their report, if there had been any further criminal investigation, whether their case was brought into court, and if so, what the decision of the court was.

Results

On average the 704 respondents were 38.2 years old (Sd=11.0, min=20 max=64); 43.5 percent of them were men and 56.5 percent were women. Amongst them were psychiatric nurses (n=371), sociotherapists (n=150), managers (n=23), psychiatrists/doctors (n=19) and psychologists (n=8). As shown by the results in Table 1, the reported incidents differ in nature and severity.

Table 1: Nature of the incidents (704 incidents)*

Nature:	Frequency
Threatening with object, liquid	231
Threatening physically	227
Beating, kicking	219
Fire setting	119
Attempted throwing with object, liquid	103
Throwing with object, liquid	68
Attempted stabbing	43
Attempted strangling	36
Hair pulling, scratching	23
Hostage	18
Biting	15
Assault sexually	10
Stabbing	9
Various	11

*Respondents were allowed to give more than one answer.

The victims were asked for the reasons that made them decide to report the incident to the police. As can be seen in Table 2, these decisions were mainly based on rational motives.

Table 2: Reasons to report the incident to the police (n=699)*

	Frequency
Patient was violent repeatedly	399
To build a file	397
To set a limit on this behavior	384
To protect others (colleagues, other patients)	305
Reporting is the institution's policy	233
The reporter wanted to report	112
To cope with the incident emotionally	78
A report is needed for the insurance	28
The incident was very severe	9
The patient deserved to be punished	6
Violence was not caused by the psychiatric disorder	3
Other	11

*Respondents were allowed to give more than one answer.

How had these reports been received by the police? In about a fifth of the cases (n=137, 19.5%) the police made a registration whereas the victims asked for an official report. And in about 5 percent of the cases (n=37, 5.3%) neither a report nor a registration was made, since, as the victims were told, "violence is part of their job". This is a remarkable result as some of these incidents were definitely severe. These 37 incidents included fire setting (n=4), attempted strangling (n=3), attempted stabbing (n=2), biting (n=1) and sexual assault (n=1).

In half of the reported incidents, the victim had no information about the way the judicial authorities had handled the incident. In 85 other cases the victim knew that the case was dismissed. If there was any further investigation, the offender was usually heard by the police (n=119). In 76 cases witnesses were heard and in 34 cases an independent psychiatric assessment of the offender was conducted.

According to the victims' knowledge a total of 69 cases had been brought into court. In 45 cases the victim knew that a verdict had been reached. As can been seen in Table 3, punitive sanctions (such as imprisonment or community service) as well as measures (which implies treatment in a high security forensic psychiatric hospital) were imposed by the criminal judge. Relatively often the judge imposed a punitive sanction; in Dutch law this implicates that the judge regards the offender as (partly) responsible for the offence.

Table 3: Conviction (n=45)

	Frequency
Punitive sanction	16
Measure	13
Financial compensation for the victim	6
Acquittal	2
Conviction without imposing a penalty	2
Judicial verdict has been reached, but victim has no knowledge about it	6

Conclusions

The number of (severe) violent incidents against staff caused by psychiatric patients is high. In this study it appeared that about a quarter of the physical violent incidents that mental health care workers encountered were reported to the police. Even though the victims mainly had based their decision to report the incident to the police on rational reasons, the police not always made an official report. Subsequently, the incidents were not often further investigated by the police. According to the victims' knowledge, only 69 cases that had been reported to the police, were brought into court. Relatively often, the criminal judge regards the offender as (partly) responsible for the offence. Victims were poorly informed about their case.

Discussion

The aim of this study was to reveal the judicial authorities' perspective on violence against mental health care workers. It appeared that judicial authorities are reluctant to react on violent physical incidents mental health care workers encounter and that victims are poorly informed about their case. This result is in sharp contrast with the current tendency to give priority to the prosecution of the assailants of public officers and care workers and to punish the offenders more severely.

One of the arguments not to prosecute a psychiatric patient who acts violently is that a psychiatric patient cannot be held responsible for his acts. In this study, however, it appeared that if a violent act is brought into court, the judge relatively often regards the offender as (partly) responsible for the offence. Moreover, in quite some cases a forced treatment in a high security forensic hospital was imposed. In the Netherlands such a measure can only be imposed by the criminal court.

Prosecution should certainly not be seen as the solution for violence that takes place in psychiatry. In order to reduce these acts it is necessary to invest in the prevention of these incidents by training staff to improve their de-escalation skills as well as in control and restrain techniques. But even if staff is well trained, violent incidents may occur. In these cases it is necessary that judicial authorities also take their responsibility. We strongly advise that mental health care workers, who want to report a violent act, should be received well and in all cases an official report ought to be made. Moreover, it is necessary to take notice of the victim's motives to report the violent act and it might me necessary to further investigate a violent incident. This study did not provide insight into the decision of the Pubic Prosecutor to bring a case into court or not (see also Harte & van Leeuwen, 2013). Future research is needed to study this aspect.

It is also crucial that mental health institutions have a joint policy together with the police and the public prosecutor on how to respond to violent incidents caused by psychiatric patients who are seriously or repeatedly violent. At this moment some interesting local initiatives have been developed and implemented in the Netherlands. It is of great importance to study and evaluate these projects and to share the experiences.

Acknowledgements

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Educational Goals

- Learn how victims of violence in psychiatry can be supported, advised and informed.
- Learn about the judicial authorities' perspective on violence that takes place on the psychiatric ward.

Correspondence

Ms. Joke Harte
VU University/NSCR
De Boelelaan 1105
1081 HV Amsterdam
The Netherlands
j.harte@vu.nl

Dealing with Psychiatric Patient Violence in Private Clinical Treatment – Professional and Ethical Dilemmas

Suzana Roitman & Ronit Kigli (Israel)

Abstract

Residing in the community are many mental health patients that use private health services providing treatment, assistance, support and supervision to patient as well as family members. People dealing with a mental disorder may at times experience crises and life events which bring them to situations of acute distress, which in the lack of appropriate control and regulation mechanisms increase the risk of violent outbreaks resulting in damage to property or to the people closest to them.

The issue of mental patient violence has further implications in the context of a private framework, in which the patient is living with family members, who may feel exposed, threatened and lacking in monitoring abilities with regards to the patient's mental condition and risk of escalation.

In the framework of a private clinic, personal and family treatments were conducted with patients who indicated a preference for treatment in the community with the support of the family. Some of these patients experienced violent outbreaks that may not have caused physical harm and yet required appropriate therapeutic responses aimed at dealing with violent urges, gaining anger management skills, learning appropriate family communication skills and learning to turn for help when required.

At the congress representative cases will be presented, as well as ethical dilemmas regarding subjects such as patient confidentiality, patient and family dignity, security, public safety and more.

Educational Goals

1. Learning the meaning of dilemmas in private practice
2. Community treatment

Correspondence

Ms. Suzana Roitman
Privare practice; Tel-Aviv university
12 Arie Dulchin St. Apt. 11
6936045 Tel-Aviv
Israel
suzanaroitman@gmail.com

How violence is imagined in psychiatry: a philosophicalper-spective on violence andtrauma

Daniel Nicholls, School of Nursing & Midwifery, University of Western Sydney, Australia

Introduction

To speak about violence in a non-reductive and considered manner, especially one informedbyHusserl (1970) one firstly recognises one's position vis-a-vis the problem. To speak aboutviolenceotherwise would place it as something already known: some known entity that needs to beman-aged. At the other extreme it would be injudicious to suppose that a final word might be saidaboutviolence: that it may indeed be managed once its nature is fully realised. Thus I will declare thatIam unclear about the nature of the problem, qua problem, though I do have a position with regardtoits nature: a position which is also variously informed by Wittgenstein (1974) and Plato (2013)andothers. The essay then will try to describe the nature of violence in clinical psychiatry, as I seeit,starting from and referring back to the self in an unselfconscious way: the self as at least theclinicalself which may include myself, you and us, but never them. In a similar vein the essay will alsotryto say something about imagination and its relation to the problem of violence in psychiatry.Somehistorical perspectives will be invoked as a general foreground to the placement of the clinicianinthe scene, in building a picture of this important element of 'the mental health imaginary'(Nicholls, 2014). Importantly, the essay will not be a finished product as time will have transpired fromitswriting and oral presentation: the time itself and the speaking to the essay will result in(re)absorp-tion of ideas that are constantly worked. In this way the problem and its elements will continuetounfold (Deleuze, 1993). In another sense this essay will be diffuse in that there are manyideascompeting for a hearing in a short space; hopefully in a non violentmanner.

It could be argued that we are all born into a turbulent world. From the very first slap (for manyofus), to our parents' sleepless nights and angry exchanges, we learn to survive in an uncertainemo-tional environment; and all too often in an uncertain physical environment. Children can bere-duced to fear by a look, a shrug, a back turned; and then come to anticipate such fear in the faceofreal or imagined stimuli. Add to that the capital punishment at school endured by those of us ofacertain generation, the fear and its anticipation can be soul destroying. You'll see I amspeaking

from a certain western perspective here: the so-called developed world. For we know thatmanychildren still face severe physical and emotional trauma in all parts of the world. So I need toqual-ify here that this paper on violence in psychiatry pertains to a largely European placement as wellasthat European dissemination to other parts of the world, an encroachment which has not beenwith-out its own violent exchanges (Deutscher, 2007). Within these limitations I will explore violenceasit might have arrived at this stage of my clinicalimagination.

Violence asimagined

We at least imagine violence, even as we experience or anticipate it, or might have, as receiversandperpetrators, even if we are unaware perpetrators: denying our actions to ourselves. That is, wehavethoughts and images of it: thoughts and images which can manifest as feelings. To some of usitmight present as a punch to the face, a push to the floor, a severe caning at the hands of asadisticteacher: as "physical force intended to hurt, injure or kill" (cited from *The Oxford Dictionary*by Large & Nielssen, 2011). In fact this is the working definition implied in most papers onclinicalviolence. For others it may also bring to mind the specificity of a broken bottle and plenty ofbloodin a psychiatric ward. For still others, it may bring images of being crushed by a strongerpersonand sexually abused - here the image of violence may be manifested as sensations ofasphyxiationand terror. And for others, it may bring auditory images of shouting, screaming, swearingandsmashing - smashing windows and furniture. And then there may be guns, canes and otherweaponsinvolved - images may flood a person of explosions, wounded flesh. Where there are no imagesofphysical violence the image may be of rejection, abandonment, humiliation, guilt, angry faces,andother more subtle expressions of violence such as sexist or racist remarks, or social exclusion.Whatwe imagine is often what we experience, anticipate or witness. The image can be

invokedthroughour senses: for example, the smell of alcohol may take us immediately to the original event(Kris-teva,1993).

Whether or not you agree that you are constructed in an imaginary relation with the world(Lacan,1977) or that imagination is something superimposed on an otherwise constructed self, it is stillafact that each of us has an image, or images, of violence and various experiences which may ormaynot contribute to these images. Interestingly these images of violence are externally located evenasthey are internally self-forming or apprehended: violence is something that is manifested intheworld and which I encounter. It is an external force that I exercise or that is exercised upon me.Inthis sense my image is overcome to a great extent even as it is internally experienced. To thatex-tent, an image may be sufficient in an everyday fashion in conceptualising/empathising violencebutif I am lying on a beach and am suddenly shot what matters my image? Violence can appearunex-pectedly, physically and/orpsychologically.

I have separated above the image in some manner from the feelings that accompany it, even asIhave tried not to. These feelings would be the internal character of violence, insofar as we acceptaninternal world. Thus there may be a false depiction of the nature of an image as externallymani-fested - can I even speak dispassionately about violence as I think it? All of the above 'images' -doI invent them? Were they someone else's experience? Can I ever know someone else's pain? WhatIam suggesting here is that each of us experiences images in our own way. Some of us havebeenthrough these scenarios, others have heard about them from loved ones or via the media, othershave heard about them clinically. But even the latter may not truly be able to be dispassionateintheir hearing. Does a clinician 'connect' through her and his own experiences of violence, or through what they read in a textbook or online? Indeed, can they read or hear about violencewith-

out experiencing it? Thus it may be more than a question of past experiences: it is at least aquestionof the force that I feel or the force that is effected upon my body and/or psyche in theencounteringor remembering of violence, in whichever guise it manifests. In this sense, violence may not beasufficient word to fully connote the phenomenon at hand: it may also include my willingness toap-prehend it as a primary force. This facet of violence will be explored in a later work (afterNietz-sche, 1968; Arendt,1977).

So here we have arrived as clinicians who have experienced, heard and/or read about violence. Iamincluding as clinicians all those who work clinically, 'by the bedside' (from Greek Klinikos).Thereis a certain quality of metaphor in this as the 'bedside' in psychiatry may include a clinicalinterac-tion at the local shops. Additionally, we are situated within our various cultural myths andfamilystories. European myths are populated with gods of warfare, sacrifice and vengeance, as wellasthose of the nurturing family hearth, with copious feasting and drinking. Are these mythsantitheti-cal? Or are they necessary corollaries? Family stories of heroism, discovery and greatness sitalong-side stories of murder, suicide and madness, the latter group often remaining in the closet ...withthe door slightly ajar, otherwise how would we even glimpse them? Clinicians will know thatmad-ness does not necessarily result in violence towards others, but we also know that it can becon-nected with violent situations, past or present, and that madness and violence have beenhistoricallyconflated in the popular imagination [Foucault,2009].

Not so long ago we were not explicitly concerned with external violence in psychiatry (e.g.,Roche,1961) - we approached the patient in terms of his and her own pain and the way it manifestedforthe person. Of course, we were taught how to keep out of the way of someone who might dousharm, and how to defuse potentially dangerous situations, but we focussed our attention on thepa-tient's symptoms. Violent scenarios were separated from the internal world of the patient. Weman-aged the environment through subtle physical manipulations - keeping danger at bay throughaheightened awareness of proximity of ourselves and others; proximity both physical andpsycho-logical. We *managed* patients by speaking to them about violent intent or reactions and workedto-wards their self management of violent passions; and where self management was not evidentwedid this with medication. More recently we manage our own psychological and thinkingprocessesthrough clinicalsupervision.

In an evolution of the way clinicians viewed violence there was a move towards 'zero tolerance',arelatively straightforward concept which became quite complicated (Jones, 2013). Duressalarmsappeared on wards as well as security guards. I recall patients and their advocates warning usthatthese measures could exacerbate tensions on a ward, but their voices were drowned out byoccupa-tional health and industrial concerns. It could be argued that violence became politicised atthatpoint: it turned into an exercise of external behavioural control. We were still concerned withtheinternal world of the patient but more and more in relation to how it might be externallymanifested
- harm to self or others became a major focus of assessment and on-going management.Traumastarted to be thought of as something which applied to clinicalworkers.

Trauma asimagined

Historically, trauma (wounding) was not such a problem for Western society. In AncientGreecephysical violence was conceptualised quite differently from now: wounds were not linked tovio-lence, they were linked to appeasement and courage (Loraux, 1991); differently for men andwomen

- there were better and worse ways to be injured or killed. Both physical and psychologicaltrauma

were accepted as par for the course in families and between countries: the fruits of war wereex-pected. Consider the huge loss of life and disfigurement throughout the Napoleonic wars -familiesleft without a father/provider; the expected night terrors and screaming and shouting of thosewhoreturned from war, and the fearful anticipation of family members that a wrong word or lookmayevoke a sudden violent reaction. Of course these matters were hardly ever discussed away fromthefamily hearth, as with intra-familial sexual assault. We have even closer memories now withtheviolent destruction of much of Europe in the 20th century; and now global violence on anunprece-dented scale. How many of us have not been touched in some way by the events of the past100years; even the past ten years? What's new now is that we have become seeming experts inpsycho-logical trauma, its causes and ongoing effects. We have given it a name and we treat it. But in asense we may have distanced ourselves from a more complete world of the patient by limitingourimage of violence to either an external or internal emphasis. Trauma linked to violence is anactualoccurrence even as we have images of it. Hence it may be incomplete to see its image in termsofthought or metaphor (for a discussion on the dangers inherent in the image see Sontag, 1978;LeDœuff, 1989). Trauma is not a metaphor - I might even suggest that it is an intraphor. It hauntsoureveryday whether we are awake or asleep (see Deutscher, 2014 for an interesting working ofmad-ness and dreams). It manifests internally andexternally.

It is not too difficult to imagine that the rantings and lashings out of a mentally ill person werenottoo troublesome, objectified as they were in a removal from self and family. The mentally illwerenot so different from what we would expect from those who were affected by war. Sometimestheywere shut away in attics, to be brought out when there was work to be done: as I recall frommyyouth in the vineyards around Bordeaux. There was some safe physical distance kept whereneces-sary, mixed with good humour that maintained a sense of ease and safety. While the mentallyillmay have been the objects of amusement in former days (Foucault, 2009), they were alsoverymuch part of good humoured camaraderie and valued members of socialeconomies.

Conclusion

In my own nursing training in a major Australian psychiatric hospital violence was consideredanancillary element and was equally distributed among those identified as mentally ill and thosenotso identified. As I recall from my own experience, violence was not tolerated no matter whenceitoriginated, but the emphasis was on the internal world of the patient (delusions andhallucinations)rather than on the external effects of individual outbursts. External emphasis was placed on theen-vironment through removal of dangerous objects and the minimisation of potentially inflamingsce-narios. Thus environmental management was future oriented in terms of prevention. Inrecognisingthe way that violence is all around us it might be important that we don't re-violate others orour-selves by operating within a limited image of violence. That is, our reactions may themselvesbeviolent: restrictions of liberty, forced exclusions. These reactions may be politicallymotivatedrather than clinicallyhelpful.

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Correspondence

Dr Daniel Nicholls
Senior Lecturer
University of Western Sydney
Locked Bag 1797
Penrith NSW2751
Australiad.nicholls@uws.edu.au

Chapter 14 – Sexual offending & violence

Does Psychological Treatment of Pedophiles' work? A Meta-Analytic Review of Treatment Outcome Studies

Abstract

Several meta-analyses and reviews through the years been conducted on the effectiveness of psychological treatment of sexual offenders in. But no meta-analysis has been done on sexual offenders against children (SOAC) specifically. Some studies report moderate treatment effect while many scholars maintain that the question remains quite unanswered until better studies with a strong research design have been carried out. In our meta-analysis, 14 studies were evaluated selected and coded according to Collaborative Outcome Data Committee (CODC) criteria. They included 1,421 adult offenders in psychotherapy and 1,509 non-treated controls, with a minimum average follow-up period of 3 years, published in peer-reviewed journals since 1980 or later.

Recidivism was defined as rearrests or reconviction. Study quality was classified into strong, good, weak or rejected. The analysis revealed a treatment effect size of $r = .03$ for nine studies evaluated as Good or Weak, while all studies yielded an effect size of $r = .08$, including five studies classified as rejected. The results illustrates that the available research is not able to establish any effect of treatment on SOAC. Despite a large amount of research, it is surprising to find that only a tiny fraction of studies meet a minimum of scientific standards, and even fewer provide sensible and useful data from which it is possible to draw conclusions.

Educational Goals

- To learn if treatment of sexual offenders of children reduce recidivism
- To hear about the quality of the studies in this field

Correspondence

Mr. Pål Grøndahl
Centre for Research and Education in Forensic Psychiatry, Oslo, Norway
Sognsvannsveien 21
0424 Oslo
Norway
pagron50@gmail.com

The compulsory notification of violence against women in Brazilian public policies and academic production

Paper

Mariana Pedrosa de Medeiros & Valeska Zanello (Brazil)

Keywords: violence against women; compulsory notification; Brazilian public policies; domestic violence; Brazilian academic production

Introduction

Violence is a social problem that affects many women around the world. According to the World Health Organization's study (2005), 15% to 71% of women will be victims of physical and/or sexual violence. The notification of violence against women is one of the most important instruments in the combat of violence, because it makes it possible to measure the problem and to create public policies more suitable to solve the issue.

In the notification form, it is possible to insert data related to the types of violence, the profile of victims and aggressors, where it occurred, etc. Therefore, this document contributes to evidence production that serves as basis for the development of public policies and governmental actions. It also allows violence against women to gain visibility in various services, such as in the health care system, making it possible to have a more accurate dimension of the profile of women who seek these services (Saliba, Garbin, Garbin & Dossi, 2007).

In Brazil, the public policy directed to encourage the reports, in cases of violence, took form with the "National Policy of Accidents and Violence Reduction". This document treats this matter as a social and historical problem and situates it within the framework of health promotion and quality of life. The approval of this policy by the Ministry of Health and the encouragement it gives to the participation of different sectors of society, among them, universities, helped it gain force. It also helped the creation of new politics and laws directed to violence (Gawryszewski, Silva, Malta, Mascarenhas, Costa Matos Neto, Monteiro, Carvalho & Magalhães, 2007; Minayo, 2007). Among them is the "Law 10.778/2003", enacted in 2003, which "establishes the compulsory notification in national territory, in cases of violence against women who seek public or private health care systems".

Furthermore, according to this law, all citizens and public or private entities are required to report cases of violence against women. However, the routine of health care systems, particularly of mental health institutions, evidences a lack of compliance with this law. Also, there is little debate about compulsory notification and its importance within universities, mental health conferences, and conferences on violence against women. The present study aimed to analyze the insertion of such compulsory notifications of violence against women within the main Brazilian conferences about mental health and policies for women as well as in the national academic production.

Method

To comply with the objective of this study, it was made an analysis of the "Mental Health Conferences" reports, the "Law of Psychiatric Reform", the "National Plans of Politics for Women", and "Maria da Penha Law ". The search made in these documents, of the term "notification", attempted to find out what was discussed in the conferences and what governmental actions was proposed for the matter.

A survey of the academic production, in two important Brazilian databases: "Lilacs" e "Scielo", was also conducted. The used descriptors were: "violence" and its correlates and "notification" and its correlates, combined generated a total of nine different combinations, which produced a total of 1078 results. After repeated articles were taken out, 397 remained for analysis. A detailed analysis was held, only accounting articles that problematized compulsory notification of violence against women in health care systems. Five compatible articles with the objectives of this research remained.

Results/Discussions

The "Maria da Penha Law", enacted in 2006, is the most relevant normative of prevention, care and punishment in relation to domestic violence against women. It aimed to curb all forms of violence against women.

The "National Plans of Politics for Women" (PNPM) had as its main objective the effectiveness of women's rights. In total, three conferences were held consolidating the "National Plans of Politics for Women". The first "National Plan of Politics for Women" (I PNPM), 2004, foresaw actions in four areas: autonomy, equality in the world of work and citizenship; inclusive and non-sexist education; women's health, sexual and reproductive rights; and combating violence against women (Narvaz, 2009; SPM, 2004).

The second "National Plan of Politics for Women" (II PNPM), 2008, expanded the performance areas of action from four to eleven. The new areas were: participation of women in positions of power and decision; sustainable development in rural areas, in the city and in the forest with ensuring environmental justice, food sovereignty and security; right to land, adequate housing and social infrastructure in rural and urban areas, considering traditional communities; culture, communication and egalitarian, democratic and non-discriminatory media; confrontation of racism, sexism, and lesbophobia; coping generational inequalities that affect women, with special attention to the youth and the elderly; and plan monitoring management (SPM, 2008).

The III "National Plan of Politics for Women" (III PNPM), 2013, proposed as focus to reframe key concepts to the wider understanding of inequality production and sought to transform the crystallized spaces of oppression and invisibility of women within the state apparatus (SPM, 2013).

From the analysis of these documents, it was possible to observe that the focus given to the compulsory notification is operational, that is, these documents sought to improve its form, with the inclusion of new items, and the need for greater focus on questions that are underreported, such as race. The following example, of the I "PNPM", clarifies the situation: "the underreporting color variable ("color item") in most health care information systems complicates the analysis of black women's health in Brazil" (SPM, 2004, p. 26).

The documents, in general, also addressed the compulsory notification with the bias of seeking ways and propose actions to implement them throughout the national territory. Thus, the second "PNPM" proposed as a target: "to implement the compulsory notification in 100% of the counties of the prioritized states in the "National Pact to Combat Violence against Women" (SPM, 2008, p. 104). The third "PNPM" proposed as a target "to monitor the implementation of compulsory notification in Brazilian counties, according to the 'Law 10.778/2003' and to the 'Ordinance 104' of January 25, 2011, from the Ministry of Health" (SPM, 2013, p. 32).

The "Law of Psychiatric Reform" (Law 10.216/2001), enacted in 2001, due to the Brazilian anti-asylum fight disposed of protection and rights of people with mental disorders. The "Mental Health Conferences" (CSM) also played a strategic role in the development and consolidation of the principles of Psychiatric Reform. In total, there were four Mental Health Conferences.

The I "Mental Health Conference" (I CSM), 1987, focused on the hospital-centered model, and predominantly based on the medical-psychiatric model, considered ineffective and costly for users and society, violating fundamental human rights. The II "Mental Health Conference" (II CSM), 1992, formalized the outline of a new assistential model which changed the way to deal with people with mental health disorders, focusing on their citizenship rights (MS, 2001).

The third "Mental Health Conference" (III CSM), was held in 2001, after the approval of the "Law of Psychiatric Reform". It had the slogan "Caring, yes. Excluding, no." This was a central theme of the discussions, in accordance with the World Health Organization which proposed this approach for the year of 2001. Another discussed theme in this conference was "Committing to the Psychiatric Reform, with Access, Quality, Humanization and Social Control" which was current, and fundamental to the Brazilian reality.

The IV "Mental Health Conference" (IV CSM), 2004, reaffirmed the general principles of the Psychiatric Reform underway in the country. In it, the participants opposed to all proposals for privatization and outsourcing services, securing a public mental health system.

These documents, in general, dealt with the compulsory notification related to cases of attempted self-extermination and development of mental disorders in workplace. This can be seen in the proposal 68 of the III CSM: "notify, compulsorily, the "State Secretary of Health", any attempt of self-extermination that is answered in public and private emergencies department" (p. 35). As well as in the proposal 167, of the IV CSM that says "ensure the compulsory notification by mental health services for mental disorders related to work "(p. 44).

The focus on violence against individuals with mental disorders, started with the IV CSM. However, it did not take into account who these individuals were, therefore, issues of race, gender, sexual orientation, and class were invisibilized. This can be seen in the proposal 608: "(...) it is emphasized the need to strengthen the "National Surveillance System" about the cases of violence, false imprisonment and death of people in psychological distress (...), ensuring compulsory notification "(p. 104).

Despite the magnitude of violence against women in Brazil, the national mental health policy did not bother to establish unique proposals to deal with this demand. In other words, it does not take into account the specificities of women with mental illnesses, much less its association with the fact of them being victims of violence, treating this fact, all together, with other forms of violence. For example, the proposal 989, which deals with interpersonal violence, does not specify violence against women: "(...) to encourage the early identification and reporting of cases of interpersonal violence. Promoting the wide dissemination of mechanisms and reporting possibilities in situations of social deprivation and abuse of people in vulnerable social and psychological distress".

Through the survey of academic production, it was revealed that the issue of compulsory notification in cases of violence against women is incipient in universities. Out of the 397 articles found, only five (1.26%), problematized this issue. It is important to emphasize that no article was written in mental health services.

The articles that discussed compulsory notification demonstrated that health professionals have many difficulties or concerns regarding the compliance with its obligation. Their difficulties are related to their lack of knowledge about violence, how to handle it, how to approach the subject with women, and how to make sure that the violence really happened. In addition, because they are not qualified, they believe in social myths related to violence against women, which are full of prejudices and moral values. Thus, they do not report the cases nor provide an effective support to meet this demand.

The analyzed articles also reported that the professionals do not understand the real reason for the notification and do not identify the value that it has for the creation of public policies. Therefore, they end up not making the notification because they consider it irrelevant.

The articles also bring up practical issues that harm the notification. There are problems related to the size of the forms, also to the appropriate professionals who fill it in, and to the work overload. The notification form is seen as more of a burden on the excessive demand. There is also the fear of retaliation and problems with the justice system.

However, the lack of visibility of violence against women in the health care system is the most noticeable issue. Professionals believe that it is a police and justice problem and not a health care system problem. This happens due to their lack of knowledge on the issue, and also because of the technical-scientific rationality that underlies medical practice and distances them from social issues (Kiss & Schraiber, 2011).

Final Considerations / Acknowledgements

The analysis of the Brazilian papers and academic research has shown that the problem of compulsory notification of violence against women is still very incipient. It is possible to notice that although there is a government attempt to increase the issue visibility and to implement the notification in national territory; advances in the legislation have not yet reached professionals who work directly with women in the health care system, in a daily basis.

In addition, it is important to note that there is a need for investment in their education, not only to identify violence and work with women, but also, it is necessary to make them aware of their role to create more effective public policies, being compulsory notification one way with which they can collaborate.

It was possible to see the latent need to implement this discussion in the mental health care system. It can be seen that these services have been more concerned with creating a policy of assistance to mental disorders, but these disorders are reified and taken as a given, separated from the social context. In addition, it is

necessary to create public policies that highlight the issue of violence against women within the mental health care system, so that they are not camouflaged in psychiatric diagnosis.

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Educational Goals

- The participants of this presentation will learn about the Brazilian Mental Health System.
- The participants will be able to reflect about the importance of including the discussion about violence against women in mental health services, as well as the implication of it on health professionals' performance at work.

Correspondence

Ms Mariana Pedrosa de Medeiros
Brasilia University / Psychology Institute / Mental Health and Gender Group
SQSW 100 BLOCO A Apartment 202
70670011 Brasília
Brazil
mari.pmedeiros@gmail.com

Impact of context on attributions of rape victim culpability: Are online dating victims blamed more?

Poster

Graham Tyson, Melanie Lucas, Paola Castillo (Australia)

Keywords: Rape, victim blaming, online dating, attribution theory

Abstract

Romantic dates are increasingly being arranged via dating websites. Such sites, however, offer sexual predators a tool to seek out potential victims and an increasing number of sexual assaults arising from online dating appear to be occurring. Previous research has shown that the female victim in "date rape" cases is often judged as having more responsibility for the rape and blamed more than the victim of stranger rape. Such research, however, has focused on traditional dating situations rather than dates arranged online. Working within the framework of Weiner's Attribution Theory, the current study investigated the attributions of responsibility, controllability and blame assigned to a rape victim arising from a date organized online relative to the judgements made for a victim of traditional date rape and stranger rape. The degree of sympathy for the victim and the perceived intent of the victim to have sex with the date was also assessed.

A total of 263 male and female participants from the USA and Australia participated in the online study. Each participant read one of three vignettes. The first vignette presented a case where the victim was raped at the end of a date arranged via an online dating website, whereas in the second vignette the rape occurred at the end of a traditional date. The third version of the vignette described a case of stranger rape. After reading the vignette, the participants answered a series of questions relating to the victim.

Results indicated that there was a significant difference between the three groups in the judgement of the controllability of the situation. The victim in the online dating situation was seen as having greater control over the situation than the victims in the traditional dating or stranger rape situation. There was no difference in the degree of controllability between the latter two groups. There were no significant differences between the groups on any of the other measures. The only significant gender difference was in relation to intent to have sex with the date with male respondents having slightly higher scores than the female respondents.

Overall the results of the study are encouraging in that they showed that irrespective of the situation the tendency to blame the victim was relatively low and there was a high level of sympathy for her.

Educational Goals

- Recognize the importance of situational factors that influence people's perceptions of rape victims.
- Recognize the impact of gender on the perception of rape victims

Correspondence

Mr. Graham Tyson
Charles Stuart University
Panorama Ave
2795 Bathurst
Australia
gtyson@csu.edu.au

Revenge and forgiveness after victimization: Differences between violent offenders and male students from various educational settings

Poster

Coby Gerlsma (Netherlands)

Keywords: victimization, aggression, violence, interpersonal motivation, revenge, forgiveness

Abstract

Being harmed by another person may elicit strong emotions about the perpetrator(s). Among others, the experience may call for revenge. Recent formulations picture revenge as a primary motive for violent offending in general, for fire setting, sexual violence, mass murder, and (suicide) terrorism. A review of empirical findings put revenge forward as a causal factor in up to 20% of homicides worldwide, 61% of school shootings, 27% of bombings, and as an inspiring factor for recruitment in terrorist organizations. Such findings and formulations suggest that violent offenders might be victimized and vengeful offenders. Indeed, many violent offenders report a history of victimization but do individuals who have committed a violent offense also report more negative motivation (revenge, avoidance) and less positive motivation (benevolence, forgiveness) toward their victimizers than individuals from the general community?

Sixty-two men (mean age 36.6 years, SD= 10.5) convicted for violent offenses, and 193 male students (mean age 18.5 year; SD=2.5) from various educational settings were compared on the following variables: (1) type of victimizing experience(s), i.e., whether they had experienced incidents that involved direct or indirect aggression, and physical or sexual violence; (2) interpersonal motivation toward the perpetrator of the reported experience(s), i.e., thoughts and feelings of revenge, avoidance, benevolence, and forgiveness (assessed with the Transgression Related Interpersonal Motivation (TRIM; McCullough, Root & Cohen (2006), Journal of Consulting and Clinical Psychology, 74, 887-897).

Compared to the students, the offenders reported significantly more experiences that involved physical and sexual violence. The proportion of experiences with indirect aggression they reported was smaller. The offenders also reported more revenge and avoidance motivation, and less benevolence and forgiveness, but these differences in motivation appeared to be due to the differences in type of victimization: Experiences that involved direct aggression and physical violence elicited more revenge and less benevolence in both groups, whereas sexual violence elicited predominantly avoidance in both groups. Controlled for type of victimization, the offenders and students did not differ in revenge, avoidance, and forgiveness motivation toward their victimizers.

Bearing in mind the methodological limitations of this pilot study (e.g., cross-sectional, correlational, self-report data in small and unrepresentative samples), these preliminary findings suggest that the type of victimization experienced might be a moderator of revenge, avoidance, and forgiveness. Taking the kind of their victimizing experiences into account, the violent offenders did not appear more vengeful and unforgiving than the students. In the context of clinical (forensic) practice, these findings suggest that (1) the TRIM might be useful as a screening instrument in the general community in order to signal threat and prevent violent offending and (2) might yield useful information in the context of risk assessment in known offenders.

Educational Goals

- Describe the interrelationships between victimization, victims' interpersonal motivation toward their victimizer(s), and victims' risk of violent offending
- Discuss the way a particular type of victimizing experience might interact with thoughts and feelings of revenge, avoidance, and forgiveness toward the victimizer, and with victims' risk of violent offending

Correspondence

Ms. Coby Gerlsma
University of Groningen, Clinical Psychology & Experimental Psychopathology
Grote Kruisstraat 2/1
9712 TS Groningen
The Netherlands
j.gerlsma@rug.nl

Chapter 15 – Specific populations forensic

Forensic Assertive Community Treatment (ForACT): an essential integrated cooperation with key-partners (illustrated by ForACT The movie)

Workshop

Diana Polhuis, Rene Mooij, Harry van Putten & Jaap Keijzer (Netherlands)

Keywords: Forensic, Assertive, Community, Treatment, Cooperation, Key-partners, Film

Introduction

The Forensic ACT model (ForACT) is used in the Netherlands to provide care and treatment for criminal offenders suffering from a severe mental illness (Place, Van Vugt, Kroon & Neijmeijer, 2011). The patients all are convicted for a crime or show offensive behaviour. Addiction is often a co-morbid problem. The primary focus of the treatment is the offensive behaviour. In order to be effective the underlying disorders, problems and readiness to change are treated. We work according to the risk-needs-responsivity model by Bonta & Andrews (2007). The target group we refer to consists of psychiatric patients, with a high level of intellectual disability (IQ 50-85) who suffer from mental illness, often in combination with substance abuse (AAIDD, 2010; APA, 2015). They form a group of criminal offenders with complex needs (Tenneij et al, 2009). ForACT is an intense recovery oriented multidisciplinary team with a shared caseload approach (Place et al, 2011; Rijkaart & Neijmeijer, 2011). The forensic psychiatric treatment is primary focused on risk reduction, decreasing violence and offences and improving daily functioning and quality of life (De Kogel & Nagtegaal, 2008; NIFP, 2008). Measurement instruments such as the HoNos, CANSAS, HKT-30 (Dutch version of HCR-20) and START are used (Webster, Martin, Brink, Nicholls, & Middleton, 2004; Yates & Ward, 2008). We also use diagnostics for people with intellectual disabilities on social emotional development (http://www.seo-r.nl/). Interventions include emotion and aggression regulation, treatment of trauma, preventing sexual offences and structuring daily life. Our success is partly due to our cooperation with non-natural key-partners like the police. The cooperation consists of information exchange, using practical creative solutions, prevention by consultation and expertise exchange. We work intensively together with several key-partners like facilities for intellectual disabled people, police, the justice system, parole officers and regular psychiatry and general health system. We also started consultation for the population in the regular flexible assertive community treatment teams to provide prevention strategies for offensive behaviour. Several studies underline the importance of cooperation among specialists in mental health, forensics and intellectual disabilities in relation to offences (Kaal, 2010; Männynsalo L, Putkonen H, Lindberg N & Kotilainen I., 2009).

The purposes of this symposium are (a) to clearly describe the principles of Forensic Assertive community Treatment, (b) to illustrate how we work by a short film (23 minutes) and (c) discuss the advances of cooperation with (non-natural) key-partners. Participants will learn the usefulness of intense cooperation between police and Forensic ACT in order to provide risk management and a save society.

Cooperation

Forensic assertive community treatment teams in the Netherlands work intensively together with several key-partners. Those key-partners consist of mental health or wellbeing facilities like mental health care institutions or facilities for people with intellectual disabilities, youth or community facilities. Those partners are so-called natural partners. We all work together in some way to increase wellbeing and health. We aim at having common goals (RVZ, 2012). Non-natural partners do have different aims like punishment or protecting society from crimes and offensive behaviour. Non-natural partners are the police,

prosecutors or parole officers. Forensic ACT teams cooperate with both natural and non-natural partners due to the goals of Forensic ACT teams: risk management and prevention of offences by severe mental illness (SMI) consumers and social inclusion of people with SMI and criminal behaviour.

Aim

Participants will be better able to describe how Forensic ACT and risk management is organized, and discuss the usefulness of cooperation with key-partners, especially the police. Participants will learn about future developments in Forensic outpatient care in the Netherlands

Conclusion

In practice we work together with non-natural partners in early detection, casefinding and prevention of offencive or criminal behavior. We would like to illustrate how we work together by a short film. In the film we show the daily work of a forensic ACT team working together with patients and (non) natural partners. We show how we provide care and treatment, taking both the offensive behavior as well as the cognitive, social and emotional development into account. This requires special attention for the way we communicate with our comsumer and how we act as his trustworthy partner.

