

Ian Needham - Patrick Callaghan - Tom Palmstierna - Henk Nijman - Nico Oud

Proceedings of the 6th European Congress on

VIOLENCE IN CLINICAL PSYCHIATRY



KAVANAH

Violence in Clinical Psychiatry

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Editors

Violence in Clinical Psychiatry

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Preface

Fifteen years ago the very first conference on Violence in Clinical Psychiatry was held in Stockholm. This year we return to Stockholm and offer once again a platform for practitioners, researchers, users, and policy makers to exchange, debate and discuss strategies to address violence in clinical settings.

The return to Stockholm offers us the opportunity to report our impressions on some of the developments in clinical psychiatry we have observed in the last 15 years.

It has come to our notice that practitioners, researchers, and policy makers are endeavouring to understand the views of patients who employ violence and who are also on the receiving end of institutional measures used to counteract violence. The appraisal of such institutional reactions may – depending on one’s own standpoint – be located anywhere on a continuum ranging from the legitimate use of executive power to handle violent behaviour to malicious counter violence. In earlier years the focus was on the management of violent patients based on the assumption that violent behaviour was an objective entity inherent in the perpetrator alone. More recently, some have advocated that violence is attributable to or at least provoked by professionals. The current state of knowledge would suggest that both positions taken concurrently may offer a better explanation of the cause of violence. Attempts to understand violent behaviours are not only to be found in ethical papers on violence in clinical psychiatry but in the form of a reflexive approach by staff which is apparent in many of the conference presentations.

We can also report that some large-scale national efforts have been initiated to reduce the use of coercive measures, such as seclusion, in Europe. As mentioned above the use of coercive measures per se is viewed by many to be a form of institutional violence against patients and thus all efforts to reduce these will be welcomed by patients and professionals alike.

Our observations suggest that there seems to be a rise in cross-cultural comparisons of practices surrounding coercive measures in the various countries represented by the papers in this conference. Discussions involving professionals from different countries reveal that many cultural differences exist in their views of various kinds of coercive measures. In some countries belts for mechanical restraint are deemed barbarous, but the use of psychotropic substances is seen as more humane. Professionals in some countries abhor the use of seclusion and would condemn

this as solitary confinement. In at least one case the value attached to coercive practices is expressed in the linguistic term: The Dutch word for a belt or strap to mechanically restrain a patient is termed the “zweedse band” (the Swedish strap). These observations underscore the necessity to be sensitive to the cultural context of violence and aggression.

The use of aggression assessment and prediction tools also seems more uniform and standardised across Europe. More and more countries are using translations of the same tools, such as the BVC, the HCR-20, and the SOAS-R which renders comparisons between institutions, regions, and countries possible. This trend toward standardisation is to be welcomed providing that these instruments are used carefully, are open to development and are a means of predicting and registering violence and not an end in themselves.

Another important observation is the augmentation of studies aiming to investigate the effectiveness of interventions aiming at reducing aggression or coercive measures at ward level. Some of this research includes randomised controlled trials or other well-controlled designs. Studies like these show that ward teams and ward managers understand the necessity of including adequate control conditions in attempting to learn which interventions work in reducing aggression. This development indicates that the scientific community is gradually transcending the stage of descriptive or epidemiological research – although such studies remain important – and striving to find the best empirical evidence for specific interventions.

This – rather sketchy and impressionistic – tour d’horizon of the last 15 years shows that much progress has been made. We must, however, confess that there is still a lot of work ahead before we can contend that we have the adequate knowledge and capabilities for assessing, treating and caring for potentially violent patients. Therefore it would seem that we have ample goals and motivation for the 7th European Congress on Violence in Clinical Psychiatry to be held in Prague, Czech Republic, from the 20th till the 22nd of October 2011., However, for the meantime we hope you enjoy and profit from the current conference in Stockholm.

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Patrick Callaghan
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Chapter 1 – Keynote speeches

Evaluation of an overall comprehensive institutional programme for reducing violence and coercion

Anna Björkdahl

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Keywords: Psychiatry, violence, training, ward culture, prevention

In 2005 we introduced a programme to prevent and manage violence in psychiatric inpatient care to almost one hundred psychiatric wards in Stockholm. The programme originates from the Norwegian ‘Bergen-model’ developed by Olsen, Hanssen and colleagues in Helse Bergen, Sandviken. The model is taught in a four day course for staff of all professions on wards. Half of the time is spent on theory and half on physical techniques and choice of strategies for problem solving by integrating theory and practice. The content is based on evidence, basic ethic principles and clinical integration, emphasizing an understanding of the complex processes involved in difficult and dangerous situations from both a patient and staff perspective. Collaboration among staff and between staff and patient is vital to the model. Trainers are handpicked from clinically active staff who are trained in a ‘training trainers’ course. Refresher hours are offered on all clinics on a regular, often weekly, basis where the content is based on the participants’ present situation and encounters with patients and colleagues. To evaluate the programme several studies are in progress including both quantitative and qualitative aspects.

Since we started this programme questions and thoughts have emerged that mirrors many aspects included in violence in psychiatry. And although answers are important, sometimes questions can be more interesting.

This presentation raises the following questions:

- Should a general reduction of aggression in psychiatry be understood as both a reduction of aggression from patients towards staff and from staff towards patients? Or should only aggression from patients count? Is the frequency of aggressive incidents and coercive interventions partly a measure of patient aggression, staff aggression or both? Is it possible to measure staff’s aggressive behaviour?
- How much anger should be allowed for patients to express before it becomes aggression? Scientists argue that today’s ideology of humane psychiatric care and treatment is founded upon a double set of values. One is the humanistic values of equality, respect and dignity of all human beings, the other is the value of order and discipline in society as well as on wards. How can these values coexist?

- How do we find a balance between a naïve and hard approach in these questions? Do we have a situation where communication and negotiation are the most desired skills in conflict situations and restraint and use of coercive measures is the ‘dirty work’ and a sign of failure? Could a way forward be to clarify what staff behaviour patients’ have described as helpful and not helpful in controlling situations?
- What about medication? Is a quiet ward with low incident rates always a good ward? What if the patients are all drugged and sedated? Some wards are good at using correct acute aggression medication at appropriate times while other wards use improper types of medication and may have more incidents although staff’s violence management strategies are much the same. As much as medical studies usually do not include variables concerning staff-patient interaction, most non medical studies on violence in psychiatry do not include patients’ pharmacological regimens.
- Do we use role play in violence management training that further establishes stereotypes of patient and staff behaviour? A recent study describes how participants get rewarded for showing aggressive behaviour in role plays. A certain level of aggression in role play is common, motivated by a need to train under realistic conditions. How does that influence the participants’ picture of a conflict situation when a real situation is about to develop?

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Towards Systematic Risk Management of Institutional Violence: Structured Professional Judgement using PRISM

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Violence within hospital and prison settings is a significant problem: patients, prisoners, visitors and staff can be assaulted. The impact of such behaviour can have profound, wide-reaching and long-term consequences both at a personal (e.g., injury, disability, psychological trauma etc.) and at an organisational level (reduced service delivery, impoverished regimes and resources, low staff morale etc). To-date, much of the focus on managing violence has centred on identifying and targeting for change individual risk factors such as mental disorder, substance abuse problems, antisocial beliefs etc. However, human behaviour does not occur in a vacuum of internal drives and motivations; situational and contextual factors are relevant. In comparison with the literature on individual risk factors, much less is known about the relevance of situational risk factors.

In this paper I will consider three issues. First, I will consider the benefits of focusing on the individual institution rather than the individual patient or prisoner when developing risk management strategies. Second, I will describe the development of a set of structured guidelines for assessing situational risk factors for violence (i.e., PRISM: Promoting Risk Intervention by Situational Management). The PRISM guidelines are based on both empirical research and clinical experience. Third, I will describe how the approach may be used to evaluate an institution and allow the development of systematic interventions to manage violence risk.

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Ethical care of patients who are aggressive

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Principlism, deontology and consequentialism are commonly used theories in medical ethics. These theories focus on actions taken and are used to determine whether an action is justified or not justified. These theories, however, do not reflect the interactions between the clinician and the patient. Therefore, although these theories are relevant to the care of patients who are aggressive, they do not provide the complete picture. In this paper, I will present models of ethics that take into consideration the persons involved in the interactions. These models include ethical caring, relationship-based care, and an ethical consideration of the “other”. I will use examples from research to support the use of these theories and will show how these theories can be used in practice.

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Coercion in Europe – experiences from the EUNOMIA project

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This presentation will report some results from the EC-funded project “European evaluation of coercion in psychiatry and harmonization of best clinical practice” (acronym: EUNOMIA). The project was carried out in 11 European countries (Dresden – Germany; Sofia – Bulgaria; Prague – Czech Republic; Thessaloniki – Greece; Naples – Italy; Vilnius – Lithuania; Wrocław – Poland; Michalovce – Slovakia; Granada/Málaga – Spain; Örebro – Sweden; London – United Kingdom, and Tel Aviv – Israel).

According to its main objectives this project a) assessed from a clinical viewpoint all legally involuntary patients consecutively admitted to general psychiatric departments (recruitment period: 2 1/2 years) who lived in 13 clearly defined catchment areas and a sub-group of voluntarily admitted patients who felt coerced at admission; b) produced standardized reports on the national legal situations on coercive treatment measures in psychiatry, on the basis of the original national legal texts; and c) developed suggestions of good clinical practice on involuntary hospital admission and coercive treatment measures like mechanical restraint.

One of the clinical results (established by the assessment of 2326 legally involuntary patients) was that in the different countries, between 39% and 71% of the patients found the admission right after one month, and between 46% and 86% after three months. Female patients, those living alone and those with a diagnosis of schizophrenia had more negative views. Adjusting for confounding factors, differences between countries were significant.

Analyzing the standardized reports on the national legal situations on coercive treatment measures in psychiatry revealed major cross-national differences, e.g. for basic conditions as well as for additional criteria for involuntary admission, time periods for making decisions, the association between involuntary placement and treatment, patients’ rights to register complaints, roles of relatives, and safeguard procedures of these processes.

Suggestions of good clinical practice on measures like mechanical restraint were worked out by local expert groups in 11 countries, mostly in semi-structured group discussions. By use of a system of categories developed with a content-analytical method, these national documents were comparatively assessed, and integrated into a common clinical recommendation. Results focused on legal and clinical pre-conditions for the use of mechanical restraint, specific instructions for the clinical behaviour of different professional groups, ethical issues, and procedural aspects of quality assurance, and will be reported in detail.

The discussion section of this presentation will focus on (clinical and legal) issues which could be (cross-nationally) harmonized in the sensitive field of coercive treatment, and will highlight areas of future research.

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Soothing while secluding

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Introduction

This article reports parts of the research that was presented in the proceedings of the conference to launch ENTMA, Meymandi (2008), without the accompanied literature review. Those reviews were partly focused on the long lasting and negative effects that often influence psychiatric patients who have to be secluded in the hospital. The objective of that research was to evaluate the effectiveness of an environment that was designed to promote relaxation for the patients who were secluded.

The research was phenomenological and qualitative in nature collecting patients' observations and stories as they experienced the special room named "Retreat". During post seclusion interviews most patients could project their individual and idiosyncratic approach to their thought organization, preoccupations, assumptions and outcomes.

Although none of these patients initially volunteered to enter the room and some had to be restrained, they did ask their nurses several times later to use the "Retreat" for meditation, relaxation or the prevention from getting out of control. One patient wrote "After being restrained by local officers and sent to the psychiatric ward, I felt calm and naturally at ease inside your room with the landscape wall paper which I believe you call retreat."

The Thoughtful room "Retreat"

"Retreat", is best described by Rubinow, D. (2009), the chair of Department of Psychiatry, where it is applied as a method for managing anxiety for the psychiatric inpatients. He writes: one of the nursing staff hand painted a panoramic landscape in an 8 x 10 ft seclusion room. This painting transformed the room's barren walls creating the illusion of sitting on the back porch of a simple country home, looking at a fishing pond in the distance. It is purposefully designed to activate natural calming responses in patients who are experiencing anxiety and frustration or who feel danger through an altered sense of reality. Subliminal messages in "Retreat" are aimed at neutralizing the stressors that might provoke a "flight or fight" response.

The artistic style used in creating "Retreat" was inspired by Gestalt Theory of "Closure" as described by Richards (1975). The closure concept suggests that human mind tends to complete a picture or figure when part of information about that picture/figure is missing and the available information otherwise would combine to create a unified entity or theme. Mark Wallace (2004), points out that at the developmental neurology level, individual sense not only identifies its own sensory cortex, but it also echoes to other regions of brain and contributes to the integration of information across different senses. This integration is the biological basis for the perceptual gestalt, when the world is experienced as a whole rather than a patchwork of separate sensations. As a result, one sense may enhance the perception of other senses, as exemplified by lip reading, which in turn enhances one's hearing and understanding of the words.

"Retreat" is further based on the integration of two distinct psychological concepts. One is the concept of an inherent relationship between primordial man and nature. People activate their limbic relationship with the outdoors when they take vacations in natural settings, go on nature walk or work outside in a garden. From Roger Ulrich's (1984) observation "The view through my window may influence recovery from surgery" to more contemporary findings, the positive and healing power of color, aroma and sounds of nature are well-documented. For example, hearing birds sing sends the subliminal message that the environment is peaceful and available for safe

living. Aroma of flowers gives the feeling that there are vegetation and possible food and the sound of running water supports the notion that thirst will be satisfied. Whatever supports life can be very comforting.

In contrast to the spontaneous response of primitive man to nature, the second concept in the design of "Retreat" is the civilized man's intentional attempt to accommodate for safety and comfort. The notion of sitting on the back porch of a home was initially derived from interviews of more than 40 patients who were asked to describe their favorite calming places. Some of the most heart – touching and sensitive descriptions of home were given by those who were homeless or had difficult family dynamics; those who longed or coveted a home. Psychiatric nurses are keenly aware of the fact that many of their patients frustrate their family's love and exhaust their supportive care. It is often the case that those patients jeopardize their own self- respect and dignity because of their life style. Many patients described home as a place where one would find love, care and respect. Some patients could elaborate on the emotional implications of home; others expressed greater insight as to the philosophical extension of man in his place of comfort.

The artist of "Retreat" delicately creates the concept of "home-ness" by reducing the structural details of the house to simple, functional elements. For example, the columns, railings and walls are simple gray hues that delineate the beauty of the home itself from the perspective of sitting on the back porch, where one's entire visual field is surrounded by splendid view of nature. The characterless windows are made to look like home by their elegant and graceful lace curtains, through which one can peek at family portraits hanging on the interior walls. The visual impact of the room is augmented by an audio system that gently plays the sounds of nature that one would expect to hear while sitting on the country home's porch and just listening. A patient can sit quietly and hear birds singing, water trickling in the pond, and the soft wind rustling through the trees. In some supervised situations, lavender aromatherapy is used to add a sense of calm and further support the patient's feeling of contact with nature. Many patients have stated that they felt good knowing that so much effort by their nurses was invested to create a place of comfort especially for them.

Under controlled conditions, a number of patients voluntarily participated in an IRB-approved research, looking at the effectiveness of "Retreat" to reduce anxiety. Synergistic effect of multisensory input provided in the "Retreat" to a great statistical significant can lower the vital signs while patients subjectively report the experience of calmness.

A Case Study

This is one of the cases that the patient's post seclusion interview, after patient's consent it was tape recorded:

Linda was a 60 years old female who had suffered from more than 40 years of depression, reported of "being sick and tired of being sick and tired." She was admitted to the Crisis Unit because of her suicidal ideation, where she wanted to kill her dog first and then kill herself. In the beginning Linda maintained her focus on finding a way to kill herself while in the hospital. When she was laying on the floor of her room, she wanted to break the night light bulb under her bed and mortally injure herself. Although Linda was constantly monitored by her nurses, she started to get physically entangled with staff and struggled toward her death wish objectives. It became evident that patient started to get some secondary gain from this constant attention and physical engagement, and probably could benefit from isolation of the Retreat.

Linda spent about 4 hours in the unlocked seclusion in the "Retreat" before she decided to contract for safety and go back to her room. She was informed that she could use the "Retreat" at any time for her relaxation or getting away from the noise and activities of the unit. After That initial introduction, Linda voluntarily used the room eight more times for meditation and anger management before being discharged from hospital.

In the post seclusion interview patient expressed her understanding of depression, her difficulties of being around people, her lack of interest and the lack of vision regarding her future.

Patient's anxiety around people and her lack of skill to deal with others was the most emphasized issue for her. Patient wanted to write her impression of the Retreat by sitting in the room away from everybody else. She wanted to be by herself rather than talking to the research nurse and being tape recorded. She spent about two hours to write the following: "As the night comes around that is when I find my emotions creeping up on me and I find the desire to run and hide. Then I go to the retreat room and sit in the chair or on the floor and look all around the room at the different scenes and go there sometimes I cry, think. I love the weeping willow tree; it reminds of the lost soul in search of something weeping for a lost one over the water that gives it life. Then there is the path I find my thoughts going down the trail and searching for something there. What I do not always know yet I travel down this gravel road into the unknown not quiet sure what is beyond while music plays sometimes with intensity and other with low soothingness I travel this trail scared to continue yet at peace with my decision to not turn back.

Then we have the pond and this is where I always end up at last after I have had my tears and the fear hasted I come to the pond where I spend time with those I loved and love. I walk along the grass next to the blue water and hold hands laughing and playing. We sing and have so much joy to see one another again. This is why I like to retreat in such beauty. Because it grounds me."

Conclusion

Linda's poetic feelings reflected in her writing were very helpful for her nurse therapist to start talking about the sensitivity and the gift that was obvious in the patient's work. During her stay, Linda wrote more of her stories and could talk about her feelings. In one conversation she pointed to the fact that her poetry is very dark and conveys suffering. The quality of her poems was not as important as the fact that she actually had poetry as was noted by her nurse.

It appears that Retreat offers opportunity for patients to project out their feeling about peaceful self that is somehow useful and non traumatic. Completely eliminating seclusion room may be proven to be unrealistic, yet what is provided should prevent fear and trauma while supporting patient's sense of self determination and dignity. Number of seclusion on the psychiatric units can be dramatically reduced by nursing knowledge and preparation for recognition of the signs of escalation and proper and rapid interventions.

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Pharmacological treatment of violent patients

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Keywords: Violence pharmacology neuroleptics, review aggression

Introduction

Violence by mentally ill persons may have at least three distinguishable reasons. Violence can be directly related to psychic symptoms such as delusions or hallucinations, it can be a consequence of impulsiveness due to the mental disorder, to intoxication or to axis II disorders, and it can be related to antisocial behaviour and/or personality traits. Theoretically, pharmacological treatment can exert its effects by treatment of the psychiatric disorder itself - if there is a causal relationship to the aggressive behaviour - and by direct effects on violent behaviour. Practically, separating these effects is often difficult. Treatment of violent behaviour can be separated in acute treatment of violent or agitated patients (rapid tranquilisation) and continuing treatment for purposes of prevention.

Methods

Literature review, based on reviews, the author's commitment for the establishment of a German guideline for the treatment of aggressive behaviour (1) and recent original articles.

Results

For acute treatment, good evidence is available from short-time studies. Neuroleptics and benzodiazepines are equally effective, seemingly independent from diagnosis. There is no evidence for better efficacy or safety of second generation neuroleptics administered for this purpose. For the prevention of violence, the best evidence is available for schizophrenia. Neuroleptics are rather effective against violent behaviour predominantly by their effects on schizophrenic symptoms. Analyses of the CATIE study suggest that olanzapine, ziprasidone and perphenazine are more effective than risperidone and quetiapine. There is no evidence for better efficacy of higher doses. Some evidence suggests that clozapine may have specific anti-aggressive effects independent from sedation and its antipsychotic properties and that clozapine may be particularly effective in severely disturbed patients. However, all these effects are considerably stronger during in-patient treatment than under out-patient conditions. In the CATIE study, adherence to antipsychotics was a negative predictor for future violence only in those patients who did not exhibit antisocial personality traits (2). Other substances which have been investigated for the treatment of aggressive behaviour in schizophrenia and other disorders are valproic acid, carbamazepine, lithium, beta-blockers and antidepressants. Generally, studies are often small and the evidence is rather limited. All the substances mentioned seem to have moderate anti-aggressive properties in some cases.

Conclusions: Rapid tranquilisation is safe and effective with neuroleptics and benzodiazepines. Pharmacological prevention of violence primarily requires adequate treatment of the underlying disorder. Pharmacological treatment of violent behaviour can exert effectiveness only if it is embedded in a treatment plan and accompanied by social support and needs-adapted interventions.

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Psychological approaches to the treatment of violence in mental health settings: An overview

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Psychological approaches to understanding how people construe and respond to challenging and threatening situations are central to any attempt to reduce a propensity for violence and thus to increasing the liberty and life-chances of those at risk. This paper will present preliminary findings from a broad systematic review of psychological interventions for violent people who have mental health problems and/or are offenders and will draw some conclusions on the state of the art. The review has attempted, some might say unwisely, to apply the focussed rigour of gold-standard review methods to a deliberately broad range of violent populations and outcomes in order to examine the effectiveness of psychological interventions. The relevant clinical and criminological literatures are fragmented from each other and practitioners and researchers in both settings should benefit from such an attempt to reintegrate evidence from across setting (Hollin 2008). However, the respective literatures are vast and highly diverse which creates problems of heterogeneity. The first stage of the review covers studies published from 1976 to 2001 (n=142 studies of a psychological intervention) and is largely complete whilst the second stage captures studies published 2002 to 2007 and is still underway (n=130 studies of a psychological intervention). In brief, the field is characterised by a state of methodological anarchy (Feyerabend 1978) which may be seen as healthily fertile or unhelpfully chaotic according to one's epistemological position. New systematic review methods such as 'realist synthesis' (Pawson 2006) may be more suitable for interpreting the body of evidence in such complex areas. The paper will draw on the full analysis of Phase 1 and preliminary analysis of Phase 2 to consider these issues and to present an overview of conclusions that may be drawn about psychological interventions in this area.

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Chapter 2 – Auto-aggressive and Suicidal Behaviour

Self-injurious behaviours in prison

Poster

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Background

The setting is the remand prison of the Geneva district, situated in the French speaking part of Switzerland. This centre was built thirty years ago. Initially conceived for 270 beds, the average number of inmates is currently around 450.

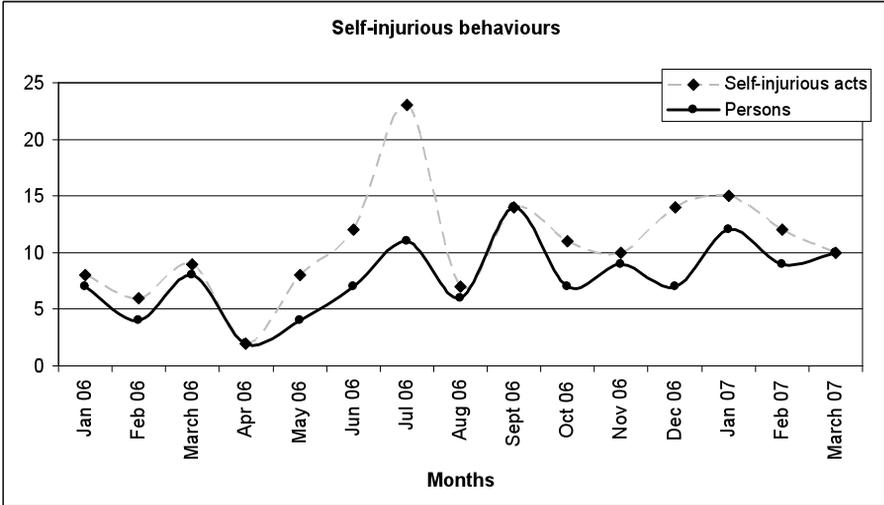
Method

We reviewed the medical records for self-injurious behaviours recorded by nurses over a 15 months period (January 2006 to March 2007). This time period was chosen to assess the impact of a dramatic event that took place on the 7th of July 2006. On that day, two inmates died in a fire that was started by one of the two victims.

Results

Over this 15 month period 80 inmates committed 161 self-injurious acts. The monthly distribution of acts is presented in Figure 1. The most frequent type of self-injurious behavior was self cutting or scratching (74%), followed by strangulation or hanging attempts (9%). The sewing of lips was observed exclusively among sub-Saharan African inmates, while the ingestion of cutting objects was specific to inmates from North Africa. Clusters of suicides were reported in small communities, institutional settings and prison. Copycat behaviour or imitation of an earlier suicide occurring in the same prison may be a factor in about 6% of prison suicides.

Figure 1: Self-injurious behaviours



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Chapter 3 – Consumer and Staff Perspectives on Violence

“You don’t leave an intensive care patient alone”: The implementation of Psychiatric Intensive Care for long-stay patients in the Mental Health Care Centre West North Brabant in the Netherlands

Workshop

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Keywords: Intensive psychiatric care, seclusion, restraint prevention

Introduction

Many long-stay patients in mental health care show behaviour that endangers themselves and others. This behaviour frequently led to long-term-seclusion with often a negative impact on the treatment relationship. It is currently appreciated that this behaviour can be corrected by adopting an attitude based on equality and characterised by negotiating. Two main components guided us, when we started a Psychiatric Intensive Care Unit (PICU) in 2006, in the development of this ward: 1) greater safety and thus less seclusion and fewer restraint measures, 2) the need to speed recovery through more intensive treatment; the two components reported as the biggest advantages of PICU in comparison with general acute wards (Bowers et al. 2008). The elements of Picu: four beds, a higher nursing staff level, a maximal length of stay of two years and one seclusion room shared with other units. The unit fits also the general definition of PICUs: small wards, with higher levels of nursing and other staff, mostly locked and sometimes with facilities of seclusion (Bowers et al. 2008 p.66). PICU Patients do have an involuntary admission status, have been identified with a higher risk either to themselves or to others and have a history of long seclusion episodes and have had substantial unsuccessful admissions at different acute or long-stay units in the hospital.

The aim (Crowhurst and Bowers, 2002) is to find a balance between ensuring security needs and creating an environment where the patients is offered a level of autonomy in making decisions. Care is focused on rehabilitation and recovery that will offer perspectives for the patients’ future development and for supporting their autonomy. Staff approach is based on the assumption that each person possesses potential for maturation, learning and growth if an environment is offered that preserves their dignity and fosters mutual respect and acceptance. A high quality multidisciplinary team supports stable working alliances based on trust, mutual cooperation

and special treatment policy. A prevention-based approach to care is introduced. Guidelines and protocols describe and organize the treatment processes, and the safety in the ward.

The permanent physical presence of the staff is necessary to ensure an intensive patient-staff involvement that facilitates a stable relationship with the suspicious, agitated or very anxious patients. Close observations give the opportunity to respond quickly to patients' needs and thus to prevent aggressive incidents. Sometimes one-to-one supervision is required, possible by a high staff to patient ratio. Training of the team is focused on changing the staff's attitude from controlling patients' behavior to one of negotiation, to use a non-authoritarian, non-condemnatory way of communication that allows patients to express any anger or confusion. Patients' individual needs will be respected, acutely disturbed patients will not be talked down to, and patients' autonomy will be stimulated. Conditions, to maintain contact and commitment with the patient.

The treatment involves various therapeutic activities, including cognitive behavior therapy with elements of mentalising and elements derived of the attachment theory. Mentalising is the developmental achievement of being able to reflect one's own behaviors and those of others (Fonagy et al, 2004); by providing a "buffering" process between emotionally charged behaviors of others and a patients' emotional reaction (Schore, 2003). The PICU staff aims (the attachment theory (Ainsworth, 1969)), to replace disturbed, often destructive patterns of interaction with normal ways of relating, thereby establishing a healthy pattern of attachment. Treatment protocols such as care plans (Donat, 1998), and personalized crisis-management plans are used as tools for planning therapeutic activities and offering structured crisis-prevention treatment.

The main workshop

"A long way to happy"

The patient can make an appeal to the staff any time, by day and night. During delegation-time the staff also strives for presence with the group of patients. If this is not possible, there will be negotiated with the patient about how to make it possible to tide over this time. When a patient does have a question which not simply can be answered with "yes", there will be immediately looked for other possibilities. Important for the patient in this matter is the feeling to be taken seriously. It's the way making co-operation possible. The premise is equality, so ruling and controlling becomes a less large pitfall for the staff.

The instrument is the personalized-crisis-management plan. The patients' personal coach and the patient describe a possible crisis in four different stages of emotional arousal. The signals give the patient as well as the staff a warning about the possibilities of escalation and how to deal with the signals. With the patient there will be negotiated about the measures that must be, or must not be taken. The early recognition of these signals is very important. The permanent physical presence of the staff makes it possible to observe, recognize and deal with these signals.

Many patients do have the experience to be secluded when they did turn into a crisis. The seclusion of a person into a crisis strengthens often this crisis. At the very moment that the patient is in big trouble, the presence of the staff is mostly required. This can also happen by night, for just in the dark hours awful feelings and thoughts can be felt stronger, which makes the presence of the staff even more important.

The patient who is at risk turning into a crisis, turns into a cannot position. Accepting this cannot position, offers the staff much more elbow room into nursing. The patient does want, but cannot at the very moment. Making a difference between "will not" and "cannot", requires a radical change in the way of thinking of the staff and in attitude. For such a change a supplementary training is required. When it is obvious that this "problem-behavior" cannot be considered as a

matter of “not wanting to change behavior” but above all as a matter of “having no other way”, it does make it possible to explore what the patient needs to acquire other behavior, that is more helping in reaching patients’ goals. Forbidding problem-behavior, for example according to a non-suicidal-contract, is in this vision not a real option.

Taking something away means a loss when nothing can be offered in place of it. Patients already have suffered loss many times in their life, which means that the attitude must be: what can be offered to the patient.

If the patient anyhow shows problem-behavior, the staff and the patient choose to examine all that had gone before to find out what other choices can be made by the patient. By supporting the patient in looking for choices, more options will be possible. The patient will be able to learn taking direction in his daily life by himself. The vicious circle – the problem-behavior – can be broken through. The patient may learn to experience that the staff is trustworthy in making a commitment. The patient may also show that he is trustworthy in making a commitment. As long as the patient and the staff can negotiate, many options are possible, even when the patient is in possession of contraband goods (for example a knife, or medicines).

Every patient, how complicated his case looks, is an unique person. An unique person, with his own unique limitations and potentials. If the staff the limitation cannot (or in the worse case will not) accept, the patient also cannot be successful in accepting his limitations and finding the best prosthesis.

Discussion

The PICU promoted a philosophy of providing care in the least restrictive environment and succeeded in almost eliminating the use of restrictive measures with seriously disturbed patients. We attribute the great success of the intervention to the introduction of multiple therapeutic approaches at different levels of the ward’s organization. We also believe that five factors were the key to the successful delivery of this seclusion-free type of care: the staff’s therapeutic and de-escalation skills, their close involvement with the patients, the cultural change from control to negotiation, the skilled leadership and the introduction of personalized treatment and crisis-management plans. The relative impact of each particular component of the reduction in seclusion we do not know yet, but a review of interventions for reducing the use of seclusion (Cadeyrm et al, 2007) in psychiatric facilities has already reported on the effectiveness of some of the core components implemented at the PICU: personalized treatment plan, leadership, higher staff-to-patient ratios, staff education.

Most studies report that patients with psychotic illness are the largest diagnostic group admitted to a PICU (Wynaden et al, 2000; Brown and Bass, 2004). The majority of our population was diagnosed with a severe form of borderline personality disorder. This group of patients had the highest risk of suicidal and/or self harm and/or aggressive behavior at our hospital and spent long periods in seclusion. By delivering a special intensive care, we managed to transform the vicious circle of clinical regression to a virtuous circle of improvement.

Dawson and MacMillan (1993) suggest that hospitalization of patients with borderline personality disorder is ineffective and counterproductive. The PICU shows that it is possible to eliminate restrictive measures, at least of patients diagnosed with borderline personality disorder, which Hoch (2006 p.181) already concluded.

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Violence and aggression in psychiatric departments: Evaluating the Greek staff's point of view

Poster

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Introduction

Psychiatric patient assaults on staff or other patients are a serious and continuing problem in health care settings. Violence that takes place during psychiatric hospitalization has unique implications for both patients, treatment facilities, and for research on violence. The impact of violence on institutions is not hard to discern: staff and patients are physically injured and may become psychologically disturbed, property is destroyed, and regimes and programs are disrupted and thereby impoverished. Furthermore, violent individuals are not only incarcerated for longer but are held in more expensive and more restrictive conditions. The literature on violence by psychiatric inpatients provides some evidence that rates of violence may be increasing over time. The risk of psychiatric patient violence and aggression on staff members or other patients is increasing yearly, with resultant increases in employee victim suffering, medical expense, and lost productivity.

Aim

The purpose of this study is to estimate the opinions and the attitudes which are considered appropriate in the difficult situations mentioned above and to highlight the predominant attitudes practice of the psychiatric departments. The research tool used in this evaluation is 'Management of Aggression and Violence Attitude Scale' (MAVAS), an appropriate questionnaire for the evaluation of the experiences, attitudes and opinions of healthcare professionals that can specifically examine views on the subject of aggression and violence in healthcare. This scale examine approaches to the management of patient aggression, more specifically the balance between seclusion or other restrictive measures and the less restrictive attitudes of the staff and the de escalation strategies.

Results

The study is performed on a total sample of 220 members of the staff recruited from both the Attiki Psychiatric Hospital of Athens and the two University Phychiatric Departments located at Attiko General University Hospital and Eginitio University Hospital of Athens. Findings show that staff working in different institutions show different attitudes. Nursing staff attitudes are related to the years of experience and training.

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Aggression and violence in mental health care settings: Patient and staff perspectives on causes and management

Paper

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Introduction

Despite rather extensive research worldwide the last 20 years, the occurrence of inpatient aggression and violence in health care in general and mental health care in particular is still reported to be on an increase. Violent episodes harm patients and staff, it damages the relation and alliance between patients and staff and it constitute a threat to the therapeutic environment on the wards. Previous research on violence from psychiatric patients tends to focus on the staff's perceptions and reactions to aggressive behaviour and its management. The patient perspective on the cause and management of aggression is rarely emphasized, and patients have up to now usually been the objects of research rather than active participants.

According to a recent literature review on violence and aggression among psychiatric inpatients, future research needs to focus on the interactive variables between staff, patient and environment in order to deepen the understanding of how and why aggression occur and the effects of preventive interventions (Woods, 2007). Consumer involvement and user-focused care requires participation from service users in all aspects of care. It is obvious that this should also include service users' perspectives on how to understand and reduce violence in the mental health system. This paper reports on a comparison, exploring the attitudes and beliefs held by patients and staff as to the causes and management of aggression and violence in psychiatric inpatient settings in Norway.

Aim

To compare the beliefs of staff and patients regarding the causes and management of aggression and violence across different mental health inpatient settings.

Methods

The study was conducted among staff and patients in acute and forensic psychiatric wards in Norway from July 2008 until July 2009. All participants completed the Management of Aggression and Violent Attitude Scale (MAVAS), developed by Duxbury (2003). MAVAS is a 27 item self-report questionnaire with statements about causes and management of patient violence and aggression. The items within the MAVAS guide the respondents to mark their views on causes of patient aggression reflecting three explanatory models for aggression (situational, external and internal). MAVAS also asks the respondents to mark their views on aggression management strategies.

Results

Data will be collected until July 2009; preliminary results will be presented and discussed. Capturing the insights of patients and recognizing differences in patient and staff views of causes

and management of aggression may increase the understanding of aggressive situations and lead to more effective ways of prevention and intervention in managing aggressive behaviour.

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How do we avoid consumer anger resulting in seclusion? What Strategies do consumers identify as needed for a behavioral emergency?

Paper

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Purpose

This study was funded by a SIPP Mark III grant to explore consumer experiences and treatment suggestions concerning the nursing management post admission. Admission to mental health services is a confronting experience that often results in consumer transfer to high dependency or seclusion. Consumers provided an insight into the experience of being triaged through emergency / engaging the CATT team during periods of crisis and how people found nursing practices, High Dependency and Seclusion and revealed the mysteries of nursing practices from the consumers perspective.

Methods

A participatory action research approach was chosen for the project. This was very appropriate as it resulted in consumer engagement and staff involvement. We presented our code grey data from the previous six month period to consumer focus groups and used a schedule of open ended questions to explore their suggestions and reactions.

Results

1. The project reviewed all code grey response events over a 6 month period for the whole of the Alfred.
2. A new 3 hour training program on post seclusion counseling has great potential to reduce consumer seclusion events and possibly to assist consumers in other options when they become agitated.
3. A new brochure aims to engage staff with consumers early in their admission and to assist consumers in understanding the hospital and its protocols. The therapeutic use of seclusion is also discussed with an invitation for consumers to provide future feedback as to our clinical processes.
4. The aggression training program has been revised using the consumer feedback and a less physical intervention based curriculum has resulted. This new curriculum focuses on de-escalation and calming and considers the five phases of aggression. As such a focus on counselling strategies has replaced a focus on control.

Conclusions

This project assisted us to integrate the perceptions and beliefs of consumers of the Alfred to develop better ways of orientating consumers to the health care environment and de-escalating agitation that could result in aggression and or violence.

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Difficult Decisions: Families of Individuals with Severe, Persistent Mental Illness Experiencing Mandatory Treatment

Paper

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Keywords: Families, Mental Illness, Mandatory Treatment

Families who have a member with a severe, persistent mental illness (SMPI) frequently live with considerable uncertainty and fear for the safety and well-being of their loved one (Corring, 2002). They also bear the stigma and societal misperceptions of SPMI. While there are ongoing efforts to combat this, considerable ignorance concerning SPMI continues to exist (Corrigan & Miller, 2004). When families reach out for help, they often face challenges in obtaining the support and education they need (Jensen, 2004). While these difficulties may fluctuate over time, they frequently linger and burden the family, necessitating difficult choices being made. This paper will explore the literature concerning the experiences of families of individuals with SPMI, including those related to mandatory community treatment. It is imperative for health care providers to discuss these issues in order to be aware of and sensitized to the realities in which these families live.

Severe persistent mental illness

SMPs are “brain disorders that are neither preventable nor curable, but are treatable and manageable with combination of medication, supportive counseling, and community support services, including appropriate education and vocational training” (National Alliance on Mental Illness (NAMI), 2006, p. 5). Examples include schizophrenia and bipolar disorder. SMPs are stigmatizing conditions in many societies. An individual or group is stigmatized when they are assigned “negative characteristics and identity” that causes “the person or group to feel unaccepted, devalued, ostracized, and isolated from the larger society” (Austin & Boyd, 2008, p. 953). For example, there are many misperceptions of individuals with SPMI being dangerous and violent. The burden that stigma brings with it is not felt exclusively by the individual with SPMI, but also the families involved (Corrigan & Miller, 2004). Families, and especially parents, often feel as if they are responsible for their loved one’s mental illness (Corrigan & Miller, 2004; Doornbos, 2002; Jensen, 2004). While much of this blame may result from a lack of knowledge concerning the complex etiology of SPMI, it nonetheless causes much hardship for families.

Difficulties with services and supports

Families of individuals with SPMI often require considerable support. Services and adequate supports for mental health concerns are limited and when they are available, they can be difficult to find and access. It is documented in the literature that a lack of services can result in considerable suffering and concern for families (Doornbos, 2002; Greenberg, Greenley & Brown, 1997). Living in rural areas can impact the availability of these and other services (Jensen, 2004; Tryssenaar & Tremblay, 2002). Many families have also expressed concern with services that are not necessarily appropriate for individuals with SMPI (Hanson & Rapp, 1992).

Caregiver burden is considerable in families who experience mental illness and there is a need to offer them support. Typically, the more an individual is supported, the less caregiver stress they experience (Jeon, 2003). Family intervention programs have been helpful in improving caregivers' well being. However, these programs are not always implemented as part of standard practice.

Health care professionals

Families face considerable challenges in dealing with mental health professionals. Many families feel excluded in the provision of health care and experience a lack of support (Doornbos, 2002). While families can be challenged to trust health professionals and the care they provide, they also want to feel as if the health professional could trust them (Talseth, Gilje & Norberg, 2001). Power differentials also arise between families and health professionals, often in the form of information exchange. Gaps exist between families wanting to be kept informed about the progress of their family member and the professionals' obligation to maintain confidentiality (Winefield & Burnett, 1996). Collaboration is important, as families are often the first to see early signs of relapse. However, this is not entirely reciprocal as the service provider has a duty to maintain client confidentiality. These disparities in power must be addressed in order for a therapeutic relationship to exist between health care providers and families. This lack of information sharing can impede individuals with SPMI in making a successful transition from an institution to the community. This is worsened by lack of follow-up by the hospital or by the community services, limited or absent availability of community services, and an unwillingness or inability of the individual with mental illness to follow-up with discharge and recovery planning (Hanson & Rapp, 1992).

Families' feelings of desperation

Families act as surrogates for health professionals to the point where "Families, rather than institutions, have become the major providers of the long-term care necessary for those with serious and persistent mental illnesses" (Doornbos, 2002, p. 39). They have also reported feeling they have to be in crisis in order to receive assistance (Doornbos, 2002). This desperation is difficult, isolating, frightening, and can impact on health and wellbeing. Corring (2002) explored quality of life issues for individuals living with mental illness and their families and found that many families felt that they were the "bottom line" (p. 353); they were the ones who were left to pick up the pieces for their loved one in the absence of other supports. They felt that many people either do not understand or, more alarmingly, do not want to understand what it is like to live with mental illness.

Making Decisions Regarding Mandatory Treatment

Many families resort to making difficult and painful decisions based on their level of frustration and caregiver burden. For some individuals with SPMI who, as a result of their illness, become a risk to themselves or others, community treatment orders (CTOs) may be used. CTOs are court mandated community treatment for individuals with SPMI who have a history of frequent readmissions to hospital and repeated non-adherence to treatment plans. In being mandatory, if individuals do not comply with treatment, they can be automatically readmitted to a treatment facility against their will (O'Reilly, Keegan, Corring, Shrikhande & Natarajan, 2006). This creates significant ethical concerns for families. While many families do not like the idea of mandatory treatment, they also do not want to see their family member ill nor do they want the individual to be at risk of harming themselves or others. There is some evidence that family members view CTOs as necessary to deal with difficult situations involving individuals with SPMI such as frequent and serious deteriorations in functioning and wellbeing. O'Reilly et al., (2006) conducted a study that explored CTOs and found that families felt that CTOs could bring

control to an out of control situation as families often struggle with the crises that can arise from the mental illness. While CTOs could be helpful, families also noted that the process of implementing a CTO can be “too cumbersome” (p. 520) as there are many administrative details involved in their implementation. In addition, the duration of some CTOs were felt to be too short to provide any long-term stability for the individual with mental illness. Families also felt that while legal and police involvement was sometimes warranted to deal with certain crisis situations, the experiences with the legal system led participants to feel that the family member with mental illness was being “criminalized” (p. 520).

Many jurisdictions in Canada have or are in the process of phasing in the use of CTOs. While more research is needed to understand their efficacy, there is a need for the input of families to be meaningfully appreciated. Many of the concerns families have voiced regarding the lack of support and community follow-up, if addressed and changed, could very well reduce the need for the use of CTOs. The ethical debate continues to be deliberated in many venues. It is neither a widespread suitable response to the issues facing many individuals with severe and persistent mental illness. Nor is it something that should be excluded *carte blanche*. What is certain is that while CTOs are controversial and not necessarily desirable, they may bring some certainty to families who live out their daily lives with many unknowns.

Conclusions

SPMI are not curable but they are manageable with appropriate treatments, medications, and socioeconomic supports. For many individuals with SPMI, vital assistance is derived from their families. While many families are gladly willing to act as a support, an advocate, and as a caregiver to their members with mental illness, the plethora of challenges they face cannot be ignored. The process of accessing services requires further attention. Coping is an elusive entity for many families. The manner in which families cope and its mediating factors requires further investigation. Families themselves need to be heartened in their endeavor to support their loved ones. This is required from the public, health professionals, community resources, and the families’ network of extended family members and friends. This can be difficult as the misperceptions of mental illness may cloud people’s willingness to become involved. However, stigma and ignorance are not acceptable responses. Unfortunately, however, they are insidious and often permeate society’s approach to mental illness and those it affects.

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Chapter 4 – Legal and Ethical Perspectives on Violence

Policing mental health, the St Andrews Scheme: Raising awareness of criminal justice proceedings & mental health

Paper

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Abstract

Assaults against healthcare staff have gained increasing attention (Friend 1998), prompting the Zero Tolerance Zone campaign in the NHS (DOH 1999). Hospital managers were advised that treatment could be withheld as sanction, although not from 'anyone who is mentally ill or under the influence of drugs'. More recently the NHS Security Management Service (DOH 2005) highlighted that the greatest number of assaults - over 43 000, were found in mental health and learning disability environments. Nursing staff in the UK are four times more likely to experience work related violence than other workers (Wells & Bowers 2002). Violence towards doctors and other professionals has also been highlighted (Hobbs & Keane 2006). A 2007 national survey found that 41% of staff in inpatient mental health National Health Service settings had experienced physical violence from patients or their relatives in the previous 12 months alone (Healthcare Commission 2008).

There has been concern over patient violence to mental health staff and patients for a number of years. The Zero Tolerance philosophy is not readily applicable, and a concerted response has been lacking. Most people who experience mental illness retain capacity, and to regard them as otherwise (by default) is stigmatising (Szmukler 2001). Judging capacity to take responsibility for one's actions is not always straightforward, but attempting to answer that question is likely to yield a more ethically defensible result. The key point is that although mental illness may be a cause of incompetence, many people who experience mental illness retain competence and should therefore live by the same rules as the rest of society (Behr, Ruddock et al 2005).

Any discussion on the contentious issue of prosecution of psychiatric patients will undoubtedly be controversial. The various professional and lay views are compounded by the complex relationship issues involved in caring for those with mental health problems. It is nonetheless a very significant area that has been relatively ignored in professional journals. The benefits of

prosecution include a trial of the facts, a finding beyond reasonable doubt regarding the alleged offence and the identification of a suitable outcome by the courts.(Coyne 2002).

Current training of police officers focusses on diversion from the criminal justice system. Police officers see psychiatric hospitals as places of safety where a patient should remain (Bayney & Ikkos 2003). The police often perceive psychiatric patients as poor witnesses, unlikely to assist in prosecution, and are unclear where the public interest lies, especially for those detained under the Mental Health Act (Brown 2006). The Crown Prosecution Service has in the past been similarly reluctant to progress proceedings (Joseph 1990), although the Home Office (1995) has highlighted prosecution for serious offences and risk of repetition.

A memorandum of understanding between the Department of Health, the Association of Chief Police Officers and the Health and Safety Executive sets out a collaborative approach to the investigation and management of behaviours that compromise safety in National Health Service environments (Health & Safety Executive 2006).

Dinwiddie & Briska (2004) outline the dilemmas around confidentiality, and in balancing the rights of patients and staff. They recommend an algorithm for reporting and prosecution of violence, and collaboration with criminal justice system as the only way to safeguard other patients and staff. Below is their suggested framework:

- Clinical staff have informed a patient with a history of violent behaviour that assaults will be prosecuted when other interventions have failed and prosecution is considered clinically appropriate
- Unprovoked physical aggression which resulted in significant physical trauma to the victim (e.g. fracture, loss of consciousness, severe bruising, cuts requiring stitching etc)
- Sexual assault or attempted assault with physical contact
- Intentional destruction of property causing damages beyond an agreed amount.

We report a novel in-hospital policing scheme, which has allowed the development of a clear policy regarding police & prosecution issues in a 600 bed mental health hospital. Benefits include clear information sharing agreement, clearer understanding by staff, patients, Crown Prosecution Services & Local Police on the issues. Areas of work for the Police Officer include Education, Violence Reduction, Safeguarding adults & Children & Victim Support.

The policy gives a clear structure and process for the reporting and management of crimes within the service, and we will describe the structures that support the process (Mann, Sugarman et al 2007).

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The ethical dilemmas in exploring power and coercion to manage risk in community: mental health practice

Paper

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Keywords: risk, coercion, mental health, ethics

Individuals with severe persistent mental illness (SPMI) often lose their right to self-determination based on an assessment of risk for harm. While there is a need to protect the client and society, power conflicts occur when their interests are not in harmony. In attempting to manage the possibility of adverse outcomes, there is a tendency to exert considerable control over the actions of others. However, the perception of risk is not entirely accurate and is intensified in community mental health settings. With the lack of control perceived to exist outside of institutional settings, concerns exist, particularly for psychiatric mental health (PMH) nurses who are often the agent of the mental health system with whom the client has the most contact. This paper examines the controversy that surrounds the concept of power in PMH nursing and attempts to shed new light on how PMH nurses, other health professionals, and society can view and explore this issue.

Power and Ethics

Power is often viewed as negative or oppressing. People, organizations, and other groups are viewed as having power to influence or control the thoughts, beliefs, and actions of others. While it can be seen as an entity for one to possess and wield (Frankford, 1997), Foucault (1980) saw power as more pervasive in nature. As such, everyone has power. People have the ability to resist the influence of others, thus exerting their own power. As well, Foucault (1980) saw power as being neither negative, nor positive. It exists and motivates people for productive as well as negative means.

Ethics in health care often refers to the principles of autonomy, beneficence, non-maleficence, and justice (Beauchamp & Childress, 2001). Autonomy is the right to self-determination and values independent decision-making. Beneficence is the desire to do good while non-maleficence is the desire to do no harm. Justice is the goal of doing what is fair in a given situation. These principles form the basis of other ethical approaches guiding practice. Teleology, for example, considers the moral nature of behaviors by their outcomes and includes utilitarianism and consequentialism. Utilitarianism involves doing good for the greatest number of people while consequentialism bases ethical behaviors on outcomes and does not consider the harm that may befall people in the process (Beauchamp & Childress, 2001). Deontology considers how a person is dutifully bound to behave in a certain manner. A person is obliged to act, even if it may contradict one's personal morals and ethics (Johnstone, 2004).

These principles, while helpful in guiding practice, do not encompass the diversity found in PMH care ethical dilemmas. Relational ethics takes a difference approach. Instead of being guided solely by principles, it also considers the situational context in which the issues arise. There is

meaningful acknowledgement and respect of the embodied knowledge that each person brings to this situation. The nature of interpersonal interactions is such that there is considerable uncertainty as to what outcomes will occur. Relational ethics embraces this uncertainty as part of the human experience (Austin, Bergum & Dossetor, 2003; Bergum, 2004).

Community mental health issues

Risk

Ethical issues often arise in PMH practice in response to managing a client's level of risk. Risk is the relative likelihood of something occurring. Risk assessment not only considers the client's history and mental status, but also the policies of the organization that is represented by the assessor (Crowe & Carlyle, 2003). PMH nurses are involved in performing risk assessments (Kudless & White, 2007). They use their professional knowledge of SPMI in making clinical care judgments. However, the organization represented by the PMH nurse also outlines the manner in which risk is assessed. The structure of and what is included in assessments are subject to outside influence. Obtaining an accurate appraisal of risk is more often affected by societal fear than on accurate evaluations (Kaiser, 2002). Society is influenced by a number of sources in this matter. The media for example, exerts considerable influence over the population's perception of public safety and the risk of those with SPMI in the community. The fact that people can be swayed by information that may or may not present all the facts, or lends itself to a certain perspective is a cause for concern (Keen, 2003; Crowe & Carlyle, 2003).

Compliance and competency

PMH nurses strive to provide and manage PMH care so that a person's risk for harm is minimized. This is not an easy goal to achieve, as compliance in PMH care is a deeply contested issue. The client's role is often seen as being passive to the wishes or advice of the health care personnel entrusted with their care (Playle & Keeley, 1998). Compliance is an expectation on the part of the client who often defers decision making to health care personnel. Noncompliance is seen as deviant (Graham, 2006; Keen, 2003). In PMH, refusal to comply with treatment is often viewed as an impetus for considering the client as incompetent (Graham, 2006).

In order to make autonomous decisions, it is generally expected that the client must be mentally competent. Competency is a legal term referring to a person's capacity to make decisions and understand their consequences (Kent-Wilkinson & Boyd, 2008; Robertson, 1994). Given the nature of SPMI, a person's ability to accurately perceive the world, process information, and make rational decisions can be adversely affected. However, it does not preclude clients from making any decisions regarding care as competency can fluctuate with time and circumstances (Robertson, 1994). Competency is also not necessarily tested if the individual agrees to treatment. Clients may engage in treatment voluntarily despite the fact that they do not have the mental capacity to provide consent to do so (Robertson, 1994). However, legally, consent for admission and treatment must be given by a competent person (Kaiser, 2002).

Mental health nursing practice

The risk for self-harm is the strongest motivator for taking coercive measures (Kaiser, 2002). In preventing harm, PMH nurses have a number of options, including chemical and physical restraint. As well, individuals with SPMI can be forced to engage in outpatient treatment against their will. While it is not a nursing function to enact legal intervention, PMH nurses are those who often coordinate the treatment and monitor adherence and progress. Szasz (1970) has described many mental health interventions as a means of exercising social control. PMH nurses tend not to be comfortable with forcibly controlling their clients (Hannigan & Cutcliffe, 2002; Leung, 2002).

They attempt to balance the need to exert control over clients (O'Brien, 2000) and have described their ambivalence in using forced treatment (Coffey & Jenkins, 2002) and restraint (Bigwood & Crowe, 2008) as there is the concern such actions negate the therapeutic relationship (Heffern & Austin, 1999).

PMH nurses tend to be more amendable to using subtle coercion only if it is seen to benefit the client (Lützén, 1998). This "benevolent coercion" (Stevenson & Cutcliffe, 2006) has been described as efforts to "manipulate patients' behavior, disguised as a more 'human' approach to relationships" (Playle & Keeley, 1998, p. 307). In doing so, PMH nurses use their power in a covert manner that still has coercive results (Holmes, 2005; Stevenson & Cutcliffe, 2006). Using such an approach continues to negate the value of clients as active participants in their care. In "allowing" clients to make independent decisions, there is also the connotation of the PMH nurse exerting power (Hess, 1996). PMH nurses are the bearers of knowledge that subsequently gives them power in the nurse-client relationship (Foucault, 1980; Hegyvary, 2003). Foucault (1980) however, argues that power can neither be granted nor taken away from anyone as everyone has power, including the power to resist. While resistance is necessary in order for power to exist, it creates an uncomfortable position in which PMH nursing care takes place.

While PMH nurses want to respect autonomous decision-making, there are instances where clients' behavior compromises their well-being (Hess, 1996). PMH nurses intervene only when necessary and experience difficulty in waiting for a crisis to occur (Magnusson & Lützén, 1999; Magnusson, Severinsson, & Lützén, 2002). However, there can be uncertainty as to how long one should wait and what constitutes crisis. Unfortunately, much of the care delivered in the community amounts to crisis intervention. Often, the climate of PMH care is such that nurses report feeling overworked with less time to spend with clients (Haque, Nolan, Dyke & Khan, 2002; Muir-Cochrane, 2001). This jeopardizes providing individualized attentive care and follow-up (Roberts, Battaglia & Epstein, 1999; Timms & Borrell, 2001).

Conclusions

There is a negative perception that those with SPMI are more at risk for harming others than those who do not have such concerns. The perception of this risk is not accurate and further stigmatizes those with SPMI. PMH nurses are vital to care of individuals with SPMI in the community, often encountering many ethical issues in the process. There is a need for open discussion of these concerns and a willingness to explore them in a manner that is respectful and embracing of the situational complexities involved.

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Chapter 5 – The Impact and Effect of Violence on Patients

Reducing impulsive aggression: A comprehensive cognitive rehabilitation programme in a High Secure Hospital

Workshop

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Keywords: Organic Impulsive Aggression, cognitive deficits, frontal lobe, brain Injury, neurobehavioural

Introduction and background

The Cognitive Rehabilitation Service (CRS) in Ashworth High Secure Hospital, UK, provides specialist treatment programmes for men with cognitive deficits and severe impulsive challenging behaviours. These individuals fulfil the criteria for high secure hospital admission, due to their ‘grave & immediate danger to the public’. The CRS has developed over the last ten years, initially providing outreach programmes for individuals with acquired brain injury & frontal lobe cognitive deficits giving rise to impulsive behaviour. The success of the outreach service in working with some individuals who had exhibited severe impulsive violence over many years, led to the commissioning of a dedicated inpatient unit in 2006, with admission/high dependency & recovery wards.

The Cognitive Rehabilitation model used within the CRS is based upon neurobehavioural rehabilitation approaches developed within mainstream (non-forensic) acquired brain injury services, with origins in behavioural & cognitive psychology, & learning theory (Wood & Worthington, 2001). The key features of the model can be summarised as follows:

- a. the use of a ‘whole system’ approach to minimise triggers for challenging behaviour (‘antecedent control’);
- b. the provision of compensatory systems for cognitive deficits;
- c. the development of functional skills using an ‘errorless learning’ approach within a coaching format;
- d. the development of a positive therapeutic alliance & consistent team-working on a 24 hour basis.

The selection criteria for admission to the CRS were also extended, not just to include individuals with acquired brain injury, but also those with frontal lobe cognitive deficits secondary to other

conditions such as attention deficit hyperactivity disorder (ADHD), degenerative conditions such as Huntington's Disease & fronto-temporal dementias & severe forms of schizophrenia. Cognitive deficits are increasingly recognised as a major factor in poor rehabilitation outcome for individuals with schizophrenia (Green, 2006). The experience of the CRS over this time has been that Cognitive Rehabilitation is an effective intervention in terms of reducing violence & other impulsive behaviours & improving the prospects for transfer to less secure conditions. The Cognitive Rehabilitation Service also provides multidisciplinary training programmes (including a 5-day Certificate in Cognitive Rehabilitation Course), as well as Consultation & Advice service to other teams & units who are providing treatment for individuals with cognitive deficits & severe challenging behaviour. The CRS Team has provided training to teams from a wide range of units from secure inpatient settings, units for offenders with learning disabilities, through to community settings. The training provides practical skills which can be successfully used by staff without formal professional qualifications, making this model a potentially very cost-effective approach to supporting highly challenging individuals.

Main workshop

The evidence base & principles of the CR model will be described, with data describing the characteristics of the inpatient population within the CRS. This population has very complex needs & high levels of co-morbidity, particularly in relation to acquired brain injury, treatment resistant schizophrenia, developmental disorders & substance misuse. Challenging behaviours include severe impulsive violence, self injury property damage & sexual disinhibition.

The application of the CR model will be described in relation to two case examples: an individual with acquired brain injury & another with treatment resistant schizophrenia. Audience participation will be encouraged in relation to the clinical application of this model with potentially a wide range of individuals with complex needs.

The outcome data from the CRS over the last four years will be presented, in which the cohort has shown a significant reduction in incidents of violence & time spent in seclusion whilst receiving the CRS programme.

Conclusion and Discussion

The Cognitive Rehabilitation Service at Ashworth High Secure Hospital in the UK, has adapted cognitive neurobehavioural rehabilitation approaches to the needs of a high risk forensic population with cognitive deficits and severe impulsive challenging behaviour. This approach has been shown to have potentially wide applicability, as frontal lobe type cognitive deficits are found in a range of conditions including acquired brain injury, severe forms of schizophrenia & other neuropsychiatric disorders. The intervention has been shown to reduce both violent incidents and time in seclusion for a highly challenging population.

Cognitive rehabilitation can be taught to 'front line' healthcare staff without professional training, in order to provide a consistent 'whole system approach' to treatment on a twenty four hour basis. There is potential for this model of rehabilitation to be delivered in a wide range of settings, from high secure forensic services to community based units.

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A comparative study of aggression towards health care workers in psychiatric and others hospitals facilities in Spain

Poster

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Background

Until recently, the evidence of aggressions towards healthcare workers was based on studies carried out at psychiatry institutions and very few had dealt with violence in other types of centres, services and areas. Given the peculiarities of this sector, it is not appropriate to generalise results.

Aim

The aim of the present study was to characterize the phenomenon of aggression by patients towards health workers, not only in psychiatry services, but also in other areas.

Method

Participants

The study was performed in four hospitals of different sizes in Spain. A stratified sample, proportional to the number of health workers in each centre was studied (N = 1,826). The proportion, broken down by profession, was: 33.5% doctors, 47.5% nursing professionals, 7.9% administration staff, 1.7% managers, 2.8% patient attendants, 6.6% technical staff and other professions. The average age of participants was 41.84 years (S.D. 8.427). 64.2% were women and 35.8% men.

Instruments

The health workers filled out a booklet containing the following questionnaires:

- Demographic data record with personal, family and workplace information.
- Aggression questionnaire. This contained descriptions of the different types of aggression. The items refer to whether any type of violence had been suffered in the previous 12 months (regardless of the type or the resulting lesion), whether the subject had suffered insults, threats, etc., descriptive information of the characteristics of the aggression and the aggressor (patient, accompanying person), and whether the health worker has received specific training with regard to this problem and feels that he/she has the support of the health service administration.

Results

Eleven percent of health workers had been a victim of physical aggression, whilst 64% had been exposed to threatening behaviour, intimidation or insults. A logistic regression analysis confirmed

that physical aggression occurred more frequently in the largest centres, especially in Psychiatry and Accidents & Emergencies. Working in the service of Psychiatry was prognostic of physical aggression and insults. An important proportion of health workers had been victims of violence in more than one occasion. The highest levels of repeated violence were once again found in the divisions of A&E and Psychiatry.

In general, 73.3% of cases aggressors were unequivocally responsible for their actions, whilst 21% were affected by a mental disorder or cognitive deterioration, and 5.7% were under the influence of alcohol or drugs. Obviously, these rates were different in Psychiatry. The most frequent cause of aggression was the result of waiting times (58%), followed by anger at not being given a doctor's note for time off work (15%), and disagreement regarding the prescription of medicine (10%). In Psychiatry, the most frequent cause of aggression was the obligation to remain in the centre.

Conclusion

The results show the levels of the different types of violence in the Spanish health sector, and confirm that Psychiatry are one of the principal scenarios of physical and non-physical violence, although other areas, especially casualty and surgery departments also show very high rates.

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Accumulated coercion and short-term outcome of inpatient psychiatric care

Paper

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Background

Little is known about the impact of coercion on outcome of psychiatric care. Multiple measures for coercion have been recommended to be used in outcome studies.

Aim

To study the impact of accumulated coercive incidents on short-term outcome of inpatient psychiatric care.

Methods

101 involuntarily admitted patients, 16 voluntarily admitted and subsequently involuntarily detained, and 116 legally voluntarily admitted patients, who stayed voluntarily throughout the treatment period, were interviewed within 5 days from admission and at follow-up at discharge or after three weeks of care. Coercion was measured as number of coercive incidents (CI): involuntary legal status at admission or voluntarily admitted and thereafter involuntarily detained, high perceived coercion at admission according to the Coercion Ladder, subjectively experienced measures against own will during treatment, and forced medication, restraint by belt, and seclusion during treatment according to the case record. CI could range from 0-8 subjective and recorded events for each patient. Outcome was measured as subjectively improved or not improved and as change in GAF scores. An increase in GAF scores ≥ 10 was considered as an improvement.

Results

67 % of the patients were subjectively improved and 33 % not improved. According to GAF, 58 % were improved and 42 % not improved. 37 % of the patients had no coercive incidents. The median CI value was 2.0 (range 0-7). Neither subjective nor assessed improvement according to GAF was predicted by CI.

Conclusions

Coercion was not related to short-term outcome of psychiatric inpatient treatment, even though a measure likely to capture the amount of coercion experienced by the patients was used.

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Psychiatry in the age of neuroscience: The impact on clinical practice and lives of patients

Paper

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Keywords: Coercive medication, neurosciences, patients perspective, social empowerment, dialogical ethics

Neuroscience gives us not only insight into how the brain works, but also claims to produce new scientific solutions to repair the brain (Andreason, 2001). Because of this, clinical psychiatrists are interested in applying the methods and results from neuroscience to the diagnosis and treatment of psychiatric diseases. The biomedical model of mental illness, which prevails in the neurosciences, does have an impact on clinical practice. Among psychiatrists and patients in mental hospitals, expectations about the use of medication are rising. Nowadays, in the Netherlands most psychiatrists consider medication as the best way to avert danger (as opposed to seclusion or the use of other physical restraints, such as bandages). Even if the patient refuses the medication (Landeweer et al., 2007), they favour supplying medication against the patient's will. Are these expectations concerning medication justified? Do neurosciences and the new psychopharmacological solutions really support patients who suffer from mental illnesses?

From the perspective of patients, other issues besides appropriate medication are important for recovery from a mental illness. In daily life, having a psychiatric disease and coping with it is a complex process. In spite of the developments in the neurosciences, recovery from a mental illness is not easy. Patients have to find ways to cope with a mental disorder, develop new values, and accept a different life perspective (Deegan, 1988). This is made explicit by the story of Jolijn, who spent her adolescent life in a mental hospital. Her experiences with the clinical practice of psychiatry demonstrate benefits and negative effects that are relevant for recovering from, or coping with, a psychiatric disease.

Coercion makes it worse

The first point we would like to make is that enforced medication does not contribute to recovering from a psychiatric disease. Coercion makes it worse. For Jolijn it resulted in feeling scared and insecure. It made her distant, lonely, distrustful and resistant. It severed contact with others and caused an increase of the problems that she experienced. Eventually in the story of Jolijn it was the offer of marijuana by fellow patients, which opened a door for her.

Jolijn's story tells us that during her stay in the first mental hospital, lack of trust diminished not only her contact, trust and personal development, but also her ability to find an appropriate and right dose of medication. The medication she received against her will did not help her at all. It made her frightened and insecure. She became scared of her own feelings. But when some other patients secretly offered for her to smoke marijuana with them, she was open to it and therefore experienced a moment of change. For the first time in a long period she felt a sense of happiness. So the start of her recovery story was triggered by chemical influences of her neurological state, but more importantly it was possible because she had chosen it, and did not resist the effects. The marijuana helped her to feel more self-confident and in control. However, we cannot say that her

recovery solely depended on her use of (self-administered) medication. – it was about finding a new step towards happiness.

The importance of mutual trust

Her use of marihuana started after she got in contact with other patients in the hospital. They offered her marihuana, and said it would give good feelings, so she gave it a try and was open to it. They did not force her to take the marihuana, but rather invited her to either choose or refuse the drugs. Jolijn experienced she had a choice and rediscovered her own agency and responsibility – responsibility not only for herself, but also for others, since her fellow patients trusted her in keeping the secret of smoking in the hospital. “I felt accepted and respected because they gave me responsibility, by inviting me to join their group”. Eventually the psychiatrist agreed that using marihuana was a better option than cutting herself. The story of Jolijn illustrates that the use of this self-administrated medication contributed to her recovery, but that recovery is not about (self-administrated) medication alone. The decision offered to her by her fellow patients triggered a process of empowerment. From this story we conclude that recovery is not just about finding the right medication for a particular psychiatric disease, but is mainly about social conditions of the particular person who is suffering from a certain psychiatric disease.

So administrating drugs is not a simple and unambiguous process; rather, it requires deliberation and dialogue between the patient, the psychiatrist, and the people in the social surrounding of the patient.

Medication alone is not enough for recovery

The second point we would like to make is that recovery is more than medication. For Jolijn, recovery meant finding meaning in her life again. The social support from others to cope with life was of major importance as well. In the second hospital she stayed, she experienced a caring, supportive attitude from the staff. Because of positive feedback and not rigidly sticking to the hospital rules, Jolijn was able to take on her own responsibilities. For Jolijn, rehabilitation meant being treated as a person and a moral agent with capabilities to direct her own life (go outside, smoke, enjoying music etcetera), and not primarily as a patient. The staff showed trust in her capacities by giving her responsibilities, which enabled personal development and self esteem. Jolijn experienced (fair) personal communication and equal human relations and was empowered by this approach of the staff. This recognition made her trust the staff in return. According to Jolijn, her recovery was dependent on being recognized as a person, and trusting others again, taking up responsibilities, making contact, developing friendships, and enjoying and participating in life.

Dialogue and deliberation are the most important medicine

Reflecting on the implications of Jolijn’s story for the biomedical model of the neurosciences and for clinical practice, we will draw some conclusions. The biomedical model may have benefits for patients with psychiatric diseases. It explains what is happening when a person experiences a mental illness by referring to dysfunctions of the brain and it suggests that the solution is to take the appropriate medication and repair the malfunctions. But as Jolijn’s story pointed out, some significant aspects are neglected if clinical psychiatry only addresses this model.

First, clinical psychiatry should not forget that social aspects are crucial for the working of medication. What exactly is in the best interest of the patient is not objectively given, but rather determined and constructed in (inter) personal processes. Finding proper medication is not simple. Every person has personal perceptions and different physical features and this complicates

finding the right match of medication. Standard solutions are furthermore problematic because of the severe side effects they sometimes cause (Helmchen, 2005). Dialogue and deliberation are necessary in order to arrive at a constructive pathway to recovery.

Second, the way the biomedical model looks at persons with psychiatric diseases does not do justice to the patients' experiences in daily life. Patients hardly explain their disabilities in neuroscientific medical terms (Deegan, 1988). Jolijn mainly refers to aspects in the social context. Clinical psychiatry needs a broader model to include these factors. People need to find hope (that bad times will pass), empowerment (to trust in their own power to change and to direct their lives), acceptance of their own responsibilities in the recovery process, and the development of a social role in society.

In mental hospitals, most professionals still consider (coercive) medical treatment as the best option for averting dangerous behaviour. Yet it is important to realise that clinical psychiatry is more complex than that. Trust and recognition are important features for clinical practice aiming at and working on the recovery of psychiatric disorders (in terms of coping with the illness, instead of repairing it). From the perspective of patients, medication alone is not enough to help them in their recovery. As the story of Jolijn shows, coercive medication even worsened things. This means that even in the context of a crisis, professionals should strive for dialogue and deliberation with the patient to come to a joint perspective of what is in the best interest of the patient. It implies a shift from a paternalistic to a deliberative relationship in which patients become partners and co-owners of their own treatment. The primary focus should always be on restoring and building trust. We conclude that medication alone is never enough for recovery. Medication should match with the wishes and values of the person suffering from the mental illness. Dealing with psychiatric diseases is much more complex than the biomedical model presupposes and therefore should include the social context of the patient within the recovery process.

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Use of Mechanical Restraints in Sweden from a historical perspective

Paper

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Keywords: Restraint, coercion, gender, violence, history of psychiatry

In Sweden the use of mechanical restraints in psychiatric care has been debated and criticised both within the discipline and by a well-informed public. Attempts to control and limit their use were seen at the time as expressions of humanism and the prevalence of restraints has emerged as a marker of quality in psychiatric care. Some restraints have been condemned and linked to neglect and undue coercion. Others have been seen to reflect ethically acceptable or unavoidable coercion. The forms of restraints used and considered acceptable have varied over time.

In the eighteenth century, isolation in a dark room was not only a restraint, but also a form of treatment. When shackles and iron chains gave way to straitjackets in the late 1700s, this was seen as a humanistic advance linked to a medical outlook on mental illness. The criticized use of restraints in nineteenth century asylums, particularly isolation in a cell, was gradually replaced by more varied and individually adapted forms of restraint. Recording of restraints and their duration of use has been mandatory in Sweden since the late nineteenth century. While the data remain unreliable even today, the statistics provide guidance for determining the methods used and their gender distribution.

In the early 1800s, a model for non-restraint psychiatric care had evolved in England and Scotland based on the practice of "moral treatment" under humane conditions and a healing care environment. The absence of restraints was to prevent violence. Patients who did become violent were to be restrained by a reliable staff cohort; so-called "manual restraint". In extreme circumstances, patients would be transferred to a padded cell for temporary isolation. Conflicting views on the non-restraint ideology arose in different psychiatric camps who challenged each others' claims to scientific superiority and humane philosophy. Critics considered isolation a greater ill than mechanical restraints and claimed that manual restraint could injure both patients and personnel. The method furthermore required a large staff, resulting in higher costs. Opponents concluded that since coercion was unavoidable in psychiatric care, mechanical restraints were preferable as well as therapeutically and morally defensible (Tomes 1988). Critics of the non-restraint movement were joined by Swedish psychiatrists, among them Wilhelm Öhrström, first Professor of Psychiatry at the Karolinska Institute (Öhrström 1866). Treatment ideologies advocating freedom from mechanical restraints were rejected as unrealistic by leading Swedish psychiatrists.

Carl Ulric Sondén (1857), physician at Danviken asylum in Stockholm, outlines an alternative use of restraints which he links to superior continental practices. The main principle is never to apply coercion if gentler means suffice and to carefully monitor the use of restraints. Doing without straitjackets would create major inconveniences and considerable costs and prevent patients from enjoying fresh air outdoors and being among others, claims Sondén. His forceful defence of restraints on broad indications shows a determination to take charge of the patient's unwanted motor behaviour. Sondén wanted to implement the care and treatment deemed justified regardless

of the patient's wishes or physical resistance. Some Swedish physicians nevertheless expressed cautious approval of the non-restraint ideology.

In the late nineteenth century, foreign visitors to Swedish asylums recorded the restraints they saw being used and the number of patients in isolation and made comparative studies between countries. They noted that constraints world-wide are as varied as they are cruel. It would appear that visitors regarded coercion-free care and design of the exterior environment as the primary criteria of good psychiatry and that this was predicated on careful recruitment and training of suitable personnel. Visitors appear to have reacted negatively, not to the use of restraints in Sweden, but to the poor impression made by the asylums. An American on a study visit summarised his impression of Nordic psychiatric care as having a harsh and forbidding attitude where protection of society takes precedence over patient care (Svedberg 2000).

In the early twentieth century, prolonged baths were introduced as a humane and scientific remedy offering alternatives to restraints. Gradually, prolonged baths under bath covers nevertheless came to be associated with coercion and served as mechanical restraints (Svedberg and Bjerén 2000; 2002). During the first half of the twentieth century, the choice of restraints gradually changed as common forms became associated with obsolete and inhuman psychiatric care. In the 1930s, leather belts increasingly came to replace straitjackets, protective gloves and restraining bed covers. Prolonged baths were still used in the 1940s.

Restraints were manufactured at local workshops where patients also participated in the work. Restraints were used more extensively in female patients, which agrees with contemporary perceptions of female patients as more aggressive and unmanageable. Gender differences also existed with greater variation in the forms of restraints used in women. Nurses' narratives (from the 1940s) demonstrate how such use was bolstered by fear. Their narratives also bear witness to variations between asylums in the amount of restraints used. Such variations, unexplained by differences in patient population, are also seen in statistics concerning restraints (Svedberg 2003; 2006, Svedberg and Bjerén 2008). Swedish psychiatry emerges in contemporary literature as treatment-intensive, especially in the 1940s. Individual asylums reported increased calm and reduced need for restraints resulting from expanded interaction between various somatic treatment modalities. Other asylums reported extensive use of restraints, especially on female wards. How restraints, drugs and other medical interventions at that time were thought to complement or replace each other is difficult to grasp and presently underexplored.

The use of belts combined with continuous nursing attendance is nowadays the most common form of mechanical restraint. Seclusion behind a locked door does occur, but is rare. This is a tradition which contrasts with the practice in several other European countries where isolation is preferred over other forms of restraint. Cultural differences live on in the way methods of restraint are regarded. A study comprising sixteen European countries shows major variations between countries in the mechanical restraints used (Steinert & Lepping 2008).

Conclusion

In Swedish psychiatric care, restraints have been regarded as unavoidable in certain situations for short periods. It is the type and extent of coercion that was debated and is reflected in historical sources. Use of restraints has been found to relate to deeply held perceptions concerning what may or may not be acceptable, and the choice of restraints has varied over time. Restraints have been used more often in female patients. In Sweden a consistent approach has been applied from the mid 1800s to the present day which rejects manual restraint and holds that isolation is an unethical and harmful form of coercion. With a few exceptions, entirely restraint-free care has been rejected as unrealistic. Restrictive use of mechanical restraints has been considered ethically

defensible. This official approach to the use of restraints appears to have been generally applied in clinical practice, but the reliability of statistical information from the late 19th century to the present time is uncertain. Leather bed straps (“belts”) under staff supervision is nowadays the most frequently used mechanical restraint in Sweden.

