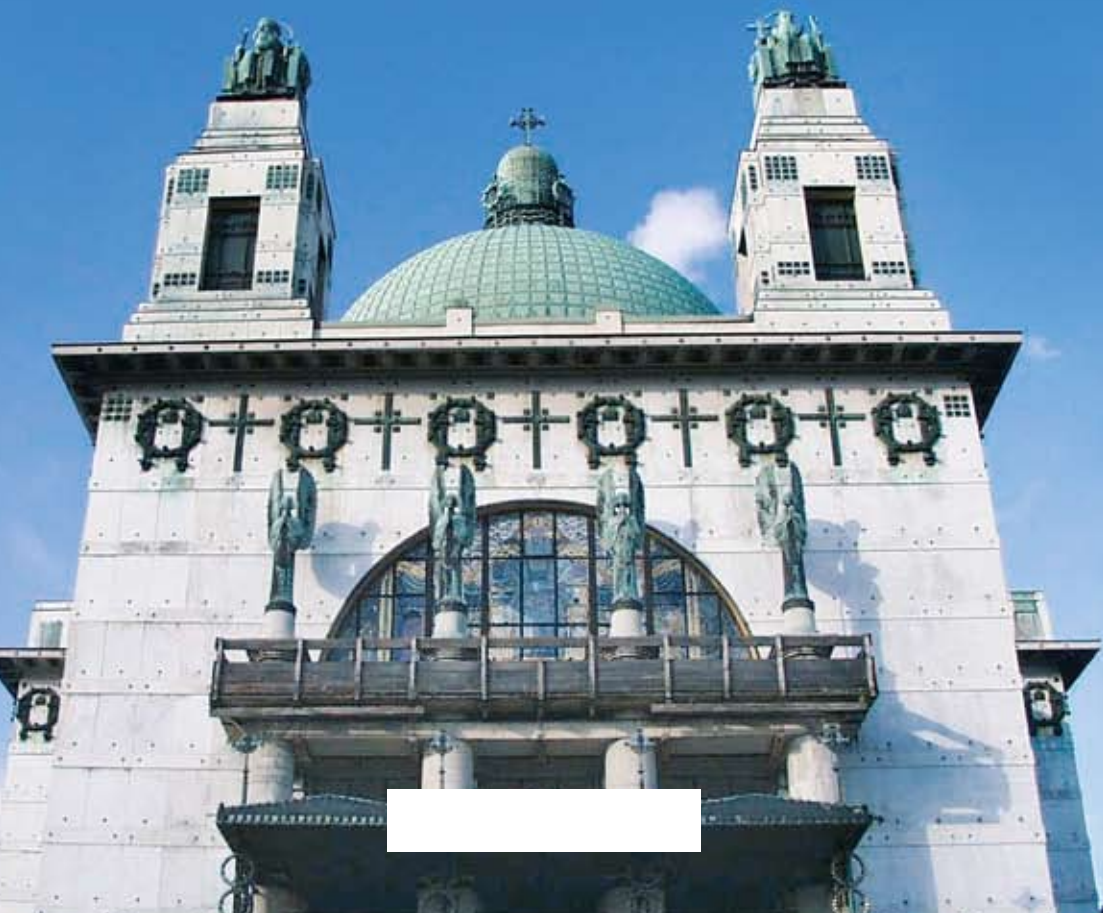


Tom Palmstierna – Henk Nijman - Nico Oud

Proceedings of the 4th European Congress on

VIOLENCE IN CLINICAL PSYCHIATRY



Violence in Clinical Psychiatry

Prof. Dr. Tom Palmstierna
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Editors

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Introduction

Violent and aggressive behaviour is a complex phenomenon of great importance in society as well in clinical psychiatry. It has become a global problem crossing borders, work settings and occupational groups, and within clinical psychiatry, violence is one of the major obstacles for effective treatment and rehabilitation, and with regard to health care workers, violence is the major occupational health hazard.