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http://www.seo-r.nl/

Correspondence

Ms. Diana Polhuis
GGZ Noord-Holland-Noord
De Olvendijk 72
1851 VN Heiloo
Netherlands
d.polhuis@ggz-nhn.nl

'Fight, Flight or Freeze' – I'm fighting! The application of EMDR in a group based violence reduction treatment programme

Purpose

The purpose of this paper will be to explore the ways in which trauma may manifest both in terms of internalizing and externalizing symptoms. The paper will argue that the effects of trauma can contribute to the engagement in problematic behaviors (such as offending behavior, substance misuse and aggression) which may require those coming into contact with the Criminal Justice System to attend treatment programs to target these problem behaviors. However, standard offence focused and/or victim interventions do not sufficiently take into account the effects of trauma in terms of attending to the therapy interfering behaviors which are brought to treatment. The paper will argue that trauma related therapy interfering behaviors (e.g. flashbacks, hostility, impulsivity, emotional reactivity) should be attended, and certainly before placing individuals onto group therapies to target other problem behaviors.

Approach

The paper will introduce TIA-P which is a newly designed group designed to assist clients to tolerate and modify therapy interfering behaviors which are present as a result of trauma in order that they can then go on to attend standardized offence focused/victim centered interventions.

Originality/Value

The TIA-P attends to the latest research in the treatment of trauma utilizing Eye Movement Desensitization and Reprocessing (EMDR) within the group to enhance safety and reduce therapy interfering behaviors. It is the first of its kind to with a forensic client group.

Practical Implications

Practical implications are indicated for professionals working in the criminal justice field with clients with a history of trauma in order to assist them to engage clients more effectively.

Educational Goals

1. Participants will be expected to increase their knowledge of how information processing models of aggression map onto the information processing models of trauma and how interventions such as EMDR can target both of these
2. Participants will also be expected to apply newly learned knowledge in relation to trauma, aggression and EMDR within their practice and learn practical methods for assisting their clients

Correspondence

Ms. Rachel Worthington
Psychology Department University of Central Lancashire and Alpha Hospitals
Buller Street
BL8 2BS Bury
United Kingdom
rachel.worthington@alphahospitals.co.uk

Dissociation and Violence-Fools Venture Where Angels Fear To Tread

Paper

Julian Gojer, Adam Ellis & Monik Kalla (Canada)

Keywords: Dissociation, Violence, Criminal Justice

Abstract

Failure to recall details of a violent act has posed clinical and legal problems for courts and clinicians assessing individuals in such situations.

Violent acts can be associated with complex behaviours that arise out of medical, neurological and psychiatric states. When the individual claims amnesia for the event, it is important to determine if this amnesia is post event or is an integral part of the events encompassing the violent act. Post event amnesia has been reported in many cases of homicide but this does not exculpate an individual of criminal responsibility. However, amnesia during the act may have underlying reasons that are medically based or that it could be fabricated.

That a person can be in a dissociated state is well-accepted. However, establishing that a person was actually in a dissociated state at the time of the offense requires a significant leap in terms of accepting diagnostic certainty and ultimately credibility of the accused.

We will trace the history of dissociation and how this phenomenon has been used in the courts as a full defence leading to acquittals or a partial defences and the pitfalls in evaluating such cases. We will examine the case of R.v Husbands, a man who suffered from Post-Traumatic Stress Disorder and subsequently shot and killed two men and wounded several others in a crowded mall.

Educational Goals

1. Understanding the complex association between Dissociation and Violence
2. Learning how to evaluate such situations from a clinical and forensic point of view.

Correspondence

Mr. Julian Gojer
University of Toronto/Manasa Clinic
720 Spadina Rd.
M5S 2T9 Toronto
Canada
juliangojer@gmail.com

The role of (forensic mental health) nurses and group workers in the reduction of violence and aggression

Paper

Petra Schaftenaar (Netherlands)

Keywords: forensic mental health nurses, contribution to diminishing aggression, therapeutic relationship, meaningful activities, recovery

Aim

In this presentation the author will present the results of a review of the literature of the key elements of forensic mental health nursing.

Method

a review of the literature was conducted in (the second half of) 2014. More than a 1000 pages of articles and books were studied.

Results

The study identified the key elements of forensic mental health nursing. The therapeutic relationship, meaningful activities, characteristics of the ward and recovery principles were shown to be important factors. Specific characteristics of these elements are revealed. The research also showed certain aspects (mainly in the way we manage relationships) that do not contribute to treatment outcomes.

Furthermore, the study showed the contribution of these key elements in forensic mental health nursing to the reduction of inpatient aggression.

Research of both worker and patients' views were included.

Conclusion

Forensic mental health nurses can contribute to reducing inpatient aggression by the way they work, their role and the facilitation of meaningful activities. Reflexivity of nurses is important to maintain healthy and empathic therapeutic relationships.

Educational Goals

- After attending this presentation participants will be better able to identify the key elements of forensic mental health nursing and understand how the key elements of FMHN contribute to reducing aggression.

Correspondence

Ms. Petra Schaftenaar
Inforsa
Duivendrechtsekade 55
1096 AH Amsterdam
The Netherlands
petra.schaftenaar@inforsa.nl

Toxicology in Suicides and Homicide-Suicides

Paper

Carrie Carretta, Ann Burgess & Michael Welner (USA)

Keywords: Suicide, homicide, prescription drug abuse

Abstract

Gaps in crises of mental health include differentiating between various types of lethal violence of people who suicide and those who murder and then kill themselves and the role, if any, that substance use has in the outcome. In this study, a sample of medical examiner investigative and toxicology reports from Los Angeles and Orange counties in California were available for analysis for 432 suicide cases and 193 homicide-suicide cases.

Variables examined in the analysis included toxicology reports, cause of death, type of weapon used, race, age, sex of perpetrators and victims, and location of the homicide. Significant differences noted were levels of alcohol were higher in suicide victims than homicide-suicide perpetrators (p=.004). Homicide-suicide perpetrators had almost twice the level of stimulants in their system than suicide victims (p = .022) but did not have elevated levels of drugs or alcohol compared to suicide deaths.

Educational Goals

1. Identify themes related to demogaphic and psychosocial factors for those having committed homicide and homicide/suicide
2. Explore and be able to discuss research related to violence (suicide and homicide) and the relationship to prescription drugs.
3. Affect use of this information to facilitate better client assessment and identification of possible at risk population

Correspondence

Ms. Carrie Carretta
Rutgers, The State Univeristy of New Jersey
65 Bergen Street, SSB GA 219
07101 Newark
USA
carrie.carretta@sn.rutgers.edu

Risk management and reduce of recidivism through relational care in a forensic psychiatric hospital

Paper

Petra Schaftenaar & Ivo van Outheusden (Netherlands)

Keywords: Forensic psychiatry, recidivism, risk management, relational care

Aim

In this presentation the authors will present the results of ongoing research into recidivism and relational care.

Method

We developed new insights based on clinical practice and scientific research.

Results

Research shows that recidivism among forensic patients with an involuntary hospital admission, a short judicial measure, in The Netherlands is high. Characteristics of the background of patients are a history of discontinuity and many efforts by care institutions to build up a working alliance. All patients have psychotic disorders and addiction problems. With yet another relative short-term stay in a hospital, the forensic specialty (risk-management) doesn't seem to keep up when transferred to the regular health care. In this presentation we will show the preliminary results of scientific research at Inforsa's forensic psychiatric clinic. We will present the recidivism rates and compare them to earlier (baseline) research.

Conclusion

A new paradigm of relational care, with core elements of trust and sustainable connection was developed and after one and a half year, we measured recidivism. Results are at least remarkable and we will discuss the impact of it.

Educational Goals

- Learn how relational care and special aftercare programs can contribute to risk management and reduction of recidivism;
- Understand the key components and the important elements in culture and structure to deliver this way of treatment

Correspondence

Ms. Petra Schaftenaar
Inforsa
Duivendrechtsekade 55
1096 AH Amsterdam
The Netherlands
p.schaftenaar@ziggo.nl

Development of the therapeutic relationship in music therapy with forensic psychiatric inpatients – a mixed method case study

Background

The development of the therapeutic relationship and cooperation with psychiatric patients in general is crucial in order to prevent violence in clinical psychiatry.

In forensic psychiatry the development of a therapeutic relationship is challenging because the patients have little insight into their psychiatric illness and the interaction is often characterized by power struggles and aggression.

Studies document the effect of a good therapeutic relationship, but not how to facilitate the development of this relationship. Moreover, there are no studies on therapeutic relationship with forensic psychiatric patients.

Aim

The aim of the study is to describe how a creative, non-verbal and active approach like music therapy can facilitate a constructive interaction with forensic psychiatric patients including sustaining the development of understanding, dialogue and support in the relationship between the forensic psychiatric patient and the therapist. Moreover, support the patient´s motivation to be involved in the treatment and the development of the therapeutic relationship.

Method

The study is a mixed method case study carried out as a PhD-project at two forensic psychiatric units at the Department of Forensic Psychiatry, Region Zealand, Denmark.

Data will be collected from weekly music therapy sessions during the first six months of a course of individual music therapy with 4 in-patients.

Data will consist of: Thorough qualitative descriptions of each music therapy session, McGlashan 11 process levels, and daily structured staff ratings on the contact with the patient. A range of clinical information from daily patient files: medicine status, use of rescue medicine, BVC violence risk assessments, and observational level. Furthermore, the patients complete the Mood adjective checklist and the Session Rating Scale, and finally, semi-structured interviews are carried out with the patient twice during the six-month course of music therapy.

Results and Conclusions

Data from the pilot course of music therapy and preliminary results from the study will be presented, illustrated by audio taped vignettes from a course of music therapy. It will be discussed how elements in musical interaction and communication with forensic psychiatric patients can be transferred to interaction and communication in general with forensic psychiatric patients.

Educational Goals

1. How to meet and interact with forensic psychiatric patients and their aggressive reactions and expressions in a therapeutic setting
2. Development of the therapeutic relationship

Correspondence

Ms. Britta Frederiksen
Department of forensic Psychiatry, Region of Zealand
Annebergparken 35
4500 Nykøbing Zealand
Denmark
brif@regionsjaelland.dk

ADHD & delinquency: double trouble?

Workshop

Rosalind van der Lem & Marijn DuPrie (Netherlands)

Keywords: ADHD, violent behaviour, treatment program, scientific evidence

Abstract

ADHD may be associated with an elevated risk of aggressive and other criminal behaviour, since ADHD is related to several criminogenic needs (Risk Need Responsivity model, Andrews & Bonta, 2006): rage/anger management, substance abuse, impulsive behaviour, family dysfunction and low level of education.

Attention Deficit Hyperactivity Disorder (ADHD) is a disorder in which impulsivity, lack of concentration and diminished planning skills are the core symptoms. Twenty-five percent of the adult incarcerated population suffer from ADHD. Among adolescents and young adults, the prevalence of ADHD in forensic institutions is even higher. Furthermore, ADHD is often undetected in criminal adults. Patients with ADHD tend to be convicted more often, for more serious crimes (often violent), and are punished more severely by the justice system. ADHD together with oppositional defiant behaviour is associated with future crime. ADHD is associated with high rates of substance abuse, marital problems, intimate partner violence, problems in raising children, and lower performance on school and labour. All these factors can enlarge the risk on criminal/aggressive behaviour. Crime rates seem to be reduced dramatically, when ADHD patients are treated pharmacologically. Yet, forensic patients with ADHD are very likely to have major problems to benefit from regular treatment programs on aggressive behaviour and/or pharmacological treatment in daily outpatient psychiatry. A specific (multimodal) approach for aggressive behaviour in forensic ADHD patients is needed.

In this workshop, participants will learn more about the problems that are associated with forensic outpatients suffering from ADHD and our specialized treatment program. Participants will be invited to actively answer quiz-questions and vote on assertions on ADHD. Modern technologies like web-applications, together with theatrical means, will be used to facilitate interactive communication with the audience. The presenters will teach the audience about the latest scientific knowledge on ADHD and violent behaviour. Furthermore the audience will be encouraged to look at their own traits that might be similar to the ones of ADHD patients. In a provocative setting, participants will be stimulated to challenge their and our opinion on the following hypothesis:
ADHD and delinquent behaviour means at least...double trouble!

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Educational Goals

- Evaluate the current scientific knowledge and the use thereof on ADHD in relation to violent behaviour
- Discuss the opportunities and limitations of the treatment of patient with ADHD in forensic outpatient psychiatry

Correspondence

Ms. Rosalind van der Lem
Kijvelanden/Het Dok
Diergaardesingel 69-73
3014 AE Rotterdam
The Netherlands
rosalind.van.der.lem@hetdok.nl

Change management in juvenile forensic psychiatry aiming at the prevention of violence and the improvement of treatment outcome

Paper

Michael Bruenger (Germany)

Keywords: forensic psychiatry, adolescents, de-escalation techniques, post-traumatic care, staff counseling, architecture, change management, treatment outcome.

Abstract

Psychiatric care for convicted mentally ill offenders in Germany (Massregelvollzug) envisages the strict separation of adolescents from adults. This leads to the need of rather small forensic units for adolescents with an often very heterogeneous population.

In the adolescent forensic department of Pfalzinstitut Child and Adolescent Psychiatric Service, Germany, the growing rate of aggressive behavior towards staff members and malicious injury to the unit's equipment has led to deleterious effects to the therapeutic and educational work being done on the ward.

An analysis of the situation revealed a range of causes:

- Insufficient architectural structure of the facilities
- Heterogeneity among the group of adolescents differing by age, sex, cognitive ability, psychiatric disorder, behavioral disposition e. g. aggression,
- Heterogeneous needs: school, professional education, training of social competence, offense-centered intervention, intervention addressing the psychiatric disorder by psychotherapy (individual or group) and/or medication.
- Diverging levels of threatening behavior needing an appropriate response in terms of assuring safety for staff and inmates.
- Diverging stages of rehabilitation
- Diverging developmental potential of adolescents.

Triggered by an increasing rate of critical incidents a broad approach addressing the improvement of the facilities, the continuous education of staff members and most of all the differentiation of therapy and care provided was newly designed. Following these measures fluctuation of employees was very low, critical incidents were connected to a minority of patients. Safety precautions were newly conceived including a close cooperation with local police authorities. Specific teaching of de-escalating techniques was implemented as well as a newly designed process of debriefing and post-traumatic care for staff members after critical incidents. Leading psychiatrists and staff managers sought for peer-to-peer coaching from neighboring institutions giving care to a comparable group of patients. This paper reports on the positive and fundamental changes achieved by our two year's ofeffort.

Educational Goals

- Participants will learn on the prerequisites of forensic care with juvenile mentally ill delinquents.
- Participants will evaluate the outcome of change management in a forensic psychiatric unit by discussing the change of key figures after implementation of a compound of specific measures.
- Speaker and participants will discuss change management in the field of forensic psychiatry referring to their respective working contexts.

Correspondence

Mr. Michael Bruenger
Pfalzinstitut Child & Adolescent Psychiatric Service - Pfalzklinikum
Weinstrasse 100
76889 Klingenmuenster
Germany
michael.bruenger@pfalzklinikum.de

Extensive Hostile Interpretation Bias Regarding Emotional Facial Expressions among Forensic Psychiatric Outpatients

Introduction/Background

Reactive aggressive behavior typically occurs in response to particular social situations, situational factors such as social interactions should also be considered when investigating problematic behavior [1]. An important aspect of social interaction is facial expression. Facial expressions carry a broad range of socially relevant information: They give information regarding the internal states of the sender, and our impressions of others are for a large part derived from facial expressions [2, 3]. Accurate processing of facial expressions is critical to normal socialization and social interaction [3]. However, in everyday life, situations are not always straightforward and often consist of ambiguous information. Likewise, one does not necessarily express prototypical expressions; subtle facial expressions are often displayed instead [3]. This renders it even more difficult to process facial expressions correctly. Furthermore, associated with psychopathology, some individuals lack the ability to process facial affect accurately. For instance, individuals displaying antisocial personality traits have been associated with deficits in the recognition of facial affect, specifically fear and sad affect [4, 5]. Incorrect recognition may also arise from an a-priori tendency to interpret facial expression in a certain way, i.e. to have an interpretation bias. With respect to aggression, it has been suggested that aggression occurs as function of making a hostile attribution that "the self" has been threatened [6]. This tendency of aggressive individuals to perceive or attribute hostile intent to others is often referred as "hostile attribution bias" [7].

Studies on hostile attribution biases showed that this bias, in children as well as in adults, is associated with reactive aggression [6, 8-12]. Furthermore, these studies suggest that aggressive individuals tend to attribute hostility to others in socially ambiguous situations. This attribution of hostility can have detrimental effects, as the perception of aggressive intent in others is a powerful cause of anger and aggressive behavior [13]. Moreover, hostile attribution biases not only cause and predict aggressive acts [14], they also contribute to the maintenance of aggression. When attributing hostile intents to others, one is more likely to act aggressively, which in turn causes others to respond more aggressively, which will further strengthen the person's hostile view of others [15, 16]. Despite the fact that these studies revealed the existence of hostile attribution biases, they solely made use of vignettes, using videos or written stories. The vignettes describe hypothetical situations in which someone is provoked by a peer who is acting ambiguously. Participants are asked to indicate the intention of the peer. Research showed that a hostile attribution bias occurs in these ambiguous situations. With regard to this aspect of hostile biases, vignettes are suitable materials. However, as stated earlier, facial expressions play an important role in social situations and may even induce aggressive intentions and behavior when not processed or interpreted accurately. It is possible that this hostile bias not only occurs in the attribution to others' intentions in ambiguous situations, but also with respect to the interpretation of ambiguous facial expressions.

Until now, only a few studies have investigated interpretation biases regarding facial expressions [7, 17, 18]. However, these studies focus on emotion recognition, lack a control group, or were conducted among adolescent or adult general populations and, therefore, do not provide clear-cut evidence of a bias in the interpretation of facial expressions in individuals displaying pathological aggressive behavior. Nonetheless, Schonenberg and Jusyte [2] recently investigated the hostile response bias toward ambiguous facial cues in antisocial violent offenders using morphed pictures. The authors conclude that aggressive individuals interpreted ambiguous facial cues as hostile and showed a tendency to overrate the perceived intensity of anger. However, the morphed pictures all consisted of two emotions shown simultaneously. Even though these stimuli are ambivalent, in everyday life, these emotions are rarely displayed together. Furthermore, previous studies on biases assume that rating a picture as angry suggests one also interprets it as hostile. This notion suggests that anger and hostility are interchangeable. To our knowledge, it is unknown whether individuals interpret only an angry face as hostile. It could be that other emotions are

also experienced as hostile. In addition, none of the previous studies asked participants to indicate whether they experienced a certain picture as hostile.

To address these issues, the goal of the present study was to investigate the presence of a hostile interpretation bias with respect to facial expressions among forensic psychiatric outpatients (FPOs) with aggression regulation problems, and diagnosed with an antisocial personality disorder. In order to investigate this bias, a computer task was developed in which affective pictures of various intensities were used. To create different intensities, pictures were morphed. Moreover, affective pictures were morphed with neutral pictures in order to avoid images showing multiple emotions simultaneously. Instead of asking participants which emotion is shown or to indicate the intensity of the emotion, participants were asked to indicate whether the picture looked hostile or not. Furthermore, to investigate whether a hostile interpretation bias is displayed by FPOs and whether this bias is associated solely with pathological aggression, healthy, non-aggressive, controls (HCs) were recruited. To be able to discover a possible association between hostile interpretation bias and type and severity of aggression and even social anxiety, a number of questionnaires were included.

Methods

Thirty male forensic psychiatric outpatients (FPOs) with problems of aggression regulation, diagnosed with antisocial personality disorder, and 30 male healthy, non-aggressive, controls (HCs) participated in the study. The patients were recruited from a consecutive series of patients admitted to "Kairos, Pompestichting", an outpatient clinic for forensic psychiatry at Nijmegen, The Netherlands. After receiving information about the nature of the study, participants signed a consent form. The FPOs were screened by trained clinicians with the Structured Clinical Interview for DSM-IV axis II personality disorders [SCID-II; 27]. FPOs had to meet the criteria of an antisocial personality disorder. Moreover, in the current study, FPOs with a borderline- or narcissistic personality disorder were excluded from participation. In addition, all FPOs meet the research criteria for Intermittent Explosive Disorder (IED), confirmed by the Research Criteria set for IED [IED-R; 28]. Furthermore, all participants were screened with the MINI International Neuropsychiatric Interview [M.I.N.I; 29, 30]. FPOs and HCs with lifetime bipolar disorder and psychosis, current major depression, or current severe addiction were excluded from participation. The age of the FPOs ranged from 21 to 58 years ($M = 33.27$, $SD = 9.3$), and the age of the HCs ranged from 19 to 61 years ($M = 37.27$, $SD = 12.6$). A t-test revealed no significant age difference, $t(58) = 1.404$, $p = .17$. The HCs were recruited via online postings on the clinic's website. All participants were compensated for their time with a monetary reward. The current study was approved by the Research Ethics Committee, CMO region Arnhem-Nijmegen, The Netherlands.

Questionnaires

The Social Dysfunction and Aggression Scale [SDAS; 31] is an observer-scale that measures severity of actual aggressive behavior. In the current study, due to lack of observers, the SDAS was used as self-report. Participants had to rate their aggressive behavior over a period of three months. Moreover, only FPOs with a total SDAS score of five points or higher were included in the study.

The Inventory of Interpersonal Situations [ISS; 32] is a self-report measure that was used to assess social anxiety and social skills.

The Reactive Proactive Questionnaire [RPQ; 33, 34] is a 23-item self-report questionnaire to measure reactive versus proactive aggression.

The Aggression Questionnaire [AQ; 35] is a self-report questionnaire to assess an overall trait of aggression.

Paradigm

The *Hostile Interpretation Bias Task* (HIBT) was developed to assess a hostile interpretation bias. Photos of faces with emotional affect (angry, fear, disgust, happy) of four male and four female models were selected from the Radboud Faces Database [36]. Each affective picture was morphed (using WinMorph 3.01) with the neutral image of the same individual, creating 20%, 40%, 60%, 80% and 100% emotion intensity. The task consisted of a practice block and two experimental blocks. The practice block consisted of 16 trials (8 models x 2 emotions). Only pictures with happy and angry affect and of 100% intensity were used to familiarize participants with the task. Each experimental block consisted of 168 trials (8 models x 4 emotions x 5 intensity levels + 8 neutral images). The order of the pictures was pseudo-randomized and equal in both blocks. Participants received the instruction that they had to indicate whether the picture looked hostile or not. In case they thought they saw a hostile picture, they were asked to press the Z-key, otherwise the M-key (on a qwerty keyboard). They had to respond as quickly as possible. The picture was presented for four seconds, in the center of the computer screen against a black background. The labels were displayed in the left (Yes, hostile) and right (No, not hostile) bottom corner of the screen in white

Arial font, size 30. If a response was not given within four seconds, the words "Too late" appeared on the screen in red. In total, it took participants approximately 10 minutes to complete the HIBT.

Results

To analyze whether FPOs show a different pattern of hostile interpretation as compared to HCs, first a 4 (emotion: anger, happy, fear, disgust) x 5 (intensity: 20%, 40%, 60%, 80%, 100%) x 2 (group: FPOs vs. HCs) repeated-measures ANOVA was conducted. Due to violation of sphericity, Greenhouse-Geisser correction was used. Significant main effects of *emotion*, *intensity*, and *group* were found, $F(2.15, 124.78)$ = 137.76, $p < .001$, $eta^2 = .704$; $F(1.68, 97.51) = 67.65$, $p < .001$, $eta^2 = .538$; and $F(1, 58) = 9.06$, $p = .004$, $eta^2 = .135$, respectively. The *emotion* x *group* and *intensity* x *group* interactions were not significant, and neither was the *emotion* x *intensity* x *group* interaction. These results indicate that the interpretation of hostility differed for each emotion and intensity. Moreover, they suggest that FPOs and HCs differed in their overall level of perceived hostility, but not in their patterns of hostile interpretations of facial expressions.

As the previous analysis indicated that the hostile interpretation was different across emotions and intensities, four different 5 (intensity: 20%, 40%, 60%, 80%, 100%) x 2 (group: FPOs vs. HCs) repeated-measures ANOVAs were conducted, one for each emotion, to analyze more specifically on which emotions FPOs and HCs differed. Due to violation of sphericity, Greenhouse-Geisser correction was used. Regarding anger, a significant main effect of *intensity* and a marginally significant main effect of *group* were found, $F(2.23, 129.2) = 150.23$, $p < .001$, $eta^2 = .721$; and $F(1, 58) = 3.57$, $p = .064$, $eta^2 = .058$, respectively. For disgust, significant main effects of *intensity* and *group* emerged, $F(2.29, 132.9) = 50.89$, $p < .001$, $eta^2 = .467$; and $F(1, 58) = 6.42$, $p = .014$, $eta^2 = .100$, respectively. These results indicate that angry and disgusted pictures of higher intensity were more often interpreted as hostile. Moreover, FPOs tended to interpret these facial expressions as hostile more frequently than HCs. For fear, a marginally significant main effect of *intensity* and a significant main effect of *group* emerged, $F(1.86, 107.9) = 2.96$, $p = .060$, $eta^2 = .049$; and $F(1, 58) = 8.87$, $p = .004$, $eta^2 = .133$, respectively. For happiness, significant main effects of *intensity* and *group* were found, $F(1.92, 111.2) = 15.85$, $p < .001$, $eta^2 = .215$; and $F(1, 58) = 5.22$, $p = .026$, $eta^2 = .083$, respectively. The intensity effect for happiness showed that high intensities of happiness were interpreted as less hostile than low intensities. The *intensity* x *group* interaction was not significant for any of the four emotions.

To explore the associations between hostile interpretation bias and type and severity of aggression and social anxiety, correlational analyses were performed. In order to examine variables related to pathological aggression in more detail, these analyses were conducted in the FPOs solely. Moreover, considering the sample size, only the total scores of the questionnaires, except for the RPQ, were of interest in the current analyses. Correlations were computed using the percentage of "hostile" responses per emotion condition, averaging across intensities. To determine confidence intervals and to test the significance of the correlations, a bootstrapping (1000 samples) procedure was used.

Significant correlations emerged with aggression and social anxiety. A hostile interpretation bias regarding angry faces was associated with the total AQ score, reactive aggression (RPQ) and total SDAS score. Furthermore, an association was found with social anxiety as measured by using the ISS. The correlation analyses yielded no significant associations between "hostile" responses to fearful, disgusted and happy faces and aggression and social anxiety.

Conclusion/discussion

This study showed a clear hostile interpretation bias with regard to facial expressions among FPOs with aggression regulation problems. A hostile interpretation bias was found for disgusted, fearful and happy facial expressions. Moreover, an association emerged with type and severity of aggression and social anxiety. Future research will have to determine the nature of this relationship: Is a hostile interpretation bias the cause or consequence of a disposition to react with inappropriate aggression? Or is there a vicious circle of attribution, interpretation and aggression?

The present findings are in agreement with the findings of Schonenberg and Jusyte [2], who found that antisocial violent offenders interpreted ambiguous facial cues as hostile. Previous studies suggested that aggressive individuals tend to attribute hostility to others in socially ambiguous situations [6, 8-12]. Together with the study by Schonenberg and Jusyte [2], the current study provides support for the idea that not only a hostile attribution bias exists regarding ambiguous social situations, but also a hostile interpretation bias with respect to ambiguous facial expressions. In agreement with previous studies, the present study revealed an association with reactive aggression. Moreover, clear associations were

found between hostile interpretation bias and severity of aggressive behavior as well as the overall trait of aggression. These associations only emerged with respect to angry faces. Perhaps individuals high in aggressive behavior and with a hostile interpretation bias are the ones who respond most to angry expressions. This, however, has to be elucidated by future research. The current results underline the idea that individuals with aggression regulation problems, in real life, have an increased disposition to respond aggressively to ambiguous situations as well as to ambiguous and less ambiguous facial expressions.

Furthermore, not only was the interpretation of hostility towards facial expressions related to aggression, it was also related to another trait, namely: social anxiety. It is well known that socially anxious individuals have biases regarding social situations and threat-related stimuli [37]. With respect to the current results, it is possible that FPOs who are also high in social anxiety focus more on threat-related facial expressions and therefore display hostile interpretations. It could also be the case that these individuals tend to interpret facial expressions as threatening and therefore also more often as hostile. The latter is in line with the suggestion by Crick [8] that individuals with poor perspective taking skills tend to attribute hostility to others' intentions. With regard to aggression, it might be suggested that aggressive individuals experience some kind of social anxiety and therefore also have difficulties in interpreting facial expressions. This is in line with previous research, which suggested that the comorbidity of social anxiety and antisocial personality disorder is related to a greater impairment in social and emotional functioning and may even be derived by the same underlying cognitive and emotional mechanisms [25]. The current results seem to confirm a link between social anxiety and aggressive behavior in individuals diagnosed with an antisocial personality disorder, which has to be explored in more detail. By all means, the results indicate that a combination of these traits could result in more misinterpreting and eventually more aggression.

Notwithstanding the limitations, this study revealed the existence of a highly generalized hostile interpretation bias with regard to ambiguous and even less ambiguous facial expressions of various emotions. Moreover, to our knowledge, this is the first study which draws attention to the fact that hostile interpretation biases are associated with numerous clinically relevant characteristics.

Acknowledgments

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Educational Goals

- Discuss the development of a neurocognitive computer task based upon clinical practice
- Discuss an understudied vulnerability factor regarding pathological aggressive behavior

Correspondence

Ms. Danique Smeijers
Radboud University Medical Centre Nijmegen
Department of Psychiatry (966)
PO Box 9101
6500 HB Nijmegen
The Netherlands
danique.smeijers@radboudumc.nl

The Early Recognition Method used to identify precursors of aggression in prisoner

Paper

Frans Fluttert, Gunnar Eidhammer, Christine Friestad, Kari Yngvar Dale, Stål Bjørkly & Åse-Bente Rustad (Netherlands)

Keywords: Risk management, forensic, prisoners, Early Recognition Method, aggression, selfharm

Background

The Early Recognition Method has been successfully applied in forensic psychiatric institutions across Europe. Use of the ERM and the FESAI seem to combine into a good strategy for clinicians in detecting early warning signs of aggression. ERM also contributes to implement risk management strategies by enhancing interactions between patients and caregivers. The results of ERM studies suggest that ERM contributes to improved management and reduction of aggressive episodes.

Aims

The main scope of this preliminary research is to explore if: (1) prisoners and prison staff can benefit from using the ERM strategy, (2), this can result in a better understanding of aggression in prisoners, and (3) ERM may have a positive effect on prison staff's team climate and 'feeling of safety'.

Methods

The ERM protocol and Early Detection Plan have been modified in order to guide prison staff on how to apply ERM in the prison services to manage situations that may escalate into aggressive incidents. This descriptive pilot study investigates how prison staff experienced applying ERM. Qualitative interviews and the 'CESEssen Prison version team climate questionnaire' were applied in order to gain knowledge concerning staff experiences with ERM and staff's feelings of safety.

The recorded early warning signs were transposed to the FESAI . Rank-order correlation analyses were done in order to gain knowledge regarding the most frequent early warning signs.

Results

The first results of this pilot study suggest that the adjusted ERM strategy for prison services assists prison staff in having a better understanding of early warning signs in prisoners. By means of this knowledge, and by the structure of ERM, prison staff seems to be better equipped to have structured interactions with prisoners concerning the early stages of escalation towards aggressive episodes by prisoners. The preliminary result also suggest that prison staff, by means of the FESAI, were able to detect and record early warning signs of aggression more efficiently than without applying the tool. The type and ranking of early warning signs in prisoners will be presented. We'll also discuss how ERM was introduced and applied in prison services and the prison staff's experiences with this process.

Educational Goals

- Observe in a structured way the early warning signs of aggression in prisoners in order to apply early interventions aiming the prevention of incidents.
- Identifying, clarifying and ranking early warning signs of aggression in prisoners aiming to have a better understanding of precursors of aggression in prisoners.

Correspondence

Mr. Frans Fluttert
Centre for Forensic Psychiatry SIFER Oslo University Hospital NO,
Molde University College Molde NO,
FPC Dr. S. van Mesdag NL
Weerdjesstraat 64-3
6811 JE Arnhem
The Netherlands
faj.fluttert@hccnet.nl

Is fire-setting performed in adolescence associated with future diagnoses of schizophrenia/schizoaffective disorder?

Annika Thomson, Jari Tiihonen, Jouko Miettunen, Matti Virkkunen & Nina Lindberg (Finland)

Background

Schizophrenia (SCH) is a severe, pervasive mental disorder characterized by positive symptoms such as hallucinations, delusions and disorganized speech, and negative symptoms such as marked apathy, a paucity of speech, and blunt or incongruent emotional responses. The onset of the disorder is typically in late adolescence or early adulthood. Before SCH becomes clinically manifest and the diagnosis is established, the person often goes through a prodromal phase with behavioral abnormalities as well as subtle cognitive and affective changes lasting a few years. Both aggressive and disruptive behaviors are reported to precede the onset of the disorder. Fire-setting is a major cause of property damage, injury, and death in many countries. Individuals with SCH have significantly increased risk of arson convictions. Arson is one of the crimes most strongly associated with psychotic disorders.

Aim

The aims of the study were to investigate if fire-setting in adolescence or early adulthood was associated with a future diagnosis of SCH/schizoaffective disorder and how long the delay of being diagnosed was.

Methods

The study population comprised a consecutive sample of 15 to 21-year old males who were charged with fire-related offenses and who underwent a pretrial forensic psychiatric evaluation in 1973-98 at Helsinki University Central Hospital in Finland. For each firesetter, four controls were randomly selected and matched for age, gender and place of birth. Information on diagnoses, mortality and moving abroad was gathered from national registers. The follow-up began the day the forensic examination was finished and ended 31.12.2012, or earlier if the subject died or moved abroad.

Results

We identified 80 fire setters with a mean age of 19.8 years (standard deviation, SD, 1.70). Ten (12.5%) of them were diagnosed with SCH or schizoaffective disorder in the examination. Another 10 (14.3%) of the 70 fire setters not initially diagnosed with SCH/schizoaffective disorder developed the disorder during follow-up. Eight (2.5%) of the 320 controls had or developed schizophrenia or schizoaffective disorder. Among fire setters, the delay between the forensic psychiatric examination and the diagnosis was on average 9.8 years (SD 9.23, range 1.2-24.9 years). The fire setters with SCH/schizoaffective disorder did not differ from those without with respect to the number of fire-settings, previous convictions or mortality rate. Among 32 firesetters with an initial substance use disorder, six (18.8%) were diagnosed with SCH/schizoaffective disorder during follow-up.

Conclusion

Young fire setters were 11 times more frequently diagnosed with SCH/schizoaffective disorder compared to controls and they were nearly five times more likely to develop a substance use disorder. On the other hand, subjects with initial substance use disorders had a slightly increased risk of later being diagnosed with SCH/schizoaffective disorder. Our findings are in line with earlier studies, and emphasize the importance of assessing youngsters with fire-setting behavior for psychotic symptoms.

Educational Goals

- The participants will be better able to identify the risk of comorbidities when assessing fire setters.
- The participants will be better able to discuss and justify the treatment needed for persons with fire-setting behavior.

Correspondence

Ms. Annika Thomson
Kellokoski Hospital
Vanha valtatie 198
04500 Kellokoski
Finland
annika.thomson@hus.fi

The Forensic Patient in the Psychiatric Hospital – Dealing with Patient Violence during Court Ordered Examination in a Psychiatric Department

Poster

Ronit Kigli, Hilik Levkovich, Avigdor Mizrachi & Moshe Kotler (Israel)

Keywords: violence, forensic patient, psychiatric hospital, court order

Abstract

The phenomenon of violence in the health system in general, and in the mental health system in particular, has been well-known for many years and presents a complex issue to be dealt with therapeutically and organizationally. The medical team in the mental health system is exposed to many situations with the potential of becoming violent, presenting a risk to the staff and the surroundings.

One of the unique groups of patients in the psychiatric department includes patients arriving on court order for examination, which is aimed at producing an expert opinion for the court regarding the legal competence of patients. The volume of these cases in the psychiatric department is increasing, along with the accompanying toll for the department and staff. We are witnessing a substantial rise in the number of violent incidents on the part of patients directed towards the professional team and other patients. These events are perceived by the team as distinct in characterization, differing from violent behavior exhibited by patients with ongoing psychiatric conditions. The majority of these patients exhibit criminal behavior, attachment patterns which involve exploiting and taking advantage of the other, as well as anti-social behavior. This creates double-impact consequences of court decisions for the department and the treatment programs.

These events weigh on the morale of the department, as well as on the perception of personal and professional safety. It presents dilemmas relating to the appropriate course of action for dealing with situations of behavioral escalation in forensic patients, as well as financial and organizational challenges resulting from harm inflicted on staff members.

As part of a process of professional re-organization in a combined conformation, a work plan was developed in the purpose of structuring a working environment which promotes safety and a violence-reduced organizational climate, formulizing a policy for dealing with courts and with a logistical safety-supporting formation. The organizational process included:

1. Creating an organizational policy which promotes safety and prevents damages in cooperation with a risk-management formation

2. Mapping violent events and their characteristics

3. Setting up an institutional committee for dealing with violence with the goal of promoting education on the subject, comprising a multi-professional team of representatives, managers and employee representatives

4. Providing supplemental education for teams on the subject of violent event inquiries

5. Clinical discussions for processing ethical issues arising from physical violent contact

6. Guidance for medical teams on the subject of providing quick and practical responses for court orders

7. Dealing with the police and prison service

8. Allocation of organizational resources to protective measures for the benefit of the medical team (cameras, help buttons)

This combined program contributes to carrying out the tasks set out as well as to creating cooperation and organizational synergy, contributing in turn to the reduction of the risk presented to the team and patients which comes with working with this class of patients.

The multi-professional work process will be described as well as underlying principles, legal and ethical dilemmas raised by the team and safety and security outputs for the organization, various departments, team and patients.

Educational Goals

1. Understanding complexity of violent behavior of the court ordered patient
2. The role of the psychiatric hospital

Correspondence

Ms. Ronit Kigli
Tel-Aviv University`; Be'er Yakov mental health center
147 alkalai st.
76304 Rehovot
Israel
ronit495@netvision.net.il

Violence against psychiatric inpatients in forensic psychiatric hospital setting

Mari Leskinen, Anssi Kuosmanen & Hannele Turunen (Finland

Aim

Violence and aggressive behavior is a acute problem in psychiatric care and it also causes a threat to patient and staff safety. Majority of studies have focused on violence against psychiatric health care personnel. The purpose of this study was to clarify 1) the number and quality of violent incidents that occurs against psychiatric inpatients in forensic psychiatric hospital setting and 2) what kind of consequences the acts cause to the inpatients.

Methods

The study period was 1.3.2012-28.2.2014. The data were collected retrospectively from Niuvanniemi Hospital's web-based error-reporting database (Haipro). A total 337 violent incidence reports were analyzed statistically using SPSS 21.0 program. The results were reported using frequencies and percentages.

Results

Of all the incidents 62.9 % reports concerned violence caused by another patient and 32.9 % was self-harm or suicidal behavior. 4.2 % concerned on coercive measures. 65.1 % of the incidents happened to the patients; the rest (34.9 %) were near misses. The majority of incidents was reported in March (13.4%), on Saturday (16 %) and between 3 pm and 6 pm (24.9 %).