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Chapter 6 – The Impact and Effect of Violence on Staff

The consequences of workplace violence directed at nurses working in a non-tertiary hospital

Paper

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Introduction and background

Workplace violence (WPV) in health care settings is of national and international concern with nurses being in the front-line of these dangerous situations (Chapman and Styles, 2006). The impact of WPV in regard to the victim, employer, community and society at large are significant (Chapman et al 2009) and may include physical injury and negative psychological effects such as burnout and post-traumatic stress disorders (O'Connell et al 2000).

In addition, WPV can affect the nurse's job performance and in turn increase the costs to the organization. Direct costs of WPV relate to sick leave, resignation, staff turnover, recruitment difficulties, litigation, disability and death (Chapman et al 2009). In fact, on the basis of figures from several countries Hoel et al (2000) state that the stress associated with WPV in all workplaces may account for 1-3.5 per cent of Gross Domestic Product (GDP) annually.

Although the literature has highlighted that the effects of WPV are significant (Bowers et al 2007) no previous research could be found that investigated the perceptions of this phenomenon by nurses working in non-tertiary hospitals. In order to decrease the impact of WPV in all health care settings it is important to gain an understanding of nurses' perceptions of the consequences of these events.

Aim

This study aimed to identify the nurses' perceptions of the consequences of WPV to themselves, the perpetrator and the organization.

Design

This study involved the collection of qualitative data through surveys and interviews. Trustworthiness was met by establishing a chain of evidence and presenting a draft case study to the key informants for checking. Trustworthiness which includes credibility, applicability,

dependability and confirmability is constructed to parallel the conventional criteria of inquiry of internal and external validity, reliability, and neutrality respectively (Lincoln and Guba, 1985).

Participants

All 322 nurses working in several areas of a non-tertiary metropolitan hospital in Western Australia, and who had direct patient contact, were invited to participate in this study. Ethics approval was obtained from the ethic committees of the case study hospital and a university. All nurses participating in the study were given an information sheet about the study and gave written informed consent prior to completing the questionnaire or participating in the interviews. The envelope containing the questionnaires and information sheet also included a 'consent to interview' card. Thirty-five participants agreed to be interviewed. There was no perceived risk of participating in this study for the nurses.

Instrument

A self-administered survey was distributed to the nurses in 2006 to determine their experience of WPV within the previous 12 months. Of the 322 questionnaires sent to nurses 113 (34%) were returned. Two open-ended questions within the survey were directly related to the nurse's perceptions of the consequences of their most recent experience of WPV. The responses to these questions were transcribed verbatim.

Interviews

Twenty semi-structured interviews were conducted, tape recorded and then transcribed verbatim. The interviews ceased when the researcher failed to obtain any new information and all categories and themes appeared to be complete. This process is known as theoretical saturation (Sandelowski, 1986).

Data analysis

All transcribed data were analysed following the standards of qualitative data analysis procedure, i.e. finding categories and clustering (Speziale-Streubert & Carpenter, 2003). Transcripts were read line-by-line and significant words and phrases identified. Following this procedure the major thrust or intent of the transcripts were conceptualised. The findings were then presented back to the participants to check the validity of the researchers' interpretation (Lincoln & Guba, 1985).

Findings and discussion

Although our study provided only a 'snap shot' of nurses' perceptions of the consequences of WPV working in one general non-tertiary hospital, and thus the generalizability of findings to other situations may be limited, the results resonate strongly with those reported in other studies, suggesting that the consequences of WPV will be similar in other health care settings (Erickson & William-Evans, 2000). These findings have implications for organizations, government and society at large.

The participants in our study reported experiencing both physical and emotional consequences due to being a victim of WPV. These findings confirm those found in the literature (Arnetz & Arnetz, 2001). This paper also presents new knowledge of general nurses' perceptions of the consequences of WPV. Namely those directly related to the impact of restraint on all people involved in an episode of WPV. We and others (O'Connell et al 2000) argue that these responses to WPV are in conflict with the nurse's role as a carer. In order to reduce the dire effects of these events on both the victim and the offender, steps should be taken to decrease the number of these

incidents and to offer support to all people involved. Effective policies need to be developed that provide staff and patients a safe and therapeutic environment in which to work or be cared for.

The consequences of WPV were not isolated to the work environment. The participants in this study also noted that on some occasions they would take their feelings of fear, anger and intimidation home with them and as a result their personal relationships were affected. We were unable to locate any other studies that identified general nurses' perception that their inter-personal relationships were negatively affected as a consequence of WPV.

To our knowledge this is the first study to focus on general nurses' perceptions of the consequences of WPV. Furthermore, when we attempted to find literature that highlighted the impact for the offender of these incidents we found that the most common consequence for the perpetrators of WPV was a verbal reprimand from a senior nurse (Mayhew & Chappell, 2003). However, the participants in our study identified much more severe consequences for the offenders of WPV.

In particular, the nurses in this study believed that a negative consequence for violent patients was being physically or chemically restrained. Researchers have argued that episodes of violence are usually managed in the most restrictive way by either restraint or seclusion (Duxbury, 2002). The literature on manual (holding) restraint in the general hospital is limited and focuses on either the use of mechanical restraints or control and restraint in the mental health settings (Duxbury, 2002).

Providing safe patient care is fundamental to the nursing profession, therefore, there is little wonder that the participants in this study felt that restraint was a negative consequence for the offender. This finding could be due to the conflict that manually restraining a patient brings to the nurse's belief in a therapeutic nurse-patient relationship. Nurses employ touch during their interactions with patients and these actions are used to demonstrate caring. The act of caring is fundamental to nursing, thus the requirement for nurses to practice physical restraint can cause ethical and personal conflict (Bigwood & Crowe, 2008). Although the participants in this study reported that restraint was a necessary intervention when patients became violent or aggressive, they also recognised that this intervention was extreme and negatively impacted the victim, perpetrator and the organization.

The participants in this study considered that incidents of WPV directed at the nurses had both a direct and indirect cost for the organization. These costs included reluctance to care for patients, increased workload for other staff, lowered staff morale, resignations, lack of motivation, a decrease in staff confidence in the organization, depersonalization of patients and lower job satisfaction. All of these consequences have been highlighted in the literature as leading to a decrease in quality patient care (Arnetz and Arnetz, 2001).

Many researchers have highlighted the benefits of staff training and education on prevention and management of WPV. Existing research has demonstrated that staff perceptions of personal safety and confidence in managing aggressive patients have increased following completion of a management of aggression training program. These programs not only develop confidence in managing a volatile event, they can also assist nurses to circumvent WPV (Wand and Coulson, 2006).

Although most of the literature highlights the benefits of training and education programs for WPV, the nurses in Zenike and Sharpe's (1998) study found their prior training was inadequate to assist them to deal with the range of events that they had encountered. Therefore, in order to offer training programs to nurses that meet their educational needs courses need to include both theory and practical sessions that are tailored for the staff and the area in which they work.

Conclusions

This study has demonstrated that nurses experience physical, psychological and emotional harm as a consequence of WPV. It is possible that the physical injuries inflicted on the victims of WPV

heal quickly. However, the emotional and physical consequences may take much longer to repair and can interfere with their everyday lives (Rippon, 2000). The nurses in this study considered that being a victim of WPV was just part of the nature of the job although the consequences of these events for the victim, offender and organization were extreme and far-reaching. Organizations have a legal and ethical requirement to ensure that staff work in safe environments. We accept that the risk for staff of being involved in an incident of WPV remains high because health agencies cannot control who is admitted to their hospitals, and that patients who are distressed, in pain, frightened, have a mental illness or who are under the influence of drugs or alcohol will continue to present for treatment. However, we would argue that organizations are required to ensure that all efforts have been made to reduce these risks. One way to achieve this goal is to provide staff working in all areas of the hospital with relevant and up-to-date WPV education and training. In addition, to diminish the negative consequences of WPV, organizations are obliged to offer staff and offenders emotional and physical support following these events.

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Aggression and burnout in psychiatric healthcare workers

Poster

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Background

Burnout may be defined as an extreme situation of stress when all the individual's strategies have failed. It has long been considered that it is only manifested through emotional stress generated by work overload. However, recent work shows that a conflict of values (lack of reward, personal conflicts, etc.) may influence such exhaustion, in turn aggravating the dimensions of cynicism and lack of efficiency. These feelings of unfairness may increase greatly if the worker is a victim of aggression by patients and, furthermore, does not receive support by management.

In Spain, burnout is not recognized as an occupational disease. However, many courts pass judgements which consider burnout as a work accident. According to the Ministry of Work, the population with the greatest psychosocial risk is that of hospital workers, especially psychiatric healthcare workers. It is paradoxical, that those who look after our health are those who are most vulnerable to burnout.

Aims

The aims of the study were to ascertain the burnout levels in the psychiatric healthcare sector, to explain how these professionals lose their involvement in their work and the satisfaction they get from it, and finally to see if the areas of stress are the same for Psychiatry and other medical specialities. Additionally, it was hypothesized that aggressions are an important source of stress. Taking into consideration existing models of burnout, we analysed the impact of aggression on burnout in the context of other variables, specifically values, fairness, rewards, etc.

Method

This was a retrospective study using a self-reporting format to elicit the levels of burnout and the experiences of aggression over the preceding twelve months. The study was performed in four hospitals of different sizes in Spain.

Sample

The participants were 1,826 healthcare workers, of which 191 are work in psychiatry.

Instruments

We used the following instruments:

- A Demographic Data Record (personal, family and workplace information).

- The Areas of Worklife Scale (Leiter & Maslach, 2000, 2007) comprising 29 items that produce distinct scores for six areas of worklife: manageable workload, control, reward, community, fairness, and values.
- The Aggression Questionnaire (Martínez-Jarreta & Gascón) comprising descriptions of physical aggression, verbal threats, threatening behaviour and verbal abuse.

Results

The study explored the two-process model of burnout (proposed by Leiter and Maslach). A series of multiple regression analyses examined the relative contributions of these two processes. One process was evident in the contribution of workload to predict exhaustion that in turn predicted cynicism that predicted a reduction of efficacy. In parallel, value congruence contributed significantly to the regressions in each of the three aspects of burnout in addition to the workload-exhaustion-cynicism-efficacy process. The levels of burnout were statistically significant, being more higher in psychiatric healthcare workers than in workers of others facilities, especially in the variable of Depersonalization.

Only 19,8% of healthcare workers felt they were supported by the management or administration in cases of aggression. This variable was seen to be a modulating factor of the psychological effect of aggression.

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The advisability of prosecuting psychiatric patients for violent acts against staff

Paper

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Keywords: Prosecution; psychiatry; violence; criminal law

Introduction

In the Netherlands intimidation or violence against public officers, such as police officers and ambulance personnel, is currently receiving a lot of attention. The incidents coming up for criminal trial are amid great public interest. In some recent cases the Public Prosecutor suggested relatively severe punishment in order to make clear to the general public that this kind of behaviour can no longer be tolerated.

Especially in psychiatry, nurses have to deal with a lot of violent aggression from patients. This has led to a large amount of research. Instruments have been developed to predict short term assaultive behavior, like the Brøset Violence Checklist (Almvik, Woods, & Rasmussen, 2002) or to assess the nature, prevalence and severity of aggression among psychiatric inpatients, like the 'MOAS' (Kay, Wolkenfeld & Murril, 1988), de 'SOAS-R' (Nijman & Palmstierna, 2002), the 'attacks' (Bowers, Nijman, Palmstierna & Crowhurst, 2002) and the 'QoVS' (Bowers et al, 2002). From this research it can be concluded that the Netherlands has a relatively high incidence of aggression on acute wards (Nijman, Palmstierna, Almvik, & Stolker, 2005).

It seems that judicial authorities are not acquainted with the prevalence and severity of violent incidents in psychiatry. This can be explained by the fact that the victims frequently choose not to report these acts to the police. Quite often aggressive incidents in a psychiatric clinic are seen as an occupational hazard. However, if they do report an incident, it seems unpredictably whether or not the psychiatric patient, responsible for the violent act, is prosecuted. It appears that incidents which have been reported to the police are handled in divergent ways. We will illustrate this with some real-life cases.

Case 1: Mary

A nurse is attacked by Mary, a psychiatric patient diagnosed with schizophrenia and a personality disorder. The assault seems to be a reaction on some new regulations on the ward. Mary, who appeared not to be in some kind of psychotic episode at the time of the offence, afterwards explains that she wanted to show "who was the boss". The nurse, who is severely injured, reports this incident. The Public Prosecutor, however, considers prosecution useless since the offender already resides in a closed institution. He also argues that Mary probably cannot be held responsible for her behaviour because of her mental illness. Mary concludes that being a psychiatric patient means that she cannot be punished and she continues her violent behaviour on the ward.

Case 2: Rob

Rob, a psychiatric patient suffering from schizophrenia of the paranoid type, pushes a nurse and makes stabbing movements with a knife in his direction. Rob clarifies that his action was by mutual agreement with God and had to do with the fact that the nurse did not want to shake hands with him earlier that day. A few days later Rob causes a similar incident. He is prosecuted and is sentenced to imprisonment for a period of 2 months and treatment in a high security forensic mental health hospital.

The above examples are part of a large sample of cases, which show that in The Netherlands the prosecution of psychiatric inpatients who assault nurses seems to be almost random. This results in a lack of clarity and inequality of justice for the victim as well as the offender. As mentioned before, the occurrence of aggression of incidents in psychiatry is relatively high. However, not all incidents should be conceived as serious or severe. In this research we try to answer the question in which cases prosecution is advisable. In order to answer this question, the problem is examined from three perspectives: criminal justice, forensic psychiatry and the victim's perspective.

Three perspectives

1 Criminal justice

Arguably, the major goals of criminal justice are retaliation and prevention of crime. The question is whether these goals can be achieved by prosecuting psychiatric inpatients for violent acts towards staff in institutions. In many cases, retaliation might be achieved by prosecution. The victim realizes that the assault is taken seriously; this might help to cope with the mental effects of the assault, like grief and anxiety.

It is also imaginable that prosecution helps to prevent recidivism. The above presented case of Mary shows that the absence of punishment might convey the idea that violent behaviour is tolerated (see also Cyne, 2002; Dinwiddie & Briska, 2004; Kumar et al., 2006). Moreover, prosecution might result in conviction to treatment in an institute with a higher level of security, as was the case in the example of Rob. This means more supervision, also during social rehabilitation, diminishing the risk of re-offending. Research indicates that only a relatively small number of patients is responsible for a majority of the incidents (Dinwiddie & Briska, 2004; Flannery, 2002; Owen, Tarentello, Jones, & Tennant, 1998a; Owen, Tarentello, Jones, & Tennant, 1998b; Quanback, 2006). This strengthens the idea that prosecution of an offender who already resides in a closed institution can be useful.

2 Forensic psychiatry

From the perspective of forensic psychiatry we examine the assumption that the psychiatric patient cannot be held responsible for violent behaviour. Diminished responsibility means that there is a serious disorder that substantially determined the offender's actions. In the Netherlands the degree of criminal responsibility is described by means of a five-point scale, with full criminal responsibility on the one hand and fully irresponsible on the other hand. Fully irresponsibility usually involves a psychotic disorder that entirely determined the behaviour at the time of the offence. However, notwithstanding the strong relationship between the disorder and the offence, it has to be examined by mental health experts that there were absolutely no alternative courses of conduct available (Sierink & Van Mulbregt, 2007). In this perspective, it is at least remarkable that psychiatric inpatients, without any mental health assessment, are regarded as fully irresponsible on

beforehand. Research has shown that patients suffering from a psychotic disorder, seldom commit sexual crimes (Alish e.a., 2007; Nijman, Cima, & Merkelbach, 2003; Soyka, Morhart-Klute, Schoech, 2004). Especially in cases of sexual crimes, an independent mental health assessment to determine the extent to which the disorder could have been a factor in the commission of the crime, is strongly recommended.

3 The victim's perspective

There is no consensus on what type of aggressive incidents should be seen as an occupational hazard, and in which cases it is reasonable or even necessary to report an incident to the police (see Dinwiddie & Briska, 2004). In many cases, the treatment relationship might dissuade the caretaker from reporting (Cyne, 2002). Sometimes, the treating professional is convinced that he handled the patient in an inaccurate way and that the incidence was his own fault (see Quanback, 2006). In the Netherlands, some caretakers think that it is not possible for them to report an incidence to the police, because of their professional secrecy. This is untrue. However, when reporting an assault to the police, the victim is only allowed to provide the bare essentials of the incidence.

A major problem with reporting to the police is the fact that many victims are seriously afraid that the offender will take reprisals against him. There seem to be several ways to avoid this problem, for example by not mentioning the private address in the report of the assault. It appears that the policy of the institution plays a crucial role in the way in which the incidents are handled. Unfortunately, some institutions try to withhold their employees to report an incident to the police in fear of negative publicity (Bowers et al., 2006).

Discussion

In the Netherlands, violent incidences which take place in psychiatric institutions are not handled in an uniform way. First, it depends on the victim whether or not an assault is reported to the police. In this decision, the policy of the institution plays an important role. Subsequently, the Public Prosecutor decides whether or not the offender is prosecuted. In this stage of the process, there seems to be a lack of guidelines. We argue that in case of a severe incident or repetitively aggressive patients, an independent mental health assessment is indicated, in order to extent the relation between the disorder and the assault. Moreover, uniform guidelines based on empirical research, have to be developed.

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Psychological effects of differing types of aggression on mental health staff

Paper

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Background

Workplace violence is frequently encountered by mental health staff and the consequences of psychological effects are well known.

Objectives

To identify the psychological effects of differing types of aggression in a mental health organizational environment and its impact on clinical decision making by the staff.

Method

Cross-sectional study. The study was conducted among 250 members of staff from 9 departments in a mental health hospital including doctors, nurses and social workers. A questionnaire was prepared for the requirements of this study. The questionnaire presented 26 situations related to patient and patient's family aggression (verbal and physical aggression), involvement of family in care and interaction with patients at high risk for violence such as drug addicts. Staff members rated the effects of these situations on them using three parameters: discomfort, feelings of threat and continuous stress-fatigue. Each parameter was rated on a 4 point scale. In addition they were asked to rate their response when confronted with such situations in the work place.

Results

Our preliminary results showed higher levels of continuous stress and feelings of threat associated with higher frequency of over attention during care in violent situations.

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The exploration of violence in schizophrenics and care needs and burden degree of their primary caregivers in southern Taiwan

Poster

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Keywords: Schizophrenia, violence, care need, burden degree of caregiver

Background and aim

Violent behavior in schizophrenics is a major issue and the main reason for admission. The study aimed at investigating the violence in schizophrenics and the care needs and burden degree of their primary caregivers.

Methods

Schizophrenia patients with onset and time of illness for two years and above and their primary caregivers from the day care and acute wards of two teaching general hospitals were selected for the study. A total of 126 valid questionnaires were collected from April to October in 2003. The demographic data sheet was applied to collect demographic information of patients and their primary caregivers, while the Caregiver Burden Inventory-Brief Version, the sheet of violent behavior of patients in the past two years, and that of care needs were used to assess the caregiver burden and needs.

Results

1. The mean age of participating patients was 36.5 years old, 62.4% were males, and 43 patients (34.4%) had a history of violence in the past two years, of whom 66.2% were males. The mean age of onset of illness was 24.5 (s.d. = 5) years old, and the mean course of illness was 11.3 (s.d. = 0.8) years. Most of these (77.2%) patients had no fixed partner and 75.7% had no or little religious involvement. The mean length of acute ward stay in the past two years was 56.9 (s.d. = 4.3) days. The six types of violence these patients exhibited were, in descending order, destruction of property (29.6%), verbal threats (26.4%), physical violence (25.6%), self-mutilation (17.6%), suicide (13.6%), and sexual harassment (2.7%).
2. The three care needs of caregivers were, in descending order, as follows: emergency care intervention and management by medical professionals and institutions (45.9%); government-sponsored nursing projects (39.2%) including long-term care, home care, someone to accompany with, and medical care assistance, and vocational training and employment opportunities (13.5%).
3. The caregiver burden scores (25.9, s.d. = .7, ranging from 3 to 61) revealed a moderate burden level. The first two dimensions of burden were burden level of caregiver anxiety (2.13, s.d. = .86) and dependency of the patient (1.85, s.d. = 0.02). The first three rankings of burden were "I worry about his/her safety when he/she is alone?(2.26, s.d. = .15), "I worry that she/he will become sick at anytime?(2.23, s.d. = .10), and "I feel he/she depends on me very much?(2.02,

s.d. = .29). No significant difference existed in the burden of primary caregivers between the violence group and the non-violence group ($t=0.98$, $p=.33$).

Conclusions

We found that the principal type of violence in schizophrenics is the destruction of property and that the major need for primary caregivers is emergency care intervention and management provided by medical professionals and institutions. In addition, the heaviest caregiver burden results from the family interference of patients, while patients with or without violence present no significant predictors of caregiver burden. The study suggests psychiatric medical and nursing staff should meet the needs and provide family-centred and home-based services, support as well as resources for caregivers so as to effectively assist them in caring patients and improving life quality.

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Nursing students' experiences of violence

Poster

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Study objective

This study aimed to examine the extent to which adolescents were exposed to various type of violence as either victims or witnesses and their violent behaviours.

Methods

The study used a descriptive and cross-sectional design with an anonymous self-report questionnaire administered to high school students (grades 9 to 11) in 5 public schools in Istanbul. Tools used in this study were Exposure to Violence Scales (Recent/Past) (Singer et al. 1995) and Violent Behaviours Scale (Song et al. 1998) as well as Information Form consisted of questions on socio-demographical characteristics of subjects. Validity and reliability analysis for all Violence Scales were performed with Exploratory Factor Analysis and Cronbach Alpha Correlation at the first stage of study. In statistical analysis used by SPSS program (Istanbul University 11.0), descriptive (percentage, mean, standart deviation, median) and comparative statistics (Mann-Whitney U, Kruskal Wallis and Spearman correlation analysis) were carried out.

Results

The mean age of students was 16 ± 0.99 years and 61.4% (n=494) were male. The most frequent kind of violence was having witnessed someone been beaten (66%, n=451) in the past. Students were also witnessed to violence at school as someone else been threatened (42.7%, n=344) and someone else been slapped/hit/punched (56.1%, n=452) in the recent past. The most frequent violent behaviour amongst students was beating someone up (34.5%, n=278). Students' exposure to violence in the past and recently was positively associated with self-reported violent behaviours ($p < 0.001$).

Conclusion

This study represents one of the largest investigations to date in our country regarding the relationship between violence exposure and violent behaviours among high school students and illustrates the strength of violence exposure as a contributing factor to adolescents' risk for engaging in violence.

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Psychiatric and Nursing Staff Support Groups in a newly established acute psychiatric unit in Greece

Poster

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Introduction

The 2nd psychiatric department inpatient unit was established at the General University Hospital of Athens called 'Attikon' on the 7th of April 2008. Stress as well as psychological difficulties that psychiatric and nursing staff may encounter when trying to deal with psychiatric patients are well documented.

Aim

There is a prominent necessity to elucidate the effects of psychological interventions of support in the staff. In our psychiatric ward, there is a support group that takes place once a month consisted of psychiatrists, psychologists, social workers and nursing staff. Complaints concerning the difficulties of not relaxing at home due to work distress of work are frequent in support group discussions. We describe the principals that this group is based on and the difficulties that members of the staff may encounter.

Discussion

The support group is a form of psychosocial intervention that has been suggested as a significant method to release stress and enhance coping with patients, especially in an acute psychiatric clinic, in which patients may potentially express violence against the staff. It is important for the group to receive the knowledge and support they require, in order to meet the needs of the unit appropriately. We suggest that communication, information and support of the staff in the working environment provides the opportunity for any of the negative feelings to be articulated, thus learning from each other in a way that facilitates their interpersonal working relationships.

1. The description of the difficulties that members of the staff may confront in a acute psychiatric clinic.
2. The effects of psychosocial intervention in the staff support group.

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Tolerating violence: a follow-up study to a survey identifying the extent of and reasons for the non-reporting of incidents of aggression in one NHS Trust

Paper

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Introduction

It is clear that people with learning disabilities, though never a homogeneous group, have a history involving forced incarceration, denied human rights and casual violence, recent decades of increased community integration seeking to redress the balance against this litany of crimes. A small number of people with learning disabilities, nevertheless, engage in a degree of aggressive and violent behaviour which persists over time. The care provided for people with learning disabilities within NHS Trusts is largely directed at countering such aggressive behaviours, encouraging alternative means of communicating needs and providing therapeutic responses where appropriate. These approaches constitute the core care delivered to people with learning disabilities where aggression continues to pose a real problem. The interpretation of this violence, however, by direct care professions working with service users continues to present mixed and confusing messages, despite the clarity of purpose of NHS Trusts in relation to instigating a policy of zero tolerance over the last decade. This study sets out to talk to people from different professional groupings, currently working directly with people with learning disabilities, where aggression and violence constitute an ongoing concern. It builds on a previous study, a survey by the same researchers (see Skellern & Lovell, 2008), which identified the extent of and alleged reasons for the non-reporting of violent incidents within the same NHS Trust discussed here. The findings, despite according with the literature, revealed concerns about the continuing under-reporting of violence and aggression, irrespective of the policies and protocols in place.

Literature Review

Violence within the NHS has been considered a high priority issue for over a decade (e.g. Whittington, 1997), since being first identified as continuously under-reported by the zero tolerance campaign (DOH, 1999). The paucity of evidence has been problematic with the assembly of a clearly accurate picture being 'fraught with difficulties' (Turnbull, 1994: 8). A good record of incidents has been recognized as crucial to effective prevention (RCN, 1998) and the accuracy of statistical evidence significantly enhances the increasingly central strategy of risk management (UKCC, 1998). The annual numbers of recorded violent incidents against NHS staff increased from 65,000 to 84,000 between 1999 and 2001 (DOH, 2001), though as much as three times greater within the spheres of learning disability and mental health (McGregor, 2006). The establishment of the NHS Counter Fraud and Security Management Service (CFSMS) in 2003 sought, besides investigating fraud, corruption and security, to address the issue of violence (CFSMS, 2006). Violence continues to attract concern around the number of incidents recorded (McGregor, 2006), particularly the recent increases in mental health and learning disability services (CFSMS, 2008).

A recent study of violence in learning disability in-patient units found that 79% of staff had experienced violence (Chaplin, McGeorge & Lelliott, 2006). Recording of incidents of violence vary according to organisation (Vanderslott, 1998), though historically there is a tendency towards under-reporting (DOH, 2002) and underestimation in relation to health care is 'certain' (UKCC, 2002: 9). Government targets to reduce incidents by 30% over a 5-year period (DOH, 1998) have been singularly unsuccessful, a renewed emphasis subsequently advocated in the areas of risk assessments, action plans, comprehensive reporting, staff training and follow-up staff support (NAO, 2003). Such measures basically reiterated the guidelines of the Health and Safety at work regulations, wherein inadequate risk assessment, that is, which hadn't been based on all available information (Vinestock, 1996), could result in enforcement action varying from improvement notices to criminal prosecution (RCN, 1998).

The creation of a safe environment for nursing care necessitates a written record of circumstances, 'which could jeopardise standards of practice' (NMC, 2002), and recognition that more frequent entries should be made when patients/clients 'present complex problems, show deviation from the norm, require more intensive care than normal, are confused and disorientated or in other ways give cause for concern' (UKCC, 1993). Despite such long-established and ongoing concerns, under-reporting of violence appears to remain entrenched within health care settings (RCN, 1998; UKCC, 2002).

Discrepancies

The extent of under-reporting appears, therefore, to be the primary issue, one study of psychiatric settings found that only 1 incident in 6 was recorded (Lion et al., 1981), and a further one, based on video evidence, suggesting as many as 12 out of 13 incidents go unrecorded (Crownier et al., 1994). One theory for such gross non-reporting revolves around the erroneous, but deeply held, belief that nurses should be able to cope and not doing so constitutes failure (RCN, 1998). Other possibilities are worth examining:

Lack of time: A high incidence of workplace violence might preclude the recording of all incidents (Stark & Kidd, 1995), staff simply forgetting because of being too busy (Kiely, McCafferty & McMahon, 1999), the danger of a vicious circle of escalation thereby becoming a real possibility (NAO, 2003).

Lack of support: Despite claims of 43% of staff having been assaulted or harassed, less than half were reported because of confusion over inclusion criteria (RCN, 2002), though accurate completion of documentation has since been identified as a priority (NICE, 2005). Staff might also be reluctant to report a patient they consider mentally unwell (Turnbull, 1994), an insufficient reason, however, to disregard important data (McGregor, 2006), and the need to take responsibility for one's actions is a corollary of promoting independence (Radcliffe & Cort, 2001: 24).

Classification of incidents as 'minor': The likelihood of reporting increases according to severity of the incident with 95% of those considered 'major', for example, being reported, in contrast to only 28% of incidents of verbal abuse (Kiely et al., 1999). Furthermore, tolerance of violence appears to be greater in learning disability and mental health settings (NAO, 2003).

Waste of time: The most significant issue is an anticipated lack of response from line managers (Kiely et al., 1999), particularly since 'firm backing' is considered so important in enhancing a safe environment (McMillan, 1998: 10). Nearly 30% of respondents considered it to be unproductive to report incidents of verbal aggression, which, perhaps surprisingly, increased to over 33% in the case of physical aggression. This is despite well documented concerns (for example, UKCC, 2002) relating to the need for accurate records in the workplace, and how these can directly influence

qualitative changes to policies, training, procedures and practice. The importance of clinical audit has been recognised as the primary mechanism for improving quality (NICE, 2002). Furthermore, NIMHE (2004) recommended all Trust Boards undertake an analysis of what constitutes the root cause(s) of violence and aggression, which should comprise information surrounding number of incidents, type, location and time, possible causes, injuries sustained and outcome of reviews. Such information should then be used to assess emergent themes, lessons learned, strategies proposed, implications for staff training and issues of ethnicity, age and gender.

Fear of repercussion: The use of physical restraint appears likely to discourage official reporting, and less than half such incidents from learning disability units included the names of those involved (Dowson et al., 1999). The view of the 'prevailing organisational culture' seems to be significant in fostering the acceptability of issues such as coping alone, making mistakes, bad luck and being part of the job (Rees & Lehane, 1996: 47).

Consequences of exposure to violence

The cost of violence encompasses the victim, staff team and entire organisation (DOH, 1999), though the psychological and emotional effects of minor incidents, such as fear, anxiety and reduced confidence (Millington, 2005) can be the equal of major ones (Needham, 2005) involving the more obvious physical injury and subsequent medical attention (Devine, 2004). Other possible effects include poor sleep, increased reliance on cigarettes and alcohol (RCN, 2002), general health decline (Needham, 2005), with recovery sometimes taking years (NMC, 2005). The implications for the service can include increased sickness and absenteeism (Patterson, 2005), which may compromise service quality and workplace safety (CFSMS, 2006), increased litigation concerns (Devine, 2004), and subsequent difficulties in recruitment and retention (Millington, 2005).

Aims and Objectives

1. To examine the reasons (previously identified) for why staff fail to report incidents of violence and aggression by service users.
2. To explore the ways in which service user violence may be conceptualized by nursing staff.
3. To identify ways in which services might respond to the under-reporting of violence within clinical areas.

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The emotional impact on psychiatric nurses caring for individuals with a diagnosis of borderline personality disorder

Paper

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Keywords: Psychiatric nursing, borderline personality disorder, self harm, emotional impact.

Introduction and background

There is a body of research reporting nurses working with individuals who have a diagnosis of Borderline Personality Disorder have been found to have negative experiences working with them. These experiences reinforce nurses' negative attitudes towards these patients. This in turn can result in nurses distancing themselves from these individuals. This can lead to stigmatization of these individuals, and as a result reduce the level of care provided for them.

Nurses have been found to have inadequate training and knowledge of caring for clients with Borderline Personality Disorder. This highlights the need for providing training and support to nurses in caring for this client group.

This study aims to explore the emotional impact on nurses working with these individuals. A sample of nurses from a psychiatric unit based in an academic general teaching hospital in the Dublin region was identified as the research site.

A qualitative approach using a phenomenological Heidegger philosophy has underpinned the research. One to one semi-structured interviews were digitally recorded as a method of data collection. Finally the data was analysed using an Interpretive Phenomenological Analysis Framework. Findings which emerged from the data resulted in the formulation of the following themes.

- Nurses' Emotional Experiences
- The Multidisciplinary experience
- Professional and Personal Struggle.

The main article (methods – results)

This research aimed to explore the experiences of psychiatric nurse caring for patients with a diagnosis of B.P.D. A phenomenological approach guided by a Heideggerian interpretative philosophy was chosen as the research methodology. This methodology facilitated the phenomenon to be presented from the nurse's perspective in a clear and undiluted manner as the nurse experiences it. Furthermore, in this study the researcher aimed to acknowledge individual nurses' account of their experience. A phenomenological approach is viewed as 'highly appropriate' means to describe human experience (Wimpenny & Glass, 2000).

Conclusions and discussion

Implications for nursing practice

Williams (1996) describes the life world of psychiatric nursing in post modern practice as an opportunity to escape the postulated reality of diagnosis and syndromes. The opportunity to escape the postulated reality of diagnosis and syndromes is only an opportunity if seized upon. The recognition of the nurse as an independent practitioner within the MDT is a challenge to nursing itself. The opportunity to expand and develop the role of the nurse is a modern day challenge that nursing must recognise and embrace. This study has highlighted some of the difficulties in caring for patients with BPD. However it has also highlighted areas of development and strategies to improve supports and skill of nurses that in turn will improve patient care.

Caring for patients diagnosed with borderline personality disorder was considered as both emotionally demanding and conflicting for the nurses involved in this study. With regard to the emotional impact on the nurse, nurses may benefit from clinical supervision and protected time to avail of this. This service should be available routinely for all the nurses involved caring for patients with borderline personality disorder. Clinical supervision in practice can develop nurse's professional expertise and in turn improve the overall care delivered to patients.

Nurses stressed the importance of a multidisciplinary approach when caring for patients with borderline personality disorder. Therefore regular multidisciplinary sessions may be required in order to provide an opportunity for all healthcare professionals involved in the care of patients who present with this disorder an opportunity to discuss their feelings and concerns. The emotional impact on the individuals and on the team as a whole could also be acknowledged thus reducing the burden any one discipline or individual. These multidisciplinary sessions may reinforce and encourage all health care professionals to work collaboratively thus improving overall patient care.

Implications for nursing education

This study and its findings has implications for undergraduate and continuing education of psychiatric nurses in Ireland. Gustafson and Fagerberg (2004) argue that life-long learning is necessary in a profession that is in constant change as it enables professionals to be prepared for these changes. None of the participants described having any formal education or strategic skills training in BPD. The generic nursing skills of the RPN are vital in the care of this disorder. However specific systematic nursing treatment strategies are integral to quality evidence based care. The skills of Dialectical Behaviour Therapy (DBT) while evolving from the behavioural sciences could be adopted and interpreted to inform nursing practice. The uniqueness of the DBT model is that it not only treatment focused but offers a unique and alternative understanding of the disorder of BPD. It also emphasises the understanding of the experience of the individual with BPD and how this experience influences the negative behaviours exhibited. The researcher is convinced that the understanding of the negative behaviours exhibited by patients could contribute to nurses coping with their own emotional responses to patients with BPD.

Individuals in the area of education may consider the following recommendations:

- Journal clubs and group discussion within the clinical area.
- The exploration of specific nursing educational strategies in undergraduate training for BPD.
- The development of training in Dialectical Behavioural Programmes specifically targeted at nursing staff should be developed.
- Role playing or portfolio development would encourage nurses to reflect and learn from clinical experience.

- The investment in the education of trained nurses in Clinical Supervision would be an investment in both the profession and patient. This is a long overdue development in nursing in Ireland.
- Encouragement and the facilitation to participate in formal workshops and national/international conferences would allow the development of nursing education and skills in clinical practice.

Implications for nursing management

In order to address the emotional impact on nursing staff caring for patients with BPD nursing management will need to acknowledge and address:

- Create an environment and culture of reflection in and on nursing practice.
- This creation of the environment and culture will be influenced by the following,
- Creating opportunities for nurses to avail of structured Clinical Supervision. This should be routine and within an agreement of protected time.
- Debriefing following an incident should also be routine and not left to chance. It is not the responsibility of nursing staff to request debriefing. This should be seen as the promotion of staff welfare and influential in the retention of staff.
- Promoting a positive learning environment for all the staff nurses. The use of journal clubs and encouragement of the sharing of education and learning should be encouraged by managers at local level.

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There is an extensive reference list that has been completed in the course of the study. This is available if necessary.

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Nursing students' experiences of violence

Poster

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Study objective

This study aimed to report of a study to describe the nature, severity, frequency and sources of various aggressive behaviour experienced by nursing students while gaining experience in clinical practice.

Methods

The study used a descriptive and cross-sectional design with an anonymous self-report questionnaire administered to nursing students in two nursing schools of a state university in Istanbul. Data were collected using an information form developed by researchers based on literature. In statistical analysis, descriptive statistics (percentage, frequency, mean, standard deviation) were carried out. In this study, aggressive behaviours were examined being witnessed and exposed separately.

Results

The mean age of the students was 20.96 ± 1.57 ($n=158$) years and 98.1% (155) were female, 1.9% (3) were male. Of the students, 88.3% (130) had witnessed to verbal aggressive behaviours in their private life. The rate of sexual-verbal aggression was 72% (114) and less frequently types of witnessed aggression witnessed by students were physical (61.8%-98) and sexual-physical (42%-67) respectively. The most frequent kinds of aggression students exposed to in private life were verbal (65.2%-103) and sexual-verbal (62%-98). Students experienced less physical (25.9 - 41%) and sexual-physical aggressive behaviour (20.3 - 32%) in their private lives.

On examining the kinds of aggressive behaviour in terms of perpetrators, students had most frequently witnessed verbal aggression from patients in clinical settings (56.3%-89). The rates of verbal aggression witnessed perpetrated by relatives and nurses between students were lower compared to former (from relatives: 48.8%-77/from nurses: 42.4%-67). Students were also most frequently exposed to verbal aggression from patients (51.3%-81) in clinical practice. The rates of exposure to verbal aggression from nurses and relatives were 36.1% (57) and 32.3% (51).

Almost half of the sample (54.5% (67) reported the aggressive event that they had endured. The most common responses after assault were anger (45.6%-57), lack of interest to clinical practice (32%-40) and loss of interest to profession (27.2-34). The reasons for patients' aggressive behaviours to students were poor environmental conditions (67.7%-107), being mentally ill (65.8%-104), or their belief of misunderstanding by others 63.9%-101).

The groups of persons most frequently exposed to violence in clinical settings were nurses (65.2%-103) and student nurses (56.3%-89) according to the students. The vast majority of students (96.2%-152) felt safe when they were in practice placements. The most safe place practice settings to students were paediatric clinics (40%-62), and the least safe places were psychiatric clinics (3.2%-5).

Conclusion

Nursing students witnessed and were exposed to different kind of aggressive behaviours from various sources in both private life and clinical practice. Education and healthcare providers should prepare students to manage such untoward events during nursing education.

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Verbal aggression in healthcare: A review of methods and findings

Paper

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Verbal aggression is obviously a neglected topic in research and prevention of violence in healthcare. Only few studies have been conducted which explicitly dealt with threats, abuse or sexual remarks towards healthcare staff. Due to the severe methodological problems concerning the operationalisation of verbal aggression either small scale studies can be identified or the topic has been one among many others in larger studies. This paper aims at reviewing the available evidence about verbal aggression in healthcare. Epidemiological data are going to be reviewed as well as data on the consequences of verbal aggression on healthcare staff.

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Chapter 7 – The Nature and Epidemiology of Violence

Are psychological diseases the highest risk-levels for aggressive behavior at emergency health services (EMS)?

Paper

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Aggression and violence at the workplace have become increasingly topical for various professions recently. Research studies in this area have been published in psychiatry and education journal; there is a paucity of papers on EMS. In a two-year period, the researcher analyzed 203 recorded aggressive and/or violent assaults against the staff of the Vienna Ambulance service. The monitoring system for this study was an adapted version of the SOAS-R questionnaire. From the total number of 268,528 treated patients the rate of violent incidents was 0.08%. Patients with psychological disorders were involved in 43 out of 203 cases and 13 were aged between 31 and 40 years. In 59 patients with who were intoxicated with alcohol, psychological disorders did not constitute the highest risk for aggressive behaviour in the EMS. The lower assault rates of patients with psychological disorders may be explained by the fact that most of them are transported by police officers in the EMS vehicle.

In 148 of the 203 cases, paramedics were the target of the assaults, followed by 52 drivers and 31 physicians. 45,8% persons were injured, 15 off whom required medical help.

86,2% of the aggressors used verbal aggression. Everyday items were used by 14,8%, parts of the body 89,2% and dangerous weapons or methods by 6,9% of aggressors.

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Validation of the Turkish version of the Perception of Aggression Scale (POAS)

Paper

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Background

Workplace violence towards health care staff is pervasive and common problem in both industrialised and developing countries. It is an epidemic which constitutes the 'occupational hazard'. It is so toxic that it may lead many nurses to give their career. In other words, the exposure to violence is recognized as significant factor in making health industry unhealthy and unattractive workplace for health care professionals (ILO/ICN/WHO/PSI 2004, ILO/ICN/WHO/PSI 2007).

Aggressive behaviours take on various forms such as verbal, physical, and emotional and threaten the health, safety and well-being of patients and workers in health care industry (Nolan et al. 2001, Abderhalden et al. 2002, Gerberich et al. 2004, Jansen et al. 2005a, Maquire&Ryan 2007, Rippon 2000). Its negative consequences produce damage both to the individual and institutions ranging from emotional reactions (stress, anger, guilt and fear, etc.) to a loss of productivity and unsafe work environments (Rippon 2000, Jansen et al. 2005a, Camerino et al. 2008).

Violent behaviour affects all staff working in health care industry but there is a common idea that nurses are the main target of violent behaviour in the workplace (Camerino et al. 2008, Maquire&Ryan 2007, Nolan et al. 1999, Rippon 2000, Jackson et al. 2002). In the UK the risk of workplace violence for nursing staff was 9.5 in any year (Wells & Bowers 2002). Nurses reported very high levels of exposure to workplace violence worldwide. In a study commissioned by the Joint Programme (ILO/ICN/WHO/PSI 2002), 62% of nurses were exposed to violence while they were working in Brasil. This study also expressed that more than half of nursing staff had been victims of abusive behaviours in previous year. According to studies conducted between 1999 and 2007 in Turkey, nursing staff experienced any kind of violence ranging from 58% to 81% (Ozcan & Bilgin 2007). Verbal abuse is more frequent and physical abuse tends to become increasingly common. There is no doubt that the high level of workplace violence is a problem for nurses worldwide.

Nursing students are the future professionals who secure the future of the profession and they are expected to gain skills to become a qualified member of profession. Today's modern world requires new challenges appropriate to changing conditions of the time including health care environments. Patients and their rights are at the centre of modern health care and everyone who works in health care is responsible to meet the patient's total needs through a holistically individualized approach. Some studies have reported that nursing students are more vulnerable to aggression than other workers (Muro et al. 2002, ILO/ICN/WHO/PSI 2004, Rippon 2000, Ferns & Meerabeau 2007). In recent study (Ferns & Meerabeau 2007), 45% of nursing students reported that they experienced verbal aggression mostly from patients during clinical practice. Nursing students are required to have experience in different clinical areas during their education process. For this reason, clinical areas play an important role in their violence experiences. They are inexperienced and often change their clinical wards depending on course circulation. Each course means meeting with new environment and climate and new patients and their relatives. Nursing students have to deal with additional stressors of being exposed to and being a victim of aggression and violence (Ferns & Meerabeau 2007). The International Council of Nurses (ICN) believes that appropriate security measures must be applied to protect nursing students who are particularly at risk of workplace violence (ILO/ICN/WHO/PSI 2004, 2007).

Although violent behaviour towards health care workers has been frequently studied during the past decades, most studies on this topic have been conducted for the assessment of the prevalence and prediction of aggressive behaviour (Whittington 2002, Jansen et al. 2005a). Whereas the determination of staff's perceptions to aggression and violence is very important but not been studied sufficiently. Researchers emphasize the need for research on the influence of perception of aggression (Jansen et al. 1997, Abderhalden et al. 2002). Jansen et al. (2005a) emphasized that staffs' attitudes to patient's aggressive behaviour has a significant impact to find efficient ways in the management of aggression. Knowing the perception of patient's aggression for nursing students is also important because they can learn about some skills how to manage it. Differences on perceptions are hypothesised as reasons of the variance in the definition and reporting of aggressive events (Abderhalden et al. 2002, Jansen et al. 1997). A tool developed in order to determine different dimensions of concept is the Perception of Aggression Scale (POAS) (Jansen et al. 1997, Abderhalden et al. 2002, Whittington 2002, Needham 2004).

While making a clear definition of aggression is not easy due to differences of individual and cultural judgements, perceptions towards aggression also vary in specific to different cultures. In the present study, it is attempted to determine the validity and reliability of Turkish version of the Perception of Aggression Scale (POAS). Moreover, it will be possible to gain insight into Turkish nursing students' perceptions towards aggression within clinical settings.

Material-Method

Sample

The study was conducted in two nursing schools. Data were obtained from two groups consisting of second- and fourth year nursing students. Of 210 questionnaires distributed, one hundred and fifty eight were returned. Of those, 37% were second course and 63% were fourth course. Mean age of students was 20.96 ± 1.57 ($n=158$). 98.1% (155) were female, 1.9% (3) were male.

Instrument The Perception of Aggression Scale (POAS) consisting of 32 items on a 5-point Likert scale was used to evaluate perceptions of student nurses towards patient aggression in this current study. Jansen et al. (1997) created the Perception of Aggression Scale (POAS), in which each item is a different definition of aggression that can be variously approved or rejected by respondents ranging from 'strongly agree' (1) to 'strongly disagree' (5). This scale shown to have a strong two-factor structure: aggression is dysfunctional (unacceptable/undesirable phenomenon), and aggression is functional (acceptable/comprehensible phenomenon). The former represents a negative moral judgement of aggression, and the latter is an understanding that aggression is an element of normal human behaviour that can be healthy (Len et al. 2005, Abderhalden et al. 2002, Jansen et al. 1997, Needham 2004). Cronbach alphas of the two factors are reported as 0.88 and 0.80 in a study of Abderhalden et al. (2002). Recently, Jansen et al. (2005) decided to reliable the POAS as the Attitude Toward Aggression Scale due to the view regarding evaluative character of the POAS items.

Translation Process The Turkish version was prepared using an iterative process of translation and independent back translation followed minor differences were discussed and removed by native authors. In addition, additional comments of the authors of original study were evaluated in the translation process. The questionnaire was applied to the students and second application for retest reliability was done after a two-week-period (15 days).

Statistical Methods: The psychometric properties of Turkish version of POAS were analyzed using relevant statistical methods. The factor analysis (principal component analysis (PCA), including Varimax rotation was used to examine the factor structure of POAS. Items with factor loading lower than .30 were excluded from further analysis. The retest reliability was assessed by determining the Spearman-rank correlation coefficients. The intercorrelations between items and POAS subscales were examined using Spearman-rank correlation coefficients. Spearman correlation coefficients

(intercorrelations) were calculated to determine significant relationships between factors (subscales) of the POAS. The reliability coefficients (Cronbach's alpha) were computed for all components of POAS. All analyses were carried out using SPSS software (11.0 version).

Results

Validity Analysis of POAS

Factor analysis

The results of principal component analysis of the data of Turkish sample revealed a similar factor structure such as original instrument in the study conducted by Abderhalden et al. (2002). The Kaiser-Meyer-Olkin (KMO) measure of sampling adequacy of the 32 variables was between 0.758, Bartlett's Test of Sphericity: χ^2 : 1582,1; 496 df, ($p < 0.001$) suggesting that factoring is appropriate. The criteria of examining the Scree plot suggested a two-factor solution. The data then were subjected to Varimax rotation to obtain an initial two-factor solution. From the original 32-item set, five items (item 3, 20, 21, 28 and 29) were removed according to criteria described below:

- Variable's factor loading was lower than .30,
- Variable did not fit well into one of the factors,
- Variable loaded on both factors.

After checking other factor solutions five items were excluded, and the final two-factor solution was calculated, using Varimax rotation. The two factors of the final solution cumulatively account for 33,5% of the variance. The KMO measure of the 27 variables was 0.789, Bartlett's test of sphericity was significant with $p < 0.001$ (χ^2 : 1431,6, 378 df). Twelve items load on factor 1 (aggression as functional/comprehensible phenomenon), and fifteen items load on factor 2 (aggression as dysfunctional/undesirable phenomenon). The results of Principal Component Analysis were presented in Table 1. The items with the highest loading according to the factor solution are also shown in Table 2.

Table 1. Principal Component Factor Analysis (Factors and Factor Loadings) ($n=158$)

Items	Component		Items	Component	
	1	2		1	2
4	.424		1		.326
7	.444		2		.471
8	.572		5		.463
9	.628		6		.340
17	.341		10		.493
19	.553		11		.481
22	.631		12		.546
25	.745		13		.563
26	.701		14		.555
27	.645		15		.393
30	.634		16		.595
31	.554		18		.467
			23		.507
			24		.535
			32		.413

Table 2. Factors and items with highest loadings

Factor 1: Aggression as functional /comprehensible phenomenon	Loading
Aggression ...	
...is a form of communication and as such not destructive (Item 25)	.745
...is the protection of one's own territory (Item 26)	.701
...is the start of a positive nurse-patient relationship (Item 27)	.645
...will make the patient calmer (Item 30)	.634
...is a way to protect yourself (Item 22)	.631
...is an attempt to push the boundaries (Item 9)	.628
...is energy people use to achieve a goal (Item 8)	.572
...is a healthy reaction to anger (Item 31)	.554
...is an expression of emotions, just like laughing or crying (Item 19)	.553
Factor 2: Aggression as dysfunctional /undesirable phenomenon	
Aggression ...	
...is repulsive behaviour (Item 16)	.595
...is unnecessary and unacceptable behaviour (Item 13)	.563
...is hurting others mentally or physically (Item 14)	.555
...is an impulse to disturb or interfere in order to dominate or harm others (Item 12)	.546
...is a tool patients use to exercise power over others (Item 24)	.535
...in any form is always negative and unacceptable: feelings should be expressed in another way (Item 23)	.507

Inter-Component Analysis (Relation between factors):

A weak negative correlation was found between the mean summated scores of the two factors (Spearman: -0.247 , $p < 0.001$). Therefore, there seems to be a slight tendency that disagreement on statements of dimension 1 is correlated with agreement on statements of dimension 2. The correlation between means of items and factors were moderate (Spearman r_s for factor 1: $0.347-0.753$, r_s for factor 2: $0.399-0.703$).

Reliability Analysis of POAS:

Reliability analysis rendered satisfactory internal consistency with Cronbach's alphas of $.847$ for factor 1 (functional dimension) and $.819$ for factor 2 (dysfunctional dimension), respectively. Test-retest correlations across a 2-week period (15 days) ranged between 0.182 and 0.555 (Table 3). Furthermore, a strong relation was found between factors in terms of time (r_s for factor 1 to re- r_s for factor 1: $.668$, $p < 0.001$ / r_s for factor 2 to re- r_s for factor 2: $.615$, $p < 0.001$). These results mean that there was a consistency between components of POAS in different time intervals.

Table 3. Test-retest correlations of POAS

POAS Items	Factor	r at 15 days	p
4	1	.259	.001
7	1	.457	.000
8	1	.363	.000
9	1	.512	.000
17	1	.347	.000
19	1	.410	.000
22	1	.375	.000
25	1	.555	.000
26	1	.341	.000
27	1	.506	.000
30	1	.422	.000
31	1	.439	.000
1	2	.247	.002
2	2	.307	.000
5	2	.521	.000
6	2	.318	.000
10	2	.428	.000
11	2	.283	.000
12	2	.296	.000
13	2	.529	.000
14	2	.281	.000
15	2	.383	.000
16	2	.527	.000
18	2	.182	.022
23	2	.543	.000
24	2	.396	.000
32	2	.534	.000

Discussion

The main goal of the present study was to establish the Turkish version of the Perception of Aggression Scale (POAS). Two factors were clearly identified in the Turkish version as in the original scale (Abderhalden et al. 2002). The Turkish version of the POAS rendered a similar factor solution as in the original instrument: Firstly, aggression is perceived as a functional/comprehensible phenomenon, and secondly, aggression is perceived as a dysfunctional/undesirable phenomenon. Cumulatively the two factors account for 33,5% of the total variance compared with 35,0% of explained variance of the original factor solution using the full POAS (Abderhalden et al. 2002) and 39,4% of explained variance of shortened version of POAS (Needham et al. 2004). This result could be interpreted that the instrument constitutes mainly two different dimension of aggression in the manner of positive and negative meaning.

Other evidence on the validity of the scale were presented with the existence of a weak negative relation between the two factors and correlations, between means of items and factors. It is clear that there is no concrete pattern in the perception of aggression in our sample. Our data showed only a very weak negative correlation of the two dimensions similar to study conducted by Abderhalden et al. (2002). As aggression is a complex concept perceptions against aggression could not be ultimately categorized. Furthermore, it can be assumed that the perception of aggression is strongly influenced by the characteristics and experiences in different situations.

With regard to the test–retest reliability as measured by the Spearman correlation coefficients, considerable variability across items of the original scale was discovered. Most of the correlations were under 0.5. The items with the poorest reliability did not show any clear conceptual pattern in representing aggression as a positive or negative phenomenon. The item with lowest correlations is ‘Aggression is behaviour the patient knows might cause injury to another person without their consent’ (item 18, factor 2). Other examples of items with correlations of .30 or lower are: ‘Aggression is emotionally letting off steam’ (item 4, factor 1), ‘Aggression is a tool patients use to exercise power over others’ (Item 24, factor 2).

Given the erratic patterns of some POAS items across time intervals in the Turkish version, the context of the POAS items could be discussed. According to Abderhalden et al. (2002), the POAS consisted of items including mainly cognitive aspects and judgements. This view seems to be correct because this current study found similar tendency in retest correlations. Furthermore, the sample of this study comprised of nursing students. Contrary to professionals, their attitudes’ may tend to be more sensitive and volatile than those of professionals. It is possible to say that the POAS items lack of emotional aspects.

Finally, the internal consistency of the two subscales was satisfactory as in the original POAS study (Abderhalden et al. 2002) which indicates that the items of the scale fit very well to the aim of the instrument developed.

Conclusion

These results are representative of this sample. This study shows the Turkish version of POAS is appropriate to determinate perceptions of aggression in nursing students. It is clear that it is difficult to differentiate what the patterns of perceptions of aggression are. Trans-cultural differences may play a role in understanding of some the POAS items because of the complex meaning of terms. This explanation could be considered to interpret the low correlations of some items in this study.

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Pathological narcissism and violence: Making the link

Paper

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A degree of narcissism is a normal and health aspect of the personalities of all of us. Exceptional levels of narcissism are noted in high achievers – or in those who think their achievements deserve special acclaim and reward. Pathological narcissism, characterised by dysfunctions in self-construct, affect regulation, and interpersonal style, is a feature of a small number of our clients who may request mental health treatments for other reasons (for example, for major mood disorders, or for drug or alcohol dependency). Pathological narcissism is also a feature of a number of clients who pose a risk of harming others, for instance, their intimate partners – or former partners – their work colleagues, and their children. However, the link between pathological narcissism and violence is not altogether clear. What is the mechanism of the connection between a lack of empathy and violence? How does a grandiose sense of self-importance generate an act of violence? What is the relevance of a diagnosis of narcissistic personality disorder to violence risk? This paper briefly summarises the literature on pathological narcissism and examines the relationships between what we understand to be its similarities and differences to malignant narcissism and psychopathy. The paper then proposes a model for how pathological narcissism may result in violence towards another person, which may assist practitioners in the formulation and intervention processes.

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Registration of inpatient aggression in routine outcome monitoring: coping with underreporting and reporting fatigue

Paper

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Aggression by patients in inpatient facilities has attracted a lot of research during the past decade. In most studies, the focus is on the prevalence, determinants or impact of the aggressive behaviour. Comparatively little attention has been given to the registration of aggressive incidents as dependent variable in treatment outcome research. This is surprising because, especially in correctional settings, aggressive behaviour is a common reason for admission, and treatment programs typically contain interventions designed to reduce aggression (e.g. anger-management trainings, pharmacotherapy).

Two related and widely recognized threats for the utility of incident registrations in treatment outcome research are 'underreporting' and 'reporting fatigue', that is, an interaction of underreporting with time. The purpose of this paper is to explore these phenomena and to offer a strategy for coping with them.

During 4 years, aggressive incidents by more than 150 inpatients have been recorded on 21 wards of an inpatient treatment centre for individuals with mild intellectual disability and severe challenging or delinquent behaviour. Two registration methods were employed, the SOAS-R and an adapted MOAS with a count-scoring system. A large difference in the number of recorded incidents indicated that more underreporting took place with the SOAS-R. Underreporting was also investigated by interviews with ward staff and a reporting-quality questionnaire, revealing that, depending on ward culture, some underreporting also occurred with the MOAS. Reporting fatigue was investigated by an experimental design, in which the staff of each ward was twice subjected to an anti-underreporting intervention, with a one-year interval in between. The longitudinal pattern of recorded incidents provided evidence against reporting fatigue on most wards. Where reporting fatigue occurred, the collected data enabled a correction, which is likely to approach more closely the true number of incidents.

From the presented data, several conclusions can be drawn for the use of aggression registration methods in treatment outcome research. First, due to the occurrence of underreporting, the utility of the SOAS-R for measuring behaviour change in inpatient treatment during long time-periods seems limited. Second, the MOAS with a count-scoring system seems more suitable for measuring treatment outcome, but an exhausting registration of incidents on a constant level cannot be taken for granted. The quality of the registration should be assessed for each ward. Third, it seems possible to successfully cope with reporting fatigue by a combination of efforts to keep ward staff alert for underreporting and employing a correction on the recorded incidents when reporting fatigue is observed. Finally, considerable efforts by ward staff and research staff are required to obtain incident figures, which accurately reflect behaviour change of patients.

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Aggression and violence in hospitalized mentally ill patients precipitated by caregivers

Poster

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The potential for aggressive and violent behaviors are of constant concern for mental health caregivers. Most caregivers diligently monitor and intervene effectively when a hospitalized patient displays any indication of aggressive behaviors. As aggression escalates, violence can erupt, affecting patient care and the safety of patients and caregivers. Identifying factors that generate or escalate aggression in mental health patients, including those that exist within the therapeutic alliance is important to providing a safe environment. However, the literature describing the interactions within the caregiver/patient relationship that trigger aggression was limited. The purpose of this study was to investigate the interactions mental health care professionals perceived as triggers of an aggressive event and how the interactions between the caregiver and patient affected the aggressive episode.

Two research questions were developed through observations, reviewing the literature, and discussions with other mental health professionals. Naturalistic Inquiry was employed to answer the research questions: 1) What factors do licensed and unlicensed mental health professional workers perceive as triggers of aggressive behavior responses in hospitalized mental health patients and 2) How do licensed and unlicensed mental health workers perceive their actions and behaviors influence the precipitation of the aggressive behaviors among hospitalized mental health patients?

A purposeful sample of 15 experienced mental health care workers was necessary to obtain saturation and redundancy. Demographic data was compiled from caregiver-participants who represented both nursing and social services departments. Guided by the theoretical framework of Symbolic Interactionism, interviews with the participants gathered rich descriptions of aggression events. The interviews were recorded and later transcribed. Analysis of the transcripts established categories to answer the research questions. Three major categories that emerged from the data comprise the overarching theme of precipitation and resolution of aggression: 1) recognizing aggression, 2) managing aggression, and 3) processing aggression. Findings from this study show that aggressive events can be mitigated or aggravated by caregivers' experience, attitude, and behaviors towards hospitalized patients with a mental illness. These findings provide a direction for further research involving triggers of aggression in the mentally ill, the influence of caregivers' attitudes and behaviors on the hospitalized mentally ill, and promoting a safe work and healing environment.

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Violent behaviour in long-term psychiatric inpatients

Poster

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Sample

From the 150 in-patients of the psychiatric hospital of Teruel (Spain), those who had shown violent behaviour during the past 5 years were selected. Violent behaviour was classified in 2 levels of severity: Minor violence, corresponding to simple assault, and serious violence corresponding to any assault resulting in injury. The demographic characteristics, diagnoses and CGI scale at the moment of violent behaviour, were evaluated.

Results

Ten aggressors were identified, only 2 of them showed serious violence. Most of them (8) were re-offenders within the past 5 years. All of them had demonstrated previous signs of psychopathological deterioration, and high scores in CGI scale.

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Validating a quadripartite typology of violence

Paper

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According to the typology proposed by Howard (2009), violence may be either impulsive and unplanned, or controlled and premeditated. Within each of these two categories, it may be appetitively motivated (associated with positive affect) or aversively motivated (associated with negative affect). This yields 4 violence sub-types: appetitive/impulsive, appetitive/controlled, aversive/impulsive, and aversive/ controlled. Each of these 4 violence sub-types is thought to be associated with either excessive up-regulation or excessive down-regulation of positive or negative affective states. By examining the violent index offences committed by a sample of young male offenders (N = 150) while intoxicated with alcohol, we have attempted to validate this typology, both qualitatively and quantitatively; qualitatively, by examining the youths' accounts of their violent offence; quantitatively, by administering a brief 20-item questionnaire comprising items that tap each of the 4 violence sub-types.

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Violence in addicted patients: An exploratory study

Poster

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Aim

The aim of this study was to carry out an accurate assessment of violent behaviours in addicted patients, as well as to compare patients with and without associated violence on several variables.

Method

The sample was composed of 143 addicted patients (132 male and 11 female), who sought outpatient treatment at the Proyecto Hombre Addiction Treatment Programme in Pamplona, Spain during the period from November 2006 to August 2008. All participants were assessed at entry to the therapeutic programme in order to collect information on socio-demographic and addiction related variables, as well as about violent behaviour.

Assessment

All participants were evaluated using the EuropASI (Kokkevi & Hartgers, 1995), the European version of the Addiction Severity Index (ASI) (McLellan, Luborsky, Woody, & O'Brien, 1980). The Spanish version was used in this study (Bobes, González, & Sáiz, Bousoño, 1996).

Results

Problems with maintaining violent behaviour under control were experienced by 34.96% of the sample at some time in their lives. In the previous month this had occurred for 7.69% of the sample (11 cases). There were no significant differences between males and females, with 36% of males and 31.3% of females having experienced problems with violence at least once in their lives. Regarding the previous month, violence affected 8.1% of males (n=9) and 6.3% of females (n=2). A comparison of addicted patients with and without associated violence problems showed statistically significant differences in several variables. In general, violent addicted patients showed higher severity than nonviolent patients in both addiction and consequences of addiction.

Conclusions

The results of this study showed a high prevalence rate of violent behaviours among users of a drug addiction treatment program. These findings indicate the need to assess the presence of violent problems in addicted patients. Likewise, these findings suggest the need for additional studies about the effectiveness of treatment programmes for drug addicted patients who present violent behaviours.

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The effect of introducing the BVC on a medical ward - preliminary results of a randomised controlled study

Paper

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Objective

The BVC has been developed in Norway to predict violence in forensic psychiatric patients. It has since been used successfully on acute psychiatric wards. The SOVES was developed to measure violence against hospital and community health staff and has been widely tested and used in Ireland. The objective was to test whether the introduction of the BVC reduces violence towards staff on acute medical wards. Secondly, to gain data regarding the prevalence of violence towards staff in a Welsh district general hospital. Thirdly, to measure whether the introduction of the BVC reduces restraint.

Method

We adapted the SOVES to measure the prevalence of violence in the last three months. We tested the adapted version in a small pilot that confirmed prevalence of violence against staff similar to previous Irish and Swiss samples. We then asked all staff on the acute medical wards in the first instance to fill in the SOVES at baseline and six months after intervention. We randomised all seven acute medical wards to either intervention (use of BVC at least twice a day for at least 4 days with a protocol of intervention if BVC score of 2 or above) or non-intervention (no BVC, treatment as usual). We collected incidents, report data and analysed differences in SOVES results at baseline and six months after the intervention.

Results

We report about the difficulties setting up such a study as well as the results of the pilot SOVES data. We also report preliminary results as the study will not have been finished at the time of the conference.

Conclusion

Violence towards staff in the Welsh hospital chosen was similar to data collected in Ireland and Switzerland. It is difficult, but possible, to set up an interventional study on violence on a medical ward.

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The links between childhood sexual abuse and adult violence: A case study

Poster

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Sexual abuse in childhood is linked to psychiatric symptoms in adulthood. Early and recent experience of violence in childhood is a strong predictor violent behaviour in adults and a risk factor for developing psychiatric symptoms in adulthood.

In addition to neglect, the lack of parental care and a lack of willingness among parents to believe and understand sexual abuse performed by a family member is associated with personality problems, and psychiatric symptoms in adulthood.

A case study of a 32 year old female teacher, with a long history of violent behaviour is presented. This case study shows a picture of poor interpersonal relationships between the woman and her mother, grandmother, husbands, colleagues and students. The effect of this brought the young lady to the attention of the forensic medicine service.

Maladaptive and violent patient behaviour in the present may be suggestive of past experiences of violence. Therefore, a detailed psychiatric assessment is indicated.

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What is evidence? Sense and nonsense in treatment guidelines for aggressive behaviour

Paper

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Keywords: Violence, evidence, guidelines, meta-analysis

Background

Together with a multi-professional working group, the author was responsible for the development of the German Psychiatric Association's treatment guideline on Aggressive Behaviour. Using this experience during this process, some critical comments on the current methods of developing evidence-based treatment recommendations are given.

Method

Treatment recommendations derived from established levels of evidence were examined regarding their possible bias.

Results

The following sources of bias were identified: 1. The levels of evidence are related to the quality of studies, not to reported effect sizes. Small or contradictory effects can thus lead to strong recommendations. There is no rule how to weight big studies under naturalistic conditions such as the CATIE trial against evidence from randomised controlled trials. 2. Limitations of external validity of studies are not taken into account systematically. This is particularly true for studies on aggressive behaviour, where subjects included in pharmacological studies are highly selected. E.g., agitated and aggressive patients with alcohol or drug intoxications are frequent in clinical practice, but such intoxications are exclusion criteria for all clinical studies. Derived treatment recommendations such as benzodiazepines for acutely aggressive patients may be wrong for those patients. 3. absence of evidence is not evidence of absence. E.g., all studies on pharmacological treatment of violent person have been done with intramuscular medication and so are the treatment recommendations. However, there is no evidence that oral or intravenous medication is worse or more dangerous. 4. The ethical framework of many clinically relevant objectives cannot be represented adequately in randomized controlled trials. 5. Achieved consensus between professionals, users, and relatives may be highly important and receives inadequately low levels of recommendation due to the definition of evidence.

Conclusions

There is an urgent need to use a clear and transparent method how to get from the analysis of existing evidence to treatment recommendations. As a consequence of such considerations, the recent NICE guideline on schizophrenia abandons levels of treatment recommendation. However, this does not resolve the problem, since the process how to achieve recommendations becomes more intransparent.

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Chapter 8 – The Pharmacological Treatment and Biological Determinants of Violence

Aggression and as-needed medication: patients' and nurses' beliefs

Paper

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Keywords: Aggressive behaviour, as needed medication

Background

Although as-needed medication is frequently used in Mental Health Care, little evidence exists for the efficacy of as-needed medication regimens. In a previous study we found that aggressive patients have an increased use of both psychotropic and somatic as-needed medication. The reasons for this increased administration are unclear.

Objectives

To gain more insight into the reasons for the increased use and efficacy of 'as-needed' medication of aggressive psychiatric patients by focusing on the beliefs of both patients and nurses.

Methods

A semi-structured interview was developed to compare the views of both patients and nurses for aggressive and non-aggressive patients. Explored items included: who took the initiative for administration of the 'as-needed' medication, persistence of asking for it (once, more than once), reason for asking/giving the medication, perceived effectiveness (yes, no), time to onset of effect, duration of effect, frequency of administration (frequent/not frequent enough) and strength of dose (high/not high enough). Patients using 'as-needed' medication were interviewed within 24 hours after 'as-needed' medication administrations. Due to irregular shifts, nurses were allowed to complete the semi-structured interview up to 96 hours after administration. A sub-analysis was done for severely aggressive patients compared to non-aggressive patients.

Results

We interviewed patients and nurses. The most frequently administered as-needed medications were benzodiazepines (59%) and analgesics (36%). Patients reported a time to onset of effect significantly earlier than nurses ($p = 0.003$). In about 85% of all 'as-needed' administrations, patients took the initiative (i.e. asked for medication). For severely aggressive patients -but not for mildly aggressive patients- psychotropic medication was more frequently administered on the nurses initiative compared to non-aggressive patients (48% and 19%, respectively, $p=0.02$). Furthermore, aggressive patients perceived the dosage of the psychotropic as-needed medication as high enough more frequently than non-aggressive patients (65% and 35%, respectively, $p=0.02$). Concerning the reason for administration, remarkably, only one (aggressive) patient said that the reason for administration was aggression.

Conclusions

In general, patients frequently ask for as needed medication, suggesting they are keen on it. Aggressive patients are more likely to receive satisfying dosages than non-aggressive patients. Furthermore, as needed medication is more administered on a nurses initiative to (severely) aggressive patients- compared to non-aggressive patients. These three findings could at least partly explain the increased use of as-needed medication among aggressive patients. Additionally, these results bring up the question whether the rewarding aspect of getting as-needed medication might sustain aggressive behaviour.

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Systematic review of PANSS score changes in schizophrenia research

Paper

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Objective

To establish mean PANSS score changes from the existing literature on schizophrenia research. Also to establish whether these mean PANSS score changes fulfil criteria for remission or response as suggested by Andreason and Van Os (30% reduction for response) as well as more recently by Leucht (28% reduction for response). The treatment of schizophrenia with antipsychotics is a main cornerstone in the reduction of violence in psychotic patients. It is therefore useful to know about the clinical relevance of the research that supports the efficacy of antipsychotics in regard to aggression and violence.

Method

We copied the methodology of Davies's meta-analysis published in 2003. We updated the search by including all studies published until 2007. We included the following studies in our systematic review: randomised and placebo controlled trials, participants had to have a diagnosis of schizophrenia or schizo-affective disorder, at least one second generation antipsychotic drug had to be used as an intervention, outcome had to be a change in mean PANSS score from baseline to end point, the design had to be at least a single group pre post design, results had to be published in peer review journal in English, French or German with a reported sample size for each study and availability of a full text version.

Results

We retrieved a total of 202 data sets, which included PANSS scores from 142 studies with a total of 21,751 participants. For all drugs the mean PANSS the mean percentage reduction was 17.53. For first generation antipsychotics the mean percentage reduction was 13.64. For second generation antipsychotics the mean percentage reduction was 18.89. For placebo the mean percentage reduction was 6.91. There was no statistical difference between placebo and first generation antipsychotics but there was a statistically significant difference between second generation antipsychotics and placebo indicating a slight superiority of second generation antipsychotics as a group. However, only Amisulpride achieved a mean percentage reduction of over 30% (36.1%) and therefore achieving a response under the more recent stricter criteria for response. We will present individual figures for each antipsychotic with total sample sizes, data sets included and standard deviations.

Conclusion

Amisulpride was the only antipsychotic drug that had a mean percentage PANSS score reduction that fulfilled stricter criteria for response. All other antipsychotics remained below this response line. Our results confirm results that were obtained at the CATIE and Cutlass studies with the exception of Clozapine which only achieved a mean PANSS score reduction of 18.9% in our

study. There is probably a mild advantage of using second generation antipsychotics in terms of PANSS score reduction but the clinical relevance of this is at best small.

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Brain-environment interactions in violent crime

Paper

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Keywords: Genes, violence, antisocial personality disorder, epigenetics, conduct disorder, PTSD

The prediction, prevention and treatment of individual violent behaviour are extremely important, but difficult tasks of mental health professionals. The challenges posed by these tasks are partly due to the multiple (but still incompletely described) underpinnings of the human pathological aggression and violent behaviour. Research data from various fields propose that both genetic and environmental factors play a role in the development of pathological aggression and criminal violent behaviour.

Violence and aggression can be classified in several ways, according to the target of violence (self-directed, interpersonal or collective) or mode of violence or aggression (physical, sexual, psychological or involving deprivation or neglect). One of the most widely used dichotomies of aggression and violence is into impulsive-reactive and instrumental-proactive-planned. Impulsive-reactive forms of violence and aggression can occur in a variety of psychiatric and neuropsychiatric conditions, such as mood disorders, alcohol and substance use disorders, schizophrenia, borderline personality disorder, post-traumatic stress disorder, traumatic brain injury and complex partial seizures. Instrumental forms of aggression and violence typically occur in a subset of people with antisocial personality disorder who also satisfy criteria for psychopathy and can at times co-exist with impulsive forms.

Longitudinal studies show that aggression is a common, gender-differentiated behaviour in child development that drops as the child develops social skills and language. The persistence and progression of childhood aggression into pathological forms are mediated by both genetic and environmental factors. Strong genetic components to individual variations in a variety of human traits and behaviours, including antisocial and violent behaviour have been emphasized by several studies in the last decades. Genetic influences were also found to play a major role in individual differences in liability to a broad range of mental disorders.

As with many psychiatric and non-psychiatric disorders, the genetic underpinnings of violent and aggressive behaviour are complex and they are usually part of a multifactorial causation chain. Single gene mutations could only explain a very small minority of instances of violent behaviour. This is the case with a rare mutation of the X-chromosome located MAO-A (monoamine oxidase A) gene (which metabolizes serotonin, involved in impulsive aggression and violence) that causes a functional knockout of the gene in affected men, leading to impulsive violent behaviours. Most of genes that have been found to provide susceptibility to violence or psychiatric illnesses are however normal allelic variations that are common and do not prevent vital functions. This means that they are implicated in the causal processes leading to violence or psychiatric illnesses, but only along with other genes and/or certain environmental factors. A particular combination of genetic vulnerabilities and environmental risk factors might be more important for the expression of criminal behaviour than the separate additive effects of genetic and environmental influences. For example, the combination of a genetic predisposition to antisocial personality disorder and a

high (home) risk environment leads to greater pathology than would be expected from each factor alone or their simple addition.

The promoter polymorphism associated with low expression of the MAO-A gene can be encountered in approximately 35% of population, but only predicts higher rates of violence in particular population groups, such as male carriers with early severe maltreatment. Genetic susceptibilities for violence likely codes for subtle molecular abnormalities, which, in conjunction with other genetic and/or environmental factors, influence physiological processes and synaptic plasticity mechanisms. These could subsequently alter neural circuits and information processing, which may in turn predispose individuals to violent behaviour. The low expressing polymorphism of the promoter of the MAO-A gene is associated with morphological and functional changes of the cortico-limbic system, such as smaller volumes in limbic structures (amygdala and anterior cingulate cortex), larger volumes in lateral orbitofrontal cortex (only in males) and hyperactivity of amygdala and decreased reactivity in regulatory prefrontal areas.

Though compatible with normal psychiatric health, these changes may lead to impulsive violent behaviours when certain environmental and/or genetic factors co-occur. Dysfunctions of the cortico-limbic system (involved in the coupling of emotion with cognition) have been described in people with violent behaviours. Offenders who committed violent crimes were found to have significantly more structural pathological changes of the brain (especially involving the frontal and temporal areas) as opposed to offenders who committed non-violent crimes and controls. Impulsive forms of aggression and violence were found to be associated with hyperactivity of amygdala and inefficiency of orbitofrontal /cingulate cortex processing. In psychopathy, dysfunctions of the brain circuits involved in stimulus-reinforcement learning, empathy and moral judgment were found, such as reduced amygdala reactivity during aversive conditioning, reduced amygdala–ventromedial prefrontal connectivity and disturbed function of the right superior temporal gyrus.

Several abnormalities of neurotransmitters (serotonin, but also dopamine, norepinephrine and acetylcholine, glutamate, gamma amino butyric acid and nitric oxide), neurohormones (such as vasopressin, oxytocin and melatonin) and neuromodulators (opioids) have been linked to violence and aggression. Alterations of the function of the hypothalamic-pituitary-adrenal axis (HPA) have been reported in individuals with high aggression and may reflect their frequently problematic backgrounds. Several sex hormones play a role in aggression and likely account for part of the observed gender variance in violence. Sexual brain dimorphism resulting from differential prenatal exposure to sex hormones may partly account for gender differences in theory of mind functions, empathy and altruistic cooperativeness. The earlier development of communication skills and socialization in women and their higher capacities for empathy and theory of mind may inhibit or delay the onset of delinquent behaviours.