Since the first congress in 1992 in Stockholm, we have had two other successful congresses in Stockholm (2001) and London (2003). The 4th European Congress was held in Vienna – Austria at the Otto Wagner Hospital, which was built between 1904 and 1907 as the lower Austrian federal county charity for people with nervous and mental diseases “Am Steinhof” in a “Pavillion-System” and it got its final form by the famous Austrian architect Otto Wagner. The church of the institution “The church of St. Leopold” is the main example of the Viennese Art Deco Style, and a visit to this church was therefore part of the program.

The purpose of the congress was to promote and disseminate current knowledge within relevant areas of the recognition, assessment, prevention, treatment, interventions, post-incident interventions, and therapeutic safety management of violence in mental health care within clinical psychiatry. The congress offered researchers, health care practitioners (psychiatrists, psychologists, psychiatric nurses, and other professionals) managers, educators, developers, theorists, and others the opportunity to present their work, to exchange information, to network, to learn from each other and to promote international collaboration. For that matter this Vienna Congress offered 9 keynote plenary lectures, 10 symposia / seminars / workshops, 45 concurrent lectures and 30 poster presentations by colleagues from 23 different countries.

Yours sincerely,

On behalf of the Scientific Committee

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Prof. Dr. Henk Nijman (Netherlands) (Co-Chair)

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Preface

Evidence based practice for understanding and managing aggressive behaviour: the 4th European Congress on Violence in Clinical Psychiatry

In this book, the reader will find a selection of papers and posters presented at the 4th European Congress on Violence in Clinical Psychiatry. The focus of the Violence in Clinical Psychiatry congresses has, per tradition, been on the clinical reality of having to deal with aggressive and violent behaviour of (forensic) psychiatric patients. For mental health care workers, work-related violence is without any doubt one of the major occupational health hazards.

The past three Violence in Clinical Psychiatry congresses, this practical focus was illustrated by a high number of papers on easy-to-use instruments to quantify and measure aggressive behaviour. The evidence base for understanding and managing violence in psychiatry, in our opinion, grew substantially over the past decade by this increased use of reliable and comparable aggression registration methods.

In this 4th congress, more emphasis appeared to be on the empirical study of the effects of well-defined interventions and therapies. Further, some participants presented detailed checklists aiming at helping staff to choose and evaluate preventive strategies more systematically. The harsh clinical reality, however, is that in many cases only small decreases in violence rates could be reached. Yet, we feel that the current selection of papers makes clear that many more interesting hypotheses and interventions will be put to the test in the near future.

Recent research further seems to have concentrated on how to minimize the impact and consequences of patients' violence. Possibly, this has to do with the fact that inpatient violence has proven to be such a persistent phenomenon. The prevention of psychological consequences, in particular, seems to have been the object of study of several aggression researchers in the past few years. To be

more specific, a number of papers addressed the associations between exposure to work-related violence and post traumatic stress symptoms, or discussed the way post-incident care for victimized caregivers can be most effective.

The specific aim of the 4th Congress was to share practically useful, evidence based information on how to treat and manage violent behaviour of psychiatric patients. The number of participants at the Vienna conference stresses that the severity of the problem of violence in clinical care is recognized by many. It also suggests a strong desire to share expertise about this topic between disciplines, treatment settings, but also across countries. The presenters with more than 20 different nationalities truly made this congress an international forum for disseminating insights on violence prevention. We like to thank everybody who presented, participated, or otherwise contributed to this congress in Vienna, and hope we will meet again at the 5th European Congress on Violence in Clinical Psychiatry in Amsterdam, the Netherlands.

Tom Palmstierna, Henk Nijman & Nico Oud

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Keynote 1 – Measurement and management of inpatient aggressive behaviour

Prof. Dr. Henk Nijman

Professor in forensic psychology at Radboud University, Nijmegen, the Netherlands, Senior researcher at forensic psychiatric hospital de Kijvelanden, Poortugaal the Netherlands, and visiting professor at City University, Department of Mental Health and Learning disability in London.