Most common form of violence caused when another patient was hitting (25.5 %) followed by verbal aggression. The majority of these incidents happened on the corridor or in the day room. Most common form of patient self-harm was hitting the head against the wall (24.3 %) and most of these incidents (35.1 %) happened in patient rooms. Reports of coercive measures included using physical force when holding the patient or taking the patient down.

Majority of the incidents did not cause any harm to the patients (43 %) or were estimated to have caused mild harm (44.8 %). Severe harm was reported in four incident reports and they all were suicidal attempts when one was leading to death. When evaluating the harm to patients, the focus wase on physical injuries, emotional harm was noticed only in few reports.

When filling in the indecent report, the filler was asked to define own view how incident could be prevented. Only a portion (9.8 %) mentioned that educational and therapeutic conversation with the patient would prevent the violent incident. In 35.3 % of the reports this section was left unfilled and in 11.9 % of the reports the filler thought that these incidents cannot be prevented.

Conclusions

Forensic psychiatric inpatients experience violence during their hospitalization. Self-harm and suicidal attempts cause more serious injuries than violence caused by another patient, although emotional harm and traumatic experiences were ignored. Staff using physical force to the patient is not perceived as a risk for patient safety.

Educational Goals

• To produce information which can be used to understand and prevent violent incidents and develop and improve patient safety practices in units and at organizational level.

Correspondence

Ms. Mari Leskinen
University of Eastern Finland
Niittytie 13
70700 Kuopio
Finland
Tel: +358405580037
mari.leskinen@niuva.fi

Chapter 16 – Specific populations intellectually disabled

From integrated diagnostics to integrated treatment: the results of the cooperation between a treatment facility for people with intellectual disabilities and a forensic ward

Workshop

Diana Polhuis & Hans Kruikemeier (Netherlands)

Keywords: intellectual disability, forensic treatment, cooperation

Introduction

The Forensic ACT model (ForACT) is used in the Netherlands to provide care and treatment for criminal offenders suffering from a severe mental illness (Place et al, 2011). The ACT model is also used for people with an intellectual disability and complex problems (Rijkaart & Neijmeijer, 2011). The ACT model works with a recovery oriented multidisciplinary team with a shared caseload approach. The target groups show many similarities like addiction as a comborbid problem and a combination of mental illness and intellectual disabillity (IQ 50-85) (AAIDD, 2010; APA, 2013; Tenneij et al, 2009). They often show problems due to their social emotional development (http://www.seo-r.nl/). In the northern part of the Netherlands a ForACT team works intensively together with an expert team from an organisation specilized in treatment 'De Rotonde' and guidance of people with an intellectual disability and complex behavioral problems. This people form a group of criminal offenders with complex needs. The cooperation in the treatment is focused on risk reduction, decreasing violence and offences on one hand, and on the other hand improving daily functioning and quality of life (De Kogel & Nagtegaal, 2008; NIFP, 2008). Several studies underline the importance of this cooperation (Kaal, 2010; Männynsalo L, Putkonen H, Lindberg N & Kotilainen I., 2009; RVZ, 2012).

The purposes of this symposium are (a) to illustrate how we work together, illustrated by a case, (b) to mention the principles for cooperation and (c) discuss treatment aspects that are important.

Participants will learn the usefulness of intense cooperation between facilities for people with intellectual disabilities and Forensic ACT in order to provide risk management and quality of life.

Intellectual disabilities, psychiatric disorders and offensive behaviour

The prevalence of intellectual disability in the population of criminal offenders is difficult to determine. This has to do with problems in diagnosing intellectual disabilities in a reliable way, a limited willingness to cooperate and an incomplete registration of IQ-figures in files (Kaal, 2014). We speak about people with an intellectual disability with an IQ of 55-85 (AAIDD, 2010; APA, 2013).

An intellectual disability seldom exists without other problems. People with intellectual disabilities do have the same range of psychiatric disorders as people with an average intelligence (Dosen, 2005). Others say that there even is a higher rate of developing a psychiatric disorder with people with an intellectual disability (Lindsay, Dana, Dosen, Gabriel & Young, 2007).

Although exact figures are not available, we assume that 30 to 40% of all people in sight of the criminal justice have an intellectual disability (Kaal, 2010). This group is misunderstood and treated badly. Very often their intellectual disability has not been discovered because of their streetwise appearance and often

offensive and aggressive behaviour (Teeuwen, 2012; Toorn, 2008). They form a subgroup of criminal offenders with complex needs (Männynsalo L, Putkonen H, Lindberg N & Kotilainen I., 2009).

Modern society is becoming much more complex. Especially younger people with an intellectual disability are confronted with more and more demands, expectations and rules, but also with many more temptations. At the same time, this group needs more attention and support on many levels. A lack of self-control and a greater risk of being influenced by others often lead to committing crimes. In recent years there is a growing awareness that intensive cooperation between the world of people with intellectual disabilities and criminal justice is necessary to bridge the gap between those two worlds. Judges, prosecutors and forensic treatment facilities have to gain insight in the phenomenon of intellectual disability and workers in the field of people with intellectual disabilities must become aware that risk-assessment is a necessary element in dealing with this group (Van den Berg & De Vogel, 2011). In working together we experience how much there is to be learned.

Cooperation

In 2009 the Department of Forensic Psychiatric care (DFP), part of GGZ-NHN, started a cooperation with the Rotonde-Expertisecentre VG-GGZ, part of Esdege-Reigersdaal. GGZ-NHN delivers mental health care and treatment to clients in the north of the province Noord-Holland and Esdege-Reigersdaal takes care of and provides treatment to clients with intellectual disabilities. A common vision was developed: The DFP and the Rotonde both want their clients to integrate in society as far as possible. People with forensic psychiatric problems and an intellectual disability have the right to participate in the society. At the same time social inclusion helps to prevent offensive behaviour.

In the previous European Congresses in Prague and Ghent we presented our first and second experiences. Two years later it's time to show if and how individual clients have benefit from this cooperation.

Aim

A case study is presented by which we show a successful cooperation between a treatment facility for people with intellectual disabilities and a forensic ward in the north of the Netherlands. Necessary elements in diagnostics and treatment as well as success- and risk factors will be mentioned. Advice will be given for further elaboration in the future.

Method

Cooperation between two different sectors of the mental health system is much more difficult than it looks at first sight. Culture-differences should be overcome and a common language, which enables fast and adequate communication, has to be found. In developing a common mind-set is was necessary to focus on:
- Early diagnostics of intellectual disabilities (SCIL) (Kaal, Nijman & Moonen, 2013)
- The importance of the level of emotional development in understanding all kind of behavioural problems
- The necessity of being reluctant to diagnose personality disorders
- Adequate treatment and appropriate level of communication
- The devastating effect on self-esteem of chronic 'asking too much'
- All kinds of inadequate coping mechanisms
- The role of drug abuse as a kind of self-medication
- Creating a safe 'trial-area'
- Risk-assessment and risk-management

Conclusion

In practice we work together in assessment, diagnostics, treatment and guidance in daily living. We woult like to illustrate how we work together in a case where one of our consumers lives in a sheltered house, organised and guided by the facility for intellectual disabled people. We show how we provide care and treatment, taking both the offensive behavior as well as the cognitive, social and emotional development in account. This requires special attention for the way we communicate with our comsumer and how we act as his thrustworthy partner. We also need to negiotiate with the parole officer. In some ways we need more flexibility regarding the rules from the justice system in order to be creative in our interventions and help our consumer with his further development.

The success of cooperation between a forensic ward and a centre for clients with ID can be measured by the extent to which the quality of life of individual clients has improved. In this workshop it is demonstrated by the introduction of Andy.

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http://www.seo-r.nl/

Educational Goals

1. Participants will learn the usefulness of intense cooperation between facilities for people with intellectual disabilities and Forensisch ACT
2. Participants will learn about the usefulness of integrated diagnostics and treatment in order to provide risk management and quality of life.

Correspondence

Ms. Diana Polhuis
GGZ Noord-Holland-Noord
Kennermerstraatweg 464
1851 NG Heiloo
Netherlands
d.polhuis@ggz-nhn.nl

Meeting the sexual identity needs of people with intellectual disabilities: could this have a role in managing aggression?

Paper

Liz Tallentire, Trainee Clinical Psychologist, Lancaster University Doctorate in Clinical Psychology, University of Lancaster, Lancaster, UK
Dr Ian Smith, Senior Clinical Tutor & Lecturer in Research Methods, Lancaster University Doctorate in Clinical Psychology, University of Lancaster, Lancaster, UK
Dr Paul Withers, Head of Psychological Treatment Services, Calderstones Partnership NHS Foundation Trust, Whalley, Clitheroe, Lancashire, UK
Sarah Morrow, Assistant Psychologist, Newhaven (Fieldhead Hospital), South West Yorkshire NHS Foundation Trust, Wakefield, UK

Introduction

LGBT people are at elevated risk of experiencing psychological distress (Chakraborty et al., 2011, King, 2008) compared to their non-LGBT peers. Research indicates that experiences of discrimination and difficulties with identity formation contribute to this distress (Meyer, 1995, Toomey et al., 2013). People with intellectual disabilities may be more likely to have negative views of LGBT identities and thus LGBT people with intellectual disabilities may have increased risk of experiencing conflict about their own sexual identities (Murphy and O'Callaghan, 2004, Burns and Davies, 2011, Fitzgerald and Withers, 2013). This may contribute to raised risk of them presenting with aggressive behaviour (Hanby et al, 2011, Weinstein et al, 2012). Some research about community-based support groups has demonstrated that they can help to address issues of identity conflict (Elderton and Jones, 2011, Withers et al., 2001).

The co-researcher participants in this research attended a support group for LGBT people in a secure intellectual disability service. The group has been held monthly since November 2009. Average attendance is 12, with a minimum of 6 and a maximum of 24, from a total hospital population of approximately 190. The group was established at the request of service users and although it was intended to be supportive, it did not initially have a clear therapeutic focus. It was seen as a 'safe' LGBT space in which service users could discuss issues relating to their sexualities. However, attendees rapidly began to report that attendance at the group made them feel happier and more confident. An evaluation of the group was undertaken in order to investigate this.

Research relating to support groups for LGBT people who have an intellectual disability is of limited quantity and no published literature was identified relating to LGBT support groups for people with intellectual disabilities in a secure setting.

Method

The research was undertaken employing a participatory approach, with service users being involved in the design, data collection, and analysis. Narrative analysis was utilized to explore the data. In total, there were 18 co-researchers. Nine co-researchers took part in interviews. Eight further co-researchers provided written information. One co-researcher did not contribute data but was part of the analysis group. Four co-researchers took part in a group analysis session. Two of these participants also took part in the interviews and one provided written information. Results were compared to routine aggressive incident frequency audit data gathered by the service. This enabled comparison of the frequency of aggressive episodes in the LGBT group to the frequencies occurring on wards and in Occupational Therapy sessions.

Results

The research identified that initial attendance at the group was difficult for the participants as they feared bullying and ostracization by their peers. However, they reported rapid abatement of their anxieties about attending, and identified that attendance at the group reduced their levels of distress and strengthened their confidence in their sexual identities. Service users reported that their self-esteem improved, and

attendance at the group supported some service users in developing goals that would assist with their eventual rehabilitation. These included forming plans to develop or support similar groups in their home communities. Comments made by service users about their attendance at the group included "[you] change in yourself really, you don't feel stressed or upset or angry or anything...It was because of the group".

Scrutiny of the audit data revealed that during over 60 meetings of the group, each lasting 90 minutes and attended on average by 12 service users, there were no incidents of overtly aggressive behavior (0.0000 per hour). Examination of the data concerning numbers of incidents of aggression on wards (0.0037 per hour) revealed that the expected number of incidents of aggression at the group would be approximately 4 if attendance at the group did not impact upon aggression. As might be predicted, the levels of aggression exhibited during Occupational Therapy (OT) sessions were also lower (0.0005 per hour) than those found on the wards, but were higher than those found in the group. The periods of time spent on wards and in OT sessions were much higher than the periods of time spent in the group and these findings must be regarded as extremely tentative.

Discussion

Attending the group appears to have helped co-researchers develop and take pride in their sexual identity, which improved their perceived psychological wellbeing. Theoretically, this could impact positively on aggressive behaviour. Analysis of audit data regarding incidents of aggression in the group compared to in other service settings provides tentative support for this. Some co-researchers linked attending the group with their rehabilitation as they took pride in helping others and wanted to continue this upon leaving the secure service. Some also made direct links between attendance at the group and reductions in their levels of anger.

Conclusion

This research provides preliminary evidence that supporting LGBT people with intellectual disabilities in relation to their sexual identities may have a role to play in reducing aggressive behaviour. Further research is required to ascertain whether these promising indicators translate into more sustained and generalized aggression reduction.

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Educational Goals

Participants will be able to:
1. Identify the specific factors that might contribute to aggression amongst LGBT people with intellectual disabilities;
2. Describe the role that a support group might play in reducing incidents of aggression.

Correspondence

Mr. Paul Withers
Calderstones Partnership NHS Foundation Trust
Mitton Road
Whalley, Clitheroe
Lancashire BB7 9PE
UK
Paul.withers@calderstones.nhs.uk

Characteristics of aggressive behavior in people with intellectual disabilities and co-occurring psychopathology

Paper

Kim van den Bogaard, Henk Nijman & Petri Embregts (Netherlands)

Keywords: Intellectual disabilities, aggression, SOAS-R-ID

Introduction

Aggression is a common phenomenon in care for people with intellectual disabilities (ID). Aggression can both have negative consequences for the person showing the behavior as well as their environment. Understanding and effectively responding to the aggression of people with ID requires a broader view of potential personal and environmental influences.

Until now little systematic observational research is done in the care for people with ID towards aggression. Therefore the aim of this study is twofold: first to identify precipitates and consequences of aggression, and second to develop a reliable and valid instrument to assess aggression in people with ID in a clinical setting.

Method

The study was conducted at three wards of one unit, including 10 beds each. Participating clients were adults with mild intellectual disabilities to borderline intellectual functioning and psychiatric disorders.

Support staff completed the Staff Observation Aggression Scale-Revised-Intellectual Disability (SOAS-R-ID; Nijman, 2005; based on the SOAS of Palmstierna & Wistedt, 1987) every time they witnessed an aggressive incident over a period of 9 months (April 2014 until January 2015). The SOAS-R-ID identifies a) the precipitate that led to the incident, b) the way the aggression is shown, c) the target of the aggression, d) the consequences for the victim and e) the measures of staff members to stop and control the aggression (Palmstierna & Wistedt, 1987).

Descriptive analyses of the five columns were executed to get more insight in the characteristics of aggression of people with ID. Correlational analyses of the clinical severity ratings and the SOAS-R rating scale was executed in order to determine the reliability and validity of severity scoring system and scale.

Results/discussion: In the period of data collection 35 clients and 40 staff members were included in the research. In total 234 SOAS-R-ID forms were completed. In this presentation we will focus on the provocation that occurred mostly, what forms of aggression (e.g., verbal or physical) were shown, at whom they were aimed at and with what kind of consequences. And we will look at the way staff controls and stops the aggression. As far as the reliability and validity of the SOAS-R is concerned in this specific population, will these results be comparable with the results of patients who show aggression in general psychiatry?

Educational Goals

- After following this presentation, the listener will be able to differentiate between the SOAS-R and SOAS-R-ID.
- After following this presentation, the listener will be able to cite the specific precipitates and consequences of aggression in people with intellectual disabilities.

Correspondence

Ms. Kim van den Bogaard
Dichterbij Science and Innovation/ Tranzo Tilburg University
Warandelaan 2
Postbus 90153
5000 LE Tilburg
The Netherlands
k.j.h.m.bogaard@uvt.nl

The relation between team climate, attitude towards external professionals and attitude towards aggression of staff working with clients with intellectual disabilities and aggressive behavior

Paper

M.H. Knotter[1,2], G.J.J.M. Stams[2], X.M.H. Moonen[2,3], & I.B. Wissink[2].
1. De Twentse ZorgCentra, Den Alerdinck 2, 7608 CM Almelo, The Netherlands
2. University of Amsterdam, Nieuwe Prinsengracht 130, 1018 VZ Amsterdam, The Netherlands
3. Hogeschool Zuyd, Nieuw Eyckholt 300, 6419 DJ Heerlen, The Netherlands.

Keywords: staff, aggression, clients with intellectual disabilities

Background

The results from the study of Knotter, Wissink, Moonen, Stams, and Jansen (2013) suggest that the context of the team in which direct care workers (staff) work with clients with ID is strongly related to the type of intervention used in response to aggressive behaviour of these clients. Hereafter we examined in a further study (Knotter, Stams, Moonen & Wissink, submitted) whether team climate (Anderson & West, 1994) and attitude towards external professionals (Rose, Ahuja & Jones, 2006) were related to staff's attitudes towards aggression (which are thought to influence the type of intervention used in response to aggressive behaviour of the clients with ID) .

Aim

We examined the relationship between team climate (Anderson & West, 1998) and staff's attitudes towards external professionals (Rose et al., 2006) on one hand, and staff's attitudes towards aggression (Jansen, 2005) on the other hand taking into account several individual direct care worker and client background variables. It was expected that a negative team climate and a negative attitude towards external professionals of staff were positively associated with a negative attitude of staff towards aggression (for instance client aggression perceived as offensive, destructive and intrusive). And that a positive team climate and a positive staff attitude towards external professionals were positively associated with a positive attitude of staff towards aggression (for instance client aggression perceived as a form of communication or self-defence).

Data analysis

Data were analysed using multilevel regression in SPSS-20.

Participants

Participants were 475 direct care workers (working in 71 teams) employed in 7 different facilities for the care for people with intellectual disabilities in the Netherlands.

Measurements

Care Staff Attitudes Questionnaire (CSAQ; Rose et al., 2006) translated in Dutch.
Team climate was assessed using the Dutch version (Strating & Nieboer, 2009) of the Team Climate Inventory (TCI; Anderson & West, 1994).
Attitudes towards aggression were assessed using the Attitude Towards Aggression Scale (ATAS; Jansen, 2005).
Several individual direct care worker and client background variables were assessed.

Results

A positive team climate was associated with both staff's positive and negative attitudes towards aggression of their clients with ID. These results are striking and will be explained together with recommendations for practice and further study during the presentation on Saturday 24 october at the conference.

Staff's positive attitude towards external professionals influences their attitude towards aggressive behaviour of their clients with ID in a positive way. Thus when staff receive effective support from for instance a psychologist their attitude towards aggression will be more positive. A 'social buffer' influences not only the wellbeing of staff (Rose et al., 2006) but also their attitude towards aggression in a positive way. There were no associations found at a team level. However the proportion variance explained, predicting the influence of factors on a positive and negative attitude towards aggression, was not high indicating that there are still other factors which may influence staff's attitude towards aggression.

Conclusion

It is important to strengthen the quality of positive contacts between direct care workers and their clients with ID, and to reduce the rate of aggression of clients with ID, by using effective and non-intrusive behavioural interventions. The type of intervention used in response to aggressive behaviour of clients with ID is strongly related to the context of the team in which interactions between an individual care worker and a client with ID are embedded. Team climate, staff's attitude towards external professionals and several staff and client characteristics were associated with staff's attitudes towards aggression. More knowledge about the influence of team processes on staff's attitudes towards aggression of their clients with ID could emerge opportunities to develop effective training programs.

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Educational Goals

- This study provides more information about the influence of the working context on staff's attitude towards aggression of their clients with ID.
- This study provides more information for developing training for teams working with people with intellectual disabilities and aggressive behaviour.

Correspondence

Ms. Maartje Knotter
De Twentse Zorgcentra / Universiteit van Amsterdam
Den Alerdinck 2
7608 CM Almelo
The Netherlands
maartje.knotter@detwentsezorgcentra.nl

Chapter 17 – Specific populations child & adolescent

Prevalence of Physical Restraint in Psychiatric Treatment and Research Unit for Ado-lescent Intensive Care (EVA)

Poster

Janne Virta (Finland)

Keywords: Mental health nursing, aggressiveness, coercive measures, holding therapy.

Background

Patients' violent behavior has increased in psychiatric nursing during the past decades. Researchers have only recently focused on how to decrease the use of coercive measures in psychiatric nursing.

Aims

The purpose of this study was to detect the prevalence of aggressive behavior that has led to physical restraint in Pirkanmaa Hospital District's Psychiatric Treatment and Research Unit for adolescent intensive care (EVA).

The study questions were:

1. How many times physical restraints were used in the unit in the year 2011?
2. At what time did these situations occur?
3. In which place did they occur?
4. What kind of coercive measures were used?
5. How many members of staff did participate in these situations?

Methods

This was a quantitative study. The data were collected from forms used to monitor physical restraint in the unit (n=453).

Results

Units of observation were: total number of physical restraints, time, place, coercive measures used and staff participation. The data was analyzed via SPSS statistics programme for percentage distribution and absolute numbers.

The results indicate that most aggressive situations requiring physical restraints occur during afternoon (38 %), and in patients' room (45.4 %). The most common coercive measure used was physical restraint such as holding (78. %). Mechanical restraints occurred less than 20 %. The numbers of staff participating was two or three members.

Educational Goals

The results of this study gave information that could be used:
1. While allocating staff resources
2. For planning new premises in the unit

Correspondence

Mr. Janne Virta
Pirkanmaa Hospital District / Tampere University Hospital / Pitkäniemi Hospital
Pitkäniemen sairaala
33380 Pitkäniemi - Nokia
FINLAND
janne.virta@pshp.fi

Healthcare support network to families involved in domestic violence against children and adolescents in Brazil

Paper

Diene Monique Carlos, Maria das Graças Bomfim Carvalho Ferriani,
Elisabete Matallo Marchesini de Pádua, Lygia Maria Pereira da Silva & Michelly Rodrigues Esteves
(Brazil)

Keywords: Domestic violence. Child. Adolescent. Social network. Nursing. Family.

Introduction

Violence is responsible for over one million deaths worldwide each year, totaling 2.5% of the global mortality. In the population aged between 15 and 44 years, violence is the fourth leading cause of mortality worldwide. However, these statistics only represent the top of the pyramid, which is the best methodology used to understand the magnitude of the problem. The highest number of people represented in the base of the pyramid suffers daily violence, but will never report to protection services. Studies indicate that the main populations who suffer violence in silence are children, adolescents, women and the elderly [1,2].

Violence is the intentional use of force or physical power, real or as a threat, against a person, group or community that either results or has strong possibility to result in injury, death, psychological harm, deprivation or developmental change[3]. As previously mentioned, children and adolescents are among the main victims of violence. According to the World Health Organization (WHO), around 227 children and adolescents in the age group of 0-19 years die every day worldwide as a result of interpersonal violence; it is difficult to estimate non-fatal violence with epidemiological accuracy[2]. In Brazil, violence appears as the first cause of mortality in children older than one year and adolescents. Generally, this violence occurs in a space of relationships of trust, responsibility or power: the intra family space [4].

The intervention with families involved in *interfamilial violence against children and adolescents* (VICCA – Violência Intrafamiliar Contra Crianças e Adolescentes) is still a challenge to the sectors of health, justice, human rights, among others. The Ministry of Health in Brazil proposes the integration of the resources available for assistance in a network of care, guided by the primary health care (PHC) and following the model of care line according to the WHO recommendations[5]. The staff working in PHC has privileged space to access and identify possible situations of VICCA. However, given the specificities of this phenomenon, these professionals live the dichotomy of breaking the present silence in these situations.

The literature has mentioned important characteristics for managing VICCA, such as the difficulty with identifying and intervening in suspected cases due to the complex circumstances and the professional unpreparedness to deal with these situations [6,7,8]. Given the remaining gaps in the scientific literature, this study aimed to contribute to understanding the healthcare support network to families involved in VICCA, in a municipality of São Paulo, Brazil. The paradigm of complexity will be used as theoretical framework to apprehend this study subject. It proposes the approach of what is 'woven together', which implies considering the different and sometimes contradictory parts articulated in the phenomenon composition, inserted in a context in dialogical perspective [9].

Methods

This is a strategic social research of qualitative approach [10], anchored in the Paradigm of Complexity. The methodological course was guided by the notions of understanding and contextualization, and by the dialogic, recursive and holographic principles [9,11].

The study field was a municipality of São Paulo, located in a 796 km² area with population of 1,144,862 inhabitants [12]. The study participants were 41 health professionals of five PHC units.

Data collection occurred through minimum maps of the External Institutional Social Network [13], focus groups and semi-structured interviews[10], in the period between April 24, 2013 and December 17, 2013. The participating units have been designated by the letter U and the numbers 1, 2, 3, 4 and 5, according

to the sequence of data collection, and to maintain the identity confidentially. The speeches of groups were identified by the letters Gp and numbered according to the sequence in which they were performed. The interviews were designated by the letter E, and listed following the same pattern of sequence of performance.

The maps were printed at 90x110 cm for best visualization. After the professionals' permission, the groups and interviews were recorded through the Easy Voicer program in an MP5 device, then transferred to the computer, and transcribed verbatim.

The study was approved by the Ethics Committee of the Ribeirão Preto School of Nursing, University of São Paulo, on November 14, 2012, under protocol number CAAE 01726512.0.00005393, number 217/2012. The subjects agreed to participate spontaneously by signing the Informed Consent form.

Data analysis comprised the following steps[14]: classification and organization of information collected; organization of reference tables with the main points of the professional answers in order to have a group view of all the information for its categorization; and establishment of relationships among data. This work presents the category *The nodes of the care network to families involved in VICCA*.

Results and discussion: Although the health units are located in different territories and contexts, they have certain peculiarities in common. The analysis of minimum maps involves the evaluation of their size, density, distribution, composition, dispersion and homogeneity/heterogeneity [13]. It was observed that U1 and U2 had a median network, while the others showed a reduced network. The oldest units in the city are the U1 and U2, and despite their location in areas of great economic and social vulnerability, they have a greater number of institutions (network), particularly those linked to social assistance.

The five units showed a low density of networks, because many fragile links and few significant links were identified. Regarding the distribution and composition, we found (i) a greater number of institutions linked to the sectors of health, social assistance and education; and (ii) important gaps highlighted by the absence of concrete institutional links in other sectors.

The dispersion of the links on the maps express the geographical distance between the units and institutions, and it indicated that significant links are not directly related to the geographical proximity. Professionals emphasized other ways to establish communication, considered an important factor for the network effective operation. However, the issue of differences in geographical division among the sectors appeared as a weakness in this process.

The maps showed a homogeneous network, focused on significant links in three sectors - health, education and social assistance, not allowing the dialogue with many institutions and sectors necessary for establishing the care to complex phenomena such as VICCA. The health workers have identified (i) the families as significant bonds with the unit; and (ii) the drug trafficking/organized crime as a 'fragile' bond, which emerged as a factor of protection and vulnerability to violence.

The interviewed professionals revealed two main characteristics in the organization of care to families involved in VICCA: the geographical issue and the centrality of care networks in people. The municipal policy presented a different territorial division for the sectors of health, education and social assistance, generating large disagreements and discoordination, preventing the strengthening of the previously initiated bonding: *Oh, it was good that you raised this issue of territory because depending on the situation, we will have bonds with people who are more distant than close... (Gp 5)*

The geographical distance of the institutions was not the major impediment to the care network, but other distances and disruptions were, such as those of relations and access: *It isn't the physical distance, but the personal distance. (Gp 3)*

The absence or practical inefficiency of some policies aimed at certain segments and social problems was as an element that triggered the care network disorganization: *Theoretically it's all good, only in theory, it's a display... (Gp 5)*

Families need to be resumed 'as starting points of alterative social practices and not simply alternatives' [15]. The attention provided to families, outlined by social policies, has been considered a conservative and ineffective practice, because it is rooted in a stigmatizing culture of guardianship that does not invest in the autonomy of families [16,17].

Although the permanent fragmentation and individualization of public policies aimed at families seems controversial, it has been the reality experienced in the daily routine and in the practice of health services and assistance institutions. This issue has caused the disruption or duplication of actions, not revealing all the institutional potentiality for care, neither offering comprehensive care to families since it is assumed that such care can be achieved by the inter-institutional and inter-sectoral integration and articulation. In this way, families are subjected to various atomized actions.

The professionals also emphasized that the lack of knowledge of institutions and sectors of the care network has contributed to weaken the bonds of this structure, becoming evident in the area of social assistance. This sector has a particular and specific organization that contributes to generate part of the lack of knowledge on the activities, as reported by professionals. Since the social assistance has non-governmental organizations co-financed by the municipality, the institutions change depending on their territory. The industry has been undergoing reorganization and an institutional reordering throughout the national scene.

In addition to social assistance, the health professionals cited the education sector among those considered significant for the network care to families involved in VICCA. However, despite the importance of this institution in the problem dynamics, the bonds established with the education sector showed to be fragile.

The main difficulty of professionals was the relation with the Guardianship Council and the Child and Youth Court. The main and recurring discussion was the relationship based on paper that does not meet the principles of care to a complex phenomenon, without sharing nor diluting the responsibility for the situation. The matter of strength and opponency of power relations became clear in the statements of professionals: *I already got a letter from the Childhood Court... I made the visit and returned the letter ... With that clause on the bottom ... It's a coercion to make the visit you know, you have to do it ... I don't wanna get arrested... (Gp 4) It's a must... an obligation... (Gp 2)*

The logic of referrals, called 'empurroterapia' ('cop out' of the responsibility, transfer the task to someone else) by some professionals, has generated fragmentation of interdisciplinary relations and consequently, the care involved in VICCA. Some health professionals understood the idea of network of care as the referral of cases: *If there's a teenager who is addicted to drugs, we'd have to pass the problem to someone ... (Gp 1)*

The fragility of the care network brings significant consequences with direct relation to the care offered to families. The first, reported by professionals, was an agglomerate of institutions and sectors operating separately in spite of their common goal. There is a juxtaposition of services with a sum of actions, but without resulting in the performance of integrated care. Although they act in cases of violence, they 'do not recognize each other as institutions reinforcing their interventions, and which may actually have something to share'[18]. This organization can be called 'weft' of services, but not network of care[18].

There is the idea that the care network is a major challenge because it contradicts the dominant paradigm and opposes to it, with a divisive logic[19]. The maps 'woven' and 'intertwined' among unified dimensions that direct to a common goal: the care to families involved in VICCA. This practice can lead to a rupture with the fragmented and sectorized thinking, and presents itself as a space where all the dimensions of a territory of acting belong to one another, without losing their social and personal reference[13].

Conclusion

Together, the results of the present study indicated that the current model of healthcare support networks leads to institutional isolation and to the fragmented care to the families. In fact, this model is designed only to provide care for children and adolescents victims of domestic violence. The fragility of the healthcare support networks highlights the necessity to broaden the knowledge of VICCA, especially from the perspective of the families, and to seek for new contributions to understand the multidimensionality of the phenomenon.

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Educational Goals

1. To understand the in-network care for families involved in domestic violence against children and adolescents in the light of the complexity paradigm.
2. To employ the acquired knowledge to discuss interventions for families involved in domestic violence against children and adolescents, and to develop transdisciplinary and intersectorial actions.

Correspondence

Ms. Diene Monique Carlos
Avenida dos Bandeirantes, 3900,
Campus Universitário - Bairro Monte Alegre,
Ribeirão Preto - SP – Brazil.
CEP: 14040-902.
diene.carlos@usp.br

How to effectively reduce coercive measures in an inpatient unit of child & adolescent psychiatry – a ten years' overview of Pfalzinstitut C & A Psychiatry/Klingenmuenster, Germany

Paper

Michael Bruenger (Germany)

Abstract

The Pfalzinstitut Child and Adolescent Psychiatric Service has more than 700 inpatient admissions annually and a catchment area of 1 Million inhabitants in the southwest of Germany.

Within a ten years period of specific attention to measures aiming at the reduction of coercive measures Pfalzinstitut was able to reduce the amount of restrictions - locked doors of an inpatient unit, fixation, and time out procedures - considerably. The elaboration of internal and external guidelines, continuous staff training, implementation of dialectic behavioral therapy for adolescents (DBT-A) and the improvement of internal complaint management procedures were among the most important measures taken throughout the last 15 years. Despite the fact that the number of adolescents with severe conduct disorder grew continuously coercive measures are clearly on the decline in Pfalzinstitut C & A Psychiatric Service. The analysis of data from 2003 to 2012 indicates critical times during the day and during the week as well as critical moments during the patients' stay in hospital. Key figures such as the risk of injuries for the patient or staff members were monitored. Future developme nts will take place in the field of staff training and supervision according to DBT criteria thereby promoting validation both among staff members and towards our patients. Procedures of complaint management are presently being revised.

Educational Goals

- Participants will hear about measures taken to reduce coercion in C&A inpatients units effectively.
- Speaker and participants will review the interpretation of data presented thereby gaining new insights on the matter.
- Speaker and participants will reflect the relationship between validation and conflict solving within psychiatric teams and staffs' attitude towards patients.

Correspondence

Mr. Michael Bruenger
Pfalzinstitut Child & Adolescent Psychiatric Service - Pfalzklinikum
Weinstrasse 100
76889 Klingenmuenster
Germany
michael.bruenger@pfalzklinikum.de

The relationship between media violence exposure and aggressive behavior of children and adolescents

Poster

Maria Teresa Ferreira Côrtes (Brazil)

Keywords: Violence, violent media, violent media exposure, aggressive behavior, child and adolescents

Abstract

Exposure to violence is a reality all over de world. This exposure happens not only in real-life, but also by the contact with violent content presented in media. Youth is particularly exposed to great amounts of violence presented in video-games and movies. This poster has the objective to summarize what is already known about the relationship between media violence exposure and aggressive behavior of children and adolescents, focusing in both behavioral and brain functioning.

The concept of desensitization is particularly important to this work and it is known as the reduction of behavioral, emotional and cognitive responses to a recurrent event. That is supposed to be the main modification caused by violence exposure. As a result, we may conclude that, although researchers have not yet reached final conclusions about the desensitization to violent media stimuli, many studies revealed that this relationship truly exists and that it may also be related to the increase of aggression and the decrease of prosocial behavior.

Educational Goals

- Discuss exposure of child and adolescents to violent content presented in media
- Analyze the relationship between media violence and aggressive behavior

Correspondence

Ms. Maria Teresa Ferreira Côrtes
Universidade Estadual de Campinas UNICAMP
Francisco de Campos Abreu, 860
13043710 Campinas
Brazil
mariateresaferreiracortes@gmail.com

Psycho-pathology of victims and bullies in school violence

Poster

Sun Mi Cho, Yun Mi Shin, Eun Ha Jung (Korea)

Keywords: adolescence, juvenile delinquency, cybercrime, psychopathology

Abstract

School violence is associated with the diverse forms of psycho-pathology and mental health problems. It is important to aware that the victims and bullies are the target of being cared and educated, and especially the high-risk victims should be supported consistently.

This study was conducted to examine the association of school violence, cybercrime and psycho-pathology in Korean adolescents. Participants are 518 middle school students in Korea, and the K-YSR (Korean-Youth Self Report) data were subjected to ANOVA analyses. The students who were both victim and bully showed significant higher scores on depression/anxiety, attention problems, delinquency, and aggression, self-harm on YSR. The students who were both victim and bully of cybercrime showed depression/anxiety, and the bullies showed highest scores on attention problems, thought problem.

These results suggest that the psycho-pathology and mental health are associated with not only the victims but bullies. Also, we can insist that the medical assessment and intervention of the students are important and should be considered as part of the on school delinquency.

Educational Goals

- Cognitive domain of learning: We alert people's attention to the importance of interventions on school violence, since majority of victims and bullies have difficulties with mental health.
- Affective domain of learning: The bully can become the victim, so simplistic interventions such as punishment are not effective.

Correspondence

Ms. Sun Mi Cho
Ajou University, School of Medicine
San 5, Wonchon-dong, Yeongtong-gu
443-721 Suwon
Korea, Rep.
smcho@ajou.ac.kr

Associations among parental education, inhibitory control and aggressive behavior in children

Poster

Maria Gutierrez-Cobo, Rosario Cabello & Pablo Fernandez-Berrocal (Spain)

Keywords: Go/NoGo task, parental education, inhibitory control, aggression, children

Background

The question whether parental education and inhibitory control in children are associated with conduct problems remains controversial. Although the origins of aggressive behavior are to be found in early childhood, findings from parental education and inhibitory control studies in children with aggressive behavior are inconsistent.

Aims

This study used a cross-sectional design to analyze associations among parental education, inhibitory control and aggressive behavior in children and, specifically, to examine whether inhibitory control mediated the associations of parental education with aggressive behavior.

Methods

The sample consisted of 147 children (7 to 10 years of age) from different Spanish public schools. Parents provided data on parent education. Children completed an inhibitory control task assessed through the Go/NoGo task (Go/NoGo). Finally, teachers completed the aggressive behavior scale of the Behavior Assessment System for Children (BASC).

Results

Results showed that both parental education and inhibitory control predicted aggressive behavior in children. In addition, inhibitory control partially mediated the associations of parental education with aggressive behavior after accounting for child age. However, this mediation effect was moderated by gender. Specifically, parent education was associated with aggressive behavior independent of inhibitory control for girls, but not for boys.

Conclusions

These findings demonstrated that both parental education and inhibitory control predicted aggressive behavior in children, supporting the idea that both constructs are relevant to understand these conduct problems in the schools. Furthermore, parental education may shape inhibitory control which in turn influences aggressive behavior, especially in boys.

Educational Goals : Cognitive goals

1. The participants will be able to know about associations among parental education, inhibitory control and aggressive behavior in children.
2. The participants will be able to understand the applications of mediation and moderation analyses in aggression research.

Correspondence

Ms. Maria J. Gutierrez-Cobo
Department of Basic Psychology, Faculty of Psychology, University of Mï¿½laga, Spain
Bulevar de Louis Pasteur, 25
29010 Malaga
Spain
mjgc@uma.es

Different clinical courses of children exposed to a single incident of psychological trauma: a 30-month prospective follow-up study

Poster

Bung Nyun Kim & Soon-Beom Hong (South Korea)

Keywords: Single Trauma, Witness, Development, Child, Depression, Violence

Background

We investigated the distinct longitudinal trajectories of posttraumatic stress symptoms in a sample of 167 children, who witnessed death of two mothers of their schoolmates.

Methods

The cohort was followed-up at 2 days (T1), 2 months (T2), 6 months (T3), and 30 months (T4) after the traumatic event. The children's posttraumatic stress symptoms (T1-T4), depression (T1, T3 and T4), state anxiety (T1, T3 and T4), and quality of life (T4) were assessed, along with parental stress related to child rearing (T4). Different trajectory patterns of the children's posttraumatic stress symptoms were identified using growth mixture modeling (GMM).