Genetic effects are crucially dependent on the gene expression. Certain environmental factors can have epigenetic effects leading to heritable changes of gene expression, in the absence of a change in the underlying DNA sequence. The epigenetic mechanisms include DNA covalent changes (methylation) and post-translational modifications of the histone tails (via methylation and acetylation). Cigarette smoking, which was found to have epigenetic effects in cancer patients, has also been linked to the development of conduct disorder in prenatally-exposed children. The development of conduct disorder may be linked to structural and functional brain changes that are a result of cigarette smoking–induced MAO-A inhibition in the fetal brain, particularly in those with a promoter polymorphism associated with a low expression of the MAO-A gene. Animal studies show that variations in maternal care can lead to epigenetic changes in gene expression in offspring with long-lasting effects. Adult rats who are offspring of mothers with low rates of maternal licking and grooming have altered stress response, altered synaptic functioning

and reduced expression of the glucocorticoid receptors within hippocampus compared to the offspring of mothers with high rates of maternal behaviours. This reduced expression of glucocorticoid receptors was found to be mediated by increased methylation of the promoter of the glucocorticoid receptor gene (effectively repressing gene expression) and was established in the first week of life. In humans, parenting was identified as an environmental factor that was associated with the development of antisocial behaviour, even after controlling for the impact of evocative gene–environment correlations. An adoption study identified maternal depression as an environmental factor not only for major depressive disorder, but also for disruptive disorders in adolescents. Antenatal maternal stress was associated with abnormal cortisol responses in adolescent offspring and the intergenerational transmission of cortisol abnormalities from women with posttraumatic stress disorder (PTSD) to their children was proposed to be epigenetically mediated. Pharmacological inhibition of MAO-A during fetal development, but not during adulthood led to aggressive behaviours in animal models. These findings advance the idea that environmental factors can affect brain plasticity and the expression of genetic vulnerabilities for violence in a manner that is time sensitive. Critical periods comprise gestation, neonatal period and puberty.

Based on the findings of developmental and epigenetic studies, preventive interventions that target the liability to violence should start early, preferably prenatally. After birth, specific measures to prevent the development of pathological forms of aggression in children should target children at risk (and their families) before or during pre-school years that is during the period of time when they learn to shift from aggressive to non-aggressive forms of interaction.

Conclusions

With the exception of rare circumstances where environmental hazardous events can override genetic influences (such as in cases of massive brain injuries), violent behaviours result from the complex interplay between genetic predispositions and environmental factors. The capacity of certain environmental factors for affecting gene expression and the age –dependent effects of environmental experiences on brain structures and functions suggest a role for time- sensitive environmental manipulations. A crucial task of the future research is to identify and describe valid environmentally mediated risk factors, which interact with specific gene and brain constellations. Equally important is to accurately describe windows of vulnerability for environmental factors and windows of optimal timing for environmental manipulations. More neurobiological (especially longitudinal) studies should aim for the identification of specific endophenotypes associated with violent behaviour, which would help to design effective treatment strategies.

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Do we agree with AGREE? An appraisal of rapid tranquillisation guidelines

Poster

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Background

Surveys of rapid tranquillisation practices undertaken in the 1990s are punctuated with use of high dose parenteral medications, inconsistency in choice of medication and some sudden deaths. These heralded calls for guidelines for management of acute aggression and many have appeared in the last two decades. Most assimilate data from the same pool of limited studies, but seem to convey different messages, leading again to inconsistency in management.

Objective

To evaluate the causes for ambiguity between guidelines.

Methods

We searched multiple databases for relevant guidelines in English. We then used AGREE (Appraisal of Guidelines, Research & Evaluation) to objectively assess potential biases of guidelines. Four raters independently rated them using the AGREE instrument on six domains (scope and purpose, stakeholder involvement, rigour of development, clarity and presentation, applicability and editorial independence) and 23 key factors. The scores were then standardized according to validated recommendations which could range from 0 to 100%. We separately assessed quality and content of the guidelines.

Results

We identified seven guidelines on rapid tranquillisation. AGREE scores ranged from 33 to 100% across domains - no one guideline did well on all domains. All guidelines scored well on 'scope and purpose', however they all scored poorly on applicability (33 to 67%) apart from UK's NICE. This, however, scored poorly on editorial independence (63%). USA's PORT fared poorly (44%) on stakeholder involvement and TIMA did not do too well (46%) on editorial independence.

Guidelines vary. Recommendation of an antipsychotic or a benzodiazepine as the first line option is common. However, Canadian guidelines strictly prefer a second generation antipsychotic whereas the TIMA prefers a first-generation drug or a benzodiazepine. The RANZP guidelines recommend only a benzodiazepine. NICE and the APA guidelines are equivocal about choice of first or second generation drugs. NICE and Canadian guidelines recommend zuclopenthixol acetate to avoid repeated injections except in drug naive patients whereas the RANZP recommends it even in the drug naive. Though withdrawn from some countries, APA and RANZP guidelines still advocate droperidol in non-responsive patients. Parenteral midazolam features as an option for very severe cases in both NICE and RANZP guidelines. Despite robust evidence in the Cochrane database for haloperidol plus promethazine, this is not favoured by any guideline with the exception of NICE which recommends its use in exceptional cases.

Conclusions

Treating acutely agitated people, often against their wishes, is fraught with moral and ethical dilemmas. Guidelines are supposed to aid clinicians make decisions and, taken individually, often fulfil this task. When viewed together, however, they take different perspectives of the same evidence and provide conflicting messages. Some evidence is emphasised, other data ignored. Interpretations suggest an underlying element of cultural and clinician preferences and that this is not just prevalent ? but dominant. There is clearly both a need for better, larger, relevant and definitive trials. There is also a need to have better transparency in the process of how guidance evolves.

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Prescription preferences of clinicians for acute aggression: a survey in Leeds, UK

Paper

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Keywords: Rapid tranquillisation, survey, clinician preference and acute aggression

Background

Violence or aggressive behaviour amongst psychiatric patients is an emergency that requires immediate attention and mobilisation of resources. Violent behaviour can induce aggression amongst other inpatients and effective management of this can reduce the risk of injury to self, other patients, carers and staff thereby limiting staff absenteeism (Hunter & Carmel, 1992). Rapid tranquillisation is the use of medication to manage agitated or aggressive behaviour when, resource permitting, psychological and behavioural approaches have failed to calm the patient (Pereira et al, 2005). There has been controversy and difference of opinion amongst clinicians regarding the best choice of medication. This is not surprising given the varied choice that is available, absence of definitive answers from trials and systematic reviews and conflicting guideline recommendations. A comprehensive literature search has revealed ten surveys exploring this topic: eight surveying the actual clinical practice and two dealing with clinician preferences. They have shown a wide range of choices depending on medication availability and cultural influence. This prompted us to conduct a clinician preference survey in Leeds.

Method

A case vignette based questionnaire was designed and electronically disseminated amongst 95 psychiatrists working in General Adult Psychiatry in Leeds between August 2008 and October 2008. Responses were received by email, fax or post. An independent person sent reminders to clinicians based on a unique coding system. Two reminders were sent fortnightly. The authors were blind to the respondents. Approval for the survey was sought from the Associate Medical Director for Adult Directorate, Leeds Partnerships Foundation Trust and the Drugs and Therapeutic Committee, Leeds.

Results

60 doctors (63%) responded. 51 (54%) returned the completed questionnaire. 9 did not return the questionnaire (3 felt the scenario was inadequate, 3 felt incompetent to respond, 3 were on leave).

First line option- Majority doctors (23, 45%) preferred lorazepam as the drug of first choice followed by olanzapine (17, 33%) and haloperidol (6, 12%). Haloperidol plus lorazepam (3, 6%) and haloperidol plus promethazine (1, 2%) were the other preferences.

Second line option- Olanzapine and haloperidol were preferred by an equal number of clinicians (16, 31%). Lorazepam (12, 24%) was the next popular choice followed by haloperidol plus Lorazepam (5, 10%) and haloperidol plus promethazine (1, 2%).

Average doses conformed to the British National Formulary (British National Formulary, 2008). 40 (78%) preferred oral route. Only seven (14%) preferred intramuscular route as the first option. The primary aim of 47 (92%) doctors was calming the patient without sedation. 49 doctors (96%) expected rapid tranquillisation to be effective within an hour. In the event of the first agent not eliciting the desired response, 17 (33%) were willing to repeat their initial choice with one-third opting for a change in route of administration. Four doctors (8%) opted for their initial choice supplemented with another drug. The rest (59%) opted for another agent not tried before.

Discussion

A study among anaesthesiologists has reported that electronic participants are half as likely as postal participants to respond to questionnaires (VanDenKerkhof, et al, 2004). As survey response rates vary, to maximise our results, we encouraged clinicians to respond using electronic mail, post or fax. The response rate was comparable to an earlier survey (Simpson & Anderson, 1996). Amongst the completed questionnaires, 33% were from the junior trainees whereas only 18% were from the consultants with the specialist registrars and staff grades amounting to 27% and 22% respectively. This could be due to a variety of reasons. Senior clinicians are likely to have more clinical and other commitments and may be receiving numerous questionnaires from other sources thereby making it difficult to retrieve completed returns. It is also equally possible that the trainee doctors are more eager to find answers to day-to-day clinical dilemmas and are more enthusiastic in responding to such surveys.

The older surveys have generated varied opinions probably reflecting the clinical practices that were prevalent then. Paraldehyde featured as one of the choices in a survey by Cunnane (Cunnane, 1994). In another survey (Pilowsky et al, 1992) a wide range of drug dosages were administered most of which exceeded the maximum recommended dose in the British National Formulary (British National Formulary, 1989) and most of the prescribers opted for parenteral medications.

Consistently, over time, clinicians have held the view that they would expect rapid results within an hour (Pilowsky et al, 1992, Cunnane, 1994) which was also reflected in our survey. There however appears to be a change in prescribing practices. The prescribed drugs and the most preferred route of administration were in concordance with the NICE guidelines (National Institute for Health and Clinical Excellence, 2005).

The choice of medication was not influenced by the grade of the clinician. In keeping with the Expert Consensus Guidelines (Expert Consensus Panel for Behavioural Emergencies, 2005), it is likely that a benzodiazepine was the most popular choice when limited background information was available about the patient and the clinicians could not have clarified their queries to arrive at a psychiatric diagnosis. Benzodiazepines are perhaps the most frequently administered medication in psychiatric emergencies especially when the diagnosis is unknown (Macpherson, Dix & Morgan, 2005) and are probably preferred for their relative safety, easy availability of antagonists such as flumazenil to reverse adverse effects if any and a wide choice of routes of administration. Some of the enquiries focusing on sudden deaths in acute psychiatric settings (SHSA, 1993; Hampshire and Isle of Wight Strategic Health Authority, 2006) that have revealed antipsychotics to be the contributing factor may also have influenced clinician preferences. Following the publication of Thompson's article (1994) increasing reports have suggested that the practice of rapid neuroleptisation and use of high dose antipsychotics in the long term have no clinical benefits (Rifkin et al, 1991). On the other hand, they cause a significant increase in physical complications (Andrade, 2007) and are therefore unjustified for routine use (Kane, 1987).

Most clinicians aimed to achieve a calming effect without sedation thereby conforming with the Expert Consensus Guidelines (Expert Consensus Panel for Behavioural Emergencies, 2005) and the NICE guidelines (National Institute for Health Clinical Excellence, 2005) that state “the aim of drug treatment in such circumstances is to calm the person and reduce the risk of violence and harm” and that “an optimal response would be a reduction in agitation and aggression without sedation.” In contrast 68% opted for sedation as the desired outcome in a survey in Oxford (Cunnane, 1994). However, there is no evidence that sedating drugs are more effective than non-sedating drugs in controlling disturbed behaviour (Kane, 1987).

Conclusions

Guidelines have narrowed the choice of medications; nonetheless inconsistency in prescribing is still prevalent. It must also be remembered that when clinicians respond to a clinical vignette ideal preferences supersede the actual choices which is one of the limitations of a questionnaire survey. Our results largely conform to the UK’s NICE guidelines (National Institute for Health and Clinical Excellence, UK). The evidence base for NICE guidelines comes from an insignificant number of randomised controlled trials as suggested by the Cochrane database. There is no robust evidence for haloperidol plus lorazepam. It is interesting to note that the haloperidol-alone-arm was withdrawn from a large well-conducted Brazilian trial due to toxicity (TREC 2007). Yet NICE recommends its use and UK clinicians continue to prescribe it. A survey in Brazil (Huf et al, 2002) acknowledged their psychiatrists are more consistent than those in the UK in managing psychiatric patients. This paved the way for a good quality randomised controlled trial (TREC, 2003) which eventually proved the superiority of haloperidol plus promethazine combination. However this is recommended by the NICE only in exceptional circumstances. There is clearly a need for guidelines to be swiftly responsive to evidence from relevant real world trials.

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Effects of antipsychotics on aggression and neurocognitive deficits in schizophrenia

Paper

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Although most patients with schizophrenia are not violent, there is a subgroup of persistently violent patients who are responsible for a large proportion of incidents of aggression in this population. Persistent assaultiveness is associated with neurocognitive deficits. The mechanism that links such deficits to violent behavior in schizophrenia is not well understood. Antipsychotics may improve neurocognitive functioning and reduce violent behavior. This presentation will examine recent data pertaining to these dual effects, and interpret them in the context of previous evidence on violence subtypes.

Clozapine has consistent antipsychotic and antiaggressive effects in schizophrenia that have been replicated in numerous studies over the past two decades. However, its effects on cognition are not impressive. A recent randomized, double-blind trial has compared the effects of olanzapine, clozapine, and haloperidol on aggressive behavior, neurocognitive function, and psychotic symptoms in 100 aggressive schizophrenic patients (1). Clozapine was superior to olanzapine and haloperidol, and olanzapine was superior to haloperidol, in reducing aggressive behavior. The improvement in the cognitive function differed significantly among the 3 treatment groups; olanzapine was superior to both haloperidol and clozapine. Further analyses revealed significantly greater improvement with olanzapine in verbal memory, disorientation, and attention. Importantly, improvement in the general cognitive index was significantly associated with a decrease in aggression in the olanzapine group but not in the other 2 medication groups. As clozapine markedly reduced aggression, there may be different pathways for the antiaggressive effect of olanzapine and that of clozapine.

A corollary hypothesis proposes that those pathways affect specifically different subtypes of aggressive behavior. Factor analysis of interviews with assailants, witnesses, and victims of assaults by patients on a psychiatric inpatient ward has yielded 3 factors that characterized subtypes of violent behavior (2). One of the subtypes, clinically characterized by confusion, showed impairments in the cognitive domain that was later found to be specifically improved by olanzapine in the randomized trial described above (1). It is thus possible that antiaggressive effects of individual antipsychotics are not expressed equally across all subtypes of aggressive behavior. Instead, the antiaggressive efficacy may be subtype-specific.

In conclusion:

1. Clozapine remains the most effective agent against aggression in schizophrenia, but it does not improve cognition.
2. Olanzapine reduces aggressive behavior and improves cognition.
3. Olanzapine antiaggressive effect may be mediated, in part, by improved cognition.
4. This mediated effect may be specific for a subtype of aggression characterized by confusion.

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Chapter 9 – The Psychological Treatment of Violence

Compliance with command hallucinations – What do we really mean by compliance?: Development of the Command Hallucinations Rating and Interview Schedule (CHRIS): A measure of command hallucinations and associated behaviour

Paper

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Keywords: Voices, command hallucinations, violence, self-harm, compliance

Introduction

Despite repeated historical reference being made to command hallucinations (CH) and their relationship to risk (Bleuler, 1930; Schneider, 1957), their significance has largely gone unstudied. Command hallucinations have been defined as auditory hallucinations that “order particular acts, often violent or destructive ones..(and)... instruct a patient to act in a certain manner - ranging from making a gesture or grimace to committing suicidal or homicidal acts” (Hellerstein et al., 1987). A plethora of case studies suggest that CH are indeed associated with a risk of, for example, sexual offending (Pam & Rivera, 1995; Huckle & Jones, 1993; Jones et al., 1992); violence to others (Good, 1997), self amputation of a limb (Hall et al., 1981), self amputation of the penis (Hall et al., 1981), swallowing objects in prisoners (Karp et al., 1991), self mutilation of the eyes (Field & Waldfogel, 1995), self inflicted lacerations (Rowan & Malone, 1997; Kasper et al, 1996) and suicide (Zisook et al, 1995).

Despite these case studies, the scientific evidence that CH are related to high risk is limited and the findings are equivocal at best. In 1999, Rudnick concluded that most studies revealed no relationship between CH and dangerous behaviour to self or to others. However, this conclusion was based upon a review of studies with major methodological flaws such as not controlling for the content of the command, not utilising a standardised measure of the outcome variable (violence or self-harm), and relying entirely upon case note data for classification of the dependent variable (commanding content).

More recently, several well designed studies have demonstrated that when the content of the command is controlled for and when a robust outcome measure is employed, a positive relationship between a lifetime or recent history of CH and subsequent violent or self-harming behaviour is detected (McNiel, Eisner, and Binder, 2000; Monahan, Steadman, Silver, Appelbaum, Robbins, Mulvey, Roth, Grisso, and Banks, 2001; Rogers, Watt, Gray, MacCulloch and Gournay, 2002).

Despite some consistent findings beginning to emerge, decisions about the risk associated with CH remain problematic. Whilst the issue of controlling for the nature and content of the voice has been identified and addressed in some of the later studies, there remain a number of methodological issues that decrease the generalisability of the findings. For instance, there is a good deal of inconsistency amongst the studies in terms of what constitutes compliance and how compliance behaviour is assessed. Whilst some have conceptualised compliance as a dichotomous variable (Rogers et al, 2002), others have noted an additional category of partial compliance (Junginger, 1996). Conceptualising those that do not obey the exact instructions of the voice as non-compliers may underestimate or misguide the assessment of risk and fail to capture the complexity of the individual's behavioural response to the command.

It would appear that the preponderance of the existing research has focussed on violence. It is clear from those studies that have been conducted that whilst a minority of individuals obey commands to commit dangerous and violent acts to harm others, a significant proportion obey commands to harm themselves (Beck-Sander et al, 1997; Fox et al, 2004). If we are to begin to fully understand compliance behaviour, it is essential that we understand voices in the full context. For instance, an individual may be instructed to harm someone else but chooses instead to harm themselves which perhaps explains why two individuals in the Zisook et al (1995) study committed suicide during the process of the research (see Beck-Sander et al, 1997). Categorising this individual as a non-complier almost overlooks the risk that they pose to themselves and perhaps the risk they may pose to others in the future since they are clearly not able to fully resist the voice.

In order to begin to explore the complex relationship between CH and risk it is essential that there is a standardised measure of the command and associated behaviour. Whilst a number of measures of CH do exist they are limited by a lack of psychometric data supporting the reliability of their use for clinical and research purposes. This paper describes the development of the Command Hallucinations Rating and Interview Schedule (CHRIS) – a means of assessing and categorising CH, subsequent behaviour and the reasons for such behaviour. It will provide clinical examples obtained by the CHRIS of the complex relationship between the CH and the subsequent behavioural response before presenting the reliability of this new tool.

Method

CHRIS consists of an interview schedule that facilitates the development of a detailed account of the experience of CH and associated behaviour. Based on the cognitive model of CH, it explores the presence and nature of CH, the perceived identity of the 'command giver', the emotional and behavioural consequences of CH (e.g. compliance and non-compliance), and the perceived consequences of the compliance behaviour in terms of the effect on the individual, the voices and the wider social consequences of acting. The second component of CHRIS is a scoring manual that defines and exemplifies the core components of the compliance cycle: the content of the command, behavioural response to the command, the function of the behavioural response and coping strategies.

The current study was designed to assess the inter-rater reliability of the coding of the core components in an attempt to develop a measure that will help to improve the methodological rigour of future studies of CH. As part of a larger scale study, the CHRIS was administered to 74

individuals aged between 18 and 65 who reported ever having had an experience of CH and who reported hearing voices within the month preceding the interview.

Ten cases were randomly selected from the total sample in order to explore inter-rater reliability of the CHRIS. The selected group consisted of six males and four females all of whom were of white British ethnic origin. Sixty per cent of the group were or had been married and 40% were employed at the time of interview. The mean age of the group was 41.1 years ($SD = 10.55$) and the mean length of time hearing voices for this group was 12.5 years ($SD = 8.24$). Four of the group had a diagnosis of schizophrenia, one had a diagnosis of schizoaffective disorder, four of the participants had a diagnosis of personality disorder and one a diagnosis of psychotic depression. Four of the group were inpatients in acute adult psychiatry facilities at the time of interview and six were community outpatients.

Measures

Participants completed the following measures after providing basic demographic information and a forensic and psychiatric history: Command Hallucinations Rating and Interview Schedule, Brief Psychiatric Rating Scale (BPRS; Overall and Gorham, 1962), Psychotic Symptom Rating Scales – Auditory Hallucinations Subscale (PSYRATS, Haddock, McCarron, Tarrier, Faragher, 1999), Belief About Voices Questionnaire – Revised (BAVQ-R, Chadwick, Lees & Birchwood, 2000), Post-traumatic Diagnostic Scale™ (PDS; Foa, 1995), Evaluative Beliefs Scale (EBS; Chadwick and Trower, 1993), The Social Comparison Scale (SCS, Allan and Gilbert, 1995), Gudjonsson Compliance Scale (GCS), Gudjonsson Suggestibility Scale (GSS) Wechsler Test of Adult Reading (WTAR; Wechsler, 1999), Wechsler Abbreviated Scale of Intelligence (WASI; Psychological Corporation 1999).

For the purposes of this study the following variables were examined: CHRIS, BPRS, PSYRATS, BAVQ-R.

Procedure

The ten transcripts of the responses to CHRIS along with the CHRIS manual were given to four independent raters for coding. All four raters were Clinical Psychologists with good working knowledge of the concept of CH.

Results

Results indicated that this was a representative population of voice hearers. The participants all reported hearing voices on a regular basis and reported hearing voices that were distressing and disruptive. The group as a whole reported predominantly negative beliefs about the voices they heard believing them to be malevolent in purpose (mean score 15.2, $SD 3.65$) and omnipotent (mean score 14.1, $SD 3.04$). As expected they reported predominantly resistant behavioural and emotional consequences (mean score 22.0, $SD 2.54$). According to BPRS scores, the group were “moderately unwell”. Seventy per cent of the group reported hearing multiple commands suggesting that they were among the more complex of command hallucination cases.

With regard to reliability, the reliability coefficients returned were uniformly very high ($K = 0.527 - 1.0$) with two of the core components (content and coping) returning perfect reliability ($K = 1.0$).

Discussion

These results demonstrate the reliability of the coding criteria outlined in the manual. The quality of the transcripts used in this study also indicates that the CHRIS is a useful tool for exploring the key constructs involved in an individual's emotional and behavioural response to command hallucinations. It appears able to elicit and structure pertinent information even when participants are moderately – severely unwell.

The data discussed in this study highlight the true complexity of the phenomenon of command hallucinations and perhaps goes some way to accounting for the large degree of inconsistency across existing studies. It is clear that unless the experience is explored in detail key constructs can be misinterpreted or missed entirely.

Overall, the CHRIS is a tool that appears to facilitate the collection and reliable categorisation of information that is pertinent to assessing compliance with command hallucinations. The inter-rater reliability described here is comparable to that of other popular measures in the field of auditory hallucinations (see for example, Garety et al, 1999), and supports the use of this as a standardised measure of command hallucinations in the current large scale study. It also suggests that the CHRIS holds a great deal of potential for development for publication and wide spread use.

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Family Mode Deactivation Therapy

Workshop

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Mode Deactivation Therapy (MDT) has been shown to be an effective treatment for a variety of adolescent disorders (Apsche, Bass & Siv, 2006) including emotional dysregulation (Apsche & Ward-Bailey, 2004) behavioral dysregulation (Apsche, Bass & Murphy, 2006), physical aggression (Apsche, Bass & Houston, 2007), sexual aggression (Apsche, Bass, Jennings, Murphy, Hunter & Siv, 2005), and many harmful symptoms of anxiety and traumatic stress, (Apsche & Bass, 2006). MDT Family Therapy has been effective in reducing family disharmony in case studies (Apsche & Ward, 2004), and has been shown to be efficacious as compared to treatment as usual (TAU) in treating families with a variety of problem behaviors (Apsche & Bass, 2006) and in reducing and maintaining treatment effects through two years of tracking recidivism rates (Apsche, Bass & Houston, 2007).

We completed a Family MDT clinical study of fourteen adolescents who evidenced problems such as sexual and physical aggression as well as oppositional behaviors including verbal aggression (Apsche & Bass, 2006). The results indicated that MDT out performed treatment-as-usual. At the eighteenth month of observation the MDT group has zero incidents of sexual recidivism, while the TAU group had ten reported incidents. The MDT group reported three incidents of physical aggression while the TAU group reported twelve incidents. The results were promising for MDT as a family therapy, and indicate that further study with a larger group should be pursued (Apsche, Bass & Siv, 2006).

A study of outpatient Family MDT (Apsche, Bass, & Houston, 2007) was also completed comparing an MDT group and a separate TAU group. This study examined physically aggressive youth with conduct problems and characteristics of personality disorder. A total of fifteen families were studied – eight in the MDT group, and seven in the TAU group. MDT surpassed TAU at the twenty week interval of treatment. The most compelling point of data was that the MDT group had no referrals for out of home placement, while the TAU group had seven. The results show potential for this population, although the small number of participants limits the claims of efficacy for Family MDT (Apsche, Bass, & Houston, 2007).

MDT Family Therapy also examines the process of family interactions (Apsche & Ward, 2003; Apsche & Bass, 2006). MDT attempts to move the family to a new script or mode of interaction, based on the collective case conceptualization process (Apsche & Ward, 2004; Apsche & Bass, 2006). MDT focuses on the system of family beliefs and modes based on the collective and individual modes of the family. MDT therefore tends to be a psychotherapeutic intervention rather than a system of treatments. One therapist is central to the individual, group, and family process. The therapist is the team captain and coordinates individual, family, and group psychotherapy. MDT is a process that focuses first on the adolescent following the completion of the family core conceptualization, then the family. MDT includes a family workbook, (Apsche & Apsche, 2007), and exercises which help to reintegrate the troubled youth and his or her family.

MDT, in individual and family work, offers the therapist and client the ability to objectively structure, measure and track progress in treatment in the treatment manual (Apsche & Apsche, 2007).

MDT incorporates treatment strategies from behavioral, cognitive, dialectical and other supportive psychotherapeutic approaches. It is administered systematically via a method that is clearly delineated in the MDT Clinicians Manual. MDT is comprised of weekly individual and group therapy sessions, provided for an average of eight to 12 months, depending upon the level of cooperation and amenability to treatment of the individual and family.

The MDT treatment process starts with a comprehensive Case Conceptualization obtained through the use of a structured diagnostic interview called the Typology Survey. This survey allows the clinician to develop an understanding of the client's behavioral and family history, and incorporates a detailed inventory of traumatic events. The Typology Survey is conducted with the child, guardian, and referral source, with each providing a response to every question.

Further individual assessments are determined by responses to the Typology Survey, and the acuity of conduct problems of the adolescent. MDT uses a continuum from reactive to proactive on a successive.

1. The Fear-Family Assessment: An assessment of sixty items that identifies basic difficulties, anxieties, or fears of the family. Each family member participates in completing the assessment, the scores are totaled, and a mean score is determined for each item.
2. The Family Core Belief Assessment: An inventory of ninety-six questions related to the family's belief systems. The Family Core Belief Assessment is scored in the same manner as the Family Fear Assessment.
3. The Functionally Based Treatment Development Form: This form addresses the collective family beliefs and supplies the family a specific methodology to develop and maintain more functional family beliefs.

A Family MDT Workbook accompanies this process, and is designed to structure the family therapy following the MDT methodology process. The workbook creates a collaborative effect for all family members by addressing the following topics.

1. Commitment to Treatment
2. Responsibility for the Family
3. Family Belief Analysis (Compound Core Beliefs)
4. Modes of the Family
5. Your Family's Beliefs and Problem Behaviors
6. Problem Behaviors and MDT
7. Substance Abuse in Your Family
8. Empathy for the Family
9. Becoming Survivors

The families are taught how to balance their beliefs with the V-C-R method. While there may be some identification of opposing beliefs, this method attempts to expose the irrational, illogical belief deeply held by families in crisis. The individual components of the V-C-R method include:

- Validation: Each family member's thoughts and beliefs are validated initially. Therapists search for the 'grain of truth' in each family member's responses. It is important to assure each member that his or her responses are accurate as far as he or she interprets perceptions. Each member is given appropriate therapist reinforcement to indicate that he or she is understood and believed.
- Clarification: The therapist clarifies the content of responses. Therapists also clarify the beliefs that are activated. It is important that the clinician understands and agrees with the content of the clarification. The clarification step is crucial in understanding the long held thinking schemas – it reveals the family member's perspective of reality and beliefs.

- **Redirection:** The therapist redirects responses to help the family members consider other possibilities on the continuum of held beliefs. The goal of redirection is to help find the exception in the belief system. It involves examining the opposite side of the dichotomous or dialectical thinking. It is crucial to partner with the member to see the 'grain of truth' in each of the dichotomous situations presented.

MDT has been shown to be more effective as other approaches such as CBT, DBT and SST. This review also showed the results of a thorough review of literature delineating the effectiveness of MDT in treating adolescent clients with reactive emotional dysregulation, who presented with behaviors involving parasuicidal acts, sexual offenses other aggression. Case studies confirmed that MDT showed as much merit as conventional cognitive therapy. Clients with complicated histories of sexual, physical, or emotional abuse, as well as neglect, and multi-axial diagnoses, can be helped using this approach, enhancing clinical rapport.

This is seen as preferred alternative to other approaches, which sometimes sets up an atmosphere of argumentativeness. This confrontational approach is contraindicated with juveniles who present with proactive or reactive disorders. Clinical attractiveness can be enhanced, which can lead to decreased resistance from the client.

Data indicates that MDT is effective in reducing the rate of physical and sexual aggression across treatment. The evidenced-based approach of MDT readily lends to providing clinical data in a real-world setting that has profoundly positive impact in reducing extremely life interrupting behavior.

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“To pull together is to avoid being pulled apart” – the application of positive psychology to both the Life Minus Violence - Enhanced group work programme and the management of violence within the secure units in which it is delivered

Paper

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The concepts of “emotional intelligence” (Payne 1986) and “positive psychology” (Seligman 2000) are broad frameworks that are increasingly influencing the provision of psychological treatments, both within groups and on an individual basis. If these principles are to be embraced holistically as efficacious for mentally disordered offenders, then consideration needs to be given to the whole environment aspect of institutionalised care.

Rather than viewing institutions as purely negative influences that can only disempower and damage the individual, this paper considers the possibilities that embracing a positivistic approach to the management of violence within secure psychiatric hospitals, as well as to therapy, can potentially develop 24 hour emotional intelligence therapy for individuals within such a setting. An initial review of the delivery of whole team training which uses positive principles to deal with aggressive behaviour will be presented.

The Life Minus Violence - Enhanced (LMV-E) programme is an intensive groupwork programme that has been developed specifically for the treatment of violent patients within both low and medium secure psychiatric settings. This programme utilises a positive psychology approach to aggression, and uses the concept of emotional intelligence to underpin the therapy.

This paper will briefly outline the theoretical underpinnings of the programme, and an overview of the methods used within the LMV - E package, and specifically the adaptations that have been made for patients within medium and low secure units. It aims to provide information about a new and evolving programme aimed at addressing violence and aggression in patients with mental disorder. The initial findings of the pilot programmes will be discussed and presented.

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First minute intervention at the start of a compulsory admission at a psychiatric hospital. A descriptive qualitative research among nurses in acute psychiatric wards

Paper

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Keywords: Mental health care, compulsory admission, first minute intervention, contact, coercive measures.

Introduction

In The Netherlands coercive measures, e.g., seclusion and involuntary medication have to be decreased. An approach to achieve this aim is to improve the contact between healthcare workers and patients. The author worked as a Nurse Specialist Mental Healthcare at an acute psychiatric ward and noticed differences in the interventions nurses took in the first minutes of compulsory admission. Also a literature-study proved a lack in descriptions of interventions healthcare workers should do in the first stage of compulsory admission. In 2008 in a study the best-practise among the first stage of a compulsory admission of patients in psychiatric wards was described.

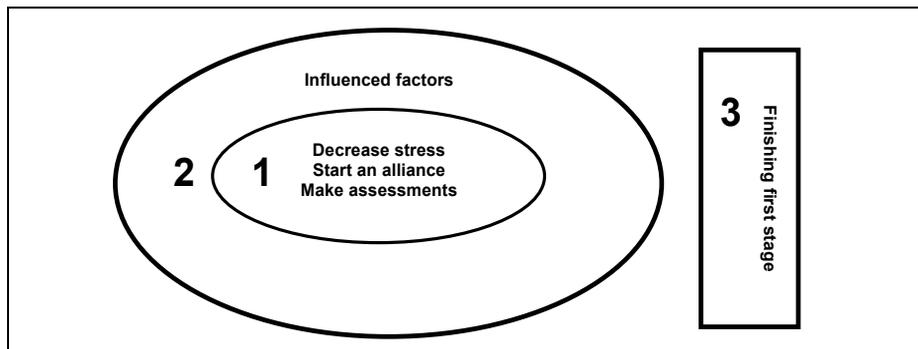
Method

A descriptive qualitative research design was performed. Subjects were eight nurses, selected from 53 psychiatric hospitals. A semi-structured interview was applied. All interviews were typed ad verbatim and analysed according the research methodology of Baarda (2005). To increase the reliability of the findings, an external supervisor checked the several stages of the research. To increase the validity of the research, the results were discussed with several experts, including consumers with a psychiatric background which experienced compulsory admission at psychiatric wards.

Results

The most important interventions (Figure 1) mentioned by the nurses were, firstly a mix of the following interventions in the first minutes of contact between nurse and patients: efforts to decrease stress, to start an alliance, make an assessment. Secondly nurses described items which influence the core of the first minute intervention. The third aspect is taking care of finishing the highly intensive first period. General speaking are all interventions tailored care, every situation will be unique and ask for an individual approach. A prominent result is that some nurses did interventions they described as unusual and initially didn't want to tell, e.g. to give individual care for an hour and a half or to provide a cigarette to a patient in order to calm him.

Figure 1



1. Decrease stress, start an alliance, make assessments

Decrease stress

Nurses decrease stress by offering food, drinks and a smoke, most patients claim that they did not eat or drink for a long time. Nurses then inform the patient on several aspects: who are nurses, where the patient is, when it is all happening, what the patient can expect and why. Nurses differ in the information they give about the reason of the admission, some nurses are transparent and read the report of the ambulant crisis-team. All nurses agree that they don't want a discussion about the reason of admission, but there should be clarity that the choice of involuntary admission has been made, and that nurses cannot change that. Nurses find it hard to describe their own attitude in the first stage of admission. An important issue is to be emphatic and use a low expressed emotion, what is been shown as calm, neutral, friendly, predictable and concerned. Some nurses describe it as 'just act normally'. At the same time nurses emphasize that 'friendly' does not mean 'unbounded'. Clarity is important, e.g. which behaviour is accepted and which is not. Nurses try to conceive what they would need in patients' situation and find reliability essential to decrease stress. Finally, according to the nurses, the patient should be accompanied all the time, to prevent that the patient could think that he is left alone.

Start an alliance

The aspects mentioned in the previous part (calm attitude, clarity, reliability, conceiving) are also used to start an alliance. In the period prior admission, several decisions are made against the will of the patient. The first minute interventions are purposed to increase patients' autonomy, by giving choices and let the patient decide about the order of the choices. E.g. does the patient first want refreshment or a phonecall?

Nurses emphasize that the used interventions are tailored care and depending on the behaviour of the patient. Some patients can handle more autonomy then other patients.

Make assessments

Prior to admission, nurses make assessments based on the pre-information. They have to decide how many nurses should be available in those first minutes, to guarantee safety for staff without overawe the patient. Nurses observe behaviour, verbal and nonverbal signs and make assessments. Nurses find it important to verify their interpretation with the patient to ensure that that the

intervention is well-fitted. A quarter of the nurses use their intuition to make assessments about safety.

2. Influenced factors

The building and furnishing is an important aspect which influences the first minute interventions. Nurses prefer a warm, calm en friendly environment above a welcome in the seclusion-area, with bright light and metal doors.

Secondly the work-experience and the fact if the nurse and patient know each other are influencing the first minute interventions. It can be positive and negative. Nurses realise that the react differently towards a patient who is well known and appears to be friendly and cooperative in comparison with a patient who is known as aggressive and dangerous.

At least nurses mentioned that their own attitude is important in the first minutes, they are willing to meet the patient unbiased and with hospitality, despite the pre-information and the experiences.

3. Finishing first stage

Nurses find it important to pay attention at the end of the first stage of the admission, an intensive period. They give the patient a helping hand in things the patient can do and introduce the patient to the other patients and staff. Nurses explain the way the patient can keep in touch with staff.

Finally the nurses inform their colleagues.

Conclusion

The results of the study were presented to multidisciplinary teams of acute admission wards and the healthcare workers responded enthusiastic. The first minute intervention is a part of a larger project in which the use of coercive measures in frequency en duration with at least fifty percent in two years decreased. Since 2009 the results of the study are part of a protocol in respect of compulsory admission in a psychiatric hospital. An article of this study was published in 'Praxis Geestelijke Gezondheidszorg Verpleegkundig Specialist 2009'.

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Factors related to the treatment of impulsive violence

Paper

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Keywords: Impulsive violence, aggression, associated factors, treatment, review

Introduction

Although we are familiar with factors associated with impulsive violent behavior (IVB), we want to know all the factors that are associated with this topic. This study focuses on identifying the neurological, cognitive-emotional and social psychological factors in the literature related to IVB and examining whether these factors discriminate and have a predictive value. It is estimated that 60 to 90% of violent crimes are impulsive in nature, although there is considerable correlation between instrumental and impulsive violence. Impulsivity and violence are factors in diagnoses like borderline personality disorder, psychopathy or antisocial personality disorder but not essential. Does this situation always involve a violent act or do people get into such a state like this without demonstrating violent behavior? Are we dealing with an affliction, a separate psychopathological entity?

A key understanding is that the violent act is excessive, not proportionate to the extent of the provocation, if provocation takes place at all. Sudden alterations in the situation can promote unexpected results and it is hypothesized that a changed state of mind is a result of a sudden elevation in arousal.

The striking thing is that none of the factors found, proves to have a discriminative value. Even impulsivity is not significant enough to predict IVB. Neurobiological risk factors associated with IVB are an increased cortisol production in aversive stimulation or provocation and reduced serotonin activity (both possibly related to alcohol or cocaine use). In addition, personal characteristics such as a strongly positive, though unstable self-image, impulsivity, problematic self-control, difficulty with verbal expression, a low self-disclosure and hostility seem to increase the risk. Being in a violent group and having a weapon at hand are apparently social psychological factors that increase the chance of IVB. Practically all these factors were found in perpetrators of impulsive violent criminal acts. The following factors are more prevalent in the perpetrator group: presence of weapons, alcohol and drug abuse, low verbal intelligence, increased arousability, having been subjected to physical violence in childhood, problematic self-control and impulsiveness, violent friends or acquaintances and hostility.

The risk factors can be grouped into three factors that constitute the profile of the perpetrator and are most importantly related to the situations in which drugs and alcohol and weapons were used. Next are poor verbal skills that express capability, followed by factors representing a tendency towards impulsive aggression, physical violence, hostility, anger, impulsiveness and arousability.

Objective

The aim of the study is to present treatments which seem to be effective for impulsive violence (aggression). Previous research shows that there are three discriminating factors that influence impulsive aggression: use of drugs and weapons, verbal skills and impulsive aggressive moods. The current study investigates whether the found treatments have a connection with the three discriminating factors.

Methods

This paper is a review. To get a broader prospect, this study also included treatment for aggression in general. The following words: impulsive aggression, violence, anger, prison, rehabilitation treatment, intervention, anger management, therapy, (cognitive-) behavior therapy, psychotherapy and aggression management, were run through the databases PsycINFO, PICARTA, PubMed, Web of Science (ISI), SocINDEX en Google SCHOLAR.

Results

There are no studies that investigated all the factors related to IVB. Only studies were found that had a separate topic. Five meta-analyses and seven exclusive studies were found. The meta-analyses identified the following treatments: relaxation, cognitive-behavioral therapy, cognitive therapy, behavioral therapy, social skill training and a combination of the previous named treatments. Relaxation turns out to be the most effective treatment but especially in driver anger. In the group that suppressed violence, relaxation therapy was not effective. In that group cognitive therapy was most effective. In the group expressed violence group cognitive behavior therapy was more effective. Within the exclusive studies, only the cognitive-behavioral treatments are highlighted. These exclusive studies show significant and non-significant results in relation to the reduction of anger, aggression or violent behavior.

Conclusions

In search for more effective interventions to reduce IVB more differentiation is needed. There are no studies found that investigated integrated treatments with all relevant factors. Relaxation and cognitive-behavioral therapy both are effective in reducing anger and aggression in general. No treatments are found specifically for IVB or could be related to the three discriminating factors: drugs and weapons, verbal skills and impulsive aggressive moods.

The presence of a factor does not say anything about the process between provocation and violence and the place of that particular factor in the process. Moreover, we know little about the interaction of the various factors and how they may reinforce each other. In addition to the need for more research there is also a need for a theoretical framework on the course of such a process. The general aggression model from Anderson and Bushman, 2002, is a good example how the factors in this study can play a role in violent behavior especially anger (affect) and arousability (arousal). Or the social information processing model from Crick and Dodge (1994) and especially the response evaluation and decision model from Fontaine and Dodge (2006). We can even speculate that cognitive blockage plays a major part in the process of impulsive violent behavior.

Apart from these factors this survey provided other interesting facts. Impulsive violent behavior (affective defense) is distinguished from instrumental violent behavior (predatory attack). The literature shows that there are different views on impulsivity. On the one hand, it is consistently argued that impulsivity can be related to the inability to delay a certain response (reward-delay

impulsivity). On the other hand, according to the antecedent viewpoint the key issue is that the context is not involved in determining the response. For a better understanding differentiation of impulsive violence is welcome and we propose to split up impulsive violent behavior in two separate forms. The first type (based on reward-delay) can be related to personality traits and functions as a diagnostic criterion for periodical explosive disorder (inability to resist aggressive impulses). Consequently, a second type impulsive violent behavior can be considered a separate psychopathological entity on the basis of rapid response impulsivity.

Treatment of perpetrators seem to affect the reduction of violent relapse and treatment is more effective when specific types of violence and their related factors are identified and dealt with in full in perpetrators with IVB.

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Aggression Management in General Hospitals: A joint Nursing Science - Design Research Project

Workshop

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Keywords: aggression management, nurse, general hospital, interdisciplinary, methodology, design analysis

Introduction

Aggressive behaviour of patients towards nursing staff is a subject that has been increasingly discussed over the last 20 years. Internationally, patient aggression is classified as a severe and dangerous problem in health care system, as staff members run a great risk at experiencing patient aggression during their career. In general, nurses report more patient or visitor aggression than other health care professionals. Almost all nurses have been exposed to patient aggression [1]. This has a negative effect on their health, their job motivation and consequently on the patients' quality of care [2, 3]. On this account different organisations, such as the World Health Organization (WHO), call for the development of studies on the issue of aggression in day-to-day care. The aim is to close information gaps, to stimulate the discussion and to improve the cooperation in the field of aggression in the health care system worldwide.

Research on aggression management in general hospitals is still in its beginnings. There is some evidence on the prevalence of aggressive assaults from hospitals in North America and in the United Kingdom. However, evidence from continental European healthcare institutions is still lacking. Nonetheless, guidelines or de-escalation strategies often synthesize findings on violence in the mental health inpatient setting [4, 5]. Although this setting has some similarities with the general health care setting, the remaining differences do not allow a straightforward generalization across settings [6]. This hampers the implementation of efficient management strategies to prevent patient and visitor aggression in general hospitals.

Patient's and/or visitor's health state (e.g. cognitive processing, emotional state), the architectural and organisational work environment in which health care staff is working (e.g. type of ward, organisational procedures), the staff characteristics (e.g. closeness of patient and visitor contact, professional experience, attitude), the interaction process (e.g. frustrating experiences, painful interventions) are seen as important factors in the development of patient aggression in general hospitals [1, 7, 8]. Studies have only partially described these factors related to patient aggression and existing results are conflicting. Furthermore, patient aggression seems to depend on the social context or cultural background of the health care system [9].

Therefore, the present study on patient aggression in general hospitals was conducted in Switzerland with a joint research team from the Department of Health Sciences of Bern University of Applied Sciences and the main research area Communication Design of the Bern University of the Arts. This interdisciplinary research team consists of sociologists, psychologists, nursing experts, communication designers, interior designers and product designers. We investigated the prevalence of aggressive incidents, the consequences for staff members, the nursing interventions following the incidents, and the communication between patients and staff. Furthermore, we

collected data about the situational and the design variables of the sites where the incidents occurred.

Aim

The aim of this ongoing research project is to identify risk factors of patient aggression and to improve both preventive measures and the handling of aggressive assaults in general hospitals with an interdisciplinary methodological approach.

This workshop will...

- sensitise researchers to the problem of violence in a general hospital setting.
- present an interdisciplinary methodological approach and how it could lead to new perspectives
- discuss the pros and cons of new and interdisciplinary research approaches.

The Workshop

Methodologies from different research areas were applied in this study to obtain a comprehensive view of incidents of aggression in general hospitals in Switzerland. We will present this methodological approach and discuss experienced successes and pitfalls. The discussion includes the presentation of study results. Study results will be presented and a vivid description of the interdisciplinary work will be given.

Sample and Setting

A sample of 32 medical, surgical, geriatric, psycho-somatic and mixed wards from 8 different general hospitals in the German-speaking part of Switzerland participated in the study. Only nursing staff in contact with patients and visitors and adequate command of the German language participated in the study.

Data Collection

The study was conducted between August 2008 and April 2009. Data were collected using prevalence measures with incidence forms, qualitative interviews and room inspection. Permission for the investigation was given by the Ethical Commission and by the heads of nursing staff in the participating general hospitals. These head nurses, who had previously been informed about the study by the principal investigator, informed the nursing staff on their wards about the study. On all wards incidence forms along with written information on the study were available.

Instruments and methodologies used

A mixed method approach was used to investigate aggressive behaviour of patients against nursing staff in general hospitals to identify activators, forms of aggression, frequency, nursing interventions following the incident and consequences for staff members. For this purpose different instruments and research methodologies were used. First, the Staff Observation of Aggression Scale – Revised, SOAS-R adapted for general hospitals [10, 11] was applied. This reporting instrument gathers incidents of aggression from the nursing staff's point of view, immediately after the incident has occurred. Second, to better understand aggressive incidents in the specific medical field on the different ward, the design team asked the nursing staff to sketch the situation on a special room-analysis survey. Each staff member drew his/her position, the position of the patient and of other attendant staff members or visitors, similar to filling out an accident report form. Additionally, as a third step, the nursing research team conducted half-structured interviews with nurses following violent incidences. Finally, as a last investigation tool, the design team was

guided by staff members into rooms where aggressive incidents have increasingly occurred. On the basis of photographs (of the room, furniture, materials, view), sketches, semantic differentials and definitions of colours, the rooms have been registered.

Analysis

In a traditional way each discipline analysed the data with their common methodological approaches. The SOAS-R was analysed with standard descriptive statistics to describe and summarize the data. Associations between categorical variables were tested with chi-square tests. Interviews and room surveys were analysed with qualitative content analysis and the room inspections were analysed by design parameters. In addition, in regularly meetings guided discursive discussions were carried out from which an interdisciplinary methodological approach emerged.

Results

Based on this interdisciplinary approach the research team developed an optimised communication environment including attentiveness for the situation of the patient (anxiety, confusion, pain), focussing on verbal and non-verbal communication skills (stress and information management) and concern of environmental arrangement (noise, colour, arrangement). As an ongoing work the interdisciplinary solutions was and will be didactically prepared. They will be exemplarily used in educational programs in order to improve communication skills.

Conclusions

The study allows conclusions beneficial to human resources, organizational practices and development of theory. This research project delivers a fundamental contribution in the fields of assault prevention and intervention by closing information gaps. Finally, we are exploring and developing new ways of communicating knowledge in an interdisciplinary team.

Acknowledgments

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Mindfulness: Does it have a role in reducing violence?

Paper

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Keywords: Dangerous and severe personality disorder, mindfulness, treatment

Those delivering therapeutic interventions for violence, particularly for violent offending, have been very influenced by the Risk-Needs-Responsivity framework for offender rehabilitation. Within this framework, cognitive behavioural therapeutic methods have dominated, largely because of the evidence that such methods have been demonstrated to be most effective, at least when the goal of treatment is to reduce the frequency of subsequent violence or violent recidivism. The premise of the present paper is that the cognitive behavioural model is not static or fixed in stone and that, consequently, it is important for practitioners involved in therapies to reduce violence to keep abreast of new developments and to ask whether such developments might be relevant.

In recent years there has been a considerable expansion of interest within clinical psychology and psychiatry in so-called “third wave” approaches to treatment arising out of contemplative, spiritual traditions such as Buddhism. The most developed and evaluated of these approaches has been the application of mindfulness training, particularly in the fields of depression, stress and general health, where there is increasing evidence in controlled trials that mindfulness training can have a positive impact on outcomes.

What is mindfulness?

Bishop et al. (2004, page 231) describes mindfulness interventions in the following way: “The clientattempts to maintain attention on a particular focus, most commonly the somatic sensations of breathing...whenever attention wanders from the breath to inevitable thoughts and feelings that arise, the client will simply take notice of them and let them go, as attention is returned to the breath....in a state of mindfulness, thoughts and feelings are observed as events in the mind, without over-identifying with them and without reacting to them in an automatic, habitual pattern of reactivity. This dispassionate state of self-observation is thought to introduce a space between one’s perception and response....thus mindfulness is thought to enable one to respond to situations more reflectively(as opposed to reflexively)”.

In effect, mindfulness concerns awareness of and attention to all events experienced in the ongoing stream of consciousness. Mindfulness implies particular qualities of this awareness and internal observation, notably ‘bare attention’; a simple non-judgemental noting of phenomenological events. A mindset of ‘acceptance’ and non-judgemental noticing is encouraged, as is a focus on the present moment. Thus thought sequences about the past and future, which constitute a major part of normal everyday thinking are seen as mere thoughts and distractions from the task of remaining present.

There have been three major clinical areas in which mindfulness training has been applied: Mindfulness-based Stress-Reduction (MBSR) Programs; Mindfulness-based CBT (MBCT),

particularly depression relapse prevention; and Mindfulness skills within Dialectical Behaviour Therapy. Brown et al (2007) have produced an extensive review of the utility and impact of mindfulness training in all three of these areas as well as of mindfulness effects in experimental social psychology.

Controlled treatment studies (including RCTs) of MBSR have demonstrated greater reductions in stress and distress for those undertaking MBSR, compared with waiting-list controls. Similarly, for MBCT RCTs have demonstrated reductions in relapse rates for patients with three or more previous episodes of depression (for example, Kuyken et al, 2008). There is also evidence that mindfulness alters both brain processes and immune function in a positive direction.

To what needs of violence perpetrators might mindfulness be relevant?

Mindfulness would appear to have the potential to address a number of psychological processes and states that are clearly relevant to risk of violent recidivism. Firstly, negative affective states have been identified as relevant to many forms of offending (Day, 2009), and the evidence available as to the impact and mediators of mindfulness suggests it is particularly relevant to the reduction of negative affect. Secondly, self-regulatory breakdown (particularly for negative affect) leading to impulsivity is widely recognised as an important causal influence for many forms of offending and may be particularly important in personality disordered offenders. By its nature, mindfulness is about reducing impulsive responding by increasing awareness of mental states and their role in eliciting automatic and impulsive behaviour. Mindfulness promotes control of mental states and processes (Macicampo & Baumeister, 2007).

Thirdly, anger is recognised to be a major antecedent for many forms of violence, and mindfulness grew out of a philosophical, psychological and spiritual tradition - Buddhism- in which states of anger have received extended and detailed attention. Within such traditions anger is viewed as a major “mental affliction” (Dalai-Lama & Goleman, 2003), and mindfulness has been proposed as a helpful technique in the control of anger and its possible contribution to cognitive behavioural therapy. Given the limitations of conventional anger management programs, as currently delivered, for improving anger problems in offenders (Howells et al, 2005) there would appear to be room for increasing the range and sophistication for anger interventions along mindfulness lines.

There are also potential difficulties relating to the cultural acceptability (for patients, offenders, professional staff and the institution or service) of the language and concepts underlying mindfulness, taken as they are from other, Eastern, cultures, notwithstanding the rapid and continuing expansion of Buddhism in the West and its increasing expression in a more Western form. Inwardness, reflection and introspection (all aspects of mindfulness), intuitively, are not widely valued or practiced in many Western societies and may meet resistance, particularly within criminal justice environments in which psychological practice is underpinned by values that are punishment oriented . More optimistically, and contrary to this assumption, however, is the widespread existence and apparent popularity of meditation and similar groups within the prison system (see, for example Samuelson et al., 2007) and the successful delivery of mindfulness within programs such as Dialectical Behaviour Therapy in forensic settings.

Arguably, the most important amongst unresolved issues are those relating to the roots of mindfulness within spiritual, contemplative traditions such as Buddhism. As utilized in psychological and psychiatric interventions, mindfulness has been largely severed from its fundamental roots and treated in relative isolation from the extensive, deeper and sophisticated philosophical, spiritual and psychological system which generated it (Rosch, 2007).

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“Sinnemestring Brøset” : A cognitive-behavioral therapy program for the violent executive in domestic violence

Poster

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Sinnemestring Brøset has been developing a cognitive therapy model for spouse battering for ten years. We have educated 80 therapists all over Norway to administer group therapy for men and women that abuse. The common psychological problem lies in the offender's perception or misperception of himself and other people. Domestic violence does not occur in a vacuum but is frequently the culmination of a conflict in which husband and wife use whatever resources they have to attack or defend each other. The batterer must learn about his own vulnerability and the hurt feelings. In his eyes, she has wronged him, and he must use force to reduce the perceived threat, and restore the proper balance to the relationship.

When deadlocked in a conflict, the violent-prone husband believes:

- That physical force is the only language that my wife understands.
- Only by inflicting pain can I get her to change her abusive behavior.
- The impulse to use physical force becomes a strong imperative, practically as much a reflex as defending oneself from physical attack.

However, these pro-violence beliefs can be modified. Our program is based on the assumption that cognitive deficits and distortions are learned rather than inherent. Our programme therefore emphasizes individual accountability and the attempt to teach the batterer to understand the thinking processes and choices that immediately preceded the violent behavior. The anger management training focuses on teaching the batterers to monitor their patterns of automatic thoughts to situations in which they tend to react with anger or violence. Various strategies are then rehearsed for assessing the validity of those “hot” or “trigger” thoughts. Cognitive skills training aims to teach such thinking skills as interpersonal problem -solving; critical reasoning, goal setting, long -term planning, perspective taking, and relapse prevention planning.

Our cognitive -behavioral therapy program (CBT) is a promising rehabilitative treatment for spouse abuse. Meta -analyses have consistently indicated that CBT, on average, has significant positive effects on reducing recidivism.

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Presentation of a new method: A prevention plan based on group dynamics signals

Workshop

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Keywords: New method, group dynamics, high-tension, violent behaviour, crisis development model, prevention

Introduction

In this workshop a newly developed method is presented. A prevention plan is developed which is based on group dynamics signals. By using group dynamics signals the healthcare worker is able to predict and prevent aggressive patient behaviour within forensic units. Experience learns that if high-tension builds up within a group of patients, the staff's reflection abilities are affected. This new method supports the reflection abilities of the health care worker. This makes a collective intervention possible even when the tension building in the group continues to stay at a high level. In doing so, the autonomy of the staff increases. This new method is implemented together with the common individual prevention plan.

The main workshop – methods and results The health care worker dilemma

Within Forensic Psychiatry, prevention of recidivism is an important issue. Individual prevention plans are an important tool for reaching this goal. In these prevention plans individual coping style and crisis development are important elements. The individual coping style predicts aggressive behaviour. Beside these elements, experience learnt us that there is an other important issue. If on a forensic ward the tension stay's on a constant high level for a long period of time the risk of escalations and recurrences increases. An important health care workers experience is that the most vulnerable patients (with a lacking coping skills) are the first to decompensate or to escalate. In an attempt to decrease this high tension-build-up for these patients, health care workers are usually attached to rules and regulations instead of relationship management and de-escalation.

These preferences for working with rules and regulations can frustrate the working relations and the treatment on the long term. To much safety measures hospitalize the patients and have an negative effect on the quality of the treatment. Beside the fact that the health care worker can become a victim of an aggressive incident, the psycho hygiene of the health care worker can be affected in case of working in a long term high tension build-up. This affect on psycho hygiene if often not noticed.. The staff's reflection abilities are affected and also the creativity of the interventions itself are decreasing. Rule- and regulation based working and the chance of a burn-out by the health care worker are increased.

In evaluations of the high-tense periods the health care worker can tell that step by step he or she adepts to the high tension situation which slowly escalates. Looking back the health care worker is able to give you the precise point where it went wrong.

The instrument

This prevention plan based on group dynamics signals consists of two parts.

1. A written part called: group prevention plan in which signs and signals of tension build up are subscribed, including the interventions based on de-escalation of the group and support of the staff.
2. An instrument which measures the tension building called: Grid. This is an important element because the health care workers themselves are part of or influenced by this tension building. So this Grid is an important objective.

The group prevention plan

The group prevention plan is just as the individual prevention plan based on a crisis development model. This model is based on the solid phases of the development in a crisis and it includes a set of possible actions and interventions to deescalate.

The basic situation is called phase 0 (the normal value; tension level is normal) to indicate what level the basic tension is in a certain group of patients. By internal or external influences this tension level can increase. This is described in level 1 to 3.

Figure 1: Schematic overview of the four tension levels:

Tension level	Signs and Signals	Intervention staff towards the patients and themselves
Level 0: "Standard value"	Grid-level 0 Relaxed environment	Normal routine, Self coaching
Level 1:	Grid-level 1 Irritated environment or busy group	De-escalate Self coaching aimed at result
Level 2:	Grid-level 2 Group- and staff destructives	Directive acting External coaching
Level 3:	Grid-level 3 Aggression out of a group	Physical intervene Management makes decision External support

The group prevention plan is written in a quiet period by all staff members. The most important characteristics of each phase, each level and the possible interventions are described. Also the agreement is made that an inventory by the Grid is made on a daily basis. Further more, agreements are made what will be done if the Grid shows derogatory values.

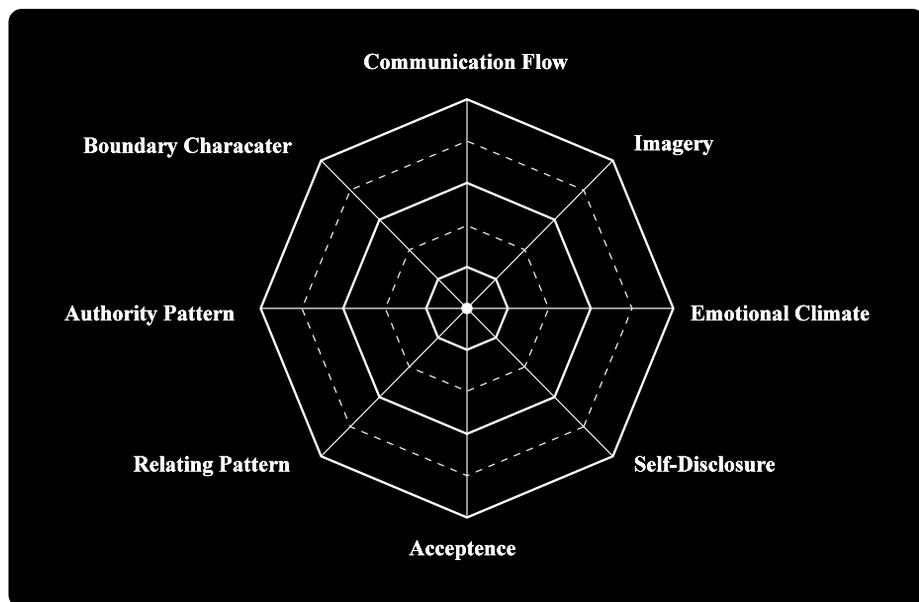
Explanation of the Grid

An instrument which's measures the tension building: Many group indicators are hidden within the communication and relation level between group members mutually and between group members and the staff. The staff who cooperate closely with group members is by definition part of this group dynamics. Thus we see often that the ability of reflection on communication and relation level reduces within the staff if the tension in the patient group increases.

The reflection of the staff members on action out of the patient group will decrease. For this reason a prevention plan on noticeable group indicators is not sufficient, there is also a monitor necessary to objectify the tension level. We found such instrument in the Matrix Representation Grid by G. Ahlin from Sweden. The Matrix representation grid, shortened called; Grid, measures the communication and the relation level in the patient group by means of 8 dimensions. The idea

is that this instrument deviates from its normal pattern the tension level in the group increases. Because this Grid is unique for each group, the 'normal' pattern will be different by each group of patients.

The Grid



The Grid is a spider web or an array. The 8 most important characteristics of the group functioning are described on 8 lines. Staff members value which level the group functions on each of these dimensions. Number 1 gets the outer thick circle, number 5 gets the interior. Each group has an unique 'standard value' Grid, when a group functions normally a pattern arises which is characteristic for that group. If a group comes under stress and tension the Grid will change. Regular, daily inventory is reached by a standard fill in of the automated version of the Grid. This standard fill in rapidly produces an indicator of the changing or increasing tension. In combination with the group prevention plan it helps the further diagnoses of the tension build up and the adequate actions which should be undertaken.

Conclusion

In my presentation/workshop I have tried to show you how we work with a prevention plan based on group dynamics signals to predict and prevent aggressive behaviour. Our experience has taught us that aggression often starts within relationships and that these relationships are for the health care worker the most important tools to use when it comes to prevention.

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How to verbalize difficult experiences and emotions with the use of photographs

Paper

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Keywords: photo-elicitation, photo-stories, shame, shame management, stigmatization

Abstract

The photo-instrument is a group-therapy that aims at finding and expressing (new) meanings for sometimes diffuse experiences and complex feelings that are difficult to verbalize. It is a combination of an arts based therapy with narrative therapy. It can be used for patients in therapy for whom violence plays a role in their lives, as victim or as offender. Because of its focus on strengths and expectancies the approach helps victims and offenders to connect their life story with valued goals or relationships and engagements. This will contribute to a more reflexive stance and weaken regressive or defensive cognitive schemes and responses.

Background

In the field of trauma treatment there are basically three approaches. They can be summarized as:

- creative arts therapies (CAT): e.g. drama therapy, dance, movement
- cognitive behavioural therapies (CBT): e.g. exposure therapy
- narrative-based therapies (NBT): e.g. reminiscence therapy, guided autobiography

CBT has been shown to be effective in research, but most of the studies have several shortcomings: e.g. dropouts were not counted and of the included patients up to 50 % continued to have serious complaints (Institute of medicine, 2007). Only exposure therapy as component of CBT can stand the rigor of critique and has gathered enough evidence to suggest efficacy for PTSD. There is no empirical evidence for the efficacy of CAT and NBT: little quantitative research is being conducted. There are however many qualitative studies that explain the therapeutic actions of CAT or NBT, but few do so specific for trauma treatment. The therapeutic actions of CAT and NBT specific for trauma treatment are based on:

- **assimilation** of memories into newly developed contexts of meaning (versus an emphasis on accommodation to an external set of 'healthy cognitions' in CBT)
- **expression** of disclosed memories and cognitions which is set in a relational context and linked with containment
- **the relational** context in terms of the possible reactions of listeners and emotional-relational needs of patients involved in disclosing laden memories

Victims of violence

In NBT reminiscing often plays an important role, but is not often used in trauma therapy because it is argued that it would elicit too many painful memories of the experience of abuse or violence and might re-activate certain cognitive schemes of self-blame and self-depreciation. However, studies of women that were survivors of abuse and violence have shown that reminiscence as a therapeutic intervention had a positive effect where women were encouraged to reminisce on self-efficacy beliefs and expectancies prior to their personal experiences of abuse (Fry & Barker, 2002). In these studies facilitators of reminiscence groups made sure that the story-tellers did not

engage in too much self-criticism or blame as a stick with which to beat themselves. They ensured that a potentially regressive or negative 'series of events' or 'turn of events' in the narrative of the client about recent life is propelled in the direction of a valued goal or valued relationship or engagement. Thus survivors of violence and abuse were helped to find again a purpose of living, a personal meaning for life even where the present was painfully filled with despair (Fry & Barker, 2002).

Offenders

The free exploration of memories related to committed violence may result in efforts to deflect feelings of shame and maintain a sense of pride and self-respect in the face of personal and public stigmatisation. Offenders will externalize their feelings as anger or escape shame through drugs or material consumption (Maruna & Ramsden, 2004). There is a need for shame management (Braithwaite & Braithwaite, 2001) that involves a social process of auto-biographical reconstruction to prevent remission into self-justification of criminal and violent behaviour. The transformative power of narrative reconstruction helps offenders to overcome their stigmatization and re-align them with community. Although cognitive-based correctional treatment in offender rehabilitation programs have been successful in breaking down self-justifications there is still little experience with how to help patients develop new positive scripts that support changes in cognitive patterns associated with violent behaviour, addiction and other forms of deviance.

Expression and context

The expression of thoughts and feelings within a trusting therapeutic relationship can reduce mental suffering caused by fear, shame and anxiety. In CAT the artistic expression with images, dance, music and drama is combined with the talking or writing about experiences. The sharing of stories in CAT and NBT builds a strong sense of connection and fellowship. It helps victims and offenders to imbue their personal story with greater significance and meaning, as well as coherence (Maruna & Ramsden, 2004).

Methods: the photo-instrument

The therapeutic elements of CAT and NBT were integrated in a new therapy that was developed by the author for working with patients with severe mental disorders. These patients had in common that they were recovering from the impact of psychiatric crises and hospitalization which often had resulted in traumatic experiences.

The therapy spans 2 x 8 photo group sessions, each series finished with an exposition of the photo stories. Participants select a limited number of their photographs with text to show at the exhibition. This guarantees a commitment and strengthens accountability for one's story and ultimately for actual 'real' lives they represent. From art therapy we introduced photographs, because from literature we knew that there were elements of participants' experiences that could not easily be presented in a coherent logical narrative (Maruna & Ramsden, 2004). Photographs often trigger a reflective process in which images become the carriers of symbolic and metaphoric associations, even where the photographer had no clear idea when taking his pictures (Hagedorn, 1996). The facilitators of the group invite participants to tell what the pictures mean and ask questions in a dialogical way. Group members can also ask for explication. There is no contesting the validity or truth of what someone tells. Personal truths are accepted as such. Facilitators have a non-judgemental attitude in this respect. However, learning the stories of other group members will open up new perspectives and contributes to a more reflexive stand (Sitvast et al, 2008). The sharing of stories among group members prevents denial of shame and substitution of shame by anger (Nathanson, 1992). The structured and dosed build-up of the intervention helps containing emotions that concur with newly found insights (Randall & Kenyon, 2002). An important aspect

of the therapy is that there is no direct confrontation with traumatic experiences. The assignment that sets the topic to be photographed focuses on: a) what one considers valuable in life and b) wishes or goals one would want to realize. Thereby it circumvents a short-circuiting of emotions and defensive responses associated with trauma experiences. Of course experiences from the past may interfere with acting upon what one values most. These experiences may then be reflected upon but they remain contained within an agenda of growth, development and realizing positive aims.

Results

In a study (N=42) that we did (Sitvast et al. in press) we found that in making their photo-stories many, almost half of the participants explored in depth emotions and meanings. The photo-instrument succeeds in committing people to an openness that lies at the basis of therapeutic reflection on experiences and the life story. More than half of the participants mentioned illness experiences explicitly and reflected on them. An example is William who, after several sessions, openly admitted to having an alcohol addiction. Talking about one's experiences with mental illness relieves the pain of isolation and alienation caused by feelings of shame. When people hear stories of others they identify with them and recognize themselves in them. This draws them out of their isolation. Half of the participants tended to evaluate their lives in their stories and more than half of the participants chose to express their views on their future. It shows that images - and photographs are images - can be a stimulating impulse to broaden or renew one's perspective. This is necessary for a fresh, perhaps less limiting and self-accusing (stigmatising) way of looking upon the course of one's life.

Discussion

The social context of the photo group acts as a motivator to discover and take on responsibilities, both for one's life as well as towards others. It seems to provide the context for a relational and moral learning. We think that, although the intervention has been implemented in psychiatric rehabilitation only, this context of moral learning may not be very different from the one needed in offender rehabilitation programmes where self-justifications must be fought and new positive script must be built. Likewise, the focus on a 'valued life' will help victims of violence to reorient their lives and find new meaning, as it did with patients recovering from severe mental illness.

Conclusions

The experience of sharing one's photo stories with others contributes to opening up, connecting again with values, wishes and options in life and prepares someone for first steps in rehabilitation. This widening space for reflection, the chance to express and represent oneself through images and text and the sharing are aspects of the moral and the psychological conditions for a successful recovery from trauma.

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Practical management of violence in a forensic psychiatric hospital in Finland: From theory to practice

Workshop

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In forensic psychiatry there exists a great challenge to use the theoretical knowledge in a good daily practice to make the patient care safe and therapeutic at the same time. In addition to this, also the safety of the staff has to be taken into account. Violence is not a part of a good daily practice. According to the legislation of work safety, one should not need to face violence at work. However, high numbers of violent acts take place during the hospitalisation of forensic patients, because nearly all of them have been committed involuntarily to the hospital and they have very often problems with aggression management. In Niuvanniemi Hospital there were 411 violent incidents between patients and nurses or between patients in 2008 (SOAS). Most of these cases were not very serious but a strong feeling of fear existed in all of them.

The name of this project is FORENSIC AVEKKI (a Finnish acronym that denotes aggression, violence, early prevention, development, education and integration, within thought/theme structure of doing things together). The aim of this permanent project is to make the whole organisation aware of this problem and work towards the same direction in violent management. The main topics of the project are predicting and early prevention of violence, communication in risk situations, the stress reactions, the influence of fear, nurse in a provocative situation and debriefing. The frequency and impact of existing violence must be known before one can do anything. Therefore, we have built a reporting system telling the frequency and the impact of existing violence to create an adequate basis to train the staff. Traditionally nurse education as well as the hospital organisation have given quite little support to staff for these challenging situations. This presentation tells a history of the development of a violence management training program in one forensic psychiatric hospital in Finland. It also describes some training practices in violence management techniques. A good daily practice and legislation call for continuous development of the support systems.

Niuvanniemi Hospital has reserved three nurse vacancies for working as supervisors for violence management. These supervisors have a high expertise on practical nursing. Every nurse is obligated to participate in a 24 hour training of violence management. Half of it composes of theory and the other half is practical training. After this training, every one of them has to participate in two hours repetition training once a month. The main principles of these lessons are: how to unite the therapeutic way of care, safety and security, painless care and respect of the human dignity. During and after an aggressive act it is easier to evaluate the situation when each nurse knows that all other nurses have the equal ability to operate.

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Chapter 10 – Reducing Coercive Measures

A protocol to reduce the use of seclusion among adult psychiatric inpatients

Poster

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The use of coercive measures in psychiatry has always been a subject of reflection and clinical concern. Seclusion is a challenging intervention for clinicians and its outcome is uncertain. In Geneva, if the patient's freedom is restricted, we use a protocol that adheres to governing body requirements and in conjunction with the health policy set out by the federal government. This protocol covers medical prescription, re-engaging the clients into therapeutic activities, delivering care and close monitoring.

Although the aim of using seclusion is designed to be therapeutic it can have a traumatic impact on the client's mental state. From the patient's point of view, restraint in a closed secluded room is often seen as a source of suffering. Care givers, on the other hand need to balance the use of seclusion as therapy, with its oppressive nature.

In this study, the researchers tested the effect of a new protocol to manage challenging behaviours of patients. The first part of the protocol consisted of introducing a semi structured assessment investigating patients' views of using different approaches to handling their challenging behaviour based upon the "Patient Reported Therapeutic Interventions Survey" Milwaukee County Mental Health Division, Milwaukee, USA at the time the patient is admitted on the ward. During the initial assessment, the nursing and medical team considers with the patient different options other than seclusion if his/her mental state deteriorates during hospitalisation.

In the second part of the protocol, the focus is successive assessments for patients who are placed in seclusion. The first assessment is conducted one hour after the start of seclusion. If the patient remains in seclusion area after this assessment, a second assessment is carried out after four hours.

The third part of the protocol is to assess the patient's perceptions and feelings when placed in seclusion. This assessment, based upon the "Patient Debriefing Tool Following Restraint/Seclusion" (Stone Institut of Psychiatry, Northwestern Memorial Hospital, Chicago, USA) allows the patient to express openly his/her views and helps ensure a dialogue between the patient and the team.

Through this protocol, the researchers were interested to investigate if such a protocol could reduce the frequency and the length of seclusion and respond more positively to this clinical

concern. At the time of writing the study is underway and we are in the process of data collection. We will be able to present our results in October.

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Guidelines to regulate the use of coercive measures. A comparative study 2006-2008

Poster

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Background

In our psychiatric hospital we have guidelines in order to regulate the use of coercive measures (isolation in special rooms and use of safety straps). When verbal coercion is not adequate, it is sometimes necessary to use other coercive measures to avoid injuries to self or other patients. Those measures are the last kind of intervention we use. The guidelines provides us with the procedure for using the different coercive measures, like specific nursing and medical care, control, and observation. In this work we analyze the use of coercive measures in our psychiatric unit, after and before the optimization and application of those guidelines.

Methods

First period: First developments and draft from June 2006 to December 2006.

Second period: Staff improves during 2007 the guidelines in order to try to use less coercive measures like use of straps.

Third period: Implementation from January 2008 to December 2008.

We collected the reasons to enter in a seclusion-rooms unit (an special sub-unit with 10 rooms, one dining room, washrooms, medical office, sickbay, one yard) and when it was necessary use mechanical restraint.

Results

2006: The sample was 206 patients, with an average length of stay of about 3 months. 53.9% were male, and 46.1% were female, and the average age was 40.3 years (19-77)

The most frequent diagnoses were schizophrenia (58.7 %), affective psychoses (9.7%) , other psychoses (12.1%), use of toxic substances (6.8%) , personality disorders (4.8%), and others diagnoses (7.8%).

During 6 months the use of the seclusion-rooms unit was 2029 times: 1139 times (56.1%) because of a behaviour disorder, 862 times (42.5%) because a worsening of psychotic symptoms, and in 28 times (1.4%) for drug abuse. It was necessary to use mechanical restraint in 89 times (4%).

2008: The sample was 251 patients, with an average length of stay of about 3 months. 55.1 % were male, and 44.9 % were female, and the average age was 43.1 years (18-86).

The most frequent diagnoses were schizophrenia (48.2 %), affective psychoses (20.3 %), other psychoses (9.1 %), use of toxic substances (6.3 %) , personality disorders (7.5 %), and others diagnoses (8.3 %).

During 12 months the use of the seclusion–rooms unit was 2890 times: 1931 times (66.9 %) because of a behaviour disorder, 822 times (28.4 %) because a worsening of psychotic symptoms, and in 137 times (4.7 %) for drug abuse. It was necessary to use mechanical restraint in 91 times. (3.1 %)

Conclusions

1. The number of coercive measures is less in 2008 than in 2006.
2. When verbal coercion is not enough , the most used coercive measure was seclusion in 2006 and in 2008.
3. Mechanical restraint were used only in 4% times in 2006 and 3.1% in 2008.
4. Coercive measures are less used when patient suffers a worsening of psychotic symptoms, it is a management indicator of our better clinical practice based on our guidelines.
5. Guidelines are useful to regulate attitudes of professionals, safety measures, ethical aspects or alternatives to the coercive treatment.