Introduction

Severe inpatient assaults may result in harm and injury, and consequently, to sick leave by nursing staff. A recent, anonymous survey among 148 psychiatric nurses working in East London (Nijman, Bowers, Oud & Jansen, 2005) revealed that a little more than one out of every five nurses reported to have not been able to go to work due to workplace violence at least once during the year reported on. These nurses had stayed at home for a total of 172 days, with an average of 5.2 days per sick nurse (range 1 –23 days).

For effective prevention, proper assessment of aggressive incidents is essential. Instruments for measuring the aggression of psychiatric patients can roughly be divided in self-rating and observer aggression scales (Bech, 1994). Bjørkly (1995) noted that “(..) major problems in obtaining self-report measures from psychotic patients complicates this approach to prediction research” (p. 493). On a related note, Yudofsky et al. (1986) suggested that “many patients are not angry between aggressive episodes, and do not reliably recall or admit to past violent events” (p. 35).

In this paper, several reliable - but easy-to-use – observer based instruments for recording aggressive incidents of psychiatric inpatients are briefly presented. More specifically, the clinical usefulness of the Staff Observation Aggression Scale (SOAS; Palmstierna and Wistedt, 1987), and its revised version (i.e., the SOAS-R; Nijman et al., 1999), and the Attempted and Actual Assault Scale

(ATTACKS) are illustrated. Apart from that, SOAS(-R) aggression frequencies found in the psychiatric literature up till now are compared in this paper. Comparisons between different ward types (e.g., acute psychiatric admissions wards versus psychogeriatric wards) and different countries are made as far as the reported aggression frequencies are concerned. For this, the SOAS or SOAS-R aggression frequencies reported in the literature were converted (when possible) into annual numbers of incidents per patient or per bed.

The SOAS(-R)

The SOAS (Palmstierna and Wistedt, 1987) comprises of 5 columns pertaining to specific aspects of aggressive behaviour (i.e., provocation, aggressive means used by patients, the target of aggression, consequences and measures taken to stop aggression). Every time a staff member has witnessed aggression by one of his or her patients, a SOAS form is supposed to be completed. It is possible to quickly record aggressive occurrences as the answer options in the instrument's five columns only have to be marked (i.e., taking a total of about one minute).

Since 1999, a revised version of the SOAS (i.e., the SOAS-R; Nijman et al., 1999) has been in use. This adapted version has a validated, more finely tuned severity scoring system, which could increase the possibilities of further comparing aggression rates, as well as differentiating severity.

In the original SOAS severity scoring system, a maximum score of 12 indicated the most severe incident. The revised SOAS-R severity score ranges from 0 to 22 points, higher scores again indicating greater severity (Nijman et al., 1999). The rationale behind this revised severity scoring system was that the severity of aggressive behavior depends on an array of features, with some, such as the consequences for victims, being more important than others (e.g., means used by the aggressive patient). With regression techniques an empirically validated severity scoring system was developed (Nijman et al., 1999) in which separate features are weighted in a way that they make a differential contribution to the overall aggression severity score.

The Attacks

The Attacks is a more recently designed instrument (Bowers, Nijman, Palmstierna & Crowhurst, 2002; Bowers, Nijman & Palmstierna, 2005), that seeks to measure interpersonal physical violence in great detail. Again, the Attacks is to be completed by staff members witnessing aggression, directly after a violent incident has taken place on their ward. The centre table is the most important and innovative part of the scale (see Bowers, Nijman & Palmstierna, 2005). In this table, all physically violent actions that have been witnessed during an (attempted) assault are to be recorded. More specifically, all weapons used (e.g., sharp objects, hot liquids, spitting, poking etc.) are to be noted down in combination with the targets aimed at (e.g., head, limbs, torso etc.). The frequencies of the separate physical actions are also to be estimated, as it can be assumed that striking more than once increases the capacity of violence to cause serious harm.