Results

Four different patterns of symptom change were identified, which were consistent with the prototypical model, and were named Recovery (19.9%), Resilience (72.7%), Chronic Dysfunction (1.8%), and Delayed Reactions (5.6%). Significant differences were found in depression and anxiety scores, children's quality of life, and parental rearing stress according to the distinct longitudinal trajectories of posttraumatic stress symptoms.

Conclusions

The present study suggests that individual differences should be taken into account in the clinical course and outcome of children exposed to psychological trauma. The two most common trajectories were the Resilience and the Recovery types, together suggesting that over 90% of children were evidenced with a favorable 30-month outcome. The latent classes were associated with significant mean differences in depression and anxiety scores, supporting the clinical validity of the distinct trajectories.

Educational Goals

1. The audience will learn the long term naturalistic course of children who exposed to the single severe traumatic accident.
2. The audience will learn that the two most common trajectories in children will be the Resilience and the Recovery types with a favorable 30-month outcome.

Correspondence

Mr. Bung Nyun Kim
Seoul National University Hospital
101 Daehakr
110744 Seoul
South Korea
kbn1@snu.ac.kr

Chapter 18 – Specific populations elderly / dementia

Prevalence of violence and health personnel's experience with violence from elderly residents in nursing homes

Paper

Rita Helme (Norway)

Keywords: violence, elderly residents, nursing homes, cognitive deficit, reaction patterns, prevalence of violence

Background

Previous research show there is high prevalence of violence towards health personnel in nursing homes during daytime. However, there is little information on prevalence of violence during night shifts or how health personnel provide care after a violent incident.

Aim and objectives: The aim of this study is to assess the prevalence of violence during night shifts in nursing homes, and give insight into care given to residents after violent incidents.

Method

A mixed method was used, triangulating information from a survey of 186 health personnel with information from a focus group.

Findings

Numbers indicate there is a high prevalence of violence during night shifts. Health personnel have to use knowledge of the residents' reaction pattern to decide whom to care for first when violence occurs. Health personnel report acceptance of violence from elderly residents with cognitive deficit based on knowledge of disease, relational and contextual knowledge, and own role. Health personnel show great concern for residents' safety when violence occurs. Registered nurses role is found to be mostly consultative when violence occurs in colleagues' departments.

Conclusions

Low staffing during night shifts, make care for residents more difficult, where health personnel must choose whom to care for first. Care for the residents' safety seems to be the main focus of health personnel in situations with violence. Knowledge of residents' reaction pattern is important when calming the situation.

Relevance to clinical practice: The information of prevalence and experience with violence during nightshifts is of importance for RNs who work nights and are responsible for all residents and colleagues during the shift. This study suggests that health personnel with knowledge of residents' reaction pattern may have an advantage, and thus calm down residents more quickly after an incidence with violence. This research appeal to RNs to consider the staffs' knowledge of the residents' reaction pattern, to allow the person with most knowledge to be the one who care for the department when violence occur.

Educational Goals

- Participants will have an understanding of prevalence of violence by residents during night shifts. Participants will also learn that knowledge of the residents' reaction pattern is important to calm a violent situation.

Correspondence

Ms. Rita Helme
Municipality of Harstad/ University of Nordland
Postboks 102
9481 Harstad
Norway
ritahelme@gmail.com

Chapter 19 – Training and education of interdisciplinary staff

The Interaction Skills Training Programs: Improving Cooperation through Effective Interactions

Workshop

Jan Boogaarts & Bas van Raaij (Netherlands)

Keywords: improving cooperation, difficult circumstances, research, interaction skills training,

Abstract

Bureau de Mat strives to improve cooperation under difficult circumstances through research, assessment and training of interaction skills.

We offer courses, tailor-made programs and coaching to achieve increased goal-effective cooperation for participants in dealing with patients with mental disorders, pupils and psychiatric family members.

Participants get insight into their own possibilities and boundaries in increasing the cooperation with the client and in the possibilities and boundaries of the client to cooperate.

Effects of power and influence strategies on cooperation become visible and recognizable.

The training uses practical instruments that people never forget even continue to apply: The Mat (red-green), The Bag, cannot/will not cooperate.

Training is given per target group (professionals – preferably in teams, family members or patients). After all, each target group has its own problem areas in the interaction.

80% of the time is spent on practical exercises.

It is skills training, not a therapy. Skills that are object of improvement are for instance: active listening, sending clear signals, maintaining boundaries or overcoming resistance.

Participants will get an insight in how de Mat helps analyze and possibly improve efficacy of cooperation through improving interaction skills.

Training is given in the skills that are needed to recognize sham co-operation and hostile interactions.

Furthermore participants will be informed about evidence that has been developed related to The Mat.

The presentation will first give an example of the method of de Mat. In the second part an overview of research will be presented. The research designs differ from qualitative descriptive research to randomized controlled trials.

Participants of The Mat Interaction Skills Training programs develop through the training: a language to reflect on interaction problems alone or with others, even months after the course had ended;

Furthermore it delivers:
- Awareness and insightfulness in responsibility and ability / disability;

- Impact on attitude: the client cannot or will not cooperate
- Impact on professional relationships
- Impact on job perception; and
- A linguistic frame of reference

The presentation will conclude with an overview of research results published in national and international professional literature.

Educational Goal

- The participant will know (at beginner level) in which way The Mat can contribute to solving problems in daily interaction with patients with the objective to improve cooperation under often difficult circumstances.

Correspondence

Mr. Jan Boogaarts
Bureau de Mat
Burgemeester Pabstlaan 10d3
2131 XE Hoofddorp
The Netherlands
janboogaarts@demat.nl

Therapeutic communication provided by nurses in general hospital – common or rare?

Paper

Marie Treslova & Jaroslav Pekara (Czech Republic)

Keywords: therapeutic communication, nursing, stress, encouragement, prevention, aggression

Background

The actual process and discussion about the direction of nursing education and practice in Czech Republic have strongly influenced our decision for this survey. We argue that nursing should relieve suffering and contribute to patients' health. Patients are the center of nurses' work and often find themselves in a strange, potentially threatening environment. This is the reason why we intensively pay attention to what patients experience and what the nurse can do with and how she can use professional interventions to save the patient from unpleasant and uneasy experiences. Therapeutic communication is not explicitly defined in Czech nursing. Therefore, it is not known how nurses intervene in cases of stressful situations to prevent aggressive or violent behavior of patients, caused by the new - unknown environment, procedures and care that the hospital provides. Therapeutic communication is the "tool" (skill) for understanding how to cope with obstacles connected with health prevention, support, disease and dying. When thinking about the term therapeutic communication we can consider several views. Rossiter (2006) states that "therapeutic communication is health promoting (p. 127)". The World Health Organisation (WHO) generally describes "health" as well-being (balance). This indicates the aim and intended effect of therapeutic communication. Other authors define this communication as a "patient orientated interactive process, including verbal and nonverbal behavior as indivisible and integral part of patient recovery" (Jones, Fitzpatrick, Rogers, s. 9, 2012) Also Joseph & Worsley (2005) deal with the patient-oriented inter-personal approach. To understand why there is a problem with providing therapeutic communication in Czech Republic, the historical changes of the last 25 years have to be taken into account. EU recommendations of nursing competences can be found in the Tuning project (Tuning Educational Structures in Europe), which also states that the nurse should use a range of communication techniques to support patient well-being (balance), should be able to cope with aggressive behavior, identify stress and depression and give emotional support. So far though, nursing practice does not fulfill this theoretical and ethical approach which is characteristic for this profession stated in ICN Code of Ethics for Nurses, or nursing process and nursing interventions in a satisfactory manner.

Aims

To find a suitable position for therapeutic communication in nursing care from the point of view of both nurses and patients; what skills of therapeutic communication the patients are missing; what obstacles nurses meet when providing therapeutic communication

Methods

Quantitative method in the form of self-constructed questionnaire based on the theory of therapeutic communication was used. Data were analyzed with SPSS 16 statistics program. Semantic differential (Chraska, 2007) was used to find out how nurses tend to necessity, usage and effectiveness of therapeutic communication using pairs of antonym adjectives on a 7-grade scale. The survey sample was composed of two groups of 249 nurses and 169 patients from 7 hospitals in South Bohemia in Czech Republic

Discussion

Many researchers focused their survey on violence and aggression occurring in psychiatry wards. Fewer authors (Hahn, 2008; Duxbury, 2012, 1999; Jones et.al., 2014; Demasceno, et.al., 2012) dealt with this element in other disciplines or more precisely in nursing care of patients hospitalized in wards other than psychiatric. This is logical as hospitalized patients experience stress, uncertainty, the loss of safety and autonomy to a great degree (Smiar, Papenberg, 2012; Křivohlavý, 2001). Such exposure can lead a person to react unreasonably, to an agitated state or aggressive behavior and possible violence. However, in these circumstances such behavior should be recognized as a natural defense.

The results of our survey show that even though nurses are unfamiliar with the term therapeutic communication to a high degree (59.0 %) and they have not met it in practice (78.3 %), they are aware of specific interventions such as listening (75.1 %) and observing (43.8 %). On the other hand, they think that giving explanations (73.1 %) comes under therapeutic communication while questioning is not seen as an effective therapeutic skill (35.7 %). Burnard (2001) and Crawrord et al. (2006) mention listening and questioning as fundamental for therapeutic communication that helps a person cope with difficult situations. To ensure that the respondents will be clear about the term therapeutic communication we inserted a short explanation after a few introductory questions. 77.5 % nurses think that patients need therapeutic communication and 78.8 % think that therapeutic communication belongs to nursing care. The semantic differential showed inclination of nurse respondents to the positive adjectives showing effectivity, usage and necessity of therapeutic communication on the 7-grade scale.

Nurses reported the reasons for not providing therapeutic communication such as the lack of time (26.9 %) and that the patients do not know about this option (25.7 %). The lack of time is also underpinned with the lack of personnel and poor documentation.

Patient respondents stated that their need for therapeutic communication is very strong (16.7 %) or strong (51.9 %). They experience that the reason for nurses communicating with them is to inform them (42.3 %) and to obtain information (34.3 %). Only 21.1 % patients stated that the reason for communication is to find out what worries them, and 10.9 % to encourage them. Clearly, information given could reduce patients' uncertainty and anxiety in many situations, it is however up to the nurse to reason whether more communication skills are needed in each particular case (Rubenfeld, Scheffer, 1995).

Obstacles to the application of therapeutic communication by the nurses that patients report is lack of time of (52.7 %). Patients would like the nurses to react more to what they say (48.0 %), to have more time for them (33.1 %) and to listen to them more (25.1 %). These answers prove the importance the mentioned fundamental therapeutic communication skills (nursing interventions). To be able to listen a therapeutic environment is necessary (calm, with no rush, sit down, not showing that there are other tasks to be done etc.) To listen however, the nurse needs time to recognize what could be "hidden" behind the words the patient expresses (Stickley, Freshwater, 2006)

Nurses' preoccupation with other tasks is, according to the patients, the biggest obstacle to realizing therapeutic communication than their own bashfulness to ask the nurse for deeper conversation was confirmed in patients up to 45 years of age and hospitalized up to one week. For the respondents older than 45 years and hospitalized more than one week this was not apparent. Also the hypothesis that nurses use therapeutic communication to provide information more often than other characteristic skills was not supported by the findings of this study. The hypothesis that the obstacle for therapeutic communication is the shortage of time that nurses can spend with each patient was supported.

In the Czech context of historical and cultural tradition, work with feelings and their impact on the quality of care or agitation, aggression and violence differs from other countries. The expression of feelings or the will to ask the question: "Would you like to talk about it?" is not natural or common in Czech nursing traditions. More often a more directive approach is used to obtain or give information to be able to ensure adherence to required administrative processes.

Conclusion

Our results show the reality in Czech nursing practice regarding therapeutic communication. Although it is theoretically tangible and, according to many authors, it is the key nursing skill, there is not much space for it in Czech nursing practice. Our findings show that therapeutic communication provided by nurses is needed and useful, but the most important and effective skills of therapeutic communication are missing, especially listening, questioning and creating an effective therapeutic environment. The primary obstacle is the lack of time seen both from the nurses' and from patients' points of view. Therefore, nursing education and lifelong learning should include ongoing training in therapeutic communication. Also it is important that managers include therapeutic communication as a key criterion of professional nursing care.

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Educational Goals

- To learn about the situation of therapeutic communication provided in general hospitals in Czech Republic which should prevent aggressive behavior of patients
- To compare the attitude and need of patients towards therapeutic communication in different states

Correspondence

Ms Marie Treslova
South Bohemia University in Ceske Budejovice
Faculty of Health and Social studies,
U Vystaviste 26, 37005 Ceske Budejovice
Czech Republic
treslova@zsf.jcu.cz

Communication Skills Training for Healthcare Workers as a technique to reduce patient perpetrated violence – A Randomized Controlled Trial

Workshop

Maria Baby, Nicola Swain & Chris Gale (New Zealand)

Keywords: aggression, communication skills training, healthcare workers, mindfulness, violence, patients

Introduction

Aggression towards healthcare workers is a known risk (McKenna, Poole, Smith, Coverdale, & Gale, 2003; Baby, Carlyle &Glue, 2014). In hospital based studies it has been shown that nurses experience the highest levels of all aggression (Swain, Gale & Greenwood, 2014; Hahn, Hantikainen, Needham, Kok, Dassen, & Halfens, 2012; Franz, Zeh, Schablon, Kuhnert, S & Niehans, 2010). This appears to be because nurses spend most time having close contact with the patients. There have been several attempts to examine why this violence occurs (Duxbury & Whittington, 2005; Jacobwitz, 2013; McKenna et al, 2003). Although well recognized, efforts to reduce the experience of aggression in healthcare have not been widely successful (Muralidharan & Fenton, 2012; Campbell, McCoy, Burg, & Hoffman, 2014).

One candidate for intervention is communication. Staff training is often recommended as an essential part of any comprehensive approach for preventing and managing workplace violence; yet there is paucity of scientific evidence on the effectiveness of such interventions (Campbell et al, 2014; Swain & Gale, 2014). Most training programmes focus of crises management and the content of training includes physical interventions like breakaways, restraint and seclusion (Duxbury & Whittington, 2005; Schablon et al, 2012; Whittington & Wykes, 1996; Muralidharan & Fenton, 2012).

Professional training of medical, nursing and allied staff includes communication skills training as part of the curriculum (Maguire, 2000; Medical Council of New Zealand, 2014; Nursing Council of New Zealand, 2010). The training in communication skills aims to improve the quality of patient care, improve confidence levels and deal with distressing situations that may arise when working with patients and families (Stubbs & Dickens, 2008; Richmond et al., 2012) There is strong research evidence to support improved health outcomes by enhancing communication process between clinicians and patients (Spector, Zhou & Che, 2014; Smidt, Balandin, Reed & Sigafoos, 2007).

Interestingly in New Zealand, much of the day- to -day care of people with challenging behaviours and those vulnerable are provided by Non- Governmental Organisations (NGOs) in community based residential settings. These community residential settings are often staffed by untrained support workers. Previous research suggests community support workers can be faced with challenging situations in their day- to- day work with minimal training on how to deal with such crises (Swain & Gale, 2014; Gale et al, 2009). It has been established that training in professional courses helps improve patient care and outcomes. It seems logical that expanding this type of training to community support workers may also be useful.

"It's All about Communication"

Background
Gale, Hannah, Swain, Gray, Coverdale and Oud (2009) reported the distress experienced by community support workers from patient aggression and the need for appropriate interventions to help support workers cope with aggression. Another survey of medical students by Mackay, Hannah and Gale (2009) re-iterated the association between hurried, non-confident and anxious communication style to an increase in the risk for assaults from patients. The problem of aggression and violence faced by community support workers is worsened with restrictions in safety measures such as personal alarms, panic buttons, immediate access to qualified healthcare professionals and crisis management teams and having to work in isolation at times (Gale et al., 2009). Gale et al (2009) suggested the development

and delivery of communication skills training as a suitable intervention to reduce support workers experiences of aggression.

Swain and Gale developed an educational package called "It's All about Communication" which is a group based, fully scripted and structured intervention that introduces the basics of communication skills and uses a DVD to provide examples of clinical situations (Swain & Gale, 2014). Staff training is recommended as an essential part of any comprehensive approach for preventing and managing workplace violence; yet there is paucity of scientific evidence on the effectiveness of such interventions (Muralidharan & Fenton, 2012; Campbell et al, 2014; Swain & Gale, 2014).

"It's all about Communication" package was tested in an open label trial with positive results (Swain & Gale, 2014). Although the results from the pilot study were promising, the study had no control group and no measure of communication change before and after the training course. Therefore, a randomized controlled trial of "It's all about Communication" versus "Mindfulness" is currently being conducted to demonstrate the effectiveness of communication skills training as a suitable strategy to minimize patient perpetrated violence against healthcare workers (Table 1: Outline of "It's All about Communication" versus Mindfulness Training).

Components of "It's All about Communication"
"It's All about Communication" is a four session training package designed to teach some of the most essential communication skills. The sessions are structured from basic to complex. It involves pair wise and group discussions for each of the components but no role play. The communication skills package was developed on the basis of years of experience teaching communication skills to medical students, previous research and clinical expertise. The exemplars on DVD were enacted by professional actors and these exemplars were based on true clinical situations but de-identified and modified to ensure privacy. A facilitator's guide and a participant guide were developed (Swain & Gale, 2014).

Session 1: Communication techniques
The first session focuses on the very basics of communication. The session starts with an ice breaker to set the scene for the training session which shows how we all perceive and interpret things differently. The first section is *'Understanding how our words are received: Non-verbal'*. The way we communicate and act can make things better or worse depending on our actions and people's unrealistic expectations of us. When things get difficult, our communication is important to manage the other person's emotions and our own. This is when we need to be able to read the non-verbal behaviours of clients and be mindful of the non- verbal behaviours we are displaying. This component is re-iterated by asking participants to discuss with their neighbour and then facilitate a wider group discussion on examples of non-verbal behaviour.

'*Understanding how our words are received: Verbal'* is the next section. This begins by asking participants about the qualities of verbal communication which includes pitch, rate, volume, rhythm, silence, pauses and tone. A clip of three different tones is played and participants are asked to identify the tone in each clip and write in their workbooks. Then this is discussed as a group

The next section is about '*Our body language'* which includes posture, proximity, touch, body movements, facial expressions and eye contact. Participants are asked to write down a few examples of body language and then contribute their ideas. This is followed by a video example of the impact of non-verbal communication. This is followed by group discussion.

The next section is '*Showing empathy through a process called mirroring'.* Participants are asked to discuss among themselves how they develop rapport. Empathy is about identifying an emotion and its source and being able to reciprocate it in a clear manner. Rapport is a component of empathy and at times can be gained by *mirroring*. Mirroring is a technique of being like the other person. If there are aspects of communication that you do not want to mirror, then be careful not to focus on it.

The importance of body language and empathy along with verbal and non –verbal communication are discussed at the end of the first session in a scenario that is displayed on DVD. A general discussion of the body languages and mirroring are discussed. The next video shows a female support worker talking to an upset client. Participants are asked to write down things the support worker does to get the client to talk. This is followed by a general discussion on words, tone, body language and empathy.

The last video in this session shows a young male client admitted to the ward the previous night and waiting to see the consultant psychiatrist the next day. Participants are asked to focus on the non-verbal behaviour and during the discussion the implications of professionalism, team identity, respect and

approachability are discussed. The session finishes with a summary of all the essential aspects of good communication.

Session 2: Working in groups
The second session of the Communications Skills Training focuses on how to manage discomfort within a team, group dynamics, use of open and closed questions, empathy and setting an agenda. All these sections include visual examples of scenarios on DVD and discussions as a group.

The first section is *'Managing discomfort in a team'*. The video shows a team manager (female), team member (younger male) and an Education officer (older male). As participants watch the video, they are asked to focus on who is uncomfortable, how we recognize they are uncomfortable and how the situation was handled and this is then discussed as a group. The next video is focused on '*Group dynamics'*. The scenario is of a team member (young male), team manager (female) and unwell client (older male). This video shows the difference in approaches of the two staff members.

The second section focuses on use of *'Open and closed questions'*. One of the ways to communicate effectively is the use of open and closed questions. This section is related back to the previous video to re-iterate the nature of questions used by both staff members and the implications of open and closed questions are discussed. The last section *'Empathy and setting an agenda'* highlights the importance of empathy and the need to set an agenda to let the other person know what you would like to achieve. This is reinforced by a video which shows a psychiatrist introduce himself to a client in two different ways. The group discussion focuses on the nature of the introductions, how the agenda was set and empathy. This session finishes with a summary of the aspects of working as a group.

Session 3: Difficult Situations
The third session focuses on suggestions to improve communication like control and structure, working in pairs, difficult situations and worries and concerns as members of a team. This session requires the participants to work in pairs and then have larger group discussions along with examples from work that are displayed using the DVD. The rationale behind working in pairs initially before group discussions for the participants is to give them a feeling of the reality of working with someone who may have different opinions to themselves.

The section *'Control and Structure'* focuses on some problems that can arise from supporting people to live in their own homes. Participants are asked to work in pairs and list the things that they can control in another person's house followed by group discussion. This followed by a video of a support worker arriving at a client's house to take him to a hospital appointment that he is reluctant to go to. Participants are asked to focus on the way the support worker maintains control and structure.

The next section *'Working in pairs and difficult situations'* highlights the need for team work. This involves discussion of situations that participants deem important to work in pairs or as a team. This is re-iterated in a scenario (video-taped) of how two nurses deal with a patient with an eating disorder who presents as challenging. The final section on *'Worries and Concerns'* begins with a video clipping of the two nurses who nurse the eating disorder patient. Participants are asked to consider the interchange in this video and identify worries and concerns from the discussion of the nurses in the given scenario. The session ends with a general discussion of team work and working through difficult situations.

Session 4: When to move on
The final session consists of three sections. This includes what to do when things go wrong, when communication breaks down and taking care of ourselves that are supported by reality based scenarios displayed using the DVD. This will not be demonstrated in the workshop but further details are available from the authors on request.

Mindfulness

Mindfulness has long history and has been used in clinical practice to help people deal with difficult emotions, working in groups and communicate better (Bazarko, Cate, Azocar, & Kreitzer, 2013; Kabat-Zinn, 2003; Shapiro, Astin, Bishop, & Cordova, 2005). It was thought that this would form a logical control condition for "It's all about Communication"

Brief overview of mindfulness
Mindfulness training is a group based training adapted from an already existent training module with four sessions. Each session will begin with an introduction to the session followed by a guided audio participants will follow along to and then finish with debrief information explaining the task they had

just completed. This will be accompanied by video clippings of a person's experience with mindfulness in managing stress and dealing with aggression and a take home task.

The content in each of the four modules is drawn from suggested mindfulness explanations and exercises from mindfulness programmes developed by Kabat -Zinn (1990) and Segal et al (2002) and with guidance and help of mindfulness practitioners and researchers studying the impact of mindfulness on chronic pain and stress. The content of the course was validated by a registered clinical psychologist. *Table 1* outlines the mindfulness activities in the control condition. As an example we will focus on Session 2. Session 2 begins with a refresher video explaining what mindfulness is. The videos for the control condition were made in our research lab. This is followed by some training in mindfulness for working with difficulties, mindfulness in your daily routine, mindful eating and gratitude. We will work through some of these exercises in the workshop.

Conclusion

It is proposed that communication skills training for community support workers will improve their day to day experience with clients. We are also hoping to see a reduction in aggression experienced. The present workshop has demonstrated some of the techniques we will be using in our intervention and control programmes. When the research has been completed these programmes will be made widely available.

Acknowledgements

Table 1: Outline of "It's All about Communication" versus Mindfulness Training

Session	"It's all about Communication"	Mindfulness
1	Communication Techniques • Icebreaker • Non Verbal cues • Verbal cues • Body language • Mirroring	What is mindfulness? The basics of mindfulness practice • Icebreaker exercise • Basics of mindfulness • 5 minutes of breathing meditation and discussion • Take Five Mindfulness Activity • Practice • Gratitude Exercise
2	Working in groups • Managing Discomfort • Group Dynamics • Open and closed questions • Empathy • Setting agendas	Mindfulness in your daily routine • Refresher Mindfulness Video • Mindfulness for working with difficulties • Mindfulness in your daily routine • Mindful Chocolate Eating • Gratitude Exercise
3	Difficult Situations • Control and Structure • Working in pairs • Difficult situations • Worries and concerns	Mindful Body Scan and Mindful Colouring • Refresh mindfulness concepts • Body Scan Exercise • Mindful Colouring • Gratitude Exercise
4	When to move on • What to do when things go wrong • When communication breaks down • Taking care of ourselves	Complete Mindfulness and Mindful • Walking • Revise mindfulness concepts • Complete • Walking meditation • Gratitude Exercise

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Educational Goals :

1. Participants will gain insight into the estimates of aggression towards healthcare workers in New Zealand and the nature of training provided nationwide.
2. Participants will be able to critique and discuss the importance of communication skills training – "It's all about Communication" and describe its significance as a violence reduction strategy among healthcare workers

Correspondence

Ms. Nicola Swain
Department of Psychological Medicine
Dunedin School of Medicine, University of Otago, Dunedin
2nd Floor, Fraser Building
464 Cumberland Street, Dunedin 9054, New Zealand
nicola.swain@otago.ac.nz

Using the Rock & Water method in the treatment of forensic psychiatric patients and in educating staff

Workshop

Erik Timmerman & Ernst Janzen (Netherlands)
Van der Hoeven Kliniek, Utrecht, The Netherlands

Facilitators

Erik Timmerman is sports teacher, staff trainer and coordinator of the Sports department in the Van der Hoevenkliniek. As advanced Rock & Water trainer he provides individual workshops and group workshop for patients, as well as for staff members. He is owner of *EighT – Opleidingen, Trainingen & Coaching* in which he also predominantly works with the Rock & Water method.

Ernst Janzen is sports teacher and Rock&Water trainer in the Van der Hoevenkliniek.
He provides individual workshops and group workshop for patients, as well as for staff members.

Introduction

This workshop will be provided by Erik Timmerman and Ernst Janzen, both sport teachers and staff trainers at the Van der Hoeven Kliniek, a forensic psychiatric hospital in Utrecht the Netherlands. The Rock & Water method has been implemented within this hospital in 2008. Several workshops are provided for both patients and staff members. The workshops for patients focus on aggression regulation, learning how to set boundaries, and how to improve social skills. The workshops for staff members are provided within a professional education program that aims to learn how to intervene and de-escalate situations, conflict management and self-defence. For both patients and staff members, the focus is on becoming aware of their own behaviour and the impact of their behaviour on others in daily life.

The Rock & Water method
The Rock & Water method provides participants with skills for physical-social teaching with a focus on body awareness, emotional awareness and self-awareness. The concepts 'rock' and 'water' are being used as a metaphor to explicit different forms of communication.

By experiencing practice-focused physical exercises, it is easier to transfer these skills to situations in daily work or life. By creating moments of choice, the participants can learn to consciously make decisions and regain control over their behaviour in complicated situations, for instance, when it is needed to set boundaries without getting in an escalating conflict. Participants will learn to become aware of personal possibilities, qualities and responsibilities. The workshop focuses on social competence and inner strength. In daily life, individuals will have to be able to function as a rock (strong, immovable and with self-confidence) and as water (remaining in contact, flexible and connecting). The basics of the program include grounding and centering exercises, standing strong and rock and water attitude in physical and

verbal communication. The power of this method is that by practicing and experiencing the different physical exercises, one can learn to regain control in their daily life at work, school or society.

Golden triangle:
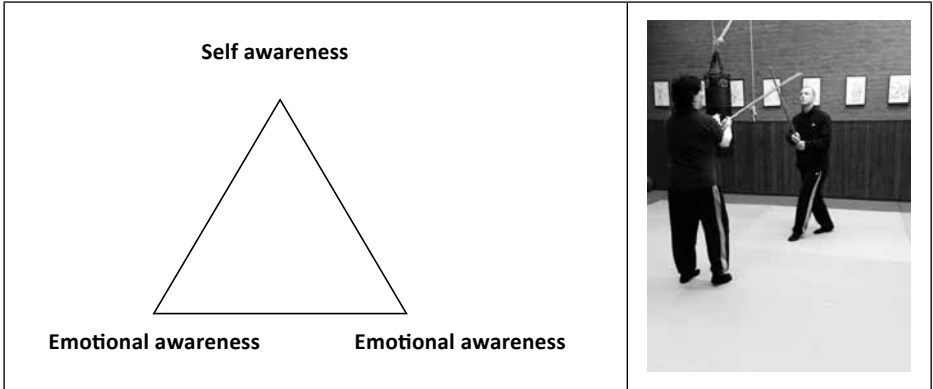
Applicability in daily clinical forensic psychiatric practice:
Since 2008, the Rock & Water program is used with the Sports department. Just like the other sport activities, the program is part of the treatment program of the patient. When the method was implemented, it was immediately successful. All patients easily recognized the terms Rock and Water and the active part was appealing to them. These lessons are provided for individual patients or to small groups of maximum 6 patients.

For the TBS (disposal to be treated on behalf of the state implying mandatory treatment) patients with severe and complex psychopathology, we offer individualized trajects in close collaboration with their psychotherapists or their supervisors. For patients with other judicial titles who usually are more short-term patients, we provide series of 10 lessons supervised by a sports teacher together with a therapist. The workshop has multiple aims. Generally, the workshops focus on reduction of tension and emotion regulation, learning how to set boundaries and improve social skills.

Applicability in daily practice educating staff:
When we introduced the Rock & Water method for the patients to the sports department, all sport teachers were very enthusiastic. Various staff members recognized that this method could also be valuable for staff members. We started providing workshops upon request of treatment teams and later, the method became the basic course in the existing trainings Physical intervention, self-defence and de-escalation techniques and conflict management.

The central focus is the body, emotions, own actions and creating own choices in the treatment of patients. The aim is improve skills in acting more effectively and professional towards patients. Furthermore, the method turned out to be helpful in looking back and evaluating situations.

Workshop

During this practically focused workshop, we aim to explain the Rock & Water method and the way it is integrated within the treatment of our patients and in a professional educational program for staff. First, we will provide some basic physical exercises. Subsequently we will demonstrate practice oriented exercises and analyse them from the Rock & Water method. Furthermore, video material will be showed from the workshops provided at the Van der Hoeven Kliniek.

Educational Goals

- To explain and experience the Rock & Water method and how it can be used within forensic psychiatric treatment
- To explain and experience how the Rock & Water method can be valuable in the professional education of staff in a forensic psychiatric hospital

Research & results

The Rock & Water method started as a method for high school children. After the implementation the method was extended to several target groups and adjusted for these different groups. A number of studies have been conducted. Overall, it has been shown that:
- The Rock & Water program contributes to the development of positive social skills, more effective strategies in coping with bullying behaviour, as well as more self-control and confidence, improved skills for introspection, decrease in social problems.
- Use of the Rock & Water program results in reduced harmful behaviour.
- The Rock & Water program results in improvement of relationships between participants and relation with sociotherapists, improved group climate better coping strategies in case of bullying.
- The Rock & Water program is a well-substantiated program aiming for improving behavioral problems, bullying and sexuality.
- The Rock & Water program improves self-regulation and general self-efficacy.

Within our hospital, it has not yet been possible to examine the multidisciplinary approach for the specific target group. After the implementation in 2008, the use of the method has expanded enormously. For the TBS patients the method is oftentimes mentioned as one of the indicated treatment activities and there is constructive deliberation between the trainers and psychotherapists in improving the treatment of patients. For the patients with other judicial titles, the standard Rock & Water program is adopted in the treatment plan. Both patients and staff members are very enthusiastic about the method. Patients indicate that "not just talking" works well for them and that they like to be able to contribute their own perspective.

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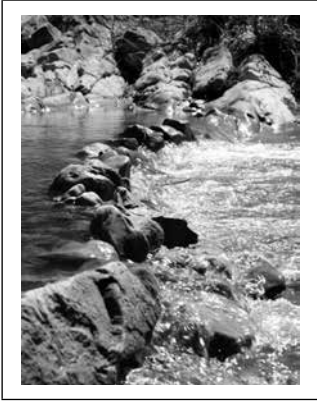
Correspondence

Erik Timmerman
Van der Hoeven Kliniek
P.O. Box 174
3500 AD Utrecht
The Netherlands
etimmerman@hoevenkliniek.nl

Maintenance of the staff's conflict preventive competencies

Paper

Line Juul Christensen & Nethe Plenge (Denmark)

Keywords: Training, education, prevention of violence and use of coercion, reduction of work-related injuries, conflicts, conflict preventive culture

Background

In 2014 The Mental Health Services, which is a part of the Capital Region of Denmark, implemented a survey to measure the working environment among the employees. The main result showed that the risk of violence and threats is one of the greatest challenges in the working environment in the organization. To meet this challenge, The Mental Health Services is constantly working with prevention of violence and conflicts by creating a conflict preventive culture.

All new employees receive training and education in prevention of violence and threats of violence. A program of 5, 5 days contains training in 1) identification of conflict level, 2) conflict preventive communication and 3) the use of physical holds.

The conflict preventive culture demands a persistent effort. Thus, The Mental Health Services has established a well-structured effort of maintaining the staff's conflict preventive competencies. The main purposes of the work are 1) to reduce the number of work-related injuries after violence and 2) to prevent the use of coercion towards the patients.

Introduction

The maintenance of the staff's competencies consists of mandatory training, feedback and follow-up. The trainers are local instructors who have completed 15 days of education with final exam. These trainers are specially recruited and essential for developing the conflict preventive culture in The Mental Health Services.

Methodology: The work with the trainers is based on 1) The Mental Health Services' policy to prevent violence and threats of violence, which mainly focuses on the working environment and 2) the action plan to prevent restraints, which emphasizes a professional approach to the conflict preventive culture.

All units in The Mental Health Services have developed local guidelines for their own use of trainers based on a guiding template with some minimum requirements. During 2015 a virtual tool box will be launched containing the necessary tools and materials for the training and evaluation.

Findings

The Mental Health Services is planning to evaluate the use of the trainers systematically by the end of 2015. The final results of the evaluation is planned to be official primo 2016.

Educational Goals

The participants will:
- get insight to a practical way to organize and prepare implementation and maintenance of a conflict preventive culture
- appreciate the potential benefits of engaging trainers in the work aiming to reduce the number of work-related injuries after violence and preventing the use of coercion towards the patients
- get inspiration from the virtual tool box containing practical tools to plan, prepare and evaluate the training of the trainers.

Correspondence

Ms. Line Juul Christensen
Mental Health Services, Capital Region of Denmark
Kristineberg 3
2100 Copenhagen
Denmark
line.juul.christensen@regionh.dk

Can physical activities reduce the use of coercive measures?

Poster

Anne Naested & Lene Lauge Berring (Denmark)

Keywords: Physical activities, Restraints, Coercion, Break Through Method, Changing practice

Background

A major national effort to reduce the use of coercive measure has failed and the number of physical restraints has remained unchanged over the last 10 years. About 20 % of patients submitted to a psychiatric hospital are involved in some form of coercion.

Aim

The poster presents the process and the result of a coercive measure – reduction program carried out in the region Zealand part of Denmark, from 2013 – 2015.

The aim was to reduce the use of coercive measures (mechanical restraints (MR.), rapid tranquilization (RT) and holding) by 20 % through implementing physical activities during hospitalization. Furthermore we wanted a culture that ensured safety for patients and staff.

Our hypothesis was that staff engaging with patients during their stay would encourage good relations Thereby staff would be aware of patient-preferences and be able to help patients to develop and use different copings strategies in disturbed and violent situations.

Method

An implementation team was established in order to lead and supervise the project.

A service user panel was used in order to supervise the process during the project.

Six teams located in different areas of the Region Zealand, were established. The teams covered all areas of the psychiatric field including forensic, elderly and adolescence. The teams were organized in a network and they were all educated in the Break Through method and physical activities.

All patients at the involved units were included to the project.

Data were collected monthly related to the use of coercive measures, BVC (Brøset Violence Checklist) and activities.

Results

Preliminary results showed individual changes in the use of coercive measures. Some teams reduced MR and some teams reduced RT. However, all together, MR remained unchanged. The use of physical activities were fully implemented and embedded in the patients' treatment plan and the culture changed toward a less restrictive environment, based on a more appreciative approach.

Conclusion

MR can be recognized as an inadequate response to harmful behavior that maintains patterns of harm and aggressive behavior. Physical activities are only one strategy when it comes to reducing MR. It is necessary to implement other leader driven strategies such as outlined in the 'six cores strategies'.

Educational Goals

- To get insight how mental health workers and patients are motivated to involve physical activities in the everyday care and treatment plan.
- To take note of how physical activities influences the culture and the use of coercive measures in mental health settings.

Correspondence

Ms. Anne Næsted
Region Zealand. Department of Psychiatry
Nørregade 54F
4100 Ringsted
Denmark
annae@regionsjaelland.dk

Sex and violence: a topic for all medical and health care professionals

Paper

Heidi Siller, Women's Health Centre, Medical University of Innsbruck, Austria
Susanne Perkhofer, University of Applied Sciences Tyrol, Austria
Martina König-Bachmann, University of Applied Sciences Tyrol, Austria
Margarethe Hochleitner, Women's Health Centre, Medical University of Innsbruck, Austria

Introduction and Background

Sexuality and violence are topics that have been discussed widely. Violence and sexuality are discussed in various medical and health care disciplines, highlighting links between physical and psychological problems resulting from violence [1-3], an association between well-being and sexuality [4] and demanding a more inclusive approach to sexuality in medical and health care [5, 6]. A previous project focused on violence and sexuality in women from a general practitioner's perspective, whereas this project targets sexuality and violence during and after pregnancy and the role of midwives. It is known that violence and in particular interpersonal violence is a known risk factor in pregnancy for the mother and her (un)born child [7-9]. Several studies have demonstrated the effects of violence on health and well-being [2, 3]. Likewise, sexuality is associated with well-being and health [4] and has been researched to assess changes in sexual behavior during pregnancy [10, 11]. Women wish to obtain more information on sexuality during pregnancy [12]. Similarly, it was found that for their medical encounters women advocate being asked about violence [13]. However, violence and sexuality appear to be taboo.

The inclusion of sex and violence in (medical) education and in history taking is recommended, although there is hesitation to recommend screening of violence on a universal level [14]. Studies about midwives including screening for violence have demonstrated that such screening is time-consuming and demanding on an emotional level. Midwives also stated that they weighed the decision to participate in this screening against their role as midwives, which primarily comprises providing (health) care for mothers and their (un)born child [15]. Training about domestic violence, but also other forms of interpersonal violence, needs to be included in the education of midwives and all medical and health care professionals to prepare and equip them with the necessary skills, and to eliminate myths and insecurity when dealing with women affected by violence [16].