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Effect of chemical restraint on use of restrictive measures and perceived coercion: randomized controlled trial

Paper

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Introduction

The use of coercive measures varies greatly per country (Steinert & Lepping, 2008; Steinert, unpublished) and it is mostly directed from institutional culture, traditions and legalisation rather than characteristics of the individual patient (Way & Banks, 1990). This variety may be explained by the lack of scientific evidences from controlled trails about the effectiveness, benefit or harm of seclusion and restraint (Salias & Fenton, 2009), and the lack of European standards for the use of these coercive measures. Differences in registration methods limit sound comparisons between countries and hospitals about use of coercive measures. Nevertheless some countries like Switzerland and Germany prefer using mechanical restraint and seclusion (Martin et al. 2007) while in other countries like Iceland these measures are forbidden. Steinert and colleagues (unpublished) underline the striking differences in use of coercive measures between The Netherlands and UK. Whilst a seclusion episode lasts nearly 300 hours on average and the rare episodes of mechanical restraint last nearly 1200 hours on average in the Netherlands, in the UK seclusion is used rarely and mechanical restraint is not allowed. This striking discrepancy can be explained by differences in use of chemical restraint. In contrast to Great Britain where violent behaviour is managed mainly by chemical restraint, Dutch psychiatric professionals choose for chemical restraint only in 22% of the situations when coercion is needed, and in 90% seclusion is used (Marle, 2007). Besides that, the majority of these patients also receive rapid medical tranquilizations after they have been secluded, a practice consisting of two rather invasive coercive measures at the same time.

Thus, seclusion is used more often in inpatient management of aggression in the Netherlands. This preference for seclusion is not supported by scientific evidences or legal regulations, because both seclusion and chemical restraint are equally ranked in the Dutch Mental Health Law when concerns acute management of violence. Nevertheless chemical restraint is less often applied, because of an existing not-evidence based cultural norm that intramuscular administration of medication is a serious violation of the integrity of individual's body, and it is considered as a more restrictive measure than seclusion. Probably this prejudice originated partly from the Dutch legislation which is very restrictive towards involuntary medication as part of planned involuntary treatment.

Not only in some European countries like UK but in America as well (Allen et al, 2005) clinical experts prefer chemical restraint to deal with behavioral emergencies instead of seclusion, which is considered as a second-line treatment and as one of the least preferable choices only suitable for imminently violent patients.

While the therapeutic effect of seclusion is seriously questioned and not proofed (LeGries et al, 1999), administration of rapid tranquilisation as all psychotropic medication improves mental health and reduces positive symptoms of psychosis. Besides that it decreases arousal particularly to stress and stimulation (Baker et al, 2008). In addition, two studies (Bloom et al, 1984; Kasper et al, 1997) have also found higher rates of, and longer periods in, restraint or seclusion among patients refusing to take their medication. Therefore we expected that usage of chemical restraint instead of seclusion will reduce the number of the applied restrictive measures and it will shorten their duration. Besides that we hypothesized that patients will perceive their treatment as less coercive. Collecting more scientific evidences on this subject should overcome prejudice and improve clinical practice.

Methods

The study took place on an acute mental health ward at a psychiatric hospital in the south-western part of The Netherlands, providing care to a catchment area of around 276,075 people. At this acute mental health ward we introduced a less popular approach for the Dutch practice to deal with acute violence. According to this approach, oral medication is primary offered and by refusal the rapid tranquilisation is intramuscularly administrated without secluding the aggressive patient. Medication is used as restraint: to reach rapid sedation or to control acute violent behaviour restricting patient's freedom of movement, without patient's consent, not being mentioned in the plan of care and not considered as a standard treatment of the patient's medical or psychiatric condition. Both restrictive measures, chemical restraint and seclusion, were applied only when de-escalation techniques have not proved sufficient in themselves.

Starting from November 2007, all new patients were randomly allocated to two groups: a group that was chemically restrained when acute aggression occurs and a group that was secluded. Both groups were compared on usage and duration of restrictive measures and perceived coercion. Data related to the sort restrictive measures and duration was prospectively collected. Before discharge, all patients were asked to fill in a self-rapport scale measuring perceived coercion (MacArthur Perceived Coercion Scale; Gardner, 1993). The study was approved by the local Medical Ethical Committee.

Results

Until now 620 admissions were included in the study but only 12% of them underwent restrictive measures during their stay at the acute ward. Patients' demographic characteristics and findings related to the usage and duration of restrictive measures and perceived coercion will be presented at the conference.

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Comparison on seclusion use between admission wards indifferent psychiatric hospitals

Paper

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Keywords: Seclusion, ward, comparison.

Background

In 2006 a new registration system, called Argus, for monitoring of all used restrictive measures such as seclusion is introduced in the Netherlands. Now fourteen hospitals use this registration method. The data were entered in and analyzed in a same way. Also these data were entered in and analyzed in a nation wide case register. Within the hospitals the output is a part of the repeated evaluation of the seclusion reduction initiatives in the hospitals and the wards. The outcomes show the developments in the use of seclusion and were related to these activities in the hospital or ward. In the last 2 years the use of seclusion decreased dramatically in terms of the number of seclusion incidents, duration of stay in seclusion, sometimes with more than 50%. Also the number of patients in seclusion decrease. On several wards is visible that patients been secluded for more episodes and shorter duration. For the nurses and psychiatrist on some wards are these developments not enough. They will visit other wards in other hospitals and will discuss the seclusion figures. Central theme is: what can they learn from practices on other wards and hospitals for a further reduction of the seclusion use. An important condition in this initiative is that wards are highly similar on some variables, to focus on the differences. Mean goal of this study is to identify variables which show the similarity of the wards that will helpful in comparing wards in different hospitals. In this presentation we discuss the variables and outcomes in our comparisons.

Methods

The seclusion incidents were recorded in the same way and analyzed in the case register on the level of the admission wards. Behind this data the hospitals provide data of all the admitted patients. This data-bases contains data about patients characteristics, such as patient identification number, date of birth, sex and foreign status, admission on a ward with data of admission and discharge of the ward, diagnosis and global assessment of functioning. After merging both databases we can calculate the number of patients admitted, the duration of their stay and mean length of stay, and divided to categories of diagnosis and GAF scores. The same outcomes can we calculate for the patients who experienced seclusion. The similarity and the differences of the wards variables and subgroups were tested by comparing means and t-test.

Results

This study is now ongoing. We expect the definitive results in the beginning of this summer. Preliminary results of all the admissions wards in nine hospitals: All the hospitals have seclusion rooms available. However the availability of one seclusion room varies between 6 beds to 22 beds. The number of seclusion incidents varies between 44 and 450 seclusion incidents per 1000

admissions and the number of seclusion days vary between the 2 to 47 days per 1000 inpatient days. The mean length of the seclusions varies between 1 hour and 14.5 hours per 1000 hours of presence. This means that patients were secluded for a part of a day. Of the secluded patients a percentage of 21 to 69 is diagnosed with psychotic disorder/schizophrenia.

Conclusions

Admission wards differ on several variables. However the case register made it possible for wards to compare them with ward in other hospitals on some variables. We expect that the results of these comparisons feed discussions on their own ward how to deal with the differences they discussed with the other wards. It allows the ward able to build up on the experiences of the ward they visit.

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Monitoring the use of restrictive measures; methodological issues in data collecting, analysis and outcome

Paper

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Keywords: seclusion, restraint, registration, analyzing, presenting, methodological issues

Introduction

In many European countries seclusion and restraint are widely accepted interventions to manage violence and aggression in acutely ill psychiatric patients. However the utilization of such coercive interventions is frequently questioned by experts (Bowers et. al, 2007) and little evidence can be found to support their therapeutic value (Sailas and Fenton, Cochrane Review 2003). In spite of the frequent use of seclusion and restraint measures, several authors concluded consistent recording to be rare (Janssen et. al, 2008). Governmental standards for monitoring seclusion and restraint vary considerable between countries (NMHA 2006, Chandler, Nelson and Hughes 1998). In general, hospitals are held responsible for the accuracy of recording the use of coercive interventions on their wards (NMHA 2006, Crenshaw and Francis 1995, Mental Health Act Commission 2005). The diversity in the ways coercive interventions are recorded impedes a national as well as a international benchmark research (Crenshaw and Francis 1995, Janssen et al 2008, Steinert et al 2008 submitted). Some authors paid attention to the feedback of the recorded seclusion and restraint measures, especially to the effects of feedback within seclusion and restraint reduction programs. Consistent data gathering is crucial for the evaluation of seclusion and restraint reduction programs (Huckshorn 2004). A high level of administrative endorsement may also impede the consistency of reporting in seclusion and restraint reduction programs, as well as the evaluation and development of alternatives (Fisher 2003, D'Orio 2004, Visalli & McNasser 2000). Comparison between the "own" ward and other wards can be helpful to learn more about each others practices. For the reasons mentioned above there is a need to enhance the objectivity, reliability, and validity of reports of seclusion and restraint rates. The aim of the current study is to solve problems in defining and recording seclusion and restraint and to provide recommendations for analyses of seclusion patterns.

Methods

In the current study we address three restrictive measures: seclusion, restraint and enforced medication. In accordance with the international literature we defined:

1. Seclusion as placing a patient alone in a locked room during some time, irrespective of the circumstances and safety preconditions, including the use of isolation room as well as bedrooms which may be locked from the outside.
2. Restraint as immobilizing the patient with external mechanical or physical devices, such as the use of belts or straps to immobilize patients.
3. Enforced medication as medication administration against patients' will.

The time frame of seclusion and restraint is defined as the period from the beginning (closing the door when the patient is in the room or locking the belt) to the discontinuation of the restrictive measure (opening the locked door or removing the belt). Such a period is indicated as "an episode", the smallest unit of registration. With respect to enforced medication only the time of the administration of medication is recorded as an episode. Within a day one or more seclusion-, restraint episodes or administrations of medication can take place.

Materials

The restrictive measures, as defined above, were uniformly recorded with a newly developed instrument for documenting restrictive measures, that was called "Argus". This scale is completed each day per patient by the nursing team. For every day the seclusion or restraint is still ongoing a new registration form is used. In the current study the data of all wards of three Dutch psychiatric hospitals were included. These assessments contributed to an evaluation of the effects of several seclusion reduction projects initiated by the Dutch government .

Levels of analysis

In line with Bowers (2000), several levels of analysis are applied to evaluate outcome. These levels have different input variables providing output only comparable to the same level and are used as input for the next higher level. The highest level is the hospital, with their own context (rural or urban), number of inhabitants and relationships with other mental health provisions in the area. The second level is the ward which may vary in size and function. The third level is the patient. Patient characteristics differ; length of stay differs strongly from longer than a year to not more than a couple of days. Some patients experience several constraints, other patients none whatsoever. The fourth level concerns the admission. This level focuses on the constraints a patient experiences during a stay on the ward. All higher levels are aggregations of the data on this level, supplemented with data on the mentioned level. Each level consists of (calculations of) specific variables as well as aggregations of the data of a lower level.

Results

In this paper we present the results of three hospitals, their admission wards and also their patients. The results will be presented in absolute numbers and ratios (see Bowers 2000). For the purpose of clarification we focus only on seclusion. These hospitals cover the psychiatric care of about the 1.8 million inhabitants living in the eastern and southern regions of the Netherlands. In total the hospitals contain 2411 beds distributed over 79 wards, of which 16 were admissions wards. The hospitals contain 53 seclusion rooms. In 2008 these hospitals admitted approximately 5500 patients.

The hospital level

On the level of the hospitals we related the incidence of seclusion to the number of inhabitants of the hospitals' regions and the number of admissions. Secondly, the number of seclusion days was related to the number of days beds were occupied.

	Number of seclusion incidents per 10,000 inhabitants	Number of seclusion incidents per 1000 admissions	Number of seclusion days per 1000 occupied beds.
Hospital 1	2	279	8
Hospital 2	4	445	10
Hospital 3	3	309	19

The ward level

For each hospital, one admission wards was selected, to perform further analyses on ward level. The selected admissions wards contain 55 beds. These wards vary in size between 12 and 27 beds. In 2008, 515 patients were admitted. Mean length of stay varied between 39 and 121 days. The wards have between 2 to 4 seclusion rooms. The incidence of seclusion was related to the number of admissions, and again the seclusion days were related to the number of days the beds were occupied. Also, the number of seclusion episodes and the total number of hours in seclusion were calculated. The mean number of hours per seclusion episode was also calculated.

	Number of beds on the ward	Number of admissions	Number of seclusion incidents per 1000 admissions	Number of seclusion days per 1000 occupied beds.	Number of seclusion episodes	Mean number of hours of seclusion per day
Admission ward H1	16	193	295	26	547	11:45
Admission ward H2	27	200	297	19	338	14:30
Admission ward H3	12	193	476	51	325	7:01

The patient level

On these admission wards, a total of 515 patients were admitted, 58 % male and 42 % female. Of these 515 patients, 118 patients experienced one or more seclusion episodes. About, 27 % of the admitted patients was diagnosed with a major psychotic disorder-schizophrenia. Below, we present a subgroup analysis on patient characteristics. In this table we compare the diagnosis of the all the admitted patients with the diagnoses of patients who experienced seclusion.

	Number of patients	% Male	No diagnosis	Mood disorder	Bi-polar disorder	Psychotic disorder	Drugs abuse
Admitted on ward H1	193	46.6%	30.6%	15%	5.7%	21.2%	4.7%
Secluded on ward H1	43	71.8%	35.9%	12.8%	10.3%	30.8%	7.7%
Admitted on ward H2	168	54.8 %	22,0%	11.9%	3.6%	30.4%	11.3%
Secluded on ward H2	24	62.8%	20.8%	0	4.2%	37.5%	25%
Admitted on ward H3	154	74.7%	50%	4.5%	2.6%	23.4%	14.3%
Secluded on ward H3	51	74%	62%	4%	2%	20%	8%

The admission level

The patients presented below were randomly selected, only one for each ward, in order to illustrate how seclusion rates can be expressed on the admission level. These three patients had been admitted once or twice during 2008. Mean length of stay at the wards varied between 72 and 121 days. Here we analyzed the frequencies of episodes, days and incidence of seclusion per patient and calculated the number of hours spent in the seclusion room from start to finish of the seclusion-episode.

	Number of admissions	Length of stay in days	Number seclusion days	Number of seclusion episodes	Number of seclusion incidents	Length of seclusion in hours
Patient Admission ward H1	2	5	2	2	1	14:30
Patient Admission ward H2	1	362	74	125	7	1310:30
Patient Admission ward H3	1	6	1	2	1	10:15

Discussion

The data on the level of the patient provide the basic information for all the other levels. This kind of information is standardized in the Argus rating scale. The levels above the admission level provide new information in combination with data of the patients, ward and hospitals characteristics. The combination of these data may tell us something about the ward and hospitals policy. Are patients secluded frequently but for a short period or are patients secluded in a lower frequency but for longer periods. Repeated presentations of this kind of outcomes can display developments in the use of seclusion and restraint and may be helpful in evaluating interventions, that aim at reducing the use of seclusion.

Conclusions

This study suggests that coercive interventions such as seclusion can be reliably assessed in a standardized way, but methodological consensus is needed in order to allow cross cultural comparisons and international multi-centre studies.

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Ethical Restraint: Oxymoron or Obligation? Applying an evidence based framework to the prediction, prevention and management of violence in mental healthcare settings

Workshop

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Introduction

For many, the concept of an ethical restraint is something of an oxymoron. The idea of one human being holding onto another with the sole intention of restricting their movement is a concept many mental health practitioners find not only abhorrent, but also contradictory to their role as the caring professional (Marango-Frost and Wells, 2000). In the UK clinical guideline 25 (NICE, 2005) provides practitioners with a multi-faceted approach to the management of violence and aggression. Prediction and prevention strategies are empirical within the guidance and should hold priority within any violence reduction strategy. However, there is an acknowledgement that should these strategies fail then there may be a need for more invasive methods of intervention. This may include the administration of rapid tranquilisation or physically intervening with a person at the point of crisis.

Recent publications from the National Institute for Mental Health in England (NIHME) and the NHS Security Management Service (NHS SMS) have raised the profile of the need for ethical constructs to inform the management of aggressive service users in mental healthcare settings (NIHME, 2004, NHS SMS, 2005). However the transition from guidance to practice is left open to the interpretation of respective service providers and practitioners.

The workshop will encourage participants to consider the ethical implications of the aggression management strategies and interventions and then introduce an ethical model developed by Beauchamp and Childress (2008) for use within health care and supported by the NHS SMS. The presenters will then discuss the adaptation of this perspective into a workable framework for use by practitioners. The model will act as a guide for staff when considering the application of ethical tenets during episodes of predicting, preventing and intervening with a person who exhibits aggression and violence.

Ethics and Restraint: A Traditional Perspective

Beauchamp and Childress (2008) suggest ethics as 'a generic term for various ways of understanding a moral life'. Mental illness finds itself in a unique position in that its definition and consideration of severity is often determined by societal values and concomitant tolerance of behaviours deemed unreasonable (Szasz, 1989, Hopton, 1992). Since morality is in a state of flux practitioners find themselves having to strike a balance between public and service user expectation. However, traditional mental healthcare perspectives have tended to uphold the weight of societal morality to the detriment of those in its assumed care.

To date, ethics (and its place within the management of violence and aggression) has, understandably, hinged upon the notion of a defensible construct to protect staff and service users (Paterson and Leadbetter, 1998). However, this has not been a constant. Beech and Leather (2005) observed that aggression management training systems within the UK were inconsistent and lacked any real substance. Furthermore Lee et al (2001) found that 31% of respondents in their study had not received any ethical or safety information in relation to restraint. This lack of inclusion regarding ethical principles within staff training has been consistently challenged both in research articles and high profile guidance (Gournay, 2001, Wright, 2001, Ayard, 2004). As well as making the statement that pain has no therapeutic value, NICE (2005) have made a recommendation for further study in relation to pain compliance and the validity of the ethical arguments which purport its continued use in the UK. This is an argument that has been strengthened by the revised Mental Health Act (1983) Code of Practice (DH, 2008a), which has suggested that any techniques should not rely on the deliberate application of pain.

In terms of restraint, it has been traditionally suggested that ethics can be defined by a professional group and parameters set as to how they are utilised when working with service users (Tarbuck, 1992). Yet such notions make the assumption that carers and service users have the same perspective as to what constitutes acceptable practice. Whilst using ethical tenets to establish defensible argument has its place, guidance on how such constructs can be effectively synthesised to support mental health professionals in clinical practice is scant (Hopton, 1995). This has a propensity to compound the dilemma for mental health professionals managing challenging behaviour.

The four principle approach to clinical decision making developed by Beauchamp and Childress may offer a useful perspective for practitioners attempting to explore ethical constructs during the management of violence and aggression (NHS SMS, 2005). These principles are illustrated below introducing some of the potential ramifications for managing aggression and violence.

Autonomy	<ul style="list-style-type: none"> - Self-Governance - Informed decision making - Ability to act with freedom
Beneficence	<ul style="list-style-type: none"> - Concerned with doing good - Actions being taken for the benefit of others
Non-Maleficence	<ul style="list-style-type: none"> - To do no harm - Intentional harm is prima facie wrong - Some interventions may be justified when examined against the balance
Justice	<ul style="list-style-type: none"> - The notion of equity - Moral rightness - Access to appropriate treatments

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Decompression from long term isolation in a high secure forensic hospital

Paper

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Introduction & Background

The use of isolation in psychiatric practice is largely confined to the short term removal of a patient from the ward community in response to acutely disturbed behaviour. Often referred to as seclusion, this process allows for the management and subsequent care of the individual in an area away from peers. In the vast majority of cases this will be for a relatively short period, with the patient often rejoining the ward community after a period of stability and reduced agitation or hostility. A small group of individuals however, largely in high secure hospitals, present with chronically challenging behaviours characterised by the propensity for extreme violence. The risks these patients present towards others do not ameliorate within the short term, but are often a static component of their clinical presentation. Such patients, whilst few in number, often present considerable clinical and organisational challenges, can remain highly dangerous to others for significant periods, and require prolonged isolation from their peers and staff to maintain the safety and wellbeing of those in the ward community.

This presentation will discuss the effects of long term isolation with this group of patients, discuss and describe the structure and delivery of individualised decompression programmes within one high secure hospital setting, offer opportunity to examine and review the potential benefits and effectiveness of de-compression programmes with the long term isolated, and provide guidance for the formulation, delivery and evaluation of such programmes.

Long term isolation

Long term social isolation can often give rise to adverse emotional, cognitive and psychological functioning. Indeed the literature on the subject is substantial and clearly indicates the negative and harmful effects upon the individual (Grassian, 1983; Brodsky & Scogin, 1988; Haney, 2003; Arrigo & Bullock, 2008). These adverse effects can include increased social anxiety, temporal disorientation, depressive symptoms, emotional fragility, and decrease in cognitive functioning and adaptability. Behaviourally, such individuals can often present as hostile and violent, with the focus of such at times directed towards themselves as much as towards others.

These social, psychological and behavioural effects of long term isolation are often exacerbated when the person suffers from a pre-existing mental disorder. In such patients social withdrawal and anxieties can be compounded by the re-emergence or worsening of psychotic symptoms, emotional and organisational fragmentation, diminution of cognitive flexibility, and hypersensitivity to external stimuli. These can often hinder attempts at successful adaptation, habilitation and re-integration into conventional hospital life and at times contribute to the reinforcement and maintenance of the maladaptive behaviours that initially gave rise to the instigation of the isolation regime.

Presentation

The presentation will offer the audience insights into the systems and processes employed within one high secure mental health care facility in England, U.K. in successfully decompressing a number of male mentally disordered patients from long term isolation regimes, leading to engagement with

treatment and ultimately social re-integration. The presentation will discuss the effectiveness of structured decompression programmes and the positive impact such regimes can have upon the social integration and psychological, emotional and cognitive functioning of this small group of patients.

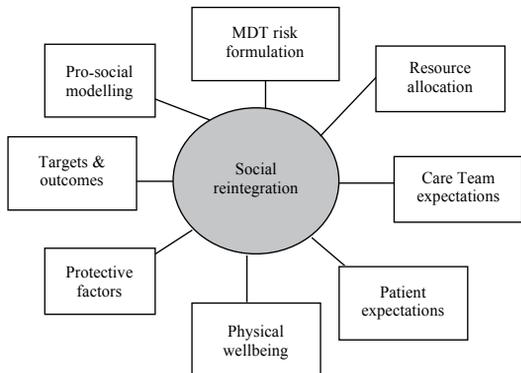
The Positive Interventions Team

The formal programme for decompression from long term isolation at Ashworth Hospital is known as the Positive interventions Programme. It is delivered by a team of dedicated clinicians, supervised and managed by a multi-disciplinary group who offer support, supervision and advice on strategic planning. The team members themselves have been specifically chosen to undertake this role and bring with them a variety of experiences, skills, attributes and a willingness and enthusiasm to work with this difficult and extremely challenging group of patients. The team comprises of 6 staff who work closely with other front line staff during the delivery of the program, and liaise closely with other departments such as the physical health care centre, the service for the management of violence and aggression, and the rehabilitation services (educational, vocational, occupational and recreational services). A team leader is responsible for the day to day running of the programme, the processing of referrals, ongoing liaison with clinical teams and other departments within the hospital, and for the line management of the other team members. A further qualified psychiatric nurse is responsible for the risk formulations, clinical decision making pre and during sessions, and for the live monitoring of risk during interventions with the patient. A third member of the team has extensive experience in the teaching and delivery of management of violence and aggression methods. This role is to co-ordinate and plan the mechanics of the interventions with the patient; of particular importance during the initial phases. Three further staff bring with them a variety of vocational, educational occupational and recreational training and skills and often lead on engagement with the patient at various stages of the programme.

Components of the decompression programme

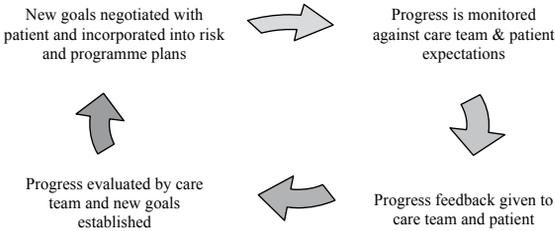
The programme is based on a multi-dimensional approach to service delivery, with the social reintegration of the patient central to the core of all activity. The diagram below (Diagram 1) illustrates the core components that underpin the delivery of the programme. These include a full multi-disciplinary risk formulation, the allocation of appropriate resources, realistic and explicitly stated care team and patient expectations, aspects of physical activity and functioning within a health promoting model, identification of protective risk factors and characteristic patient strengths, explicitly identified behavioural targets and outcomes, and an overall philosophy within the programme of pro-social modelling of behaviour.

Diagram 1: Core components of the decompression programme



The programme itself is monitored through a process of ‘constant evaluation’ between the dedicated staff team that deliver the programme, the patient, and the patient’s care team. Diagram 2 (below) illustrates the cyclical nature of the review process.

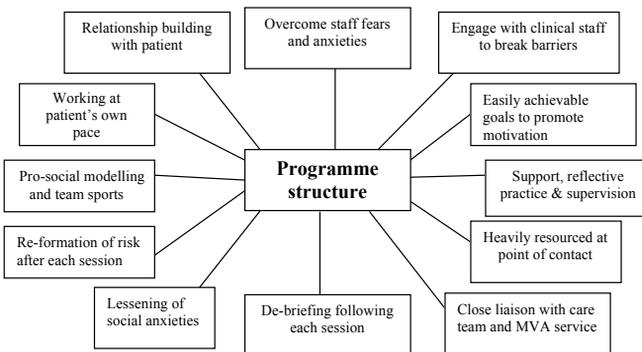
Diagram 2: The review cycle



General structure of the decompression programme

The general programme structure follows an established framework, although specific components are tailored to meet the individual needs of the patient, the programme team, and the care team. Diagram 3 (below) illustrates the general programme structure. A major component of the programme is the support of not only the patient themselves, but also of the staff delivering the programme and the ward based staff tasked with the management of the patient during and post programme. The management of this group of patients often gives rise to heightened anxiety and fear in front line staff, who are, understandably, apprehensive about some of these patients being integrated back into the ward community; particularly given their often extensive history of extreme violence towards others. The acknowledgement, understanding and acceptance of these concerns are integral to the successful delivery of the programme and in ensuring that clinical or interpersonal barriers are overcome at an early stage, so that the staff delivering the programme, the care team, and the front line ward staff are working together towards the aim of re-socialisation.

Diagram 3: Programme structure



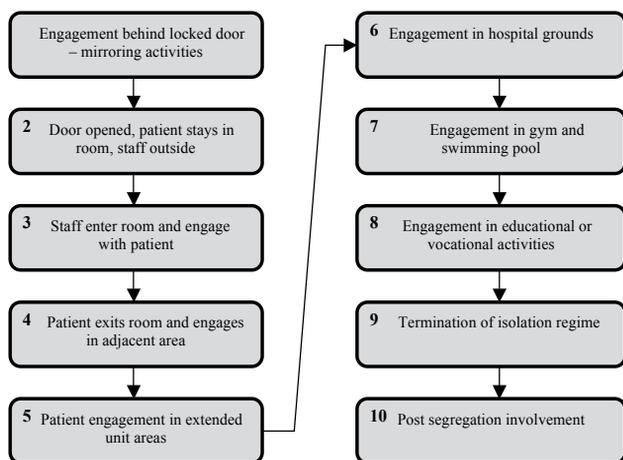
Further components integral to the structure of the programme is the recognition of the need to work at the patient’s own pace, the continued importance placed upon pro-social modelling of behaviours through the use of team sports and activities, and the identification of any patient protective factors that can help in reducing social anxieties that may arise as part of the decompression process.

Phases of the programme

Whilst delivered within the general framework as described above, there is a need to tailor the programme delivery itself to reflect individual patient risk, level of social and psychological functioning, rate of progress, and ability to cope with progress made. Within this individualisation of the process there are a number of basic phases that the patient moves through to achieve the ultimate goal of social re-integration and ending of their long term isolation regime. Diagram 4 (below) illustrates the basic phases integrated into the programme. The speed at which the patients move between phases will largely depend upon clinical progress mapped against expectations and behavioural targets and outcomes, continued re-formulation of risk and patient's own pace; with movement between phases lasting anywhere from a number of weeks through to several months.

The principles for the phases are based upon graduated but structured exposure, with live monitoring and feedback not only at each phase, but also during and after each session. This allows for not only flexibility in approach, but also provides greater opportunity for support for the patient in potentially anxiety provoking situations, minimises risk, and allows accounting for and anticipation of any untoward patient behaviour or aggressive or destructive acting out.

Diagram 4: Ten phase approach to programme delivery



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Incidence of mechanical restraint and seclusion in 6 psychiatric hospitals – Is there a relationship between duration of mechanical restraint and clinic, diagnosis and gender?

Paper

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Keywords: Mechanical restraint, seclusion, coercive measures

Background

Although coercive measures are one of the indicators of the quality of psychiatric in-patient care, reliable and valid data comparing the practice are hardly available. It is well known, that there are huge differences between different clinics regarding the incidence and lengths of mechanical restraint and seclusion. [1, 2, 4, 5, 9]. Coercive measures can be experienced by the patient as a traumatic situation [3, 11]. On the other hand the employees of a clinic face a higher risk to become victims of aggression and violence [6]. There is a risk for mental health problems such as Posttraumatic Stress Disorder (PTBS) [10, 12].

The purpose of this study was to analyse the incidence and duration of mechanical restraint as well as seclusion in psychiatric hospitals in Germany. We hypothesised that the duration of mechanical restraints is associated with gender and diagnosis of the patients, but also with the clinics themselves.

Methods

In all six participating hospitals the use of mechanical restraint and seclusion among patients with F0 to F9 ICD-10 Diagnosis was analysed for a period of time in the year 2004. Data collection lasted six months (01.01.2004 until 30.06.2004).

Furthermore, the association of the length of mechanical restraint (as practised in all hospitals) with diagnosis, gender, and hospital was analysed using analysis of variance (ANOVA).

A total of 20704 patients were admitted during the year 2004. The sample included about half, the exact number was 10352 patients.

The following indicators were used for comparison:

1. Average duration of mechanical restraint in different Diagnoses
2. Average duration of mechanical restraint in different hospitals.

Differences between hospitals and Diagnoses were tested for statistical significance using the analysis of Variance (ANOVA).

Results

3.0 % (339 Cases) out of 10352 cases treated in 2004 were exposed to coercive measures (range: 1.9 % to 7.4 %). The overall average age was 41.2 years (SD 16.3) (men: 41.02 (SD 15.9),

woman: 41.5 (SD 17.7). 315 cases were affected by mechanical restraint, 24 cases by seclusion. 203 men (60.4%) and 133 women (39.6 %) were affected by coercive measures. On average, these measures were applied 3.7 times per patient (case) with each single intervention lasting 5.0 hours (mean, range <0.1 - 290.8h). The incidence and duration of coercive measures varied between different diagnostic groups and not so high between different hospitals. The duration of coercive measures did not differ statistically significant between men and woman ($p>0.05$).

Schizophrenia and schizoaffective disorder was found to have the highest rates of coercive measures (178 cases, 51.2%) followed by F1 - substance-related disorders (51 cases, 15.5%), F6 – personality disorders (30 cases, 9.1%), F4 neurotic and psychosomatic disorders (22 cases, 6.7%) and F0 – organic mental disorders (21 cases, 6.4%).

Table 1 presents the length of interventions among hospitals and diagnosis respectively.

The length of mechanical restraints differed significantly between hospitals ($p < .001$) and diagnoses ($p < .001$). In patients with organic psychiatric disorders (ICD-10 F0) we observed the longest duration (Table 1) ($p<0.05$).

Seclusion was used in three clinics (clinic B, E and F) and 24 cases. The 24 cases were affected by 173 seclusion measures. 163 seclusion measures were used in one clinic (clinic F).

Taking mechanical restraint and seclusion as a whole of here investigated coercive measures; the proportion of seclusion was 7% in clinic B and 63% in clinic F.

The average duration of seclusion was 515 minutes (range: 10-17.445; SD=1.405). Furthermore the investigation concluded that the average duration of seclusion in clinic B was with 242 minutes (SD 545) lower than in clinic F (426 minutes; SD= 1.085). The difference was statistically not significant ($p>0.05$).

People affected by seclusion mostly had a diagnosis of schizophrenia (F2) ($n=121$, 69.9%) followed by F7 (behavioural impairment) ($n= 27$; 15.6 %).

Duration of mechanical restraint differed statistically significant between clinic C (low average duration) and clinic D, E and F (high average duration).

The analyses taken post-hoc (Scheffé) do not show significant differences between the different diagnosis groups. Furthermore we could not find any differences concerning gender (Table 1).

Conclusion and discussion

The proportion of cases affected by mechanical restraint and seclusion was less than in comparison with Martin et al. in 7 German and 7 Swiss psychiatric hospitals with 7.8 % and 12.5 % [7]. On the other hand the number of measures with 3.7 are similar to the results at the German hospitals and higher than in the Swiss hospitals [8] and the duration with 5.0 hours less than in Swiss hospitals with 48.7 hours (mechanical restraint) and 55 hours (seclusion) [8]. Different patterns seem to exist concerning the use of mechanical restraint and seclusion in German and Swiss hospitals with higher duration in Swiss hospitals and higher number of measures per affected case.

The results of this comparison show that there is a difference in the duration regarding mechanical restraint comparing diagnosis and hospitals, the variance can only partly be explained. Data interpretation should consider numerous confounding factors such as case mix and hospital characteristics.

Further research is needed to obtain comparable data on the use of compulsory measures. Although there are methodological difficulties, comparisons allow critical reflection of different procedures using compulsory measures and help to achieve transparency.

Table 1. Analysis of variance of length of mechanical restraint

		Length of mechanical restraint (Minutes \pm SD)	ANOVA
Clinic 1	n = 99	208 \pm 451	
Clinic 2	n = 114	212 \pm 469	
Clinic 3	n = 197	38 \pm 27	
Clinic 4	n = 415	358 \pm 291	F = 10,3; df = 5; p < .001
Clinic 5	n = 22	544 \pm 617	
Clinic 6	n = 102	357 \pm 358	
Total	n = 938	261 \pm 358	
Male	n = 513	306 \pm 405	F = 3,6; df = 1; n.s.
Female	n = 457	210 \pm 273	
Diagnosis			
F0	n = 143	541 \pm 396	
F1	n = 76	149 \pm 154	
F2	n = 407	265 \pm 352	
F3	n = 25	211 \pm 236	F = 3,7; df = 7; p < .001
F4	n = 51	229 \pm 665	
F5	n = 68	206 \pm 166	
F6	n = 105	128 \pm 200	
F7	n = 63	62 \pm 83	

The model explained 36.2% of the variance ($R^2 = 0.362$ (corrected: 0.294)).

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Decision to use seclusion in psychiatric care – issues of instrument construction

Paper

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Introduction

The purpose of this article is to discuss issues related to instrument construction on decision making process in using seclusion. A common belief among nurses is that seclusion is an effective and safe method of controlling patient behaviour and appeasing an agitated patient quickly (Bowers et al. 2007). However, there are no specific existing instruments to measure this decision making process. This article is based on a study where a theory describing this decision making process was generated and further an instrument to measure this decision making process was constructed and pilot tested (Laiho et al. 2009).

Instrument construction

Because we did not find any available instrument on the topic, we developed a new instrument (Streiner & Norman 1999): Decision to Use Seclusion Scale (DUSS). Instrument development is frequently undertaken as a collaborative activity as in the study forming the basis for this article. Collaboration in which each individual plays an active role based on particular areas of expertise is often necessary to produce a high quality instrument. (Waltz et al. 1991). Instruments can be developed in many ways. Three common ways are to develop an instrument on a base of a qualitative research, usually on interview study (Choi et al. 2008), or on base of a systematic literature review (Engin & Cam 2009), or by using both methods (Tennart et al. 2007). In this case we used systematic literature review.

Literature review and theory generation on decision making process

The literature review and the theory generated have been described in another publication (Laiho et al. 2009). In this article we describe factors associated to the decision making process in using seclusion in psychiatric care.

Patient related factors.

The most common motivation for the use of seclusion/restraint is to control the patient's behaviour when he is disoriented, agitated or behaving in a disruptive manner (Evans & FitzGerald 2002). Secluding or restraining a patient because of violent or threatening behaviour is less common. In a situation like this seclusion/restraint is conducted in order to protect the patient himself or other patients and staff (Foster et al. 2007). Any previous experience of the patient displaying violent tendencies or having been previously secluded/restrained increases the probability of the patient being secluded/restrained also in the future (Wynaden et al. 2002). Seclusion/restraint is used in order to control violent outbursts, but sometimes nurses also use it to "train" the patient to behave properly (Vatne & Fagermoen 2007). Seclusion/restraint can also be used as a form of punishment; regardless of the fact that most countries have restricted the use of these measures only to be applied to control violent and disruptive behaviour. The use of seclusion/restraint as a form of punishment also violates the codes of ethics (Vatne & Fagermoen 2007).

Factors related to other patients and situation on the ward.

The safety of other patients is also a significant factor in the decision-making process. The nursing staff is aiming at inhibiting a patient from disturbing or harming others and reducing any fear at the ward (Kaltiala-Heino et al. 2003). Another goal is to prevent chaos and to restore peace and harmony at the ward (Evans et al. 2002).

Personnel related factors.

The gender of the nursing staff affects the decision-making of seclusion/restraint; young, male nurses are more likely to seclude/restrain a patient than other nurses (Janssen et al. 2007). Older male nurses usually display a negative attitude towards seclusion/restraint. Gender as such does not affect the attitudes towards seclusion/restraint (Bowers et al. 2007). The amount of working experience, however, is directly related to the likelihood of seclusion/restraint, in that experienced nurses are less likely to seclude/restrain a patient, and are more critical of these measures than relatively inexperienced nurses (Janssen et al. 2007). The educational background of the nursing staff is also a factor in that nurses with a lower level of education are more likely to seclude/restrain a patient than nurses with a higher education (Janssen et al. 2007).

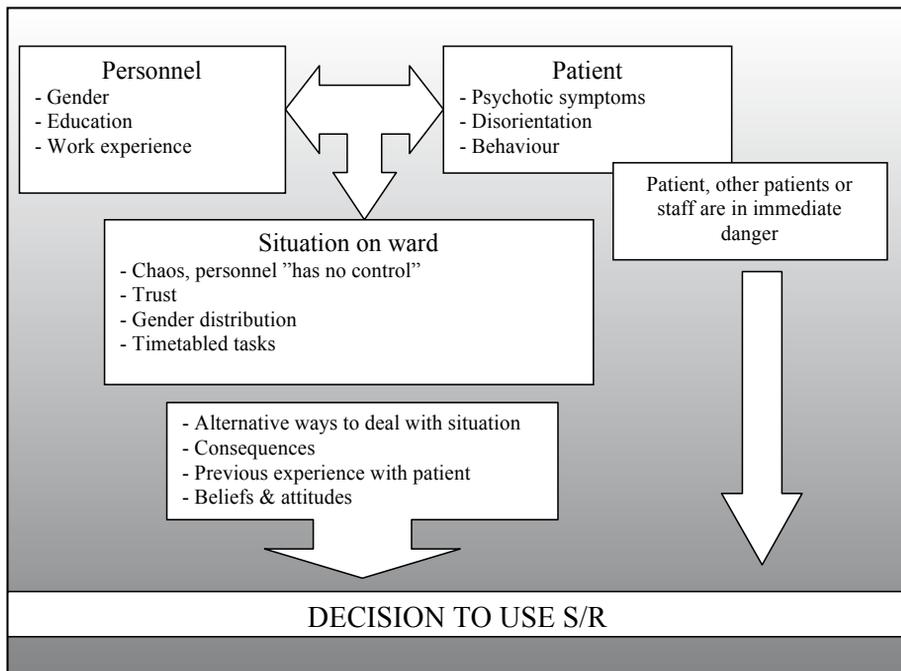
Decision to seclude.

The decision to seclude/restrain a patient is usually made under circumstances in which the staff is simultaneously having problems with the behaviour of the patient, the overall situation at the ward and taking care of routine tasks, and they have feeling that other methods of controlling the situation are insufficient (Marangos-Frost & Wells 2000). The decision is based on the staff's evaluation of the clinical condition of the patient (Busch & Shore 2000) and the severity of the potential risks involved (Marangos-Frost & Wells 2000). Information on the patient's behavioural history and knowledge on the efficiency of other methods of treatment also play a vital role in the decision-making process (Wynaden et al. 2002). In some cases the staff will rather seclude/restrain a patient than try to control a potential risk with PRN medication. In most of these cases the decision is based on previous knowledge of the patient's history and the most efficient form of treatment for him/her (Wynaden et al. 2002).

The decision can be made as preventative or immediate. The preventative decision is made as result of a mechanistic chain of deduction. During this process the staff member systematically estimates all of the methods available for controlling the situation and their plausible effects (Mason 1997). The decision made under acute threatening circumstances is quick in nature and largely based on intuition. Under these circumstances there is no time for evaluating options, and the consideration of the justification of restraining and alternative methods will take place only after the restraining has been completed (Wynaden et al. 2002). It is usual that in a pre-seclusion scenario one member of staff takes charge of the situation and makes the decision to seclude/restrain the patient while other staff members adhere to this decision (Schreiner et al. 2004).

The basic elements of the decision making process are described in Figure 1. Based on these elements an instrument was constructed and pilot tested (Laiho, Kattainen & Kylmä 2009). The instrument is based on the Likert scale rating system (Likert 1952).

Figure 1. Decision to use seclusion/restraint in psychiatric care.



Issues of validity and reliability in instrument construction

Quantitative studies derive data through the measurement of variables. Measurement is a language of communication. Numbers are less vague than words and can thus communicate information to a broad audience. However researchers work with fallible measures. Values and scores from even best measuring instruments have a certain amount of error. We can say of every piece of quantitative data consisting of two parts: a true component and an error component (Polit & Beck 2006).

Validity.

Usually expert panel's assessment is used to evaluate the face and content validity of the instrument. Face validity simply indicates whether, on the face of it, the instrument appears to be assessing the desired qualities. The criterion represents a subjective judgement based on a review of the measure itself by one or more experts. The second evaluation point of the instrument is content validity of the instrument, consisting of a judgement whether the instrument samples all the relevant or important content or domains. These two forms of validity consist of a judgement by experts whether the scale appears appropriate for intended purpose (Streiner & Norman 1999).

In developing a new scale, it is straightforward to administer the new and old instrument to the same sample. This approach is described by several terms in the literature including convergent validity, criterion validity, and concurrent validity. Although there are often measures which have, through history or longevity, acquired criterion status, a close review usually suggests that they have less than ideal reliability and validity. Any measurement has some associated error. As a

result we should expect that correlations among measures of the same attribute should fall in the midrange of 0.4-0.8. (Streiner & Norman 1999). The validity and reliability of the instrument are not totally independent. If the measuring is not reliable, it cannot possibly be valid. An instrument can be reliable, however, without being valid (Polit & Beck 2006).

Reliability.

Reliability assessment of a quantitative measure is a major criterion for assessing its quality. Three aspects of reliability are of interest to quantitative researchers: stability, internal consistency, and equivalence. The stability of a measure is the extent to which the same scores are obtained when the instrument is used with the same people on separate occasions (Polit & Beck 2006).

To test the internal consistency of the instrument Cronbach's alpha (α) is used (Polit & Beck 2006). The problems with α is that it is dependent not only on the magnitude of the correlations among the items, but also on the number of items in the scale. If we add items to the instrument, α will probably be higher than in the shorter version. One problem is that α is too high. It may suggest a high level of item redundancy; that is, a number of items asking the same question in slightly different ways. Cronbach's alpha should be above 0.70, but not probably higher than 0.90 (Nunnally & Bernstein 1994). The equivalence approach to estimating reliability is used primary with observational instruments. When two independent observers score some phenomenon congruently, the scores are likely to be accurate and reliable (Polit & Beck 2006).

In this article we have discussed issues related to the instrument construction on decision to use seclusion in psychiatric care. The scale (DUSS) has been constructed and pilot tested. However, the scale needs further elaboration.

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Physical restraint in an Italian psychiatric ward: A follow-up of 3 years

Poster

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Introduction

Physical restraint is an ultimate instrument which can be adopted when relational and pharmacological containment is ineffective or not suitable. Its intents are to reduce aggressive and/or dangerous behaviour, with the aim of solving the condition which caused it, and, meantime, to ensure the safety of both patient and medical personnel (1).

Aim

The purpose of this work is to examine the behaviour of inpatients and assess whether the response of staff is appropriate. Finally, it has the aim of inviting operators to reflect on the need to adopt the more appropriate containment and on whether physical restraint is actually useful.

Methods

An analysis was conducted on physical restraint adopted from the 1.1.2005 to the 31.12.2007 in the "Servizio Psichiatrico di Diagnosi e Cura 1" (SPDC1) of Mental Department of Modena, a psychiatric ward for voluntary and compulsory acute admissions. Epidemiological, clinical and care data were taken from clinical records and special survey sheets, used within the ward for describing motivations, modalities, therapies and nurse assistance procedures related to physical restraint (2).

Results

During the period examined, physical restraint was adopted on 181 patients in total, who represent the 13% of all patients here admitted. The 60% of restrained patients were male with an average age of 47.07 years, while the female patients (40%) were 44.65 years of age (on average). The most prevalent diagnosis (according the DSM-IV-TR) (3) of these patients was Schizophrenia or other Psychotic Disorders (30%), following by Dementia or other Cognitive Disorders (13%), Alcohol-related Disorders (13%), Manic (7%) and Depressive (10%) Episode, Personality Disorders (8%), Adjustment Disorders (5%), Delirium (4%), Mental Retardation (3%), Substance-related Disorders (4%), Anorexia nervosa (2%), Obsessive-Compulsive Disorder (1%). This procedure was adopted on the 12% (182/1544) of admissions during the three years examined and was more frequently motivated by "psychomotor agitation" or "aggressive behaviour" (68%) than the need "to prevent a fall" or "to inject an infusive therapy" (32%). With the exception of patients affected by Dementia, Delirium or other organic mental disorders, the restraint procedure was mainly limited to the first 7 days of hospitalization. When there were more operators in the ward, for instance during the morning shift, physical restraint was adopted less frequently.

Conclusions

Physical restraint, inside SPDC 1, was mainly adopted as an acute and not routine procedure with the aim to contain an assault or self-dangerous behaviour which could not be faced otherwise. According to these data, a complete and numerous team generally acts as a method of containment itself since this condition reassures the operators who are able to respond to the patient with therapeutic means rather than physical ones only.

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Psychiatric Emergency Service Unit (PESU) unique model of patient care

Paper

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The Psychiatric Emergency Service Unit (PESU) at University Health Network (UHN) Toronto Western Hospital (TWH) site provides a wide range of emergent and urgent Mental Health Services. Comprehensive emergency psychiatric assessments are conducted in a safe and secure environment and, in collaboration with the TWH Emergency Department; mental health patients in crisis receive prompt access to the appropriate service. PESU department is requiring more intensive care and/or monitoring. The goal is to ensure the provision of medically necessary psychiatric treatment in an environment that is safe for patients and staff. The secure area is designated to regulate biological, psychological, social and environmental boundaries.

The psychiatric nurses in PESU, in collaboration with ER physician, psychiatrists, residents, and various clinicians, form an interdisciplinary team that perform patient assessments and provide treatment patients, delegate patient transition throughout the services, offer linkages to community agencies, and facilitate ongoing treatment. This interdisciplinary approach endeavors to create an outpatient path, while ensuring quality treatment with sensitivity to dignity, gender, religious beliefs, ethnicity and sexuality.

The PESU model which is based on the philosophy of providing the best care, welfare, safety and security for the client as well as incorporating high levels of communication throughout the treatment periods results in a reduced the rate of 38% psychiatry inpatient patients admission.

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Reduction of seclusion and restraint measures: outcome in nine hospitals in the Netherlands

Paper

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Keywords: registration, reduction of seclusion and restraint, outcome

Introduction

Reduction of seclusion and restraint is a major political issue in the Netherlands, especially after a number of incidents related to errors in seclusion care. From 2001 onwards a number of Dutch hospitals have aimed efforts in improving their quality of enforced treatment, focussing on less restraint and more consent with both the patient as well as their family². How to measure outcome in a way managers as well as nurses can use the findings in an ongoing evaluation of their activities, is currently in development both within research as well as within the Dutch organisation of Mental health care institutions, in collaboration with the experience gathered in the UK^{3,4}. Several hospitals and university based research groups collaborated in a nation wide database covering approximately a catchment area of above 5 million inhabitants. This report presents the first findings of assessments within nine hospitals over various time frames, as the hospitals participated in the study at different moments in time.

Methods

In the current study we address changes in seclusion corrected for the use of enforced medication to rule out possible substitution effects. In accordance with the international literature we defined:

- Seclusion as placing the patient alone in an outside locked room during some time, irrespective of the circumstances and safety preconditions, including the use of isolation room as well as bedrooms which may be locked outside.
- Enforced medication as medication administration against patients 'will.

The time frame of seclusion and restraint is defined as the period from the beginning (closing the door when the patient is in the room or locking the belt) to the discontinuation (opening the locked door or removing the belt). Such a period is indicated as a episode, the smallest unit of registration. With respect to enforced medication only the time of the administration of medication is recorded as a episode. Within a day one or more seclusion episodes or administrations of medication can take place.

For the purpose of the current report we present three outcome measures:

1. The number of times per quarterly per hospital seclusions started and went on without a break of more than 24 hours
2. The mean number of days per quarterly per hospital a seclusion went on without a break of more than 24 hours
3. The number of times per quarterly per hospital enforced medication was administered.

We present data of hospitals with more and less than one year of assessment separately, as in our opinion the first show a valid representation of outcome, while in the second only trends

may be valued. The results are presented each hospital next to the other, without presenting any comparison. A first effort into comparing data is presented elsewhere in the current proceedings⁵. Data were gathered by means of a form administered by nurses at a day to day basis at the wards. The reliability of the assessment tool proved to be reasonable, showing a Cohen's Kappa of between .64 and .92 in comparing the assessment with other sources data such as electronic patient dossiers ore nursing reports and tested in 4 hospitals. The study was carried out in four urban and five rural hospitals and covered 104 wards. In all hospitals the nursing teams were trained by the same research associates in using the assessment tools.

At four month intervals data were presented to the wards as a means to motivate nurses to keep on gathering data, but also as a way to check whether the data had some face validity on the opinion of the participating teams.

Next to the data feedback at a quantitative level, in five hospitals a qualitative study was also carried out. In this study semi-structured interviews were held with patients, nurses, managers and psychiatrists and discussed with key informants being the project managers of the hospitals. By means of responsive evaluation data were gathered and checked by the participants⁶. The outcome of these interviews support the interpretation of the quantitative data.

Results

Figure one presents the outcome of the first four hospitals with data gathered over a time frame of more than one year. The figure shows clear trends over three of the four hospitals with respect to the number of measures started. The last hospital showed some change up front, but an increase half way assessment.

Figure 1: Two year outcome of number of seclusions per hospital per quarterly in four hospitals with follow up data of more than one year.

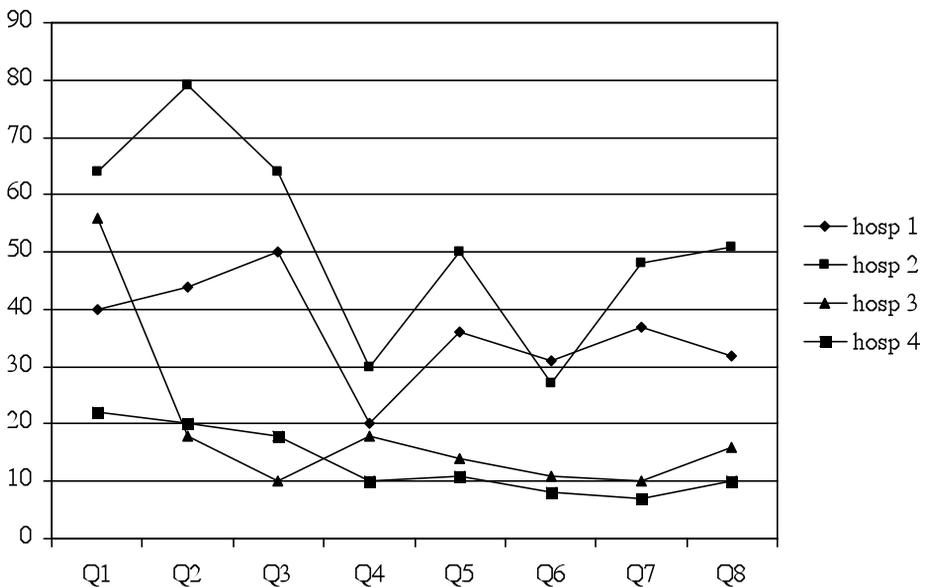


Table 1 presents data on the mean number of days measures carried on per hospital per quarterly as well as the number of times per hospital per quarterly enforced medication was administered. In two of the hospitals with a reduction in number of measures also the mean number of days

a measure carried on went down. In one hospital a substitution effect with enforced medication could be observed.

Table 1: Mean number of days measures were carried out as well as number of applied enforced medication per hospital per quarterly in four hospitals with follow up data of more than one year

	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8
Hospital 1								
- mean days	5,7	4,3	5,1	3,8	3,7	3,5	3,8	4,1
- medication	22	66	86	31	40	27	28	42
Hospital 2								
- mean days	5,6	6,7	6,3	11,2	9,2	8,3	6,4	6,2
- medication	22	36	12	9	17	23	73	54
Hospital 3								
- mean days	6,2	6,1	4,3	3,4	3,5	2,8	3,2	3,6
- medication	23	31	32	44	54	61	56	63
Hospital 4								
- mean days	4,6	6,1	5,6	5,9	6,3	9,8	5,4	7,8
- medication	41	25	18	10	12	17	22	26

Figure two presents the outcome data of the hospitals with data gathered over a time frame of less than one year. In general these data show a seasonal fluctuation and some differences as to the starting point of the several hospitals when we look at the number of measures per quarterly.

Figure 2: Outcome of number of seclusions per hospital per quarterly in five hospitals with follow up data of less than one year

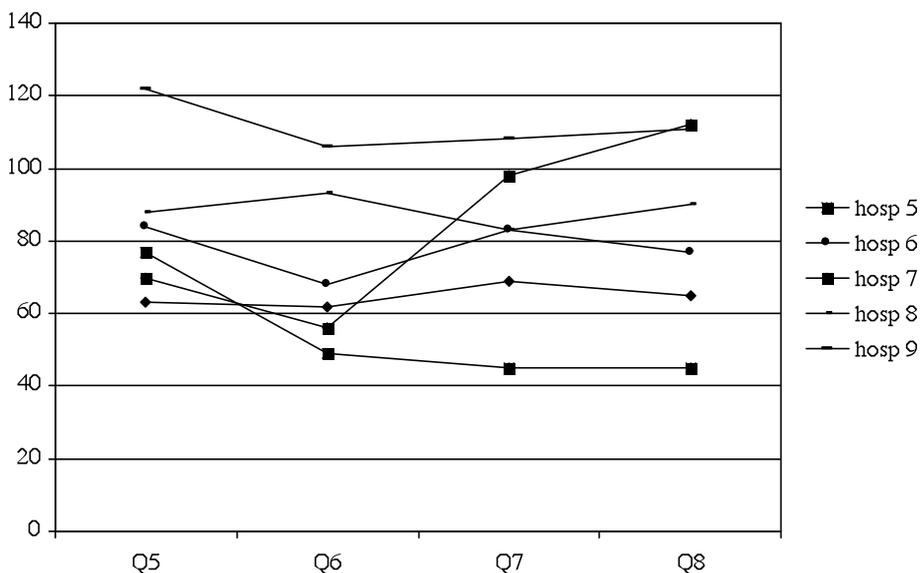


Table 2 again presents the mean number of days seclusions carried on as well as the number of times enforced medication was administered. Again the data show some differences as to the

starting point of the hospitals when we look at mean number of per quarterly as well as the mean number of times enforced medication was administered. In one hospital where a randomized trial was performed over a 10 month period data show clear differences, reported previously⁷.

Table 2: The mean number of days measures were carried out as well as number of applied enforced medication per hospital per quarterly in five hospitals with follow up data of less than one year

	Q5	Q6	Q7	Q8
Hospital 5				
- mean days	3,8	4,5	1,8	2,6
- medication	17	7	5	16
Hospital 6				
- mean days	5,6	8,4	7,5	6,8
- medication	22	18	42	43
Hospital 7				
- mean days	3,1	2,8	2,4	2,3
- medication	18	13	11	12
Hospital 8				
- mean days	12	9,4	8,3	8,6
- medication	39	41	29	38
Hospital 9				
- mean days	2,8	1,9	2,3	1,7
- medication	26	31	19	25

The qualitative interviews show the use of restrictive measures depends on a number of factors either positively or negatively related to each other. Next to this several substitution effects may be observed, such as the use of less coercion, but more argumentation with the patient, or the use of more enforced medication. Concluding a direct relation of outcome with project efforts can sometimes be quite difficult. All participants stress relationships to be dependant of a large number of variables, many of which are difficult to influence, such as the state of mind of the patient at the moment of seclusion, the number of experienced nurses at the ward, the accessibility of doctors at the ward, the day program of the patient, the accessibility of seclusion rooms or psychiatric intensive care units, the number of one person stay rooms, as well as a number of financial constraints. A major outcome is patients report the way they are engaged as to have changed. Nurses report a change in the way they make choices and are aware of the issue to reduce the use of seclusion. The weight of various variables at a specific moment in time may vary widely and are a main point in the interpretation of outcome and in valuing the effect of project efforts over time.

Conclusions

The findings of the study shows some change in outcome over a number of hospitals. We observe in two out of four hospitals with follow-up data over one year a combination of reduction in the number of measures as well as the number of days the measures carry on. In one we observe a reduction in number of measures but not in number of days, while in another we observe no change. In the hospitals with shorter follow up data some trends , but primarily a difference in starting point may be observed.

A major limitation of the current study is the short follow up. Real conclusions only may be drawn upon outcome over a period of at least five years allowing correction for seasonal variation as well variation in team complement always occurring over time as nursing teams in general tend to change importantly over time.

The findings of the study warrants the conclusion that an aimed effort into prevention of the use of seclusion provides a reasonable reduction in the number of measures and maybe also the number of days a measure takes. The number of patients undergoing a measure seems to be influenced less. A reduction in seclusion may coincide with an increase of enforced medication as one hospital shows.

Even though the results show a mixed outcome further and much more systematic research into substitution effects is necessary. The results of the current study do not allow any conclusions in this respect. The results do show preliminary results on the use of seclusion in the Netherlands as well as a first view on the development of the outcome of a major effort in to bringing about a change. The results stress the importance of a uniform registration allowing a valid way to assess outcome.

How to interpret outcome against the background of variation in patient variables, ward size, personnel training and complement, as well as with respect to readiness for change is subject of ongoing research underway in a number of publications from the research group, some of which are presented elsewhere in these proceedings.

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Principles and guidance for the use of restrictive mechanical devices for people exhibiting severe self injurious behaviour: Learning disabilities and autism

Workshop

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The project started with the collation of data, in 2004 and initial literature review. The keywords were: learning disabilities, autism, restraint, mechanical devices, self injurious behaviour. The aim of the project was to establish guiding principles for professionals supporting people with severe learning disabilities and autism who exhibited serious self injury, in healthcare settings, education and social care settings.

Over the following 3 years the author collected data and information from practitioners through focus groups, conference debates and personal contact which were a combination of e-mail and direct contact. Common practice themes emerged:

- A lack of clarity and guidance for professionals
- Often parents or carers insist on professionals identifying ways to prevent injury or stop self injurious behaviour
- A lack of professional understanding or expertise
- A lack of consistent advice and absence of frameworks
- Lack of understanding and agreement about what might constitute a mechanical device
- A “feeling” that they (mechanical devices) are more widely used within children’s services and education than in services for adults (although this is not supported by research).

The research period also highlighted that the use of restrictive mechanical devices could be split in to 3 categories, when considering severe self injury:

- Advanced planning as part of a behavioural support strategy
- As part of a therapeutic intervention
- Reactively to reduce risk to the individual and/or others as a result of their behaviour

The final document defines mechanical restraint within services for people with learning disability and/or autism as: ‘The application, as a last resort and use of materials or therapeutic aids such as: belts, helmets, clothing, straps, cuffs, splints, and specialised equipment.

Designed to significantly restrict the free movement of an individual, with the intention of preventing injury; as a result of behaviour that poses significant and proportionate risk to them self of serious long term harm or immediate injury. The use of the device must be based on the findings of a behavioural risk assessment.

As a result of the three year project good practice guidelines were published in January 2008, by the British Institute of Learning Disabilities, the author believes they are the most comprehensive of their kind to be highlighted since Sailas et al (1984).

The guidance principles also address issues of organisational structure such as risk assessment, environmental conditions and positive behaviour support as well as assessment of individuals.

The guidelines seek to establish that people should be supported as individuals within appropriate frameworks and policies.

The workshop will highlight the research methodology and results, the issues highlighted by practitioners, significant health risks faced by people who self injure, and the guidelines. The workshop will discuss current practice issues for professionals, the usefulness of such guidelines, and future work.

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What makes some seclusions and restraints extra long?

Paper

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The use of seclusion and restraint varies between hospitals, districts and countries. According to our previous studies in Finland the medium length of seclusion is approximately 17 hours and about 7 hours for restraint. However, the longest incidents of S&R can last for days. As the length of S&R increases the probability of both somatic and psychological side-effects grows. Commonly the discrepancies between hospitals have been explained by the differences in treatment cultures, but there is little evidence for this assumption.

In Finland, each psychiatric hospital is required by law to report the number of S&R episodes to their regional State Provincial Office. For every S&R episode that lasts longer than 24 hours a more detailed report is needed.

As a part of a larger study we are clarifying the amount and reasons for S&R episodes that last longer than 24 hours and comparing them with random S&R incidents of the average length. The study is performed in the Southern Province of Finland where 40% of the whole population resides. The longest lasting S&R incidents are identified, then the details of the incident, the patient in question and the circumstances of the S&R are defined and compared with usual cases of S&R. We can also find out whether the long S&R incidents can be explained by patient characteristics or by hospital treatment traditions.

The results of the study will be presented in conference.

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Reduction of aggression and the use of seclusion by means of day-to-day structured risk assessment on acute psychiatric wards

Paper

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Background

Short term risk assessment by psychiatric nurses in daily practice appears to be strongly driven by experience based expertise. In the Netherlands approximately 30 % all aggressive incidents in acute wards results directly into a seclusion intervention (1). Although rarely used relevant clinical decision making support tools are available for daily practice in acute psychiatric settings (2). Psychiatric nurses may in their frontline position establish a key role in the process of risk communication. Several studies indicates that systematic risk assessment and risk evaluation can enhance clinical decision-making (3). Support of an evidence informed risk model can reduce the false negatives and false positive risk appraisals in working with patients in a crisis episode (4). Nevertheless it should be emphasized that observation instruments could never totally replace the value of clinical judgment (3).

Intervention

A set of complementary validated observational instruments is constructed for crisis monitoring in acute daily practice. For this purpose the Broset Violent Checklist (5), Kennedy-Axis V (6), Brief Psychiatric Rating Scale (11), Scale of Dangerousness (7), and the Social Dysfunctioning and Aggression Scale (10) were used. The hypothesis was that this Crisis Monitor model may improve the quality in decision-making on the proportional application of coercive interventions in acute settings.

Methods

In a cluster randomized clinical trial the following hypothesis was tested; structural and frequent applications of risk assessment instruments enables the staff to improve their risk management in order to reduce aggressive incidents and coercive interventions. This research proposal was approved by a regional medical ethical committee and the research protocol and the preliminary findings were frequently discussed with a committee of service-user representatives. All consecutively admitted patients were included in the study (n=596). The study was performed during 40 weeks. The first 10 weeks were used to as a baseline. After this baseline period, the experimental and control wards were randomly allocated. In the experimental wards observational instruments were integrated in standard care planning. Care as usual was provided by the control wards.

Results

The findings indicated a significant reduction of aggressive incidents and seclusion hours in the experimental wards as compared to the control wards. Also, the number of patients secluded in the experimental ward was less compared to the control wards. The number of times enforced medication was applied was too little to perform statistical analyses.

Conclusion

A cluster randomized clinical in a high risk environment appeared to be feasible in this study. Data control and clinical supervision by scientist practitioners in this process is highly recommended. Structured short term risk assessment can support seclusion and violence reduction programs in acute psychiatric wards significantly.

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Well begun is half done: The first five minutes of every patient-staff encounter are crucial for reducing coercive measures

Paper

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Keywords: seclusion, prevention, patient-staff interaction, aggression.

Introduction

The Netherlands has one of the highest seclusion rates of all European countries. The Dutch Health Care Inspectorate (IGZ) reports involuntary admissions and emergency or coercive measures according to the Dutch jurisdiction (Special Admissions act for Psychiatric Hospitals (BOPZ)). According to this database the IGZ reported 16.219 involuntary admissions in 2006 (IGZ, 2007); seclusion as a coercive measure was reported 5.936 times. There is an increasing awareness among a growing number of parties that the occurrence of coercive measures, mainly seclusion, should be reduced (Abma et al., 2005; Landelijk platform GGZ, 2007). Patients report severe negative consequences of seclusion, which will negatively influence future care acceptance (Holzhorth & Wills, 1999; Hoekstra et al., 2004). Seclusion interrupts the therapeutic process and delays the recovery process. Moreover, the therapeutic effectiveness is controversial (Brown & Tooke, 1992; Seilas & Fenton, 2009).

The above-mentioned facts have renewed the interest in the reduction of coercive measures and the search for alternatives is therefore of utmost concern. GGZ Nederland (the national organization representing all Dutch psychiatric hospitals) aims to reduce the number of coercive measures by ten percent a year since 2006. The Dutch Government has subsidized this ambition and € 15.000.000 was divided among 42 Mental Health Care institutions for projects aimed at this goal.

In this article, we will present the preliminary results of one of these projects aimed at the reduction of seclusion as a coercive measure. This 2-year project, funded by the government, was conducted on three closed wards of a psychiatric hospital in the Netherlands (GGZ inGeest). The main goal of this project was a 25% reduction of the number of seclusion episodes and mean seclusion duration, without replacing seclusion by other possibly harmful coercive measures.

Method

Our basic assumption has been that the nature of the patient-staff interaction during the first minutes of every patient-staff encounter is crucial to the prevention of escalation and the use of coercive measures (Van der Werf, 2002; McAllister et al., 2004). The assumption has been that in these very first minutes of a new encounter important (verbal and non-verbal) messages are exchanged which will characterize the quality of the ongoing relationship. During these first encounters important intentions will be communicated, such as safety for all parties, mutual respect and transfer of information. This interaction starts with each first five minutes in a new

encounter, for example; with the assessment of a patient at home, in entering the ambulance, in the encounter with the police, with the admission to the hospital, with the start of every new shift.

If in these situations a pro-active, careful and empathetic treatment by staff is realised, geared to the patient's perception of his situation, this will lead to less insecurity, instability and unpredictability on the side of the patient, and thus escalation and the need for seclusion will be prevented.

A second assumption has been that especially those interventions will be effective, that the care providers regard as highly feasible (Colton, 2004).

Moreover, despite the renewed interest, there is still limited evidence for effective interventions to reduce coercive measures (Gaskin et al., 2007). For these reasons we did not define clearly depicted interventions in advance. In this project, we chose to develop best practices in essential 'first five minutes' situations together with the teams of the closed wards (a 'bottom up' formula).

So far we developed 'first five minutes' best practices for de-escalating staff behaviour for the following aspects of treatment and care:

- Admission at a closed ward
- The start of every new shift
- Registration with the 'psychiatric emergency services'
- The use of medication in crisis situations
- The contribution of the primary nurse in preventing coercive measures
- The contribution of family in preventing coercive measures

To involve working partners, such as police and ambulance services, we started initiatives for training them to cope with aggressive behaviour by people with psychiatric disorders.

Results

The registration of seclusion episodes started in April 2007. We distinguish two variables: duration of a seclusion episode and the number of seclusion episodes. In our definition, a seclusion episode ended if a patient was not secluded for an uninterrupted period of 24 hours after his/her last stay in the seclusion room. The duration variable adds up all consecutive hours and minutes that a patient stays in the seclusion room during a separation episode.

During the data collection period (April 2007-December 2008) a total of 1161 patients were admitted to the three wards, of which 289 persons (25%) were secluded 622 times. In 51% (N=316) of the cases men were secluded, in 49% (N=306) women. Their mean age was 38,9 (SD 12,8 ; range 18-60). Most patients (N= 233, 76 %) were involuntary admitted under the Dutch law governing coerced admissions to psychiatric institutions, either on the basis of a court order (22 %) or because of an acute compulsory admissions in crisis situations authorized by the city mayor (54 %).

The majority of the separation episodes was short-lived, ranging from less than 24 hours (62 %) to 24-48 hours (13 %). A small number of separation episodes lasted longer (20 % 48-168 hours; 5 % > 168 hours). The most frequent DSM IV classifications we observed were schizophrenia paranoid type (23 %), psychotic disorder NOS (13 %) and borderline personality disorder (16 %).

Comparison of the second quarter of 2007 with the last quarter of 2008 shows a reduction of 21 % in number of seclusion episodes and a reduction of 41 % in seclusion duration over all three wards. The mean duration of separation episodes dropped from 66 to 38 hours, a reduction of

42%. On the acute admission wards, seclusions rates at the moment of admission of new patients tended to drop.

Conclusion and Discussion

In conclusion, it appears that interventions directed at the de-escalation of patient-staff interaction that take place in the first 5 minutes of specific situations seem to be effective in reducing the number as well as the mean duration of seclusion episodes. We have seen that the aim to reduce the number of seclusions with 25% is not yet obtained. The data collection is, however, a continuing process. When we include the first quarter of 2009, the number of seclusions reduces again to 76; a reduction of 30% in comparison with the second quarter of 2007. The reduction in duration of seclusion episodes was successful (42%) and relatively stable over time. We also observed a beginning of a breakthrough in the engrained practice to directly seclude patients upon admission to the ward. Our findings indicate also that reduction in the duration of seclusion episodes is easier to accomplish than a decrease in the number of seclusions.

The idea and success of searching for alternatives for the prevention of coercive measures in 'first five minutes' situations is recognized and adopted by several other mental health institutes in the Netherlands and by the inspectorate (IGZ, 2008). Additional research, however, is needed to confirm our preliminary results.

A challenging future task for us is to maintain and extend the results with the full implementation of all the best practices that were developed in daily practice on hectic acute psychiatric wards.

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Reducing coercive measures by reducing expressed emotions and an aggression reduction training

Paper

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Keywords: Seclusion, expressed emotions, patient-staff interaction, aggression

General Introduction

In this article we will present the results of a research study on a project aimed at reducing the number of separations and other coercive measures in two wards in an inner-city psychiatric hospital. In one ward, the acute admission ward, quality assurance instruments were introduced and the staff was trained in handling and reducing aggressive incidents. In the other ward, the half open follow-up unit, in addition to the two interventions stated above, the staff received an intensive training in reducing expressed emotions with regard to the patients.

The ward-attitude in terms of levels of expressed emotion (EE) seems to be a reliable predictor for a psychiatric crisis or aggression followed by seclusion (Wearden et al, 2000). Our assumption was that by training the staff in handling aggression and by teaching them how to reduce expressed emotions, the quality of patient-staff interactions would improve, the number of incidents and seclusions would decline significantly and there would be no shift from seclusion to other coercive measures .

Method

On both wards the number of coercive measures including seclusion was registered on a daily basis by a newly developed instrument, the ARGUS. The instruments we used, were the Five Minutes Speech Sample (FMSS, Magana et al, 1985) which is a reliable instrument for measuring the quality of patient-staff interaction in terms of expressed emotions (Van Humbeek en Van Oudenhoven, 2001) and the Brief Psychiatric Rating Scale-Expanded (BPRS-E, translated in Dutch by Dingemans, 1986) a widely used instrument for measuring (the severity of) psychiatric symptoms of the patient.

In the acute admission ward two measurements with these instruments were carried out: one in December 2007; one six months later. In the follow-up unit three measurements were carried out: one in September 2007 just before the staff got the EE-training; one in February 2008, after the training and a follow-up measurement after a booster session, nine months later. At the follow-up unit, as a standard, patients who are being discharged, fill in a form measuring the perceived quality of received care from the perspective of the patient.

Results

In both wards patients with severe psychiatric symptoms are treated; in the follow-up unit patients have more depressive symptoms than in the acute admission ward.

a) The acute admission ward initially had a high number of seclusions: about 75 in a quarter of a year. During the research period the number of seclusions declined significantly from 75 to 40 in three months. There was no shift in the kind of coercive measures from seclusion to other, less

intrusive, measures. The mean number of hours during which an individual patient was secluded increased from about 60 at the start of the research-period to 150 in the last quarter of 2008 but declined to 60 in the first three months in 2009. The distribution in low-EE patient-staff interactions vs. high EE patient-staff interactions (about 75 % vs. 25 %) did not change during the research period.

b) The follow-up unit initially had a low number of seclusions: in the beginning of the research-period there were about 20 in a quarter of a year. During and after the EE-training the number declined to 14 to rise again after that. After the booster session, it declined again to 8, to rise in the first three months of 2009 to 15. There also was no shift in the type of coercive measures. In the beginning of the research-period the mean number of hours spend in seclusion declined from 120 to 55. In the first three months of 2009 it increased again to 100. The distribution in low-EE patient-staff interactions vs. high EE patient-staff interactions initially showed a marked increase in low-EE interactions (before the training about 75 % vs. 25 %; immediately after the EE-training 87 % vs. 13 %); at follow-up the old level was reached again.

The overall satisfaction of patients about the received treatment was remarkably positive. High scores were given for 'showing respect to the patient' and 'formulating a plan for treatment'; lower scores were given for 'together decide on the treatment', 'explaining the arguments for separation' and 'evaluating the separation'.

Conclusion and discussion

In the acute ward a shift to lower numbers of seclusions was observed. The mean duration of time individual patients spend in isolation didn't change. In the follow-up ward initially there was a decline in number of separations cases? but in the first three months of 2009 the number rose again. Also the number of hours spend in seclusion initially declined but on the long run it fell back to its initial level. On both wards a decline in separation was not accompanied by an incline in other coercive measures.

There was no direct relationship between the level of expressed emotions (as measured by the FMSS) and the number of seclusions. The level of EE initially was already rather low on both wards which means that the patient-staff relationships there were characterized by positive interaction. This initially low level of EE may explain also the small differences found after the intensive EE-training on the follow-up ward and could be seen as an impediment for further progress. The staff was very positive about the EE-training. Patients are rather satisfied about their treatment especially when it comes to the kindness and respect they receive from the staff. But the lower satisfaction rates on the items regarding decision-making and the items concerning seclusion, stresses the importance of reducing coercive measures and seclusions.

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Interactions of multiple determinants of seclusion in a Dutch psychiatric hospital: an exploratory study

Paper

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Keywords: Seclusion, determinants, psychiatric wards, NOSIE-30, logistic regression analysis

Introduction

According to the model of Nijman (2002) psychiatric inpatient aggression can be conceived of as the result of multiple determinants. Patient, staff and ward are three variables that may interact in eliciting inpatient aggression. Seclusion (of aggressive, suicidal or psychotic psychiatric inpatients) can also be conceived of as the (final) result of the interaction of these determinants. Examples of patient variables are gender, age, educational level, medication usage, DSM-IV-classification and current psychopathology. Staff variables might be age, male/female ratio, educational level, years of experience, and subjective feelings of safety. Ward variables may be acute or longstay wards, patient-staff ratio, number of patients per room, number of seclusion rooms, and percentage of beds utilized.

Interactions between patient, staff and ward variables could include: (a) do higher levels of current psychopathology increase the risk for seclusion more when the patient-staff ratio is also high? (b) given a high patient-staff ratio, do current psychosis and current aggressive behavior lead to different risks for seclusion? (c) do aggressive patients have a higher risk for seclusion on a crowded ward? (d) when the staff is feeling unsafe, are they more willing to seclude psychotic and/or aggressive patients? (e) does a lack of privacy (more patients per room) increase the risk for seclusion for acute psychotic patients?