One of the preliminary tests of the reliability and validity of the Attacks was done by means of a videotape of interpersonal assaults (compiled from regular television broadcasts). During a meeting of the European Violence in Psychiatry Research Group (EVIPRG), 22 members from 14 different countries were instructed to rate the videotaped assaults on both the MOAS and the Attacks. It was found that the intra class correlation coefficient of the Attacks severity scores was 0.70, and higher than that of the MOAS. In other words, the inter rater reliability of Attacks severity appears to be promising. The raters were also asked to provide their judgments of the severity of the assaults shown on the tape. The connections between the Attacks severity scores with the overall judgment of severity of the assaults (as provided on VAS scales by the raters) was 0.70 (Spearman's ρ). These results indicate that the Attacks scale may be a useful addition to the scales already available for aggression research and perhaps the highly detailed severity scoring system of it may also serve legal purposes. For instance, decisions on the penalization of certain violent acts could benefit from reliable and valid categorization of the severity of them. Especially, when certain violent acts are taped (e.g., in cases of assaults of football hooligans, violent crimes committed near cash dispensers etc.) the scale might be useful to arrive at a standardized judgment of the severity of performed crimes.

Comparisons of (SOAS) aggression frequencies between ward types and countries

Comparison of aggression frequencies between different wards and hospitals has been handicapped by a failure to uniformly express incidents rates (Bowers, 1999; 2000). As many researchers have used the SOAS or the SOAS-R in the past (for a complete review see Nijman, Palmstierna, Stolker & Almvik, 2005) there could be an opportunity to make a more significant comparison of aggression frequencies across countries and types of wards, as many studies have used an identical or very similar method for monitoring the behaviour.

A review in *Acta Psychiatrica Scandinavica* of all SOAS and SOAS-R data reported (Nijman, Palmstierna, Stolker & Almvik, 2005), showed that depending on the type of ward and country involved, the annual number of SOAS-incidents per psychiatric patient varied considerably from as low as 0.4 to as high as 59.9 incidents per year; 7.6 incidents per patient per year was the median value for all reports. The frequencies in this calculation were examined as far as possible at ward or subgroup level ($n = 54$ separate observations). High frequencies of incidents were found on wards providing care to selected groups of high-risk patients [e.g., 40.2 and 29.2 in selections of violent schizophrenic patients in Finland, and 31.2 in a selection of young Dutch high-risk patients who required involuntary admission]. Remarkably, several studies on aggression in psychogeriatric samples (conducted in Sweden and the UK) reported high prevalences of aggression (more than 15 incidents per patient per year with a maximum of 59.9).

When the annual number of incidents per patient were studied separately for acute admissions wards, the prevalence rates varied from 0.4 incidents to 33.2 incidents per patient per year, with a mean of 9.3 incidents. The preliminary evidence from the review, however, did suggest there may be differences in prevalence rates in the different European countries. The mean number of incidents per patient per year from the Dutch studies, for instance, was significantly higher when compared to the mean number of incidents from the other countries (e.g., the UK, Germany, Norway, and Denmark; for a complete review see Nijman, Palmstierna, Stolker & Almvik, 2005). Possibly, interesting cross-national differences emerge when SOAS frequencies can be compared on a larger scale between countries in the future.