Methods

The presented project was conceptualized over two years and commenced in November 2014. It includes training about sexuality and violence, and the implementation of questions on these topics in practice. The project was approved by the ethics committee of the Medical University of Innsbruck (AN2014-0192 339/4.1). Qualitative data on the current practice of asking about sex and violence will be obtained as well as quantitative data on practical implementation of questions on sexuality and violence during and after pregnancy. The presented qualitative part of the project included interviews and group discussions and aimed at studying current management of sexuality and violence in practice, expectations/experiences, obstacles to asking about sex and violence and psycho-hygiene in midwives and midwives in training. Midwives in training participating in the qualitative data collection were recruited from the midwifery study program and the midwives' plenary assembly. Participation was on a voluntary basis and each participant gave her written consent when participating.

Interviews and group discussions were analyzed using the Grounded Theory by Strauss and Corbin [17]. After using open coding to fracture data and extract data sequences, axial and selective coding was performed in order to find code relations and interrelations. By breaking data into codes, similarities but also differences became detectable and it was possible to categorize codes into core categories. The paradigm model was used to establish relations between codes by finding information on the phenomenon, contextual condition, causal condition, intervening conditions, actions/strategies and consequences. In order to expand and complete the drafted theory, data collection will be continued until the project is completed.

Results

Participants
To date, five midwives (*mean* age: 43 a) were interviewed individually, and 24 midwives in training (*mean* age: 22 a) participated in group discussions. Midwives in training were divided into five groups of three to six participants each. Group discussions had an average length of 30 minutes. Individual interviews with midwives lasted on average 40 minutes. All participants were female.

Findings
The central focus is set on midwives and midwives in training who manage sexuality and violence in practice. The actual inclusion of these topics depended on the work setting as this is conditional for the relationship with the women. Thus, working in a hospital was associated with higher numbers of patients, less time and less possibility for continuity in care for a patient. In this sense, it was perceived as being more difficult to include sensitive topics such as sexuality or violence in hospitals than when working in private practice. Additionally to the work setting, midwives and midwives in training differentiated between hospitals or private practices situated in an urban or a rural setting, thus the rural location was seen as a hindrance, because it afforded less anonymity and patients might be acquainted or even related to hospital personnel. Further aspects influencing the inclusion of sex and violence in practice relate to the patient's and her partner's behavior, each patient's individual needs and the context of care. In this sense, it was discussed that e.g. during childbirth and puerperium it was not appropriate to ask about violence, e.g. due to lack of privacy (e.g. visitors, multi-bed rooms) and the main focus on the newborn child. A partner's behavior was seen as a hindrance to talking about violence when he was experienced as overly controlling and obsessive. Talking about sexuality was perceived to depend on the patient's individual needs, namely if women wanted advice or further information on sexuality during or after pregnancy, specifically in the context of birth control.

Management of the topics sexuality and violence was influenced by advanced training that included violence in training, simultaneously with the lack of inclusion of these topics in midwifery training.

This was especially named by practicing midwives, who stated that these topics had been neglected in their midwifery training, whereas the current training situation recently incorporated these topics in the curriculum. Midwives in training discussed the translation of theory into practice, thus the implementation of skills.

Besides the need to include these topics in training in order to provide basic knowledge and equip midwives with the necessary skills, the question of whose responsibility it is to ask about sexuality and violence as well as hierarchical aspects in hospitals fueled discussion on inclusion of questions on sexuality and in particular violence. Limited possibilities for referring patients on short notice and lack of continuous care for patients as well as uncertainty about a smooth flow between interlocked referral systems were cited as obstacles. Additionally, concern about the patient's reaction in response to broaching these topics was emphasized as well as the need to have a trusting relationship with the patient in order to bring up these topics during history taking.

All the aspects mentioned above relate to awareness for the extent of violence in pregnancy and to the influence of violence on women's health when neglected.

Discussion

This study demonstrates that sexuality and violence are still topics that lack comprehensive inclusion in practice. Several hindrances to including sexuality and violence were discussed by midwives and midwives in training. In this case, the work setting (hospital vs. private practice; urban vs. rural) was seen as a facilitator and simultaneously a hindrance; either way, continuity of care for a woman was seen as being an influential factor. The context for asking questions on sexuality, but also on violence was seen as important, as such sensitive topics were discussed in relation to the patient's needs and when appropriate. Sexuality appears to be discussed to a greater extent than violence. However, discussions of sexuality seem to focus mainly on sexual intercourse and birth control, less on intimacy and various facets of sexuality.

There is hesitation to include violence in care for pregnant women: even if violence is suspected, it is hardly discussed with the patient. This kind of hesitation appears to be rooted in the lack of training about violence [16] as those midwives whose training included violence reported that they included questions on violence in their patient care.

Regarding violence and screening for violence, the study found that not only referral, but interlocking referral systems [18] and guaranteed continuous care for those affected were specifically stressed. It is necessary to ensure an interlocking referral system and make it more visible and believable for medical and health care professionals [18].

The discussion of whose responsibility it should be to ask about violence points towards hierarchical structures that allocate specific roles and responsibilities to medical and health care professionals. Even though screening for violence, but also discussing sexuality, appears to be more easily integrated in some disciplines (e.g. gynecology, midwifery), both subjects influence health and well-being and should thus be a matter of concern for all medical and health care professionals. In this sense, training should target not only undergraduate study programs for all medical and health care professionals, but should also be strengthened in postgraduate training and advanced training for all medical and health care professionals [15, 16]. Today's professionals act as role models for future medical and health care professionals, and it is thus important that they demonstrate the translation of theory into practice. The comprehensive inclusion of such sensitive issues in health care is one step towards reducing taboos.

Obviously, sexuality and violence cannot simply be lumped together, but the specifics of each topic need to be emphasized. Both topics share some characteristics, such as being taboo or being perceived as private and shameful as well as being the subject of reluctance to discuss these issues in health care and their impact on health and well-being. Other characteristics act disjunctively, e.g. experiencing sexuality is per se not negative, while experiencing violence is.

Slowly reducing obstacles to including violence and sexuality in medical encounters appears to be the next step that needs to be taken.

Conclusions

Violence and sexuality are subjects that concern all medical and health care professions. Training on these subjects has to be more thorough. Moreover, lay education, public campaigns and interlocked referral systems have to be focused upon to ensure the best possible patient care and to share responsibility across disciplines and professionals.

Acknowledgements

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Educational Goals

1. Violence and sexuality are topics that have to be of concern across all medical and health care disciplines by e.g. providing and implementing training
2. Hindrances to include questions on violence and sexuality have to addressed and an understanding has to be promoted how addressing these topics are beneficial in health care of women affected by violence.

Correspondence

Ms. Heidi Siller
Women's Health Centre, Medical University of Innsbruck,
Innrain 66
6020 Innsbruck
Austria
heidi.siller@i-med.ac.at

The experiences with violence and prevention of violence in The Prague Emergency Medical Service in years 2004 – 2014

Paper

Jaroslav Pekara, Zdeněk Schwarz & Alan Mejstřik (Czech Republic)

Keywords: Violence. Prevention, Emergency medical service, Prague, Communication

Introduction

The Prague Emergency Medical Service (PEMS) is an organization funded by the City of Prague (Czech Republic). Thanks to its long history, it is the one of the oldest institution of its kind in Europe. The main task of this institution is to provide specialized pre-hospital emergency medical care. Emergency calls from the entire territory of Prague are accepted continuously at the toll-free number 155. All activities are managed by the Medical Operations Centre, where operators receive over 900 emergency calls per day. Specialized pre-hospital emergency care is provided by rapid response vehicles (RRV – emergency vehicles carrying a physician) and advanced life support vehicles (ALS – large ambulance vehicles comprising a paramedic and a driver/rescue person). They operate in the rendezvous system, where a physician works together with an ALS crew in situations when a patient's life or health this in serious danger. This approach not only reduces the response time to a patient, but it also allows deploying physicians in an optimal manner because in the vast majority of cases (approximately 85 %), patients are transported to a medical facility without the need for a physician assistance during the transport. This way, doctors are not unnecessarily tied up and can be dispatched to assist other patients. Currently are only 6 doctors for all towns Prague (1, 5 million inhabitants).

This rescue staff currently uses 80 ambulance vehicles. There are 67 ALS vehicles and 13 RRV automobiles and 1 helicopter. PEMS is created by 19 bases. In addition to standard ambulances, we have unique vehicles, such as the GOLEM trailer module designed for responding to large-scale emergencies and exception all situations and an „XXL ambulance" capable to transport patients who are obese, wheelchair-bound, or confined to bed and requiring life support equipment. From the year 2005 PEMS has also the position a traffic inspector. He helps by difficult calls and he also controls staff during the work.

Rescue teams respond to emergency calls from 19 stations that are strategically situated in various parts of Prague to ensure the availability of pre-hospital care within 15 minutes. According to long-term statistics, our response times vary between seven to eight minutes and amount to less than seven minutes in the most serious emergencies. 330-350 patients are attended every day, which translates into more than 111 000 ambulance runs per year.

The main goal of this paper is to provide information about violent incidents the rescue teams of PEMS experienced in the years 2004 – 2014. The violence between patients and medical staff is not in the center of interest in the Czech Republic (CR) in EMS CR but the PEMS is an exception. Thanks to management PEMS and his education center (EC) is possible to minimize and to prevent the violent incidents between patients and medical staff of PEMS. The PEMS documents the statistics of violent incidents and tries to provide continual education of the staff in prevention of violence (communication courses, self-defense courses and the self-defense spray). There were identified the crisis places of violent incidents in capital town (Prague) and PEMS provides the help in these places only with assistance of policies. The PEMS is performed like best praxes in these phenomena in the nature of EMS. Except of the general research we present results of our detail survey from last two years (November 2013 – May 2014 and October 2014 – May 2015).

Results 2004 - 2010

In the CR still not exist continual monitoring of violent incidents in EMS. The survey study about attack the paramedics in the CR was published in the year 2006. The study confirmed that the attacks on paramedics are real in the CR and the main causes of this problematic were the escalated negative emotions by drunken patients or by nonprofessional behavior of medical staff in EMS. There were also prevention factors of violent incidents identified (these factors are provided currently only by management

PEMS in the CR). Other EMS in the CR also educated their employees in the year 2006 but these training courses weren't recapitulated.

The big boom of violent incidents in EMS in the CR started the media in the year 2003 when the relative of a patient attacked medical doctors of PEMS. The doctor didn't want to lend his mobile to the relative of an injured patient (the patient wanted to call his family). The doctor ended up in industrial disability. Picture 1 shows the results of physical violent incidents of study Pekara from the year 2006 (Attack the paramedic in EMS in the CR).

Picture 1: Physical violent incidents Pekara's study from the year 2006 (Attack the paramedic in EMS in the CR).
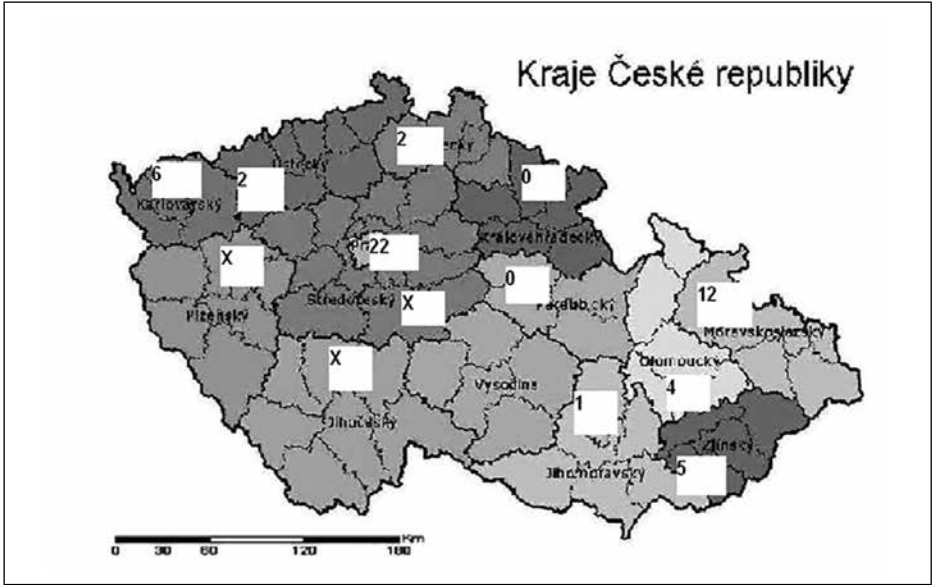
In the years 2006 – 2014 was PEMS the only one EMS in the CR who monitored violence actively. Table 2 presents the physical violent in PEMS during the year 2004 – 2014. The numbers present hard physical incidents (18 % from these incidents ended in industrial disability which takes more than three days).

Table 1: Physical violence EMS Prague

2004 - 2014	
2004	13
2005	22
2006	19
2007	14
2008	8
2009	26
2010	18
2011	8
2012	10
2013	19
2014	9

The PEMS registered one victim of a violent incident who ended in a disability pension in the last 15 years. The numbers reported are physical attacks. Verbal assaults occurred 3-4 times per day in the whole CR in environment of EMS (Pekara, 2007).

There were 22 physical assaults in 2005 therefore a director of PEMS ordered all possible prevention of violence – strong assistance with police in a dangerous causes, prevention equipment for medical staff in ambulances – alarm buttons, self-defense spray and one-shot courses in communication and in self-defense. The violent incidents decreased by 50% in 2007 – 2008 but violent incidents increased in 2009. A unique project for innovation system of EMS took place in the same year EMS (it was the first project from EU for EMS in the CR). There were 120 ambulance drivers, 150 paramedics, 50 medical doctors and 30 dispatchers) and 140 personal workers trained in total. Professional workers were trained in law, self-defense, psychology and defensive driving. Violent incidents decreased by 30% in 2010. From this year all new employees are trained in communication (de-escalation techniques) and self-defense courses. These courses are led by internal lecturers.

Results 2013 - 2014

The numbers of violent incidents were variable in 2009 – 2013. From 2013 it was decided to have regular training courses (drivers and paramedics have these courses every year – one day training). The content of seminars were as follows: a lecture about the context of violent behavior between patient and medical staff in the EMS, an analysis of real causes (one lecturer did 10 interviews with attacked paramedics), presentation of a video from the surgery ambulance of city hospital where a paramedic was attacked, and a training of critical thinking with the aim to de-escalate negative emotions. There was monitoring of the high increase of violent incidents from November 2013 therefore ED implemented regular training courses and ED started the survey questionnaires (which understanding the context of violence). The are main results from our questionnaires which reflect the time from November 2013 to May 2014 (n= 130, drivers and paramedics)were:

- 32 % medical staff (paramedics and drivers ambulances) were exposed to the physical incident (41 causes), 62 % employees (81 causes) were exposed to verbal incidents, 6% employees weren't exposed to any incidents. (Detailed information about number of violent incidents shows Table 2 + 3).
- The conflicts took place more during night shifts (87 %; 2:00 - 6:00 am).
- The most conflict happened at the place of causes (40 %) and during the transport of the patients (23 %) = we found out that the paramedics devote a lot of time to write documentation and they didn't monitor the patients.
- The attacker was mostly (66 %) a man or relative of a patient (34 %).
- Alcohol was reported as the main reason for the attack (35 %), but by deeper questioning we found out that many of the medical staff didn't want to talk with drunken patients. Nonprofessionals' approach was reported in 30%; 20 % of incidents were caused by non-alcoholic drugs; 15 % occurred during the handing over of patients in a hospital department or the police presence in the place where the violence occurred.
- 91% respondents were convinced that every incident is preventable (mostly by better communication, 58 %; 42% had the police present).
- 40% of medical staff thinks that in direct conflict a self-defense spray helps, 30 % a self-defense technique and 30 % communication.
- 77 % of medical staff perceives violent incidents as negative.

Table 2: Contact with violent patient 2013/2014, n = 130 (100%)

Verbal violence:	
Frequency	%
every shift	5
1x per week	28
2 – 4 x per week	13
1x per month	17
1x per 6 month	22
1x per year	12
never	3

Table 3: Contact with violent patient 2013/2014, n = 130 (100%)

Physical violence:	
Frequuency	%
every shift	0
1x per week	3
2 – 4 x per week	4
1x per month	18
1x per 6 month	10
1x per year	45
never	20

Thanks to management's support we organized the third season of methodical tutorial "Pražská 155". There was presented in several exercises from nature PEMS for 14 paramedics teams (one team was from Slovakia, others were from the CR). One exercise aimed to communicate with patients. In this exercise "The Attack", which was in an old factory hall, a group of homeless attacked the paramedic team. We reported this scene on cameras and then we analysed behavior on the scene with the paramedic team. Results from this exercise were unequivocal: calm behavior has a crucial role in conflict resolution.

2014 - 2015

The regularl training courses (drivers and paramedics - one training day) also took place from October 2014 to May 2015. This training aimed to solve three model situations: communication with a blind patient, communication with a psychiatric patient and communication with a stressed mother – her toddler was suffocated. The first model situation occurred with the real blind patient and she provided immediate feedback to the paramedics and drivers after the simulation. The factors which could cause a potential misunderstanding between patients and medical staff were discussed. The model situation with the psychiatric patient was organized as a discussion (we did interviews with psychiatric nurses and then we created voices which psychiatric patients experienced) with paramedics and ambulances drivers. The third model situation to communicate attributes in stress (the mother didn't want to leave medical staff to help her child). Questionnaires for research violent situations for last year were distributed at the end of the seminars. In this research we did six interviews with attacked paramedics. There are results of our research:

- We analyzed 216 questionnaires (54 questionnaires were filled incompletely).
- 148 employees (78 %) were exposed to verbal violence and 66 employees (31 %) were exposed to physical violence or attempts (handling, threatening, blocking to provide help, pushing).

Violent incidents PEMS				
year	verbal	%	physical	%
2014	81	62 %	41	32 %
2015	148	78 %	66	31 %

Detail of frequent violent incident in PEMS				
year	verbal 1x week	verbal 1x month	physical 1x month	physical 1x year
2014	13%	17 %	18 %	45 %
2015	16%	80 %	4 %	80 %

- From October 2014 to May 2015 80% of employees were exposed to verbal violence once per month, 16% of employees were exposed to verbal violence once per week and 4% of employees reported no experience of violence. Eighty percent of employees had experienced violence once per year and 4 % of employees once per month.
- In the case of hard physical incidents, 90% were documented.. In the case of any "easy" incident 10% were documented. The main reasons why medical staffs in PEMS don't document their violence

incidents are twofold: it isn't a serious incident or attempt (83 %) or medical staffs don't want to solve the incident in the future at the police station (17 %).
- The attacker was more often male (82 %).
- Many attacks happened during transport (36%) to the hospital, 32% happened on the ward.
- 97% of incidents happened in the night shifts.
- 22 % employees had incidents with other employees in the hospital (PEMS registered an increase in these problems in the last year).
- 37 % employees confirmed that the violence complicated the job.
- In 80% of cases the non-professional behavior of medical staff was a cause of violent conflict (by contact with drunk or addicted patients; more when the medical staff was asleep); 10 % of violence was caused by the presence of the police; 10% involved aspects f the patient's illness (e.g.. a kick by epileptic attack).
- 70% employees believed that the violent incidents were preventable via professional de-escalation, professional behavior and a humane approach. 10% believed that the violent incidents were preventable with reasonable assistance of the police and 10% believed violent incidents are preventable only by maintaining a safe distance.
- Self-defense sprays and , self-defense techniques were believed to be preventive measures.
- 71% of employees think that the punishments for attacks on medical staff should be harsher; 11 % of employees think the current punishments are appropriate and 16% of employees believed punishments don't prevent violence.
- After violent incidents 43% of employees want a pause (one hour time out), 23% want to go home and 35% wanted to punish the attacker.
- In addition to seminars and the survey we created in January 2015 a video to educate and prevent violent incidents. In March 2015 twenty employees went through a one day course with instructors from Krav-maga.

Conclusion

In general we can state that the paramedics and ambulances drivers of PEMS are exposed to most verbal violence (15 % per week, 80% per month); 80% of employees are exposed to physical violence each year. Industrial disability as a consequence of violence between patients in the PEMS is rare. Most attackers are male and most violent incidents happen during the night shift. Nonprofessional behavior with drunken or addicted patients increases the possibility the violence by 70%. Hard violence is more common than 'easy' violence; the latter is only documented on 10% of occasions. PEMS provides many training courses for its employees and invests much in the training staff in communication skills to de-escalate violence.

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Educational Goals

1. Development of violent incidents in The Prague Emergency Medical Service (analysis recorded in years 2004 - 2014)
2. The paper contains also qualitative study (interviews with paramedics who were assaulted) and evaluation of prevention methods (self-defense, communication, use of pepper spray) during 10 years.

Correspondence

Mr. Jaroslav Pekara
The Prague Emergency Medical Service
Nádražní 1573/60
15000 Prague 5
Czech Republic
jaroslav.pekara@zzshmp.cz

Staff training and violence prevention in coercive care institutions: A newly revised program in Sweden

Workshop

Caroline Björck, Karl Glifberg, Mikael Malmberg, Carina Moen & Gunilla Nötesjö (Sweden)

Keywords: Staff training, violence prevention, coercive care, physical interventions, conflict management, last resort measures

Introduction/Background

The National Board of Institutional Care (Statens institutionsstyrelse, SiS) is a Swedish government agency that delivers individually tailored compulsory care for young people with psychosocial problems and for adults with severe substance abuse. SiS provides care and treatment where voluntary interventions have proved insufficient and care on a compulsory basis has therefore been deemed necessary. Orders for compulsory care are made by the Administrative Court, following application from municipal social welfare boards. Care is provided according to the Care of Young Persons (Special Provisions) Act (LVU), the Care of Substance Abusers (Special Provisions) Act (LVM) or the Secure Youth Care Act (LSU) for youths who have committed serious criminal offences.

The National Board of Institutional Care consists of a central head office with around 80 administrators and 35 institutions (24 residential homes for young people and 11 LVM-homes) spread across the country. The total number of beds are 992 (345 beds for substance abusers and 647 for youths) and the total number of staff at the institutions is approximately 3000. SiS is supervised by a number of bodies, including the Health and Social Care Inspectorate, the Swedish Schools Inspectorate and the Parliamentary Ombudsmen (*JO*). SiS, as many other organizations with responsibility for coercive care, suffers from different work place related problems among staff as well as many serious incidents of violence. This leads to both treatment failures and high rates of sick leave.

In the last years many different activities have taken place within SiS in order to solve problems related to violence, one of which was the revision of the staff training program "No Power No Lose" (NPNL) in line with existing evidence. Prior to the revision, an examination of violent incidents within SiS was undertaken. The results showed that many violent incidents arise in the everyday interactions between staff and clients concerning things like medication, correction of behavior, disappointing answers on inquiries etc. The NPNL stresses the importance of staff performance in crisis situations and provides basic theoretical knowledge about anger and conflict management. The NPNL-R (revised) puts more focus on early signs of violence in every-day situations and aims to educate staff on the difference between short-term management of violent behavior and long-term strategies for behavioral change. The goal is to establish an active but "defensive" staff approach in potentially harmful or destructive situations.

Traditional breakaway techniques have been replaced with "Basic rules of safety" (BRS). The rules aim to provide guidance on how to act at the scene of a conflict, to stay calm and only proceed with coercive measures if there is an imminent risk of injury. The program also includes training in physical restraint techniques (physical interventions). Any physical intervention should, however, be coordinated and only executed under supervision of specially trained conflict managers. To ensure a user perspective (client participation) all youths and clients are given the opportunity to develop a so called joint crisis plan. Stress management and mental preparation are focus. Through role-playing and other exercises staff is continuously trained in how to practice BRS, verbal de-escalation techniques and physical interventions in realistic scenarios.

No Power No Lose (NPNL-R)

Aims to provide staff with knowledge of:
- Aggression and violence within SiS and other inpatient settings
- Basic theory of aggression and conflict
- The impact of alcohol and drugs on violence
- Early warning signs of tension and aggression

- The importance of staff performance and stress management in conflict situations
- Verbal de-escalation techniques
- Physical interventions and risks associated with coercive measures
- Basic rules of safety (BRS) – how to act at the scene of a conflict
- SiS ethical guidelines and their significance in conflict situations

Strengthen the following skills:
- Mental skills – to be aware of risk situations, to be prepare for them and manage own stress in threatening situations
- Communicative skills – to be confident and good at verbal de-escalation in challenging situations
- Tactical skills - to take a responsible stance in threatening and violent situations and always consider safety for everyone on the scene of the conflict.

Build competence to:
- Act calmly and goal-oriented with the intent to defuse anger and tension, enhance self-regulation among clients and, if possible, avoid coercive measures in challenging and/or violent situations.

Educational plan:
The program consists of five modules of both theoretical and practical nature. Training over the year includes one day of education and four two-hour training sessions per employee.

Module 1: Violence and aggression in inpatient settings
The purpose is to put the conflict management program (NPNL-R) in context. Verbal threats, violence, and other challenging behaviors are not unique to SiS, but needs to be prevented and managed. Participants are given a presentation on how SiS works with violence prevention at different levels, the type of violence staff face, to what extent and in what situations. A key-point in this module is to highlight the everyday situations where there is an increased risk for violence. NPNL-R is introduced as a method or tool for short-term management of escalating violent situations which is different from long-term strategies (treatment) for behavioral change

Module 2: Theoretical orientation
The purpose is to provide staff with basic knowledge of aggression- and conflict theory. Participants are introduced to the main psychological theories of human aggression and key triggers for aggression and violence in inpatient care settings. Some key theoretical models of conflict dynamics are also presented.

Module 3: Introspection and stress management
This module builds on the fact that violent situations are associated with high emotional tension. Participants will gain knowledge about how stress and tension affects perception and decision making, and learn the importance of mental preparation and self-regulating strategies in conflict situations. Training aims to make staff better prepared for typical everyday situations on the ward.

Module 4: Early signs and client participation
This contents in this module aims to highlight early interventions as a key-factor in successful de-escalation. The importance of the ability to identify individual warning signs of anger and agitation is introduced. Participants are trained to identify and respond to early signs of emotional tension and different forms of ecalating behaviors among clients. The module contains exercises in verbal de-escalation techniques and low arousal-approaches to conflict. The importance of clients' participation is highlighted together with strategies on how to better take in the client´s points of view in conflict situations. The joint crisis plan is introduced as a tool for client participation, monitoring and mutual learning about conflict management. The joint crisis plan can help staff and clients to identify and discuss individual early warning signs and together agree on strategies for management of crisis situations.

Module 5: Conflict management
The purpose of this module is to give staff an overview of an escalating sequence of events, and how de-escalation strategies can be used in different phases of the conflict process (see figure 1 below)

Figure 1. An illustration of phases in a conflict used in NPNL staff training.
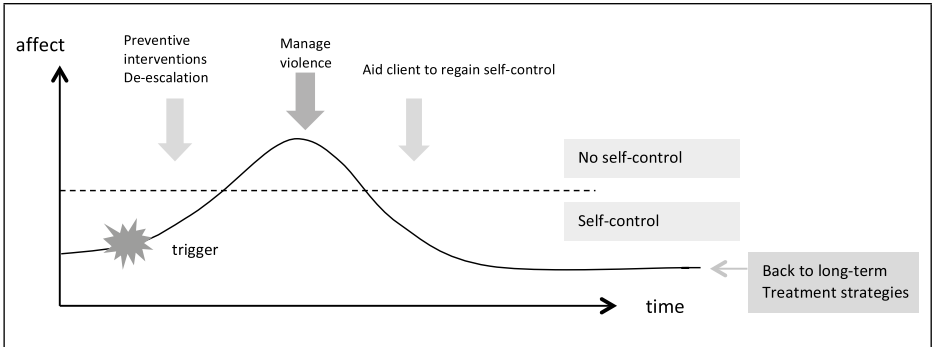
In this module, the Basic Rules of Safety (BRS) is introduced and how they can support staff to act at scene of a conflict, to assess risks, make sound decisions and plan interventions. Verbal de-escalation strategies in different parts of a conflict process are also introduced as well as physical interventions and their associated risks.

Physical interventions
A set of physical interventions are introduced with specific and well defined aims and purposes. The goal is that participants after training are more competent and aware of when, why, how and with what type of physical intervention is appropriate when de-escalation have failed and there is a high risk for immediate injury.

Training sessions
Through role play, group exercises and training of physical interventions, participants practice different de-escalation techniques in realistic scenarios. The purpose of role-playing as an educational tool in NPNL is to practice behaviors that have a de-escalating function and that enhance safety in an escalating or violent situation. The rationale behind this is the assumption that the more staff practice expressing themselves and act constructively in relation to challenging behavior in training situations, the greater the possibilities that they will manage to act accordingly in stressful real-life situations. Role play is supposed to provide opportunities for participants to better understand a conflict situation from various points of view and be aware of own reactions and interpersonal style. Participants also practice how to assess risks, decide and plan interventions according to the principles of the Basic Rules of Safety (BRS). The role play exercises are based on high risk situations within SiS.

Discussion

There is a lack of studies presenting practical examples of staff-training in violence prevention. This paper aims to contribute to the discussion on how to train and prepare staff to act calm and goal oriented when they meet challenging behaviors that can lead to serious violence. In NPNL-R the focus is on client participation, early signs in everyday situations and planned and coordinated physical interventions. Although NPNL has been developed for SiS, many similarities regarding staff training can probably be found in other inpatient settings and further discussions on the topic is most welcomed by the authors of this paper. We have found it useful to consider the distinction between short-term behavior management and long-term behavior change in order to create a better understanding among staff of the importance of preventive strategies and the negative consequences of physical interventions in coercive care. The examination of violent incidents indicated that some decisions to use coercive measures were motivated with an intension to treat instead of, or in combination with, the intent to protect from injury. Therefore we found it meaningful to build the staff training on a principle that helps to separate it from clinical training. Many questions remain to be answered in order to improve staff training. One important question that remains to be answered and that needs to be discussed is for example how to define when a violent situation can be considered to have reached a need for last resort measures? Or differently put: How can a violent situation be considered to be at the final stage and a more restrictive intervention is necessary? The question can have important implications on how to improve and develop staff-training. In NPNL-R we introduced a specific and defined set of physical interventions. The purpose with this was to ensure more uniform and safer behaviors among staff and also to increase the possibilities to evaluate physical interventions. Another question that can be discussed is the role of breakaway

techniques in staff training. The decision to replace them with a set of rules (BRS) was to prevent staff acting irrational in conflict situations and instead take a risk-minimizing and responsible stance that focus on assessing risks before making decisions to intervene. The rational for this change was also to use training time to increase staff skills in detection of early signs, instead of training in self-defence and break-away techniques. Our internal examination of incidents indicated that many situations were caused by irrational and spontaneous actions from staff resulting in physical injuries on both staff and clients. We therefore concluded that there was a need for more training in detection of early signs and how to keep a responsible stance in a conflict situation. Our assumption was also that effective training in self-defence and breakaway techniques require much more training time than what is possible to provide and may put unnecessary focus on anticipated physical attacks from clients. Although this was a decision based on our own assumption rather than evidence a future evaluation could help to show if BRS are sufficient enough to prevent physical injuries or other incidents within SiS. The future goal is to evaluate NPNL-R and the different components in order to increase the knowledge on effective ways to train staff, reduce violent incidents and stop the use of restraint measures within SiS.

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Educational Goals

1. Staff-training and how to prepare staff to behave safe, handle own stress and use preventive strategies to avoid coercive measures.
2. Conflict management, physical interventions and how to continue de-escalation until clients regain self-control.
3. How to use the distinction between short-term conflict management and long-term behavior change.

Correspondence

Ms. Caroline Björck, research leader
National Board of Institutional Care
PO Box 30224
104 25 Stockholm
Sweden
Phone +46104534040
Mobile +46705154004
Caroline.bjorck@stat-inst.se

Work ethics and active communication: The leader on the floor

Workshop

Baidur Karlsson (Iceland) (member of ENTMA)

Keywords: Ethics, training, active listening, body language, group dynamics, leadership skills, trainers as leaders, difference between leadership and management.

Abstract

Since September 2014 the secure and forensic service at The University Hospital of Iceland has been training interdisciplinary staff, both new and old, and nursing students at a brand new education and research center called Rót (Root). The lecturers and trainers are also interdisciplinary staff members, eleven in total. The Head of Rót (me) has been running the following workshop:

The workshop is divided into two parts. First an interactive lecture on the importance of ethics, active communication and leadership in a mental healthcare setting, especially when it comes to aggressive management and why people in the front line need to have and develop these skills along with physical restraint techniques. The second part consists of active listening exercises where groups of three take turns in being the patient, the listener and the 'unprejudiced observer'. Each turn is five minutes and there are two rounds, from 'still face' to active listening, open questioning and feedback.

Educational Goals

1. To understand the importance of leadership. You need to follow managers but you want to follow leaders.
2. To be able to apply active listening skills as a part of aggressive management and to want to develop it further.

Correspondence

Mr. Baldur Karlsson
The Secure and Forensic service, University Hospital of Iceland
Kleppsvegur 1
104 Reykjavik
Iceland
baldurv@landspitali.is

Training staff to manage challenging behavior and violence - does staff safety effect the ability to de-escalate?

Workshop

Pal-Erik Ruud (Norway)(member of ENTMA)

Keywords: Training, Physical intervention, safety, de-escalation

Abstract

Training staff to manage challenging behavior and violence - does staff safety effect the ability to de-escalate? I believe there is a clear connection between employee's ability to de-escalate, and employee's ability to manage whatever behavior they need to manage.

Research is difficult and how do we formalize experience? What effect does program design have on employee's development and the experience of feeling safer and being able to manage behavior?

How doe´s employee's attitude and ability to focus on prevention change, when the working environment becomes more predictable and safe?

To what degree should we select employees based on their ability to learn and master physical intervention skills, in combination with other personal qualities, criteria, and formal education?

How does all of this affect our working ethics, professional role, and integrity of our patient or client?

How does legal regulations and medical considerations effect the debate of what is ethical and safe management?

How do competing companies and organizations affect the process of promoting 'best practice' in physical intervention?

How do training cost, budget, and politics affect organizations ability and motivation to seek 'best practice'?

What happens when academicians take control of the standardization of motor skills like physical intervention?

How can we move forward seeking "best practice", when we face such great challenges and "competition"?

Based on a professional career as a trainer since 1992, I want to share my opinions and experiences connecting the above questions. My workshop will also include practical demonstration of different techniques designed to manage challenging behavior. I will demonstrate optional techniques, with explanations on why and why not we think it is good solutions. Participants are invited to participate actively on both parts of the presentation.

About the author: Pål-Erik Ruud is based out of Norway and is the founder of Verge Training Inc (Verge Opplæring AS). Verge Training has 7 employees in Norway and 2 in Verge Eesti Oü (Estonia). They primarily work with psychiatric hospitals, nursing homes, children and teenagers with behavior problems, and schools. They deliver about 700 training days a year and have several hundred in-house instructors around the country. They have worked nationally but also internationally for many years.

Educational Goals

- The objective is to share experience and knowledge and make participants better able to reflect, ask questions, and evaluate 'best practice' in physical intervention.

Correspondence

Mr. Pal-Erik Ruud
Verge Training Inc (Verge Opplaering AS)
Hagalykkja 54
2080 Eidsvoll
Norway
ruud@verge.no

A Model of continuous professional development for instructors in the management of aggression & violence

Abstract

Background and Context: Work related violence is a serious problem within healthcare which diminishes the quality of working life for staff, compromises organizational effectiveness and ultimately impacts negatively on the provision of care services. While there has been increasing recognition that manifestations of aggression and violence vary greatly between and within services, what is clear is that staff may be affected irrespective of their work location, occupation, or department (McKenna 2004). There is compelling evidence that the extent of the problem within HSE DNE mirrors that replaced in national and international regulatory and research reports. (Mc Kenna 2004)

Recognition of the indisputable risks to service users and staff associated with the management of work related aggression and violence imposes professional, statutory, and moral imperatives upon organizations to provide staff with safe, effective and appropriate training. The provision of such training has been reported to reduce associated risks, improve staff effectiveness and result in cost savings from reduced injuries and related expenses. The provision of training should not however be considered solely in the context of risk alone. From a service perspective, the provision of compassionate and skillful care requires that staff are competent to recognize, assess, and intervene with individuals experiencing difficulty controlling their behavior McKenna K. (2006).

In 2004 the Health Service Executive, Dublin North East HSE/DNE, (then the North Eastern Health Board), conducted a thorough review of staff training in the management of aggression and violence from national and international perspectives which concluded that the provision of training lacked regulation and standards, and was a cause of concern from clinical and safety perspectives which mirrored reports by both professional and regulatory bodies internationally.

The HSE/DNE in response engaged extensively with clinical, professional, academic, and regulatory bodies, and developed the Professional Management of Aggression and Violence (PMAV), program. This program prepares healthcare staff from multiple disciplines as instructors who are competent to design and provide training which is needs assessed, service specific, fit for purpose, and responsive to the various manifestations of aggression and violence encountered within diverse clinical settings. An internationally peer reviewed study which paralleled the implementation of the program has demonstrated the safety and effectiveness of this response. In addition to being unparalleled nationally and, at the very least equaling best practice internationally, the program meets or exceeds all prevailing regulatory and professional standards in the management of aggression and violence.

While the program adequately prepares instructors, one aspect which remained unaddressed was the absence of a satisfactory structure and process by which instructors could demonstrate the ongoing professional competence and organizational effectiveness necessary for the continued performance of their role. Far from being a uniquely Irish or HSE/DNE problem, this issue reflected a broader absence of agreed standards and regulations governing this area of practice which has been highlighted internationally.

The customary practice had involved a proprietary organization providing an annual program of five days which reviewed exclusively the physical intervention component of the PMAV instructors practice. While of some benefit, the exclusive attention to the physical interventions, did little to develop the other professional, regulatory, organizational, and educational dimensions of the instructor¡s role. This historical practice, lacked formalized standards and evidence base within the Irish context, was of unproven effectiveness, and without investigation of the quantum of value added for either the instructor or the organization.

Considering the significant financial and human resource invested in recertification, there was an understandable realization of the need to undertake a cost-benefit review of the practice from the perspectives of both the instructors and the organization. This resulted in an organizational mandate to develop an evidence based best practice structure and process of instructor recertification which is fit for purpose, adds value for all concerned, and is defendable from organizational, professional and regulatory perspectives. The output of this work will provide recommendations which are robust enough to inform the formulation of an organizational policy in this regard, and achieve considerable and sustainable cost savings both in the short and longer terms.

Study aims and objectives: The aim of the study was to develop an evidence based, best practice structure and process of instructor recertification which is fit for purpose, returns value of investment for all concerned, and is defendable from organizational, professional and regulatory perspectives.

Specifically the study

Appraised prevailing practice with reference to national and international evidence based best practice.
Drew upon this appraisal to develop a revised model for recertification.
Prepared evidence based recommendations which are robust enough to inform the development of organizational wide policy and guidance in this area.

Study phases

The Study involved three distinct but related phases of work, which are outlined below.

Phase One: evaluated current practice with regard to the recertification of PMAV instructors with reference to national and international evidence based best practice. This involved a systematic review of subject related professional and regulatory literature. In addition to this literature review a series of focus groups was conducted with key stakeholders including instructors, service managers, corporate quality and risk, and performance development departments and representatives from professional and regulatory agencies. The output of phase one was an agreed *preferred future state* which adequately and equitably addressed the needs of all concerned.