We are also interested in associations between particular patient, staff and ward variables with seclusion. For instance among others, (a) is medication intake (or refusing medication) by patients a predictor for seclusion? (b) do (many) previous seclusions predict future ones?

Studies of the determinants of seclusion – patient, staff and ward – in psychiatry are mainly focused on one or two of these determinants. To date authors are not aware of any study in the literature, which included all three hypothesized determinants of seclusion and thereafter examined (all relevant) interactions between the three determinants. Therefore this study could be (one of) the first which includes all three determinants of seclusion and examines possible interaction effects between patient, staff and ward variables.

Method

In a naturalistic study the (relative) influence of multiple determinants of seclusion in four inpatient wards was examined in the general psychiatric hospital Meerkanten (Ermelo, The Netherlands). Two of these wards are crisis intervention wards and the other two wards are medium stay and long

stay wards. During 2008 (quantified) data on sets of patient, staff and ward variables associated with all seclusion-incidents (n= 180) were systematically collected. For control-subjects a similar dataset as the seclusion incident dataset was collected (non-secluded inpatients of the same wards, in the same period, n=200). Data collection was conducted by (four) psychiatric nurses in the respective wards who were trained for this purpose. Immediately after (a few hours) a patient was secluded the research nurses collected data on the relevant patient variables, viz. gender, age, medication usage, motive for seclusion, previous alternative interventions been taken.

Further, they filled in the 30-items of the Nurses Observation Scale for Inpatient Evaluation (NOSIE-30). With the NOSIE-30 the nurses rated different kinds of psychopathology during the week before seclusion. Subscales of the NOSIE-30 are psychosis, irritability, depression, psychomotor retardation, personal neatness, social competence and social interest. From the four participating wards control patients were identified in random order and subsequently the nurses collected data on the similar patient variables with respect to the control patients.

Other patient data (DSM-IV classification, GAF-Score, duration of admission) and the data on the staff and ward variables were (mainly) collected by the researchers afterwards supported by the ICT, patient administration and personnel departments. Staff variables included male/female ratio, age, educational level, years of experience, aggression training and subjective feelings of safety (on a Likert-scale). Included ward variables are short stay versus long stay, patient-staff ratio, number of patients on the ward, number of patients per (bed)room and number of seclusion rooms available.

In total a number of 100 variables were examined: patient, staff and ward variables on all seclusions in the hospital during the year of 2008. Data were analyzed using SPSS 16.0, and using binary logistic regression analysis (seclusion/non-seclusion is the dichotomic dependent variable and the patient, staff and ward variables are the predictors).

In logistic regression terms, the research is not only focused on the size of the effects of the candidate determinants of seclusion separately, but also on the interactive effects of the determinants, viz. patients, staff and ward.

Data analysis is currently ongoing and the results will be presented during the congress. The research results may have implications for future practice, theory, policy and further research.

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Chapter 11 – Risk Assessment, and Prediction of Violence

Predicting Violence in patients discharged from General Psychiatry using the Bremen Risk Assessment Scale

Paper

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

Introduction

Individuals with severe mental illness have a higher risk of committing violent crimes compared with the general population group (Böker & Häfner 1973, Fazel & Grann 2006). However, this observation does not apply to all psychiatric patients; it depends to a great extent on the individual diagnosis (Fazel 2009). The risk of becoming a victim of a crime committed by a mentally ill person is perceived as much higher than the actual risk by the public (Pescosolido et al. 1999). Especially after a violent incident the public calls for stricter laws and more effective observation of those patients (Appelbaum 2006).

Parallel to the reduction of psychiatric beds in the context of deinstitutionalization from 1999-2003 there has been a 38% increase of admissions to forensic-psychiatric units (Priebe et al. 2005). 80% of the patients admitted to a forensic ward had been treated in the general psychiatry and had, on average, committed 8,5 delicts before being convicted (Hodgins & Mueller-Isberner 2004). Colleagues working in forensic units often claim that there should be greater efforts to prevent violent acts whilst patients are still being treated in the general psychiatry by first identifying risk patients and secondly offering interventions that might help to reduce the rates of crimes committed (Weithmann & Traub 2008). In order to meet these requests we developed and evaluated a risk checklist, the Bremen Risk Assessment Scale (BRAS-GP), to predict violence before patients were discharged from their treatment in general psychiatry.

Methods

We included all in-patients that had been admitted to our hospital from October 1st to December 31st 2006. All patients that were treated involuntarily were evaluated using the BRAS-GP by their main therapist shortly before their discharge. The evaluation took the entire period of their stay into

account. The BRAS-GP consists of 17 items including 4 questions concerning the “case history”, 8 questions about “psychopathology” and 5 about “social background” leading to a score for each of the 3 subscales. At the end of the BRAS-GP there is a final question asking if severe future aggression is to be expected (yes/no). A patient is rated “positive” if there is a high score in at least one of the three subscales (case history ≥ 6 points, psychopathology ≥ 10 points, and social background ≥ 10 points) or if the question about future aggression is answered with “yes”.

In a one year follow-up, we analyzed the circumstances under which our patients were readmitted looking for any violent behavior that occurred. This led us to sensitivity and specificity of our checklist including the rates of true and false negatives and positives. In order to estimate predictive power, the area under the curve (AUC) of the receiver operating characteristic (ROC) analysis was calculated. A Kaplan-Meier survival analysis was conducted to illustrate the sequence of readmissions related to violent behavior. The Fleiss- Kappa coefficient was used to determine the inter-rater reliability.

Results

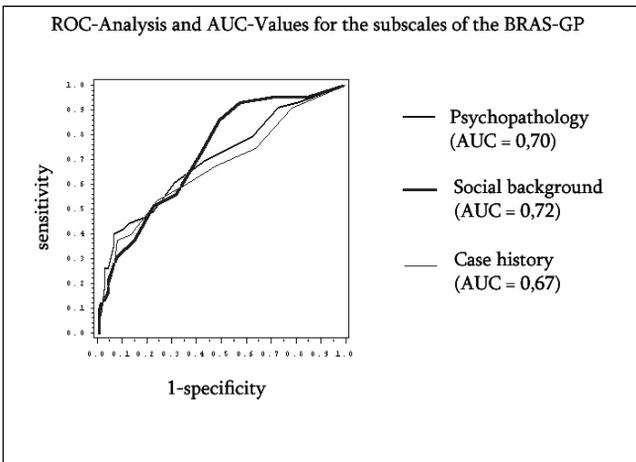
Between 1.10.- 31.12.06 we treated 816 patients on our psychiatric wards. 179 patients were treated involuntarily; in these cases the BRAS-GP was applied. 70 of these patients had a “positive” prognosis predicting violent behavior in the future and 109 cases were rated as “negative” (see Table 1).

Table 1: Number of true and false prognoses with patients that showing violent behavior rated as ,positive’

Prognosis	Violent behavior during 2007		total
	negative	positive	
negative	97	12	109
positive	39	31	70
total	136	43	179

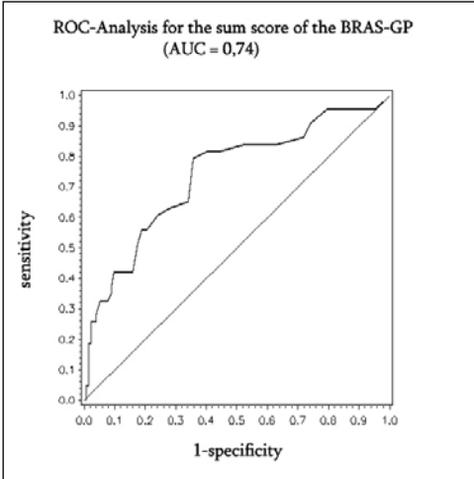
On evaluating the readmissions data in 2007 we calculated sensitivity of 0,72 and specificity of 0,71. Of the three subscales “social background” had the highest AUC at 0,72 followed by the “psychopathology” with an AUC of 0,70 and finally “case history” with an AUC of 0,67 (see figure 1).

Figure 1: ROC-Analysis and AUC-Values for each subscale of the BRAS-GP.



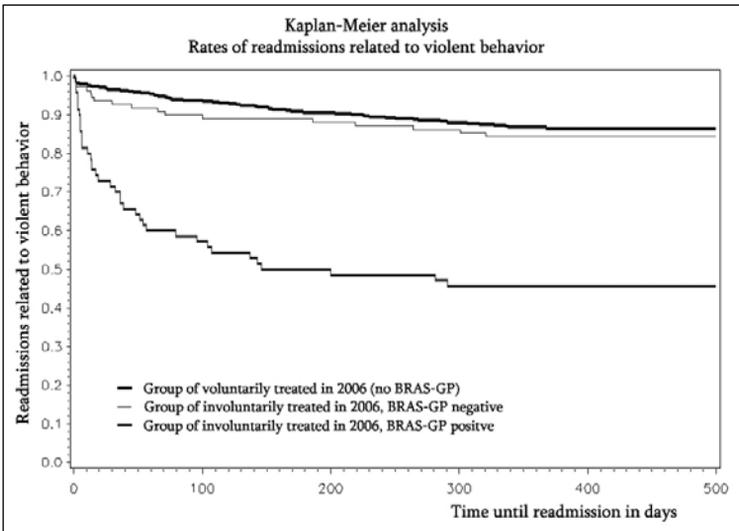
Using the sum score for the whole checklist an AUC of 0,74 was reached (see figure 2).

Figure 2: ROC-Analysis and AUC-Values for the sum score of the BRAS-GP.



The Kaplan-Meier survival analysis contained data from 457 days (see figure 3). Of 816 patients, 364 (=45%) were readmitted in 2007. Of the 746 patients that were considered “negative” (voluntarily treated in 2006 or risk checklist “negative”) 60 were related to aggressive behavior (= 8%) whereas for the 70 patients that were rated as “positive” 44% (31 patients) were readmitted under aggressive circumstances. The most “positive” readmissions occurred within one month after discharge, especially in the group of patients that had a “positive” prognosis. After one year we rarely detected any first readmissions. The inter-rater reliability of the risk checklist showed good agreement between the raters with a Fleiss-Kappa coefficient of 86,6 %.

Figure 3: Kaplan-Meier analysis illustrating readmissions related to violent behavior in 2006/2007.



Discussion

The BRAS-GP was easily introduced to general psychiatric wards and quickly accepted by therapists. It produced good values for sensitivity and specificity. An AUC of 0,74 showed a high predictive validity for this checklist. Looking at the three subscales of the checklist, items of “social background” and “psychopathology” seemed to be more valid for a true prognosis. Interestingly, those sections included items that can still be influenced by therapy or interventions, in contrast to historical items which are static. The Kaplan-Meier survival analysis revealed that most “positive” readmissions occurred during the first month after discharge, implying just how important effective ambulant interventions may be. It also showed that the follow-up of one year was an adequate period of time.

In a next step, we want to improve the BRAS-GP by emphasizing items that have a higher impact on the prognosis and by using the most effective cut-off point for the whole checklist. In progress there has to be discussions about how we can improve the treatment of risk patients after their discharge from general psychiatry (Swanson et al. 2000).

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

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Measuring the presence of coercion in psychiatric settings

Paper

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Keywords: coercion, treatment, recovery

Coercion and attempts to measure its' presence have been the subject of interest throughout the social sciences literature for many years. It has been of particular interest in the field of mental health. The foci of discussions in mental health has been on involuntary admission to substance abuse programs (Darbro, 2009), to psychiatric hospitals (Rain et al, 2003), and coercion as a phenomenon perceived by patients/clients, (Rain, et al., 2003; Prinsen & van Delden, 2009) psychiatrists and staff members (Galeazzi et al, 2007). The majority of research has centered on coercion associated with the use of various forms of restraint as perceived by patients (Bloom, 1997; Pollack, 2003; Prinsen & van Delden, 2009)

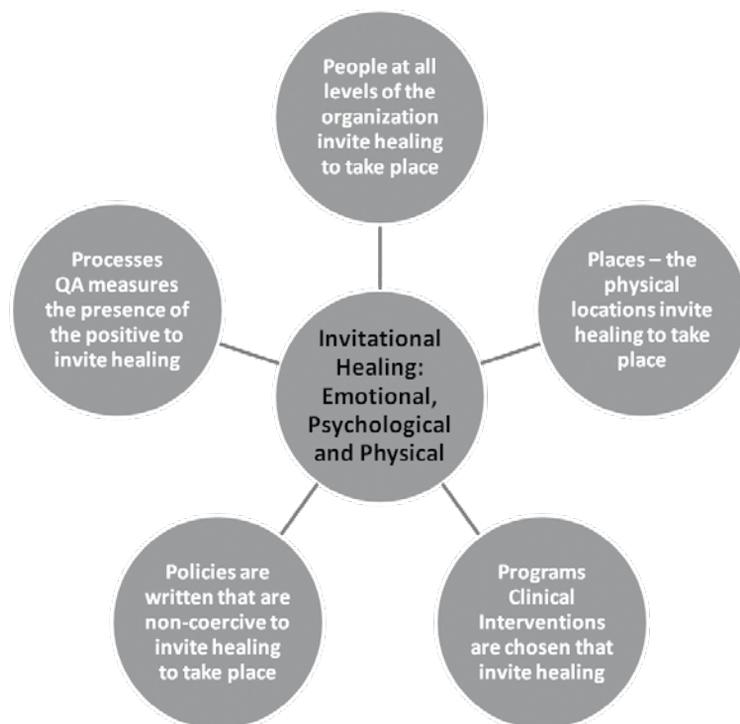
In this paper we posit that coercion is not a simple phenomenon and that it manifests in many structural factors that are interwoven subtly into the ecologies of mental health systems. We believe that the phenomenon of coercion should be defined broadly and its presence identified so that interventions to mitigate its presence can help to establish a more therapeutic environment. We contend that various levels of aggression are often responses to the way in which treatment options, requests for "cooperation" or "compliance" are presented to patients by treatment staff. Indeed studies show that aggressive incidents in treatment settings occur after staff interaction or requests (Garrison, et al., 1990; Morrison, 1992; Ryan et al., 2004; Child Welfare League of America, 2004).

A useful definition of coercion is that it is " attempting to control the behavior of others through threat or escape from unpleasant events" (Northern Arizona University , 2005). Historically coercion can be seen throughout psychiatric hospitals. Coercion can be systemic and seen throughout the milieu. It can be seen in the horizontal violence that takes place between staff members (Duffy, 1995; Thomas, 2003) and in punitive policies and procedures that are used in the work of managing human resources. It is present in the choice of programmatic approaches to structuring patient care milieus (Mohr, et al., 2009) and in the approaches used to restrain people when alternative or prevention efforts are ineffective.

Coercion is an unacceptable part of the health care milieu insofar as it diminishes the dignity of the person being coerced, elicits retaliation, and when initially ineffective in gaining expected results, results in further coercion on the part of the caregiver. This results in negative sequences of staff and patient interactions in which the patient is invariably the recipient of punitive or aversive consequences, such as restraint (Natta, et al., 1990). In order to address the systemic roots of coercion, practitioners need a framework which they can employ as a tool toward moving away from coercion toward one in which autonomy and dignity infuses organizational philosophy. The Invitational Education Model (Purkey & Novak, 1996; Shaw, 2002) provides such a heuristic. This model states that education is the nexus where the processes of teaching and learning meet, and that these processes are the result of the interaction among the People, Places, Policies, Programs, and Processes of a school.

Applying this conceptual framework to psychiatry, healing is the result of two primary actions: treatment and recovery (Bowen, 2009a). The idea is that mental health professionals, bring

treatment expertise and ideas of what health, and specifically mental health, should entail and that persons receiving treatment want to be healed and recover. Healing can best occur when all of the elements present in the culture of a mental health setting or treatment program work together to continually move away from coercion. The figure below represents the model of Invitational Healing extrapolated from the Invitational Education Model.



The elements of people, places, policies, programs, and processes are integral elements by which the processes work together to create a culture, even a coercive one as mentioned. Within the framework of the invitational conceptual model, these elements are consciously utilized to build a milieu that is a healing and non destructive. These elements and their proposed barriers and contributions to such a culture are briefly described below:

People – the relationship between staff is the context for all human services. When caregivers treat each other with dignity and respect, they create a relationally safe environment. Within the safety of respectful staff relationships, patients can begin to sense the respect and trust of the working relationship and subsequently develop trust with them. This is important insofar as so many individuals in mental health settings have trauma histories and hypervigilance is a challenge to overcome. Unresolved issues between staff can often perceived as a repetition of past tension and trauma and evoke and perpetuate further mistrust (Bowen, 2009b).

Places – the physical location, structure, aesthetic flow of the service site are determinants of how an individual perceives how safe they are in their milieu. Safety is has physical, psychological and emotional elements. An example of the importance of aesthetics and how they can communicate safety in a milieu can be seen in the efforts at Sheppard- Pratt. In 1862 Sheppard-Pratt psychiatric hospital started a building program that took 29 years to complete, partly to incorporate

architecture into the therapeutic environment to a degree never seen before and rarely since. Trees and shrubbery were given a chance to mature, grounds were developed to simulate a pastoral scene, in the belief that the more comfortable the environment was, the greater the opportunity for healing (Roland, 2007).

Policies – Written policies and procedures are critical to organizational success. Policies that are punitive towards staff, rigidly structured with a focus on process instead of outcome, can have a negative impact on the service system. For example, in state operated psychiatric hospitals in Texas, the programmatic elements for individuals served are non-coercive, and at the same time, there are policies and procedures in place that rigidly structure the hiring and training process, contributing to high staff turnover. Such balance is crucial in maintaining efficiency with an eye to meeting the human needs of all members of the organization, as well as patients.

Programs – Human service organizations either develop or purchase the programmatic interventions they will use to achieve desired outcomes. These may include habilitation, rehabilitation, treatment, therapy, and education. One programmatic approach is known as Compliance Training. In this programmatic approach, education is seen as a linear process requiring students to progress from steps A to B to C, etc. If a student does not do so, she or he is asked to do so, and if they refuse, coercive interventions are used to force compliance, up to and including physical restraint. Behavior management, behavior modification, positive behavior supports, differentiated education, sensory integration, etc. are examples of modalities underlying such programs.

Processes – Human service organizations must have a process by which they measure success, and adapt, modify, or change the People, Places, Policies and Programs utilized in the organization. The terminology most frequently used are Quality Assurance, Total Quality Improvement, etc. The most common measurement of restraint reduction is the absence of restraint. But, some settings are going beyond the minimum common measurement. For example, psychiatric hospitals in Texas, are measuring “near misses” to describe those situations in which restraint was not applied because of the preventative or de-escalation activities of staff. These processes exemplify “going the step further” in order to assure quality, as well as examine incidents for teachable moments that inform staff in ways other than the standard deficiency model.

The assessment instrument

The instrument used to measure the presence of coercion in an organization is based on the “Process of Invitational Theory” (Shaw, 2002), with modifications by Bowen. The focus is on behaviorally quantifying the terms “beneficial” and “toxic” relative to the People, Places, Policies, Programs, and Processes that combine to form the organizational culture within which the process of healing takes place. Data from mental health settings that have employed this instrument is presented in this workshop. A series of open ended questions are used to guide a group through the discussion process:

1. People
 - a. Would you trust the people with whom you work to care for someone you love?
 - b. Has leadership participated in training to the same extent as direct support staff to learn how to prevent the use of restraint?
2. Places
 - c. Do you feel safe physically, psychologically and emotionally where you work?
 - d. Has care been taken in selecting colors, furnishings, lighting, etc. in the workplace?
3. Policies
 - e. Are the personnel policies in your organization designed to teach and then reward appropriate behavior as their primary goal?
 - f. Do day to day procedures match written policies and procedures in the workplace?

4. Programs
 - g. Are the formal programs written to address behavioral issues where you work used primarily to teach new behavior or to end “challenging” behavior?
 - h. Do programs empower people to refuse to participate without fear of punishment?
5. Processes
 - i. Is the Quality Assurance program where you work focused on measuring the presence of positive events or negative events?
 - j. Is there any fear of retribution for pointing out problems?

Discussion

Participants in the training programs report that the best part of the workshop is the opportunity, in a safe place, to openly discuss their perceptions of the presence of coercion in the organization and how that presence becomes toxic over time for service providers as well as service users. Mental Health facilities in Florida, Georgia, New Jersey, Mississippi, Texas, Illinois and Iowa participated in Corporate Culture Change training to delineate specific goals to move away from coercion in their organizations. In collating their data, the organizations reported that the most coercive factors are (in descending order, most coercive to least coercive):

Processes (Quality Assurance programs) – people feel that the focus is on failures and mistakes, not on achievements and successes. Over time, they reported feeling wary and fearful of reports and saw QA staff as enemies instead of allies.

Policies – people feel there is a “disconnect” between the mission, vision, and values of the organization and how those are manifested in the written policies and procedures, and even more so in the interactions between some supervisors and staff.

Programs – there is a general perception that programs used to change behavior put staff in the position of enforcing rules and consequences that service users perceive as coercive. In this area, there was a distinct correlation between position of staff and perception. The higher the responsibility level of staff, the more likely it was that they perceived programs as non-coercive, while most direct support staff and first line supervisors perceived programs to be more coercive.

Places – most people felt that real efforts were made to “soften” the effect of the physical location. In an unexpected result, staff in larger and older facilities reported a higher level of belief that their places were highly inviting.

People – As expected, most people perceived less coercion in themselves than in the other four factors. The discussions, however, focused on the perception that the behavior of some staff who were more coercive was not addressed by supervisors and had a negative effect on all staff. One common statement was “we (direct support staff) would rather work short (fewer staff, longer hours) than with someone who does not carry their weight, is coercive with service users, etc.

Training outcomes

In a recent report to the Substance Abuse and Mental Health Services Administration (SAMHSA), the New Jersey Division of Mental Health Services reported outcome data that underscored the importance of continually moving away from coercion. When patients in the hospital reported an allegation of verbal abuse, the response was to move the staff person to a different unit to protect the patient. The administrator was surprised to find that in one month, there were no allegations

of verbal abuse. This measure had not previously been used as a QA indicator, but was added in response to positive outcomes. (Miller, 2009)

There is a need for more research in the presence of coercion within human service systems. The subjective information in this paper is useful and can be strengthened by continued research.

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The Dance of Aggression: Learning to follow instead of lead

Paper

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Keywords: Aggression, restraint, trauma

Aggression in psychiatric and general hospital settings has become a significant issue for all mental health providers. New accreditation standards from the Joint Commission and regulations from the U.S. Occupational Safety and Health Administration (OSHA) require that leadership in hospital settings address the issue of workplace violence. While workplace violence can occur in any setting, organizations in which nursing services and psychiatric care are provided by far have the highest rate of non-fatal assaults. (Hoskins, 2006)

Contrary to the concept of aggression by service users as violence directed towards others in a purposeful manner, there is a growing perception of aggression as primarily a series of responses to stimuli that are processed in neurologically different pathways as a result of the neurodevelopmental effects of trauma (Perry, 2000). When staff make a request, or when peers interact with them, people with histories of trauma focus primarily on the tone of voice, body language, and other communicative modalities that carry potential threat (Bowen, 2009). Because of their trauma history, their behavior is more correctly seen as a coping mechanism (Ursin and Holff, 2006). Their behavioral responses are conceptualized in this paper as a physical response, a dance, done to “music” whose themes are the hope of recovery and the fear that they will not recover.

Recovery has been described as “a journey, not a destination.” (Deegan, 1997) For many service users in psychiatric hospitals and mental health centres, what is called recovery is experienced not as a journey, but as a treadmill by service users, especially those with significant histories of trauma. This treadmill brings people back into service settings repeatedly, with a different medication regime and a different treatment intervention, and when they do not work, the label “treatment resistant” or “recidivistic behaviour” is applied and the treadmill continues. (Lansing et al, 1997, Woo et al, 2007)

For people on this treadmill, restraint is experienced frequently. When restraint is used consistent with law and best practice, it is in response to violence or aggression towards self or towards others. There are documented instances, however, when restraint has been used not in response to violence or aggression, but as a way to respond to non-compliant behaviour. (Weiss & Altamari, 1998, Pollack, 2004, NDRN, 2009) Mental health centres, psychiatric hospitals, and other human service organizations have either developed or procured from a vendor a training programme to use restraint prevention and implementation methodologies. In the process of developing and implementing these programmes, many focus on how to control a person who is aggressive or assaultive.

The Royal College of Psychiatrists (2003) and the National Audit of Violence (2007) both focus on the use of “control and restraint” and “breakaway” training in their descriptions of the management of violence. The phraseology used in regulatory and “good practice” statements reflects the reactive nature of the majority of programmes designed to address situations of violence. However, the “dance” in which they are engaging does not respond well to attempts to control them. In the control and restraint philosophy, service providers are in the position of

leading the dance, forcing service users to follow. It is this act of coercion that is central to the process of re-traumatization.

In order to minimize the dangers associated with the imposition of restraint, service users should lead the dance, and we as service providers should follow. We follow in ways that slow the tempo (prevent), we follow in ways that provide alternatives (de-escalate), and when our dance partner stumbles we temporarily hold them to keep them safe (restraint). When people stumble, we need to stabilize them and provide them with the physical, psychological and emotional safety they need in order to lead the dance again.

The behavior of service users does put staff at risk of harm at times. The Child Welfare League of America (2004) found that staff are injured twice as often as individuals served when physical restraint is imposed. Workers in human service settings in the United States are injured more often than workers in logging, mining, and construction combined (Mohr et al, 2003). The best way to lower the potential for injury to service providers is to increase the physical, psychological and emotional safety of service users.

People with trauma histories are people who hope for recovery, but fear they will never achieve it. They are people who hope for the experience of caring, nurturing relationships, but fear that all people will betray their trust just as the people at whose hands they experienced trauma betrayed their trust. Betrayal trauma is the most debilitating form of trauma, because the person, usually a child, has lowered their guard, has become vulnerable, and in that state of trust they were betrayed.

Over time, service providers betrayed trust by using restraint, which is experienced by service users with trauma histories as the continuation of the betrayal of trust. Their dance picks up speed as fear drives the beat faster and faster. In cases where a stimulus or trigger that appears benign to service providers appears, people with histories of trauma escalate in a predictable fashion. (Perry, 2002)

Using the chart below, it can be seen that restraint is applied when service users are either afraid or terrified. Their neurological processing of sensory input and their behavioral output are mediated in the lower regions of the brain, using reactive or reflexive neurobiological pathways. The purpose of their behavior is to protect themselves by the “fight, flight, or freeze” decisions made in the autonomic processing centres. The behaviours for which we use the general term “aggression” are more correctly understood as defensive rather than offensive behaviours. By responding to them as offensive behaviours, re-traumatization occurs in the process of restraint, as the non-verbal behaviour of staff as they impose restraint is perceived as controlling and threatening through requests or commands to “calm down” or “stop.”

Mental and Emotional State	CALM	AROUSAL	ALARM	FEAR	TERROR	
SENSE OF TIME	Present through Future	Days	Hours	Minutes	Seconds	Loss of time sense, dis-oriented Sense of time narrows when stress is increased
PRIMARY						
SECONDARY	Neocortex	Subcortex	Limbic	Midbrain	Brainstem	Cognitive process centers move from “thinking about” to “reacting to”
BRAIN PROCESSING CENTERS	Subcortex	Limbic	Midbrain	Brain-stem	Auto-nomic	
COGNITION	Abstract	Concrete	“Emotional”	Reactive	Reflexive	

(Perry, 2002)

Most approaches to responding to people whose behavior has escalated try to stop the dance. But when they do so, the music continues because the stimulus or trigger that started the dance is still present, and may in fact have been transferred to the service provider (Mandt et al, 2008) Thus the very people who are trying to stop the dance represent the stimulus that started the dance in the first place. As they restrain the person, they ask the person to “calm down” and many approaches require the person to stop moving for a period of 30 seconds to 1 minute in order to demonstrate that they have calmed down.

Restraint is not a calming event. In the containment of animals, “It takes up to 30 minutes for an excited animal to calm down. To keep animals calm in a restraint device they must be calm when they enter it.” (Grandin, 2000) Thus, when a cow is restrained, it is only when the cow is calm and can perceive safety in the process of being restrained so treatments to prevent or treat threatening conditions that restraint can be applied.

It must be understood that when restraint is imposed, it is when people are either afraid or terrified. People will only become “calm” when two conditions occur: (1) the antecedent conditions that led to the aggressive behaviour, and (2) the person feels safe physically, emotionally, and psychologically. If and when we restrain people, we need to do so in a manner consistent with the principles.

In all these movements, the important concept to understand is that we follow. People, when we restrain them, need to feel safe, so they must be always on and never off balance. Muscle groups and limbs need to be maintained in normal positions that do not hyper-extend or risk hyper-extension. Lastly, not only must they be free of pain, they must be free of pain whether or not they struggle. When people are restrained, they must feel as comfortable as possible.

People in care feel what restraints would be like, if they were applied, and have a choice of restraints they would like to have done with them, if needed. People should not be immobilized, because that stops the dance, the music builds up in the person, and we see the pattern of escalation repeat itself in the future. All physical interventions, then, should seek not to control or manage but to safely follow and in the context of a healing relationship, support the person on the road to recovery from the trauma they have experienced. Further research is needed in this area in order to fully incorporate the experiences of service users in evaluating the efficacy of this approach.

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Criminal recidivism among mentally disordered offenders

Paper

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Keywords: Mentally disordered offenders, duration of hospitalisation, crime recidivism.

Background

The purposes of the treatment of mentally disordered offenders should be to improve psychiatric symptoms, to increase quality of life and to reduce the risk of recidivism. Our knowledge about the outcome for hospitalised mentally disordered offenders is limited.

Study aim

Aim of the study was to analyse the rate of criminal recidivism in a population based sample of people sentenced to forensic psychiatric treatment in Sweden.

Method

The sample includes all mentally disordered offenders in Örebro County, Sweden, discharged from a forensic psychiatric hospital during the period 1992-2007. Variables studied were gender, age, index offence, diagnosis, duration of treatment and recidivism after discharge. Follow-up data concerning recidivism was retrieved from the The Swedish national Council for Crime Prevention. Mean follow-up time was 9.4 years (range 0 to 16.8 yrs). Two patients with no follow-up time died in hospital.

Results

Eighty-eight patients were discharged from forensic care during the follow-up period. The mean age of the whole group at admission was 36.4 years (range 16-79 yrs). The most prevalent primary diagnoses at admission were personality disorders, schizophrenia and other psychoses. Frequent index offences were assault (48%), murder/manslaughter (20%), sexual offences (6%) and fire raising (4.5%). The mean duration of the first hospital stay was 3.5 years (range: less than 1 year to 19.8 years). At follow-up, eighteen (20.5%) of the patients had died. Follow-up data concerning recidivism are collected until May 2009 and will be presented at the Congress of Violence in October.

Conclusions

The study is expected to add valuable knowledge about one important aspect of forensic psychiatric treatment outcome.

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The clinical use, validity and reliability of the V-RISK-10, a new screening instrument for the assessment of violence risk after admittance and discharge of acute psychiatric patients

Workshop

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Accurate assessment of the risk of violent behaviour is equally important and complex both at the time of psychiatric hospital admission and at the time of discharge. The failure of unaided clinical judgments in assessing violence risk has led to considerable research attention on development of tools to improve decision making about patients' potential for violence. Violence risk screening procedures are used to detect who should or should not be selected for further risk assessment. Whilst risk assessment is best undertaken by using multiple sources of information, screening requires a simple, efficient and easily used method. Screens should also be population specific and able to identify low levels of risk. The V-RISK-10 was developed to meet these demands.

In this workshop we will first give an introduction of the V-RISK-10 as a potential violence risk screening tool. The V-RISK-10 is a structured clinical screen with historical, clinical and future risk assessment items: 1: Previous and/or current violence, 2: Previous and/or current threats (verbal/physical), 3: Previous and/or current substance abuse, 4: Previous and/or current major mental illness, 5: Personality disorder, 6: Lack of insight into illness and/or behaviour, 7: Suspiciousness, 8: Lack of empathy, 9: Unrealistic planning, 10: Exposure to future stress situations. There is a brief scoring instruction guide that accompanies each item in the scoring form. The individual item is scored on a 3-point scale: 0 = No: The item does definitely not apply; 1 = Maybe/moderate: The item is possibly or to a limited extent present; 2 = Yes: The item is definitely present. After the scoring of the 10 items is completed, the clinician is requested to select one of the following three clinical consequences of the assessment: (1) no further risk assessment recommended, (2) further violence risk assessment recommended, and (3) implementation of immediate risk management measures recommended.

After this introduction we will present and discuss findings from a naturalistic study of the predictive validity of the V-RISK-10: 1) in the intra-institutional context of two acute psychiatric wards (N=1017 acute psychiatric inpatients), 2) three and 12 months after discharge from these wards (N=381 patients), and 3) a naturalistic test of the inter-rater reliability of the screen (N=25 clinicians and 73 patients).

Risk assessment scores on the V-RISK-10 at admission and discharge, respectively, were compared to violent behaviour (physical threats, physical assaults, or both) that actually occurred in both inpatient and post-release community follow-up periods. Episodes of inpatient violence were registered prospectively by the nursing staff. The combined base rate (any violence) for physical threats and assaults was 9%. The predictive validity test of the screen yielded a large ROC-AUC value for any violence. The validation of V-RISK-10 assessment concerning occurred violence after discharge involved 381 patients who were followed up in the departments' outpatient clinics. Violence after discharge was recorded at 3-month intervals during a 1-year outpatient follow-up period and yielded an accumulated base rate of 26 % for any violence. An optimal V-RISK-10

cut-off score yielded large ROC-AUCs for any violence after 3 months and a medium value after 12 months. In the reliability test every patient (N=63) was scored independently by two clinicians (N=25). The clinicians volunteered to participate and patient recruitment was based on the natural patient flow and the natural distribution of patients with the clinicians that participated in the study. This procedure resulted in a total of 49 different pairs of raters. The average measures intraclass correlation coefficient (ICC) of V-RISK-10 was high. In sum, the initial tests indicate that the V-RISK-10 is a valid and reliable screen and that it is both easy-to use and time-saving.

In addition to a general discussion of the clinical use and feasibility of the V-RISK-10 we would like to address basic questions related to risk assessment in acute psychiatry, such as:

- Is it ethically acceptable to use a screen if it results in detaining patients for further risk assessment that eventually turn out to not pose a risk of violence?
- What would be the acceptable maximum number of actually non-violent patients to be detained for identifying one patient with actual risk of violence?

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Future time orientation and temperaments: Exploration of their relationship to primary and secondary psychopathy

Poster

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Recently considerable attention have focused on how certain temperamental features related to the neural circuits (i.e., Gray's Behavioral Activation and Behavioral Inhibition Systems) presumed to modulate self-control can either enhance or reduce a child's risk for various forms of antisocial features (cf. Lykken, 1995). With regard to maladaptive behavior that is antisocial or impulsive in nature, a central approach is that temperamental factors related to disinhibition underlie and drive behavioral manifestations. Psychopathy is an prototypical example of a clinical syndrome that have disinhibited behavior as a prominent feature (Wallace & Newman, 2008). Gray's reinforcement sensitivity theory has figured appreciably to explain the disinhibition in externalizing disorders (cf. Fowles, 1987). A central hypothesis in this theory is that antisocial behavior would be most severe and persistent in individuals who combine an excessive incentive drive (high sensitivity in the behavioral approach system; BAS) with deficient inhibitory control or low awareness of potentially dangerous situations (low sensitivity in the behavioral inhibition system; BIS). However, different strands of thoughts have considered more elaborated cognitive functions as the child's time conception or future orientation as tapping the ability to delay of gratification (cf. Levine & Spivak, 1959). According to Gjesme's theory of future time orientation (Gjesme, 1979) a foreshortened sense of the future is one of the factors that are associated to an inability to cope with environmental frustrations that result from situations that require postponement of gratification. The latter is, however, certainly not a new direction. According to some of the classical approaches to social learning theory, delinquents (as compared to non-delinquents) are insufficiently socialized with regard to time-specific norms and values (Trommsdorff & Lamm, 1980). Thus, they fail to develop the ability to control their impulses and to differentiate and integrate temporal systems; their future time orientation is less extended and their actions less future-oriented (cf. Stein, Sarbin & Kulik, 1968).

The participants in this study are hundred and fifty-eight adolescents, consisting of a target group of 79 adolescents who have a defined behavioral problem, and a matched referential group of 79 adolescents who do not have any behavioral problems. The two groups constituted two independent samples. Therefore, the Mann-Whitney U test was appropriate for analyzing the data. The data was further examined by correlation (Pearson's r) and hierarchical multiple regression.

The results suggest that attributes related to primary psychopathy are associated with behavioral inhibition insensitivity, behavioral approach reactivity and low future time orientation. Moreover, attributes related to secondary psychopathy is related to an overactive behavioral approach system and low future time orientation and are positively associated with dysregulation of negative affect. Robust positive associations for behavioral approach reactivity and low future time orientation with primary and secondary psychopathy suggests that high behavioral approach/low future time orientation may represent a common core that cuts across the two factors of psychopathy.

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Neuropsychological deficits in violent schizophrenia patients

Poster

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Objective

In this study we comparatively investigated certain neuro-cognitive functions of schizophrenia patients who have committed a crime against a human being leading to death or severe injury.

Method

The Violent Schizophrenia group comprised of 22 male inpatients which satisfied the defined criteria of seriously injuring or leading to death of a person upon attack for inclusion in this study. The non-violent schizophrenia group comprised of 22 male patients who to date have exhibited no violence against humans. Also the healthy control group was comprised of 22 healthy male individuals with no psychiatric disease. The Positive and Negative Syndrome Scale was utilised to determine the clinical states of the patients. Both the patient and control groups were subjected to the Wisconsin Card Sorting Test, STROOP Color-Word Interference Test and the Continuous Performance Test seriatim.

Results

We observed that violent schizophrenia group patients performed worse than non violent schizophrenia group patients on the Continuous Performance Test reaction time, STROOP test 3 and 4. According to these results, in all statistically significant differences we observed, the disease (schizophrenia) plays an obvious role. Moreover, the illness also plays a role in the differences we have seen in CPT reaction time and STROOP tests 3 and 4.

Conclusions

In terms of executive functions, disinhibition and attention functions all schizophrenia patients performed worse than healthy controls. However, violent schizophrenia group patients also exhibit poorer performance in attention functions in comparison to nonviolent schizophrenia patients.

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Occurrence of aggressive and violent attacks on the psychiatric emergency wards in Hungary

Poster

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Background

Despite the fact that in the last decades several studies have provided evidence about a relationship between mental disorder and violence, as of yet it has been a neglected area of research in Hungary.

Goals

The objective of our study was twofold: 1) to determine the characteristics of violent and aggressive patients and compare our results to those from other countries; 2) to examine how adequate management of aggression can reduce its occurrence.

Method

Data was collected prospectively from four different inpatient wards, in three different regions of Hungary according to a case-control design. Patients who commit any forms of violent acts were rated on the Modified Overt Aggression Scale and thus selected for the study. We compared them to non-aggressive control patients, matched for age, gender and education. We excluded patients under the age of 18 years or with an organic psycho-syndrome. Diagnostic classification was based on DSM-IV, according to Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-I). To determine the psychopathological, psychological and demographic factors related to violent behaviour we used a semi-structured interview, Positive and Negative Syndrome Scale (PANSS), Structured Clinical Interview for DSM-IV Axis II Disorders (SCID-II) and the Buss-Perry Aggression Questionnaire. Also we are planning to conduct neuropsychological tests, such as Continuous Performance Test (CPT) and Dice test to assess impulsiveness and risk taking behaviour in our patients. To evaluate how the management of aggression and the attitude of patients and staff about violent behaviour influence aggressive incidents, we used Duxbury's Management of Aggression and Violence Attitude Scale.

Conclusion

To our knowledge this is the first study in our country that aims to detect and describe aggressive incidents on different adult psychiatric wards. Our intention is to open a new field in Hungarian psychiatric research by estimating the frequency of aggressive incidents and identifying main risk factors.

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Detached Concern of nursing staff to forensic patients in perspective of risk management

Paper

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Objective

In the literature there is an increasing attention of staffs' attitude towards inpatient aggression. Inpatient aggression is related to the interaction between nurses and patients. Detached concern is defined as the ability of staff to neutralize the emotional appeal of patients by a mentally balance in nearness-distance to patients. More specifically detached concern could be explained that the staff has to neutralize the emotional appeal of patients by an attitude of objectivity and at the same time show emotional involvement in which cynical and distant reactions are avoided.

This paper addresses the measure of detached concern of forensic mental health nurses staff who applied risk management by means of the Early Recognition Method (ERM) in a maximum security forensic hospital. In applying ERM, early signs of risk are detected and evaluated between staff and patients. The results of the study on ERM showed a significant decrease of inpatient incidents. The application of ERM, a decrease of incidents, as well as the degree of detached-concern of staff towards their patients, were expected to be interrelated. In this paper the focus is on the detached concern of the forensic mental health nurses who applied ERM

Method

Aim of this study was to assess the degree of detached concern of nurses who worked in a forensic hospital in The Netherlands. For this purpose nurses filled in the Patient Contact Questionnaire, measuring detached-concern. PCQ was applied in a 'delayed implementation design'. One hundred sixty six nursing staff members filled in the PCQ. Studied was detached concern in the following sub-group nurses: nurses with medium and high education levels, nurses who had professional experience with forensic patients for 0-1 year, 2-5 years and more than 5 years and staff working with patients with personality disorder and those working with patients with schizophrenia. The scores on the PCQ were tested by means of the Wilcoxon signed rank test.

Results

Results show that the baseline scores of male nurses indicated significantly higher levels of concern than those of female nurses. Also, more experienced nurses scored significantly higher with regard to concern than less experienced nurses. When comparing the scores before and after applying ERM no significant differences were found. However, the application of the PCQ could contribute to a better understanding of the interaction between nurses and their patients.

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Promoting Positive Attitudes in PMVA Training

Workshop

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Keywords: Service users, physical intervention training, control and restraint

Introduction and background

Physical Interventions have historically and consistently presented ethical dilemmas and legal concerns for clinicians. The safe management of violent, aggressive and challenging behaviours sometimes escalates to the point of requiring physical intervention. These methods of physical intervention can often contribute to the service user experiencing trauma which can slow the recovery process considerably. So how can practitioners be equipped to balance safety and best practice therapy when faced with challenging behaviour that presents a real and immediate threat to the safety of service user, staff and others?

The delivery of training in physical intervention is clearly key, and it is essential that areas beyond skills and knowledge are addressed in a meaningful way. Since English law makes reference to “honestly held belief”, there must be an underlining component of attitudinal learning incorporated into physical intervention training. The author considers it to be highly significant that such attitudinal learning has been established within Oxfordshire and Buckinghamshire Mental Health Partnership Trust in the UK. This has progressed from a pilot course to a key component of routine training that has been established and welcomed by trainers and participants alike. Attitudes are not so transparent and cannot be easily measured or taught, unlike an identified skill competency level or knowledge that can be tested in a variety of ways. So how can the shaping of cultural and individual appropriate attitudes be achieved?

The main workshop (methods – results)

Understanding of physical intervention through the perceptions of the service user gives an unique insight that promotes a greater depth of understanding of the dynamics in a restraint setting, and results in a more constructive and empathic approach. This in turn reduces the trauma experienced from being physically restrained and maintains, builds or starts a constructive therapeutic relationship with the service user.

Over the last 10 months the author has presented this attitudinal module in the initial training courses as well as in the yearly refresher courses, with a view to ensuring that every practitioner within the OBMH has this input. The training module is split into two components with approximately half an hour to describe the details of the author’s own experience of physical intervention, then opening up the session for any questions from the participants. Through giving a first hand account of not only how it feels to be physically restrained, but how the situation and events were interpreted by someone who was unwell, practitioners have been given an insider’s perspective. Teaching points on good practice are more powerfully expressed and readily received by practitioners from someone who has been through the experience and is open and willing to discuss the subject. Some personal experiences (as well as those of others with whom I have interacted) of restraint and related teaching points are:

Teaching point: Clinicians are only human and carry prejudgements and prejudice which when mixed with feelings of fear, anxiety or even excitement can influence the actual level of force required. A self fulfilling prophecy is a familiar concept alongside attribution theory. Loaded words or phrases as well as the concept of Chinese whispers, can heighten anxiety and adrenaline even before arriving to the scene of the need. This in turn heightens the importance of taking time to gain and pass on accurate information and identify what resources are necessary to safely manage the incident.

Personal Experience: What words were used to describe the situation in the call for assistance? Where words like “tall, large, male, banging on doors, running loose in hospital” were used? What thoughts went through the minds of those practitioners responding? One of the doors I knocked on was the person who was to be my psychiatrist, and his comment a year after the event was I knocked on his door and politely asked if he could help me.

Teaching Point: A human’s natural and instinctive reaction to pain is to pull away. If this reaction is misinterpreted by the practitioner as resistance, more pressure is applied, escalating the situation and creating a downwards spiral, ultimately increasing the likelihood of rapid tranquillisation. This prolongs the period of the physical intervention, increasing the risk of positional asphyxia. This can also result in the possibility of retribution or predatory aggression behaviour in the future.

Personal experience: the practitioner on my left hand, continually applied flexion throughout the restraint, resulting in me beginning afraid my wrist would be broken. Once I had been tranquillised my wrist went numb and could no longer feel the pain.

Teaching Point: It is essential to assess situations accurately and evaluate the level of force used, including pain based a technique, which is ethically and legally justified - going through a process of de-escalation, and only resorting to physical intervention or force when it is actually required.

Personal Experience: Although I was clearly unwell at the time, I had good insight and was looking for help, rather than the team going straight into restraint; I believe any attempt of de-escalation would have proved successful.

Teaching Point: Verbal communication throughout the restraint process with the service user is a key element of the de-escalation and management procedure. The volume and voice intonation of this communication is critical. Shouting at the service user can trigger or heighten their paranoia and fight or flight reaction (regardless of whether the service user is shouting).

Personal Experience: Had the person on my left responded to me, and not applied the flexion so vigorously the restraint would not have lasted so long and there would have been no need for rapid tranquillisation. Having a 3/5 person team rushing felt very threatening quite apart from my mental health issues making things harder.

Teaching Point: The importance of a thorough and effective de-briefing of the service user, the aim to enable the service to be able to understand and retain information so as to actively reduce trauma and prevent reoccurrences of violence and aggression. Consideration also needs to be given to the affects of a physical intervention event on witnesses of de-briefing is that of witnesses. They too may need a debriefing opportunity.

Personal Experience: As far as I am aware I was never de-briefed, Apart from a few flash backs I do not remember the 3 days after falling asleep after being tranquillised, and it took another 4 days to begin to return to being able to remember events on a hourly/daily basis (so if I was

de-briefed I do not remember it happening). While I was on the first ward, I witnessed other service users being restrained which had an effect on me.

Teaching Point: Lastly, perhaps most importantly, physical intervention can be the initiation point of the therapeutic relationship, and need not be the death of an existing therapeutic relationship, it can be maintained or even have a positive effect.

Personal Experience: The person on my right was very different, had good technique and was responsive. Four weeks after the restraint I was being transferred to a new ward, an anxious time. However one of the first staff members I met on the new ward was the person on my right, just seeing them resulted in my feeling more secure and settled about being on the new ward, although we had not seen or communicated apart from four weeks earlier in the restraint situation.

Feedback from training course participants

After every session feedback sheets are filled out. The following is just a few quotes from what people have anonymously written about the session:

- “Hugely important to appreciate patient perspective, very useful to understand the long-term impact on the patient and family. It is more meaningful coming from a patient who has experienced restraint than a trainer who has not.”
- “Gave a very honest and real account of being restrained made me really appreciate the need for clear communication both within the team and with the patient.”
- “Made the experience very real and really makes you consider the power you have with the use of pain compliance and how much effect this can have on an individual.”
- “It’s really good to hear about restraint first hand to know that actually it can be relatively positive and not jeopardise rapport and actually aid it.”
- “Lets have more session like this - it gives a whole new perspective.”
- “Full of reality, a worthy listen, very good helped me reflect on my practice.
- “Listening to Paul’s account of his experience of restraint and the affects this had on his aftercare was illuminating. It highlighted the need for communication and empathy and not allowing first impressions to control judgement.”
- “Paul’s views were very helpful – showing aspects that could not be appreciated without having the experience personally.”
- “Very interesting to hear Paul’s view of restraint, I will definitely think a lot more about client’s point of view.”
- “Very relevant to the PMVA training and also to my practise as a registered nurse and how this impacts on patients. Paul was very open and clear about his experience and therefore very effective.”
- “It makes PMVA more tangible in practice and certainly brings to the fore patient/client issues which is where they should be!”
- “Please bring this session on to the wards. It will be most helpful.”
- “Thank you very much. Please continue to do this session because it is so helpful and relevant.”
- “It was very informative, a lot of time could be given.”
- “Please continue with your input, it is AS valuable as techniques learned on this course.”
- “The message should get across to every service provider in the service.”

Discussion and conclusion

Training of this kind can only be brought out and delivered in a powerful way through service users’ involvement within PMVA training programme. It is recognised that each service user will have their own personal experience and insight. In view of this the author is progressively learning

from and incorporating the experience of others. Understandably due to traumatic experiences not all service users would be able to or willing to talk about their personal experience, but this also points to the need for a change in physical intervention training and resulting practice.

It is clear that someone with first hand experience of these matters can more powerfully express the key issues, and gain respect of practitioners on the training courses. Not only does it make service user input essential, highlighting both good and bad practice leading up to and within a restraint situation, but it also points towards the obvious advantages of having those with service user experience being employed as PMVA trainers; as well as the de-briefing process of staff and service users.

Therefore the significant chasm between the service user experience and the delivery of training in physical intervention can be bridged by involving service users at particular points in training timetables. This is evidenced based practice and attitudinal teaching at its very best.

Acknowledgements

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Assessing risk of future violence in inpatients using the Classification of Violence Risk (COVR)

Poster

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Background

Instruments are needed to help clinicians make decisions about a patient's risk of future violence in order to manage the future risk, allocate resources and protect others.

Aims

To test the efficacy of the Classification of Violence Risk (COVR) in a UK sample of forensic psychiatric inpatients.

Method

A fully prospective study of 52 patients within four medium secure units over a period of 6 months. Outcome behaviours were coded from nursing records.

Results

COVR was a good predictor of a variety of institutional behaviours from verbal aggression and actual physical harm to others. Its predictive efficacy was similar to another well-established violence risk prediction instrument (VRAG).

Conclusions

The results provide the first independent validation of the COVR, and provide an evidence base for the use of the COVR to predict harmful behaviour in forensic inpatient settings, and for use in the UK.

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Challenges in research and practice development in acute psychiatric wards, the process of implementation of short term risk assessment

Workshop

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Introduction

Psychiatric nurses are frontline officers in the recognition of alarming behavioral problems of patients in severe distress. However several validated short term risk assessment scales are available nurses rarely seem to apply those support tools in daily practice (1). Therefore the transparency of clinical decisions made by nurses involved in the care of acutely admitted patients can be questioned. Several studies indicate that frequent use of short term structured risk assessment tools can reduce the number of false negative and false positive risk appraisal in high risk environment (2). Therefore all nurses at two experimental wards at an urban psychiatric hospital were trained to apply a structured short risk assessment model (CrisisMonitor) in daily practice. Whereas two control wards provided care as usual. The aim of this workshop is to focus on the impeding and stimulating factors in the process of getting psychiatric nurses involved in research activities and systematic reflections on preferences in crisis interventions. In addition to this some case vignettes are used to demonstrate how the CrisisMonitor model can apply in clinical practice.

Intervention

All nurses were trained to work with a set of complementary validated observational instruments (CrisisMonitor) constructed for crisis monitoring in acute daily practice. For this purpose the Broset Violent Checklist (3), Kennedy-Axis V (4), Brief Psychiatric Rating Scale(5), Scale of Dangerousness (6), and the Social Dysfunctioning and Aggression Scale (7) were used. The hypothesis was that this Crisis Monitor model may improve the quality in decision-making on the proportional application of coercive interventions in acute settings.

Implementation approach

Testing the application of the CrisisMonitor in clinical practice seemed to be a double loop innovation. In the experimental wards several challenges had to be faced. From this perspective six major components (8) were relevant; a.) consistent leadership in research and ethics, b.) utilization of research based instruments, c.) reflective practice d.) structured risk reasoning, e.) learning from post incident evaluations. f.) dialogue with service users. Seclusion and restraint reduction programs in the USA indicate long term and time consuming processes (8). In this workshop delegates are challenged to reflect on opportunities and pitfalls in similar types of projects. Finally the lessons learned from the CrisisMonitor project will be discussed.

Conclusion

Implementing structured risk assessment in day to day practice is feasible, nurses can play a key role in data-collecting and practice development. However consistent application of multi-level innovation strategies in a longitudinal framework is recommended (8).

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From guidelines and directions to daily practice: A process orientated method for the prevention of violence

Poster

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Introduction

The intention with this practice project is to examine, how the current applicable guidelines and directions are used in the prevention of violence. At the medical record audit (method of self regulation) for February 2009; the conclusion showed: Risk assessment 12 out of 14 possible patients, violence prevention files 7 out of 9 and follow up interviews 1 out of 7. All patients were given a screening level, but this did not correspond to the patient's actual state. Five patients were not assessed. Seventeen forcible physical restraints were performed in 2007, whilst in 2008 the number was 96.

The problem is also that a dramatic increase has occurred and the current guidelines and directions do not function as intended. This requires that we examine this in more detail, as we suspect that: The violence prevention file is not being used systematically, follow up interviews after restraint are not performed consistently, and assessment of screening levels is not kept up to date

The purpose of the project

That the number of violent episodes are reduced, if the tools are used consistently.

Study aims

- To examine the occurrence of forcible physical restraints before and after the start of the project via SEI (the Danish National Board of Health electronic incident reporting) retrieval
- To intervene in relation to risk assessment, use of violence prevention files, assessment of the screening level and the follow up interview after forcible physical restraint
- To evaluate the interventions with a view to seeing whether the number of forcible physical restraints have fallen.

Method

Thus there is mention of an intervention study where we compare two time periods of equal length (6 months). On the basis of the SEI retrieval the number of forcible physical restraints which were performed from 1st January, up to and including June 2009, and after the completion of the project on 1st September 2009, up to and including February 2010 will be examined. The pilot project starts on 15th September 2009 and finishes on 15th March 2010.

Emphasis on the tools will be increased through training in October/November 2009 in these subjects:

- Information about the risk assessment

- The setting up and use of electronic violence prevention files
- Information about how a potentially violent patient is given a screening level
- Information about how the follow up interview is held and is used as a link in violence prevention

Every 14th day the development nurse carries out an audit about whether the use of the tools are documented in the EPJ of the patients included. On the basis of the audit results the staff members are offered specific help to carry out the process. All audit results are discussed at a monthly staff meeting with one of the three project managers.

The method includes:

- SEI retrieval on forcible physical restraints
- Introduction
- Training and guidance (Him and Hippe 2003)
- Audit (Blomhøj & Mainz 2000)
- Questionnaire survey (NHS, Modernisation Agency; 2004))

The measurement tool originates from 'The Sustainability Model' (NHS, Modernisation Agency; 2004). At a staff meeting in the spring of 2009 the staff will be informed about the project.

Data

The study is being conducted in a forensic psychiatry department with 19 beds. Inclusion criteria: Patients with the double diagnosis of F 20 and F 10-19 together with F 60 and F 10-19 admitted in a closed department. In violence prevention four guidelines and directions are used.

Results

All permanently employed staff in the department will receive a questionnaire mid January as well as in mid July 2010. Preliminary results are expected to be available in October 2009. Subsequently, the project will be entered into the psychiatry research day 2010 with a view to presenting the results.

- The intention of the project is that the patients, with the help of the staff, become more active in coping with aggression and violence.
- Optimised and consistent use of guidelines and directions can contribute to the specialist argumentation so proposals for interventions are professionally supported to a greater extent.
- As an indirect consequence it is expected that the department becomes a safer workplace for the staff.

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Horizontal Violence among Practicing Nurses

Poster

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Introduction and purpose of the study

Horizontal violence among nurses has become a topic of recent interest. An exhaustive review of extant nursing research reveals several contemporary studies that point to a variety of causes. Stressful working conditions, lower pay, competitive and hierarchical environments are implicated as contributing factors.

Methods

In an effort to understand the epidemiology of horizontal violence in the Midwest, baccalaureate prepared registered nurses attending graduate school are invited to describe incidents of horizontal violence in the workplace.

Findings and Conclusions

The present study will highlight results and implications for practicing nurses and other health professionals.

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Risk assessment in psychiatry – a new approach (EuRAX). Organizing information according to an Integrated Criminological Theory seems to work

Paper

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Background

Risk assessment and management is a necessary and integrated part of clinical work. Methods developed in the legal context are alien to clinical work but have been used to an increasing degree in such contexts, partly because of political pressure. Recent studies question the use of individual risk predictions in legal contexts and thereby also in the clinic. In general, traditional clinical assessment methods can be improved by using structured instruments. With respect to risk management, well-established criminological theory is worth testing. EuRAX is a new comprehensive and structured clinical risk management tool which integrates concepts from important criminological theories.

Method

A stratified selection of 139 forensic psychiatric patients was scored according to EuRAX.

Results

Scoring was rather problem-free given the rich documentation in Swedish forensic case history files. Construct and discriminant validity was surprisingly good. The patients displayed a wide array of problems assumed to be associated with criminal propensity. The concepts of “social bonds” and “lack of self-control”, as operationalized in EuRAX, displayed highly meaningful and discriminant patterns with respect to the other EuRAX variables, in contrast to conventional risk indices.

Conclusions

The use of well-established high-order criminological concepts, rated in a structured way, seems to provide important information relevant to the task of clinical risk management.

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The comprehensive assessment of psychopathic personality: A new measure of the dynamic traits of psychopathy

Paper

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Psychopathic personality is a critical construct in forensic practice. The Dangerous and Severe Personality Disorder (DSPD) project within England and Wales requires a measure that can be used to assess the stability and change in psychopathic personality in response to intervention. This paper will describe the development of a clinical model of psychopathy, the Comprehensive Assessment of Psychopathic Personality (CAPP), and a rating scale based on the CAPP model intended for use in institutional settings that is potentially sensitive to change over time (the CAPP-IRS). The paper will begin with an overview of the limitations of existing models and measures of psychopathy. A major limitation of existing models and measures is their incomplete coverage of the construct domain and their insensitivity to change over time. The requirements for developing a comprehensive, change-sensitive measure of psychopathy will be emphasised. The paper will then describe the development of the CAPP. The first step involved the systematic review of the clinical and theoretical literatures on psychopathy and others personality disorders. The second step involved interviews with expert clinicians and important theorists in Europe and North America. The third step involved the rational identification and definition of symptoms using a lexical approach. The resulting CAPP model comprises 33 symptoms of psychopathy that reflect six broad domains of functioning. The research that attempts to validate the clinical model, including translations into languages other than English, will be reviewed. The final and ongoing step has been the development of assessment tools intended to evaluate the CAPP model in clients suspected of having psychopathic traits. The format and administration of the CAPP-IRS, which is scored on the basis of a semi-structured clinical interview, structured observations, and a review of institutional records, will then be described. A brief description of the validation research on the CAPP-IRS, currently in progress, will conclude the paper.

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Implementation of an aggression risk assessment and flagging system in an integrated multilevel health authority

Paper

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Keywords: aggression, violence, risk assessment, flagging system, policy implementation

Background

Approximately 40% of all violence-related claims come from health care workers, although these workers make up only 11% of the workforce in British Columbia (WorkSafeBC, 2009). In the Fraser Health Authority (FHA) alone, approximately 10% of all workplace related injuries in 2008 were related to workplace violence (FHA, 2009).

In 2005, FHA's Workplace Health Prevention and Management of Aggressive Behaviour (PMAB) program began literature reviews and communications with other health providers across North America searching for best practices for patient aggression flagging systems. This led to close collaboration with Vancouver Coastal Health's (VCH) Workplace Violence Prevention program. Results from the VCH evaluation of their flagging system showed their system tools for identifying risk for violence correctly identified real or eventual risk 71% of the time with high specificity of 94%.

FHA's PMAB program adapted and further developed a system for flagging patients at risk for aggressive behaviour. The ALERT (Aggression Likely Employees Respond Thoughtfully) system incorporates an aggression risk assessment tool, electronic and non-electronic flagging, and flagging review processes to communicate risk to all workers. In August, 2008, the FHA, with support and funding from WorkSafeBC, began a comprehensive implementation process at two of its larger sites.

Objective

To provide an overview of the process, challenges and successes which have led to the implementation of a system for the designation, identification and review of patients at risk for aggressive behaviour within a health authority which oversees the operation of 12 acute care hospitals and 115 community based services, employs over 34000 staff, contractors, students and volunteers, and serves almost one third of the population of the Province of British Columbia.

Method

Pre-policy: This phase began in early 2005 with literature reviews and discussions with other acute hospitals across Canada, the United States and Australia looking for practices that may be in place for identifying patients who may pose a risk of aggression towards workers. Literature reviews also looked at risk assessment tools for aggression. The results of this phase of research showed that other than the rare site with department based informal communication structures for sharing of such risks, other than the Vancouver Coastal Health Authority, there really were no facilities found during this phase that had such a system in place. In fact, some of the hospitals expressed concern about the prospect of violating patient confidentiality by sharing such risks

with other staff and/or other area hospitals. In terms of risk assessment tools, literature reviews found that tools available were quite specific to a population, for example forensic psychiatry, and would not meet the general needs of a health authority with its diverse population being served.

The Vancouver Coastal Health Authority (VCH) was, during this time, in the process of their pilot implementation of an aggression risk flagging system and thus began the close collaboration with the lead for the development and implementation of the system in VCH.

The Fraser Health PMAB Program Consultant began developing a system that would meet the communication needs of workers in Fraser Health incorporating data systems already in place. Focus groups were held in all 3 regions within Fraser Health with between 30-50 representatives from different areas attending each meeting and providing feedback throughout the development process. With this came the development of the draft 'Designation, Identification and Review of Clients at Risk for Aggressive Behaviour' policy and procedure. This policy provides systemic and formal procedures for an electronic flagging process that has been available for use within the data systems in use in Fraser Health (Meditech Client Server and Meditech Magic) as well as the added layer of a visual communication process – purple dots and indicators - to ensure inclusion in the communication for all workers regardless of electronic access. The policy also initially included the required use of three policy forms; the first being a general risk profile which included numerous potential risks to staff safety including aggression, the second form, a risk assessment form for determining the designation of a flag for aggression for a client, and a third form being a form for the review of applied flags.

Pre-implementation

WorkSafe BC provided the Fraser Health's PMAB program with funding which has assisted with the pilot implementation at two sites. Planning began with a meeting with the larger site's health and safety committee from which a steering committee was assigned. Then, meetings with site leadership and educators, communications planning, and staff surveys followed soon after. A method of survey development and distribution based on a study by L.Thomas-Olson (FHA, 2008) was utilized and resulted in a survey rate of return of 40% including 100% return rates from 14 departments.

Implementation

ALERT system education sessions with varying delivery methods commenced in the fall of 2008. Education was delivered directly via numerous in-services, staff meetings, and during department shift change. Updates to the Nurse Educator groups (CRN, CNE, PCC) and to the site Leadership via email, during their monthly meetings and generally to all staff via the site email newsletter was frequent during the implementation. Policy forms were distributed and the official 'go live' date for the use of the policy and risk assessment tools was on February 1st, 2009. Following an ongoing communication, evaluation and feedback process, numerous improvements to the policy forms were made and trialled throughout the implementation period. The final process now includes the use of two tools, one required form which serves as a quick reference and assessment tool of risk to workers; the second, an aggression risk assessment form which is used when a client is deemed to meet criteria which indicate they may be at an increased risk for aggression towards workers. This form also includes a review process and a sample careplan with possible controls and interventions.

Evaluation

Random chart audits of almost 400 charts from 2006 to 2008 were conducted. These audits looked at the use of the electronic communication system and criteria used to flag patients pre-policy implementation. Incident reports for the same phase were also studied. Chart audits from 2006 showed only 19% of the client aggression-related incidents resulted in the designation of a client as posing a risk towards workers. In 2007 these same statistics decreased to only 11% of incidents

resulting in the communication of risk to workers. By 2008, education about the upcoming policy implementation had commenced (September 2008) and the communication of risk using the electronic flagging process had increased to 50%. Chart audits pre-policy implementation also showed that only 10% of flags applied were done so preventatively, with 89% of flags applied post-incident and post staff injury. Preliminary policy and chart audits for 2009 show that the appropriate use of the ALERT system has already more than tripled.

Departmental charts were randomly audited during the post-implementation phase to assess policy compliance and use. A less formal post-implementation survey was also conducted which showed a change in knowledge of the electronic flagging system amongst nurses from 37% pre-policy implementation and education, to 100% post policy implementation and education.

Summary

By including all levels of workers and management from policy development to implementation while allowing for ongoing feedback and communications, the process of implementation at the initial FHA sites has been well received and support for the implementation of a process promoting worker safety continues. Audits of pre-policy flagging of high risk patients showed sporadic flagging mainly in high risk areas as a post-incident reaction and process. Preliminary post-policy chart and departmental audits show a significant increase in flagging of patients at risk for aggressive behaviour both post-incident and preventatively based on the risk assessment tool implemented as part of the ALERT system. Patient flagging also expanded from being applied mostly in higher risk areas (emergency and psychiatry) to other departments and programs including outpatient services and long-term care.

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Decreasing Workplace Violence Means Increasing Workplace Safety Through Positive Behaviour Support

Workshop

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Keywords: positive behaviour supports, violence, collaborative problem solving

Introduction and background

The purpose of this workshop is to identify critical points in which violence in psychiatric settings becomes an outcome of situational variables and sequences of staff-patient interactions. Additionally, the authors distinguish between restitutive and restorative strategies that are based on very different approaches and philosophies toward educational and treatment milieus. Violence in settings that service patients/clients with psychiatric illnesses and developmental delays is disturbing and unacceptable. The variables governing violence are myriad and complex. Some of them defy prediction, but many can be traced to the culture of coercion that too often governs these settings. When violence happens as a result of a coercive milieu, it is unacceptable and it has attendant detrimental consequences (Lowe, et al., 2006). It is also antithetical to the idea of therapeutics itself. Such situations are those that are within the power of leaders and care providers to identify and which they are called upon to transform. Such efforts have a noble history.

The first documented use of a treatment philosophy employing non-coercive and humane measures in the modern psychiatric literature is exemplified by The York Retreat, an English Quaker community. The York Retreat was developed as a reaction against the callous treatment of the mentally ill during the 18th century (Digby, 1985) and it was built on benevolence, order and trust, and a minimal use of restraints.

In 1837, one of the first attempts to pioneer the principle of non-restraints in the U.K. was published by Robert Gardiner Hill (1857), a physician and superintendent of a hospital that treated individuals who were ill and prone to violent or self-injurious behaviour. Gardiner-Hill found that when coercive techniques, such as seclusion and restraint were abolished in favor of non-coercive approaches, a very different type of treatment setting emerged. The wards became quiet and orderly, people started attending better to their personal hygiene and there was a precipitous decline in the frequency and intensity of violence of any sort. There were no suicides and people who were expected to stay in the hospital long-term were able to recover and be discharged.

Over the past dozen or so years an approach to services known as positive behaviour support (PBS) a high visibility movement in the same tradition has emerged similarly from the controversies surrounding the use of aversive measures characterizing many programs for educating, training, and treating persons with developmental disabilities and psychiatric conditions (Horner, 2000, Horner et al, 1990). The PBS movement has emphasized a set of values in its approach to service provision. These include commitment to respect for the individual, meaningful outcomes, dignity, person centered planning, stakeholder participation, and normalization among others.

PBS is predicated on the idea that a supportive environment driven by these values should be the focus of professionals, moving away from a person driven problem to a context driven problem approach.

One of the principles of PBS is that practitioners would find ways to move away from the use of coercion in providing in the implementation of behavioural interventions (Evertsen & Weinstein, 2006). This move away from coercive practices translates into focusing on changing antecedent interventions to support people and not just address their behavioural issues through manipulation of consequences. Although there is an ample body of knowledge demonstrating the ineffectiveness of punishment at changing behaviour in the long term, the use of punishment in behavioural interventions reflects the gap between research and practice (NDRN, 2009).

The application of the principles of PBS in educational and psychiatric settings requires that practitioners use a “restitutional model” rather than a “retributive model” in the application of consequences for behaviour. Consequences are designed to inform the individual about the effectiveness of their behaviour in the acquisition of or escape from their antecedent (Bowen, 2008). Ideally, all consequences help people to change their behaviour in the future. This understanding of behavioural terms and their applications in mental health settings require a distinct shift from retributive punishment that says people must pay for what they did to a restorative consequence which identifies ways in which the person can learn from the past, change their behaviour in the future, and restore the physical and social environments to build healthy relationships in the workplace.

Such distinctions become important when discussing children’s psychiatric and educational settings. In contrast to the adult world in which patients are coaxed into accepting clinical recommendations about how they should be cared for, in the U.S., children usually are not able to choose. They are forced to accept being pushed through programs that are often alienating and in which they feel powerless. Too often children’s treatment settings are characterized by an authoritarian model which is retributive. Participation in any type of program is mandated, requires no choice on the part of the child, and participation itself has become a means of enforcing their compliance rather than engaging them in any form of decision making (LeFrancois, 2008).

One type of programming that represents a retributive model is frequently employed in U.S. residential and acute psychiatric care settings is known as a “point and level” system. Practitioners know very little about level systems other than descriptions of them found in the literature and they represent programming that is based on tradition and cultural transmission rather than empirics (VanderVen, 2000, 1995; Farrell, Smith, & Brown, 1998). In theory residents/students in a level system learn appropriate behaviour through a series of steps for which points are assigned and work their way through levels that have increasing expectations and increasing privileges. In practice this type of programming is regimented, inflexible, often counterproductive, and sometimes destructive. Staff members focus on giving and taking away points, often letting caprice rule their judgments, thereby creating a coercive, punitive or retributive culture. Unacceptable behaviour is not seen as a “teachable moment” but as a moment to be (sic) consequence (punished). Staff and patients/client interactions tend to focus on awarding or taking away of points. The discourse converges on blame rather than mutual engagement in the therapeutic process (Benson, et al., 2003).

In contrast, restitutional models of programming, move toward a more positive approach toward unit programming, and research has validated their efficacy. Three examples of these are The Sanctuary Model, the Collaborative Problem Solving Model, and the Response Abilities Pathways Model. A common theme of these models is that the focus on changing antecedent conditions to target behaviors. Addressing antecedents effectively undercuts potential power struggles and

avoids having to choose among several consequences that may in fact be maintaining the behavior in tandem (Conroy and Stichter, 2003).

The Sanctuary Model (Bloom, 2005) is based on the premise that many patients/clients in psychiatric settings are victims of abuse and trauma; seeing the world through the template of danger. It is comprehensive approach to developing a full system, trauma-sensitive culture in which psychological and social trauma can be addressed and resolved. The Sanctuary Model requires extensive leadership, staff and participant involvement at every level. By providing a comprehensive plan and process for creating a trauma-sensitive, democratic, nonviolent culture, the goals are to recognize and overcome the natural tendency of programs which serve traumatized participants becoming “crisis environments,” which risk of re-traumatizing participants.

The collaborative problem solving model (CPS) sets forth two major tenets: first, that children with maladaptive behaviours are best understood as the byproduct of lagging cognitive skills and that these challenges are best addressed by teaching children the skills they lack (Greene & Ablon, 2006). Hence, the model moves the discourse from such ideas as attention-seeking, manipulative, limit-testing, or poor motivation to difficulties to be overcome. It also focuses on teaching skills and way from reward and punishment and imposition of adult will.

The Response Abilities Pathway (RAP) model is a practical, non-punitive, strength-based curriculum that draws its approach from research and best practices in positive behavior support. Its foci include connection to others for support, clarifying challenging problems, and restoring the bonds of respect. Similar to The Sanctuary Model, RAP recognizes that challenging behaviors and maladaptive coping are rooted in past traumas. Clients/patients are encouraged to take responsibility for their actions and taught to recognize how their past behaviors were not effective in goal attainment (Forthun & McCombie, 2007). Method: In this interactive workshop 5 scenarios are presented for discussion. The goals are for attendees to identify the points at which power struggles develop and escalate to violence and to discuss measures that might have prevented an inevitable “meltdown” in which the child (and perhaps staff members) become incoherent and irrational.

Conclusion

Research suggests that children in psychiatric settings are often victims of trauma and themselves well versed in the art of coercion, and they elicit coercion from staff who are concerned more about maintaining safety and order. Studies also suggest that such coercive rule driven systems are associated with increases in negative behaviours, with patients become the victims and perpetrators of the coercive systems in which they are supposed to be helped (Goren, Singh, Best). The counterproductiveness of ensuing practices, such as seclusion and restraint, that are the inevitable end result of coercive milieus (Garrison, et al., 1990; Natta, et al. 1990) pose a danger to staff and clients.

Prior efforts at decreasing workplace violence focused less on changing culture and more on simply eliminating coercive measures such as seclusion and restraint. Present efforts recognize that coercive processes are part of a culture in which coercion begets more coercion (Pollack, 2004). Power struggles constitute a conflict between two opposing forces. Within authoritarian milieus they are a result of a patient’s attempt to satisfy an unmet need. Children who feel a sense of power and control, are making progress toward their goals, are supported by their caregivers have avenues to share concerns, and are given choices and not backed into corners by arbitrary rules and harsh directives and they will be much less likely to feel the need to engage in a power struggle.

Positive behavior support methods that focus on changing antecedent conditions, using consequences to shape future behavior, and providing concrete information so that patients/clients have been reported to be successful in patient/clients learning more adaptive responses. Future research and program evaluation is needed to further refine, evaluate, and implement across a variety of educational, treatment, and corrective settings.

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Aggressive Behavior in Psychiatric Inpatients with a Psychotic Disorder: Prevalence and Intra-individual Risk Factors

Paper

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Keywords: Aggression; mental disorders; psychosis; schizophrenia

Introduction

According to a study by Link, Phelan, Bresnahan, Stueve, and Pescosolido (1999), over 60% of the general population believes that patients with schizophrenia are dangerous and violent. The relationship between aggressive behavior and mental illness has been studied extensively and epidemiologic studies indicate that there is indeed an association between the occurrence of mental disorder and aggression, especially among patients diagnosed with a psychotic disorder such as schizophrenia (Lindqvist & Allebeck, 1990; Hodgins, 1992; Wallace, Mullen, & Burgess, 1994). This relationship is even stronger when patients suffer from a substance use disorder (e.g., Räsänen, Tiihonen, Isohanni, Rantakallio, Lehtonen, & Moring, 1997). Despite the recognition of this high prevalence of aggression in psychotic populations, only few studies have focused on intra-individual determinants or mechanisms that might explain the nature of this behavior, such as the content of the psychotic experiences or the emotional reactions to these positive symptoms (e.g., anxiety and anger), which could lead to aggressive responses.

As acute psychosis is found to be a consistent risk factor for violent behavior and because violent behavior frequently occurs during an acute psychotic decompensation episode (Krakowski & Czobor, 1994), it may well be that specific psychotic symptoms trigger aggressive behavior in this patient population. Junginger (1996) described this aggressive behavior as psychotic action, which specifically refers to the extent to which behavior is consistent with the content or themes of delusions or hallucinations. For example, patients may hear voices that ask them to hit or kill someone or think that they are followed and threatened and therefore start a fight with the presumed perpetrator in order to defend themselves. In this context, Link and Stueve (1994) refer to delusional threat/control-override (TCO) symptoms, which specifically pertain to a patient's feeling that he or she is threatened by or losing control to an external force. Indeed, it has been shown that these symptoms play a significant role in the aggressive behavior of psychotic patients (but see Swanson, Borum, & Swartz, 1996; Walsh et al., 2004).

In an attempt to explain psychotic action, Junginger (1996) focused on the role of a disturbed mood and the experience of specific emotions in this context. Kennedy, Kemp, and Dyer (1992), for example, found that fear and anger were precursors for the assaultive behavior of patients with a delusional disorder. In another study by Buchanon et al. (1993), it was also noted that psychotic action was related to feelings of fear and anxiety. On the basis of these findings it can be assumed that affective reactions to positive symptoms may contribute to the phenomenon of aggressive behavior in psychotic patients. Thus, anxiety, triggered by suspiciousness or threat, could lead to a defensive, aggressive response towards the person who is believed to be involved in the threat, which is in keeping with the fight-flight theory as described by Cannon (1929). In a similar vein,

anger may also act as a mediating factor in the relationship between aggressive behavior and psychotic symptoms (Cornell, Peterson & Richards, 1999).