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Keynote 2 – Psychiatric Intensive Care in UK – Unit and Patient Profile

Dr. Stephen Pereira, chairman NAPICU (UK)

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

Keynote 3 – Short-term prediction of the risk for violence in acute psychiatric inpatient settings

Mr. Chris Abderhalden, MNSc (Switzerland)

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

Keynote 4 – A nursing intervention to handle patient aggression – the effectiveness of a training course on aggression and coercion rates in acute psychiatric in-patient settings

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Summary

Patient aggression in psychiatry is a major problem especially for nurses. Often coercion is used to handle patient aggression with detrimental effects for patients and carers. This study tested the effectiveness of a staff aggression management training and a systematic risk prediction on coercion and aggression. 273 aggressive incidents including 131 attacks were reported. With hospitalisation days as the unit of analysis no significant reduction in the incidence rate of aggressive events resulted. However coercion rates sank significantly. Despite some caveats the training course and the systematic risk assessment are deemed valuable in the reduction of coercive measures and aggression.

Keywords: Patient aggression, violence, risk assessment, training course, nurses

Introduction

Aggressive incidents perpetrated by patients are a major concern in psychiatric acute admission wards. Care workers in in-patient psychiatry are frequently subjected to patient aggression with a percentage of over 50% of physicians, psychologists and social workers being seriously injured during their career in German psychiatric hospitals (Steinert, Beck, Vogel, and Wohlfahrt, 1995).

A recent study (C. Abderhalden, Needham, Friedli, Poelmans, and Dassen, 2002) shows that 70% (n = 729) of nurses in psychiatric setting reported being physically attacked at least once in their career. Thus, nurses constitute one of the most vulnerable professions regarding subjection to aggression. Patient aggression can have severe detrimental affects on staff (I. Needham, Abderhalden, Halfens, Fischer, and Dassen, 2005) and therefore all effective measures to alleviate the problem should be welcomed by patients and careers alike.

Coercive practices are major interventions for controlling patient aggression (JCAHO, 1998; Visalli, McNasser, Johnstone, and Lazzaro, 1997) Therefore, coercion and aggression rates are closely related. A recent study on coercive practices (I Needham, Abderhalden, Dassen, Haug, and Fischer, 2002) demonstrated that considerable deficits in the application of coercive practices.

Staff training courses have been suggested and introduced as possible non-pharmacological interventions to reduce aggression and many studies have been conducted on the efficacy of training courses in psychiatric settings (Forster, Cavness, and Phelps, 1999; Ilkiw-Lavalle, Grenyer, and Graham, 2002; Ramirez, Bruce, and Whaley, 1981; Rice, Helzel, Varney, and Quinsey, 1985; Turnbull, Aitken, Black, and Patterson, 1990; van Rixtel, Nijman, and Jansen, 1997).

However, many investigations are small scale studies and thus not generalisable. A recent literature review on aggression management in mental health settings found from an original data set of 10000 publications only 11 which met the basic requirements for randomised controlled studies (Royal College, 1998). The authors infer that no strong evidence-based conclusions can be drawn from the current studies on the effect of training courses on the rates of aggression.

Thus, the aim of the study reported here was to test the effectiveness of a training course on aggression and coercion rates in in-patient acute psychiatry.

Methods

Study sites: Two 12-bed acute admission wards (an urban and a rural area) in the German speaking part of Switzerland participated in the study which was approved the institutional review boards and the local ethical committees. All patients admitted to these wards during the study period were included.

Study design: This prospective non-randomised intervention study with before-after comparisons during 10 months consisted of three study phases: A three

month baseline period (no interventions), a three month period in which the first intervention (risk prediction) was introduced, and a final phase in which the nursing staff on both wards received one week of training in aggression management. In the final stage of the study both interventions were implemented concurrently.

Interventions: The first intervention was the use of the extended version Brøset-Violence-Checklist BVC (R Almvik and Woods, 1998; R. Almvik, Woods, and Rasmussen, 2000) risk prediction instrument. The extended version BVC-R (C Abderhalden et al., 2004) requires nurses to rate six patient behaviours (confused, irritable, boisterous, verbally threatening, physically threatening and attacking objects) as being present or absent. In combination with this scale a slide-ruler - ranging from “no risk” to “very high risk” - was used to estimate the risk of an aggressive incident occurring based on nurses experience.