Phase Two: drew upon this *preferred future state* to develop a draft structure and process of recertification in line with the project goal which was distributed to stakeholders for review.

Phase Three: involved the implementation and evaluation of the reformed structure and process of recertification.

Methodology

An action research methodology involving three cycles underpinned the study. Cycle one evaluated current practice through a collaborative engagement with stakeholders and developed an agreed *preferred future state* which adequately and equitably addressed the needs of all concerned.

Cycle two involved the development of a reformed structure and process of instructor recertification which reflected the stakeholder *preferred future state*.

Cycle three involved the implementation and evaluation of the reformed structure and process of recertification.

Presentation of Findings

- The congress presentation will:
- Discuss the challenges and potential involved in the ongoing continuous professional development and recertification of instructors.
- Present a proposed framework which structures the ongoing learning needs of instructors within a continuous professional development frame.
- Present the experience of implementing a revised instructor recertification program.
- Provide an opportunity for delegate engagement/discussion

Conclusion

The education and training of those who teach and support staff in the safe and effective management of aggression and/or violence plays a pivotal role in a properly integrated total organizational response. It is imperative that the trainers, staff, service users, and the organization have confidence in a process that delivers safe, effective training which reflects relevant and up to date evidence based best practice.

There is considerable financial and human resources invested in preparing instructors in the management of aggression and/or violence, and there is evidence to support the proposition that this can be done effectively. There is a considerable difference however in the challenge to establish the competence of an instructor in the first instance and the process by which their ongoing competence and practice is validated.

There is a need therefore for the perception of the instructor training as an *end point* producer of *instructors* to be replaced by an understanding of instructors as professionals whose practice should be held to standards of review, and demonstration of ongoing competence similar to other professionals. It is equally important that this shift in understanding is paralleled by the necessary evidence, standards and resources.

Implications

The implications for instructors, the organization, professional bodies and regulatory agencies will be discussed.

Acknowledgements

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Educational Goals

1. Participants will have an understanding of the importance, purpose and function of ongoing continuous professional development for instructors in the management of aggression.
2. Participants will have an understanding of the key components of a best practice model of continuous professional development of instructors in the management of aggression

Correspondence

Mr. Donal Mc Cormack
Child & Family Agency
20 Chord Road
000 Drogheda
Ireland
donaluna@eircom.net

Developing the Role of Clinical Nurse Educator for Behavioral Health

Paper

Timothy Meeks (USA)

Keywords: Clinical Nurse Educator, Behavioral Health

Caring for patients with serious mental health issues can be challenging even when nurses have the knowledge and tools to succeed. Treating patients with psychiatric disorders becomes more difficult when generalist nurses care for patients with highly decompensated psychiatric illnesses. The Healthcare Cost and Utilization Project estimates that approximately 51.2 million Americans, or 22.5% of the adult population, experience either a mental disorder, a substance use disorder, or both over a twelve-month period (Heslin, Elixhauser, & Steiner, 2012). Patients admitted to today's acute care hospitals for common health problems such as chest pain, hip replacement surgery and pancreatitis, are placed in medical-surgical acute care units, and cared for by nurses trained to work with general medical-surgical illness and recovery.

Most nurses who have chosen to work outside of psychiatry have not received post-graduate training in mental health. This deficit is heightened by the paucity of psychiatric content in nursing school curricula. When nurses who care for individuals with psychiatric diagnoses lack the necessary knowledge and skills, both patients and caregivers are at risk. Patients are at increased risk because nurses are not aware of potentially dangerous drug combinations and side effects. Patients with recent histories of self-harm are particularly vulnerable. Untrained nurses are vulnerable because they may use authoritarian or coercive approaches that could increase patient aggression (Daffern et al., 2010). Although most patients with psychiatric diagnoses are no more violent than the general population, a subset of individuals with severe mental illness can become assaultive to caregivers. Patients with substance use disorder, antisocial personality disorder, paranoia and persecutory delusions are noted to have increased rates of violence and aggression (Daffern, Howells, Ogloff, & Lee, 2003). To increase caregiver safety, hospitals must address the gap in psychiatry knowledge for medical-surgical nurses.

Background

Harborview Medical Center (HMC) is a large, public, 413-bed, level I trauma center in Seattle, Washington with a diverse, urban patient population. Harborview is committed to serving vulnerable, underserved individuals in the Pacific Northwest United States. HMC's mission population includes patients with mental illness, particularly those treated involuntarily. HMC has three inpatient behavioral health units with 66 beds to treat patients with primary psychiatric diagnoses. However, patients with primary medical diagnoses receive treatment on HMC's medical-surgical units, even if they have psychiatric co-morbidities. To insure that generalist RNs have adequate training to care for patients with mental healthcare needs, HMC began offering a twice-yearly, 8-hour continuing education course in 2014 on the fundamentals of psychiatric nursing. To date, approximately 180 medical surgical nurses have voluntarily completed "Contemporary Issues in Psychiatry for Medical Nurses." Although this educational offering has been well received, hospital leaders noted the need for additional real-time training and support.

Harborview has a robust psychiatry consult liaison (CL) service to treat patients with mental healthcare needs on medical units. This team includes psychiatrists, a social worker, and the Clinical Nurse Specialist for Psychiatry (CNS-P). CNS-Ps have a long-established role in mental healthcare delivery and the CNS-P is an integral part of the CL service at HMC. The RN in this role has a wealth of experience and knowledge, along with a well-earned reputation for providing effective clinical interventions for patients.

In a hospital, however, with more than 400 beds, the CNS-P's ability to provide immediate assistance to staff is limited. To avoid diluting the CNS-P's direct practice with patients, hospital leaders hypothesized that a Clinical Nurse Educator for Behavioral Health (CNE-BH) could provide focused attention to the nursing staff, providing real-time, bedside education for generalist RNs caring for psychiatric patients. In particular, leaders hoped that a CNE-BH could promote empathy for vulnerable patients with mental illness by modeling therapeutic behaviors.

Although the role of CNS-P is relatively common, the CNE-BH role is a novel one. A web search in October 2014 for CNE-BH produced one result—a job at a pharmaceutical company. Queries in jobs. ana.org, nurse.com, nursingjobs.com, healthcareer.com listed no jobs for CNEs in behavioral health or psychiatry.

Role Development

The CNE-BH was hired at HMC in October 2014. The successful candidate had seven years of experience in mental healthcare, teaching experience, and a master's degree in nursing. The primary responsibilities for the CNE-BH were described as follows: increase empathy for patients with mental illness, role model therapeutic interactions, and educate staff on standards of care for psychiatric patients.

Increasing Empathy

Promoting empathy for patients with psychiatric diagnoses involves shifting nursing attitudes. And while culture change can take years, subtle changes in nursing practice are already beginning to appear.

Case Example: Cindy was a 37-year old Caucasian woman with paraplegia and borderline personality disorder. She was admitted to 3North, a hospital medical unit, with a stage III pressure ulcer. Prior to admission, staff members at her skilled nursing facility had struggled with her aggressive and disruptive behavior. In the hospital, these behaviors intensified. 3North nurses became increasingly frustrated and began to request to not work with her. As staff empathy faded, Cindy demanded more contact. Cindy demanded to hold nurses' hands during hygiene and nurses felt that Cindy pulled on their hands placing them at risk of injury. When nurses declined to take her hand, Cindy refused all care. This power struggle continued for several days until the CNE-BH was called for consultation. "It's likely that the only time that Cindy gets touched is during hygiene. Cindy is isolated. She's undoubtedly lonely and craves engagement and contact with others," he explained. When phrased in this way, her attempts to quite literally reach out to others gained new meaning. Slowly, 3North nurses began to soften their approach. Within days, nurses volunteered to care for her. Shortly thereafter, Cindy's behavior improved; her outbursts decreased in number. Increasing empathy is a painstaking effort, modeled one patient at a time, but each effort produces measurable, positive effects.

Role Model

Role modeling effective, empathic therapeutic approaches is a primary responsibility of the CNE-BH. Promoting caregiver empathy has the added benefit of decreasing the potential for aggressive behavior. This is particularly important when working with patients who have been diagnosed with antisocial personality disorder (ASP) or have a recent history of violent behavior.

Case Example: Kyle was a 58-year old African-American man admitted to a surgical unit with an infection in a new amputation site. He had recently been incarcerated for eight months for assault. On the unit, he was a disruptive and sometimes scary presence. He tended to linger near the nurses' station and make demands. When his needs were not immediately met, he quickly escalated and threatened the nurses. The nurses had taken an authoritarian tone to set limits with Kyle, but their approach only served to escalate his already agitated state. After several calls to security services for assistance, the nurses consulted with the CNE-BH to determine how to deal with Kyle's disruptive and threatening behavior.

At the first meeting, the CNE-BH found Kyle at the nursing station yelling at staff. The CNE-BH asked to speak to Kyle in a more private space. Kyle continued to yell and make demands. The CNE-BH quietly said, "Kyle I'd like to help you, but it scares me when people yell. If you can lower your voice, I'd be happy to assist you." Kyle lowered his voice and apologized. The CNE-BH and Kyle walked away from the nursing station conversing in a normal tone of voice. The encounter allowed staff to witness effective limit-setting with an agitated individual, content that was new for nearly all of them.

During a huddle with the staff, the CNE-BH discussed the use of a relaxed, collaborative approach with patients with ASP. Nurses came to understand that the use of an authoritarian tone with a patient vying for dominance can ultimately lead to verbal or physical threats. Kyle's frequent outbursts at the nursing station were his attempts to establish dominance with his caregivers.

Before leaving the unit, the CNE-BH initiated a care plan that suggested a more collaborative approach with Kyle. The care plan included:

Caregiver Approach:
- Avoid coercion and authoritarian limit-setting styles. Using a firm tone with Kyle will probably result in refusal, opposition or aggression.
- Use humor, if possible. Irreverence is often useful when working with patients like Kyle. Be cautious, however, as humor can be misinterpreted.
- Kyle frequently asks questions of providers that they can't answer. Simply reply, "I don't know. Your social worker/case manager/doctor/etc. might be able to answer that. Is there anything that I can do for you right now?"
- Find the "soft spot." Everyone has something that is important to them. Try to find what is important for Kyle. It could be music, sports, motorcycles, tattoos, etc.
- If possible, talk about non-hospital related topics. This will help to normalize Kyle's experience in the hospital and improve rapport.

Providing Care:
- Avoid power struggles: Pick your battles. If the Kyle is refusing care, walk away and offer later.
- Be flexible: This is another way to avoid power struggles.
- Offer choices whenever possible. This is often the only way that you can give power and control back to Kyle.

De-escalation:
- Give personal space when Kyle is agitated. He has a history of assault and should be given ample room when agitated.
- Don't argue with Kyle. If he is having a hard time, just say: "You seem upset. I will come back when you're feeling better." Make sure to return when he is calm.
- Have tolerance for aberrant behaviors, when possible (yet another way to avoid power struggles).
- Avoid limit-setting and saying "no." Try to offer choices that are acceptable Kyle.
- Collaborate with Kyle, if possible. If he is disruptive or hostile, help him to identify alternate, safer, less disturbing activities when he is calmer.

This care plan had almost immediate positive results. Within two days, documentation on Kyle revealed that he was "pleasant and cooperative." No further assistance was required from security services. Although disposition for Kyle was initially difficult due to his disruptive behavior, social workers were able to find suitable housing for him when his presentation improved.

Standard of Care

Case Example: Marcus was a 23 year-old Asian-American man admitted to the hospital after sustaining multiple abdominal stab wounds. Background information on Marcus was scarce and details of the events prior to hospitalization were vague. Chart notes indicated that Marcus had choked his 14-year old brother while they were in the kitchen. The brother, in an effort to protect himself, grabbed a butcher knife and stabbed Marcus several times in the abdomen.

Nurses described his behavior on the unit as bizarre and oppositional: he defecated in his bed, then scooped up the feces with a plastic urinal and placed it on his bedside table; he often refused to speak; and he would not engage with the treatment team. Staff contacted the CNE-BH regarding Marcus's nonadherence to medical recommendations. On approach, Marcus was in his bed staring straight ahead; his gaze was wide-eyed and intense. He was holding his arms straight out in front of him with his hands clasped as if in prayer. After the CNE-BH introduced himself, he asked Marcus if everything was all right. Marcus stared motionless for what seemed like a full minute. He briefly looked at the CNE-BH and nodded yes. The CNE-BH prodded further: "Why are you holding your arms like that?" There was another long pause. Then, with his arms still outstretched, he replied, "Everything's ok right now. I am required to do this." When asked about this requirement, Marcus quickly glanced at the CNE-BH and confided, "I have to do this to save the world." Immediately, the CNE-BH realized that Marcus was exhibiting signs of psychosis. He recognized this particular behavior as a grandiose delusion. The busy nursing staff of this medical unit had been unable to accurately assess Marcus's behavior. Their untrained eyes saw a patient who was bizarre, oppositional, and defiant, not a young man who was psychotic and scared. The events prior to admission began to make sense. Marcus had likely attacked his brother because of paranoid delusions, not senseless aggression.

The CNE-BH used this patient story to teach about the hallmarks of psychotic disorders: disorganized thought processes, delusions, hallucinations, and paranoia. He educated nursing staff about the standard of care for patients like Marcus. At least for the short-term, Marcus would need antipsychotics until he was psychiatrically stabilized.

Because the CNE-BH cannot be at the hospital at all times, he developed educational handouts on best practices when working with psychiatric diagnoses. These evidence-based tip sheets serve as at-hand tools for the bedside nurse. Handouts were developed for psychotic disorders, bipolar affective disorder, borderline personality disorder, antisocial personality disorder, dementia, and delirium. These templates that can be modified based on the patient's presentation. Care suggestions are referenced so nurses can explore the primary source for further information.

Conclusion

The CNE-BH role has been in place for nearly one year at HMC and the triadic purpose has not changed: Increase empathy for patients with mental illness, role model therapeutic interactions, and educate staff on standards of care for psychiatric patients. It is believed the availability of a consultative psychiatric nurse specialist to support real-time nursing practice will improve not only attitudes and outcomes but also nurse satisfaction, safety and retention.

Disclaimer: In patient stories, demographic information and details of behavioral events have been altered to protect patient privacy.

Acknowledgments

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Educational Goals

Participants will be able to:
1. Describe how the role of Clinical Nurse Educator for Behavioral Health can decrease the potential for patient aggression.
2. List two tools that the Clinical Nurse Educator for Behavioral Health can use to teach non-psychiatric nurses how to treat patients with mental illness.

Correspondence

Mr. Timothy Meeks
Harborview Medical Center
513 E. Harrison St.
98102 Seattle
United States of America
timotm1@uw.edu

or

Timothy Meeks
325 Ninth Avenue
Seattle, WA 98104

How to train ourselves to assess the risk of violence ?

Poster

Anthony Djurkov (New Zealand)

Keywords: education, violence, ACTION model, Tarasoff situations

Abstract

Assessing risk of violence is a daily task and a mandatory skill for mental health professionals. In a team with different specialties including psychiatrists, nurses, social workers, occupational therapists, peer support workers and employment specialists using agreed assessment is crucial. We aimed to ensure that we had two consecutive discussions. The first discussion was to assess the current knowledge and the assessment methods used by different professionals especially in Tarasoff situations and to discuss the ACTION model introduced by Borum and Reddy (Behavioral Sciences and the Law Behav. Sci. Law 19: 375±385-2001). The second one was a follow up three months later to assess the impact of the first educational session on knowledge and clinical practice.

The poster will present the findings from both sessions and opinion about the effective educational intervention.

Educational Goals

- Understanding effective education
- Learning ACTION model to assess violence in Tarasoff situations

Correspondence

Mr. Anthony Djurkov
Te Rawhiti CMHC
15 Aberfeldy Ave
2010 Auckland
New Zealand
djurkov.anthony86@gmail.com

Violence in health and social care settings training resource package: A multicenter evaluation study.

Joanne Skellern, Tibor Ivanka & Marie Treslova (UK)

Keywords: Violence, aggression, training, evaluation study, multicenter

Abstract

Violence within health and social care settings is now established as a major international concern, attracting the attention of Governments, intergovernmental agencies, nongovernmental private sector associations, policy-makers, scientists and researchers. Organizations are required to develop effective strategies for the prevention and management of violence and aggression perpetrated by patients/service-users (NHS SMS, 2009). Whilst many organizations, agencies and individuals have sought to provide training programs to reduce workplace violence and aggression experienced by health and social care professionals, there is a paucity in the research conducted to establish the validity of the programs (Needham et al., 2005).

The aim of this study was to establish the effectiveness of the Violence in health and social care: A training resource package (Skellern and Lovell, 2013).

The specific objectives were:

1   To establish how participants have felt after dealing with patients/service-users who are violent/ aggressive.

2. To assess if participants feel more confident to deal with patients/service-users who display violent and/or aggressive behaviors after undertaking the training session.

3. To assess if any increase in confidence experienced by participants following the training session is sustained following return to the workplace.

4. To collect participants general thoughts on the design and delivery of the training resource package.

5. To ascertain if the training resource package is transferable to other countries.

Three sessions using the training resource were each held at the University of Chester (UK), the University of Debrecan (Hungary) and the University of South Bohemia (Èeské Budìjovice) concurrently. 15-25 staff members currently employed within organizations offering adult mental health and learning disability and/ or social care services attended each session.

Data was collected prior to each session using the validated Impact of Patient Aggression on Carers Scale (IMPACS), (Needham et al, 2005), the validated Confidence scale (Thackrey, 1987) and the Eysenck Personality Questionnaire revised - short form (EPQR-S), (Eysenck et al., 1985). Data was also collected immediately after undertaking the training session and three months later when participants repeated completion of the confidence scale. Additional data was gathered through facilitation of semi-structured focus groups involving 10 participants, who had attended one of the three training sessions held in each center, in order to collect their views on the training resource package and its delivery.

Data analysis was conducted with the assistance of the statistical computer package, SPSS. The data from the psychometric response scales was subjected to factor analysis to identify variance and the loadings of each factor. Data from the focus groups was thematically analyzed using the framework offered by Braun and Clarke (2013).

The preliminary findings of the multicenter evaluation study of the Violence in health and social care training resource package are presented within this poster.

Educational Goals

- It is intended that visitors to the poster will gain an awareness of the Violence in health and social care settings training resource package (Skellern and Lovell, 2013) as an available training tool and knowledge of its effectiveness in providing training for staff in alternative approaches to managing violence within the workplace.

Correspondence

Ms. Joanne Skellern
University of Chester
Warrington Campus
WA2 0DB Warrington
United Kingdom
j.skellern@chester.ac.uk

How we train staff to avoid violence in forensic milieu therapeutic environments

Paper and poster

Thor Egil Holtskog (Norway)

Keywords: Simulation, Staff training, Forensic psychiatry, Violence, Milieu therapy

Abstract

Training and securing nursing groups in regional security department (RSA) includes many challenges. At RSA , psychiatric observation, evaluation, security and treatment is our job. RSA Helse Sør-Øst is one of three highly specialized services in Norway. RSA, Helse Sør-Øst has responsibility for nearly half the population (2.85mill./5.1mill.). 3 clinical units; Intensive Psychiatric inpatient Unit, Security Psychiatric inpatient Unit, and the Forensic Psychiatric inpatient Unit. In these units 7-9 staff members is locked inside with 5-6 patients. The environment is very much like prisons. The community, staff and other patients must be protected against the high risk of violence. Treatment is based upon milieu therapeutic principles. This is complicated because of the measure, use of restraint and often aggressive communication. De-escalation, security thinking and teamwork skills is central. The Personal group at RSA consists of approximately 170 employees, of which approximately 140 work inside the three units, and these are targeting for the education/training program. 10 to 20 participants train 45-60 minutes every Tuesday. Most often in two parallel teaching groups at our training center in the basement. Mostly 2 x 10 employees every Tuesday. With special focus on environmental staff and developing their practical skills. On Thursdays we arrange more general theory lessons.

SIMBA (Simulation Training in Treatment of Aggression) is Regional Security Division Helse Sør-Øst' s (RSA) program for education, training and education of employees who work with patients in our clinical units.

Practical skills training is adapted to a form where simulation of challenging scenarios is the starting point. It is believed to provide greater learning if the participants are physically involved, more than just reading about the challenges, or be lectured to. When working in the Norwegian forensic psychiatry, non-technical skills such as working together in teams, interpreting situations, and decisions in crise situations is especially important. These skills we believe is developed best at training and followed by structured monitoring in analyzing focus groups immediately after (Bjerklund, 2014), based on theory and model after the SIM training principles(www.simoslo.no).

The treatment is based on a high degree of human relationship within the physically secure environment. Several forms of therapy is used, but mainly pharmaceutical therapy, psychoanalytic therapy and nursing based milieu therapy. This can be called forensic psychiatric milieu therapy, unlike other milieu therapy, as the guardian role is a big part of the therapist's role. A number of dangerous situations can occur. We therefore consider it important to continue basic education and training in various scenarios with agitated and aggressive patients, often unstable when arriving the unit. This patient group provides a variety of challenges when they in addition to individual differences have different diagnoses and therapy requirements within the same unit. New employees follow training programs for various professional groups, going through a five days structured program plus buddy system.

What do we train ?

Scenario simulation training(www.simoslo.no). Communication, de-escalation, teamwork and leadership is central. Here it is particularly the personalized educational review after scenario that focuses on the specific learning objectives.

Protecting skills. Staff training on physically protecting themselves against damage from violent attacks. This means no active countermeasures that will inflict patients pain or injury. It's about the first seconds when an attack occurs, next seconds the colleagues should be there.

Restraints. Theoretical and physical review of important principles using the "holding and "mechanical restraints". Practical exercises, theory, demonstration and coordination .

Reflection groups. Led by current resource persons or teaching group's instructors.

Security thinking and skills. Education and training in search of space and person. Prevention of dangerous situations for both patients and staff.

SIM-theory. Tuesday theory is based on e-learning courses you can find on the website, CRM, Medical Simulation and Debriefing. But also the law, de-escalation techniques, warningsigns and expected behaviour. This is small groups, 6-10 persons(www.simoslo.no).

Theoretical sessions for all employees (Thursday sessions). Different actual themes, mainly disease, theory and treatment. Research and external resources.

Motivation and continuation

Beyond the technical content there are two other issues that is very challenging, and worth elucidating. This is the implementation of training and establishment of motivation among employees, and to keep the program continuing. In several periods over the last 25 years the current form of training has extinguished and the activity around it has been almost absent., the staff probably accepted that we work well enough without. Training without adequate structure has also been shown to provide more injuries and challenges than we can accept. Rationale then has probably been that they will use the energy on other tasks.

A passive period was the situation in 2008, when an educational action research study was used to develop our teaching structure (Garborg, 2009). Participation was in focus throughout that study; democracy, active participation and learning to discover important knowledge yourself. Participators described in a log scheme after every training and then we could modify the training to match our staff's needs. This is the way we do it also now. The teaching group analyzes logs every 4 months, adjusting teaching and trying out new measures based on the feedback we get from the participants.

Implementation follow up every Tuesday with detailed planning, organizational choice of instructors and participants, venue and program, is a necessity for everyone to get the necessary training and education. In addition, the department's management wanted an action research project that can give clear knowledge of what we should do next to have the best possible professional standards, and prevent training being abandoned for various reasons.

Simulation of situations have been the main content of teaching at RSA since more than 30 years ago. But the SIM model is a quality-assured educational tool, we found great benefit in adapting ourselves to this. We tried it and converted the model for use in psychiatric wards.

Medical simulation in psychiatry

Oslo University Hospital has a simulation and training department at Ullevål Hospital. This serves as a training unit where the simulation of both medical and psychiatric scenarios trained on, and is particularly facilitated with SIM teaching methods. (www.simoslo.no)

In the initial phase of the project, we received guidance on implementing SIM Oslo's model of teaching. Several key personnel were sent to SIMOslo. RSA has since been developing our program after this educational principles of SIM Oslo. In scenario training participants will not longer be playing roles, but be themselves at work as a real team. This focus has given us greater flexibility in the choice of methods for dealing with violence risk and we also train in different solutions. And it becomes more understandable that you actually need to exercise to possess the skills we need in daily clinical practice. Individual safety will turn into common safety by such training.

The Instructors

We are a teaching group consisting of 6 instructors from all units at RSA, in addition to the leader of the group, a research person and a professional educator. Everyone with clinical positions.

The instructors attended education in SIMOslo. This course is an educational course "Train the Trainer", where they are taught and trained to become instructors and to facilitate personal learning and development of the participants in their group(www.simoslo.no).

Leader of the education group has a 20% position to organize teaching. He watch individual lessons every Tuesday in relation to use instructors who are at work, whether we should have one or more groups in education, and who should be on training from the three units.

The Registration

All participants will be registered for the record of who has participated in wich teaching, who has which roles in scenarios. Like being patient contact and leaders often are leaders in the scenarios, while the instructors themselves often play the role of patient. It is also important that all participants is registered because the employer is obliged to provide important and relevant education and training to employees (Arbeidsmiljøloven.§ 3-2).

Participant Involvement

We place great emphasis on participant involvement in teaching. All participants will write its log for all teaching. Through the use of logs, participants are made aware of in terms of what they think is meaningful and relevant teaching and we get feedback on each participant's thoughts, feelings and experiences in relation to the attending; we ask those concerned. (Hartviksen & Kversøy, 2008)

The logs are summarized after each teaching session and collected as data, to adjust instruction according to participants needs. And participants are allowed to participate in the further development of teaching and experience a meaningful and relevant training in relation to their clinical work with patients (Garborg, 2009) Data from history, from studies and experiences (Holtskog, 2011) suggests that the interaction between the less experienced and the experienced is of great importance. It is a challenge to facilitate so those with little experience as quickly as possible to gain knowledge of by those with the most experience. And it is a challenge that these experienced can experience it as unnecessary to participate in teaching when they believe they do not need it at the moment. This also means that we focus on training more than pure teaching. We plan and organize so that well experienced staff joins more inexperienced staff. Participants can learn from each other. By simulation training the experienced could train directly with the less experienced and learning will be meaningful for all participants. The learning curve by "from novice to expert" (Benner) can be shortened slightly. A high enough level of interaction with individual safety as the basis for a collective safety, means that staff are staying longer at their working place, and joint training, we presume gives a positive circle of where patients can also take part in this safety.

The practical simulation and how to continue

We have developed our own teaching template, but now based on SIMOslo principles (www.simoslo.no). In order to adapt the teaching program to our needs, we have booked it all down from 2 hours workouts to 45 minutes. Training and education takes place in the changing of the teams on Tuesdays. We must take personnel from the clinic. The SIM center at RSA is where all scenario-training takes place. This center consists of several rooms that can be used separately or linked together as a smaller or larger unit depending on which needs we have. Some of the teaching is also done in an athletic hall. Staff can be back in the units in seconds if necessary. Noise or disturbance will not disturb patients. Several finished scenarios is ready, so that instructors who are unable to prepare can use one of these. New clinical challenges and new scenarios will be created as the need appears. The scenario itself last 5-8 minutes. The following debriefing use to last 40 minutes.

Structured debriefing (www.simoslo.no) is led by instructor. First with a short session in relation to what actually happened. Then analysis phase with a focus on learning outcomes. Each participant is asked what he or she did that was good. What assessments were made along the way? What could have been done differently? At this stage it is important to focus on the positive so that participants are experiencing coping. When adverse events in the scenario the instructor during the debriefing ask questions like: Can you offer suggestions for better ways to do it? What could have made the situation more transparent? Do you know other characteristics of good communication? How do you think the patient experienced the situation? Feedback shows that the participants experience this as very instructive. The instructor concludes with a summary and participants then writes comments in preprinted sheemes.

Student Teaching is done in cooperation with the College of Oslo and Akershus on a special training that is largely built on a simplified version of SIMBA. Teaching cycle follows here the students practice periods. Students get not initially participate in the department's other SIMBA training. Because we do not find space for this.

In the future

We continue to focus on participant involvement and to keep up the variety in teaching so that staff will want to participate. A big challenge so far has been the weekly follow-up, we see that the individual units have prioritized other tasks at the planned teaching time. At the beginning of the project we experienced often that meetings and other were added at teaching time by management so that teaching was canceled. We also have a focus on why training is important, and that it is mandatory. This has been pointed out and will probably have to be monitored routinely.

The aim of the action research project has been to develop teaching methods allowing participants on training should experience a relevant and meaningful training / coordination training, in relation to their clinical work with the patients. Whitehead and McNiff 's criterias for action research tells that the end of the research work will be beginning of a new one (McNiff & Whitehead, 2009). The project is the beginning of a process where the road ahead would be developing the SIMBA programme this way at RSA Helse Sør-Øst.

Cooperation with SIMOslo, based on European SIM has proved to be very useful for us. We get a lot of free pedagogic knowledge and we are now cooperating with several county-wide hospitals about our psychiatric training model where we both give and receive.

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2 educational goals for the participants of your presentation

1. How we train teamworking skills to avoid violence in a forensic psychiatric unit.
2. How we keep up motivation and practical training for the staff every week.

Correspondence

Thor Egil Holtskog
Research coordinator/ psych.nurse/Msn
Oslo University Hospital
Department of Mental Health and Addiction
Center for National and Regional mental Health Service
Regional Department for forensic and Security Psychiatry
Sykehusveien 18
1385 Asker
Norway
UXTHLT@ous-hf.no

SIMBA – a staff education and training programme in forensic milieutherapeutic environments

Poster

Mr Thor Egil Holtskog (Norway)

Keywords; Simulation, Staff training, Forensic psychiatry, Training center, learning curve

Aim

To develop a training and education programme that imorove the knowledge and skills for employees working at a high security hospital.

Challenges

The employees is supposed to train every week on different challenges.

3 clinical units; Intensive Psychiatric inpatient Unit, Security Psychiatric inpatient Unit, and the Forensic Psychiatric inpatient Unit. In theese units 7-9 staffmembers is locked inside with 5-6 patients. The environmentals is very much like prisons. The community, staff and other patients must be protected against the high risk of violence. Treatment is based upon milieutherapeutic principles. This is complicated because of the measure, use of restraint and often aggressive communication. De-escalation, security thinking and teamwork skills is central. The Personal group at RSA consists of approximately 170 employees, of which approximately 140 work inside the three units, and theese are targeting for the education/training program. 10 to 20 participants train 45-60 minutes every Tuesday. Most often in two parallel teaching groups at our training center in the basement. Mostly 2 x 10 employees every tuesday. With special focus on environmental staff and developing their practical skills. On thursdays we arrange more general theory lessons.

Experienced workers is supposed to learn less experienced collegues their skills. Everyone have to be good together because the working in this units is very much about teamwork together with patients that have done dangerous things and milieutherapeutic principles have to balance with high security thinking.

Our training center is inside the main building. Our staff members can be back in the units in seconds if neccesary.

This model contents different training programmes

*   Scenario simulation (SIM)
*   Restraint use
*   Protecting skills
*   Reflection groups
*   Security thinking and skills
*   SIM-theory
*   Theoretical sessions
*   Registration and logistic
*   Who is training on what?
*   What do the leaders want?
*   What do the participants want?

Educational Goals

1. Raise the level of non tehcnical skills in the staff group
2. Train deescalation in teamwork

Correspondence

Mr Thor Egil Holtskog
Oslo University Hospital
Sykehusveien 18
1385
Asker
Norway
uxthlt@ous-hf.no

Education Experiment: Short Time Education – Long Time Results for PracticePaper

Jaroslav Pekara, Marie Trešlová, Lidmila Hamplová

Keywords: Education. Violence. Nurses. Nurses' assistants. Prevention. Seminars.

Introduction

The problematic of violence in the Czech health care area is prominence four big projects (three projects run, one is currently running) but particularly via medial news. The first big project is focused only on verification of violence in the health care area run in 2004. The study found that violence in the healthcare system in the CR is a serious problem. 42% of staff members had experience of verbal violence and 13% staff had experience of physical violence. In 2010 there was another research project realized. This project had two parts. The first part of this project was the research (Czech-Moravian Confederation of Trade Unions, the project: Prevention of Violence in Health and Social Systems in the CR in 2010 which detected that the physical violence was admitted in 17% and the psychological violence was admitted in 41% (mobbing, sexual harassment, bossing and racial harassment). The numbers of violent verbal attacks was similar to the numbers of violence attacks shown in the projects of the year 2004. The incidence of physical violence was even higher.

From the first project (2004) some things were improved (measures associated with the safety and occupational health screening and patient) but there were still persisting deficiencies in the work environment, human resources development, increasing staff numbers, or staff training in communication skills. Even though 6 years passed from a similar project, the main problems remained the same: overworked staff, non-professional communication and unawareness. Both of the projects confirmed also non-professional behavior staff which was the trigger of conflicts with patients. The second part of project from 2010 was focused on education of 1004 staff members (one day in the management of violence, two days in communication skills, and two days in physical self-defense). Unfortunately minimum people of the 1004 persons didn't repeat the knowledge gained and lecturers weren't experts or they had minimal experience with problematic of violence.

Within the above-mentioned time, other studies about violence in the health care system in the CR were carried out. Unfortunately, these research undertakings failed to contain valid data and the numbers of respondents were too few [1]. In the years 2011-2013, another big educational project for medical staff in CR was performed. The project was unique in its practical approach. It was the only educating project without quantitative research, but a great emphasis was placed on the quality and experience of the lecturers. In total, 1948 staff members in the health care were educated in 26 seminars and 9 conferences. In this project, a mini project was included. 550 healthcare staff members from the hospital in the town of Jihlava were educated in the approach and communication with aggressive patients or their relatives [2].

Methodology

550 healthcare staff members (nurses and nurses' assistants) from the hospital in the town of Jihlava were educated in the approach and communication with aggressive patients or their relatives. Nurses (N) and nurses' assistant (NA) were educated during 14 seminars (seminars was taking place eleven months). One seminar was for max. 40 staff members and took 120 m. The main goal of this mini project was to find out the possibilities of staff members education in the health care area in a short time period and to present them the key skills in approach with aggressive patients. There was the evaluation made after 12 months from start of the mini project. Seminars were unique not only with evaluations but also with the own contain (impact by experiences, influence by emotions and infinite number of really situations).

Seminars implemented during the year 2012 (last seminar implemented in November 2012). Every seminar took 120 min and maximal 40 N and NA participated on them. The most important was to motivate the trainees for their home preparation of the seminars. The course of seminar was interactive and involved all N and NA continuously. The seminar used role play, prepared like a story of patient who came to the hospital. All seminars were guiding via one lector (an expert in prevention on violence in the nursing in Czech Republic—seven years' experiences in study in prevention of violence, five years' lecturing experience with verbal self-defense and experience in a mixed martial arts). Lector interpreted the story about patient who found a lump in his armpit and he went to the hospital—ensued many situations cross

the ambulances, wards, expect of laboratory and histology examinations. In every situation were projected staff-patients conflicts—this conflicts we gained by the interview with head of N and NA of hospital Jihlava before preparation of seminars.

Lector performed role of patients (man, woman and their generally different perception by hospitality) like an actor. In every conflict situation lector at first played the conflict and then he came back and then N and NA tried to make the analysis of the conflict, to explain key factors of the conflict and to change conflict conditions. Lector performed by resolution in every situation like a mediator and constantly was remembering other side of the situation—patients' emotions. The analysis and the try of N and NA to resolve the situation is very important in an effective feedback and this method is crucial for to remember and understanding the whole situation (critical thinking). This method enables to keep in mind the gained information and to use it in the practice later on. The main instruments for to resolve conflicts was recommend: the professional communication—lector showed and recommended easy techniques to deescalate conflicts: introduce itself, open questions, the mirrors technique—talking about emotions (I can see, I can hear, I can feel); absurd theatre; comment whole dealing, using positive words ("we" than "you"); using compliment to patients or interpreting patient's anger to lower level. There was put a big emphasis to the simplicity particularly to the communication techniques so as the techniques trained in practice [3].

The author determined two hypotheses at the start of the mini project:
Hypothesis 1: Is there possible to educate the larger group of N and NA in a short time period?
It is possible to educate bigger group N and NA in a short time period.
Hypothesis 2: Gained communication techniques are possible to train by own self in a practice.

Results

The main condition of evaluations was a sufficient time interval (the author preferred minimal six months). The last seminar was held in November 2012. In July 2013 the questionnaires were sent to the Jihlava hospital to 550 educated N and NA. The questionnaires were sent back after next six months (in November 2013). Then the questionnaires were evaluated.

The author sent 550 questionnaires; the payback was 42% (239 questionnaires were right fulfilled). Our group was composed of 91.9% women and 8.1% men. Most of the respondents were from 25-54 years old (80.7%), 17.6% were in an age average 55-64 years old and 1.7% was in an age average 15-24 years old. From the viewpoint of education level of group participants 75.8% had a secondary school (graduation) 15.5% had college education (non university), 5.9% had a master degree and 2.7% had only primary school education. The largest groups of our respondents were women in average 25-54 years old with secondary education (college—non university). A lot of respondents were from children's department (13.4%), dispatching of nurse's assistant (12.9%), ICU (11.2%), emergency (5.4%), and most of the respondents were from internal medicine (28 %) and surgery department (29.1%).

Table 1 Age and education degree of respondents

Gender (n = 239)	men	8.1%
	women	91.9%
Age (n = 239)	15-24 years	1.7%
	25-54 years	80.7%
	55-64 years	17.6%
	65 and more	0.0%
Education (n = 239)	primary school	2.7%
	secondary school	75.8%
	college (non university)	15.5%
	master degree	5.9%

Table 2 Department of respondents

department (n = 239)	
children	13.4%
dispatching of nurses' assistant	12.9%
JIP	11.2%
internal medicine	28%
surgery	29.1%
emergency	5.4%

In the evaluation the author work on the most interesting results and the author tried to verify our hypotheses. 63.6% respondents evaluated seminars as "great", 36% as "good" (men and respondents of average age 55-64 years old evaluated seminars less positive).

"Necessary for practice" evaluated the seminar 55.2% (more respondents of average age 55-64 years), 40.6% evaluated the seminar as required for practice. The most often contribution who respondents evaluated was a "development in communication with aggressive patients", "practical examples of de-escalation", "easy physical touch" (easy for staff and respect for patients—safety touch). For 64.5% respondents the used methods (communications techniques) were "very appropriated and contributed" (particularly respondents of average age 55-64 years), for 34.2% respondents "appropriated". 130 respondents attached own commentary from which emerged that respondents were satisfied with the good chosen situations, lector's approach and the guidance of seminar—lector like an actor in many situations, his humor and effective feedback by an analysis of model situations. 90.7% respondents were satisfied with time period of those seminars, 9.3% respondents would want the seminars longer the next time.