So far, it remains largely unknown which specific intra-individual factors contribute to aggressive behavior of patients diagnosed with a psychotic disorder and therefore more research on this issue is certainly necessary. The present study will focus on the relation between intra-individual factors, such as anxiety and anger, and the aggressive behavior of psychotic patients. A cross-sectional multicenter study was performed on acute wards in psychiatric hospitals in the Netherlands to test a model in which the content of psychotic symptoms (i.e., TCO symptoms), and the emotional reactions of anxiety and anger explain aggression in patients suffering from psychotic disorders.

Method

Participants were 106 psychiatric inpatients diagnosed with schizophrenia, schizoaffective disorder, delusional disorder, or psychotic disorder not otherwise specified, who were recruited at three psychiatric hospitals in the Netherlands. All male and female patients diagnosed with these disorders, aged between 18 and 50 years, and who were fluent in the Dutch language and in their first week of admission were included in this study. Participants were asked to participate in this study, on a voluntary basis, by verbal as well as written informed consent.

Measures used in this study were interviews, observational instruments, and self-report questionnaires. The Structured Clinical Interview for DSM-IV disorders was used to confirm patients' diagnosis and the Positive and Negative Syndrome Scale was employed to investigate negative as well as positive psychotic symptoms. Furthermore, the Social Dysfunction and Aggression Scale was used for observing patients' aggression towards the self (internal) and towards others (external) and patients completed several self-report questionnaires for measuring TCO symptoms, aggression, and emotional reactions such as anxiety and anger.

Preliminary results

A substantial proportion of the psychotic patients clearly displayed aggressive behavior when admitted to the psychiatric hospital. More precisely, of the 106 participants, 48.1% ($N = 51$) was aggressive towards others, 8.5% ($N = 9$) was aggressive towards the self, while 39.6% ($N = 42$) was non-aggressive.

Correlational analysis (see Table 1) yielded a correlation of .29 between the positive psychotic symptoms and observations of aggressive behavior. Of these positive symptoms, grandiosity, hostility, and excitement showed the strongest associations with observed aggression (r 's between .26 and .33). These correlations were most robust for external aggression (r 's between .27 and .36). Delusions in general showed a weak relation to aggression ($r = .18$) and suspiciousness and hallucinations showed no significant link with aggressive behavior (resp. r 's .07 and .06). No association was found between the negative symptoms and aggression ($r = -.03$).

Table 1. Correlations between various types of psychotic symptoms and aggressive behavior in patients with schizophrenia or another psychotic disorder

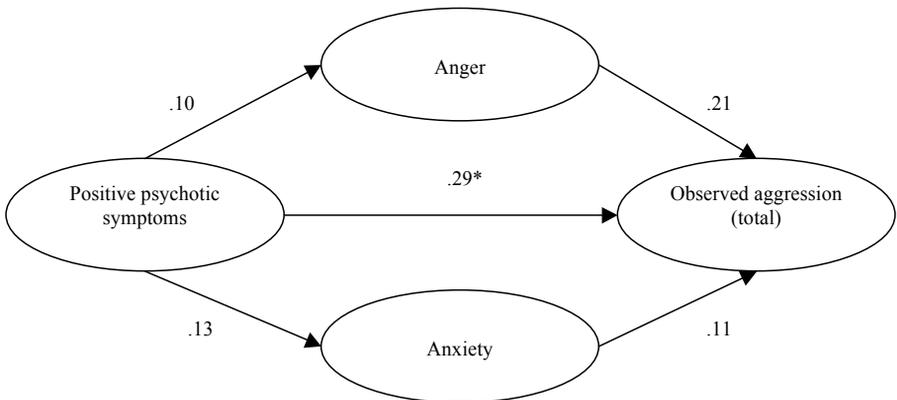
	Aggression (internal)	Aggression (external)	Aggression (total)
Positive symptoms	-.15	.33**	.29**
Delusions	-.08	.20*	.18
Conceptual disorganization	-.20*	.03	-.04
Hallucinatory behavior	.02	.03	.06
Excitement	.03	.27**	.26**
Grandiosity	-.20*	.36**	.33**
Suspiciousness/persecution	-.06	.10	.07
Hostility	-.09	.36**	.32**
Negative symptoms	.16	-.08	-.03

N = 101. * p < .05, ** p < .01

To test the hypothesized mediation effect of anger and anxiety in the relationship between positive psychotic symptoms and aggressive behavior, Baron and Kenny’s (1986) method for testing mediation effects was used. To demonstrate a mediation effect according to this approach, four conditions should be met: (1) the predictor variable (i.e., positive psychotic symptoms) should be significantly associated with the criterion variable (i.e., aggression), (2) the predictor variable should be significantly associated with the mediator (i.e., anxiety or anger), (3) the mediator should be significantly associated with the criterion variable, and (4) the impact of the predictor variable on the criterion variable should be significantly reduced or eliminated when controlling for the mediator.

As can be seen in Figure 1, the analysis indicated that the emotional reactions of anger or anxiety were not significant related to the predictor and criterion variables, which indicates that these variables did not act as a mediator in the hypothesized model.

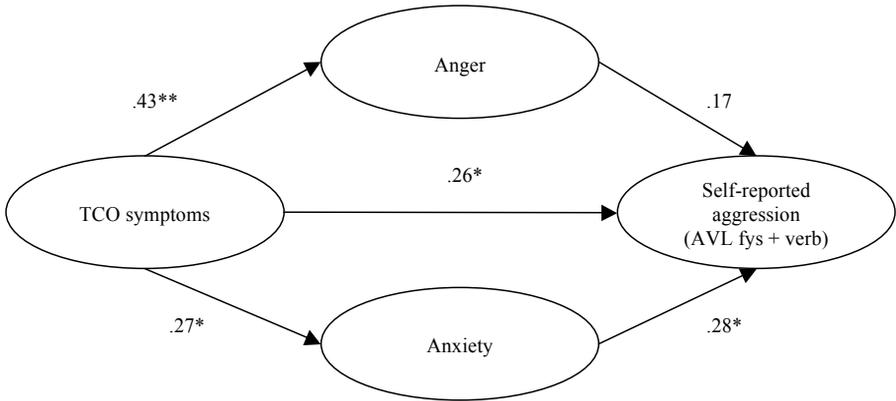
Figure 1. Hypothesized model in which anxiety and anger act as mediators in the relationship between positive psychotic symptoms and observed aggression. * p < .01



When specifically focused on self-reported threat/control-override (TCO) symptoms and self-reported aggressive behavior, stronger correlations were found (see Figure 2). As can be seen, for anxiety as a mediator, the first three conditions of the Baron and Kenny (1986) method were met: that is, the correlations among TCO symptoms, anxiety, and self-reported aggression were all positive and significant. A further regression analysis showed that the relationship between TCO symptoms and self-reported aggression ($\beta = .26$, $n = 83$, $t = 2.72$, $p < .01$) was reduced when anxiety was entered into the equation ($\beta = .19$, $n = 83$, $t = 1.97$, $p > .05$). A Sobel (1982) test indeed demonstrated that this mediation effect was close to significance ($Z = 1.62$, $p = .05$).

As there was no significant association between anger and self-reported aggression, which is considered as a prerequisite for a mediation effect according to Baron and Kenny (1986), no additional analyses were carried out to test whether anger acted as a mediator.

Figure 2. Hypothesized model in which anxiety and anger act as mediators in the relationship between TCO symptoms and self-reported aggression towards others. * $p < .05$, ** $p < .01$



Conclusion

In the present study, the prevalence of aggressive behavior and the mediating role of anger and anxiety on the link between psychotic symptoms and aggressive behavior was investigated in psychiatric inpatients who were diagnosed with a psychotic disorder. Although the data collection is still going on, preliminary analyses have already revealed some interesting findings.

Almost half of the patients who were admitted to an acute ward in a psychiatric hospital displayed, besides symptomatology, clear-cut aggressive behavior. Furthermore, the data indicate that there is indeed a relationship between positive psychotic symptoms and aggressive behavior, which is in line with the existing literature. Of these psychotic symptoms, delusions in general seems to be only weakly related to aggression, but grandiosity showed a strong relation with aggressive behavior which suggests that people who experience delusions of grandiosity or who feel superior to others seem to act more aggressively than persons who do not have these ideas. Further, people who are very excited or hostile also seem to display higher rates of aggressive behavior. No evidence was found for an association between hallucinations and aggression, neither for the link between suspicious beliefs and aggressive behavior which is inconsistent with the idea behind Junginger's (1996) psychotic action theory.

Although the results clearly demonstrated that there was a relationship between positive psychotic symptoms and observed aggressive behavior, no evidence was found for the expected mediating role of anger or anxiety in this line. However, when focusing on the specific threat/control-override (TCO) symptoms and its relation with self-reported aggression towards others, the hypothesized mediation effect of anxiety was close to significance which suggests that feelings of threat or losing control may indeed lead to emotional reactions of anxiety which in turn induces an aggressive response.

The results of this study and implications of these findings on the relationship between aggressive behavior in patients with a psychotic disorder will be discussed in detail during the oral paper presentation.

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Prediction of aggression during forensic psychiatric treatment by means of the HCR-20

Paper

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Keywords: Aggression, violence, risk assessment, HCR-20, SOAS-R

Introduction

Structured risk assessment nowadays is used on a large scale in forensic psychiatric institutions to assist the judgments about recidivism risks that have to be made in this sector (Hildebrand, Hesper, Spreen, & Nijman, 2005). One of the most widely used instruments for risk assessment is the Historical Clinical Risk Management-20 (HCR-20; Webster, Douglas, Eaves, & Hart, 1997; Dutch version: Philipse, de Ruiter, Hildebrand, & Bouman, 2000). Empirical studies on the predictive validity of this instrument indicate fair-to-good validity (e.g., De Vogel, 2005) as far as the prediction of criminal recidivism after discharge from forensic institutions is concerned. Less research up till now has been conducted on the predictive validity of risk assessment scores on violent behavior taking place during the admission. For that reason, the question remains whether risk assessment instruments can also be helpful in predicting and preventing inpatient violent behavior before discharge.

A study of Hildebrand, De Ruiter and Nijman (2003) among 92 Dutch male offenders reported a significant correlation of 0.44 between Psychopathy Checklist-Revised (PCL-R; Hare, 1991) scores and the total number of aggressive and rule breaking behaviors during admission. However, although the PCL-R scores was found to be associated with the overall number of infringements in the hospital, physically violent behavior could not be significantly predicted by the PCL-R scores. In line with this finding, McDermott, Edens, Quanbeck, Busse and Scott (2007) also found a weak association in a sample of 154 forensic patients between PCL-R scores and inpatient aggression. The Clinical and Risk management items of the HCR-20, however, showed more promising validity in predicting institutional aggression. Earlier, Gray, McGleish, MacCulloch, Hill, Timmons and Snowden (2003) reported similar findings within a smaller sample ($n = 34$). In a review on this topic, Daffern (2006) also reached the conclusion that the HCR-20, and the Clinical items of this scale in particular, may be important predictors of aggressive behavior during admission. Daffern, however, also pointed out that most of the research on this topic had a retrospective design (e.g., the data on aggressive behavior were subtracted retrospectively from the patients' files). Apart from that, many of the studies mentioned above did not use a validated, standardized reporting form to document aggressive behavior.

In the current study, the predictive validity of the HCR-20 on aggressive behavior during admission was investigated prospectively in a Dutch forensic psychiatric department. Aggressive behavior was documented during the study by means of the Staff Observation Aggression Scale – Revised (SOAS-R).

Methods

The subjects of the current study were 102 patients residing at forensic psychiatric Department Roosenburg of Altrecht mental health institute. Of these 102 inpatients, 95 were men (93 %) and

7 were women (7 %). Average age of the 102 included patients was 37.1 years (S.D. = 9.6). The majority of the patients (i.e., 70%) had been admitted to the forensic department on the basis of severe physical violence (e.g., aggravated assault, manhandling, attempted manslaughter), and most of them suffered from a DSM-IV psychotic disorder (i.e., 74%).

For each patient, the HCR-20 was completed by three independent raters which had been trained in using the instrument. After completion, the raters discussed their HCR-20 scores and arrived at a so-called HCR-20 consensus score¹. Most of the HCR-20 scores were obtained in the first weeks after admission of the patients. The HCR-20 consists of 20 items, which can be rated with 0, 1 or 2 points. Consequently, the HCR-20 has a maximum score of 40 points in case of extremely high recidivism risks. In case of missing values on the HCR-20, the missing item was replaced by the mean of the other HCR-20 items of the same person. Subjects for which more than three HCR-20 items were missing were excluded.

Aggressive behavior was recorded by the staff for all patients residing at forensic psychiatric department Roosenburg by means of the SOAS-R (Nijman et al., 1999; Nijman, Palmstierna, Almvik & Stolker, 2005) from January 2005 onwards.

Results

HCR-20 scores: The mean HCR-20 score in the current sample was 25.1 (range: 10 - 35.6; S.D. = 6.0).

SOAS-R aggression scores: In total, 174 episodes of aggression were documented during the study period. Forty-three of the 102 included patients (42 %) were ‘responsible’ for these 174 aggression incidents. In other words, 59 patients (58%) had not been observed to behave aggressively during the study period.

Predictive validity of HCR-20 scores on institutional aggression: A t-test showed that the 43 patients who had engaged in aggression at least once on the ward had significantly higher HCR-20 scores at admission [$t(100)= 3.8, p < 0.01$, two-tailed], with mean HCR-20 scores being 27.5 (SD = 4.8) for the aggressive group versus 23.4 (SD = 6.3) for the non aggressive group. In case only physically aggressive incidents were included in the analyses, patients who had displayed physical aggression also turned out to have significantly higher HCR-20 scores in comparison to the other patients [$t(100)=2.71, p < 0.01$; two-tailed]. A modest, but significant, correlation (spearman’s rho = 0.36, $p < 0.01$, two-tailed) was also found between the number of aggression incidents as reported on the SOAS-R forms and the HCR-20 scores. To assess the predictive validity of the HCR-20 on inpatient aggression, the Area Under Curve (AUC) values from Receiver Operating Characteristic (ROC) analyses were calculated. The AUC values are presented in Table 1.

Table 1: Predictive validity of HCR-20 scores on aggression in terms of AUC values

	AUC
HCR-20 total score	70
Historical	60
Clinical	70
Risk management	64

Table 1 indicates that the Clinical items in particular were associated with inpatient aggression. An exploratory analysis at the item level suggested that of the five Clinical items of the HCR-20,

¹ For more information on this so-called consensus scoring procedure the reader is referred to De Vogel (2005).

particularly items 4 (impulsivity; Kendall's tau = 0.37, $p < 0.01$) 5 (responsivity to treatment; Kendall's tau = 0.34, $p < 0.01$) were associated with inpatient violence.

Conclusion

In line with earlier findings (McDermott et al., 2007; Gray et al., 2003; Daffern, 2006), the HCR-20 was found to be a significant predictor of institutional aggression. Earlier findings that the scores on the Clinical subscale in particular appear to be associated with aggressive behavior were also replicated.

These results indicate that the HCR-20 consists of valid predictors of violent behavior, which can take place both before and after discharge. The found AUC-value of 0.70, however, may be too modest to be clinically useful for effective prevention of aggression on the ward. It is likely that other (situational ward) variables, which are not part of the HCR-20, also contribute to eliciting aggressive reactions of patients on the forensic ward. Possibly, a combination of HCR-20 variables with certain contextual ward variables might prove powerful predictors of violent behavior of forensic inpatients.

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Short Term Assessment of Risk and Treatability (START) – validity and reliability

Poster

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Short to middle term risk assessment in psychiatric hospitals is a topic of some interest in the clinical research community. In this paper, the Short Term Assessment of Risk and Treatability – START (Webster, Martin, Brink, Nicholls & Middleton, 2004), a new structured instrument for judgement of dynamic risk and treatment factors is briefly described. Interrater and internal reliability properties are analysed and the predictive validity for severe violence in a Norwegian high security psychiatric hospital is investigated. The results indicate that the START has promise as a valid tool for violence risk assessment. The authors make an argument for the importance and relevance of dynamic factors, concerning both risk and strength factors, in the short to middle time frame of risk assessment.

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Assessing aggression risks in patients of the ambulatory mental health crisis team

Paper

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Keywords: Aggression, violence, community mental health services

Introduction

The prediction of violent behaviour of psychiatric patients is not an easy task. Especially being on duty in a crisis team of the Mental Health Service can be a highly emotional and stressful experience. Pressed for time and providing a 24-hour service, team members often have to make major decisions that don't necessarily have the agreement of all the parties concerned. The East Brabant Mental Health crisis team felt they needed to find out more about the risk factors associated with aggressive behaviour of their patients during outreaching crises contacts. In order to prevent dangerous situations, a method to assess risks, before patients in psychiatric crises are contacted might be helpful.

An overview of the literature shows that in forensic psychiatry in particular much has been learned already about methods for predicting violent or delinquent behaviour. Methods for risk assessment, can be divided into various types (Hildebrand, 2004; De Vogel, 2005), such as clinical judgment, fully based on the knowledge and experience of the caregiver involved, and actuarial risk assessments such as the Violence Risk Appraisal Guide of Harris, Rice and Quinsey (in: Quinsey et al., 1998) that 'calculate' risk solely on the basis of certain objectively quantifiable factors. Finally a method exists that could be described as a combination of the former two, called Structured Professional Judgments. Such a standardized risk assessment is carried out by an expert with the help of a checklist with scientifically grounded risk factors, as is the case with Historical, Clinical and Risk indicators (HCR-20; Webster et al., 1997).

Scientific research shows that actuarial risk assessment tends to be more accurate than clinical predictions (Monahan & Steadman, 1994; 2001; Grove et al., 2000; Borum, 1996). Research done by De Vogel (2005) further indicates that structured clinical risk assessment may be superior to purely actuarial risk assessment. In using structured clinical risk assessment instruments, static factors (such as history of aggression), dynamic factors, which can vary (such as the patient's current condition), and sometimes also factors concerning situation or context (such as a patient's living environment) are taken into account in relation to one another.

To summarize, the literature shows that there are many instruments available for estimating the risk of aggression in various settings, but that there is no single instrument that is suitable for all situations. In addition, most of the above mentioned instruments are not intended for predicting risks in the short term. It would appear that there are fewer instruments available for predicting aggression in the short term (up to one week) (Nijman et al., 2002). One exception is the Brøset-Violence-Checklist (Almvik et al., 2007; Bjorkdahl et al., 2006) which is used in the closed acute psychiatric ward.

As it turns out, there are few specific instruments for psychiatric crisis teams when it comes to predicting risks prior to crisis visits. A possible reason for the difficulty in making such assessments is that crisis team members often do not know the patient in question, which means they have to get by on the rather scanty information provided by others (often the general practitioner) during the patient's registration. This study seeks to find whether it is possible, on the basis of such limited information, to predict the risk of the patient displaying aggressive behaviour during the crisis visit. So we tested the predictive validity of the Checklist Risk Crisis intervention (CRC) used in the 24-hour psychiatric crisis service. This instrument was specially designed to assess aggression risks of outpatients in psychiatric crisis, before the team member goes to visit the patient.

Method

The study was carried out by the members of the crisis team of Mental Health Institute Oost-Brabant in the Netherlands. The crisis team members completed the CRC before all outreaching visits to patients in psychiatric crisis (March 2006 to April 2008). In addition, if patients showed any aggressive behaviour during the visit, this was documented using the Staff Observation Aggression Scale-Revised (SOAS-R; Nijman et al., 1999). Also the list of team members being on duty was available, as well as information on the psychological profiles (NEO-PI-R), from the crisis team members themselves.

The CRC contains a number of items that may be related to an increased risk of aggression. For instance:

- Who called in the crisis team?
- What is the first assessment of the patient's condition/diagnosis?
- Are there any other patient-related risk indicators such as prior aggression, possible paranoid delusions, etc.?
- Are there any indicators of increased risk in the patient's living environment, such as the presence of dangerous pets, possible weapons, etc.?

Results

An earlier study concerning the years 2003-2005 (Penterman & Nijman, 2009), indicated that with the items of the CRC, about 90% of the outreaching crisis contacts might be correctly classified as involving aggressive patients or not. In the workshop more recent results of research conducted in the period March 2006 till April 2008 will be presented. Potential associations between psychological characteristics of the crisis team members and the aggressive incidents will also be addressed.

Discussion

Various CRC items were related to patient aggression, as documented by the crisis team members after visits. Many of these relations seem to possess a considerable amount of 'face validity', for instance the relation between reports made by the police and aggressive behaviour during crisis team visits. In addition, many of the found associations correspond with what we already know from the literature about predicting aggression, such as the fact that prior aggression is one of the best predictors of future aggression.

Similarly, a lack of significant associations between aggression and some of the variables studied might be of interest also to psychiatric crisis teams. For example, the present study indicated that unfamiliarity with the patient before the visit was not significantly related to a heightened risk of aggression. Although unfamiliarity with the patient will mean a higher level of unpredictability of

the situation, this does not mean that more aggression actually occurs in these situations (on the contrary, this relation rather seems to be likely to exist in the opposite direction). Either way, since the CRC needs to be completed prior to each crisis visit, more routine and standardization will be incorporated into the assessment of crisis team caregivers of possible risk factors.

Conclusions

1. The clinical view together with the structured checklist (i.e. the CRC) predicted aggressive behaviour of outpatients rather good.
2. The results indicate that the use of the so-called Checklist of Risks Crisis team (i.e., the CRC) presented in this workshop in advance of outreaching crisis team visits is useful in assessing aggression risks. This may create more possibilities for specific precautionary measures, such as calling in police assistance.

Acknowledgement

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The impact of the media in the ethical care of individuals with severe, persistent mental illness

Paper

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In much of Western society, the media has considerable influence over the populace. It is a means by which many individuals gather information, are entertained, and interact with the world around them. However, the amount and nature of attention given to some topics of interest do not necessarily depict everyday realities, particularly for those with mental health concerns.

Mental illness is a stigmatizing condition. Individuals with severe, persistent mental illness are often perceived to be dangerous and violent. These perceptions are frequently fuelled by the media portrayal of individuals who commit violent acts while suffering from a mental illness. While the effects of mental illness can place an individual at risk of behaving against social norms, there is concern that the relative risk of this occurring is not accurately depicted through newspapers, television, movies, and other media venues. In fact, the stigma created through such negative depictions can further impede individuals from obtaining much needed assistance due to the social ostracizing inflicted.

Mental health professionals generally recognize the schism in the perceived and actual risk associated with individuals with mental health concerns. There is a need to consider the rights of the patient and balance these with those of the community at large. However, how do the media influence the ethical choices that mental health professionals face in caring for those with mental illness? Mental health professionals often encounter such challenging dilemmas. In this presentation, the author will discuss the media portrayal of individuals with mental illness who commit violent acts, and stimulate reflection on how to consider and challenge such influences in the ethical provision of mental health care.

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Risk assessment in cases of violence by intimate partners

Paper

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Violence by intimate partners is a complex problem with biological, psychological, socialization, relational and environmental roots. In extreme situations, the loss of the aggressors control and domain over the victim, brings out, in the batterer, feelings like anger, rage, hate, jealousy and the urge to retaliate or take revenge for a perceived offense. These emotions associated with physical violence may lead ultimately to the victim's murder (and, sometimes, the offender's suicide). "Studies from Australia, Canada, Israel, South Africa and the United States of America show that 40–70% of female murder victims were killed by their husbands or boyfriends, frequently in the context of an ongoing abusive relationship" (WHO, 2002).

Some experts believe that while all aggressors are potentially dangerous, some are more likely to kill than others or are more likely to kill at specific times. There is not a definite way to predict whether a batterer will kill her partner; however, experts have identified a number of factors that indicate an increased likelihood of domestic violence murder such as: time of separation, escalation of risk taking, escalation of violence, threats with weapons, hostage-taking, "ownership" of the battered partner/centrality of the partner, history of antisocial behavior/personality disorders, cruelty to animals/victim's pets, stalking, depression, threats (or fantasies) of homicide or suicide, substance abuse disorders, extended history of domestic violence or other violence /violence in his family of origin.

Risk assessment is a highly complex activity, which requires more than an isolated and fragmented consideration of risk factors. The checklists available are useful tools, but they however don't allow a thorough and global risk assessment. Limiting evaluation procedures to a single methodology might become problematic since a multiplicity of circumstances influence the severity of violence.

The evaluation should be directed towards attaining a better understanding of the system, and not be focused exclusively on the individual. Collect information from multiple sources (batterers / victims/family/support network), it's fundamental, so that the professional might distinguish and identify those who have a higher probability of committing homicide. The bigger the number of indicators present and the severity of each one, the higher is the probability of homicide or murder. The decisions taken by the several professionals involved in risk assessment on domestic violence cases are as effective as the quality of the information collected. Dealing with violence on a range of levels involves, among other things, focusing on individual risk factors, providing professional help and support, addressing gender inequality/cultural, social and economic factors that contribute to violence/taking steps to change them.

About risk assessment, these are some of the questions that are brought upon the team of the Family Violence Unit (Centro Hospitalar Psiquiátrico de Coimbra, Portugal) that we would like to reflect and share in this event:

1. Is violence really unforeseeable or is this unpredictability stemming from an inability to collect important and vital information about a given situation?

2. In situations of violence by intimate partners who the batterers and victims are?
3. Which are the risk factors that must be taken into account?
4. What is the role of the health services in risk assessment in cases of violence by intimate partners (domestic violence)?

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Risk assessment for future violence in individuals from an ethnic minority group in the UK

Poster

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Background

In the UK persons of African-Caribbean origin are overrepresented in secure services. Risk assessment instruments designed for predicting future violent behaviours are now often used but their efficacy of prediction is not known for those from ethnic minorities.

Aims

To test the efficacy of two leading risk assessment instruments to predict future violent convictions after discharge in patients from a black ethnic minority, and to compare the levels of risk as defined by these instruments between ethnic groups.

Method

A pseudo-prospective study followed 1141 patients for at least 2 years. Patients were classified as „white“ (n = 834) or „black“ (n = 249) or „other“ according to self-assignment. Risk assessments were completed using only pre-discharge information and violent and other offending behaviour post-discharge was obtained from official records.

Results

Both the Violence Risk Appraisal Guide (VRAG) and the HCR20 Risk Management Scheme were significant predictors of future violence for black patients and their efficacy was very similar to that of the white patients. Risk assessment scores were slightly lower for black patients but there were no significant differences in reconviction rates for either violent or any offences.

Conclusions

The results provide an evidence-base for the HCR20 and VRAG as effective risk assessment instruments for black patients in the UK.

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A critical appraisal of two violence prediction instruments in a dangerous forensic patient

Paper

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Keywords: Aggression, violence, risk assessment, HCR-20, Brøset Violence Checklist (BVC), extended Swiss version of the Brøset Violence Checklist (BVC-CH)

Background

The prediction of violent patient behaviour is a central task in forensic psychiatry for legal reasons and to ensure the safety of personnel and fellow patients alike. To predict patient violence actuarial and clinical, short term instruments are used.

Method

This single case study will consider a single case report of violence risk prediction in a highly dangerous person suffering from chronic schizophrenia on a high security forensic ward. The case study will include an analysis of the patient's life history, his delinquency and an investigation of the patterns driving his delinquency. The characteristics of the patient's individual psychopathology including static and dynamic factors will also be considered. In a single case study we implemented a concurrent risk prediction using the HCR-20 (Webster, K.S, Eaves, & Hart, 1997) and the Brøset Violence Checklist (Almvik & Woods, 2003; Woods & Almvik, 2002). In this paper we infer some merits and limitations of the two instruments.

Casuistic

Mr T. was born in 1970 and grew up in the Balkan region. After leaving school he had to terminate his vocational training for disciplinary reasons, became involved in minor delinquency, and had his first contacts with law enforcement agencies. In 1970 he came to Switzerland and found abode in a home for asylum seekers and sustained himself financially through burglary and robbery. During a subsequent incarceration mental problems – delusions of threat and poisoning – were observed for the first time. He perceived his inmates as spies and perpetrated attacks on them. In the forensic psychiatric hospital he was diagnosed as having chronic schizophrenia and an antisocial personality disorder in 1996. The patient's delusions remained uninfluenced under treatment with antipsychotic substances and his prognosis was deemed extremely negative especially in terms of dangerousness.

After dismissal from hospital the patient brutally attacked a complete stranger claiming that the 79 year old man had touched him in an immoral manner and that the old man must be homosexual. As the old man had allegedly provoked Mr T. he had to be punished. The patient declared that he is an enemy of homosexuals and he has thus been appointed to wage a "Holy War" against such persons. In a further incarceration episode in 1999 Mr T. nearly strangled an inmate, whom he perceived to be homosexual, to death with a shoelace. In 2000 he brutally attacked a prison custodian, whom he also perceived as homosexual. Mr T. claims that he can detect homosexuals

by their facial impression, their demeanour, or by a process incomprehensible to himself – and, indeed, to us.

The patient was convicted to an indefinite period of incarceration and transferred to our high security forensic psychiatric ward for treatment. After initial difficulties the patient showed stable – but potentially dangerous – behaviour under depot medication with an antipsychotic substance. Given his dangerousness the patient was exposed to a high security procedure entailing e.g. the presence of at least three health workers when the patient left his locked room. An attempt to integrate Mr T. into a patient group was thwarted by his rejection of other patients and by him threatening to kill the healthcare workers. The patient's delusions remained virtually immune to treatment with major tranquillizers. The patient dynamically integrated fellow patients or male healthcare workers, which he perceived to be homosexual, into his delusional system. However, in daily interaction the patient was able to indicate which persons he perceived to be homosexual which allowed us (partially) to circumvent aggressive outbreaks. Mr T. also stated that he was afraid of becoming homosexual himself.

In summary it can be seen that the offence dynamical potential of Mr. T. results from his psychotic delusions which lead him to believe he is an agent in the crusade against homosexuals. In spite of numerous treatment attempts the patient was incapable of distancing himself from his delusions. On the contrary – his illness led him to dynamically integrate persons from his environment into his delusional system. Psychotherapeutic attempts to help the patient to understand the aetiology of his delusions – for example the role of his own homosexuality and his search for identity – caused the patient to terminate communication.

Instruments

To monitor the patient's dangerousness and potential for violence we used the HCR-20 (Webster et al., 1997) and the extended version of the Brøset Violence Checklist (Abderhalden et al., 2008) which was derived from the original Brøset Violence Checklist (Almvik & Woods, 2003; Woods & Almvik, 2002). The HCR-20 (Webster et al., 1997) contains 10 historical, 5 clinical, and 5 risk-relevant items and aims at predicting the risk for dangerousness. Each item is coded as 0 (low), 1 (moderate), and 2 (high), giving rise to a total maximum score of 40 points. The values of ≤ 17 , 17 to 30, and >30 are interpreted as a low, a moderate, and a high risk for future violent behaviour respectively. The Brøset Violence Checklist (Almvik & Woods, 2003; Woods & Almvik, 2002) is a short term violence prediction instrument which entails the rating of six patient behaviours (confusion, irritability, boisterousness, verbal threats, physical threats, and attacks on objects) giving rise to a maximal score of 6 points. The ratings are usually conducted by nurses twice daily. The extended version – the BVC-CH (Abderhalden et al., 2008) – utilises an additional subjective assessment of the risk of imminent violence using a slide-rule visual analogue scale. The maximal score of the objective and subjective items is 12 points.

Risk assessment

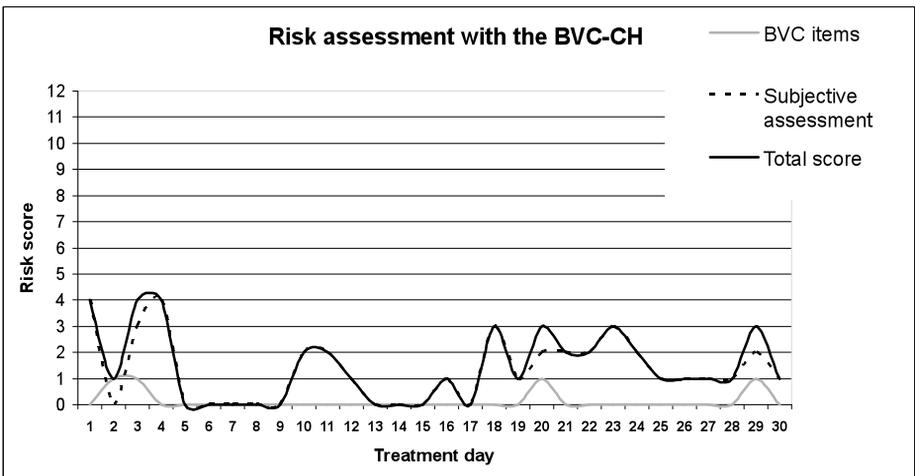
The total score for the violence risk of the patient during the treatment episode of 30 days was 31 points on the HCR-20 (see Table 1). Regarding the historical dimension the patient attained 14 out of twenty points. On the clinical and risk management dimensions the patient almost attained the maximal score of 8 and 9 out of ten points on the clinical and risk management dimensions respectively. With a total score of 31 points out of a possible 40 the patient's risk for future violence is interpreted as "high".

Table 1: Assessment of violence risk according to the HCR-20

Historical (past)		Clinical (present)		Risk management (future)	
H1: Previous violence	2	C1: Lack of insight	2	R1: Plans lack feasibility	2
H2: Young age at first violent incident	2	C2: Negative attitudes	0	R2: Exposure to destabilizers	2
H3: Relationship instability	2	C3: Active symptoms of major mental illness	2	R3: Lack of personal support	1
H4: Employment problems	2	C4: Impulsivity	2	R4: Noncompliance with remediation attempts	2
H5: Substance use problems	0	C5: Unresponsive to treatment	2	R5: Stress	2
H6: Major mental illness	2				
H7: Psychopathy	0				
H8: Early maladjustment	1				
H9: Personality disorder	1				
H10: Prior supervision failure	2				

The concurrent rating with the BVC-CH (Figure 1) gives rise to a less dramatic assessment of the patient’s risk for violence with a maximum score of four points of a possible 12 on the BVC-CH during the treatment episode. The maximal score of the original BVC items was one point and the maximum score of the subjective assessment of the BVC-CH was four points. According to the interpretation scheme proposed by Abderhalden et al. (2006) the patient has generally a “very low risk” (<1 of 300 patients will attack a person) and on three occasions only during the first four days of the treatment episode a “low risk” (about 1 out of 100 patients with this score will attack a person).

Figure 1: Risk assessment with the BVC-CH



Discussion

It is obvious that the two instruments were designed to serve different purposes. The HCR-20 is essentially an instrument to assess the legal prediction of violence risk whereas the BVC-CH assesses the violence risk for a short term of approximately the next 4 to 6 hours. Additionally the BVC-CH considers only the present situation whereas the HCR-20 integrates historical and future dimensions. In spite of these differences it is striking that the assessment of the current violence risk as represented by the BVC-CH and the clinical dimension of the HCR-20 lead to such disparate results. These differing results may be attributable to the following reasons.

- Due to his past history of dangerousness the patient was subjected to a high secure treatment regime including high dosages of antipsychotic substances, coercive measures such as fixation, and the presence of a least three health care workers when Mr T. was ambulating. Whereas these measures may have influenced some of the behavioural items of the BVC-CH – e.g. boisterousness, physical threats, or attacks on objects – some of the clinical items of the HCR-20 – e.g. lack of insight, unresponsiveness to treatment – may have remained uninfluenced.
- The clinical dimension of the HCR-20 takes psychopathological symptoms into consideration. Given the patient's (hardly influenceable) delusional system – especially his belief that he must battle against everything homosexual – it comes as no surprise that Mr T. achieves the maximum scores on “lack of insight”, “active symptoms of major mental illness” and “unresponsiveness to treatment”. These items which contribute to the assessment of the risk for violent behaviour are not required by the BVC-CH. The finding that the nurses using the BVC-CH had higher scores on the subjective measure than on the six behavioural items of the BVC may indicate that the nurses may have been taking psychopathological or historical issues into consideration when subjectively assessing the patient's violence risk.
- During the course of the treatment episode Mr T. became able to express his psychotic experiences to the care personnel. This allowed the treatment team to monitor the patient's new dynamic developments. Due to the fact that the patient was able to communicate which male health care workers he had dynamically integrated into his delusional system (by perceiving such persons as homosexual) it was sometimes possible to avoid the patient having contact with these persons. Therefore, we assume that the removal of this stimulus may have contributed to the low scorings on the BVC-CH.

Conclusions

The synoptic consideration of these two instruments leads us to propose the following tentative conclusions on their clinical application: Given the high security regime which had to be implemented based on the legacy of the patient's past violence and dangerousness (the historical dimension of the HCR-20) it is clear that the BVC-CH was applied to an extreme case in which the BVC-CH has limited value. However, the clinical value of the BVC-CH lies in its simplicity and practicability. Another advantage of the BVC-CH is the fact that it can and is expected to monitor violence risk for short time periods and helps identify daily or half-daily undulations as opposed to the longer term predictive nature of the HCR-20. The HCR-20 takes psychopathological issues into consideration which are deemed extremely important in the case of Mr T. given the dynamic nature of his delusions and the integration of health care workers into his psychotic experience.

In spite of the fact that no robust conclusions can be drawn from a single case study and that the two instruments were developed for differing purposes we can conclude that the application of both instruments concurrently offers a more comprehensive picture of the violence risk in a forensic setting.

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To decrease the risk for violence for patients sentenced to forensic psychiatric care

Paper

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Keywords: Forensic nursing, risk assessment, risk management strategies, violence reduction

Introduction

Risk assessment for future violence is an important area to do research on, since it concerns both the individual patient and the society. The occurrence of threats of violence and violence is a reality for patients and staff in psychiatric institutions therefore, the clinical work to reduce the risk for violence is important. To decrease the risk of violence by patients in forensic psychiatric care it is essential to look further into nursing. The nursing staff works closely with the patients on a daily basis. They create a relationship with the patient based on trust and hope, but at the same time they also assess the risk for violence continuously. Risk assessments are done as a routine as a part of the forensic care. In a further perspective this is done to protect society from patient related violence. The result of the risk assessment is used for risk management strategies in which the nursing staff is essential to make it work. The literature demonstrates that the forensic psychiatric care is an unexplored area, both nationally and internationally (see Brunt & Rask, 2005; Strand, Holmberg & Söderberg, 2009). In order to improve psychiatric nursing within forensic care, advanced knowledge is required. The aim of this project is to focus on “what works” in the risk management strategies that the nursing staff uses. Measurements will be made on both the patients’ experiences of care, and staff experiences’ of work. It consists of four studies. The result from the first study is now analysed and we have identified the research group. The project and preliminary results from study one will be discussed and presented.

Background

When risk assessments for violence are done in forensic psychiatric patients in Sweden, the Swedish translated version of the risk assessment instrument HCR-20 is widely used (Belfrage & Fransson, 1997; Webster, et al. 1997). The instrument consists of three different parts; the historical part (H), the clinical part (C) and the risk management part (R). “20” indicates how many risk factors the instrument contains. To assess psychopathy, either the revised version of the Psychopathy Checklist (Hare, 2003) or the Screening version is used (Hart, Cox & Hare, 1995). At the forensic clinic in Sundsvall HCR-20 has been used continuously since 1998 where the validity and reliability has been evaluated by Belfrage and Strand in several studies (Strand, 2006). The forensic psychiatric clinic in Sundsvall have approximately 100 patients in care and is thereby one of the largest forensic clinics in Sweden. Using the instrument is one important part of the risk assessment work in order to improve the work with risk prevention. The risk assessments are regularly carried out every six months at the clinic.

A central theme in psychiatric nursing is the interpersonal relationship between the person cared for and the care provider (Barker, Fletcher & Stevenson, 2002; Dexter & Wash, 1997; Tschudin, 1995). It is common that the staff have a reality-oriented approach in meeting with the patient (Hellzén, Kristiansen & Norbergh, 2004). The patients spend the majority of the time without

the staff (Hellzén, Kristiansen & Norbergh, 2003; Kristiansen, Dahl, Asplund & Hellzén, 2005). On the other hand the staff feels left alone and that they get too little guidance by the leadership as how to do the nursing care (Kristiansen, Hellzén & Asplund, 2009). Crucial for the healing relationship between nurse and patient is the verbal interaction (Peplau, 1994). Research has shown that there was a difference between how the staff and patients perceive the presence of supportive and encouraging interaction and social training within forensic psychiatry. Patients felt that the support was lower than what the staff felt. Both groups agreed, however, on the importance of the aforementioned nurse (Rask & Brunt, 2006). The literature has not been able to provide answers to what it is in the psychiatric care that result in reduced risk of violence in the patient. This is the next step towards providing better risk management strategies in the forensic psychiatric care.

Aim

The aim of this project is to identify, to examine and to get deepened knowledge about the components in the nursing care that contributes to the decrease of risk for violence for patients sentenced to forensic psychiatric care.

Methods

Research on the experiences and the identification of the work on reducing threats of violence and violence, require different methods. The use of different methods gives the opportunity to triangulation both on the methods and to gain a deeper understanding (Foss & Ellefsen, 2002). The qualitative methods will be used to illustrate, describe and identify the different phenomena's in patterns, processes and themes. The quantitative methods will be used to statistically demonstrate the assessed risk and its change over time. The project consists of four studies and will be carried out during a period of four years. All carried out in the forensic psychiatric clinic in Sundsvall. All components in the study will have gender perspectives. The first study is a quantitative study, which aims to identify patients that have lowered their risk for violence within a year from admission. Participants in study number one is patients sentenced to forensic care with at least one recurrence of risk assessment. A comparative analysis is made even in patients who are discharged from the clinic. The risk assessment instrument HCR-20 has been used in this quantitative, retrospective study. Data has been analyzed with quantitative methods where statistical tests such as; the Chi square test, the Mann Whitney U-test and the Kendall's tau was used. The material was processed with SPSS for Windows.

The results from study number one will be used for the second and third studies which are two qualitative studies. The second study consists of open interviews with the patients that has considerable decreased their risk for violence and the third study consists of open interviews with the staff working closely to the patients. The aims for the second study are to get deepened knowledge about how the forensic patients experience the psychiatric nursing care, and what they believe contribute to the lowering risk for violence, while the aim of the third study is to deepen the knowledge about what the staffs' experiences are regarding the risk decreasing elements in nursing care.

The fourth study is an intervention study that aims to examine if education on risk decreasing elements in nursing care actually lowers the risk within the patient group. Two wards at the clinic will be used. One that will get an education of four hours and one that will not. It is implemented with a combined method, where the quantitative part is used in order to examine differences in assessed risk for violence in the intervention group compared with the control group. While the qualitative part, which contains of focus groups, aims to get deepen knowledge about the impact of the intervention.

Hopefully this project will contribute more knowledge in the risk management area for nursing staff that work within the psychiatric care, which will lead to new risk management strategies in order to prevent violence.

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Why clinicians should use actuarial approaches rather than judgment in predicting and preventing homicide: A cost-effective empirical approach from infancy to adulthood

Workshop

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Keywords: Identification, treatment, prediction, actuarial, sensitivity, specificity, costs

Introduction

On average yearly, there are 18 global mass murders, 18 U.S. school homicides, and 18 U.S. university killings. One million U.S. homicides occurred since the first historical actuarial probation parole testing began in Illinois in 1928, which equals all U.S. battlefield deaths since the Revolutionary War. The homicide rate in the European Union when all the countries are included mimics the US. Each year in Chicago, there are 150 youth homicides. There are many cities around the world like Chicago. Many of these youth were seen by clinicians. Since I began my research project 23 years ago, the total Chicago youth homicides exceed the war dead in Iraq and Afghanistan. In a recently published monograph (Predicting, 2009) the highest risk groups—abused infants and children, and violent youth and adults—were oversampled in the urban juvenile court and followed into the adult court, where homicides are most likely to appear. Data from these individuals were gathered from court, medical, school, and other records and included virtually all known risks for delinquency and crime in order to improve “prediction.”

Quasi experimental design and robust modern statistical techniques (Shao’s bootstrapped logistic regression) yielded a detailed picture of the risks in abused and violent groups and their comparison groups (clinic and hospital referred clients), which were strongly differentiated. Accurate prediction of homicide was 92-93 % with less chance of false positives (unnecessary jailing) or false negatives (release of dangerous offenders). This is a considerable improvement over the past accuracy of 69-76%.

It is fascinating that clinicians resist the use of actuarial approaches to the diagnosis of mental health issues and assessment of dangerousness. Monahan (1996) found that psychiatrists and psychologists were only about 30% accurate in prediction of “dangerousness” among institutionalized patients. Similarly, Sepejak (1983) showed that psychologists were only 39% precise in rating defendants’ potential violence over two years in pretrial cases. Lidz (1993) demonstrated that psychologists correctly predicted only 53% of violence in patients during six months after release.

In contrast, actuarial or statistical prediction relies on explicit rules that specify and score the risks. Algorithms are used to combine the risk scores to yield an objective estimate of potential violence. Burgess (1928), Meehl (1954), Underwood (1979), and Grove & Meehl (1996) proved the usefulness of combining data in statistical prediction and probation-parole decision making. Statistical decision making was superior in 128 of 136 studies. Quinsey, Harris, Rice, and Cormier (1998) presented 69%-76% accuracy in violence and sexual offense risk assessment, another way of describing probation-parole decision making.

Methods and Results

Identification or Prediction

Zagar and colleagues (Predicting, 2009) indicated that there are 82 items related to characteristics or risks of the offender that are useful in “predicting” dangerousness or “return to court” from 80 years of research among 184,483 male and female, teen and adult prisoners from three continents, five countries and 15 U.S. states followed 1 to 10 years. This large and diverse sample is enough to standardize the most dependable and reliable ability or personality test. The resultant actuarial probation parole decision making tests have excellent psychometric properties and predict violence better than judgment. Yet, these instruments have not entered mainstream use by clinicians.

Date was gathered by Zagar and colleagues (Predicting, 2009) across the age range from gestation to adulthood with random sampling and comparison groups. This allowed regressions to be used in a more comprehensive manner. The risks identified allow prediction of violent behavior in children as young as 2 or 3 before any delinquency occurs. At the youngest ages, the risks for future violence do not include past delinquency, since the children are too young to have engaged in such behavior. This is the crucial goal of prevention, since individuals identified as high risk can be treated at very young ages and for longer periods of time during critical developmental stages.

The data gathered from five samples (abused infants later homicidal, abuse children later homicidal, homicidal youth, assaulters later homicidal, and sexual homicidal, $n=234$) and their comparison groups, including risks from pregnancy and infancy to adult years, provide a detailed developmental picture. This continuum includes exposure to substances during gestation, abuse by parents or guardians during infancy and childhood, witnessing familial violence, poor general health, poor executive function and resultant failure in academic or social tasks, subsequent alcohol and drug use, and association with antisocial tasks leading to contacts with authorities and eventually to incarceration.

Prior court contacts were the best overall predictor of violent delinquency confirming what is already understood by the courts. Among other significant predictor of violence and homicide was severely compromised executive function which appeared a strong risk factor from infancy and continued through adolescence and into adulthood. In youth and adults, lower social maturity was also a significant predictor. Clinicians often assess executive function and adaptive behavior (another way of describing social maturity) as part of their test batteries for determination of special education eligibility or in neuropsychological assessments or at psychiatric intake in hospitals and courts.

Data on female homicidal behavior (in contrast with males) had not often been previously reported. There was only one difference found by Zagar and colleagues (Predicting, 2009): Fewer females were gang members, which supports the validity of actuarial risk assessment (i. e., probation parole decision making tests such as Quinsey, et al., 1998) for both sexes.

Empirical Treatments

Many interventions have been developed to intercept or divert at-risk children, youth and adults. Meta-analyses show that delinquency and crime can be reduced by 12% on average by employing empirically validated treatment programs. The clear developmental continuum of risks in the abovementioned data implies that if treatments are applied in a developmentally targeted manner for longer periods of time and only to the most at risk, the resultant overall reductions in delinquency, violence, and homicide might be improved dramatically.

The cascade of risks causing most violent behavior began with fetal substance exposure, perinatal difficulties, and an abusive, violent family. These risks were closely related to poorer executive function (decision-making ability) in abused infants and children who later become homicidal teens. Poorer executive function combined with instability in the home, and missing

and/or antisocial parents, make school and social success in the neighborhood unlikely. Later, antisocial peers and alcohol and drug abuse worsen the problems of compromised decision making and lower social maturity and provide social acceptance for violent acting out. In schools, these problems result in underachievement and/or need for special education services, truancy, suspension, and expulsion.

Lipsey (2006) published meta-analyses on the types of treatments that are effective. Treatments were applied from 10 to 30 weeks with one to four contacts totaling 10 or fewer hours weekly contact time. The smallest improvements were observed for family and group therapy and individual counseling, while the largest improvement was seen for jobs, multimodal therapy, and behavior change. Effective treatments share certain characteristics. They are targeted to various ages of infants, children, youth, or adults and to particular problems: dropping out of school, alcohol and drug abuse, early offending leading to career delinquency and crime, and homicidal-prone behaviors. Applying actuarial assessment and empirical treatments to high homicide geographical areas in a city like Chicago (such as the west and south sides) would reduce murder rates 89% saving 133 lives yearly. There is no reason that doing so in other cities would also save lives. If more clinicians would use actuarial tests and empirical treatments, then lives would be saved. Of course the focus must be especially on those who are most costly (dropouts, alcoholics, addicts, career delinquents-criminals, and homicidal prone) in high homicide geographical areas, instead of current more global and less focused approaches. By focusing resources cost benefit and efficiency is obtained.

Beginning with gestation and infancy, the program with demonstrated success is nurse home visits. This targets teenage mothers during pregnancy and their infants from birth to 24 months. Nurse visits provide information and support for mothers to reduce environmental hazards and instruct mothers in obtaining good nutrition. Mothers are taught how to safely and effectively correct behavior in children. An effort is made to reduce alcohol and drug abuse by the mother. For young children, home visitation by teachers, training and resources for parents, and daycare with highly trained teachers is effective. For 2 years, 3- to 4-year-old children attend 3 hours of school weekly. Parents participate in small group training sessions. In elementary school, promoting alternative thinking strategies provides cognitive training in self-control and handling social and academic situations (specifically, modifying the use of aggressive and disruptive behavior). Functional family therapy helps provide parents with set rules and training on how to negotiate with children and teens. Therapy is given 8 to 12 times and seeks to improve problem solving and communication in the family and to set rules and limits. In high school therapy, vocational training or rewards are successful. Family and school-coordinated treatment and services delivered over 30 sessions is effective. Drug abuse prevention includes social skills to resist peer pressure and improve self management along with information on the harms of use of alcohol and drugs. The 15 classroom sessions in the first year are followed by 10 and 5 sessions in the next years. Training, community service opportunities, rewards for graduation, employment, and counselling round out the full developmental range of treatments.

Violence is extremely costly to society. The direct and the indirect costs of a single homicide are nearly \$4 million. The costs from nonviolent offenses and abuse or neglect through violent offenses are detailed by Zagar and colleagues (Predicting, 2009).

The author has a great deal of experience with "on the ground" use of risk factors. Unfortunately, my experience indicates there are problems with acceptance by professionals, despite the long history of accumulating evidence that actuarial assessment far exceeds the accuracy of judgment. Examples may help the reader. Using the risk patterns developed in the author's previous work, an individual was identified and made known. Other professionals were wary of restricting the person. Despite warnings that the individual had increased odds of homicidal behavior, the person was allowed to be without structure and therapy. A few months later when the same individual discharged a gun, others began to believe the warnings.

In another case professionals were taught the risk patterns for danger but used their own judgment and did not require treatment of the at-risk individual or restrict the environment. This

individual is now spending four decades in a penitentiary for a homicide that was preventable. The cost of intervention would have been one tenth of the cost of incarceration.

A final example involves an individual where the family was intentionally not disclosing past risk factors including weeks spent in jail for raping an 8-year-old girl and prior examinations that described dangerous and psychotic symptoms. Fortunately, with the use of an actuarial personality test, the Minnesota Multiphasic Personality Inventory (MMPI), along with a violence risk instrument, paranoid schizophrenia was diagnosed the day before this individual appeared with a 10-inch knife and a specific target. Guards, who were warned after the diagnosis was complete, intercepted him in order for him to be hospitalized.

Columbine, Virginia Tech, Northern Illinois, and the recent German school slayings were all preventable, if only professionals, including clinicians, would use actuarial approaches rather than judgment and apply empirical treatments. In each of these cases professionals including clinicians chose judgment (53% accuracy) over actuarial approaches (92-93% precision). There is a strong need for retraining and changes in standards of professional action.

On the positive side the current CEO of the Chicago Public Schools told the media during the Spring 2009 that “infant anger management” was needed, which is an improvement over the past CEO Arne Duncan, now Secretary of Education, who in an interview for Chicago 2009 said that schools were not the venue to address violence. The in services I and my colleagues provided for Mayor Daley’s Youth Violence Task Force (his chiefs of staff) are having an impact on changing leadership’s approach to an age old problem. The same can be said for the US military and insurance industry, that have shown a vivid interest in an internet screening test battery that produces a risk profile for administrators at initial selection and employment annual review and retention. Given the increasing frequency of global mass murders every year and the workplace, school and university mass homicides, using actuarial tests instead of judgment is not an option but a necessity. Given the costs decision makers, leadership and citizens will demand safety.

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Chapter 12 – Sexual Violence

Offending processes in sexual murderers and in sexual aggressors of women

Paper

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Pathways in the offending process of sexual murderers and sexual aggressors of women (rapists) have been investigated by Fisher and Beech (2007) and by Proulx and Beauregard (2009). Their results showed that rapists and sexual murderers of women have several characteristics in common. In addition, they identified three types of aggressors: sadistic; angry; sexually opportunistic. These types differ in their modus operandi and implicit theories (dangerous world, male sex drive is uncontrollable). The aim of the current study was to extend the results of these previous studies by investigating pre-crime (life events that occur during the year preceding the index offence), and lifestyle (sexual, nonsexual) factors associated with the sadistic, angry, and opportunistic offending processes.

A total of 180 sexual aggressors of women (63 sexual murderers, 117 non-homicidal sexual aggressors) participated in this study. Profiles of pre-crime, sexual lifestyle, and non-sexual lifestyle factors were established on the basis of two-step cluster analysis. The salient features of the inner world of sadistic aggressors during the year preceding the index offence were overwhelming deviant sexual fantasies, idleness, low self-esteem, and generalized conflict with women. In addition, their sexual lifestyle was characterized by compulsive masturbation and consumption of pornography. Their general lifestyle was characterized by daydreaming, reckless behaviour, and social isolation. The central pre-crime characteristics of angry aggressors were anger and generalized conflict with women. Furthermore, the sexual lifestyle of these aggressors involved the consumption of pornography and sexual contacts with prostitutes. Their general lifestyle was characterized by alcohol and drug consumption. The only salient pre-crime factor among sexually opportunistic aggressors was generalized conflict with society (victim stance, entitlement). In addition, these aggressors had a large number of sexual partners. The main feature of their general lifestyle was alcohol and drug consumption. The theoretical implications of the results in light of the Self-Regulation Model will be discussed.

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Protective factors for (sexual) violence. Results with the SAPROF in a sample of (sexually) violent offenders

Paper

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Keywords: SAPROF, protective factors, risk assessment, positive, dynamic, sexual, violence risk

Introduction

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

Inspired by research findings and reinforced by the desire of clinicians for the addition of changeable and positive factors in risk assessment, in 2007 the Structured Assessment of PROtective Factors for violence risk (SAPROF; De Vogel, De Ruiter, Bouman, & De Vries Robbé, 2007; English version 2009) was developed in the Netherlands as a positive dynamic addition to risk assessment. The SAPROF is a Structured Professional Judgment (SPJ) checklist intended to always be used in combination with a SPJ risk assessment instrument, like the HCR-20. The instrument was developed based on literature on protective and contextual factors and qualitative research findings within forensic clinical treatment.

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

Protection Judgment is combined with the HCR-20 risk factors to come to an Integrative Final Risk Judgment for future violent behavior. In De Vogel, De Vries Robbé, De Ruiter and Bouman (under review) the background and content of SAPROF is explained further and its protective factors are discussed in more detail.

Being mainly dynamic in nature, the SAPROF aims to not only assess protective factors, but to also inform treatment of potential goals for interventions. By doing so, the SAPROF can offer valuable guidance in narrowing the gap between assessment and violence prevention. In 2007, the SAPROF was implemented into general risk assessment practice for violent and sexually violent offenders in the Van der Hoeven Kliniek, The Netherlands, to complement traditional risk assessment with the HCR-20 and SVR-20.

The main paper

Although the greatest supplemental value of the SAPROF is expected to be its importance for guiding prospective treatment evaluation and planning, confirmation of its predictive validity for violent recidivism, initially retrospectively and ultimately prospectively, is an essential condition that needs to be examined. The current studies aim to provide a retrospective validation of the SAPROF for a sample of 126 male violent offenders and a sample of 84 male sexual offenders discharged from intensive forensic psychiatric hospital treatment in The Netherlands. The interrater reliability of the SAPROF is being assessed and ratings at the end of treatment of the SAPROF, the HCR-20 and for the sexual offenders the SVR-20 are related to official recidivism data in order to assess the predictive validity. Furthermore, in order to examine patient development in protective factors over time, the changeability of SAPROF scores during treatment is being analyzed by comparing pre-treatment and post-treatment ratings. For a more detailed description of the study on violent offenders see De Vries Robbé, De Vogel and De Spa (under review).

Method

File information was gathered on 126 violent offenders who were discharged from the Van der Hoeven Kliniek between 1990 and 2006 and for 84 sexual offenders who were discharged between 1984 and 2006. Because of the dynamic nature of most SAPROF factors it was important to have sufficient information about the final phase of treatment (12 to 0 months prior to discharge). In the present study, trained researchers including the authors coded the SAPROF, the HCR-20 and for sexual offenders the SVR-20 retrospectively for all cases at the end of treatment based on the available file information. The rating procedure was performed while all raters were blind to previous risk assessment codings and outcome data on recidivism. For 121 patients, additional ratings were also composed at the start of treatment (pre-treatment rating), based on available file information up to the first year of admission. Finally, in order to establish the interrater reliability, 70 randomly selected cases were coded independently by two different raters, after which consensus scores were agreed upon. The consensus scores were used for the analyses on the predictive validity. In order to be able to compare the predictive validity of the SAPROF for non-recidivism at fixed follow-up times, for each patient only official reconvicitions within one, two or three years after release were used for the comparison.

Results

For both the violent offender group and the sexual offender group the interrater reliability of SAPROF total scores was good (ICC = .88 and .85 respectively). The predictive validity for no violent recidivism after treatment of both the SAPROF total score and the Final Protection Judgment was good for all three follow-up periods for the violent offender sample (AUC = .85-.74 and .82-.71 respectively) as well as for the sexual offender sample (AUC = .87-.77 and .80-.73

respectively). Predictive validities of the SAPROF were similar to those of the HCR-20 and SVR-20 for violent recidivism. Analyses of the changeability of SAPROF scores during treatment showed significant differences between pre and post treatment ratings in the expected directions for all SAPROF factors.

Conclusion

Although the main objective of the SAPROF is prevention, the purpose of the present retrospective studies was to provide confirmation of the reliability and predictive validity of the SAPROF. The results of these retrospective validation studies showed that the SAPROF can be reliably coded by different raters and that both the SAPROF total score and the Final Protection Judgment have good predictive validity for the short-term to medium-term (one to three years) prediction of non-recidivism after discharge from treatment. Moreover, the changeability of most protective factors of the SAPROF confirms the dynamic nature of the instrument and its usefulness as a clinical tool to measure change and guide treatment intervention.

Concluding, the SAPROF demonstrates to be a promising new instrument for forensic psychiatric practice. Through effectively complementing the dynamic assessment of risk for violent recidivism, the SAPROF cares for a more balanced assessment of future violence risk, with the ultimate goal to provide a valuable positive approach to preventive risk management in forensic clinical psychiatry.

Acknowledgements

The authors wish to thank all mental health professionals who contributed to the development of the SAPROF. Special thanks go to Eva de Spa, Ellen van den Broek, Katinka van de Ven, Lotte Kerklaan, Koen Koster and Stefan Bogaerts for their contributions to the present studies.

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The factor structure and antisocial correlates of the Psychopathy Checklist-Revised in a Belgian sample of incarcerated perpetrators of violent and sexual crimes

Paper

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Keywords: Psychopathy, factor-structure, antisocial behaviour, instrumental aggression

Introduction

Psychopathy is a severe personality disorder that consists of interpersonal, affective and behavioural features (Hare, 2003). Over the last decade the instrument most frequently used to assess this disorder is the Hare Psychopathy Checklist-Revised (PCL-R). The PCL-R provides clinical forensic practitioners with a guide for making diagnoses, risk assessment and treatment perspectives. However, there is an ongoing empirical and theoretical debate on the factor structure of the PCL-R with different researchers proposing two-, three-, and four factor models. These factor models convey different concepts of psychopathy and preference for one of the models has important practical implications. In contrast to the abundance of factor-analytical studies with Anglo-Saxon samples, research in Continental European samples is scarce.

The original two-factor model was proposed by Hare in the first edition of the PCL-R manual (1991): Factor 1 taps the interpersonal and affective characteristics, whereas Factor 2 covers impulsive, irresponsible, and antisocial behaviour. This two-factor model has been replicated in Belgian, Spanish, and Swedish samples of male detainees (Pham, 1998; Molto, Poy & Torrubia, 2000; Johnsson, Andershed, Kerr & Levander, 2002). Hildebrand, de Ruiter, de Vogel and van der Wolf (2002), however, found a modified version of this two-factor structure in a Dutch sample of male forensic-psychiatric patients.

While the two-factor model is still popular in research and clinical practice, it has been criticised by Cooke and Michie (2001) on both theoretical and empirical grounds. They propose a three-factor model in which the original Factor 1 is divided into an interpersonal and an affective factor. The third factor consists of five items that reflect an impulsive and irresponsible behavioural style. Cooke and Michie (2001) rejected seven items pertaining to antisocial behaviour as redundant for the measurement of psychopathy. Hare (2003) criticised the rejection of these items and instead proposed adding a fourth factor to the model of Cooke and Michie (2001), which comprises the five items on antisocial behaviour. Studies in Anglo-Saxon samples concur that the three- and four-factor models result in a better fit than the two-factor model.

In Continental Europe, only one study has compared the different factor models of the PCL-R. That study was carried out by Cooke, Michie, Hart and Clark (2005) who grouped together datasets of male detainees and forensic-psychiatric patients from Belgium, Denmark, Germany, Norway, Spain and Sweden. To date this is the most comprehensive study on the factor structure of the PCL-R in Continental Europe. Using CFA, they found that the two- and four-factor models did not fit the data, in contrast to the three-factor model.

This study investigates the factorial structure of the PCL-R in Continental European prison populations. In a Belgian sample of incarcerated perpetrators of violent and sexual crimes we explore (a) the fit of the different factor models to PCL-R data, and (b) the relationship between psychopathy and antisocial correlates (i.e., number of previous convictions and instrumental quality of violent crimes).

Method

Participants

Participants were 91 male inmates recruited from two prisons in Flanders (Belgium). Of the sample, 31% was convicted for (attempted) manslaughter or murder, 27% for a violent crime, 42% for a sexual crime. The sample was 85% Caucasian with a mean age of 39.6 years (SD = 12.1, range = 20 – 73 years).

Measures

Psychopathy. The PCL-R rating was based on semi-structured interviews and file data. Based on independent ratings by the psychologists working in the prison, intraclass correlation coefficient was .82 for the PCL-R total score.

Previous convictions. The number of previous convictions as an adult was retrieved from criminal records.

Instrumental aggression. Instrumental aggression was measured with the coding guide developed by Cornell (1996), which proposes a primary 4-point rating for instrumental aggression, and a secondary ordinal rating of (a) planning, (b) goal-directedness, (c) provocation, (d) anger, (e) severity of violence, (f) relationship with victim, (g) intoxication, and (h) psychosis. This guide was used to code the index offence, i.e., the most recent violent or sexual crime. Independent coding was carried out for 34% of the cases by students in Clinical Psychology with a Bachelor degree. The intraclass correlation coefficient was .67 for the primary rating of instrumental aggression, and ranged between .60 and 1.00 for the secondary ratings.

Data analysis

LISREL 8.71 was used for the CFAs and for the analysis of ordinal data we followed the guidelines of Jöreskog (2002). In evaluating the model fit, the following criteria were used as standards of acceptable fit: Comparative Fit Index (CFI) > .90, Standardized Root Mean square Residual (SRMR) < .10, and Root Mean Square Error of Approximation (RMSEA) < .08 (Kline, 2005). Multiple regression in SPSS Version 16 was used to investigate the association between the PCL-R and antisocial correlates.

Results

Factor structure of the PCL-R

The fit indices presented in Table 1 indicate that a bad fit was found for the two-factor model. The three- and four-factor models fitted the data best, with preference for the three-factor model. The three- and four-factor models are not nested so they can only be compared through the AIC statistic. It appears that the oblique and hierarchical three-factor models are the most parsimonious in fitting the data.

Table 1: Goodness-of-Fit Indices for Models Tested

Model	# items	χ^2	df	RMSEA (90% CI)	SRMR	CFI	AIC
Two-factor models							
Oblique model (Hare, 1991)	17	214.6	118	.10 (.08 – .12)	.075	.75	284.4
Oblique model (Hare, 2003)	18	240.9	134	.09 (.08 – .11)	.074	.75	314.9
Three-factor models							
Oblique model (Cooke & Michie, 2001)	13	91.3	62	.07 (.04 – .10)	.047	.91	149.3
1 Higher-order, 3 lower order factors (Cooke & Michie, 2001)	13	91.3	62	.07 (.04 – .10)	.047	.91	149.3
Oblique model (Bishopp & Hare, 2008)	15	128.8	87	.07 (.04 – .10)	.058	.88	194.8
Four-factor models							
Oblique model, four factors (Hare, 2003)	18	188.6	129	.07 (.05 – .09)	.056	.86	272.6
2 Higher-order, 4 lower-order factors (Hare, 2003)	18	192.3	130	.07 (.05 – .09)	.057	.85	274.3

Note. RMSEA = Root Mean Square Error of Approximation; CI = Confidence Interval; SRMR = Standardized Root Mean square Residual; CFI = Comparative Fit Index; AIC = Akaike’s Information Criterion.

Factor 1 explains 27 to 40% of the variance in the interpersonal items, Factor 2 explains 28 to 36% of the variance in the affective items, and Factor 3 explains 17 to 37% of the variance in the lifestyle items. The correlations between the latent variables in the oblique three-factor solution were all significant (F1-F2: $r=.91$; F1-F3: $r=.35$; F2-F3: $r=.60$), indicating a higher order psychopathy factor.

Antisocial correlates

As shown in Table 2, the PCL-R total score is positively associated with the total number of convictions, versatility of convictions, and number of convictions for fraud. In the first regression model, the number of previous convictions was regressed on the three-factor model. Factor 3 appeared to be most strongly associated with previous convictions for violent and non-violent crimes, with the total number of convictions and with versatility of conviction. However, in the second regression model which included all four factors of the PCL-R most of the significant coefficients on Factor 3 disappeared and were replaced by significant coefficients on Factor 4.

Table 2: Associations Between Psychopathy Scores and Number of Previous Convictions

	Total PCL-R	Model 1 (Factors 1 – 3)			Model 2 (Factors 1 – 4)			
	β	Factor 1	Factor 2	Factor 3	Factor 1	Factor 2	Factor 3	Factor 4
Total # convictions	.30**			.51**				.46**
Versatility	.33**		-.31*	.69**		-.27*	.44**	.40**
Violent crimes:								
Robbery			-.27	.25		-.26		
Assault			-.38*	.49**		-.36*	.30	.34*
Murder								
Sex offence								-.26
Non-violent crimes:								
Theft	.18	-.24		.44**				.41**
Drugs		-.27		.40**				.31*
Fraud	.25*			.24				

Note: Only regression coefficients with corresponding $p < .10$ are displayed;

* $p \leq 0.05$; ** $p \leq 0.01$.

This procedure was repeated for Instrumental aggression. Table 3 shows that the PCL-R total score is associated with Instrumental aggression and several of the secondary ratings (Goal-directedness, and Relationship to victim). The first regression model consisting of Factor 1 to 3 indicates that Factor 3, and to a lesser extent Factor 1, are associated with the secondary ratings of Instrumental aggression. Most of these associations disappeared for the regression model which included Factor 4. Factor 4 was only associated with absence of relationship with the victim.

Table 3: Associations Between Psychopathy Scores and Instrumental Aggression

	Total PCL-R	Model 1 (Factors 1 – 3)			Model 2 (Factors 1 – 4)			
	β	Factor 1	Factor 2	Factor 3	Factor 1	Factor 2	Factor 3	Factor 4
Instrumental aggression								
Planning	.26*	.29						
Goal-directedness				-.30*				
Provocation	.27*	.26						
Arousal (anger)								
Severity of violence	-.20	-.30						
Relationship to victim								
Intoxication	-.34**			-.44**				-.26*
Psychosis		-.33*		.28*	-.27			.24

Note. Only regression coefficients with level of significance below .10 are displayed.

* $p \leq 0.05$; ** $p \leq 0.01$.

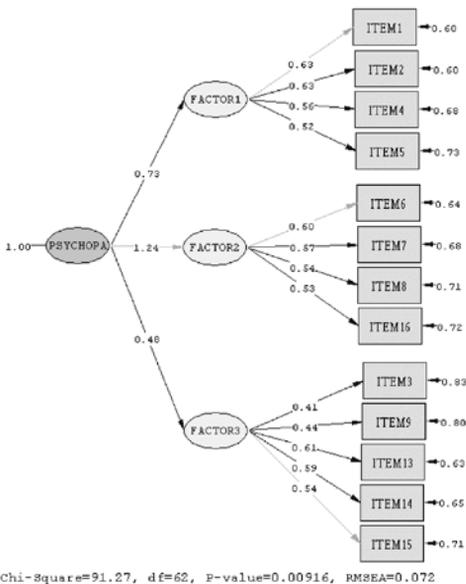
Discussion

Through confirmatory factor analysis we found evidence for good fit of the three-factor model by Cooke and Michie (2001), although we did not use testlets in our CFA. Moreover, we found that the three factors are superposed by one general psychopathy factor. Although the three-factor model displayed several significant associations with previous convictions, most of these associations disappeared when the fourth factor was introduced into the model. This finding is consistent with previous research with prisoners in England and Wales (Roberts & Coid, 2007). This suggests that past criminal behaviour cannot be explained by the interpersonal style, lack of affect, or an impulsive, irresponsible lifestyle. Rather, it is the antisocial lifestyle that explains most of variance in previous convictions. This is in contrast with the consequence-hypothesis that posits that antisocial behaviour is a consequence of Factor 1, 2 and 3 (Cooke & Michie, 2001). However, due to the cross-sectional design of this study, we cannot address this question. It is possible that the strong association between previous convictions and the Antisocial lifestyle factor is tautological.

Concerning the association between psychopathy and Instrumental aggression, Factor 1 and Factor 3 were differently associated with instrumental aggression. This makes sense: the interpersonal style contributes to the committing of crimes that are goal-directed, cold-blooded and without intoxication, while the impulsive-irresponsible traits contribute to the committing of crimes that are poorly planned, with an unknown victim and with intoxication. It is clear that the three-factor model of psychopathy contributes to the understanding of the modus operandi and motivation of violent crimes. When the Antisocial lifestyle factor was included, this explanatory power disappeared.

Concerning psychopathy and antisocial behaviour we conclude that, while Factor 4 is important for understanding the frequency of antisocial behaviour, Factor 1 and 3 are more important for understanding the modus operandi and the motivation of the crime.

Figure 1. Standardized solution of the PCL-R three-factor model of psychopathy



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Chapter 13 – Specific Organizational Interventions related to Violence

Protecting client and employee safety through embracing the Collaborative Recovery Model in a Canadian Mental Health Centre: A multidimensional context

Workshop

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Keywords: Workplace violence, collaborative recovery model, therapeutic alliance, employee and client safety, leadership, prevention

Introduction

Workplace violence is a complex issue requiring multifaceted and multidisciplinary strategies aimed at control. Traditional approaches to managing workplace violence have been focused on methods to contain or reduce the impact of the violence/aggressive act, rather than to seek out the root cause for the event and apply the appropriate controls. Controlling violence/aggression actually involves integrating safety into clinical practice. Adopting evidence-based practice in recognizing and averting the violent/aggressive act is essential to decreasing the risk of violence/aggression in the healthcare sector. In mental health facilities, the Collaborative Recovery Model is a novel approach to care that emphasizes recovery as a subjective and personal experience and the means to recovery as a collaborative effort between mental health workers and their patients. A critical outcome of supporting a strong therapeutic alliance and client collaboration in recovery is a reduction in violent incidents.

Background

Violence-related injuries are becoming increasingly prevalent in Canada's healthcare sector. In Ontario, Canada in 2007, this sector had the highest rate of lost time injuries associated with workplace violence compared to other sector groups, occupying 34% of all workplace violence lost time claims (WSIB, 2008). The categorization of different types of violence helps to align

prevention efforts, specifically those dedicated to risk assessment and control. The four subtypes of workplace violence are:

1. Type I - External: The perpetrator has no relationship to the worker or workplace;
2. Type II - Client or Customer: The perpetrator is a client at the workplace who becomes violent toward a worker or another client;
3. Type III - Worker-to-worker: The perpetrator is an employee or past employee of the workplace; and
4. Type IV - Personal Relationship (Domestic Violence): The perpetrator has a personal relationship with an employee or a client.

Type II violence (client-to-worker) is one of the most frequently occurring types of violence in the health and community care sector. Over 90% of physicians and nurses working in mental health facilities have been subjected to violence from clients at some time during their careers (Almvik et al., 2000). Further, rates of violence in mental health facilities are increasing (Almvik et al., 2000; Decaire et al., 2006).

Traditional approaches to managing workplace violence have been focused on methods to contain or reduce the impact of the violence/aggressive act, rather than to seek out the root cause for the event and apply the appropriate controls. Controlling violence/aggression actually involves integrating safety into clinical practice and patient care. Recognizing and averting the violent/aggressive act is essential to decreasing the risk of violence/aggression in the healthcare sector.

In tertiary mental health facilities, a comprehensive systemic approach is required to effectively prevent aggression and promote client and staff safety. This approach recognizes that risk of aggression is influenced by multiple elements, including leadership, environment, work life, unit milieu, co-patients, relational dynamics and staff and client factors. Instrumental to the approach is the collaborative recovery philosophy that emphasizes recovery as a subjective and personal experience and the means to recovery as a collaborative effort between mental health workers and their patients. A critical outcome of supporting a strong therapeutic alliance and client collaboration in recovery is a reduction in violent incidents.

Methods and results

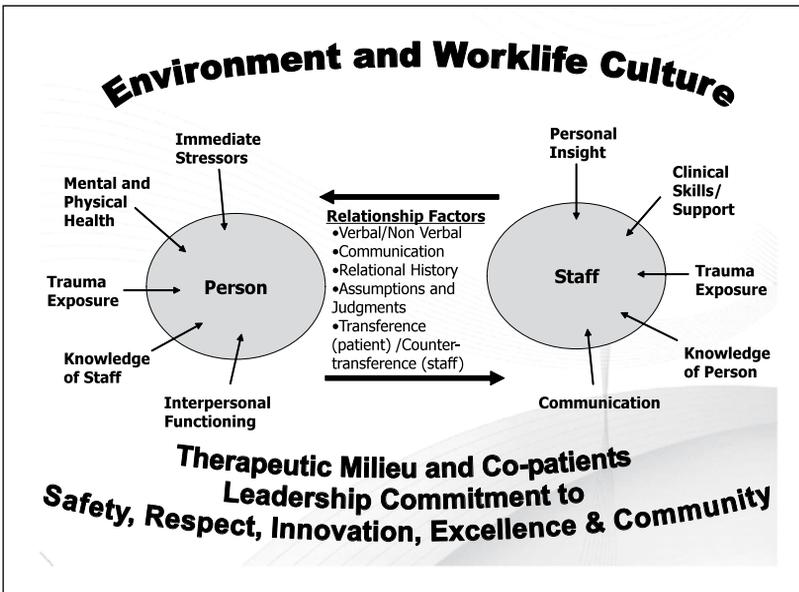
To reduce incidents of violence and aggression in their tertiary-care mental health centre in Ontario, Canada, Ontario Shores Mental Health Sciences Centre partnered with the Ontario Safety Association for Community and Healthcare to develop and implement an innovative client care strategy stemming from the collaborative recovery philosophy. Ontario Shores Mental Health Sciences Centre (Ontario Shores) is a 329-bed tertiary-care mental health centre in Ontario, Canada. With 1100 employees, Ontario Shores provides inpatient and outpatient mental health care and operates multiple community sites serving a population of 2.8 million people. Ontario Shores' multidisciplinary mental health staff provides care for severe and persistent mentally ill clients who have an on-going potential for emotional escalation that can lead to aggression.