The standardised aggression management training followed the course devised by Oud in the Netherlands (Oud, 1997). The five-day training course includes experiential and knowledge based elements (e.g. the nature and prevalence of aggression, violence and sexual harassment, the use of aggression scales, preventive measures and strategies, de-escalation techniques, post-incident care and support, ethical aspects of violence management and safety management) and practical techniques such as holding methods, break-away techniques, control and restraint. The course content corresponds well to a recently suggested core curriculum for dealing with aggressive patients in psychiatry (Lee et al., 2001). The underlying principle of this training is the intent to minimise the risk of injury and harm on either side (*primum nil nocere*) and to reduce the traumatisation when overwhelming aggressive patients.

Outcome measures: The outcomes were the frequency of aggressive events and of coercive measures using standardised reporting forms. Events were defined as any aggressive event including verbal aggression, physical attacks against persons, any coercive measure as recorded by the Staff Observation Aggression Scale (SOAS-R) (Nijman et al., 1999). The SOAS-R enables the registration of the provoking factor, the means used by the patient, the target of aggression, the consequence for victims, and the measures to terminate aggression with scorings ranging from 0 to 22 points. Attacks were defined if the means of aggression were objects, dangerous objects, or parts of the body and the target of the aggression was a person other than the patient her- or himself. Additionally coercive measures (seclusion, mechanical restraint, or medication against the patient’s will) were recorded. Incident rates were expressed as events in terms of 100 hospitalisation days and as days with event per ward. Secondary outcomes were the severity of aggressive events, measured by the SOAS-R, and by a visual analogue scale. The outcomes were recorded on forms for three

months at baseline and thereafter in the two intervention phases. The nurses were instructed on the correct use of forms and the slide-ruler. Site visits were carried out to check compliance and consistency of reporting.

Results

Patients: During the course of the study 576 patients (41.3% females, mean age 38 years, range 15 - 88 years) accounted for 721 admissions amounting to 7732 hospitalisation days. These hospitalisations comprised of 38.5% voluntary and 61.5% involuntary admissions. The length of stay ranged from between one and 367 days (median 5, Mean 11.3). The ICD-10 diagnoses were schizophrenia, schizotypal and delusional disorders (38.3%), mood (affective) disorders (15.6%), mental and behavioural disorders due to psychoactive substance use (23.9%), neurosis and personality disorders (14.9%), and other psychiatric ICD-10 categories (7.3%).

Aggressive incidents: The 273 reported aggressive incidents included 131 physical attacks against persons and 14 events of auto-aggression with incidence rates of 3.51 (95% CI 3.10 - 4.00) aggressive incidents per 100 hospitalisation days, and 1.68 (95% CI 1.41 - 2.00) of attacks against persons, respectively. The rate of days with occurrence of an aggressive attack against persons amounted to approximately one attack every six days or 15.6% per ward. Sixty-seven persons perpetrated the total of 131 attacks with two patients contributing 12 and 13 attacks.

Coercive measures: Two hundred and thirty seven coercive measures were reported rendering an incidence rate of 3.05 (95% 2.67 - 3.46) per 100 hospitalisation days. One hundred and thirty seven coercive measures were undertaken in conjunction with an aggressive incident (rate 1.76, 95% CI 1.46 - 2.10).

Effect of the interventions: On using hospitalisation days as the unit of analysis no significant reduction in the incidence rate of aggressive events and attacks against persons from baseline over the introduction of risk prediction to training the staff were evident. The rates of coercive measures per 100 hospitalisation days significantly declined from 4.0, to 2.9, and to 2.3 over the three study periods. On exclusion of the two most violent patients from the analysis the trend remained significant.

Discussion

After the introduction of the systematic risk prediction and the staff training the incidence rates of coercive measures dropped significantly compared to

baseline. However, attack rates remained when employing hospitalisation days as the unit of analysis. Attack severity showed no change although the subjective severity as recorded on the visual analogue scale significantly dropped after staff training.