The key finding was how the respondents used communications skills in practice after 12 months. 50.6% respondents used communication techniques successfully in their practice (most of the group in average age 55-64 years). 9.6% respondents tried communications techniques but unsuccessfully and 39.8% respondents had no any opportunity to resolve conflicts. Respondents used most often the communicative skills by resolve conflicts with relation with patients (30.6%) and by contact with aggressive patients (19.4%); next successful finding was detected by de-escalation conflict with superior staff (medical doctor, head nurses) and in respondent's private life (quarrels with neighbors or with children). It was found out that the respondents who tried the using communication skills in practice they had a higher courage and self-assurance to the next conflict resolutions (particularly respondents with master degree). Despite of initial unsuccessful use of communication techniques in practice by half respondents of the group 71.1% respondents want to use the techniques by conflict resolution in the future; 24.2% respondents hope to use the techniques by conflict resolution in the future.

On the basis of the found results the author can constant that both of our hypotheses come to fruition. The highly positive discovery was 81.3% respondents would want to take part in the next subsequent seminars.

Conclusion

People learn in different ways: 10% out of what the author read, 20% out of what the author hear, 30% out of what the author see, 50% out of what they both see and hear, 70% out of what the author discuss with others, 80% out of what the author experience personally, and 95% out of what the author teach to someone else [4].

The health care area in the Czech Republic registered a huge opportunity to educate member staff in the hospital area during projects from year 2000. Also there is increased number of books who are aimed to improvement the communication between medical staff and patients [5]. Majority of the project was only held as a day lecture and many medical staff doesn't have any time for reading special books for improvement of communication.

The experiences show a lot of seminars for medical staff to improve communication have not a good contribution for practice. Thanks to the project the author could prepare a mini project. The author would like to prepare seminars in cycles which would reflect the most often mistakes of the previous projects and experiences from currently education actions which aimed to de-escalation of aggressive patients. The author prepared education seminars for 550 nurses and nurse's assistants and the author would like to demonstrate that it is possible in a short time period to educate them in an approach to aggressive patients

(the only important interventions are the communication skills) which will be possible to repeat directly by the contact with patients or with their relatives. The author did special education seminars and after 12 months the author controlled our results.

The author proved that it is possible to educate very effectively the staff members in a health care area during a short time period (120 min for one seminar). The author created special education model for educating staff members in a health care area thanks to the gained skills to train them individually by direct contact with patients or their relatives.

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Correspondence

Jaroslav Pekara
Vysoká škola zdravotnická, o. p. s.
Duškova 7
Praha 5
150 00

Staff Training for the Management of Violence: Incorporating Staff Attitudes and Self-Efficacy in Clinical Training

N. Aasdal & T. Wøbbe (Denmark)

Keywords: aggression management, attitudes, self-efficacy, staff training.

Background

Violence risk assessment and staff training in the management of assaultive behaviour are crucial interventions for violence by hospitalized forensic patients. While systematic risk assessment has been an important part of managing violence risk for many years now, the application of these instruments to guide clinical interventions has been neglected, as has specific training for the management of anger and violence. Staff training, which is now a universal practice, in managing patients' aggression and violence is focused on mechanical restraint techniques (Duxbury & Paterson, 2005), and insufficient attention is given to staff clinical skills in managing anger and the disposition for violence.

The management of anger and violence is a product of knowledge, skills and attitudes and requires regular updating via training. The different attitudes towards anger and violence influence how both are managed in critical situations where staff choice of method and behaviour comes into play (Foster et al. 2007; Duxbury, 2002). The internal attitude model views patients as the cause of aggression and violence and justifies thus medical treatment, restraint or seclusion of aggressive patients. The external model focuses on environmental factors, such as the ward atmosphere and the staff, and requires therefore various interventions in the management of patients' aggression.

The situational/interactional attitude model incorporates the internal and external factors and refers to the context of the aggressive behaviour (Duxbury, 2002; Duxbury & Whittington, 2005).

Research has shown a limited effect from training programs on change of attitudes in staff members, nevertheless a revision of training quality is recommended (Hahn et al. 2006; Abderhalden et al. 2006).

Furthermore, staff's perception of own competencies in managing risk of violence has been insufficiently studied. The psychological construct of self-efficacy is related to work performance in general (Bandura, 1977) and can effect staff's behaviour and choice of strategies in the field of violence management. Therefore, comprehensive and targeted staff training in aggression management can potentially target attitudes and strengthen self-efficacy (Colabro et al. 2002) and result in lasting improvements of attitudes, knowledge and self-efficacy in managing anger and violence.

Aim

The aim of this paper is to understand which role attitudes about violence and staff's self-efficacy play in the management of anger and violence in a forensic psychiatric ward. The general hypothesis is that attitudes towards aggression and violence and staff's self-efficacy are related to the level of knowledge and skills in managing aggression and violence. In this context, the particular research questions are: (a) To which extent are staff´s attitudes, self-efficacy levels and the amount of training in violence management that staff has received related to each other? (b) How do staff´s attitudes correlate with the level of patients´ aggression and violence in a forensic ward?

Method

A questionnaire consisting of socio-biographical items (age, gender, received training, and years of professional experience), the Danish version of the Management of Aggression and Violence Attitude scale (MAVAS) and the Danish version of the New General Self-efficacy Scale (NGSE) will be distributed to all staff members in the three units of a high security hospital, with anonymous responding. The MAVAS is a high validity and reliability scale (Duxbury, 2002) incorporating 27 statements about causes of violence and approaches to its management; the NGSE is, in turn, a scale consisting of 8 items targeting

ones confidence to perform effectively has demonstrated high reliability for a variety of tasks in various contexts (Chen et al. 2001).

Data from the Staff Observation Aggression Scale – Revised (SOAS-R) will be used to outline the level of aggression in different wards for the last 12 months. Research finds that SOAS –R is a valid and reliable instrument for monitoring the frequency, nature, and severity of aggressive incidents (Nijman et al. 1999).

Pearson correlations will be used to examine specific relationships between continuous variables. Data will be analysed using Poisson regression, with SOAS-R as the dependent variable and the mean score of all staff at the ward of the two predictors (MAVAS and NGSE) as continuous predictors.

Results

Are not yet produced.

Conclusions

The long-term goal of this research is to design a specific training program for staff, addressing the core competencies and attitudes needed in manageme nt of aggression and violence in the context of forensic psychiatry.

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Correspondence

Aasdal, N. & Wøbbe, T.
Mental Health Centre Sct. Hans Boserupvej 2
4000Roskilde Denmark
E-mail: Neringa.aasdal@regionh.dk

Chapter 20 – Other related themes

Professional Commitment and Intent-to-Leave: A moderated effect of violence prevention climate

Poster

Yuan-Ping Chang & Hsiu-Hung Wang (Taiwan)

Keywords: professional commitment, intent-to-leave, workplace violence, violence prevention climate

Abstract

Insecure working environments caused by both workplace violence and staff shortage-derived work overload have seriously impacted the quality of nursing care. This study investigates links between violent incidents in the workplace, hospital-wide violence prevention attitudes and nurses' environments. A cross-sectional survey was used to recruit 973 participants. Participants were full-time hospital nurses in southern Taiwan. In addition to demographic information, the workplace violence checklist was used to collect and analyze nurses' experience of workplace violence and the frequency of violent incidents. The violence prevention climate scale was used to examine institutional policy and practice towards workplace violence. The professional commitment scale and intent-to-leave scale were used to determine nurses' professionalism, loyalty, and their desire to stay on or leave the profession. The SPSS 19.0 and the AMOS 19 software program were used for all analyses.

Results showed that 65.8% (n=640) of surveyed nurses have encountered workplace violence. Of those, 42.5% (n=272) have contemplated, following the incident, leaving the nursing profession. Patients committed the largest number of violent acts, followed in descending order by members of patients' families, nurse colleagues, doctors, and other medical professionals. However, only 18.4% (n=179) of the individuals encountering workplace violence officially submitted a written report to superiors or healthcare organizations. Of the surveyed, the average scores (total score = 5) for professional commitment, violence prevention climate and intent-to-leave were mean and standard error at 3.35 (0.58), 3.14 (0.59), and 2.85 (0.73), respectively. Professional commitment showed a negative correlation with intent-to-leave (r = -.382, p < .01); professional commitment demonstrated a positive correlation with the work environment fostering violence prevention (r = .60, p < .01). Through hierarchical regression analysis, it was clear that factors strongly influencing nurses' intent-to-leave included age, the number of times experiencing direct violence or witnessing violence, the night shift nurse-patient ratio, violence prevention climate scores, pressure to perform unsafe medical practices, and work frustration. Total variance explained by the model is 21%. The relationship between professional commitment and intent-to-leave, the frequency of workplace violence (q2 = 7.778, p < .01), experience with workplace violence (£q 2 = 5.424, p < .05), violence prevention climate (£q 2 = 12.893, p < .01), and night shift nurse to patient ratio (£q 2 = 4.439, p < .05) all exhibited statistically significant moderating effects. This study confirms the moderating effect of the relationship between professional commitment and intent-to-leave of nurses. It is hoped that by strengthening professional knowledge, improving human resources management, and establishing a friendly rapport among nurses. The congenial workplace, interactive workforce, adequate learning environment, and supportive supervisory staffs are all critical factors for nurses to remain in the job.

Educational Goals

- Nurses will be able to recognize what workplace violence is?
- Nurses will be able to analyze the risk factors of workplace violence and the critical factors for nurses to stay in the job.

Correspondence

Ms. Yuan-Ping Chang
DaYeh University
168 University Rd., Dacun,
51591 Changhua
Taiwan, R.O.C.
cyping@mail.dyu.edu.tw

Violence and Mental Illness from an US Perspective

Paper

Murali Rao (USA)

Keywords: Mental Illness, Violence, Alcohol and Substance Abuse, Guns, USA

Introduction

Violence is a major public health problem worldwide. Each year, millions of people die as the result of injuries due to violence or live with permanent disabilities. Violence is a leading cause of death among people aged 15-44 years worldwide, accounting for 14% of deaths among males and 7% of deaths in females (2). According to The National Violent Death Reporting System (NVDRS) comprised of violence surveillance data from 32 states, more than 39,000 people died by suicide in the United States in 2011; Homicide claimed another 17,000 people (4). Violence is preventable and we know these numbers can be lowered. Reviewing mass shootings in US over last several years committed by those mentally ill, there is a large concern, and sometimes misperception about mental illness and violence (18).

Prevalence of SMI in US:
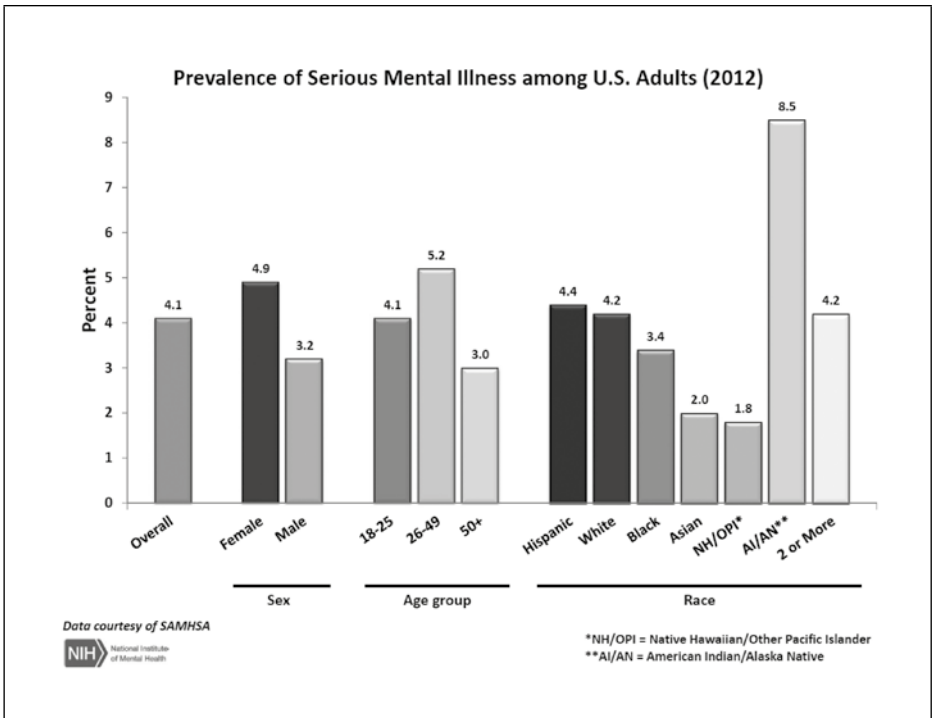
In April 2013, the American Psychiatric Association (APA) formed the Coalition on Mental Health and Violence Issues, which includes organizations representing psychiatrists and the American Medical Association, to promote better public awareness of the complex sources of violence in the United States and to recommend strategies for improving mental health care. The Coalition was convened under the leadership of then president of the APA, Dilip Jeste, MD, and included the AAGP (22). The Coalition emphasized that only three to five percent of all violent crimes are directly related to mental illness, and

that people with mental illnesses are much more frequently victims rather than perpetrators of violence. According to Thomas Insel, M.D., director of the National Institutes of Mental Health, "suicide, not homicide is the most urgent public health problem associated with gun violence" (23). About 90% of suicides involve individuals with mental illness, but only 5% of homicides (24). Dr. Insel further stated that only 6% of violent crimes were committed by someone with a diagnosed mental illness (23).

Mental health

Although mental and substance use disorders in and of themselves are only a small factor in societal violence, they can be a significant factor in fire-arm related suicide. Access to mental health care is critical for all persons who have a mental or substance use disorder. The health professional organizations represented in this article support improved access to mental health care and caution against broadly including all persons with any mental or substance use disorder in a category of persons prohibited from purchasing firearms. We also support adequate resources to facilitate coordination among physicians and state, local, and community-based behavioral health systems so they can provide care to patients, raise awareness, and reduce social stigma (12).

Early identification, intervention, and treatment of mental and substance use disorders would reduce the consequences of firearm-related injury and death (14). The overall proportion of violent acts committed by persons with mental or substance use disorders is relatively low, and those who receive adequate treatment from health professionals are less likely to commit acts of violence (15,16). Reducing firearm-related violence and suicide requires keeping firearms out of the hands of persons who may harm themselves or others, but it is important that restrictions be applied appropriately by limiting access to such individuals rather than limiting access solely on the basis of a mental or substance use disorder (17).

Further discussing patients with mental illness and violence, the *Psychiatric News* summarized that of the approximately 100,000 people (most between the ages of 16 and 20) who become newly psychotic each year but who are not diagnosed or treated are at an increased risk of violence (19). "About 38% of those within or before a first episode of schizophrenia may become violent, but once they are treated, the rate of violence decreases 15 fold (25)."

According to a study appearing in *Psychiatric Services in Advance*, mental illness is not a risk for gun violence. Prior violence and substance abuse may be better indicators of risk for subsequent violence. "Directly targeting mental illness as the major driver of gun violence is misguided. Prior violence, substance abuse, and early trauma are more likely to contribute to subsequent violence than is mental illness per se. In this regard, the politically inspired haste to focus gun control efforts on people being treated for mental illness, rather than on people with demonstrated indicators of violence risk, such as restraining orders related to domestic violence, seems particularly misdirected (19).

In an article in the *Atlantic* titled "America's Largest Mental Hospital is a Jail" it was noted that most of the crimes committed by the mentally ill, which results in their arrest, are crimes of survival such as retail theft (to find food or supplies) or breaking and entering (to find a place to sleep) (20). Arrest for drug possession can often indicate attempts at self-medication. People with severe depression might use cocaine to lift their mood. Those with schizophrenia or bipolar disorder often turn to heroin to regulate their sleep.

The Coalition recognized that there is a small minority of such individuals who are at high risk of committing violence against themselves and others, and that special measures are needed to identify these individuals and implement effective preventive and therapeutic strategies. In order to decrease the occurrences of violence the Coalition calls for the cooperation of mental health organizations, federal, state and local government agencies, the legislative and judicial branches of government, and the public at large to identify potentially dangerous individuals and intervene before major violent acts have been committed.

At Cook County Jail, in Chicago, IL, it is estimated that one in three inmates has some form of mental illness (20). In order to identify prisoners with a mental health issue, Cook County Jail has appointed a clinical psychologist who, along with the Cook County Sheriff, administers a mental health screening before they go to a bond hearing in order to form some sort of alternatives in lieu of jail that can be suggested to the judge. To that end, the Mental Health Transition Center was opened in August of 2014 which is designed to help mentally ill inmates cope with mental illness and prepare to rejoin life on the outside. They begin with 6 weeks of daily group therapy sessions and continue with classroom education (GED study sessions) and job-readiness training. Future programs will include interview and job finding skills. Another important program at the Cook County Jail is CountyCare, a health insurance program for low-income Cook County residents. For inmates with mental health illness, who might struggle to afford

prescription drugs or pay for mental health, the program significantly improves their life. Inmates are able to sign up for this program after they have completed their intake procedure.

A variety of psychiatric disorders are associated with either repetitive or acutely elevated risk for aggression and violence, such as psychosis, mania, delirium, or some personality disorders.

For all citizens, the executive staff leadership of 7 physician professional societies (whose members include most U.S. physicians) has made recommendations regarding obtaining guns in our country, which include:

1. Background Checks for Firearm Purchases: making this a universal requirement for all gun purchases or transfers of ownership
2. Physician "Gag" Laws: Physicians should have the ability to speak freely with their patients about firearms
3. Mental Health Patients: Early identification, intervention and treatment of mental and substance abuse disorders to reduce consequences of firearm injury and death

This oral presentation of this paper is to go over a few tragic events that occurred in US and to explore some facts related to the interaction of mental illness and violence with the following learning objectives:

1. To better understand the interaction of mental health and violence – public and media perceptions and facts
2. Mass shootings - Recent tragic events in US - Explore answers to some stark questions:
   a) Are they mentally ill? Definitely mentally troubled
   b) Are mentally ill individuals more violent?
   c) Are these tragedies foreseeable, preventable?
   d) Some facts about Violent Crimes and about Serious Mental Illness (SMI)
   e) Present various views – psychiatric and some contributory sociological factors and some known facts
3. To increase public awareness about the role of mental health and violence

Conclusion

Even though the violence is rare among the mentally ill, there is a high prevalence of severe mental illness among mass murderers. The recent surge of mass shootings by mentally ill in US has highlighted the following needs:

1. Early detection of severe mental illnesses,
2. Drug and alcohol abuse related issues especially among the individuals with serious mental illnesses
3. Adequate and supervised psychiatric care
4. Curtailment of easy access to lethal weapons in the U.S.

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Correspondence

Mr. Murali Rao
Loyola University Chicago
2160 S. First Ave
60153 Maywood
U.S.A.
mrao1@lumc.edu

A Pilot study examining instinctive and natural body movements during simulated assaults: developing a new approach to physical intervention skills in health and social care settings

Paper & Poster

Richard Luck, John Parkes & Phil Smith (UK)

Keywords: Training, Physical Intervention Skills, Breakaways, Disengagement, Aggression, Violence, Assault

Abstract

There are a significant number of providers of aggression management physical intervention skills within the UK. Techniques are often numerous in number and neither natural or instinctive. Techniques that are not natural or instinctive hamper retention of techniques and may actively aid attrition form memory. The inability to recall and apply taught techniques increases risks to health and social care practitioners. Techniques that are natural and instinctive and limited in number will be more effectively taught and retained by participants in training so that recall at the point of need is immediate. Further, many techniques taught are reliant on the victim of the assault engaging with the aggressor.

The aim of the pilot study was to examine the natural and instinctive body movement used by humans when faced with simulated assault. A pilot sample of 15 participants was utilized taken from the student body, participants had to be physically and psychological ly well, and have had no previous training in aggression management techniques either healthcare or analogous sports related training i.e. boxing martial arts etc. Students were filmed using Vicon 3D body mapping software whilst averting a simulated assault by a member of the research team. the simulated assault took the form of the researcher attempting to touch the participant in a range of areas of the body similar to those areas identified in standard breakaway/disengagement skills. Participants had Vicon reflective strips placed on key areas of the body. Three Basler high speed cameras were placed around the recording area and one above recording participants body movements.

Vicon 3D video mapping system utilizes Vicon Motus 7 software to analysis body movement and compares participant's movements generating themes. Initial findings indicate the whole body movement is important and males and females move in exactly the same way. Further analysis utilizing the software will be available by the time of the conference. Initial finding indicate that full body movement during the simulated assault aids the victim in averting assaults, and that both males and females respond in similar manners to simulated assaults.

At this stage of the study there are no clear conclusions as we are analyzing data in the coming weeks, however at the point of the conference we will be able to give participants a full over view of the results and provide recommendations for further studies using this same software and technological approach.

Educational Goals

1. Develop an appreciation of alternative technology in researching management of aggression and violence.
2. Describe the benefits of instinctive and natural skills in the retention of management of aggression and violence techniques

Correspondence

Mr. Richard Luck
Coventry University
Priory Street
CV1 5FB Coventry
United Kingdom
richard.luck@coventry.ac.uk

Comparing the effect of non-medical mechanical restraint preventive factors between psychiatric units in Denmark and Norway

Paper

Jesper Bak, Vibeke Zoffmann, Dorte Maria Sestoft, Roger Almvik, Volkert Dirk Siersma, and Mette Brandt-Christensen (Denmark)

Keywords: mental health, nursing, psychiatry, coercion, mechanical restraint, prevention.

Introduction

In this presentation the results from our study will be presented. The study is published in: Bak, J., Zoffmann, V., Sestoft, D. M., Almvik, R., Siersma, V. D., and Brandt-Christensen, M. Comparing the effect of non-medical mechanical restraint preventive factors between psychiatric units in Denmark and Norway. Nordic Journal of Psychiatry 23(1), 1-11. 2015.

Background

The use of mechanical restraint (MR) is controversial, and large differences regarding the use of MR are often found among countries. In an earlier study, we observed that MR was used twice as frequently in Denmark than Norway. The aim of the study is to examine how presumed MR preventive factors of non-medical origin may explain the differing number of MR episodes between Denmark and Norway.

Methods and Results

This study is a cross-sectional survey of psychiatric units. Linear regression was used to assess the confounding effects of the MR preventive factors i.e., whether a difference in the impact of these factors is evident between Denmark and Norway. The results indicates that six MR preventive factors confounded ($\Delta \exp(B) > 10\%$) the difference in MR use between Denmark and Norway, including staff education (-51%), substitute staff (-17%), acceptable work environment (-15%), separation of acutely disturbed patients (13%), patient-staff ratio (-11%), and, the identification of the patient's crisis triggers (-10%).

Conclusions

These six MR preventive factors might partially explain the difference in the frequency of MR episodes observed in the two countries, i.e. higher numbers in Denmark than Norway. One MR preventive factor was not supported by earlier research, the separation of acutely disturbed patient´s; therefore, more research on the mechanisms involved is needed. None of the six MR preventive factors presents any adverse effects; therefore, units in Denmark and Norway may consider investigating the effect of implementing, the identification of the patient's crisis triggers, an increased number of staff per patient, increased staff education, a better work environment, and reduced use of substitute staff in practice.

Educational Goals

1. The participant is expected to gain knowledge of mechanical restraint prevention in Denmark and Norway.
2. The participant is expected to gain inspiration of which mechanical restraint prevention initiatives to further investigate in practice.

Correspondence

Mr. Jesper Bak
Mental Health Centre Sct. Hans
Boserupvej 2
4000 Roskilde
Denmark
Jesper.Bak@regionh.dk

Decision-Making Factors Influencing Mental Health Nurses in the Use of Restraint: An Integrative Review

Paper

Sanaz Riahi (Canada)

Keywords: Restraint, Decision-Making, Nurse, Mental Health

Background

Control and containment measures, such as restraint, are often common first line interventions within healthcare settings (Cowin et al., 2003; Foster, Bowers, & Nijman, 2007; Kynoch, Wu, & Chang, 2011) and they are commonly used in the treatment and management of disruptive and aggressive behaviors (Sailas & Fenton, 2012). While restraint as an institutional method of control, may be perceived to seem warranted at times, there is growing literature indicating the potential counter-therapeutic effects of this practice (Borckardt et al., 2011).

There remains a gap in the body of literature related to the various factors influencing mental health nurses decisions in using restraint as a 'last resort'. Additionally, there is very limited published literature broadly exploring mental health nurses' overall decision-making related to restraint use. A greater in-depth understanding of the factors influencing decision-making may aid in undertaking future research to explore 'last resort' to enhance knowledge and influence overall strategies at both the clinician and organizational levels, to continue to advance restraint minimization.

Aim

To explore what influences mental health nurses' decision-making in the use of restraint.

Method

An integrative review of the literature was undertaken, using Cooper's (1989) framework. Cooper's framework includes five stages: 1) problem identification stage; 2) literature search stage; 3) data evaluation; 4) data analysis stage; and 5) presentation, which guided this integrative review.

Results

A total of 16 articles were included in the review, eight qualitative research articles, seven quantitative research articles and one mixed method research article. Eight emerging themes were identified: 'safety for all', 'restraint as a necessary intervention', 'restraint as a last resort', 'role conflict', 'maintaining control', 'staff composition', 'knowledge and perception of patient behaviors', and 'psychological impact'.

Conclusion

These findings reflecting the factors influencing decision-making indicate a paradoxical situation for mental health nurses, where they attempt to maintain safety for all, viewed as an integral part of their role, and use restraint to meet this responsibility, while there is existing evidence demonstrating restraint in actuality poses safety risks for both patients and staff. Recommendations from this review include undertaking research to further understand the experience and actualization of 'last resort' in the use of restraint to assist in moving the field forward and potentially provide insight towards strategies to support prevent the use of restraint in mental health settings.

Educational Goals

- Attendees will have a better understanding of key factors influencing mental health nurses' decision-making in the use of restraint.
- Attendees will enhance awareness in the gaps within literature and opportunities for future research related to restraint use.

Correspondence

Ms. Sanaz Riahi
Ontario Shores Centre for Mental Health Sciences
700 Gordon Street
L1N 5S9 Whitby
Canada
Tel: +905-668-5881
riahis@ontarioshores.ca

A Phenomenological Exploration of 'Last Resort' in the Use of Restraint

Paper

Sanaz Riahi (Canada)

Keywords: Restraint, last resort, mental health, nurse

Background

In more recent years, there has been a mandate and advocacy through various legislations, guidelines and papers in some countries, such as Canada, USA and UK, for organizations to shift towards the minimization of restraint, whereby its use is only as a 'last resort' when all other alternative interventions have been exhausted.

There is growing evidence internationally indicating that the use of restraint is counter-therapeutic, coercive, punishing, traumatic and unnecessary. Restraint is also considered to be over-used, under false assumptions that it is an effective means to manage violence and aggression and can protect and assure the safety of patients and staff.

Mental health nurses are generally the ones who implement restraint and current 'best practice' documents, reports and legislative acts promote its use as a 'last resort' only. Further insights to explore how the concept of 'last resort' is enacted within practice amongst mental health nurses are therefore warranted.

Aim

The research question explored was 'what influences mental health nurses' decision-making in the use of restraint as a last resort in adult mental health settings?' The research project aimed to gather a Canadian perspective and lived experience related to the research question.

Method

This research study adopted Moustakas' (1994) transcendental phenomenology and analysis procedures founded in Husserl's principles, to explore the phenomenon of 'last resort' in the use of restraint. Recruitment of mental health nurses was completed from across Canada.

Results

Preliminary results will be shared from the data analysis. These results will include individual textural descriptions, individual structural descriptions, textural-structural description and composite description in adherence to Moustakas' (1994) modification of van Kaam's (1959) method of analysis.

Conclusion

To date, there are no published studies, which have conducted an in-depth exploration on this topic 'last resort' in the use of restraint. This Husserlian phenomenological study therefore aims to further explore the perception and experience of 'last resort' in restraint use by nurses in an endeavor to understand why this approach remains common practice, and how and why it is used given conflicting and often contentious views.

Educational Goals

- Attendees will become familiar with the lived experiences of nurses related to the use of restraint as a 'last resort'
- Attendees will increase understanding of phenomenology

Correspondence

Ms. Sanaz Riahi
Ontario Shores Centre for Mental Health Sciences
700 Gordon Street
L1N 5S9 Whitby
Canada
riahis@ontarioshores.ca

The issue of patient aggression against nurses in Slovak clinical practice

Martina Lepiešová, Martina Tomagová, Ivana Bóriková, Katarína Žiaková, Mária Zanovitová, Juraj Čáp
Comenius University in Bratislava, Jessenius Faculty of Medicine in Martin, Institute of Nursing, Slovak Republic

Introduction / Background

Patient aggression against nurses is in the focus of research mainly in last decades. Although it is explored particularly in mental health care, it has become an integral problem of everyday professional life of nurses in all clinical disciplines. Nurses represent the largest group of healthcare professionals which is in the most frequent direct contact with the patients. Patient aggression negatively affects nurses' health and safety, their working environment, motivation to work and job satisfaction (Gurková et al., 2015) and subsequently the quality of nursing care provided. Problems in this field contribute to increased level of stress, reduced physical and mental well-being of nurses and staff turnover (Pekara, Trešlová, 2011). In the Slovak Republic this issue is not sufficiently reflected in the context of its investigation (conceptualization, operationalization of aggression and violence and their research) but also the performance of the nursing profession, thus data concerning the extent of this problem is missing. Only several partial research studies focusing on different types of workplaces were implemented in Slovakia to determine the prevalence of aggression against nurses and to analyse the problem (Kačmárová et al., 2014; Lepiešová, Nemčeková, 2013; Čerňanová, 2010). Their findings were alarming when compared with studies held abroad thus motivated us to prepare the project of broad nationwide research study.

Aim

Main purpose of three years lasting project is to explore the issue of patient aggression against nurses in the broader context of Slovak clinical nursing practice. Nationwide study aims to identification of the prevalence of patient aggression against nurses; analysis of nurses' attitudes towards patient aggression; exploration what factors nurses perceive to be most risky and how they reflect management of patient aggression in their workplaces; and addressing the differences based on individual and environmental characteristics.

Methods

Quantitative methodology was used to collect empirical data in ten faculty and university hospitals in all regions of Slovakia. The questionnaires distributed among nurses consisted of four reliable and valid self-reference instruments: VAPS, ATAS©, FAPAS, and MAVAS-L.

Violence and Aggression of Patients Scale (VAPS; Lepiešová et al., 2012) is the scale constructed to assess the prevalence of patient aggression in terms of interpretation of nurse's personal experience with different forms of patient aggression in the last year of their practice. VAPS consists of 11 items representing different forms of manifestation of aggressive behaviour which are categorized to 3 subscales structuring patient aggression to its forms: S – verbal aggression; T1 – physical aggression without the use of assault weapon; and T2 – physical aggression with the use of assault weapon and contact forms of sexual aggression. Each item is evaluated by 6-point frequency scale from *1-never* to *6-always* (the higher the score of item / subscale / VAPS, the higher the frequency of the nurse's exposure to patient aggression).

Attitude Towards Aggression Scale (ATAS©; Jansen, 2005) is standardized scale used to measure the attitudes towards patient aggression in terms of interpretation of its meaning. ATAS© consisting of 18 items implies 5 types of attitudes towards patient aggression – each type is measured by one of its domains: offensive (AO), destructive (AD), intrusive (AI), communicative (AC), and protective (AP). Items are evaluated on the Likert-type scale from 5 to 1 (*5-strongly agree*; *1-strongly disagree*). The higher the score in the domain, the more it conforms to a particular attitude to aggression represented by the domain.

Factors Affecting Patient Aggression Scale (FAPAS; Lepiešová et al., 2014) is the scale constructed to identify how various groups of contributory factors are viewed by the nurses in terms of their potentiality to increase the risk of aggression. Items are evaluated by 5-point scale from *1-the least impact on the risk of aggression* to *5-the greatest impact on the risk of aggression*. Higher score indicates rating the factor/the group of factors as more risky for patient aggression against nurses. Scale is structured into 7 subscales – the groups of risk factors: FAP1 – physical environment, FAP2 – situations of patient's emotional overload, FAP3 – nurse's factors, FAP4 – patient's factors, FAP5 – factors related to the issue of gender, FAP6 – specific factors of workplace, FAP7 – factors of work shift organization.

The Management of Aggression and Violence Attitude Scale (Duxbury et al., 2008) is scale developed to assess the attitudes to different strategies of patient aggression management in terms of interpretation of its causes and its management. This instrument was used in the form of its adapted and modified version MAVAS-L (MAVAS-Likert) as we had excluded some statements according to Gerdtz et al. (2013) and instead of VAS scale used to evaluate statements in original MAVAS we had used 5-point Likert-type scale according to Pulsford et al. (2013). The questionnaires included two additional items in which nurses' experience with restrictive methods of patient aggression management (medications and restraints) in their workplaces were investigated. The items were evaluated by 6-point frequency scale from *1-never* to *6-always* (the higher the score, the higher the frequency of their use perceived by the nurses).
Altogether, the return rate of distributed questionnaires in selected hospitals was 70.16 %. After exclusion of questionnaires that haven't met inclusion criteria, final number of 1220 questionnaires has been analysed.

Sample

In correspondence with gender representation in nursing profession in Slovakia, 92.8 % of nurses in the sample were female. Most nurses had completed non-university studies (55.2 %). The vast majority of respondents (92 %) didn't have opportunity to undergo any special training or education oriented on patient aggression and its management. As for clinical disciplines, most nurses works in surgical (30.9 %) and internal medical disciplines (23.9 %), then emergency and intensive care units (19.2 %), mental health workplaces (18.4 %), and least of them works in oncology and palliative care (7.6%). Majority of nurses (81 %) works in day and night shifts. The mean age of respondents was 40.05 (± 10.09) years, ranging from 23 to 66 years. The mean practical experience was 19.15 (± 10.94) years of practice, ranging from 1 to 49 years.

Results

Prevalence of patient aggression against nurses (VAPS)
In consonance with our assumptions, prevalence of verbal forms of aggression against nurses (97.1 %) was higher than that of physical forms (77.2 % as for physical aggression without the use of assault weapon; 26.5 % as for physical aggression with the use of assault weapon respectively). The most frequent nurses' experience with patient aggression was verbal abuse – insults, scolds (3.48±1.52) and unjustified accusations (3.32±1.40); in physical forms of patient aggression they most often mentioned spits, bites, scratches, and stings (2.50±1.35). The least experience was mentioned with sexual assault including physical harm (1.16±0.70). Prevalence of physical aggression against nurses in our sample was far much higher than it is reported in other countries where research of this issue is more in the focus of interest. Due to fact that nursing is female dominated profession in our country (1.52 % of male nurses in profession) we consider this finding to be alarming. Prevalence of patient sexual aggression against nurses (68.7 %) was quite significant as well but still comparable with findings of other studies of this issue of interest. All the forms of patient aggression (S; T1; and T2) were proved to be experienced significantly more frequently by nurses working in mental health care and by nurses working in both, day and night shifts. The results indicate enormous prevalence of patient aggression against nurses overextending the prevalence of this phenomenon in other countries, particularly in the field of physical aggression.

Nurses' attitudes towards patient aggression (ATAS©)
The highest score was achieved in the domains offensive (4.23±0.77), destructive (4.22±0.92) and intrusive (3.95±0.88). The average scores achieved in these domains are above 3.5 representing the consent with such a negative perception of patient aggression expressed by the domains (Jansen, 2005). Of the two domains stressing the positive meaning of patient aggression, higher score was achieved in the domain protective (2.85±1.24). Its value reflects neutral respectively ambiguous relation to the type of attitude towards patient aggression expressed by the domain, or slight tendency to disagree with such positive meaning of patient aggression. Domain communicative proved to be the least represented type of attitude to patient aggression in our sample, its score (2.58±1.01) indicates nurses' disagreement with such an understanding of patient aggression. Nurses predominantly understood the patient aggression

in its negative connotations even though they reflected also its protective and communicative meaning from the perspective of patient. By comparison of our findings with results of international comparative study (Jansen et al., 2005; Jansen et al., 2006) we had found out more negative attitudes towards patient aggression in our sample. The predominance of such a negative perception of patient aggression may be related to its enormous prevalence in clinical nursing practice. Our findings indicate there are significant differences in nurses' perception of patient aggression while the attitude predictors identified are education (in AO, AI and AC domains), the work in both, day and night shifts (in AI domain), and clinical discipline (in AD and AC domains).

Perception of risk factors contributing to patient aggression (FAPAS)
By the nurses of our sample, the highest risk of patient aggression was assigned to the patient's factors (70.3 % risk), then specific factors of workplace (57.8 % risk), situational factors of patient's emotional overload (54.3 % risk), factors of work shift organization (51.8 % risk), nurse's factors (51 % risk), factors of physical environment (39 % risk), and finally, the factors related to the issue of gender (30.3 % risk) were reflected to be the least risky. We had found out significant differences in nurses' perception of some groups of risk factors contributing to patient aggression based on selected characteristics. Apart from internal factors of aggression (FAP4), the nurses of our sample reflected the significance of situational and external factors (FAP6, FAP2, FAP7, FAP1 and FAP5), to which, in some cases, they attributed quite high level of the risk of patient aggression against nurses. They reflected also the likelihood of their own contribution to increased risk of aggression (FAP3), which is consistent with more and more asserted situational-interactional model of patient aggression (Duxbury, Whittington, 2005).

Perception of causative factors and the management of patient aggression (MAVAS-L)
The highest score – the highest agreement was achieved in item M7 (internal causative factors of aggression), M13 (aggression management – use of medication) and M9 (internal factors). Nurses agreed patient aggression is attributed to internal causative factors and individual patient variables and agreed use of medication is valuable approach to treat aggression and violence. The lowest score was achieved in item M27 (external causative factors of aggression), M14 (internal factors) and M18 (aggression management – restraint). Nurses disagree patients would be less aggressive if their physical environment will be changed, they don't think physical restraints are used more than necessary and they believe aggressive patients have to be assisted to calm down. Data gained by MAVAS-L have to be further analysed and compared as they are still being statistically processed at the moment.

As for the perception of frequency of using restrictive management strategies in their workplaces, nurses consider medications to be used more often (3.72 ± 1.17) than restraints (3.22 ± 1.13) while dealing with patient aggression, but both are referred to be used in the frequency between *occasionally* to *often* on 6-point frequency scale.

Conclusion

Results of our study could be considered to be the first step in our efforts to contribute to the creation of database concerning the problem of patient aggression in the context of clinical practice in Slovakia that is still insufficient. Evidences from nationwide study that patient aggression against nurses is significantly prevalent in Slovak context could be implemented to the line of reasoning the claims to establish programmes of prevention and management of patient aggression in clinical nursing practice that are still absent in our country.

Acknowledgements

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Educational Goals

- To gain the cognition about actual situation in the field of patient aggression against nurses in the context of Slovak Republic (the scope of problem, prevalence of concrete forms in clinical practice, attitudes of nurses towards this issue, perception of risk factors to be predominantly contributing to the problem, perception of management of the problem).
- To gain understanding of specific social and cultural context that may contribute to this problem in Slovak clinical nursing practice.