The Ontario Safety Association for Community and Healthcare (OSACH) is a non-profit corporation designated by the Ontario Workplace Safety & Insurance Act to assist organizations and their workers in the health and community care sector to achieve safe and healthy work environments through the prevention and reduction of workplace injuries, illness and disease. OSACH provides consulting, training and specialized health and safety services and products to more than 6500 healthcare and community organizations in Ontario, Canada. In partnership with the Ontario Ministry of Health and Long-Term Care, OSACH has recently developed several workplace violence prevention and control resources including 3 workbooks (Assessing Violence in the Community; Bullying in the Workplace; Domestic Violence in the Workplace) and four awareness posters. These new resources, in addition to existing OSACH products (Video – Raising

Awareness of Violence in the Workplace; Resource Document – A Guide to the Development of Workplace Violence Prevention Programs; Training Program – Developing a Workplace Violence Prevention Program) will assist health and community care organizations to strategically integrate prevention of workplace violence into their business model and clinical practice.

In November of 2006 the Board of Directors of Ontario Shores Mental Health Sciences Centre presented their Strategic Plan for 2007. Included in this plan was a vision statement and core values that were intended to give shape to the future of treatment and care provided by the hospital. Central to the newly defined vision was the provision of mental health services that were focused on recovery, hope and inspiration through the process of discovery and the Centre’s commitment to provide a safe environment for patients, families and staff. To assist in the realization of this vision, Ontario Shores developed an innovative client care strategy stemming from the collaborative recovery philosophy called the Multidimensional Model for Managing Relationships through the Crisis Continuum (MMMRCC) (See Figure 1).

Figure 1. Multidimensional Model for Managing Relationships through the Crisis Continuum



The MMMRCC emphasizes that a comprehensive systemic approach is required to effectively prevent aggression and promote client and staff safety in mental health settings. The model moves healthcare practice away from reactionary responses to aggression, a good example being the overuse of seclusion and restraints, towards more preventative approaches of aggression through multi-systemic risk management and therapeutic interventions. The principles of the model recognize that risk of aggression is influenced by multiple elements including leadership, environment, work life, unit milieu, co-patients, relational dynamics, and staff and client factors. Leadership vision and commitment to client and staff safety is a key element of successful implementation of the model and is required to prevent aggression and reduce rates of injury across the organization. The focus on interpersonal context within the model is another key factor in the prevention of aggression and the environment, work life culture, staffing, team dynamics, and staff skills and education need to be acknowledged as important variables that influence staff-client relationships throughout the crisis continuum. The relational dynamics between staff

and clients can be contextualized into verbal and non-verbal communication, relational history, assumptions, judgments, and transference/ counter transference. Timing is also a key factor in relational dynamics. The literature shows a strong therapeutic alliance established at the time of admission is associated with lower risk of client aggression during hospitalization (Beauford et al., 1997).

To support the implementation of the MMMRCC at Ontario Shores, the Ontario Safety Association for Community and Healthcare developed a Clinical Practice Assessment Tool to Safeguard Staff and Clients in a Mental Health Facility. This assessment tool was developed based on a review of the literature on the collaborative recovery model, the therapeutic alliance and the reduction of seclusion and restraints. The tool consists of two assessment checklists. The first checklist is completed by management within the organization and examines leadership commitment and the supporting program infrastructure to facilitate and sustain workplace violence prevention. The second checklist is for front line mental health caregivers to reflect on their individual care giving and their commitment to the principles of collaborative recovery.

Outcome measures associated with the Clinical Practice Assessment Tool fall under the three levels within the organization:

1. At the client level – e.g. numbers of clients who participated in the de-escalation preference assessment and collaborative-recovery measures;
2. At the staff level – e.g. Safe Management Group Inc. (SMG) pre & post-test scores, confidence in coping with aggression tool and involvement in SMG consultations; workplace satisfaction survey results; and therapeutic relationship measures
3. At the organizational level – e.g. code white prevalence, number of staff injuries and number of client complaints, and prevalence of restraints and seclusion use.

The use of this Clinical Practice Assessment Tool will foster the development of a system of care that integrates client and employee safety and reduces workplace violence in the mental health setting.

Discussion

Through the implementation of the Multidimensional Model for Managing Relationships through the Crisis Continuum and the Clinical Practice Assessment Tool to Safeguard Staff and Clients in a Mental Health Facility, Ontario Shores aims to provide recovery-based patient care and reduce workplace aggression and violence. The literature states that a critical outcome of a strong staff-client therapeutic alliance and client collaboration in recovery is the reduction in violent incidents towards staff and other clients (Beauford et al., 1997). The emphasis of this system of care is on the therapeutic alliance, strength and competency based inter-professional care planning and treatment and clinical practice assessment at all levels within the organization.

Using this systems approach, strategies for safeguarding staff and patients move from being reactionary through the use of restraints and seclusion to preventive where the management of aggression is seen as a therapeutic-based intervention. Patient and staff interactions are seen as being influenced by multiple factors including personal factors, knowledge of each other, environment, work culture, and staff skill and education. Therefore, the approach is multidimensional, identifying three key elements of healthcare that could positively impact staff safety and quality of care: the client's active participation, the staff's hopeful attitude and senior leadership within the organization.

The way that behavioural crises are managed by staff is an important part of the strategy and is an area that has been given a lot of attention through the proliferation of mandatory crisis intervention curricula internationally for mental health staff (Pryer et al., 2008). Client and staff interactions before, during and after a crisis are influenced by individual factors. Staff's

personal insight, values, clinical skills and support, previous trauma, knowledge about the client, and communication skills need to be considered. Equally as important, the client's immediate stressors, mental and physical health, previous trauma, knowledge about the staff, values, and interpersonal functioning need to be considered. These internal and external factors need to be acknowledged and considered by each staff member during every crisis in which they intervene so that the therapeutic alliance and preventative approach remains the focus (Churchill et al., 2008). SMG crisis intervention education for all clinical and non-clinical staff, implementation of de-escalation and mock code white practice sessions, embracing a least restraint philosophy to care, and a code white response that includes debriefing with clients, staff, and co-patients are all elements of the MMMRCC that have been put in place.

Conclusion

Ontario Shores Mental Health Sciences Centre has begun the organizational change process of implementing their new model and the use of the OSACH clinical assessment tool. The stage has been set for transformation from a traditional service delivery model in tertiary mental health, to an inter-professional, strengths-based model that relies on all team members working within their full scope of practice, while integrating collaborative team-based approaches to care. Senior leadership is committed to the implementation of collaborative, recovery-oriented care, and clinical assessment at all levels of the organization to effectively prevent and reduce violent incidents.

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The relationship between being restrained and number of admissions to Emergency Psychiatry Departments: Preliminary findings from an ongoing study from three Departments of Acute Emergency Psychiatry

Paper

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Background

As far as we know there is little knowledge about restraint exposure and the patient's number of admissions to Emergency Psychiatry Departments.

Method

The findings are from an ongoing study conducted in three Emergency Psychiatry Departments with total responsibility for representative catchments areas. All patients admitted during a 2- year period were included in the study. For each patient restrained we collected data from the handwritten protocols about pharmacological restraint and/or mechanical restraint, and the individual number of admissions from the electronic journals, and compared number of admissions in the group of patients restrained (N=258, 44 % women) with a random sample of patients without restraint (N=258, 46% women).

Results

Preliminary analyses from two of the Emergency Psychiatry Departments showed a significantly larger number of admissions ($p < 0.001$) in the group of patients being restrained (mean 2.7, range 1-23) than in a random sample of patients without restraint (mean 1.5, range 1-6). In a subgroup of restrained patients (N=24), all having more admissions than any patients in the random sample, women were in majority (62%), and had a higher mean number of admissions than the men (11.8 versus 8.4).

Conclusion

The results indicate that there are significant differences in the use of Emergency Psychiatry health services between patients being restrained and patients not restrained. In a subgroup of patients often admitted to Emergency Psychiatry Departments, all the patients were restrained and the prevalence of women was 62%. These results suggest that use of restraints is markedly increased among patients with frequent admissions to Emergency Psychiatry Departments. Further, women appear to be in majority among patients with many admissions.

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Building the Business Case for reducing restraint and seclusion use

Paper

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Keywords: Restraint, seclusion, reduction, cost, savings

Introduction and background

Researchers have begun to study the costs of using restraint and seclusion (Flood, Bowers, & Parkin, 2008; LeBel & Goldstein, 2004, 2005) and the value added by reducing their use (LeBel & Goldstein, 2004, 2005). Most recently, the Substance Abuse Mental Health Services Administration (SAMHSA) examined the business case for reducing these containment procedures (SAMHSA, in press) as part of their ongoing national initiative and goal to eliminate restraint and seclusion (Curie, 2005; SAMHSA, in press). At a time of significant fiscal constriction, leaders are being compelled to reexamine their organization's current use of restraint and seclusion from an economic perspective (SAMHSA, in press). Over the past decade, the United States has focused on restraint and seclusion reduction and prevention (Huckshorn & LeBel, 2009). Many organizations have embarked on initiatives to reduce and prevent restraint and seclusion use and reported significant success (Delaney, 2006; LeBel et al., 2004; NASMHPD, 2009; Smith et al., 2005). Several have cited additional operational and economic benefits of replacing these procedures with more supportive measures (Florida TaxWatch, 2008; LeBel, 2009; LeBel & Goldstein, 2004, 2005; Murphy & Bennington-Davis, 2005; Sanders, 2009).

Method

A literature review of restraint and seclusion costs, reduction efforts and violence in health care, specifically mental health, was conducted. In addition, inpatient and residential program organizational case analyses of published successful reduction efforts were performed. Data on the economic and operational benefits from decreased use of these containment procedures was reviewed. Specific pre-post restraint/seclusion reduction initiative costs were examined in addition to leadership, staff, and consumer perceptions of these procedures. Alternatives to restraint and seclusion were also solicited and analyzed (SAMHSA, in press).

Results

Many organizational costs result from restraint and seclusion use. The most significant day to day cost is staff time spent managing these procedures (Flood et al., 2008; LeBel & Goldstein, 2005). The full cost to an organization is unknown (Huckshorn, 2006; LeBel & Goldstein, 2005). Estimates range from \$240 to \$354 per episode depending on the type of containing methods used (i.e., physical, mechanical, and/or medication) (Flood et al., 2008; LeBel & Goldstein, 2005). Containment procedures, in total, account from anywhere from 23 – 50 percent of staffing resources (Flood et al., 2008; LeBel & Goldstein, 2005). Other studies support these findings, underscore that additional staff and resource intensity is required to manage restraint and seclusion episodes, and this, in turn, raises the cost of care (Cromwell & Maier, 2006; SAMHSA, in press). A number of other organizational costs result from restraint and seclusion use. These procedures

are associated with more medication and physical injuries to staff and persons-served (Bailey, 2006; LeBel & Goldstein, 2005; Murphy & Bennington-Davis, 2005; NASMHPD, 2009). Environmental damage has also been reported by some facilities (Banks & Vargus, 2009; LeBel & Goldstein, 2005). In addition, workforce-related volatility (i.e., turnover, industrial accidents, absenteeism/sick time, replacement costs, hiring costs, training/retraining) has been cited by many organizations as costly sequellae to restraint and seclusion use (Greene & Ablon, 2006; LeBel & Goldstein, 2005; Murphy & Bennington-Davis, 2005; Sanders, 2009; Unruh, Joseph, & Strickland, 2007).

In the event of injury or harm to the consumer or staff, increased worker's compensation, general liability, and professional liability claims and costs result (Bailey, 2006; LeBel & Goldstein, 2005; Murphy & Bennington-Davis, 2005; Rodman & Gordon, 2008; Sanders, 2009). If litigation and legal judgments follow, these costs can surpass all others, claim millions of dollars, and force facilities to close (GAO, 2008; Haimowitz et al., 2006; Hunter & Carmel, 1992; SAMHSA, in press; Stefan, 2002).

Restraint and seclusion use charges an immeasurable cost to consumers. These costs include: 1) physical injuries; 2) traumatization; 3) decrease in functioning; 4) longer lengths of stay; 5) more medicine; and 6) increased readmission to the hospital (LeBel & Goldstein, 2005; Murphy & Bennington-Davis, 2005; SAMHSA, in press; Thomann, 2009). In addition, consumers experience damage to the therapeutic alliance and mistrust of the health care system (Huckshorn & LeBel, 2009; Robins et al., 2005; SAMHSA, in press) and are subjected to "opportunity costs" – the cost of care not being provided when staff attention is focused on managing restraint or seclusion instead of treatment (Krueger, 2009).

Prevention-oriented training and supervision of staff, implementation of crisis prevention plans, and sensory-based alternatives, such as Comfort or Sensory Rooms, are most frequently developed when organizations work to reduce restraint and seclusion use (NASMHPD, 2009). The costs of these tools are less than the aggregate costs associated with using restraint and seclusion (LeBel, 2009; NASMHPD, 2009). Larger programs and state facilities have reported millions of dollars in savings and cost avoidance (Florida TaxWatch, 2008; LeBel, 2009; Sanders, 2009). Successful programs credit leadership commitment and staff dedication as the most important elements in effective reduction efforts (NASMHPD, 2009).

Conclusion and discussion

Restraint and seclusion use contributes to: 1) violence in the workplace, 2) significantly increased operational and workforce-related costs, 3) reduced quality and effectiveness of care, and 4) an unquantifiable personal costs to service users and workers (Flood et al., 2008; Huckshorn & LeBel, 2009; LeBel & Goldstein, 2005; NASMHPD, 2009). Costs incurred to reduce and prevent restraint and seclusion typically includes staff training, sensory interventions/equipment, modest environment of care changes, and new consumer roles to promote practice and culture change (Huckshorn & LeBel, 2009; LeBel & Goldstein, 2005). Reducing restraint and seclusion use ultimately leads to enhanced working and treatment conditions, greater staff and consumer satisfaction, and substantial savings which exceed the costs expended to prevent their use (LeBel, 2009; NASMHPD, 2009).

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Chapter 14 – Specific Populations and Violence: Forensic Psychiatry

Developing a forensic department by using the risk assessment tool BVC and the SOAS-R as indicators

Poster

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The poster will present how a forensic department in Denmark uses the BVC (Brøset Violence Checklist) and the SOAS-R (Staff Observation Aggression Scale-Revised) for developing the clinical practise. By using the BVC and SOAS-R we aim to have a baseline tool for developing the clinical practise.

Project aims

- To systematically train staff to use BVC and SOAS
- To implement strategies in the milieu to avoid violent situations by following the SOAS registrations
- To develop nursing strategies for preventing violent incidences
- To develop de-escalating techniques.

Background

In 2002 the European committee for the prevention of torture and inhuman or degrading treatment or punishment concluded after visits at three psychiatric hospitals in Denmark, that patients were mistreated by long term restraint. This report created an image problem for Danish nurses. This emphasises the need for research into the interacting of the nurse and the violent patient. Even though psychiatric nurses have a long history of dealing with violent situations, managing violent and threatening behaviour in psychiatric units is still in the shadow of psychiatry. Nurses don't talk about what kind of strategies they are using.

In order to reduce the use of coercion, prevent violent behaviour and develop alternative de-escalating strategies, it is a priority for nurses to articulate the strategies for managing violence. Prediction of violence has been shown repeatedly to be a difficult task, and the accuracy of such predictions has usually been deemed poor. The prediction of violence is often a team effort and the decisions are often made after input from professionals with a variety of perspectives.

To prevent violence and thereby to prevent the use of restraint, there is a need to develop clinical theory that accurately details the interaction between the nurses and the violent and threatening patient.

This poster will detail:

- The implementation phase of the BVC and SOAS (the SOAS-R registrations is followed over a 2 years period).
- The strategies implemented on the behalf of the BVC and SOAS registrations (i.e. physical activities, Cognitive behaviour therapy).

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Homicide inside and outside the family: Differences between people diagnosed with schizophrenia and those diagnosed with paranoid psychosis

Paper

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Keywords: Forensic psychiatry, homicide, schizophrenia, paranoid psychosis

Introduction

Given the variety of different forms of violence, this research was concerned with the nature of violence in the future and the boundary of human aggression. Homicide is manifestation of aggressive behavior characterized by a situation in which the perpetrator does not or can not control his own aggressive impulses and directs these to another person. Aggression may occur suddenly and may lead to homicide, thereby making many murders sudden and unexpected acts. Homicidal aggression is malignant, and brutal, while the act of homicide is sudden, usually unexpected and aimless. Homicide committed by people with mental disorder may result from psychopathology. Environmental circumstances may trigger a patient's homicidal behavior. Failing to recognize early symptoms of disease, the fear of mentally ill patients, and concealing the existence of mental disorders of family members have resulted in murder. Recent studies, especially from Scandinavia and Canada, show a moderate but reliable relationship between violent behavior and the existence of mental illness. This is especially true of the first psychotic episode. Fortunately, only 4% of mentally ill patients are perpetrators of a crime. However, there remain prejudices in society that serious crimes are usually committed by mentally ill persons. The researchers investigated associations between certain psychopathological contents of patients diagnosed with schizophrenia and those diagnosed with paranoid psychosis and the manifestation of excessive violence. To date, this link can not be determined exactly, because there is a significantly greater number of psychiatric patients who have similar symptoms and who have never expressed dangerous behavior.

Objectives

This paper compares patients diagnosed with schizophrenia with those diagnosed with paranoid psychosis on aspects of their crimes and social functioning. The researchers were interested in the idea that patients diagnosed with schizophrenia who "functionally orientate" to the family may perpetrate familial homicide. On the other hand, patients diagnosed with paranoid psychosis are "functionally oriented" outside the family and often perpetrate homicide outside the family.

Method

This retrospective study included 160 patients receiving compulsory psychiatric treatment in high secure units who had committed a murder in or outside the family. The research related to patients with the diagnosis of schizophrenia and paranoid psychosis in the period from 2004 to 2008. During the research we investigated and the following additional variables:

- age of the patients at the time of crime,
- sex,
- multiple murders,
- previous treatment,
- marital status, and
- alcohol or drugs abuse.

We processed the results using descriptive statistics.

Results

Patients diagnosed with schizophrenia (n = 132, 82.5%) were more likely to commit homicide than patients diagnosed with paranoid psychosis (n = 28, 17.5%). In the schizophrenic group, the average age at the time of committing the murder was 27.5 years. More men 122 (92.1%) committed homicide than women 10 (7.9%). Eighty-eight patients (66.6%) committed murder of family members compared with 44 (33.4%) patients whose murder was of non-family members.. The total number of multiple murders was 32 (27.2%), of which 28 were committed in and 4 outside the family. Of the patients who committed murder 114 (86.4%) were single and 18 (13.6%) were married and 30 (22.7%) had had psychiatric treatment compared with 102 (77.3%) of those who had no previous psychiatric treatment. Thirty eight patients (28.7%) had a diagnosis of alcohol abuse.

Patients diagnosed with paranoid psychosis were on average 38.4 years old at the time of committing the murder and the number of men (26, 92.8%) was much higher than women (2, 7.2%). Murder in the family was committed by 8 (28.6%) and outside the family by 20 (71.4%). The total number of multiple murders that occurred outside the family was 2 (7.1%) . Four (14.3%) persons had received previous psychiatric treatment and 24 (85.7%) had no previous treatment.. Ten (35.7%) patients were married and 18 (64.3%) were single. Two patients (7.1%) had a diagnosis of alcohol abuse.

Table 1: Comparison of groups

	Schizophrenia	Paranoid psychosis
Homicide	82.5% (n = 132)	17.5% (n = 28)
Homicide in the family	66.6% (n = 88)	28.6% (n = 8)
Homicide out of family	33.4% (n = 44)	71.4% (n = 20)
Average age	27.5	38.4
Men	92.1% (n = 122)	92.8% (n = 26)
Women	7.9% (n = 10)	7.2% (n = 2)
Multiple homicides	27.2% (n = 32)	7.1% (n = 2)
Treatment	22.7% (n = 30)	14.3% (n = 4)
Without treatment	77.3% (n = 102)	85.7% (n = 24)
Married	13.6% (n = 18)	35.7% (n = 10)
Single	86.4% (n = 114)	64.3% (n = 18)
Alcohol abuse	28.7% (n = 38)	7.1% (n = 2)
Drug abuse	none	none

Discussion

The differences found by this research can be explained in two ways: 1) these are two completely different mental illnesses, with all their specific features, and/or 2) the patients have completely different forms of social functioning. Patients with schizophrenia have a disorder of social functioning characterized by:

- social withdrawal and isolation,
- disorder of interpersonal relations,
- the fact that a family cannot usually select between adequate and inadequate and aggressive behavior,
- the patients' incapacity to control their aggressive urges and/or take care of themselves or of others,
- patients prefer to speak about what is going on within themselves rather than around them,
- serious problems of social adaptation, and
- dissonances between social maturation and separation from the family.

All these factors lead to the creation of an unnatural position, to which there is often no solution. This "functional orientation" to the 'schizophrenic' family comes from a psychopathology which does not permit the presence of other, unknown people. In the beginning, the family is the only place that offers salvation and "outlet" for the patient. Later, the family can not control inadequate behavior of the patient. On the other hand, the patients diagnosed with paranoid psychosis have a different disorder of social functioning characterized by:

- social hypersensitivity,
- the tendency to reject people close to them,
- latent aggressiveness,
- strong feelings of insecurity and inferiority which design to the selected person from the surrounding,
- high opinion of himself,
- insistence on their autonomy and independence,
- increased expectation of poor treatment of the environment, and
- paranoid pseudo community.

Better social integration of patients with paranoid psychosis lead to their "functional orientation" outside of the family. Their social behavior is directed towards achievement of their goals which depend on paranoid contents. Because of strong emotional investment in paranoid ideas and the inability to exercise, there is a risk of aggressive behavior. Most patients are younger, single and socially dysfunctional men who had not been not previously treated. This is very important, because the recognition of early symptoms of disease and treatment of mental illness is most important in the prevention of violent behavior. Two main reasons for expressing malignant aggression of these patients are: 1) the lack of treatment and 2) social disintegration.

Conclusion

Homicide committed by patients diagnosed with schizophrenia and paranoid psychosis is a complex process affected by many factors. The most important of which are:

1. the actual psychopathology,
2. the psychodynamic relationship to the family,
3. the role of victim, and
4. the reason (the current provocative situation for the expression of aggression)

Some factors can be influenced, but others not. However, the identification of these factors and the implementation of therapeutic measures may prevent dangerous behavior in people living with mental illness.

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Forensic mental health nursing: The interaction between staff and schizophrenic inpatients

Poster

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Background

The number of forensic mental health patients in Denmark is increasing at a rate of 11% per year. Forensic psychiatric patients occupy 20% of all psychiatric beds, and of the total number of forensic mental health patients, 75% are diagnosed with schizophrenia. For this group of inpatients everyday care is a part of the current psychiatric treatment offered on the forensic mental health wards. However, we know very little about the characteristics of staff care and the significance this has for the forensic mental health inpatients. Knowledge about everyday care in relation to the interaction between staff and patients is therefore necessary in order to further evaluate and develop clinical nursing practice.

Aim

The aim of the study is to examine everyday care as it is carried out on the forensic mental health ward. The objective is to describe and analyze the care provided by mental health staff as they interact with schizophrenic forensic mental health inpatients. A further objective is to examine the staff's and patients' experiences of everyday care, and what significance the care has for the patients.

Materials and Methodology

Symbolic Interactionism is employed as the principal methodological framework for the study. Taking everyday life as the starting point, the focus is on the underlying significance of actual communication and interaction as it occurs in daily nursing practice. For this purpose, explorative ethnographic fieldwork is undertaken, in the form of observations and interviews over a 12 month period. The study consists of three stages: In Stage I descriptive participant observations are carried out. In Stage two participant observations are guided by the previous analysis at stage one. Stage three involves open interviews and interviews based on the two previous stages. The study includes a maximum of 16 schizophrenic, forensic mental health inpatients over the age of 18 of Danish ethnic origin, together with the forensic mental health staff working on the same ward(s).

Data analysis

Data is collected by participant observations and interviews and transcribed into text, which is then analyzed using domain, taxonomic and content analysis. This means that the text is analyzed in relation to the terms and underlying meaning that the text constitutes as a whole. 'Meaning' is defined as the meaning expressed by the participants collectively throughout the complete data collection. The purpose of this is to find and sort semantic relations from within everyday care and the interaction between patients and forensic mental health staff in relation to the overall aim of

the study. Thereby the study seeks to provide a foundation for further development and evaluation of existing practice.

Timetable

The study begins in September 2008 and the final report is expected at the beginning of September 2011.

Ethics

The study was reported to and approved by the Danish Data Protection Agency and The Danish National Committee on Biomedical Research Ethics, Region of Southern Denmark. The study is expected to contribute with grounds for evaluation and development of inpatient care in the participating units. Furthermore the study seeks to develop knowledge about the psychiatric nursing field of research.

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A comparative case vignette study of decision making in forensic psychiatric cases

Paper

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Keywords: Forensic psychiatry, forensic evaluations, expertise, judgements, criminal insanity, comparison

Introduction and background

People make different judgements about each other all the time which is considered as a normal occurring phenomenon. When it comes to expertise however, we might expect highly skilled professions to agree with each other within a given field. But even among them quite different judgements of the same phenomena occur, also within forensic psychiatry (Murrie et al., 2008). The forensic psychiatric expert witness (expert) plays an important role in advising the courts in complex matters such as criminal responsibility, competence to stand trial, and risk assessments. The presumption is that experts will give helpful information for the courts regarding the defendant enabling them to pass correct decisions. However, a persistent criticism has been that judgements made by experts do not diverge significantly from that of lay persons, questioning the role of the expert for the courts (Jackson, 1986; Cima et al., 2002; Faust & Ziskin, 1988). But, given that there are no differences between the judgments of experts versus lay persons, then there is scarcely no point in using experts guiding the courts. Therefore we wanted to study if such criticism is reasonable in a Norwegian medico-legal context. As a hypothesis we proposed that we would not find any significant differences in the judgments between experts and laypeople concerning criminal insanity by legal terms, risk of repeated offence, or need of psychiatric treatment.

Methods

We wanted to explore if the forensic psychiatric judgements of experts (14 psychiatrists and 21 psychology specialists) differed significantly from those made by 126 laypersons, and if psychiatrists' judgements differed significantly from those made by psychologists. Based on real forensic reports we constructed 18 case vignettes with balanced sets of positive and negative psychiatric and social history, and of former convictions for minor or major crimes. Psychiatric and social history could be absent, and this classification made a total of 18 combinations (3 psychiatric * 3 social * 2 conviction). Each combination formed one case vignette. We asked the participants to rate each case on three variables: insanity [psychosis, amnesia/unconsciousness, or mental retardation (IQ<55)], risk of committing new criminal offences, and need for psychiatric treatment in the immediate future. Ratings of the variables were done on seven point Likert scales from 1 (not present) to 7 (present to a high degree), i.e. higher scale scores indicated more insanity, higher risk and higher need for treatment. The 18 vignettes were rated seven times in each of the three groups since the psychiatrists rated 9 vignettes each, psychologists 6, and laypersons 1 each.

Since the experts each rated multiple cases, evaluations from the same individual were not independent, and a Linear Mixed Model (LMM) was used for analysis of the data. The significance level was set to $p=.05$.

Results

Significant differences were observed between lay peoples' and experts' ratings on insanity, ($p = .008$), risk, ($p = .024$), and treatment ($p = .009$). No significant differences were found between psychiatrists and psychologists concerning insanity, but concerning risk ($p = .030$) and treatment ($p = .021$).

The most notable result was that the laypersons on the average rated all variables higher than the experts, i.e. considered the case vignettes as being more insane, having more risk and more in need for treatment. The psychiatrists had the lowest ratings of the three groups.

Discussion

The laypersons on average rated all variables higher (more insanity, risk and need for treatment) than the experts while the psychiatrists had the lowest ratings of the three groups. The psychiatrist group were the most experienced (most cases) in forensic work. This might imply that the psychiatrists had a higher threshold for considering a person as legally insane, or at least higher than the two other groups. Two tentative hypotheses can be drawn from our study. First, it does make a difference to be an expert in a forensic setting, due to different ratings compared to laypeople. The reason for this is perhaps a combination of clinical experience and knowledge of the threshold for insanity by legal terms. Second, psychiatrists and psychologists do not seem to diverge substantially in how they judge forensic cases regarding insanity.

Conclusions

We disconfirmed our hypothesis, i.e. we found significant differences between the experts and lay persons concerning criminal insanity, risk and need for treatment. Both professional judgement and professional experience do seem to matter in forensic cases. Perhaps the persistent criticism and claim of the fallacy of the forensic expert is exaggerated.

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Absconding from a forensic psychiatric unit

Paper

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Keywords: Absconding, forensic psychiatry

Introduction and background

When forensic patients abscond from mental institutions it tends to evoke fear among the general public, concern among mental health employees, and a general focus in the press. The present study investigates escapes from a forensic unit during the years 2006 and 2007 and was conducted at the forensic psychiatric unit of Sct. Hans Hospital in Denmark. The unit is an 80 beds treatment institution with Copenhagen as its catchment area. Security levels include high security, medium security and low security. The vast majority of the patients are admitted under psychiatric orders imposed by court on offenders who have committed a serious offence and are considered not responsible due to severe psychopathology.

Method

The method of the study was mixed method, which uses both quantitative and qualitative method to explore the same topic (Coyle & Williams 2000, Moffatt et al. 2006, O’Cathain et al. 2007 & 2008, Sandelowski 2000). The two parts 1) a quantitative part that investigates how the patients who abscond differ from the patients who do not abscond 2) a qualitative part that investigate why patients absconded or why others choose to stay at the hospital.

The aim of this presentation is to present the common themes that emerge from the semi-structured interview with six patients admitted at a forensic department in Denmark on the topic absconding. It was possible to obtain informed consent from six patients all men to take part in a semi-structured interview. Three patients that under there admissions have absconded between 4 to 16 times and three patients that never had absconded.

Conclusion and discussion

The three patients that under their admissions have absconded all told that there escapes was an impulsive act and they always returned to they’re known area of living to join up with there friends and families. Under there escape they all had the feeling of being a hunted pray that any time could be court by the police and therefore it wasn’t an enjoyable moment for the patient so in many cases the patient returned to the ward that they had absconded from on their own or went to the police and told them that they had absconded for a mental hospital and then was being brought back to the hospital.

When the patients was asked to come up with some proposals for what we as nursing staff could do to prevent the escapes. They all calls for meaningful activities that will give them a felling of doing some thing that gives meaning and can be used after there admission and more activities with the staff and fellow patients.

The three patients that never had absconded had a common theme of why they choose not to leave the hospital without permission. They had the feeling that they would disappoint their family and friends. The patients were also very concerned about their treatment, they were afraid of what will happen to them if they were unable of getting their prescribed medications.

The patients that under their admission never choose to leave the hospital were more concerned about their treatment and that they had reached an understanding of the necessity of the need for treatment and that they have reached an alliance with the staff.

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"Walk the talk" - Reorganizing a forensic unit by the use of physical training

Poster

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The Mental Health Centre Sct. Hans is a forensic unit 80 bed treatment institution with the Capital Region of Denmark as its catchment area. Security levels include high security, medium security and low security. The vast majority of the patients are admitted under psychiatric orders imposed by court on offenders who have committed a serious offence and are considered not responsible due to severe psychopathology.

The ward where the project has been conducted is a 12 bed medium security ward with 25 staff members. 13 patients participated in the project over a 10 week period.

The poster will present how a forensic department has reorganised the treatment by implementing the use of physical and other recreational activities. Through the past years we have been inspired to use different kind of treatment the treatment has been documented as relevant for our group of patients. We have developed care and treatment to be an important part of the rehabilitating work.

With the help of an electronic version of SOAS-R we recognised that violence episodes often happened on special weekdays and at special times of the day (i.e. at 11 am, Thursday and Saturday mornings).

The aim of the quality improvement project was to reduce violence incidents by implementing physical training. The secondary aims were to improve the patient health, to create a meaningful everyday life for the patient, and to establish a positive staff / patient relationship

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Are they different? A comparison of risk in Dangerous and Severe Personality Disorder and Personality Disorder hospitalized populations

Paper

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Keywords: Dangerous and severe personality disorder, risk, HCR-20

Background and aims

The Dangerous and Severe Personality Disorder (DSPD) programme within England and Wales is a government initiative which aims to provide new treatment services to a previously “untreatable” group who have a diagnosed severe personality disorder(s), who also pose a risk to the public [1]. Currently, pilot DSPD services within England have been established in two high secure psychiatric hospitals, two high secure prisons and in a range of community settings. People with personality disorder and with high risk, however, have been admitted to high secure facilities for many years. At Rampton hospital, for example, a Personality Disorder service has been in existence since 1997. Yet, it is unclear whether those admitted to the new DSPD services are different from those admitted to conventional (pre-DSPD) services. One study has explored recidivism rates in prisoners meeting DSPD criteria, compared with non-DSPD prisoners [2]. The study comprised 1,396 UK adult male offenders serving determinate sentences of a minimum of two years for sexual or violent offences. It found that significantly more of the prisoners meeting DSPD criteria were reconvicted of any offence (58% vs. 38%), major violent offences (4% vs. 1%) and acquisitive offences (33% vs. 18%) after release, relative to non-DSPD prisoners. The findings also suggested that the probability of reconviction statistically associated with DSPD was considerable at 34% for any reconviction, 71% for major violence and 47% for acquisitive offences.

This paper will address whether the level of risk posed by male personality disordered patients admitted to high secure DSPD services, under DSPD criteria, will differ from those admitted to non-DSPD services within the same high secure psychiatric hospital, on several aspects of risk: an index of predicted future violence (HCR-20)[3], pre-treatment levels of institutional risk-related behaviour, and previous offending behaviour. Given the background and rationale for the DSPD initiative [1], the following hypotheses are in need of empirical examination. Personality disordered patients admitted to a high secure DSPD facility will, compared to those admitted to a high secure PD facility,

- score higher on a measure of predicted future violence
- have higher levels of pre-treatment risk-related behaviour within the institution
- have a higher number of previous offending behaviour

Methodology

Sample

All patients included in the study sample were admitted to Rampton Hospital high secure PD (n = 60) or DSPD service (n = 44) between March 2004 and June 2008. The mean ages of the samples

at admission were 33.8 (SD = 7.5) and 33.2 (SD = 9.1) (ranging from 18-56 years) (ns). Sources of referral were prison non-DSPD (PD, 39%; DSPD, 57%) and DSPD units (PD, 0%; DSPD, 32%), medium secure units (PD, 13%; DSPD, 1.5%), other high secure non-DSPD (PD, 34%; DSPD, 3%) and DSPD units (PD, 7%; DSPD, 1.5%), and other (Court, hostel) (PD, 7%; DSPD, 5%). All admissions to the hospital satisfied the requirements of the (1983) Mental Health Act. DSPD patients (67%) were mainly serving determinate sentences (PD, 19%), PD patients (45%) mostly indeterminate sentences (DSPD, 28%) or hospital orders (PD, 36%; DSPD, 5%).

Assessment(s)

Each patient was assessed using the HCR-20 [3] within two years of admission, by psychiatric multidisciplinary teams trained in the use of this assessment tool. Conceptually, the HCR-20 aligns risk factors into historical static, clinical risk, and future risk factors. For research purposes, the items on the assessment are scored 0 = item not present, 1 = possible presence of item and 2 = item definitely present (total scores range 0-40). Higher scores have been found to predict post-discharge violence across a variety of samples and countries with moderate to large statistical effect sizes [4].

To identify differences in pre-treatment institutional risk-related behaviour across the two samples, hospital incident reports (IR1) were collated for the 12-month period following admission to the PD or DSPD service. These incidents were coded by a trainee Forensic Psychologist into subtypes reflecting i) Physical Interpersonal Aggression; any actual or attempted interpersonal violent assaults (i.e., 'punching') or physical threatening actions towards others (i.e., 'clenching fists'), ii) Verbal aggression; any incident where the patient has directly/or indirectly threatened to cause harm to another (i.e., 'I'm going to get you') or any vulgar language towards others (i.e., 'fucking bitch') iii) Total institutional risk-related behaviour; this combines points i) and ii) plus actual or attempted damage to property, direct or indirect sexualised behaviour, racial abuse, actual or threats of self-harm, suicide or hostage-taking. Twenty per cent of randomly chosen incidents were re-coded by a doctoral-level psychologist who was blind to the previous ratings to obtain a measure of inter-rater reliability which was 0.93. Data relating to offending histories were collated from patient databases and file reviews.

Data analysis

Initial exploration of the data suggested that it was non-normally distributed and therefore non-parametric statistical tests were applied throughout the analysis. Specifically, chi-square analyses were employed to identify any differences in the types of offending engaged in by the PD, and DSPD, patients. In a similar way, Mann-Whitney tests were applied to the data to explore differences in markers of general offending rates, HCR-20 scores, and rates of institutional risk-related behaviour. Finally, logistic regression analysis was used to allow confounding variables to be controlled for statistically. All analyses in the present study were conducted using SPSS Version 17. The significance level tested was set at $p < 0.05$ and all tests were two-tailed. The study was conducted under service evaluation rules approved by the research governance department of the NHS Trust.

Results

Differences across the HCR-20 assessment

Results for the HCR 20 analyses are shown in Table 1. Ten patients within the sample had not been assessed using the HCR-20 within two years of their admission date and were, therefore, excluded from this analysis. The remaining DSPD patients obtained significantly higher scores on the HCR-20 total, and on the clinical and risk subscales, relative to the PD patients (Table 2).

However, time taken to complete HCR-20 assessments for the PD sample was significantly longer than for the DSPD sample ($U = 662.0$, $p < 0.05$). Yet, even after controlling statistically for this confounding effect using logistic regression analyses, the HCR-20 total score and the clinical and risk subscale scores remained significantly greater for the DSPD sample, relative to the PD sample (all $p < 0.05$).

Table 1. Mann-Whitney U tests, medians, inter-quartile ranges (IQR) and effect sizes (r) for HCR-20 assessment scores and pre-treatment institutional risk-related behaviour for the PD, and DSPD, samples.

variable	n	Median (IQR)		U	r
		PD	DSPD		
HCR-20					
Total score	94	24.0 (8.0)	28.0 (8.5)	583.00**	0.38
Historical subscale score	94	17.0 (4.0)	16.0 (2.0)	1021.50	0.03
Clinical subscale score	94	4.0 (4.0)	6.0 (2.0)	714.00*	0.27
Risk subscale score	94	2.0 (2.0)	7.0 (4.0)	423.50**	0.51
<i>Number of Pre-treatment harmful incidents in institution</i>					
Physical interpersonal aggression	104	1.0 (2.0)	2.0 (4.0)	994.50*	0.21
Verbal aggression	104	1.5 (6.0)	7.0 (10.0)	644.50**	0.44
Total institutional risk-related behaviour	104	3.0 (8.0)	14 (22.8)	587.50**	0.47

*denotes $p < .05$, **denotes $p < .001$

$r = 0.1$ indicates small effect size, $r = 0.3$ indicates medium effect size, $r = 0.5$ indicates large effect size.

Differences in pre-treatment institutional risk-related behaviour

Within the first 12 months of admission, DSPD patients engaged more frequently in physical interpersonal aggression, verbal aggression and all institutional risk-related behaviour in comparison to the PD patients (Table 2).

Differences in offending history

Aspects of previous offending history are reported in Table 2. The results of Mann-Whitney tests revealed that DSPD patients received a significantly greater number of convictions after the age of 18, relative to the PD patients, and had been imprisoned on a greater number of occasions (Table 1). Further, examination revealed that compared to PD patients (73%), a greater proportion of the DSPD patients (95%) had engaged in minor offences during their lifetime (95%) ($\chi^2 = 10.2$, $p < 0.05$). However, this was not found for violent, sexual, acquisitive, or arson offences (all $p > 0.05$, chi-square tests). In fact, a greater proportion of the PD patients had committed murder, attempted murder, or manslaughter during their lifetime (34%) compared to the DSPD sample (17%) ($\chi^2 = 4.22$, $p < 0.05$).

Table 2. Mann-Whitney U tests, medians, inter-quartile ranges (IQR), and effect sizes (r) for offending history for the PD, and DSPD, sample.

Offending history variable	n	Median (IQR)		U	r
		PD	DSPD		
Number of convictions pre 18	104	5.0 (15.8)	6.5 (18.75)	1212.00	0.07
Number of convictions post 18	104	10.5 (23.5)	18.0 (24.0)	996.50*	0.21
Number of imprisonments pre 18	104	0 (1.0)	1.0 (2.0)	1097.5	0.15
Number of imprisonments post 18	104	2.0 (3.0)	3.0 (4.0)	834.50*	0.32
Age at first offence	104	15.0 (2.75)	14.5 (4.0)	1033.5	0.17
Age at index offence	104	24.0 (10.75)	28.0 (9.8)	1170.0	0.10

*denotes $p < .05$; $r = 0.1$ indicates small effect size, $r=0.3$ indicates medium effect size, $r = 0.5$ indicates large effect size.

Discussion

The initial hypothesis was that patients admitted to a high secure DSPD facility would score higher on a measure of predicted future violence compared to patients admitted to a high secure PD (non-DSPD) facility. Overall, our findings support these hypotheses. DSPD patients scored higher on current clinical risk factors and future risk management issues than patients diagnosed with personality disorders who had been admitted to a PD rather than a DSPD service. HCR-20 risk scores for the DSPD patients were also comparable to those of other high risk groups, namely maximum security inmates [5] (Total Mean = 26) and recidivist forensic psychiatric patients [6] (Total Mean = 30).

It was further proposed that patients admitted to a high secure DSPD facility would have a higher number of pre-treatment risk-related behaviour within the institution than patients admitted to a PD (non-DSPD) facility. Similarly, this hypothesis was supported. However, it is not clear whether the presence of a higher level of institutional incidents necessarily reflects an inherent higher risk potential on the part of the DSPD patient, or whether these incidents are a product of resentment or disturbance as a result of the context of admission, for example, the transfer from prison to a hospital setting is often late in the prison sentence. It is also possible that differences in incident frequency between the DSPD and PD groups reflect differences in the ward environments of the DSPD and PD units or a higher-endorsement of incidents by DSPD staff, perhaps due to negative expectations of, and attitudes towards, DSPD patients [7].

Finally, it was proposed that DSPD admissions would have more extensive previous offending behaviour than patients admitted to a PD facility. This hypothesis was partially supported. Patients admitted to the DSPD facility had a greater number of convictions and imprisonments post-18, than patients admitted to the PD facility. In contrast, PD patients had a greater number of murder/manslaughter convictions than patients admitted to the DSPD facility. A higher frequency of "other" minor offences (e.g. breach of licence) committed by DSPD patients, supports the overall picture that they are more anti-social and rule-breaking than their PD counterparts.

It remains unclear, however, whether patients meeting DSPD criteria are a "new" patient group for high secure psychiatric hospitals. Specifically, it is unclear whether these patients present a higher level of clinical risk from those who have previously been admitted to high secure hospitals, prior to the establishment of DSPD services. Comparing HCR-scores for PD patients before the introduction of DSPD to HCR-20 scores post-DSPD establishment might shed some light on this.

Furthermore, the study does not tell us whether the two populations differ in clinical diagnostic terms, in the severity of their personality disorder or in the specific personality traits they possess. These will be reported on in future studies.

A further limitation is that, for the most part, the HCR-20 assessment was completed after the patient had been admitted to a PD or DSPD service, and was not completed “blind” to the patient’s placement. This raises the following questions: 1) are these true “risk” differences between PD and DSPD or 2) do these findings stem from knowledge about DSPD/PD status influencing subsequent risk judgements by clinicians.

In summary, the findings broadly confirm hypotheses as to the higher risk in DSPD patients and thus offer support for one of the main purposes of DSPD services: to provide treatment for those individuals who represent the highest priority in terms of treatment need and risk to public protection [1]. It is not yet entirely clear which treatments for personality disorder are effective [8] but if some prove to be so, there is the potential to reduce the elevated risk of serious violence that characterizes this patient group [2].

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Fantasies of a Dangerous and Severe Personality Disordered Clinical Forensic Population: An Exploratory Study

Paper

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Keywords: Dangerous and severe personality disorder, violent fantasy, sexual sadism

Background and aims

The Dangerous and Severe Personality Disorder (DSPD) programme within England and Wales is a government initiative providing mental health services for those who pose a significant risk of harm to themselves and/or others as a result of severe personality disorder(s) and high levels of psychopathy. The evaluation of dangerousness and risk in such a population includes asking about fantasies that may have physically violent and/or sexual content [1]. The use of fantasy as a criterion within risk assessment is due to the assumption that fantasies have a predictive relationship with subsequent behaviour [1]. For instance, mentally ill hospitalised patients who endorsed violent fantasies within 2 months of their admission showed statistically greater likelihood of violent behaviour during admission and post-discharge suggesting that fantasy is a dynamic risk and potential treatment target [2]. Apparently motiveless crimes have also been explained by suggesting they are an enactment of fantasy. MacCulloch et al's [3] seminal paper reported that the repetitive sadistic masturbatory fantasies of their high-secure psychopathic patients had spilled over into overt behaviours, suggesting a link between fantasy and behaviour. Yet, the significance of this link may be more obvious if "normal" individuals did not engage in fantasies, yet violent and deviant fantasies are relatively common and in the majority are not acted upon [4, 5].

Other functions of fantasy within forensic populations include regulating mood/affective state; as a coping mechanism to deal with the need to escape reality or to feel in control over threats; as a mental mechanism to re-live past experiences; or as a way of creating new experiences in a process of simulation [6] (although these functions are not the sole providence of forensic populations). It is also possible that fantasy and offending are not in a causal relationship but have shared origins such as through childhood abuse [7]. Of course these functions of fantasy are not mutually exclusive and it is feasible that each has a role to play [7]. This paper aims to explore in a group of DSPD patients 1) the quality of their fantasies pre-treatment 2) the nature and functions of violent fantasies and 3) differences in institutional risk-related behaviour in the first 12 months of admission between admitters and deniers of violent fantasy.

Methodology

Sample

The sample consists of 25 forensic psychiatric male patients admitted to a DSPD unit within a high secure hospital, between May 2004 and September 2008. The majority were admitted from the prison service (95.8%). Forty percent had a lifetime history of only violent convictions and 60% had a history of both violent and sexual convictions. The mean age at admission was 38.3

(SD = 6.04) (ranging from 28–48 years). The mean psychopathy checklist score [8] was 27.66 (SD = 4.33); 72% per cent had a definite diagnosis of anti-social personality disorder, 48% borderline and 40% both.

Analysis

To assess the quality of their fantasies pre-treatment, each patient was assessed using the Schedule of Imagined Violence [1] (SIV); a structured set of eight questions with coded response categories. Only the participants answering the first question positively (whether the respondent has ever had daydreams or thoughts of physically hurting or injuring some other persons) are asked the remaining seven questions. Each question asks about a different quality of such images, e.g. proximity to target. Responses do not contribute to a total score; each question is explored separately. To assess the nature and functions of violent fantasies, a range of qualitative clinical data were collated (e.g. diary cards, treatment session notes) for those participants answering the first question on the SIV positively. The data were subjected to thematic analysis [9] and coded according to two research questions; 1) what is the nature and 2) function(s) of their violent fantasies.

To identify differences in institutional risk-related behaviour between admitters and deniers of fantasies in the first 2 months of admission, hospital incident reports (IR1) were collated for the 12-month period following admission to the service. These incidences were coded as i) Physical Interpersonal Aggression; any actual/attempted interpersonal violent assaults or physical threatening actions towards others, ii) Verbal aggression; any incident where the patient has directly/indirectly threatened to cause harm to another, or any vulgar language towards others iii) Sexualised behaviour; direct or indirect threats to sexually assault/touch and iv) Hostage-taking; any direct or indirect threats, actual or attempted hostage-taking. Twenty per cent of randomly chosen incidences were re-coded by a doctoral-level psychologist who was blind to the previous ratings to obtain a measure of inter-rater reliability which was 0.90. Initial exploration of the data suggested that it was non-normally distributed, thus non-parametric statistical tests were applied.

Results

Of the 25 assessed patients, 64% (n = 16) admitted to having violent fantasies and during the first two months of admission (9 denied having violent fantasies). In terms of their quality, they tended to be recent, frequent, commencing 12 months ago or earlier, involving different people and somewhat likely to be imagined when the patient was with, or whilst watching the fantasised target (see Table 1).

Table 1: Descriptive characteristics of violent fantasies (number) as measured by the SIV

Of those answering the first SIV question positively	n = 16
Fantasies have been in the past 7 days or more recently	69 % (11)
Had fantasies once to several times per day	50 % (8)
Started having these fantasies more than 12 months ago	75 % (12)
Fantasies are usually about different people (versus same person)	75% (12)
Injuries imagined are changeable	87.5% (14)
In past 2 months, had fantasies while with/watching person who one imagines hurting	62.5% (10)

Recorded institutional risk-related behavior during the first 12 months of admission (see table 2) did not differ across the two samples.

Table 2: Mann-Whitney *U* tests, medians, inter-quartile ranges (IQR), and effect sizes (*r*) for institutionalised incidents executed in first 12 months of admission

	Admitters of violent fantasy (n = 16)	Deniers of violent fantasy (n = 9)	U	r
Incident Type	Median (IQR)	Median (IQR)		
Physical Interpersonal Violence	0.5 (2.5)	1 (2.5)	71.0	-0.01
Verbal aggression	6.5 (14.25)	10 (11)	56.5	-0.18
Sexualised Behaviour	0 (0)	0 (0)	67.5	-0.08
Hostage Taking	0 (0)	0 (0)	70.0	-0.04

$r = 0.1$ indicates small effect size, $r = 0.3$ indicates medium effect size, $r = 0.5$ indicates large effect size.

Thematic analysis

The thematic analysis yielded four dominant themes concerning the **nature of violent fantasies**.

1. **Vividness:** Fantasies can be recent and recurrent, either rapidly shifting across themes or as longer periods of reflection. Fantasies could be clear and colourful, involving several senses and physiological responses e.g. sweating and increased heart rate.
2. **Controllable vs. uncontrollable:** Although fantasies were reported as “spontaneous”, some patients described “deliberate self-generation”, choosing to focus on them (or not). This could quickly change to subjective feelings of loss of control or preoccupation [10] - feeling unable to effectively use techniques to control them.
3. **Excessive violence and sexual sadism:** Fantasy targets ranged from the general (e.g. women) to the specific (e.g. father) with features that are significant to the patient. Victims are known and/or unknown. Consistent with non-forensic psychiatric patients, a variety of themes were entertained [11] including verbal and physical (sometimes gratuitous) aggression (e.g. murder, torture/mutilation, kidnap, cannibalism) and materially-cultural and organismic weapon usage. Given their history of sexual offending, it is not surprising that sexual aggression was evident, e.g. rape, paedophilia, necrophilia. Some themes had a sexually sadistic nature. Notably, sexual deviant fantasies were also reported by non-sex offenders. Some violent fantasies had the potential to be sexually arousing (regardless of their sexual content). Key to the fantasy is the patient taking pleasure in controlling or subjugating other people, consistent with the psychopath’s tendency to victimise and exploit others [12]. Imagining oneself strong/powerful, dangerous/invincible and the victim[s] as insignificant, powerless and vulnerable were common patterns. Imagining the victim’s distress heightened the fantasy pleasure [12].
4. **Origins:** Fantasies had been influenced to some extent by patient’s experiences [7]. For instance, patients reported “favourite” or long-standing” fantasies existing from months to years. Some were established around adolescence (9 – 13 yrs) and/or were associated with a formative traumatic event (e.g. abuse) acting as a coping or protective strategy. External circumstances could spontaneously trigger fantasies (e.g. an argument) or were “saved content” for later imagined violence.

There were two dominant **function(s) of violent fantasies** utilised in various contexts:

1. Modelling experience

Fantasy acted as a cognitive rehearsal for future violence, planning the act in imagination and fantasising the stages of the offence. Some patients engaged in behavioural mock “try-outs” [3] or offence-paralleling behaviour. This was for the purpose of offending preparation and/or to maintain the arousal associated with the fantasy and stimulate new content. Factors motivating patients towards acting on their thoughts included overwhelming urges, a lack of guilt about the fantasies they entertained, or believing that they lacked alternative adaptive coping strategies. Social or psychological consequences typically served to inhibit the transition. The latter corresponded with the anxiety felt by some patients when experiencing fantasies. Fantasy could be used to re-live past experiences and the emotional and physiological feelings associated with them, e.g. excitement at the victim’s distress. Patients will share fantasies with others to intimidate others, or to enhance arousal.

2. Affect regulation: negative & positive.

Violent fantasies were accessed during negative affect (e.g. hopelessness) to help patients deal with the painful/distressing feelings [6]. Typically, affects related to narcissistic injury, or a perceived threat, are quickly followed by violent fantasies, e.g. when they feel humiliated they imagine enacting revenge. This corresponds with the majority of the fantasy “acts” which were of a highly controlling nature. In contrast, fantasies could elevate an ambivalent mood such as boredom, or enhance a pre-existing positive mood.

Discussion

In terms of the quality of patient fantasies pre-treatment, they tend to be frequent, recurrent, involving different people and existing for some time. They could also be vivid, colourful, intense, involving several senses and were not temporally constrained. They could be internally controlled but became intrusive. Fantasy could equally occur out of experience as well as being the consequence of mental creativity [7]. Excessive violence, sexual sadism and feelings of grandiosity were common themes. That the (sexual) violence was sadistic was not unexpected given the high levels of psychopathy [12, 13] and anti-social personality disorder [14]. Sadism is also associated with multiple paraphilias and a higher risk of recidivism [15]. In terms of their function, fantasies were used to plan future behaviours, to re-live experiences and the feelings associated with them and to regulate moods [6]. Thus, treatment is likely to be lengthy given that patient fantasies are versatile, entrenched, and operate as a significant coping mechanism.

There was no difference in institutional risk-related behaviour between reporters and deniers of fantasy, but clearly some fantasies spilled over into reality. Thus, the link between “fantasising” and “doing” remains unclear [7] (although the presence of fantasy alone is likely to be a relatively poor harbinger of future conduct). Nine patients denied having violent fantasies despite their violent history. Quite possibly the role that therapists play in decision-making may have resulted in a holding back of information for these patients for fear of negative consequences for discharge and future treatment plans. This study of fantasy was subject to a number of difficulties including the subjective nature of the qualitative data and definitional issues.

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Appropriate access to psychiatric hospitalization protects patients from criminal behaviour

Paper

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Keywords: Violence, forensic psychiatry in Europe

Introduction

In the Czech Republic (CR) the criminal offenders who have a history of previous contact with psychiatry, substance abuse or sexual delinquency, are routinely screened by a forensic psychiatrist. Three conditions are required to impose forensic (protective) treatment:

- proven crime
- absent or merely diminished responsibility due to a mental disorder
- danger to society.

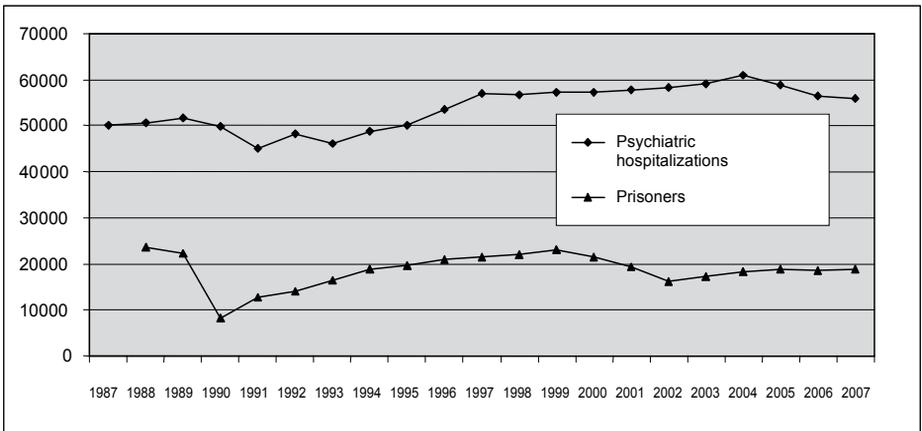
The basic types of forensic treatment are: psychiatric, substance abuse treatment and sex offender treatment. Forensic treatment is realized in outpatient units or forensic facilities (in psychiatric hospitals or prisons).

Data, Methodology and Results

Collected data from the entire CR (governmental statistics):

- The number of Czech prisoners decreased from 23.615 to 18.901 (-20%) during 1987-2007. After the President Havel's amnesty in 1990 there were only 8.231 prisoners for a moment!
- The number of all psychiatric hospitalizations in the CR increased from 50.003 in 1987 to 55.949 in 2007 (+ 12%).

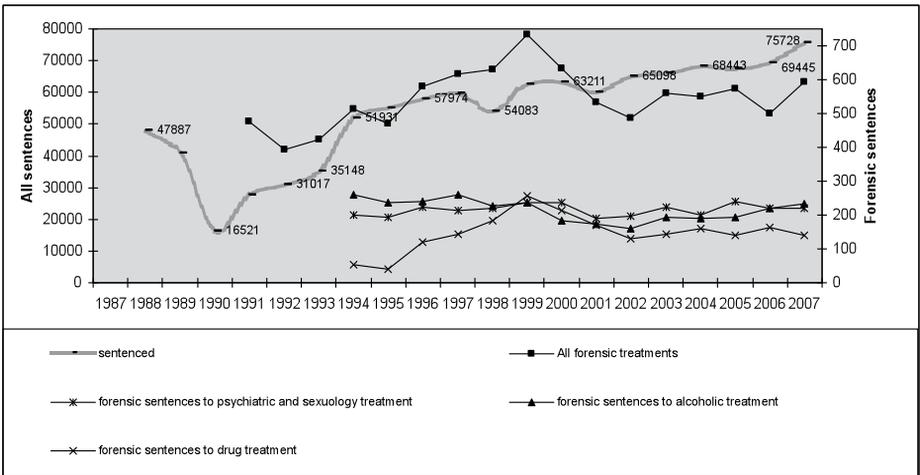
Figure 1: The number of all psychiatric hospitalizations and prisoners from 1988 to 2007



- The number of all sentenced persons rose from 47.887 to 75.728 (+ 58%) during 1988-2007. This increase occurred despite a decrease in the number of available hospital beds. There were 14.508 psychiatric beds in 1990 and only 11.452 in 2004.
- The number of sentences to all protective treatment rose from 476 in 1991 to 592 in 2007 (+ 24%).
- The number of sentences to protective treatment of substance use disorders increased from 53 in 1994 to 139 in 2007 (+ 162 %).

It should be noted that this number represents sentences, not persons. The average number of psychiatric and sex offender treatments was 215 per year. The mean number of sentences for alcohol treatment was also 215, while for drug treatment it was 147 cases per year.

Figure 2: The incidence of all sentences and forensic sentences



These data show that the proportion of the patients sentenced to the psychiatric and sexual forensic treatment remains stable, while there has been a steep increase in the number of treatments imposed for substance use disorders. A strong positive correlation between the number of all sentences to protective treatment and the number of all sentenced persons (Pearson cor. 0.647, $p < 0,001$) was found. A strong positive correlation between the number of all sentences to protective treatment and the number of prisoners (Pearson cor. 0.798, $p < 0,001$) was found as well.

Our own data

From 2002-2007 from the Prague catchment area with 1.260.318 inhabitants (12% of the population of the CR). To test the changes in diagnoses of patients hospitalized in forensic facilities we collected clinical data on all patients admitted to a forensic psychiatric hospital between 1st of January 2002 and 31st of December 2002 (2002 cohort) and from 1st of January 2007 and 31st of December 2007 (2007 cohort).

- The number of admissions did not increase between 2002 and 2007. No significant increase was seen in the number of patients admitted in 2002 ($n=68$) compared to 2007 ($n=74$).
- The majority (68% in 2002 and 72% in 2007) of the forensic patients were individuals with a substance abuse. 34% of the 2002 sample and 45% of the 2007 sample had a primary diagnosis of substance use disorder and additionally, 33% of the 2002 sample and 27% of the 2007 sample had co-morbid substance misuse diagnoses.
- The majority (80%) of patients with schizophrenia were convicted for violent crime. Violent crimes were defined as all offences causing physical harm, threats of violence or harassment,

all types of sexual aggression, illegal possession of firearms or explosives, all types of forcible confinement, arson and robbery; other crimes were non-violent.

- 12% of the 2002 cohort and 8% of the 2007 cohort of forensic patients were women.
- There were no patients admitted for affective disorder in 2007 and only 3 patients in 2002 were admitted for crimes committed in the manic phase of a bipolar illness.
- We have detected a significant decrease in the number of admitted patients with schizophrenia from 41% in 2002 to 27% in 2007 ($p < 0.0035$).
- A small decrease in the proportion of patients with schizophrenia was identified (41% in 2002 and 27% in 2007). There was no significant increase in comorbidity with substance abuse among patients with schizophrenia between 2002 and 2007.

Table 1: Description of catchment area samples

	Alcohol abuse	Drugs*	Schizophrenia	Affective disorders	Personality disorders	Sexual offenders	Mentally retarded	Total
2002	33,9%		41.2 %	4.4%	7.4 %	7.4%	5.9 %	100% (n=68)
	11.8%	22.1%						
Men/Women	7/1	11/4	25/3	3/0	5/0	5/0	4/0	60/8
Substance misuse comorbidity	NA	NA	57.1%	66.7%	60%	40%	50%	67.6%
Violent crime	12.5%	46.7%	64.3%	33.3%	40%	100%	50%	52.9%
Days of stay	171	162	427	120	396	353	185	mean 294
2007	44.6%		27%	0	12.2%	12.2%	4.1%	100% (n=74)
	16.2%	28.4%						
Men/Women	12/0	20/1	15/5	0	9/0	9/0	3/0	68/6
Substance abuse comorbidity	NA	NA	45%	0	66.7%	55.6%	66.7%	71.6%
Violent crime	66.7%	42.9%	80%	0	55.6%	88.9%	66.7%	64.9%

Our data suggest that patients sentenced to psychiatric and sexological treatment constitute a stable population, which does not reflect changes in the number of prisoners or the number of hospitalized patients. The reason might be the high number of psychiatric hospitalizations protecting the patients from deteriorating to criminal behaviour. The sexual delinquency is not dependant on the political system and social situation.

Statistical analyses were performed using SPSS, statistical software ver.16.0. The results were obtained mainly by comparing the different patient cohorts and testing the hypothesis that there would be no differences found between them. Thus, paired sample t-tests and independent sample t-tests were used. For the relationship between the numbers of prisoners and the size of various groups of psychiatric patients, testing for linear correlation has been used, expressed by use of Pearson's correlation coefficient. Specific statistical methods used for particular comparisons are further described in corresponding sections of the results.

Discussion

Data from Western Europe and the US show growing rates of mentally disordered offenders and a rising forensic in-patient population due to the absence of psychiatric beds (deinstitutionalisation). The reason for the increase in violence might be the transformation to community care, which neglects non-compliant and violent mentally ill patients. This is not true in the CR. We HAVE

found an increase in general psychiatric admissions and we have NOT found a significant increase in admissions to forensic psychiatry. Also the length of the hospitalization of psychiatric patients is quite high in the CR (82 days in 2007) compared to the Western World. Community care facilities (day clinics) have no power to diminish the violent and criminal behaviour of the patient. Longer hospitalization might be a great benefit for some - mostly to those with criminal history.

These findings are not new: Penrose in 1939¹ published a cross-sectional study from 18 European countries, in which he demonstrated an inverse relationship between the number of mental hospital beds and the number of prisoners. He also found strong negative correlations between the number of mental hospital beds and the number of deaths attributed to murder. He argued that by increasing the number of mental institution beds, a society could reduce serious crimes and imprisonment rates. The Penrose's Law was viewed as oversimplification but 70 years later Hartvig and Kjelsberg (2009)² have found the inverse relationship between mental institution beds and prison population and also crime rate in Norway:

- During 1930-59, there was a 2% population-adjusted increase in mental institution beds and a 30% decrease in the prison population.
- During 1960-2004, there was a 74% population-adjusted decrease in mental institution beds and a 52% increase in the prison population. The same period saw a 500% increase in overall crime and a 900% increase in violent crimes, with a concurrent 94% increase in the size of the country's police force.

Penrose's law has proved remarkably robust in the longitudinal perspective. Of course, the crime rise can not be attributed only to mental health de-institutionalization.

Conclusion

The Czech Republic has not had significant deinstitutionalization. Its forensic in-patient population has not changed. Therefore deinstitutionalization may fail some patients, leading to an increase in the forensic in-patient population. We found the positive correlation between the number of prisoners (as well as for the number of sentences) and the number of sentences to forensic treatment only; we have hypothesized that the high rate of adult psychiatric hospitalizations has protected patients with serious mental disorders from engaging in aggressive or criminal behavior. It is necessary to identify the subgroup of patients for whom longer inpatient care is of benefit. A sufficient number of psychiatric beds may diminish the aggressive or criminal behaviour of psychiatric patients with major mental disorders.

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Chapter 15 – Specific Populations and Violence: General Health Care

An exploration of nurses, care staff and relatives' perspectives on the causes of, and ways of responding to people with dementia who display aggressive behaviour in residential care settings

Paper

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Keywords: Aggressive Behaviour, attitudes, care homes, dementia, nurses, relatives

Background

There are over 30 million people with dementia worldwide (Alzheimer's Disease International, 2009), and with numbers of older adults increasing, there will be many more people with dementia in the future. In the United Kingdom, around one third of people with dementia live in residential care homes, and over 60% of care home residents have dementia (Alzheimer's Society, 2009). Challenging behaviour, including verbal and physical aggression is common among people with dementia in residential care: up to 86% of residents with dementia display such symptoms (Ballard et al, 2001). While most aggressive behaviour by people with dementia in residential care settings is relatively non-injurious (Astrom et al, 2004), more serious incidents can occur, including homicide (Hindley & Harvey, 2000), and being the target of aggression leads to increased stress and burn-out among nurses and care staff (Astrom et al, 2004).

Alternative perspectives on the causes and best ways of responding to aggressive behaviour by people with dementia can be identified, reflecting differing underlying philosophies of dementia care. Kitwood (1997) contrasted the "standard paradigm" of dementia care with the "person-centred" paradigm. The standard paradigm holds that challenging behaviours such as aggression are essentially random expressions of the neurological damage caused by the disease processes that lead to dementia, and that there is little that professional carers can do other than to control the person's behaviour with tranquilising medication or personal restraint (by personal restraint is meant staff manually restraining a resident in some way; it should be noted that in the United

Kingdom the use of mechanical restraint with people with dementia, involving straps or chairs with attached tables, is generally regarded as being abusive practice). The person-centred paradigm, by contrast, sees meaning in the person's behaviour, regarding expressions of aggression as "poorly communicated need" (Stokes, 2000). Professional carers should try to interpret the person's behaviour in terms of the underlying need and look for ways of meeting that need through the use of person-centred interpersonal interaction.

Statements of best practice in the United Kingdom (National Institute for Health & Clinical Excellence, 2006) and nursing guidelines in the United States (Dettmore et al, 2009) advocate person-centred means of responding to aggressive behaviour by people with dementia as the approach of choice, with controlling means used as a last resort.. There has however been little research into the attitudes of nurses and other care staff regarding the causes of, and best ways of responding to aggressive behaviour, and whether they follow the person-centred or standard paradigm philosophies. There is also little understanding of how they actually manage such behaviour in practice. The perspective of relatives of residents regarding this aspect of care has also not been addressed by research. These questions were the focus of this study.

Study aims

- To explore the views of nurses, other care staff and relatives as to the causes of, and the most effective ways of responding to aggressive behaviour by people with dementia in residential care settings.
- To explore the strategies used in practice to respond to such behaviour in these settings.

Design

- A survey of the attitudes of nurses and other care staff regarding the causes of, and best ways of responding to aggressive behaviour using a specially designed instrument (the Management of Aggression in People with Dementia Questionnaire – MAPDAQ). This instrument contrasts respondents' views related to the standard paradigm and person-centred perspectives of aggressive behaviour.
- Semi-structured interviews with a stratified sample of staff to complement the quantitative data.
- Focus groups with relatives of residents of the participating care homes to gain their perspectives on how aggressive behaviour by residents is managed.
- An audit of aggressive incidents in the participating homes to ascertain how aggression is responded to in practice, using the Staff Observation Aggression Scale (Palmstierna & Wistedt (1987) adapted to be relevant to residential care settings for people with dementia (SOAS-D), and completed by care home staff.

Settings and Participants

Six dementia care units within four nursing homes owned by the same company in the North West of England, United Kingdom were used for this study:

- 35 staff of all grades completed the MAPDAQ attitude questionnaire,
- 8 staff of all grades participated in semi-structured interviews,
- 2 focus groups were carried out in two care homes. 6 relatives participated in one focus group, and 2 in the other.
- SOAS-D forms were completed for all aggressive incidents involving a selection of residents in each participating unit over a three-month period. A total of 79 forms were completed, applying to 31 residents.

Results

MAPDAQ Attitude Questionnaire: Staff responses leaned more towards the person-centred perspective of aggression management than the standard paradigm perspective. Staff tended to regard the causes of aggression as being in residents' interactions with staff or other residents, or due to unhelpful environments, rather than being directly caused by dementia, or by personality factors. Staff strongly supported interpersonal means of responding to aggressive incidents. When considering controlling means of managing aggression, staff supported the use of medication, though not strongly, and were opposed to the use of personal restraint.

Semi-structured Interviews with Staff: Participants in interviews reinforced the views expressed by the broader staff group that completed the MAPDAQ. There was a non-blaming attitude towards residents with dementia who were aggressive, and recognition that the majority of aggressive incidents were the result of residents' frustration at not being able to get their needs met, feelings of violation when staff were attempting to carry out personal care, or misinterpreting other residents' communications. Dementia was regarded as a mediating factor rather than a direct cause of much aggression, though some aggression was felt to be without specific external cause.

Interviewees supported interpersonal approaches to aggression management, emphasising the need for a calm approach, "backing off" rather than provoking situations and finding individualised and creative ways of distracting aggressive residents. The importance of experience in dementia care and the value of knowing residents as individuals in the context of their life history were emphasised. Staff were pragmatic about the use of medication and personal restraint, regarding them as legitimate approaches, but to be used only when interpersonal means were not working, and in moderation.

Focus Groups with Relatives: Participating relatives appeared well informed about the care strategies used by staff and broadly confirmed that interpersonal approaches were used in the first instance, with medication and restraint employed moderately. Relatives were very complimentary about the personal style of some experienced staff members. They approved of the staff's view that medication should be used to "calm down, not drug up", and personal restraint was seen as sometimes necessary to achieve personal care. A minor criticism expressed was that sometimes resident to resident aggression was responded to as quickly as it might be, though it was recognised that there may be legitimate reasons for this.

Audit of Aggressive Incidents (SOAS-D): 25% of incidents were rated by care home staff as having been caused by staff giving personal care, while 15% were caused by resident-resident interaction. Interestingly, 34% were felt to have no apparent cause. 45% of incidents involved physical aggression. In 75% of incidents staff were the object of the aggression; in 33% of incidents the object was another resident. 44% of incidents resulted in no consequences for the victim; 24% of incidents resulted in minor injury and only one incident led to injury requiring treatment. 64% of incidents were resolved through interpersonal means, by talking to the resident, reassuring the resident or the use of distraction. In 24% of incidents the resident was removed from the place of the incident, and 11% of incidents were resolved by the use of personal restraint. Medication was used in only one incident.

Discussion

This study is the first systematic investigation of care home staff perspectives on aggression management with people with dementia in the United Kingdom, and the first worldwide to employ a pluralistic design, including the perspectives of relatives of residents. The findings show that

whilst staff in the participating units demonstrate a pragmatic and eclectic approach to aggressive behaviour, this is underpinned by a person-centred philosophy of care, and staff follow current best practice by attempting to use interpersonal means of responding to aggression in the first instance, with controlling strategies used as a last resort and with moderation. The fact that this perspective was present in all staff data sets (MAPDAQ, SOAS-D and semi-structured interviews) and was corroborated by the more independent view of relatives adds weight to the findings.

This study appears to contradict recent reports in the United Kingdom of excessive tranquilising medication use in care homes (All-Party Parliamentary Group on Dementia, 2008). It should be noted however that the study was carried out in a small number of specialised dementia care units in relatively well-resourced homes owned by the same national company, and further research needs to be done to ascertain to what extent person-centred approaches to aggressive behaviour are the norm within the United Kingdom care home sector.

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Aggressive behaviour in cancer patients

Paper

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Introduction

Dealing with cancer patients as in-patients on an oncological ward can be very demanding. Some of the patients do not meet the staff's expectations in behaving compliant and show overt aggressive behaviour.

Objective

To describe frequency, quality, underlying variables, and the impact of aggressive behaviour on future cutting short from oncological in-patient treatment in a group of cancer patients treated as in-patients on an oncological ward.

Group and Methods

Investigation of 388 in-patients suffering from heterogeneous cancer-types in liaison-consultation psychiatry. The patient's aggressive actions were assessed according to the Staff-Observation-Aggression-Scale-Revised (SOAS-R). The demographic variables were collated using basic psycho-oncological documentation (PO-BADO). We also identified and recorded each patient's intensity of pre-existing or cancer-induced psychiatric ailments classified according to DSM-IV criteria.

Results

Nineteen out of 388 (4.9%) patients showed overt aggressive behaviour (14: verbal aggression, 5: beating and/or kicking). In a logistic regression analysis carcinoma induced psychiatric disorders, pre-existing DSM IV axis I psychiatric disorders, current function status, and male sex were correlated to overt aggressive behaviour significantly due to the Wald criterion. 11 out of 19 patients acting aggressively showed organic psychiatric disorders (7 carcinoma induced and 4 pre-existing organic psychiatric disorders) with cognitive impairments ($p = .000$). 8 out of 19 patients with overt aggressive behaviour cut short from oncological in-patient treatment ($p = .000$). The association of overt aggressive behaviour and future cutting short from oncological in-patient treatment can be described with the help of Receiver-Operating-Characteristics (ROC): The area under the curve (AUC) was 81.9 % ($p = .000$, sensitivity: 66.7%, specificity: 97.1%).

Discussion

The results demonstrate that organic psychiatric disorders play an important role in aggressive behaviour of cancer patients treated as in-patients. Furthermore aggressive behaviour can be interpreted as a risk factor of cutting short future oncological in-patient treatment. As a consequence the staff working on oncological wards should be enabled to detect aggressive behaviour and its precursors as soon as possible.

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Violence in haemodialysis units in the UK: A mixed methods study

Paper

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Keywords: workplace violence; healthcare setting; haemodialysis; incident recording; mixed methods research

Introduction

Disruptive, abusive and violent behaviour by patients and occasionally their family members is becoming a significant problem in some Haemodialysis Units, with literature suggesting that this is an emerging problem both nationally and internationally (King & Moss, 2004; Sedgewick, 2005). This phenomenon is occurring within a context of an increase of violence & aggression reported in workplaces as a whole, including the NHS in the UK.

Violence and aggression in healthcare settings

Violence and aggression in general hospitals in the UK is an increasing problem; the number of violent incidents has been increasing significantly over time (DH, 2003) with NHS staff, particularly nurses, at greater risk of physical assault or verbal abuse than many other professional groups (HSAC, 1997; British Crime Survey, 2002). There have been a number of national programmes to tackle the problem and also local policies in individual NHS Trusts (Barts & The London NHS Trust, 2006). However, a big problem with these initiatives is the widespread under-reporting of violent incidents by NHS staff; it is estimated that 39% of incidents are not reported (National Audit Office, 2003).

Existing research studies from general health care settings suggests that potential predictors of violent incidents may include:

- Staff factors – younger age and shorter health service experience;
- Patient characteristics – mental state of patient, the presence of associated ill-health; patients living in deprived areas;
- Nature of interactions between staff and patients during the delivery of care and treatment, both verbal and physical;
- Work environment - delays in receiving treatment
- Physical environment - A study by the Royal College of Psychiatrists (1998) found that certain features of mental health settings, such as poor design of waiting areas, poor lighting, excessive noise and overcrowding also contribute to violent situations.

Disruptive behaviours in Haemodialysis Units

Different terminology has been used in the literature to describe dialysis patients whose behaviour is deemed unacceptable, including: 'abusive', 'difficult', 'disruptive' and 'noncompliant' (Johnson et al, 1996; King & Moss, 2004). These different terms demonstrate the complexity of the problem; it is not simply about aggressive behaviour, but also patients' non-adherence to treatment regimes. Little is known about what precipitates disruptive behaviour by dialysis patients and visitors, although there are a handful of publications that highlight the existence

of the phenomenon, predominantly from a North American perspective (Johnson et al, 1996; Rau-Foster, 2001).

A study by King and Moss (2004) set out to establish the extent of the problem in the USA, with a survey of 203 dialysis facilities staff at a national Nephrology meeting in 2000. The majority of respondents (69%) reported that their dialysis facilities had witnessed an increase in disruptive patient situations in the previous 5 years and most (71%) reported that they were frequently or always engaged in attempting to resolve difficult/disruptive patient situations. These findings are supported by a recent UK-based survey of 89 nurses working in Nephrology services (Sedgewick, 2005) that found that four out of five respondents (80%) had personal experience of violence and aggression in the workplace in the previous 12 months and in the majority of cases (77%), renal patients were identified as being the perpetrators.

King and Moss (2004) have provided a more comprehensive definition of 'disruptive patient behaviours', specific to haemodialysis settings, encompassing:

- Verbal abuse;
- Physical abuse;
- Non-adherence to treatment (not adhering to one's medication, diet or fluid restrictions, missing or shortening dialysis treatment)
- Substance use.

Aims of study

There are two aims of this study:

- a) To identify factors that predict disruptive behaviour in Haemodialysis Units;
- b) To identify effective strategies for the management of future disruptive behaviours.

Design and methods

The study is using an exploratory, mixed methods design, using both quantitative and qualitative research methods.

Data collection methods include: Collection of incidences of aggressive behaviour (physical and verbal) using the SOAS-R (renal version) over a 12 month period; staff and patient questionnaires; staff and patient interviews. The research team has been advised by a Project Advisory Group, composed of patients, carers, clinical staff, managers, and 'experts' in the Nephrology field.

Results

The incident data demonstrate that aggressive incidents are caused by a minority of dialysis patients and relatives. A very small minority of patients, who are involved in a larger number of the incidents, have enduring mental health problems. Temporal patterns to the aggressive incidents have emerged, with more incidents occurring on particular days of the week and certain times of the day. Qualitative interviews conducted with staff and patients provide some explanation for these temporal patterns, as well as perceptions of potential triggers leading to aggressive behaviour.

Discussion

There is a minority of 'disruptive' patients and relatives. Senior staff are placing patients with 'challenging' behaviour on the same days and shifts; this is when the majority of incidents are occurring. Those patients responsible for a greater number of incidents have enduring mental health problems. The provision of effective psychiatric and psychological support for dialysis

patients seems to be lacking, as does the provision of education and training around these issues for staff. These findings confirm anecdotal evidence from other haemodialysis units. However, a larger international study is required to provide generalisation of findings and contribute to national policy and practice.

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Aggressive behaviour of inpatients with acquired brain injury in a neuropsychiatric treatment ward

Paper

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Background

Patients with acquired brain injury relatively often have difficulty in controlling their aggressive impulses. Adequate treatment of these patients requires knowledge on prevalence, nature and determinants of aggression. The purpose of the study was to describe (1) the prevalence, (2) the nature and (3) patient-related determinants of aggression among inpatients with acquired brain injury.

Methods

A prospective descriptive study was conducted at a specialized 45 bed post acute treatment brain injury centre for adult inpatients with acquired brain injury during a 17 week period. The (convenience) sample consisted of 57 patients admitted to the centre. All these patients have neurobehavioral and/or neuropsychiatric disorders as a result of acquired brain injury. The Staff Observation Aggression Scale-Revised (SOAS-R) was used to measure the prevalence and nature of the aggression incidents. Patient's records were used to obtain information about patient characteristics.

Results

Three hundred and eighty-eight incidents were recorded (=28.9 incidents/bed/year) with an average severity score of 6.3. Twenty-four patients (42%) were involved in one or more incidents. However, a small group of 8 patients caused 85.5% of the incidents. In 83% of the incidents staff could identify a clear cause of the aggression, with 70% of provocations being linked to a prior interaction between patient and nurse, most of which involve 'the patient being denied something' (n=96; 25%), the patient being 'requested to do something' (n=49; 13%) or being assisted with ADL (n=79; 20%). The majority (90%) of the incidents was directed to other persons, mostly nurses (n=299; 77.1%).

In this study a significant relationship was found between aggression and gender, duration of admission, legal status of patients and hypoxia as cause of the injury. With these variables, 82% of the current sample could be accurately classified as being aggressive or not.

Conclusion

In this study the prevalence of aggression is relatively high compared to other studies, this underlines the importance of conducting research into interventions aiming at preventing and dealing with aggression of patients with an acquired brain injury.

Intervention strategies for individual (high risk) patients may be developed by analysing the nature and apparent triggers of their aggression incidents separately. From the analysis of incidents of

individual cases in combination with the specific patient characteristics, such as the nature of their brain injury and ensuing impairments, it may be possible to arrive at tailor made aggression prevention strategies. For a systematic registration of aggression incidents the use of the SOAS-R is recommended in daily routine.

Educational Goals

- Insight in the prevalence and nature of aggression incidents among inpatients with acquired brain injury in a neuropsychiatric treatment ward
- Insight in patient-related determinants of aggression among inpatients with acquired brain injury
- Insight in the usefulness of the SOAS-R in the treatment of aggressive behaviour in patients with acquired brain injury.

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Chapter 16 – Specific Populations and Violence: Children, Youth and Adolescents

Cognitive adolescent anger management program: Bridging the gap between thinking, feeling and acting up

Poster

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Anger is a normal emotion experienced by everyone. Human beings react to feelings of anger differently. Some respond to it by turning their anger inward which can be manifested through isolating self, being quiet, and engaging in self-harming behaviors like cutting or getting involved in high-risk activities. Some people respond to it outwardly through outbursts, cursing, and/or punching that may lead to aggressive and violent reactions including hurting others.

Societal and environmental factors as well as peer pressure may contribute and affect an adolescent response to anger. Anger can also be attributed to developmental age, maturity and learned behaviors from their environment. Some teenagers may become self-destructive and violent in an attempt to adapt to normalcy. As a result, some of them may lack the appropriate coping skills to adapt to stressful situations and will act out their frustration. The manifested anger by the adolescent needs to be managed so that it does not become detrimental to the well being of the adolescent, their care givers, their peers, and their families; management of manifested anger or potential anger can be achieved through the process of learning and mastering new coping skills.

Review of the literature reveals that a successful implementation of an anger management class in adolescent care settings can reduce acting out behaviors, aggression, and violence(Synder et al., 1999). The purpose of this poster presentation is to describe the Inpatient Cognitive Adolescent Anger Management Program (CAAMP) curriculum on the Adolescent Unit at Children's National Medical Center in Washington, D.C., U.S.A. that was adapted from the S.T.E.P. process developed by Snyder-Badau & Esquivel (2005) and the use of dramatic improvisation and role playing techniques as a teaching methodology.

The Inpatient Cognitive Adolescent Anger Management Program (CAAMP) also aims to create patient awareness about the outcomes of their responses and evaluate alternative ways of handling difficult situations. The behavior outcome criterion is targeted to developing a population who is more aware of the cues to anger and able to use coping skills to manage their own anger before it results in self-harming behaviors, aggression and violence.

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A quadripartite typology of violence (QTV): relationships with functions of aggression in violent youths

Paper

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Keywords: Aggression, violence, typology, youths

Introduction and background

A typology of violence has recently been proposed (Howard, 2009) that extends and revises the traditional dichotomy between “instrumental” and “affective/impulsive” violence. According to this typology, violence may be either impulsive or controlled, and within each of these categories, may be appetitively motivated (associated with positive affect) or aversively motivated (associated with negative affect). This quadripartite typology yields 4 violence types, each associated with specific emotions: Aversive/Impulsive violence with fear and distress, Aversive/Controlled with spite and vengefulness, Appetitive/Impulsive with exhilaration and excitement; and Appetitive/Controlled with pleasant anticipation. In addition to these emotions, each type of violence is said to be associated with a distinct type of anger: explosive/reactive, vengeful/ruminative, thrill-seeking, and coercive, respectively.

Implicit in this typology is the idea that different types of violence should serve different functions. For example, both types associated with negative affect, Aversive/ Impulsive and Aversive/ Controlled, should function to remove interpersonal threat and be associated with anger expression. In contrast, both appetitive types should function to achieve positive outcomes, either social dominance/control in the pursuit of tangibles (in the case of Appetitive/Controlled) or an increase in subjectively experienced high arousal and excitement (in the case of Appetitive/ Impulsive).

Recently Daffern and colleagues (Daffern et al., 2007; Daffern & Howells, 2007; Daffern & Howells, 2009) have proposed a system, Assessment and Classification of Function (ACF), for classifying aggressive or violent acts according to the following functions: Demand avoidance, To force compliance, To express anger, To reduce tension (catharsis), To obtain tangibles, Social distance reduction (attention-seeking), To enhance status or social approval, Compliance with instruction, and To observe suffering. For the ACF, each function is recognised through its characteristic antecedents and consequences and scored as present or absent for a particular aggressive act or episode. The ACF acknowledges that violence may have multiple functions and goals for the individual as well as for the group. To date ACF has principally been applied to mentally disordered violent offenders (Daffern et al., 2007) but recently its use has been extended to high-risk personality disordered offenders, and two further functions have been added, Sensation seeking and Altruistic defence (Daffern & Howells, 2009).

The aim of this study was to explore relationships between violence types according to QTV and the functions of violence according to ACF in a sample of youths who had been convicted of a violent offence while intoxicated with alcohol.

Methods and Results

Participants were 149 young male offenders who were resident in a youth offenders centre in UK. All had been convicted of a non-sexual violent offence against the person, committed while intoxicated with alcohol.

Procedure: Each offender was, with his informed consent, interviewed individually about his violent index offence. The semi-structured interview, conducted by one of the authors (MJ), was designed to elicit a free narrative of the circumstances leading up to, and surrounding, the offence. Prompts were given to gain information about: the day, time and location of the incident; who was involved, whether the victim was known to the perpetrator, any prior disagreements or scores to settle; what triggered the incident and what motivated it; the perpetrator's thoughts and emotions before, during and after the incident. Participants were asked to describe the day of the offence, including events that led up to the offence, their mood, the company they were in, and their plans for the day. Participants were asked about their drinking, including the time they started drinking and how much alcohol they consumed before the offence. Immediately following the interview the interviewer (MJ) made a typed transcript of the participant's narrative from notes she had made in the course of the interview.

Ratings of functions and types.

A global rating was made of each narrative by violence type (x4) and function (x11) on a 3-point scale, where 1 = absent, 2 = possibly present, and 3 = definitely present. Each participant's score on all types and functions was computed. As a check for inter-rater agreement, the first 15 transcripts were independently rated for functions and types by KH, MM and RH. Mean inter-rater agreement was, for types, 85% (range 77.8% - 88.9%), and for functions, 83.1% (range 71.1% - 93.3%). All 149 transcripts were then semi-randomly allocated to KH, MM and RH who each independently rated one-third of transcripts. Participants were allocated to 4 groups defined by the definite presence of one of the 4 violence types. Eleven participants were excluded from this group allocation because they lacked a score of 3 (definitely present) for any type, leaving 138 sets of ratings for inclusion in the analysis.

Data analysis.

Data analysis proceeded in three phases: (i) scores on the 11 functions were correlated with type scores, using Spearman's rank-order correlation; (ii) scores on the types were regressed onto functions, using logistic regression. For each violence type, a model was fitted so that only the functions that significantly improved the fit of the model were retained. Odds ratios (O.R.s) for each function, derived from the regression models, were adjusted to take account of other functions in the model; (iii) ROC-AUC analyses were performed to assess how accurately functions, as modelled in the linear regression, were able to predict types.

Results.

- (i) While all four violence types occurred in the offenders' narratives of their violent crimes, the Aversive/Impulsive type occurred most frequently (45% of narratives) and the two controlled types – Appetitive/Controlled (13%) and Aversive/Controlled (13%) least frequently. The Appetitive/Impulsive type occurred moderately frequently (25%).
- (ii) Correlations between types and functions are shown below.

	TYPE	Appetitive/ Impulsive	Aversive/ Impulsive	Appetitive/ Controlled	Aversive/ Controlled
FUNCTION	Demand avoidance	-.05	.08	-.02	-.09
	Force compliance	.14	-.22*	.33**	-.22**
	Express anger	-.39**	.57**	-.45**	.28**
	Reduce tension	-.00	.13	-.12	.10
	Obtain tangibles	.40**	-.60**	.56**	-.27**
	Distance reduction	.07	.02	.04	.06
	Enhance status	.27**	-.15	.10	-.11
	Compliance with instruction	.05	-.17*	.22**	-.02
	Observe suffering	.35**	-.14	-.11	.04
	Sensation seeking	.63**	-.38**	.07	-.15
	Altruistic defence	-.05	.20*	-.16	.04

(iii) Logistic regression/ROC analysis indicated that all four types could be accurately predicted by the presence of a unique set of functions (all AUCs > 0.74). For Appetitive/Impulsive, the combination of observe suffering (O.R. 4.3), sensation seeking (O.R. 56.2) and obtain tangibles (O.R. 3.0) predicted by their presence. For Aversive/Impulsive, express anger (O.R. 14.6) predicted by its presence, while obtain tangibles and observe suffering predicted by their absence (O.R.s 0.09 and 0.6 respectively). For Appetitive/Controlled, obtain tangibles (O.R. 55.6) and attention seeking (O.R. 13.3) predicted by their presence, while enhance status (O.R. 0.4) and sensation seeking (O.R. 0.15) predicted by their absence. For Aversive/Controlled, express anger (O.R. 4.15) predicted by its presence, while force compliance (O.R. 0.001) and altruistic defence (O.R. 0.42) predicted by their absence.

Discussion and conclusions

The pattern of correlations obtained between violence types and functions is consistent with what would be expected on the basis of the theoretical assumptions underlying QTV, viz. distinctions between (a) impulsive and controlled violence and (b) appetitive and aversive violence. While some functions (e.g. express anger, obtain tangibles) differentiated appetitive from aversive violence, regardless of impulsivity, other functions (e.g. sensation seeking, observe suffering) appeared to reflect the interaction between appetitive/aversive and impulsive/controlled dimensions, being specific to Appetitive/Impulsive violence. Results of the logistic regression indicated that each violence type was predicted by a unique set of functions, and the accuracy of the predictions, as assessed by the AUC, was highly significant in each case. The highest accuracy (AUC = 0.92) was achieved for Appetitive/ Impulsive, the lowest (AUC = 0.74) for Aversive/ Controlled.

Conclusion: Results validate the quadripartite typology in suggesting that each of the four violence types can be characterised by a unique blend of functions.

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Antisocial behaviour and psychosis in adolescence

Poster

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Background

From the adult literature, there is now evidence of a moderate but significant relationship between mental disorder and violence. Different diagnoses are known to carry different risks for violence; in particular, several studies have highlighted a link between psychosis (and more specifically schizophrenia) and violence in adult samples. Adult patients with schizophrenia are at increased risk of both violent and non-violent offending compared to general population samples, and a significant sub-population of patients with schizophrenia has been found to have comorbid antisocial personality disorder and a history of conduct disorder in childhood.

Although several studies have now confirmed a link between schizophrenia and antisocial behaviour, little is known about potential mechanisms for this association, or early developmental precursors of this comorbid pattern. The aim of this study was to examine antisocial behaviour and psychosis overlaps in a referred child/adolescent sample (i) to assess the extent to which this comorbid pattern can be identified early in development, and (ii) to identify characteristics and needs of this population, in the hope of preventing long term adverse outcomes in adulthood.

Method

This study used data collected on all outpatients referred to the Child and Adolescent Psychiatry Department of the Maudsley Hospital in South London between 1973 and 2004. Throughout this period the Department used a system of clinician-completed 'item-sheets' for gathering clinical data on referrals. The system provides structured data on symptoms, diagnoses, associated psychosocial circumstances and demographic background.

Past studies using the item sheets have found that psychotic symptoms are identifiable from age 7 years. We thus focused on all referrals of young people aged 7-18 years, excluding those with intellectual impairments. From this total eligible sample (n=6770), three groups were constituted;

1. The psychosis only group (n=221) consisted of patients who met criteria for:
 - i) an ICD 10 diagnosis of schizophrenia, schizotypal disorder, persistent delusional disorders, schizoaffective disorders, or other non-organic psychosis, (equivalent codes were used for ICD 8 ? 1973 to 1977 and ICD 9 ? 1978 to 1991) or
 - ii) one or more of the symptoms of hallucinations, delusions, ideas of reference or morbid persecutory delusions was definitely present.
2. The aggressive only group (n=1322) consisted of patients who were rated definite on the physically aggressive symptoms of:
 - i) fighting bullying, aggression, or
 - ii) violent assault (stabbing or use of other weapon, severe physical attack.)
3. The comorbid group (n=63) consisted of patients who met criteria for both psychosis and aggression.

Results

Just under 1% of young people (63/6770) in this referred sample showed a comorbid pattern of psychotic and aggressive symptoms. Of all cases with psychotic disorders/symptoms, just over one in five (22%) were aggressive; of those with aggressive symptoms, only 5% showed evidence of psychosis.

Comorbid cases showed similar age, gender and ethnicity profiles to young people in the 'pure' psychosis group. They were, however, much more likely to be living in institutional care at the time of the index referral compared to both the psychosis only group (24% vs 4%) and the aggressive only group (24% vs 13%). The majority of young people in this out-patient sample had been seen by mental health professionals in the past; by contrast with psychosis-only cases, however (where disorder was typically of relatively recent onset), 42% of comorbid cases had shown marked emotional/behavioural difficulties for 3 years or more.

In addition to aggression, comorbid cases were more likely to show higher rates of a number of other non-aggressive conduct problems (including defiance, stealing and truancy); they were also significantly more likely to have disturbed relationships within the family, and with adults and children outside. In terms of adverse experiences, comorbid cases were more likely to have been exposed to physical abuse than young people with psychosis only (18% vs 7%).

Discussion

From the findings there is a pattern emerging where by some features of the comorbid group are similar to the aggressive only group and in others they are similar to the psychosis only group. In some instances however, the comorbid group look distinct. These and other findings from the study have important implications for clinical psychiatry in terms of being able to identify young people with specific risk factors for this debilitating comorbid pattern.

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Assessing violent patients with intellectual disability

Poster

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Background

Psychopathology in combination with intellectual disability is a major cause of aggressiveness and violent behaviour. A dual diagnosis and other health problems are often an influential factor when a family is considering a request for consultation and hospital admission. The severity of retardation affects behavioural disturbances as well as the type of psychiatric disorder and they often lead to caregiver distress and institutionalization of the patient.

Methods

Thirty psychiatric patients with intellectual disability hospitalized in the A? Unit for short-term hospitalization of Psychiatric Hospital of Thessaloniki, were studied.

Results

For the majority of admissions, the caregivers reported that the main reason to seek psychiatric support was agitation, aggressiveness or violent behavior. Both non-pharmacological and pharmacological interventions were used to manage agitation and aggressiveness, but implementation and effectiveness of non-pharmacological interventions has often been limited by practical considerations, especially in emergency settings. The violence risk was significantly increased by positive psychotic symptoms. Antipsychotic drugs were valid therapeutic options for acute as well as longer-term alleviation of these symptoms and they were administered often.

Conclusion

The special features of psychopathology in patients with intellectual disability, the necessity of accurate intervention, and the management of aggression remain a therapeutic challenge for clinicians. Determination of these behavioural manifestations in combination with early intervention and treatment could provide the patients and their family environment with stability and security and, moreover, encourage and support social activities and rehabilitation.

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Addressing organizational toxicity in children's treatment facilities that leads to violence and maltreatment

Workshop

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Maltreatment in institutional care befalls traumatized and aggressive children who are looked after by adults ill-equipped to care for them in facilities with inadequate program, policy, practices, supervision, leadership, training and clinical oversight. Maltreatment is often correlated with high levels of aggression and violence between the facility's staff and the young people served, between staff members, and between resident youth. To ensure children's safety and their positive developmental outcomes, out-of-home treatment environments must design environments that are aggression and coercion free. Research has shown us that understanding and modifying organizational constructs such as culture and climate are strong predictors for success of any program whose goal is to prevent interpersonal aggression, violence and maltreatment and to improve treatment outcomes.

This workshop will be based on this author's work as an expert in civil court actions, as a researcher in child fatality studies, and as a consultant to licensing or regulatory agencies. The author has observed and examined scores of psychiatric and child welfare agencies that have had either multiple reports of child maltreatment, fatalities, increasing and dangerous levels of aggression, violence and high-risk interventions (physical and mechanical restraints/seclusion), numerous children absconding from program, and / or serious and protracted injuries to either children or staff. In the course of this work, the author has noted central themes emerging within the organizational domains of leadership, clinical management, supervision, training, and incident review that have a direct impact on the organization's ability to prevent and manage aggression and violence, as well as child maltreatment.

Through a brief presentation, case studies and discussion, this workshop will address toxic elements of organizational culture and climate that sustain and re-enforce aggression, violence, and maltreatment. These toxic elements will be addressed through a risk assessment prism that focuses on leadership's connection to the daily life of the facility, a facility's principles, its purpose, and its goals, its intake process, the clinical weight it gives to violence prevention and management, its emphasis on accurate and timely documentation, supervision, and critical incident review, and the facility's expressions of and the management of fear. A critical aspect of this workshop will be a discussion of the "inoculators" against the toxic elements of an organization that breed aggression, violence and maltreatment. A central premise of this presentation is that successful aggression and violence reduction programs are quality indicators of treatment and that these programs are leadership driven.

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Staff/adolescent interactions around tense situations on inpatient psychiatric units: Mapping the Moment

Paper

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The purpose of this research was to uncover, order, and contextualize staff interventions aimed at reducing aggression on child/adolescent inpatient psychiatric units. Building on Nijman's model of aggression, the research examined staff's response to tense, escalating and aggressive incidents in the context of unit and staff factors. This is a descriptive study. The analysis focused on aggressive incidents and the methods staff use to quell tension/aggression and help children regulate. In this study, the methods staff used in specific incidents were examined in the context of select staff variables, incident acuity, and unit conditions at the time of the incident. The tense or escalating incidents were recorded by staff on the Staff Observation of Aggression Scale-Revised (SOAS-R). Staff intervention strategies were gathered via the SOAS-R and semi-structured interviews. Via these semi-structured interviews we explored the participants' perceptions of the incident, their decision making process, what helped and what more could have been done. These intervention strategies and view of staff were examined in light of the patient perspective, gathered from patients involved in the incident; they were asked to comment on how they viewed the escalating situation and what measures should have been used to help them calm or prevent the incident from escalating. The acuity of the incidents being considered was also scored by the SOAS-R. Ward tension level was gauged by the amount of aggressive incidents that occurred within a two hour frame prior to the candidate incident and the number of admissions four hours prior to the incident. Staff's view of their confidence in managing aggression was measured by the Confidence in Coping with Patient Aggression Instrument. Findings indicate that staff is quite successful at dampening down minor incidents of verbal aggression. However since patients' escalation can come on very quickly, at times the incidents moved rapidly to aggression and thus past standard de-escalation techniques. Staff confidence in handling aggressive incidents played a particular role in how incidents are approached; the findings suggest that predictability is augmented when the nursing staff has more experience—on the unit and in psychiatry. It seems as the combination of all these factors makes a staff team stronger, and that seems to decrease the amount of seclusion. An additional feature of this research is that the study was conducted by a nurse researcher on a child- adolescent psychiatric unit in the Netherlands, Den Dolder, and a nurse-researcher in the United States (US). Included in the presentation will be a comparison of the staff methods used in the Netherlands and US units, particularly around the use of medication versus seclusion to quell escalating behavior.

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Development and evaluation of an individual proactive aggression management method for residential child psychiatry

Paper

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Because aggression is one of the most important reasons for referral to youth mental health services, aggressive behaviour and escalations in residential child psychiatry are common phenomena. Restrictive interventions, such as seclusion and restraint, can be useful with respect to the safety of the child or others but are used more often than needed (Singh et al., 1999) and can be traumatic both for children and group workers. Some important initiatives, e.g. the AACAP Practice Parameter (2002), have been published to minimize the use of these restrictive interventions. Although their potential usefulness with regard to early aggression management, these initiatives do not propose a proactive approach: they do not describe how to prevent aggressive behaviour or incidents in clinical settings. Erasmus Medical Center – Sophia has developed such a proactive aggression management method for residential child psychiatry with the aim of decreasing the frequency and impact of aggressive behaviours and incidents. The method is based on theoretical insights and practice based methods in child psychiatry (Kalogjera et al., 1989; dosReis et al. 2003; LeBel et al., 2004) and adult psychiatry (Van der Werf et al., 1998; Nijman et al., 1999; Bjorkly, 1996). The PRO-ACT (PROactive monitoring of Aggression in Children Tool), a new monitoring system for child settings based on both the SOAS-R (Nijman et al., 1999) and the REFA (Bjorkly, 1996), and an Individual Aggression Plan are the core elements of the method. The present paper discusses the methods, its theoretical framework and the results of a multi-site study (pre- and posttest) on the usefulness and the effectiveness of the method carried out in the Netherlands.

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Chapter 17 – Staff Training and Violence

The management of imminent aggression and violent behaviour in a psychiatric hospital: The nursing (preventive) approach for a (mainly) nursing problem

Workshop

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Imminent aggression and violent behaviour is an important issue in mental health nursing. More than 70% of the nurses report that they have been assaulted at least once during their career (Carlsson, Dahlberg, & Drew, 2000). Injuries cause significant emotional, social, biophysical and cognitive responses in the victim (Finnema, Dassen & Halfens, 1994). That's the main reason why continuous training is necessary.

Most training programs which focus on the de-escalation of threatening and aggressive behaviour are quite similar and contain the same principles: noticing the patient, knowing where the patient is on the continuum of losing control, understanding the meaning of the behaviour, knowing what the patient needs, connecting with the patient and matching the intervention with what he/she needs at the moment (Johnson & Hauser, 2001). These preventive forms of interaction are related to the stage of lost of control by the aggressor. So the key point is not to choose the right training, but to implement these insights in daily practice and to assure a long-term continuity in the follow-up.

In the University Psychiatric Centre of the KULouvain, we started in 1989 with a group of 12 psychiatric nurses a program, that focussed mainly on how to de-escalate imminent behaviour. Notwithstanding at the beginning of this project was expected that the emphasis would be on physical defence techniques, we consistently emphasized the importance of prevention through accurate de-escalation interventions

Literature shows that mainly nurses are physically assaulted, threatened and verbally abused. Moreover, through careful recording of all incidents of aggression in our hospital, we found out that nearly almost nurses were involved and that they were indented to intervene accurately. So we thought it was evident that the training was built up and given by nurses.

The nursing training group is responsible for the whole education programme for all nurses of the hospital. They set out, after literature review (Woods & Ashley, 2007), to develop a course, which was regularly updated. When entering, new nurses receive full training. After that, 2 trainers (the group is divided in 6 couples, each of them responsible for 3 or 4 wards) annually go to the nursing unit to ensure the follow-up. During a meeting, to which all nurses of that team participate, they discuss, sometimes addicted with role-playing, a case study proposed by the team and they look for the most appropriate de-escalation of interaction. There is an analogue practice in the Center for psychiatry and psychotherapy in Pittern. Generally the nurses experience this approach as a very concrete support, unlike to too much theoretical reflections, given by other disciplines, which are often less familiar with these realities. The fact that the courses are taught by colleagues for whom the situation is very recognizable, makes the training very well accepted. Remember a key assumption of management: the effect of a solution is always dependent on the quality of the solution and the degree of which it is accepted ($E = Q + A$).

In the workshop we will explain and discuss our methodology with other experiences and illustrate it further by means of a video presentation of such a case discussion.

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Psychiatric assessment of aggressive patients: Violence towards clinical staff

Poster

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Although violent and aggressive behavior towards psychiatrists, psychiatric residents and other clinical staff occur at an alarming rate, there is an absence of sufficient training in the area of violence risk assessment and management. In addition, many clinicians are reluctant to diagnose and treat aggressive and assaultive features in psychiatric patients, instead focusing treatment on other Axis I mental disorders, with proven pharmacological treatment, in the hope that this will reduce aggressive behavior. When an attack occurs, unclear or absent reporting policies or feelings of self-blame result in many clinicians refraining from reporting the assaultive behavior; thus preventing us from understanding the seriousness of the problem and providing the necessary resources.

Based on the case study of a young adult psychiatric patient with a long history of assaultive behavior, who strikes and injures a psychiatric resident, this presentation will illustrate diagnostic complexities related to aggressive psychiatric patients, and the necessity of training psychiatric residents, as well as other clinicians, in risk assessment, treatment, management, and reporting procedures of violent and assaultive patients. We will discuss the importance of diagnosing aggressive features in psychiatric patients and the relevance of risk assessment for treatment and management considerations. We will also discuss deficiencies in current practices for preventing violence on psychiatric wards and for reporting and dealing with the repercussions of an assault.

The presentation will provide recommendations for risk assessment practice (including standard evaluation batteries) for evaluating violence potential. Additionally, the presentation will elucidate methods for reducing stress, anger, and aggression in violence-prone psychiatric patients.

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Preparing for Rare Events: Pro-active Approaches to Crisis Situations within forensic mental health settings

Workshop

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Preparing for rare events can be a delicate balance of prediction, cost analysis and contingency planning. This paper examines the development of a strategic approach to dealing with crisis situations within forensic psychiatric services. Such crisis situations can typically include hostage situations, barricades and rooftop protests but also other situations where there is the potential for severe violence to occur. Typically these are rare events, but with high potential costs and therefore institutions need to develop practical guidance and develop the skills of staff in dealing with such situations.

The on-going development of a training package aimed at developing the role of staff as crisis negotiators, and produced guidelines to managing incidents will be examined in detail. This training and policy have been specifically developed to take into account the unique challenges that mentally disordered perpetrators and potential victims may present with. The role out of the related policy and training across three psychiatric hospitals within the North West of England will be discussed, as will the lessons learnt from taking a strategic approach to the management of crisis.

In 2005, a joint project between Partnerships in Care and Merseycare NHS Trust was established to develop a comprehensive training pack to develop the competencies of its most junior staff to deal with these violent incidents. This training pack utilised consultant practitioners and academics, and was also developed in conjunction with the Crisis Negotiation Unit at the FBI

Within Partnerships in Care, the Crisis Negotiation training has been delivered for the past three years, and currently there are thirty eight trained negotiators across three secure hospitals within the North West of England. The training looks at the history of hostage negotiation and the methods used. It focuses on the different types of hostage taking, the impact on the hostage and the role of the negotiator within this. It also focuses on the characteristics of a good negotiator, the tactics used, and the strategy for successful negotiations using the Behavioural Change Stairway Model (Vecchi, Van Hasselt and Romano, 2005).

The training also examines how the negotiation process may have to be adapted specifically to be effective with those patients in crisis who have mental disorders. As part of this training, extensive role-plays and an assessment process are incorporated. The training lasts for five days.

Additional training has also been developed to teach all staff "What to do if held against your will". Victim behaviour can often seriously impact upon the resolution of a crisis situation, and therefore this training looks at informing staff of the key issues if taken hostage. This includes a limited insight in to the negotiation process and suggested ways to react. This also includes understanding psychological responses to being a hostage, such as "Stockholm Syndrome" where a hostage may begin to develop positive feelings towards the hostage taker. The final section

examines what may potentially happen to a hostage, psychologically, after the incident. This training lasts for approximately one hour.

Detailed and comprehensive policies have been developed to ensure the successful management of these examples of extreme violence within the workplace. These policies include detailed role definitions and expectations of differing grades of staff for the duration of the crisis. These policies have been adapted to include Police contingency plans, and have developed a comprehensive service approach to the management of crisis situations within forensic mental health.

This workshop is extremely interactive in nature, and will give attendees the opportunity to examine some of the main psychological strategies used in crisis negotiation, and its adaptations for those perpetrators who have mental disorders. They will get the opportunity to experience some of the practical elements to the two training courses outlined above. They will get an overview of policy development within this area and an opportunity to explore the application of this pro-active work to their own workplaces.

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Training interaction skills: An intervention for multidisciplinary teams in the Dutch project aiming for the reduction of seclusion and restraint

Workshop

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In a recent national project in The Netherlands aiming for the reduction of seclusion and restraint many mental healthcare institutions used the Interaction skills Training developed and offered by Bureau de Mat. Because of the broad interest in this training and the effect it has on healthcare professionals, participants of this workshop will be given an introduction of the training as well as the significance of this training to the goal of reducing seclusion and restraint and preventing aggression.

The training aims at studying signs of cooperation and noncooperation and improvement of the quality of the working alliance between healthcare professionals and their clients. Cooperation where formerly the professional saw him/herself bound to using coercive measures. The training gives participants the opportunity to reflect on and gain insight into the effect of their behaviour for cooperation and noncooperation. Giving insight into several different styles of communication and several aspects of interaction i.e. does the other person's behaviour stem from "cannot" or "will not", and what is the effect influential interventions have compared to interventions based on power. The central question in the training is this: Is the effect that you get by what you say or do to the client also the effect that you want to achieve? And does this effect add to both short-term and long-term objectives of the professional and his client, or does it lead to barriers in the possibilities of client or professional to reach their treatment goals.

In the training a model is used to show these aspects of the interaction. This model consists of a red-green mat (de Mat ®) and a bag (de Tas ®) by which interaction can easily be studied and behaviour that affects cooperation or noncooperation can be made literally visible. The training follows the phases of contact between healthcare professionals and their clients en explores possibilities of cooperation in the meeting-phase, the phase of action and contact and the phase of ending the working alliance.

In the workshop an overview will be given as to what the training is and in which way it can contribute to the reduction of seclusion and restraint and the prevention of aggression. The following aspects will be presented:

- The effects of the training for the Dutch project, concerning crisis intervention in common psychiatric hospitals and its actual results.
- The effect of the training in forensic psychiatry.
- The psychological and biological determinants of aggression in psychiatry.

Following these presentations a full interactive demonstration of the training will be given by the workshop team.

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Towards suitable attitudes within a “dignified” pedagogical climate: Cultural change in the professional management of conflict and aggression in youth care, education and family

Workshop

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Although the term “pedagogical climate” seems to be an established concept, professionals in education and youth care are hardly able to express what this exactly means in practice. Especially when aggression and violence are involved and interventions are required, we can doubt if the applied approach suits the intended pedagogical climate. The two extremes we meet: either excessive control or excessive avoidance, show much similarity with the classical ‘fight-flight-freeze’ model and with the outdated pedagogical styles of the past century: the ‘authoritarian’ versus the ‘laissez-faire’ approach.

During a crisis a lot seems to be allowed, both for the professional and for the client, provided that control can be restored. Too little consideration is given to the impact of the interventions on several parties. Incompetence to act in escalating situations sometimes causes (unintended) irresponsible interventions – or the absence of it – but also interventions applied deliberately in a context of retaliation or punishment, with counter violence and overt display of power as a side effect (‘corruption of care’). As such interventions often lead to restoring control, an ‘evidence base’ is being assumed on the basis of apparent effectiveness.

The therapeutic alliance with the client can be severely damaged though and the value-base of responsible care is clearly missing here. Escalations in care and education can’t be considered as occasional incidents and the advice to the professional to get himself trained in self-defence, like the minister and the inspectorate in the Netherlands recently have suggested, does no justice to the seriousness of the problem as experienced by professionals in practice and offers no guarantee to a safer work climate. Intervening appropriately and safely in extreme, escalating situations is basically part of the occupational exercise and this should be done in a, for all parties, responsible way, so the pedagogical climate stays intact even at critical moments.

The choice of treatment and interventions should as much as possible match an authoritative/democratic approach. Interventions that take place in the context of such a pedagogical climate should not just be based upon behaviouristic principles, but also be tested by underlying values within the relationship of care, in order to secure the dignity of both the professional and the client.

The experienced incompetence to act can make extra training for professionals useful and necessary, especially when de-escalating interventions have been developed within the described context and are being trained as a means to create optimal safety. It is getting clear from (international) scientific results that the approach should be embedded and firmly rooted in a comprehensive policy of the organisation and can’t be or can’t stay the sole problem of the professional in (clinical) practice anymore.

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Dutch training and research in forensic psychiatry in a European perspective

Paper

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Keywords: Dutch training, research, forensic psychiatry

Background

In the Netherlands, only one of the five psychiatrists and professors of adult forensic psychiatry has his chair in the faculty of medicine. All the others are based in a faculty of law. Trainees can choose an optional course in forensic psychiatry, but only three afternoons are dedicated to forensic psychiatry as an essential part of the whole psychiatry training programme. So, a general psychiatrist may start working in forensic psychiatry without any forensic training or work experience.

When visiting conferences or reading articles, we noticed that most research about offender patients is done by research psychologists, even though most of those patients have a disorder with an important biological (medical) aetiology, e.g. schizophrenia spectrum disorder (Lanzenberger and Kasper, 2005; van Haren et al., 2008) or a personality disorder (Skodol et al., 2002; McCloskey et al., 2005; Popma and Raine, 2006).

We believe that insufficient attention has been given to education, training and research in forensic psychiatry in the Netherlands. This is contrary to the famous tradition of the human (psychological) approach of TBS-detainees since the 60s (van Marle, 2000; Raes, 2008).

Methods

In order to test this position, we reviewed the literature in forensic psychiatry in the Netherlands and abroad published between 1983 en 2008. A search of www.Pubmed.com and www.PsychInfo.com yielded 13 articles, using the following search terms: (forensic psychiatry) AND (training), (forensic psychiatry) AND (education) or (forensic psychiatry) AND (teaching). Four of these articles were eliminated for the following reasons: no current view on forensic psychiatry; child and adolescent forensic psychiatry exclusively; and providing only a strictly personal view of the Dutch TBS system. It was possible, however, to add six articles by following up references in the reference list, bringing the total to 15.

Results

Education and training

In their review article, Folino and Pezzotti (2008) reported finding few publications on training in forensic psychiatry. According to them, formal training and experience in research would be the best way forward for developing expertise in the field; they called for academic development and practical guidelines for court experts. Several authors concluded that some European countries have a highly organised curriculum (e.g. Germany) or forensic psychiatry as a subspecialty (e.g. UK, Ireland and Sweden), but requirements, training standards and duration of the training varied considerably from country to country (Layde, 2004a; Gunn and Nedopil, 2005; Scott, 2005; Folino and Pezzotti, 2008). Taylor et al. (in press) have set out the difficulties – and some solutions – with

respect to research training for forensic psychiatrists. There was also an agreement that basic training in forensic psychiatry is necessary for general psychiatry residents (Layde, 2004a; Lewis, 2004; Pinals, 2005; Rotter and Preven, 2005) and even medical students (Reiss and Chamberlain, 2001).

Cultural issues, such as sensitivity to an individual's native language, religion and country of origin, are important throughout psychiatry, but it is arguable that they are particularly so for forensic psychiatric evaluations in criminal cases. In addition, knowledge of culturally different notions of unusual perceptual phenomena and culturally different expressions of major mental illness is essential in evaluation of a criminal defendant's competency to stand trial and criminal responsibility for their actions (Layde, 2004b). Throughout Europe, psychiatrists are asked to provide opinions for the courts in such cases, and need training in accessing appropriate cultural resources to ensure that their advice is as sound as possible.

We could find no articles at all on education in forensic psychiatry in the Netherlands.

Research

In the UK, Taylor et al. (in press) have expressed concerns about the lack of investment in academic forensic psychiatry and the decline in the number of clinical academic training posts between 2001 and 2004. Furthermore, academic forensic psychiatrists, almost exclusively salaried by the health service, face competition for their time between clinical practice, service development, and teaching and training, as well as research. The Forensic Psychiatry Research Society (Anon, 2006) concurs, and has also concluded that forensic psychiatrists struggle with deficits in their research, teaching and presentational skills.

Other authors have highlighted the problem of drastic cuts in health spending, leading to shortages in trained staff (Folino and Pezzotti, 2008). These gaps have been filled with specialists from countries where training is less developed (Folino and Pezzotti, 2008; Taylor et al., in press). Several authors have expressed concern about this, and emphasised the importance of participation in research and writing articles while a trainee (Bloom, 2007; Simon, 2007; Folino and Pezzotti, 2008; Taylor et al., in press). Research and scientific writing skills can challenge stereotypes and misinformation, and can help trainees to develop new treatment models that are evidence based.

Discussion

First, it is obvious that there should be at least a well-defined educational programme in forensic psychiatry for general psychiatry trainees. Thanks to this programme, they could then learn to deal with legal issues and the different roles required as a medical doctor at the various interfaces with the law. More education will also lead to more understanding of and enthusiasm about forensic psychiatry.

Next, what can be said about the deficit in training for specialists in forensic psychiatry in many European countries? In some countries in Europe, there is excellent forensic psychiatry training available (e.g. Gunn and Nedopil, 2005). Perhaps those countries which do not have a highly organised and well-defined curriculum could benefit from the knowledge and experience in those that do, and so, start an educational programme as well. Our preference would be for recognition of forensic psychiatry as a subspecialty, therefore requiring a defined training, throughout Europe. In the Netherlands, there is a precedent in that child and adolescence psychiatry has already been organised as a subspecialty.

Finally, recognition of forensic psychiatry as a subspecialty could also yield more research done by psychiatrists. If training in research in the field and at least co-authorship on publications were expected, then any downward spiral of recruitment or retention in the field would be halted. Furthermore, all practitioners, not just those with academic qualifications, would become better teachers, trainers and supervisors. This is essential as more and more focus is given to evidence-based medicine (Khan and Coomarasamy, 2006). Forensic psychiatry at present perhaps relies too

much on the general psychiatry evidence base, and yet its service users differ in the complexity and extent of their illnesses, and antecedent social difficulties and traumas. The evidence base could gradually be made more specific to their needs.

Conclusions

In many countries, funding seems to be the major obstacle to the non-clinical work of psychiatrists, such as education, training and research. But we think that psychiatrists ought to take a much more proactive role in the forensic field, by drawing more attention to forensic psychiatry as a medical specialty, taking a stand on service improvements and by creating a distinct profile for the specialty.

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ePsychnurse.Net e-learning training course for psychiatric nurses: Nursing interventions to manage distressed and disturbed patients

Paper

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Introduction

E-learning and computer-assisted learning are most rapidly growing educational forms. The European Commission has announced that e-learning is one of the most important educational needs in across the European area and it will promote the effectiveness of integrating computer technology in vocational education and training. However, although ICT is widely used in educational area, the usability of computer-assisted learning among mental health care professionals is unclear.

Objectives

To describe different aspects of computer technology used in vocational education and training in the field of psychiatric nursing. ePsychnurse.Net e-learning continuing education course will be described as an innovative example. The course was aimed to nurses who are working in acute psychiatric in-patient units in different European countries and to increase their capacities to manage distressed and disturbed patients. In this presentation, experiences based on pilot course run in Finland and England will be described.

Methods

The pilot of the ePsychnurse.Net course was carried out in spring 2008 in two hospitals in Finland and one hospital in England. The course consisted of pre-and post student assessments, an orientation unit and six learning units run at Moodle e-learning platform. Pre-and post assessments included questionnaires related to students' learning needs, self-esteem, general self-efficacy, a SWOT (strength, weakness, opportunities and threat) analysis related to learning and overall course evaluation. Learning was theoretically based on reflective learning theory. Discussion forum, reflective diary and journal, virtual patient, descriptive assessment together with actual literature formed learning methods.

Results

This pilot study showed that it is important to use more innovative methods in continuing education in psychiatric hospitals. They were able to identify their learning needs both by updating their existing knowledge and by receiving new knowledge. Students evaluated identified and described the strengths, weaknesses, opportunities and threats related to the e-learning. These were mostly focused on issues related to studying, motivation, time and work. Students' overall satisfaction over the course was good and all students would recommend this course to other psychiatric nurses.

Conclusions

We can conclude that using e-learning course in clinical practice among psychiatric nurses offer new opportunities and challenges for psychiatric nurses. Therefore, it is important that nurses are offered an opportunity to participate in such courses. However, they should be motivated and they should have enough resources (computer's, internet access, time) and organisational support. It is also necessary that they have clear instructions with tutoring and support provided by experienced nurse teachers and that opportunity for face-to-face contacts are available when needed. In addition, it is important that students' have the possibility to reflect on their feelings, and that confidentiality is guaranteed in all situations.

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Benefits of international multidisciplinary visits for reflection, discussion and improvement of the treatment of aggressive behaviour

Workshop

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Objective

The working group for the prevention of coercion in psychiatry has been co-ordinating quality assessments and the reduction of coercive measures across 22 hospitals since 1996 in the South West of Germany and North Wales. What has been lacking so far was the possibility of international visits by multidisciplinary groups in order to compare and reflect on coercive measures.

Methods

We organised a visit by a multidisciplinary group from various hospitals in Germany to Wrexham in Wales. Questionnaires were filled in by all participants after the visits in order to gauge opinion about the factual situation, opinions, reflection and application for one's own practice.

Results

The visit has generated a critical reflection and many discussions about de-escalation techniques and coercive measures in all participating hospitals. This was particularly the case because of the differences in coercive measures: in Wales manual holding with relatively few members of staff was common practice in comparison to Germany where fixation on a bed with high usage of staff is common practice. The length of each coercive measure as well as the risk of injury is much lower in Wales. Ideas have been generated to further reduce coercive measures. There was a critical reflection on the fact that all participating members of staff felt that they were socialised within their particular health system and tradition.

Conclusion

There are still vast differences between de-escalation and coercive measures in Europe. The exchange of multidisciplinary staff leads to reflection and discussion about current structural and organisational circumstances as well as tradition. It led to the generation of new ideas about reducing and preventing coercive measures in each of the participating hospitals. There was also an increase in knowledge in all participants as a consequence of the visit.

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Could the gender of trainees in psychiatry influence the acceptance of hospitalization?

Paper

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Keywords: Compulsory admission, emergency psychiatry, hospitalization decision, gender, psychiatric residents

Aims

This study analyses assessment, intervention and admission decisions made by emergency psychiatry residents to determine whether these differ depending on the gender of the resident.

Methods

Data from all patients presenting to a psychiatric emergency room were collected prospectively for a three months period as part of a local quality check project. A questionnaire was used to collect patient demographic data, diagnosis, treatment decisions and the personal and professional characteristics of the residents who performed the assessments.

Results

We obtained data on all 251 emergency assessments carried out by all six residents working in the service. These were 3 female and 3 male 3rd year residents in psychiatry. There was no difference between male and female residents concerning ICD-10 diagnostic assessment, adherence to local hospitalization criteria guidelines and treatments administered. A similar distribution between male and female residents was found for diagnoses. No difference was found in the rate of hospitalization decisions between male and female residents. However, surprisingly, there were more voluntary hospitalizations by the women residents ($p=0.035$; $\chi^2=4.443$) and more involuntary admissions by the men residents ($p=0.005$; $\chi^2=7.643$). There was no correlation between the gender of the patient and the assessment or hospitalization decision of either male or female residents.

Conclusion

Although this study has methodological limitations, it suggests that female emergency psychiatry residents are more likely to convince patients to accept voluntary hospitalization. Further randomized studies could be useful to establish whether this is a more generalized phenomenon. The findings underscore the importance of training in pharmacological and psychotherapeutical approach in emergency settings and also the importance of supervision.

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Comparing instruments to evaluate the effectiveness of training in the management of aggression: Self-assessment (Thackrey-Scale) versus expert-appraisal (DABS)

Poster

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Study objective

The evaluation of trainings in the management of aggression is a critical tool for justifying the investment of time and money into staff training. There is evidence that self reported measures, as self-confidence, measure feelings but do not measure any learning that has taken place. On the other hand the evaluation of the impact on the practical placement by measurement of the severity and frequencies of aggressive incidents is biased by many other variables. Although self-confidence is deemed a predictor for successful performance there is no clear evidence that this variable predicts performance in managing patient aggression. In this study the association between self reported confidence (Confidence in Managing Patient Aggression Scale - Thackrey Scale) and performance assessed by experts (De-escalating Aggressive Behaviour Scale – DABS) is investigated.

Methods

Using a within and between groups pretest-posttest design nursing students of six educational levels (6 groups, 10th to 28th month of nursing education, $n = 65$, mean age = 22) were investigated regarding their self-assessment using the Thackrey-Scale and regarding their performance before and after aggression management training. The nursing students were exposed to two differing aggression scenarios enacted by simulation patients. The videotaped performance of the nursing students were evaluated by de-escalation trainers using the De-escalating Aggressive Behaviour Scale (DABS) not knowing whether the performance emanated from the pre- or post-test condition. Mean values and t-test, of both scales were computed. Sensitivity, specificity and predictive value of self-assessment scale's ability to identify weak performance were also computed using the scales' neutral midpoint as cut-off point. Additionally the correlation (ICC 3) between the level of self-reported confidence and quality of the performance was computed.

Results

The training led to a significant improvement of the mean of the groups in both scales. An evaluation of pre- and post-test assessments ($n=130$) revealed that 84% of candidates which performed weakly were correctly identified by self-assessed weak confidence. 79% of good performance candidates were correctly identified by good confidence before. The predictive value i.e. the proportion of being correctly self-assessed was .87 for good performance and .76 for performing in a less acceptable manner. However, within the same person the level of self-reported confidence was not a precise predictor for the quality of the performance. The training had no improving influence on the accuracy of the self-assessment (Intraclass Correlation Coefficient ICC3 pretest: 0.24, posttest: 0.28).

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Exploring what's important in evaluating training in 'The Prevention and Management of Violence.' TPMV: Training delivered at a high security hospital in England, to promote useful learning

Paper

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Keywords: Staff training; violence; capability; evaluation; Q methodology

Background and context

Training in the prevention and management of violence is mandatory for all staff in face to face contact with patients in the NHS in England (NIMHE, 2004). It is relatively easy to determine whether staff are satisfied with the training they receive at the point of delivery by administering questionnaires. However it is more difficult to determine whether such training is effective in bringing about the collective capability of staff to prevent and manage violence in the workplace. Furthermore the author found that whilst post course evaluation forms are often routinely administered the data was often rarely made use of as part of a systematic process of course development. The training department provides training according to the risks presented. This is multiply determined by the staff's clinical function, the patient group and the context in which staff work. Whilst training is provided on an annual basis, finite resources restrict the time available, further emphasising the need for continual course development based on sound evaluation methods.

The need for thorough and effective evaluation was described by Zorola and Leather (2006), to prove whether the training:

- Is aimed at important and worthwhile organisational benefits;
- Operates smoothly and effectively and is enjoyed by participants;
- Achieves important skills, knowledge and attitude objectives;
- Uses the best available and most cost effective designs;
- Is used effectively on the job; and
- Provides valuable and cost effective organisational benefits.

Aims of the study

The aim of the study was to explore trainer and trainee perceptions of what is important in evaluating the prevention and management of violence (TPMV) training, delivered at a High Security Hospital in England, to promote useful learning. This, it is anticipated, will contribute to the development of a future training evaluation model for the High Security Hospital.

Methodology

As this research was specific to one High Security hospital, the methodology chosen was based on the function to highlight a variety of views that are contextual, multiple and allow competing understanding to emerge. This involved two distinct approaches. Firstly the views of TPMV trainers were sought on aspects pertaining to the evaluation of training, using semi-

structured interviews. The interview schedule focussed upon five key areas of evaluation based on Kirckpatrick’s training evaluation model (Kirckpatrick, 1976). This includes identification of the times when evaluation should take place, the importance of and staff reaction to training, the aspects of learning that should be evaluated within training and what changes in behaviour we would want to see within clinical practice. Finally trainers were asked what would determine overall effectiveness of training in terms of organisational impact. All interviews were taped and the themes transcribed. The sample was restricted to only six instructors however opinions were varied reflecting personal preference about what is important in evaluating training e.g.

“Role play should be utilised within a safe environment to assess skills and evaluate effectiveness.”

Whereas an alternative view was:

“Role play is not an effective means to evaluate adult learners ability to manage violence.”

The resulting sample statements are therefore a reflection of varied attitudes that are reinforced by beliefs and often strong feelings (Cross, 2005). As such the sample is cultured by feelings rather than facts, and can be seen as being based on cultural knowledge and social constructions (Goldman, 1999, p.591)

The second stage entailed utilising Q methodology to identify the interconnecting themes that trainees perceived to be important within evaluation. Q methodology was developed by Stephenson in 1935 (Stephenson as cited by Brown, 1996) as a way to reveal the subjectivity involved in any situation. Q methodology is a quantitative approach that combines easily with qualitative approaches, thus the research study utilises mixed methodology. Whereas the semi-structured interviews reveal a subjective view of what is important in evaluation within the evaluation model, Q methodology numerically quantifies the data. A sample of staff (n=26) who undertook training in TPMV participated in this exercise. The interview data from stage 1 provided the source for the 62 statements used within the Q sort, thereby ensuring the content was relevant to the target population. The trainees were asked to rank these statements based on whether they agreed, disagreed or were unsure. The levels of agreement and disagreement were further refined within a forced distribution grid (NB: see Fig: 1) thereby highlighting strongly held views and reflecting each persons individuality through allocating all of the Q set items (statements) an appropriate ranking position. Using Q methodology ‘PQ Method, version 2.11’ (Schmolck, 2002), a range of accounts emerged.

Figure 1: Levels of agreement and disagreement within a forced distribution grid

STRONGLY DISAGREE			DON'T KNOW					STRONGLY AGREE				
-6	-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5	+6
2												2
	3										3	
		4								4		
			5						5			
				6				6				
					7		7					
						8						

(NB: Distribution of Q sort grid (n=62))

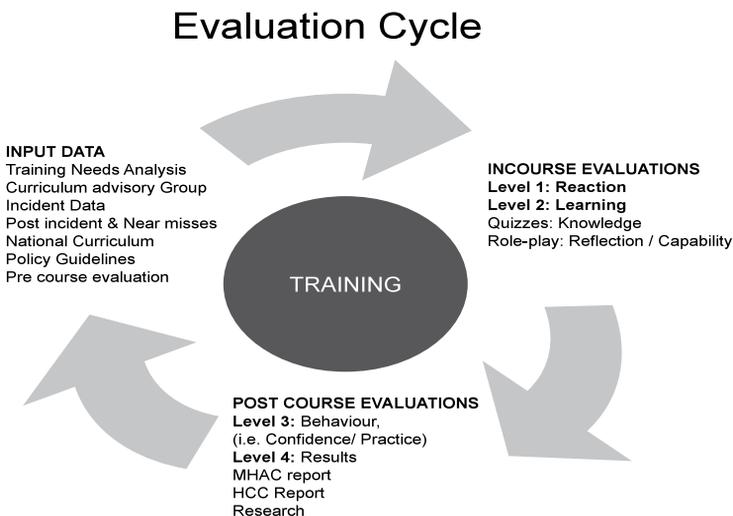
Results

Computerised factor analysis of the 26 Q sorts resulted in the emergence of six distinct accounts of proposed training evaluation. These occur when a number of participants similarly rank the statements, producing a pattern of themes that are considered important. By analysing the relationships between the statements and the level of importance afforded to them by the participants, the researcher interprets the factors to produce a descriptive narrative for each. Interpretation is also supported by interview data to maintain a contextual reading. The reading of the accounts were categorised as:

1. 'Organisational Multimodal Approach'
2. 'Generic Insular Approach'
3. 'Generic Physical Approach'
4. 'Team Approach' based on evaluating confidence, organisational learning and non-physical skills.
5. 'Evaluation Antithesis'
6. 'Multipoint Complex'

The most readily available account (rated by the majority of participants) is described as an 'Organisational Multimodal Approach' to evaluation. This provides a useful insight to how training evaluation could be developed and implemented in the High Secure Hospital. This account focuses on the need to evaluate whether training meets area specific needs, the needs of staff teams as well as evaluating training from the perspective of the individual. The wider effectiveness of training would be evaluated through the examination of near misses and how well hospital policy is implemented. Also team effectiveness would be evaluated through simulation and role play whilst individual evaluation would focus on the retention of knowledge and skills. Whilst many of these activities are undertaken in isolation the aim is to develop an organisational approach. The effectiveness of training is dependent on the development of systems in which training adapts and responds in accordance with organisational change. In this sense the training department cannot be seen as a separate entity but as an integrated component of service in the same way that an engine management system adjusts the fuel input, valve timings according to the conditions / demands it is exposed to. Figure 2 illustrates an 'Evaluation Cycle' as a means of continuing course development in response to identified needs)

Figure 2: Evaluation cycle



Discussion and conclusion

This research identified that there are a number of differing views regarding what is important when evaluating TPMV training, depending upon the participants experience and professional investment. Q methodology therefore is a useful method with which to explore the complicity of trainer and trainee perceptions of what is important in evaluating TPMV training. One account however emerged as more readily available amongst a greater number of participants.

Zorola & Leather (2006; p 58) rightly pointed out that 'the evaluation of training is a necessary but often overlooked element of the training cycle. TPMV training in the UK is evaluated according to locally developed evaluation measures and not yet subject to any prescribed standard or method. The effectiveness of mandatory training within this area is commonly measured only in terms of the number of people trained. As mandatory training is time limited the evaluation of training taking place within the training department should be simple. However the evaluation process should be planned as part of an evaluation cycle incorporating internal educational and practice indicators.

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A psychotherapeutic approach for handling aggressive behavior: the validative emotional bonding psychotherapy

Paper

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Keywords: Psychotherapy, aggressive behaviour

Aggressive behaviours are among the most frequent reasons that a youth is referred for mental health evaluation. Recently published books outline the multi-factorial origins of violence, particularly in terms of intimate or family violence and youth violence¹. Longitudinal studies have demonstrated that disruptive behaviour disorders may culminate in adult antisocial personality disorder. Bowlby and Ainsworth, the originators of attachment theory, argued that all people, be they infants or elders, seek to establish an effective tie, or attachment, with specific others to meet needs for physical and psychological security². It is a well-accepted idea that the quality of the attachment is related to psychological adaptation and the possible development of psychopathologic dysfunctions, including disruptive behaviour disorders and personality disorders.

It is our objective to introduce among staff a novel psychotherapeutic approach for handling aggressive behaviours: the validative emotional bonding psychotherapy. The validative emotional bonding psychotherapy is profiled as a model of psychotherapy of effective support, focuses on the emotional alliance between client and therapist and seeks the repair of the pattern of pre-existent attachment. The creation of a new way of representation and relationship requires the establishment of a sure bond (reciprocal attachment). Factors that should be considered in this approach include therapists' personality variables and use (or misuse) of therapeutic techniques and interventions.

Since we are still developing the validative emotional bonding psychotherapy considerable work will be necessary to establish its validity but preliminary data have shown significant improvements and the perception of both professionals and users coincides in the effectiveness of its position and results.

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Training and safety of staff when working with challenging behaviour and violence

Workshop

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Verge Training Inc is a privately owned company operating from Norway. Our company has delivered professional training related to workplace violence and crisis management since 1992. We have trained thousands of employees from several hundred workplaces. Through out the years we have evaluated and tested many different approaches to prevent and deal with violence. Our working model focuses on three areas;

1. Prevention of violence
2. Crisis management and methodology/skills
3. Aftercare of employee and patient.

Our approach is always in close dialog with the individual workplace. All training and structure is individually evaluated, re-designed and implemented. Workplace trainers are educated and regular in-house training is organized. During this workshop we will be presenting:

1. System design and the concept of “necessary employee safety”
2. Experiences from a large psychiatric hospital
3. Demonstration, active participation and explanation of skills delivered during training

This workshop is aimed at trainers and administrator seeking information about alternative approaches and skills in a sharing environment.

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Non-physical techniques that personnel uses to de-escalate aggressive behaviour of inpatients on psychiatric wards

Paper

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Background

It is a well known fact worldwide that aggression and violence are serious problems in psychiatric settings (Chou et al, 2002, Ketelsen et al, 2006, Grazzi et al, 2001, Nijman et al, 2002, Foster et al, 2006). Management of violence in hospitals are at different levels or stages in hospitals and many require the use of proper skills and training (Wesuls et al, 2005, Oud, 2006). Antecedents to violence are known and thus it can be stated that the aim of de-escalation is to hinder verbal aggression in developing into physical violence. De-escalating aggressive patients is complicated and stressful work. The worker faces a situation where he needs to rely on various skills that he has learned and trained and factors such as age, training and experience play a role.. Accidents can occur if the de-escalation is not carried out successfully and the consequences can be physically and emotionally harming. Nurses and others have written guidelines on how to verbally de-escalate aggressive patients (Lewin-Pitz, 1986; Stevenson, 1991; Anderson et al., 1996; Johnson et al., 2001; Cowin, Davies, Estal, Berlin, Fitzgerald and Hoot, 2003; Richter, 2006). The guidelines are mainly about communication and body language. Many of the guidelines seem to be built on the the author's own experience and have been helpful for nursing staff. Others have done interesting research about the management of aggression in particular circumstances (Carlson et al., 2000; Johnson and Hauser, 2001; Carlson et al., 2004; Carlson et al., 2006., Delaney and Johnson, 2006; Johnson and Delaney. 2006).

The purpose of my research was to find out what personnel said or thought should be said and what body language should be used to de-escalate verbally aggressive patients. It is clear that same guidelines can never be used to all patients. Personnel, patients and situation differ and what works in a particular situation does not necessarily for in other situations. Guidelines can therefore only be used as a helping tool along with other resources in de-escalation. However guidelines can be useful when they are built on the experience of personnel and used on wards where they work.

Aim

The aim of the research is to find out what non-physical techniques are used in psychiatric in-patient wards to de-escalate verbally aggressive patients and to build guidelines from the results.

Method

The research is based on grounded theory (Glaser and Strauss, 1967; Strauss and Corbin, 1994). In order to get the fullest picture of the subject, different methods were used in data collection. The research took place in all acute wards (4) and two of six rehabilitation wards of the psychiatric department in the University Hospital in Reykjavík.

Data collection was done in six parts.

1. An interview with 18 staff members (3 from each unit) who had managed to de-escalate verbal aggressive patients. Head nurses chose nursing staff that had skills to de-escalate aggressive patients.
2. An interview with 18 staff members (3 from each unit) who were asked to describe how they de-escalate verbally aggressive patients. Head nurses chose nursing staff that had skills to de-escalate aggressive patients.
3. After the occurrence of an incident the personnel were asked to document how they de-escalated verbally aggressive patients.
4. An interview with 52 inpatients about how they thought personnel should de-escalate verbally aggressive patients.
5. The researcher stayed on the wards where the research took place and observed communication between personnel and patients.
6. A questionnaire on how to de-escalate verbally aggressive patients was sent to all the nursing personnel in the psychiatric department of the University Hospital.

Analysis of data from items 1 – 5 in the list was coded according to Strauss and Corbin () and categories and sub-categories developed. Data from item 6 was analysed in SPSS, mainly frequencies.

Results

As the research is not completed, only preliminary results will be introduced. Final results will be introduced at the congress. However it can be said that data from items 2 – 6 underpin outcome of item 1. The results will be used as guidelines for the wards where the research was done.

1. Talking with an aggressive patient

Begin the conversation with the patient in a polite and calming manner and show him your intention to help him. Ask him to come aside with you if he is among other people. Invite him to take a seat with you. If he prefers to stand take a stance in front of him.

- Tell the patient to calm down: Tell the patient that his behaviour is unacceptable and that he has to change it.
- Give the patient explanations: Explain to the patient why he has to change his behaviour and which consequences his behaviour might have for him and others.
- Point to rules: Ask the patients to follow the rules. Tell him why there are rules, whom they are for and who made them. Do an exception to the rules on an occasion when you think it is acceptable and when you are in danger.
- Show equality: Allow the patient to express his meanings and listen to them. Encourage him to come to an agreement with you.
- Show helpfulness and understanding: Ask the patient about his feelings and why he is angry and tense. Tell him that you are willing to help him although you cannot fulfil all his needs.

2. Use the voice

- Speak as usual: Talk with the patient in a usual conversational way. Lower your tone of voice if the patient raises his voice. Never speak louder than the patients.
- Do not sound threatening: Speak with a soft and mild voice which shows kindness and no arrogance.
- Speak clear and slowly: Speak clearly and slowly so the patient understands you. Speak more slowly if tension in the patient arises.
- Sound assertive: Reflect assertiveness in your voice by speaking without hesitation and with certainty if the patient seems tenser.

3. Use facial expression

- Show facial expression as usual: Keep in eye-contact with the patient without staring at him. Express interest in listening to him.
- Show calmness and respect: Show calmness and respect while communicating with the patient.

4. Using hands and arms.

- Keep arms beside you: Keep your arms in a relaxed position in a non-threatening way but ready to defend yourself against assault.
- Move your arms slowly: Move the arms slowly and calmly.
- Keep your hands open: Show the patient the palms of your hands, it tells the patient that you are there and your willingness to help.
- Touch: Touch the patient if you think it will calm him, if you know him well and have made good connection with him.

5. Showing no fear

- Stay calm: Show fearlessness by showing calmness in your body language. Speak slowly, without hesitating and be ready to defend yourself.

6. Reading the meaning of the body language

- Read understanding and helpfulness: Patients are supposed to read that the personnel is trying to understand them and willing to help them.
- Read the requirements of the personnel: Patients are supposed to read that they are expected to do.
- Read security and fearlessness: Patients are supposed to read the safety and fearlessness of the staff.

7. Defending yourself

- Be with others: Have other staff nearby when you de-escalate a patient.
- Read the situation: Observe the tension in the patient and objects or people in the environment the patient can assault.
- Localize yourself: Stay in a proper distance from the patient near the runaway. Take a seat if the patient sits, stand if the patient stands.
- Be ready: Stay in a sideway stance. Be ready to react against assault with your arm and/or press the alarm you are carrying.

8. Know the patient

- Use your experience: Use your former experience if you are de-escalating a patient you already know.
- Rely on trust: Use the trust you have built between you and the patient.

Conclusion

The results can not be generalized to all psychiatric wards. The likelihood that the use of the guidelines will be successful could be drawn from the fact that the data were collected all of the acute psychiatric wards and 2 of the six rehabilitation wards in the psychiatric department were they will be put into practice. Nearly all reported cases of violence and aggression in the psychiatric department happen in those wards since the year 2000

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The nurse and potentially violent client

Paper

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The paper informs on the situation of psychiatry nursing in the Czech Republic and deals with three areas of nursing provision and encounters with aggressive or violent patients. These areas are various hospital wards, mental hospitals, forensic wards, and other health care placements within the prison system. The nursing profession is not very popular in the Czech Republic as nurses do not have much credit in the eyes of society unless people need nursing care. The prestige of psychiatric nurses is even lower and the fact that nurses work within the prison system is almost unknown.

This paper gives insights into nurses' opinions on this issue and reports on how nurses handle situations with aggressive and violent clients, how they are prepared for to care of these clients during their pre-graduate education, and what kind of life long learning is offered to them.

Currently a lot of discussion is going on about coercive measures such as cage and net beds and on the other hand about workplace violence caused by clients, family members and among the staff. A vast amount of articles describe particular incidents or cases relating to violence, aggression, restriction, mobbing, bullying and harassment. These articles usually prescribe what should be done and who should do it starting with the ministries, legislation, top management, finances and blaming the lack of personal and the lack of communication skills for to cope with aggressive people. However, no relevant and exact evidence or statistics exist to rely on. Increasingly journals and text books are offering recommendations, theoretical plans on how to work and what to do when encountering aggressive clients and how to prevent aggressive behaviour. In spite of such advice, statements of health care workers regarding the mastery of particular skills to be used in actual situations involving aggression are missing.

There is a difference in multidisciplinary team representatives according to whether the institution's trust granter is the Ministry of Health or the Attorney General, where the nurses work under the officer's command. The place that nurses have in multidisciplinary team and their degree of autonomy regarding decision making is also the part of this article.

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Effects of nationwide implementation of an aggression management training course: A multilevel qualitative evaluation approach among health care workers

Paper

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Keywords: aggression management training course, health care workers, violence, de-escalation, evaluation

Background

Attacks at the workplace leading to physical injuries and psychological damage are apparently frequent (Voyer et al., 2005, Crocker et al., 2006, Farrell, 2005). Thus, it has been estimated that 11% of all health care workers were confronted with physical force in 2000 (Chappell & Di Martino, 2006). Human beings are the second most frequent cause of notifiable accidents in the health service (Nienhaus, 2005). According to a review article, the prevalence of psychological and physical violence in the health service lies between 11% and 96% (Zeh et al., in press). These figures are rather unreliable, as there are some very marked differences in the study designs of the evaluated literature. The number of attacks is presumably greater, as many are not reported (Rippon, 2000). Research in this area has just started, particularly in Germany (Richter, 2002).

Although many different training programs are available for dealing with violence at work (Kienzle & Paul-Ettliger, 2007), it is still unclear how effective these are. Richter and Needham (2007) compared 38 studies performed between 1976 and 2004 in psychiatric hospitals and in workshops for people with disabilities. They found that a comparison was hardly possible, because of differences in methodology. Only a single study fulfilled the gold standard of randomised controlled study (Needham et al., 2005). In this study, the number of aggressive incidents did not decrease after the interventions. However, the programs enhanced the employees' confidence in dealing with difficult situations. The authors recommend that this finding should be used as an important criterion in quality assurance.

The Institution for Statutory Accident Insurance and Prevention in the Health and Welfare Services (BGW) offers its member companies support in questions of prevention and rehabilitation. Since 2006, the BGW has provided financial support for courses to qualify as internal de-escalation trainer. These courses are intended to help health service employees to enhance their expertise in dealing with violence and aggression from their patients. For this purpose, the BGW cooperates with the Institute ProDeMa (Professional De-escalation Management). The themes of the training provided by ProDeMa have been agreed with the BGW and aim at specific target groups. The training courses last 12 days and qualify health service employees as internal de-escalation trainers. The qualified trainers function as multipliers, by training further their colleagues within their own facilities. Some of the training topics are as follows:

- Measures to initiate and accompany professional de-escalation management in the facilities in which the trainers work,
- Teaching methods for training colleagues,
- Methods for communication and physical intervention techniques,
- Procedures and methods to provide psychological first-aid to colleagues.
- The effect of the training is observed. We will discuss the study design and report on the results from workshops for people with disabilities.

Methods

The investigation of the training's effects concentrates on three issues:

1. After the 12-day training course, were the participants adequately qualified?
2. Did the internal training increase the expertise of the employees taking part?
3. Was it possible to establish internal de-escalation management?

To answer these questions, some participants of the trainings are invited to focus group discussions. The procedure of focus group discussion is established in qualitative social research (Bortz et al., 2002). The survey of participants working in workshops for people with disabilities was performed from September 2008 to February 2009. The results are presented at this Congress. A second survey with participants from hospitals is planned for the period from September 2009 to February 2010.

The efficacy of the training measures for dealing with violence was examined in three groups by semi-standardised interview guidelines with up to 20 questions: the group of the qualified trainers (N=14), the group of the colleagues they had trained (N=26) and the group of facility managers (N=9).

1. Six months after completing their training, the qualified trainers discussed the quality and success of the qualification measure.
2. Three months after the first internal training session, the colleagues trained by the qualified trainers were asked about the training, the extent to which it had improved their expertise and their ability to overcome problems. Samples of participants were selected.
3. In order to record any changes in the organisation, representatives of the facility (e.g. facility director, managing director, nursing or ward managers, works council) were questioned about one year after the first internal training session.

The focus groups were moderated by an independent investigator (DR). Contributions to the discussions in the focus groups were recorded by a non-participating observer in a semi-standardised manner (AZ, SK). The answers were combined to give an overview.

Results

Evaluation by the qualified trainers:

The ProDeMa training course, their training concept and the trainers were regarded as being very good. The qualified trainers stated that they had greatly benefitted from the training course - both from the techniques they had learnt and from the new teaching procedures.

Evaluation by the trained colleagues:

The subjective assurance of the surveyed colleagues markedly increased after the training session. Thus, the subjects reported that they were better able to assess and interpret their patients' behaviour. The significance of the new physical techniques was controversial. Whereas employees

from some facilities would gladly have had proportionately more training on techniques for physical intervention, especially managers tended to regard these as irrelevant.

Organisational implementation within the facilities:

For most of the facilities, the support from the BGW provided the decisive impulse to introduce the training measure. Thus, participants in the focus groups reported that the demand for support had long been an issue within the facility, but that the decisive impulse to act had been missing. De-escalation management had been implemented to very different degrees in the different facilities. The amount of time made available by the management for training varied greatly. As a result, the level of training provided to the colleagues also varied. Other differences between the participating facilities were as follows:

- Training of individuals versus training of teams
- Training on demand versus training as standard program
- Obligatory or voluntary participation
- General or restricted implementation
- Exemption from work for the trainers versus integration of the work in the normal working day

In summary, it can be concluded that internal training of de-escalation trainers has made a decisive contribution towards open discussion of the issues of violence and aggression.

Discussion

The present preliminary results from workshops for people with disabilities confirm Richter and Needham's analysis. Although the intensity of the training depended on the facility, the employees' subjective security increased after the training session. This may indicate that the efficacy is not only due to the actual content of the training sessions, but rather to the fact that the introduction of these sessions is taken as a sign that the facility is specifically dealing with this problem.

The internal training sessions did not cover all of the techniques which the trainers had learnt during their qualification. The emphasis was on the use of communicative techniques for de-escalation. Physical intervention techniques were used to a much lesser extent. One reason for this was that the subjects were unhappy with the techniques, as they had not had enough practice. A second reason was that they were simply less necessary. This discrepancy between training and internal implementation indicates an interfacial problem. For the managers interviewed, the details of the themes covered were less important than the related changes in internal attitudes. This may be an explanation for the interfacial problems. It may be more effective for the facility if an internal preliminary discussion is held to decide whether the complete training program is to be adopted, or only selected components. For example, techniques of physical intervention might only be taught in selected facilities. An additional argument for this would be that the expectations of the facilities of the trainers might then be more realistic.

In summary, it may be said that the training course had a favourable effect on the trainers, the colleagues they trained and the participating facilities. There are signs that the positive effect can be enhanced if there are more intensive discussions with the participating facilities before training starts, as this can help to clarify the expectations, possibilities and limitations of the training.

We must wait to see whether the second survey, with hospitals as the target group, will confirm the first survey.

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Announcement

Please note the following details for two future conferences on violence

27 – 29 October 2010

The second International Conference on Workplace Violence in the Health Sector,
Amsterdam – The Netherlands.
For details please see www.oudconsultancy.nl

20 – 22 Oct 2011

The 7th European Congress on Violence in Clinical Psychiatry,
Prague – Czech Republic.
For details please see www.oudconsultancy.nl

“Assessing, treating and caring for potentially violent patients”

“Assessing, treating and caring for potentially violent patients” is the motto of the 6th European Congress on Violence in Clinical Psychiatry held in Stockholm from the 21st till the 24th of October 2009.

This book of conference proceedings offers an overview of the work of many clinicians, researchers, and others on topics pertinent to the field of clinical violence such as legal and ethical perspectives on violence, the impact of violence on patients and staff, coercive measures, the pharmacological treatment of violence, the biology of violence, and interventions to address the problem of violence in clinical psychiatry. The congress offers a platform to all persons interested in the subject and to encourage the congress participants to engage in discussion and exchange on the various facets of violence.

Readers of the conference proceedings will benefit from the topical findings presented here and will receive a wealth of stimulating ideas to enrich their own clinical practice.

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