Correspondence

Martina Lepiešová, MSN, RN, PhD
Institute of Nursing, Jessenius Faculty of Medicine in Martin, Comenius University in Bratislava
Malá Hora 5
036 01 Martin
Slovak Republic
lepiesova@jfmed.uniba.sk

Victimisation in adults with severe mental illness: prevalence and risk factors

Paper

Liselotte de Mooij, Martijn Kikkert, Nick Lommerse, Jaap Peen, Sabine Meijwaard, Jan Theunissen, Pim Duurkoop, Anna Goudriaan & Henricus Van (Netherlands)

Keywords: victimisation, severe mental illness, prevalence, psychopathology, substance use, violence

Background

Studies have shown that SMI patients are more vulnerable to victimisation than the general population.[1-13] However, prevalence rates of victimisation vary considerably across studies. Reported prevalence rates in people with SMI for non-violent crimes range from 7.7% to 28%, and for violent crimes from 4.3% to 35%.[12] Victimisation can be described as a stressful event and may induce a psychosis or relapse.[14] Furthermore, victimisation can render the onset of a post traumatic stress disorder,[10] especially when it concerns a violent crime.[15] We examined the prevalence of victimisation in the SMI population, and the relationship between symptoms, treatment facility, and indices of substance use/abuse and perpetration, in comparison with the general population.

Method

This research was part of a longitudinal study conducted among a survey sample of SMI patients treated by mental health care institutions of Arkin and GGZ in Geest in Amsterdam, the Netherlands. Victimization data from the SMI group were derived from follow-up data in 2011. Data of the general population came from a cross-sectional study, conducted by Research Information and Statistics (OIS) of Amsterdam in 2011. The same measure for victimisation (violent crimes, property crimes, and vandalism), was used in both data sets. For this study, 876 patients were randomly selected from outpatient treatment teams, sheltered housing facilities and inpatient care facilities. In total, 323 (37%) patients were included in the study. Victimisation, measured with the Integral Safety/Security Monitor (IVM) was assessed among both randomly selected SMI patients (N = 216) and the general population (N = 10,865). Psychopathology was measured with the Brief Psychiatric Rating Scale-Expanded.[16] Use of alcohol and drugs, substance dependence and abuse was assessed with the Measurements in the Addictions for Triage and Evaluation.[17]

Results

Compared with the general population, SMI patients reported higher rates of violent crimes (22.7% v. 8.5%). Inpatients were victimised most often (violent crimes: 33.3%; non-violent crimes: 47.1%). Risk factors for violent crimes included young age and disorganisation. Risk factors for property crimes included being inpatient, disorganisation, and cannabis use. Perpetrators of violent crimes among the SMI group were most often acquaintances.

Conclusions

The high prevalence of victimization among SMI patients indicate that prevention and intervention programs are needed for these individuals. Professionals should be aware of signals of victimisation, provide treatment and administer risk-assessments. Patients should be screened in terms of age, substance use, type of treatment facility, and symptoms of disorganisation. This research resulted in the development of several interventions to improve vulnerability for victimization. An example of such an intervention is the SOS (Streetwise, Otherwise, Selfwise) group training.[18]

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(http://tinyurl.com/StreetwiseSelf-wiseOther-wise, 85–7).

Educational Goals

Goal 1: On concluding this presentation, participants will be able to cite prevalence rates of violent and non violent crimes among patients with a severe mental illness in different care facilities (ambulant, inpatient-, and sheltered housing care facilities).

Goal 2: On concluding this presentation, participants will be able to cite two risk factors for violent crimes and three risk factors for non-violent crimes among patients with a severe mental illness.

Correspondence

Ms. L. D. de Mooij
Arkin Department of Research
Klaprozenweg 111
1033 NN Amsterdam
The Netherlands
Liselotte.de.Mooij@Arkin.nl

'My parent died in this psychiatric hospital in 1936, 1944, 1947' – Sons, daughters and grandchildren inquiring after decades of incertitude. How can we answer to their questions in Germany nowadays?

Poster

Michael Bruenger (Germany)

Abstract

In times of the national socialistic regime in Germany psychiatric hospitals were highly involved in forced sterilization of mentally ill patients beginning in 1934. Like in other European countries this was regulated by law. However, in Germany plans from the times of the Weimar Constitution were extremely tightened shortly after the Nazis came to power in Germany in January 1933: as a result of this law dating from July 14th 1933 forced sterilizations were legally executed beginning on January 1st 1934. Patients being diagnosed with a (severe) mental disorder could not be released from a psychiatric unit without an antecedent sterilization.

On the contrary, the murder of mentally ill patients in Germany beginning in 1940 was always an illegal action: although authorized by Hitler in October 1939 (by written commission on his personal paper and dated 'September 1st 1939') psychiatrists and medical staff were always aware of the illegality of the well-organized murder of 70.000 people during the 'Aktion T4' in 1940 and 1941. When this criminal campaign came to a halt after protests from parts of the church in Germany, the murder of patients continued in psychiatric hospitals in a decentralized way: sedation and hunger were used to exterminate patients with mental disorder and mental retardation.

After decades of uncertainty a growing number of relatives inquire about the fate of their parents and grandparents. Despite the falsification and disappearance of patient's records it is possible to respond to these inquiries with reference to the archives.

Skills needed to respond to these inquiries comprise the ability of interpretation of the data of patient's records dating from those times. Handwriting - often in 'Sütterlin' - is difficult to read, technical terms from psychiatry often differ, deletion have to be detected, the individual case history has to be contextualized.

All this must be done in a personal encounter with the inquiring relatives. Special attention must go to the highly emotional reaction of sons, daughters and grandchildren more than seventy years after their relative's death. In many cases they have to deal with so far undisclosed family myths and obfuscation.

The fate of patients who have died before the 'Aktion T4' and even after the end of World War II often remains unclear. Future studies need to elucidate whether the high rate of mortality in the psychiatric institution ('Heil- und Pflegeanstalt')of Klingenmuenster was due to severe hunger (common in the entire zone occupied by the French) or to ongoing crimes such as intended starvation and sedation.

Caring for relatives who are often emotionally unstable due to the impact of their relative's fate must be considered as challenging psychotherapeutic work. The disclosure by a representative of the hospital needs clearness and the readiness to assume responsibility even if the events in question date from the 1930's. Bridging several decades of time, presenting facts from the Nazi times and caring for relatives in the context of an encounter taking place 'now' proves to be a challenge to the reporting psychiatrist. In all cases relatives were very grateful and appreciating.

Educational Goals

- Readers learn about today's demands and responsibilities of psychiatry and psychiatrists towards relatives of NS-psychiatry victims.
- Readers are invited to study the history of the (psychiatric) institution they work with and take responsibility in their respective context.

Correspondence

Mr. Michael Bruenger
Pfalzinstitut Child & Adolescent Psychiatric Service - Pfalzklinikum
Weinstrasse 100
76889 Klingenmuenster
Germany
michael.bruenger@pfalzklinikum.de

The Impact of Value Incongruence between Employees and their Workplaces within Psychiatric Inpatient Units: Preliminary data related to perceived psychosocial factors

Lars-Erik Warg & Ulrika Hylén (Sweden)

Abstract

Background

Previous research concerning psychological factors in work life has found that value incongruence may have a negative impact on individual and organizational well-being. In the full contribution of a study still running, we will present data on how employees perceive their psychosocial work environment. Specifically, this is done in the light of how they rate any difference in values between themselves and their work organization. A fundamental idea in Swedish work life is that a good work environment provides the employees as well as the employers with means to work in a preventive manner with different problems that can occur. These include, for example, problems related to threats and violence. This study is part of a larger project: Threat and Violence within Psychiatric Inpatient Care. In this abstract, we will only point at some preliminary results giving an idea of what comes into focus in this study.

Methods

The study that will constitute a full presentation of results is still running but will be completed by April 2015. A well renowned questionnaire QPS Nordic34+ consisting of 75 questions that focus on psychological and social factors at work, was distributed among the entire population of first level managers and staff members in three different types of psychiatric inpatient units in central Sweden: 1) general psychiatric units, 2) an addiction center, and 3) forensic inpatient units. A total of 1 069 questionnaires were distributed. Thus far, 328 questionnaires have been answered and returned. In the final phase of the study, the data will be subjected to descriptive analyses and logistic regression. In this abstract, we are pointing to some preliminary results based on data grouped in three categories related to value incongruence between employees and their work organization – ranging from high degree of congruence to high degree of incongruence. These three categories were obtained by dividing into three equal parts a 134 mm answering scale line where the employees indicated the degree of incongruence.

Results

Some preliminary results show the following pattern: Employees who indicated a high degree of incongruence 1) more seldom receive support, help or encouragement from their nearest boss, 2) more often perceive the work climate to be distrustful, suspicious, unsupportive, unrelaxed and unpleasant and rather stiff and governed by rules, 3) more often notice conflicts among colleagues at work, and 4) more seldom describe their work as having satisfactory communication.

Conclusions

The preliminary results are in accordance with some previous studies and they are very interesting from the perspective of work environment and psychosocial factors. They strongly suggest that value incongruence at work – notably between employees and their workplaces – have a strong impact on how the former perceive their work. We know that staff in workplaces rating low on psychosocial factors can develop physiological symptoms, lose their focus on the task at hand and also – as was found in a study on employees working in churches – they can be on long term sick leave to a greater extent.

Educational Goals

- Participants will be able to describe and give examples of how value congruencies affect psychosocial factors in the workplace.
- Participants will be able to design or adapt a questionnaire on psychosocial factors and apply it to other work settings.

Correspondence

Mr. Lars-Erik Warg
Department of Occupational and Environmental Medicine
S Grev Rosengatan
SE 701 85 Örebro
Sweden
lars-erik.varg@regionorebrolan.se

Staff and caregiver attitude on coercion in India

Paper

Bevinahalli N Raveesh, Peter Lepping, Soumithra Pathare & Joske Bunders (India)

Keywords: Coercion, Attitude, Staff, Caregiver

Introduction

Coercive treatment may be required in order to promote the patient's health interests, but health interests have to be balanced if they go against the autonomous interests of the patient.

Objectives: To co-relate age, gender and experience of staff (Psychiatrist) with Staff Attitude to Coercion, to co-relate age, gender, education and relation of relative with Attitude to Coercion and to compare Staff and Caregiver Attitude to Coercion.

Methods

The study was conducted after obtaining institutional ethical clearance at department of Psychiatry, Krishnarajendra Hospital attached to Mysore Medical College & Research Institute (MMCRI), Mysore. A 15-item questionnaire to measure staff attitudes to coercion the Staff Attitude to Coercion Scale (SACS) was administered to psychiatrist and care givers. Consent was taken and confidentiality was maintained.

Results

Totally 210 psychiatrist and 210 relatives participated in the study. The data was assessed u sing descriptive statistics and Chi- square test. Aged and experienced felt coercion could be reduced by giving more time and personal contact. Both group agreed that scarce resources, security and harm reduction were reasons for coercion. Both group agreed that coercion is necessary but not as treatment.

Educational Goals

- Cognitive Domain: Understanding coercion from mental health service provider and caregiver perspective in less researched geographical region.
- Affective domain: to know the attitude of staff and caregiver in family oriented society.
- Psychomotor domain: what can be implemented in autonomy oriented European setup.

Correspondence

Mr. Raveesh Bevinahalli Nanjegowda
Professor & Head, Dept of Psychiatry, Mysore Medical College & Research Institute
Irwin Road
570001 Mysore
India
raveesh6@yahoo.com

Analysis of Nurses Experiencing Anger toward their Patients at work

Poster

Naoko Shibuya & Risa Takahashi (Japan)

Keywords: Nurses, Anger expression, Daily life versus work, Questionnaire

Introduction

It is important to gain an understanding of how nurses express and suppress anger toward their patients at work, and how their experiences differ by medical department. This study seeks to analyze those issues.

Research Question: (1) Differentiate between the nurses' expressions of anger during their daily lives and those toward their patients at work; (2) Identify the components of their process for restraining or managing anger; (3) Statistically analyze subjects' behaviors (reactions) at the moment they become angry with patients.

Method

(1) Subjects: 213 nurses in Japan. (2)The structure of the questionnaires was as follows:

Anger Expression Scale (AX), Rathus Assertiveness Schedule (RAS), Questionnaire: "The Description of the Subject's Own Experience of Anger"(developed by Averill), Questionnaire: "The Description of the Subject's Anger toward their Patients at Work" (created by modifying).

Ethical consideration for this study was approved by the Nagoya City University Ethical Review Committee.

Results and Discussion: The AX Scale was used to classify nurses into one of four categories based on their levels of Anger-Out and Anger-In, both in daily life and at work. The results revealed contrasting trends in the handling of anger between daily life and work. In daily life situations, the pattern of high Anger-Out and low Anger-In was more common than low Anger-Out and low Anger-In, whereas the low Anger-Out/low Anger-In pattern was more common than the high Anger-Out/low Anger-In in work situations.

Educational Goals

• The promotion of the mental health of the nurses by consideration and integration of the findings on both the nurses and the people with mental diseases

Correspondence

Ms. Naoko Shibuya
Chubu University
Matsumoto-cho
487-8501 Kasugai City
Japan
naoko@isc.chubu.ac.jp

WECARE - Addressing Mental Health Staff Burnout Through Organizational Culture

Workshop

Bob Bowen (USA)

Keywords: Wellness, relational violence, corporate culture

Introduction

Violence is a term most people associate with physical actions of harm from one person to another. The violence that takes place in clinical psychiatric practice at times is physical aggression, primarily from patients towards staff. Research demonstrates that the prevalence of this type of violence is less than 15% of the total episodes of violence that take place in hospital and community based psychiatric services. (Vessey et al, 2012)

The relational violence that occurs within human service settings is far more prevalent than physical violence, and has a stronger correlation with decisions on the part of mental health professionals to either leave the field entirely, or move to other settings in the hope that the stresses experienced on the next job will be less than those experienced in the last job. (Privitera et al, 2014) Sadly, this is often not the case, as relational violence is pervasive in the field of human services, not just psychiatric services.

Wellness, also referred to as well-being, is the antonym of relational violence in its' many manifestations. When organizational cultures are healthy, relational violence has fewer options and opportunities for expression. However, the terms "wellness" and "well-being" are used with either no definition or abstract definitions that are difficult to quantify. Building on and integrating the work of Prilleltensky, Fallott, Privitera, Maslow and Schlalock, the term "wellness" is defined for the purpose of this paper as the outcome of having a high quality of life.

Quality of Life as experienced by consumers of human services is the result of five factors:

1) Predictability in life, knowing what will happen in the next few hours, days or weeks and knowing how other people will respond to one's own behavior.

2) A pain free life. Chronic medical conditions that cause physical pain, chronic mental conditions that cause emotional pain have debilitating effects on individual behavior. Improving physical and emotional health is key to wellness.

3) Having a safe place to live is the third pillar of wellness. There are homes and hospitals that are physically safe and also emotionally unsafe due to the presence of predators in the environment. There are also places that are emotionally safe and physically unsafe due to living conditions associated with lower socioeconomic conditions. Creating safety is a key element for wellness to occur.

4) Having at least one good friend alleviates the loneliness that David Pitonyak believes is at the heart of all behavioral challenges. When all relationships with an individual are paid relationships, caregiving relationships, it has a potentially negative effect on individuals served. A friend, someone who is with you because they want to be, not because they have to be, provides a sense of wellness that cannot be purchased.

5) The ability to give to and receive from others in reciprocal relationships is the last pillar of wellness. (Albrecht & Devllieger, 1999; Harding et al, 1987)

Below is a short questionnaire to assess the relative level of wellness in the workplace. Respond to these questions without overthinking as your "gut response" is more emotional and reflective of emotional states. It is higher stress emotional, not cognitive states, that lead to burnout.

Key: 1 – almost always 2 – more than half the time 3 – less than half the time 4 – almost never

A. My workplace relationships are predictable in a positive, healthy way _____
B. My workplace is emotionally healthy for me _____
C. My workplace is a safe place for me _____
D. I have at least one colleague whom I can tell anything, I trust them completely _____
E. I can participate in the decision making process, giving to and receiving from others _____

Score: _____

The culture of an organization is the result of the relationships between the individuals in that culture, and external forces from regulatory and funding bodies. The external forces will be addressed separately from the internal forces. Translating the 5 factors identified above into the workplace culture is the result of the work done by individuals on a daily basis.

1. Predictability is central to safety. When the outcomes of a behavioral interaction are predictable, people feel safe. In the workplace, providing predictability is one of the purposes of policies and procedures. There are, however, workplace environments that are predictable and unsafe. The predictability needed to support wellness is that characterized by healthy workplace characteristics of interpersonal interactions. (Biggio G & Cortese CG, 2013)

2. A pain free life is the goal of all people. Workplace initiatives in health for employees is a worldwide effort. (C3 Collaborating for Health, 2011) When people are healthy and free of pain, they are more productive in their work, morale improves, and absenteeism decreases.

3. Increasing workplace safety has been the focus of the four international conferences on violence in healthcare underwritten by the Oud Consultancy. After Basic Human Needs or Physiological Needs are met, Maslow's hierarchy of needs postulates that the second set of needs related to safety. (Maslow, 1943)

4. Having at least one good friend, or colleague, in the workplace was identified by Biggio and Cortese, referenced above. The relational milieu of the workplace was found to be a central element in reducing workplace burnout. (Mossholder et al, 2005). The more collegial support is available in the workplace, the less likely it is that people will leave.

5. Being in relationships where one could give and receive was the last key element in attaining a high quality of life. Participatory decision making in the workplace has resulted in better outcomes for individuals served and decreases in stress and burnout in staff. (Helfrich et al 2014, Slate et al, 2003)

Translating research to practice and creating a culture of wellness must start with a commitment to the model of wellness. The items identified above have been translated from theory and put into practice. The acronym WE CARE provides the structure for wellness to move from the beginning of an idea to the experience of a work life well lived.

Wellness
This is our starting point, and our goal. To achieve a goal we must have measurable components of that goal that can be achieved. An old and true adage is that you cannot manage what you cannot measure. For cultures to change, there must be a pathway that can be marked with signs by which we can measure our progress.

Empathy
To achieve wellness, we will need to build the bridge called Empathy between ourselves and others. As health care professionals we have a great deal off knowledge. As William Watson Purkey states, "people

won't care how much you know until they know how much you care." Empathy is the bridge between people that transforms sympathy to Compassion.

Compassion
Empathy provides us with the sense of being connected with, not just to others.
Compassion empowers healing to transform lives. Compassion invites and empowers others to cross the bridges we build together from the lives people have to the lives people want to have. Empathy is not only with the patients, it is with caregivers first and foremost.

Achievement
In health care settings, Achievement is not an individual process or event. In order for a patient to achieve Wellness, she or he must have been empowered to achieve through the Empathy and Compassion of the health care professionals serving them. Achievement of health care goals cannot be measured at an individual level alone. Achievement of wellness occurs only when there is mutual support between all the stakeholders in healthcare, supporting each other so they can, together, support their patients.

Respect
Respect must permeate the health care system. Respect does not have to be earned, it is given freely to all people, simply because we are people. Respect is unconditional, it is a right that does not need to be claimed.

Engagement
Respect is a pre-requisite to Engagement, the invitation for people to participate in and, whenever possible, direct the process of their own healing. Without engagement, patients may not be able to achieve their goals because of a lack of investment in the process of healing.
When human service organizations can fully move to a model that treats staff with the same high level of concern for safety at an emotional, psychological, and physical level, burnout will be lowered. Workplace violence does not take place in a vacuum, there is an organizational context of and contribution to WPV. Organizational violence (Bowie, 2011) is seen as a contributor to the interpersonal violence that plagues the human service system in general.
In their book "Patients Come Second" (Berrett & Spiegelman, 2014) the authors write that for organizations to give world class service, they must have world class staff. The expectations of the human service system in most, if not all countries, is for world class service, but without the world class support. Staff are expected to care without being cared for, putting them in the untenable position of giving until they have no more to give, and are running on empty.

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Educational Goals

1. Identify the factors that comprise wellness
2. Explain how organizational supports through the WE CARE model facilitate wellness.

Correspondence

Mr. Bob Bowen
Senior Vice President for Product Development
The Mandt System, Inc.
PO Box 831790
75083 Richardson
USA
bob.bowen@mandtsystem.com

Rethinking Debriefing: A structure for aligning constituents and process

Paper

Kevin McKenna (Ireland)(member of ENTMA)

Abstract

Debriefing following any adverse event, including episodes of aggression and/or violence provide potent learning and support opportunities for all involved. While there are many regulatory and professional mandates to conduct effective debriefing, there remains some confusion as to its specific role purpose and function.

Debriefing in this context includes three distinct but associated processes all of which aim to effectively use learning from occurrences to prevent future episodes of seclusion or restraint.

Service users should be debriefed following an episode of aggression and/or violence, especially where seclusion and/or restraint have been involved. Specifically, the service user must be afforded the opportunity to discuss the episode with members of the multi-disciplinary team involved in his or her care and treatment. Critically the key function of the debriefing is to reconnect the service user and treatment team so that their collaborative working toward recovery can continue unhindered. This is especially important as episodes of seclusion and/or restraint inherently distort the power balance needed for collaborative working.

It is equally important that staff members involved in the occurrence have the opportunity to debrief. While the opportunity for reflective learning is the core of staff debriefing, it also provides a safe and supportive environment in which staff have the opportunity to work through issues and/or feelings which may have emerged during an episode.

The third component of debriefing is the organizational review which may identify either preventive or remedial quality improvements. Occurrences are reviewed to identify measures which might prevent re-occurrence, or broader improvements which are necessary across the service. A contextual understanding should inform organizational reviews with an emphasis on 'fact finding' rather than 'fault finding.'

This presentation will present a debriefing matrix which aligns the constituents and rationale of the three components

Educational Goals

- Explore the critical outputs of Debriefing
- Present a structure for implementing effective debriefing from the perspectives of service user, staff, and the organization.

Correspondence

Mr. Kevin McKenna
Dundalk Institute of Technology
Dublin Road
Dundalk
Ireland
kevin.mckenna@dkit.ie

Psychopathy: Defining the Diagnostic Construct

Daniël L. Janssen, Bachelor of Arts Graduate at University College Roosevelt, Utrecht University, the Netherlands
Elizabeth B. P. Wiese, Associate Professor of Psychology at University College Roosevelt, Utrecht University, the Netherlands

Introduction

Whilst many scholars in history have brought us closer to understanding the construct, the diagnosis of psychopathy remains elusive to most. Philippe Pinel first defined the construct as a problem of aggression, referring to it as *mania without delirium* in 1801 (Millon, Simonsen, Birket-Smith & Davis, 1998). In an attempt to specify the diagnosis further, Koch (1891, as cited in Millon et al., 1998) replaced the label with *constitutional psychopathic inferiority*, meaning to refer to the psychopath's likeness to the self-centeredness and lacking morality of a child – hence the term "constitutional". In the early twentieth century, Emil Kraepelin typified different kinds of psychopaths, several of which left a profound mark on the construct of psychopathy, which then included the criteria of youth criminality, antisocial behavior, a lack of morality, and arguably most importantly, a lack of emotion or affect (Millon et al., 1998). With Schneider's (1923, as cited in Millon et al., 1998) characterization of the more passive "affectionless" psychopath and the active "antisocial" psychopath, the diagnosis of psychopathy evolved to a two-factor approach. Still, the early emphasis on classifying psychopaths proved to a fault, as there was still too "little uniformity in usage" (p. 62) of psychopathic symptom- and terminology (Partridge, 1930).

To this day, the diagnostic construct of psychopathy has maintained a degree of vagueness and confusion. It is often associated with Antisocial Personality Disorder (ASPD), a diagnosis that the American Psychiatric Association (2013) considers to be synonymous to psychopathy in the Diagnostic and Statistical Manual of Mental Disorders (DSM), which is currently in its fifth edition. To elucidate on the diagnosis for clinical practice, the question of this research is whether psychopathy can be considered a unique diagnostic construct, one that is particularly distinct from ASPD as defined in DSM-5. The answer to this question is sought by a review of literature, in which three topics pertaining to psychopathy are examined: its history – illustrated in this excerpt by the previous two paragraphs – its likeness to ASPD, and the motivation for exclusion from the fifth edition of the DSM.

Diagnostic Constructs of Psychopathy

Halfway the twentieth century, Hervey Milton Cleckley (1976) became arguably the most notable scholar in converging and elucidating the academic discourse on psychopathy. In his *The Mask of Sanity,* Cleckley not only painted a diagnostic picture of the psychopath by drawing upon his experiences in psychiatry, but he also introduced the notion that the psychopath hides behind a severely pathological "mask" aiming to construe the pretension of sanity. This was a break from the past, as Cleckley (1976) theorized that the outward appearance of the psychopath was seemingly normal and thus not psychotic. Behind the mask of sanity, he saw an individual with a *semantic* disability, meaning that s/he is unable to truly experience socialized meanings or values, most profoundly expressed by a severe lack of emotional understanding. The latter was reflected in the psychopathic symptoms defined in The Mask of Sanity, which besides distinguishing psychopathy from psychoses divided symptoms in two categories: Chronic behavioral deviance and emotional-interpersonal deficits. Whereas the former included antisocial, unreliable and superficial behavior, the second focused on deceit, egocentricity, a lack of remorse and "general poverty in major affective reactions" (Cleckley, 1976, p. 388). Approaching the twenty-first century, the construct of psychopathy was further specified by Robert D. Hare (2003), who stayed relatively loyal to Cleckley's understanding of the diagnosis in his development of the Psychopathy Checklist-Revised – PCL-R. The latest revision of the psychometric scale, which was released in 2003, includes twenty items that are clustered in two 'factors' that are also respectively broken up into two 'facets' (Table 1).

Table 1: The Hare Psychopathy Checklist-Revised across editions (Hare, 1991; 2003)

Factor 1: Interpersonal/Affective	**Facet 1: Interpersonal**	1. Glibness/superficial charm
		2. Grandiose sense of self-worth
		4. Pathological lying
		5. Conning/manipulation
	Facet 2: Affective	6. Lack of remorse or guilt
		7. Shallow affect
		8. Callous/lack of empathy
		16. Failure to accept responsibility for actions
Factor 2: Social Deviance	**Facet 1: Lifestyle**	3. Need for stimulation/prone to boredom
		9. Parasitic lifestyle
		13. Lack of realistic long-term goals
		14. Impulsivity
		15. Irresponsibility
	Facet 2: Antisocial	10. Poor behavioral control
		12. Early behavior problems
		18. Juvenile delinquency
		19. Revocation of conditional release
		20. Criminal versatility2
Others		11. Promiscuous sexual behavior
		17. Many short-term marital relationships

A score higher than 30 out of 40 is the clinical cut-off point needed to assess psychopathy, which is scored on the following 3-point scale: "0 indicated that the characteristic definitely was not present or did not apply, 1 indicated some uncertainty about whether or not it applied, and 2 indicated that it definitely was present or applied" (Table 1; Hare & Neumann, 2006, p. 62). Several Cleckleyan symptoms were left out of the PCL-R. The two symptoms used for distinguishing psychopathy from psychotic disorders – 'good intelligence' and absence of delusions – were discontinued, as the non-psychotic view of psychopathy was generally accepted by the academic community. Most notably, Hare (2003) took out the characteristic of 'suicide rarely carried out', as the two Factors of the PCL-R were correlated with different frequencies of suicide: the social deviance factor being associated with high frequency, and the interpersonal/affective factor with low frequency. Although consumption or abuse of drugs or alcohol was included in earlier versions of the PCL-R, the symptom 'drug or alcohol abuse not direct cause of antisocial behavior' was later taken out because of its difficulty to score. All in all, whilst Hare (2003) was not the only scholar developing psychodiagnostic tools for psychopathy, his research on the diagnosis has been paramount to its modernization, its specification and the improvement of clinical practice.

However, the DSM – one of the most important diagnostic handbooks in the practice of clinical psychology – did not recognize the construct of psychopathy as Hare and Cleckley defined it (APA, 2013). Whereas earlier editions of the DSM featured definitions closer to the notions of Hare and Cleckley, the APA broke tradition with the past in the third edition, which shifted focus from the Cleckleyan traits as they were difficult to measure reliably. Antisocial personality disorder (ASPD), which was intended to be synonymous, thus focused on "behaviors (…) rather than the reasons as to why they occur" (Hare, 1996). The diagnosis was thus met with criticism, most notably concerning the extensive length of the list of symptoms, the diagnosis' dependence on memory and self-reports regarding patient misconduct and the large focus on (criminal) behavioral indicators (APA, 1980; Hare, Hart & Harpur, 1991). Overall, the diagnosis accounted very little for traditionally 'psychopathic' traits such as the lack of empathy, remorse and affect. DSM-5 ASPD has maintained its emphasis on criminal behavior. Although it accounts more for affective symptoms, it still mostly bears likeness to the second factor of Hare's (2003) psychopathy.

Regardless of the above, according to the American Psychiatric Association (2000), antisocial personality disorder "has also been referred to as psychopathy" in the DSM-IV-TR (p. 702). Whilst there has certainly been a diagnostic confusion involving the constructs of psychopathy and antisocial personality disorder, the implication that the current conceptualization of psychopathy equates the contemporary diagnosis

of antisocial personality is incorrect, as research has repeatedly illustrated (Hare, 1996). Even more, psychopathy measured by Hare's criteria has "substantial construct validity" on its own, and many statistical studies have shown that this strong relationship is most profoundly found on Factor II of the PCL-R, meaning that antisocial personality disorder is highly related to the measurements of the 'social deviance' factor of psychopathy (Hare & Neumann, 2008; Kosson, Lorenz & Newman, 2006).

This begs the questions as to what extent antisocial personality disorder and psychopathy have underlying mechanisms in common and to what extent they differ. In a study involving a large population, Kosson, Lorenz and Newman (2006) found that people with ASPD and psychopathy not only accounted for more "severe criminal behavior" (p. 798) but also poorer emotional processing than those with just ASPD. Prevalence studies show that whilst 50% to 80% of prisoners qualify for the diagnosis of ASPD, only 15% of prisoners score higher than 30 on the PCL-R (Ogloff, 2006). Moreover, neurobiological studies have shown that psychopaths have more trouble processing emotionally charged language and imagery (Ogloff & Wong, 1990; Gur, Roland & Gur, 1992).

Psychopathy and the DSM

In order to assess whether psychopathy should be featured in the DSM, one needs to consider not only the possible flaws of psychopathy, but also of antisocial personality disorder. As a large part of the prison population qualifies for the criminally focused diagnosis of ASPD, a vital criticism of the construct is its "medicalization of crime" (Millon et al., 1998, p. 293). Most of these inmates have substantial comorbidity rates for substance use disorders, which further complicates the causality of ASPD and its validity as a distinct disorder (Millon et al., 1998). According to Edens and colleagues (2015), the diagnosis also is a poor predictor of institutional violence and has considerably less predictive validity than Hare's PCL-R – a psychometric that has been named "the single best predictor" (p. 361) of overall violence and recidivism by Butcher, Minkea and Hooley (2013).

Still, psychopathy is excluded from the DSM, for the reasons of "simplifying the criteria" – for ASPD/psychopathy – and "increasing congruency and compatibility between the DSM-IV and the criteria from the ICD-10" (Hare, Hart & Harpur, 1991, p. 391). Besides the lack of clinical consensus concerning psychopathy, critics of the construct also say that the diagnosis is difficult to measure in a reliable manner. However, it is because of this reason that the PCL-R has come under immense scrutiny, whilst it has repeatedly been found to be a reliable and valid tool for the assessment of psychopathy, one that is continuously validated for different populations (Hare, Hart & Harpur, 1991). Nevertheless, the PCL-R requires many resources: Time, psychotherapeutic expertise and extensive information on patient history (Hare, 2003; Ogloff, 2006). Psychopathy, regardless of its other disadvantages, has one fundamental issue. Treatment for the disorder is perceived to be impossible or very burdensome by many practitioners, although several studies have shown promising results with e.g. Schema Therapy (Chakhssi et al., 2014).

Discussion and Conclusion

By means of reviewing the relevant literature, it has become clear that antisocial personality disorder and psychopathy not only have gained validity and reliability over time, but they also can no longer be equated as the same disorder. This research points out relevant aspects of the concept of psychopathy, indicating the importance of further discussion and revision by the APA. As a result, the recommendations stemming from this research are as follows. Firstly, more research into using the dimensional model for the diagnosis of personality disorders is necessary. The DSM-5 introduced this new hybrid model along with a specifier for ASPD "with psychopathic features" (APA, 2013, p. 765). Although the dimensional model has been shown to be more effective in covering affective traits, the specifier still considers the two constructs as if they are the same (Strickland et al., 2013). The latter ties in with the second recommendation: Psychopathy should be considered distinct from antisocial personality disorder as much as possible. In order to achieve these two suggestions, the academic dialogue about psychopathy needs to be stimulated. As of now, the diagnostic confusion is still too large, leading to misconceptions such as the perceived impossibility of treatment (Chakhssi et al., 2014). Reflecting upon these three recommendations, the research question stated at the beginning of this paper and the research in sum, psychopathy and antisocial personality disorder should no longer be considered as interchangeable terms, as research with regards to diagnostic factors, prevalence and psychometrics has consistently found the constructs to be *different* yet *related* diagnoses.

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Educational Goals

1. To gain an understanding of why psychopathy and antisocial personality disorder developed into different diagnostic constructs.
2. To be able to distinguish between psychopathy and antisocial personality disorder on the basis of clinical characteristics.

Correspondence

Mr. Daniël Janssen
University College Roosevelt
Jacob Roggeveenhof 101
4333 AZ Middelburg
The Netherlands
d.janssen@ucr.nl
daniellucasjanssen@gmail.com

Clinical features of Methamphetamine – induced Psychosis inpatients

Poster

Seyed Mohammadrasoul Khalkhali Sharifi, Reza Ahmadi, Azam Hamidi, Homa Zarrabi, Kiomars Najafi, Robabe Soleimani & Somaieh Shokrgozar (Iran)

Keywords: Methamphetamine; psychotic disorder, inpatients; violence

Background

Psychotic Symptoms are frequently experienced among individuals who use Methamphetamine that sometimes may require management in inpatient psychiatric setting. Methamphetamine use has increased in Iran in recent years and a significant percentage of psychiatric services admissions are Methamphetamine induced psychotic (MIP) patients.

Aims

To define clinical features of MIP inpatients.

Methods :All files of MIP patients from august 2013till august 2014 in shafa psychiatric hospital located in Rasht were assessed and data related to psychiatric symptoms, Duration of hospitalization and treatment methods and demographic data of 152 MIP patients were extracted .According to duration of remission of psychiatric symptoms the patients were divide to 3 groups ; Transient psychosis (Less than one week); prolonged psychosis (Less than one month) and persistent psychosis (One month or more). Data were analyzed by descriptive statistical methods.

Results

The most frequent psychiatric symptoms were violence (75.6%), Intimate partner violence (61.2%), Persecutory delusion (82%), reference delusion (40.4%), grandiosity delusion (34.2%), Infidelity delusion (31/5%) . Auditory hallucination (53.4%), Visual hallucination (19.2%), Suicidal thoughts (14.5%), Homicidal thought (3.9%), Suicide attempt (10.5%) and Homicide attempt (0.7%) . in 31.6% of patients symptoms continued more than one month. The most frequent antipsychotic drugs were Risperidon (46.1%) and Olanzapin (37.5%). Electroconvulsive therapy (ECT) were used for (17.2%) of prolonged and (20.7%) of persistent MIP cases.

Conclusion

Violence with a considerable frequency was seen in MIP-inpatients. Considering the types of delusions, it can be a serious threat to physical and psychological health of victims, especially partners and families of MIP-patients. The frequency of persistent MIP was about three fold of the only MIP inpatients study in Iran and closer to eastern and Japanese studies, and also like many increasing number of studies, showed that psychotic symptoms may last more than one month. Promising finding about successful use of ECT; especially in persistent cases, were found in this study.

Educational Goals

- Describe Methamphetamine induced psychotic disorder (MIP) and its clinical feature.
- Analyze the clinical feature of MIP and its relation to violence, suicide and homicide.

Correspondence

Mr. Mohammadrasoul Khalkhali
assistant professor of psychiatry
Golsar,alley No89,Atie bld
4163744438 Rasht
Iran
rasoolkhalkhalimd@yahoo.com

Who becomes violent, who is victimized, and who becomes both after discharge from emergency psychiatry?

Poster

John Olav Roaldset, Stål Bjørkly (Norway)

Keywords: Offending, Victimization, Mental illness

Abstract

Most research investigating offending and victimization has focused on either offending or victimization. In a review by Jennings (2012), 37 studies were found on the violence – victimization overlap. However, only three studies were from psychiatric settings. They found a significant offender – victim overlap.

The aim of this study was to explore the association between offending and victimization after discharge from acute psychiatry.

All acutely admitted patients in a psychiatric emergency hospital in Norway during one year were included in the study (n=489). Three hundred and forty-five patients (70%) were followed up one year after discharge. Baseline variables (e.g. age and gender, inpatient self-harm, diagnosis, V-RISK-10 score, MINI-Suicidal Scale score, and lipid values) were recorded during hospital stay and compared to post-discharge episodes of violent acts and violent victimization.

During the first year after discharge 48 patients were recorded with violence only, 27 patients were victims only, and 42 patients were recorded with both violent acts and violent victimization.

Multivariate comparison between these three groups; the offender only group, the victims only group, and the both offenders and victims groups, will be presented.

Educational Goals

1. The frequency of offending and victimization after discharge from emergency psychiatry
2. How extensively overlap violence and victimization?

Correspondence

Mr. John Olav Roaldset
Psychiatric Department, Ålesund Hospital
Åse
6026 Ålesund
Norway
johnolr@gmail.com

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Announcement

The 10ᵗʰ European Congress on Violence in Clinical Psychiatry will be held in Dublin – Ireland from the 26ⁿᵈ till the 28ᵗʰ of October 2017.

Congress Venue & Hotel will be the Crowne Plaza Dublin – Northwood, Northwood Park, Santry, Dublin 9, Ireland

Please reserve these dates in your diary.

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

"Advancing Knowledge – Transforming Practice"

The 9th European Congress on Violence in Clinical Psychiatry is taking place in Wonderful Copenhagen, one of Europe's oldest capitals, and its most egalitarian city.

Contemporary evidence-based health and social care prioritises the judicious use of best available evidence, ethical care, shared decision-making with service users and their representative agents, emphasises human aspects of care with strong service user choice and preferences based upon sound interpersonal skills. This is evident in the quality of presentations providing an invaluable resource to commissioners of mental health and intellectual disability services, educators, and those shaping national and international policies in violence in clinical psychiatry.

The Congress takes an interdisciplinary approach advancing knowledge and transforming practice in treating and reducing violence. For the first time we are working in practice with service users to examine how we can close the gap between the rhetoric of evidence and the reality of everyday practice. En varm velkomst til alle!

*Prof. Patrick Callaghan
Mr. Nico Oud, MNSc
Prof. Johan Håkon Bjørngaard
Prof. Henk Nijman
Prof. Tom Palmstierna
Prof. Joy Duxbury*

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