Coercive rates per occupied bed per year were 11.1 (95% CI 9.7 - 12.6) and are correspond to rates reported in other studies (Nijman, Allertz, àCampo, and Ravelli, 1997). The results of this study corroborate other Swiss data reporting that around 10% of patients on admission wards are responsible for all aggressive incidents (Geser, 1999).

Limitations

Due to the non randomised approach of this study the interpretations must be of a tentative nature. First, selection bias, e.g. the admission of patients with differing aggressive potential during the study period may have occurred. Second, reporting biases may have endured due to the staff's: reluctance to record less severe events – e.g. verbal aggression. Third, it is possible that other external factors (e.g. staff characteristics, occupancy rates, treatment regimen of the physicians, hospital policies, and season) confounded the results. Fourth, hospitalisation days were treated as independent events, and thus underestimating co linearity within patients. The final limitation applies to the fact that the effectiveness of the training alone cannot be discerned from this investigation.

Conclusion

In the light of the above mentioned limitations it is inferred that the training of staff in the management of patient aggression in combination with a systematic risk prediction may enhance the reduction of coercive measures and the reduction of aggression rates.

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Keynote 5 – The pharmacological treatment of aggressive and violent inpatient behaviour

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Summary:

An overview will be presented on pharmacological treatment of acute violent inpatient behaviour and prophylactic treatment of recurring aggressive behaviour.

Key words: aggression, violence, treatment, psychiatry

Pharmacological treatment of violent inpatient behaviour comprises two rather different aspects: The emergency treatment of acute violent behaviour and the prophylactic treatment of recurring violent behaviour. In emergency treatment, rapid and safe tranquilisation is the primary objective. The NICE guideline 25, violence: the short-term management of disturbed/violent behaviour in psychiatric inpatient settings and emergency departments (1), launched in February 2005, provides the most recent and comprehensive review of literature and recommendations. This guideline recommends lorazepam and haloperidol as first line treatment in most emergency situations and strongly favours intramuscular application over intravenous application. However, the typical limitations of evidence based medicine should be taken into account in the clinical use of this guideline: patients included in the published studies are not representative of patients in clinical routine, and this applies particularly to patients in emergency situations who receive involuntary medication. Violent patients in emergency situations are often not only psychotic but intoxicated, too, and sometimes neither the diagnosis is known nor type and grade of intoxication can be determined. Safe tranquilisation in those cases is a difficult challenge and the evidence base is rather poor.

Whereas tranquilisation should be achieved in acute situations, in the prophylactic treatment of violence sedation is an unfavourable side effect which should be avoided in most cases. While there is a clear emergency indication for rapid tranquilisation, prophylactic treatment requires careful ethical considerations and patient's informed consent. Particular information should be given in the case of off label use of substances. The best evidence is available for antiaggressive properties of clozapine. For recurring aggressive behaviour in schizophrenia patients, clozapine is the first line treatment (2). There is some evidence that clozapine can be effective in bipolar disorder and even in cases of mental retardation and personality disorder.

There is limited evidence from some randomized controlled studies, open studies, and case reports for an antiaggressive effect of other substances, e.g. risperidone and other typical and atypical neuroleptics, lithium, valproic acid, carbamazepine, SSRIs, and beta blockers in several psychiatric disorders. Benzodiazepines are not recommended for long-term treatment and maybe can enhance aggressive behaviour due to disinhibiting effects.

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Keynote 6 – Posttraumatic stress disorder in mental hospital staff following a patient assault – empirical data and prevention measures

Dr. Dirk Richter

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Abstract

Posttraumatic stress disorder is currently regarded as an important outcome following the experience of violent incidents. In mental health staff, this indicator has been researched only rarely and insufficiently up to now. The presented data come from a not yet published study which assessed posttraumatic stress disorder (PTSD) in employees, severely assaulted by patients, in nine German state mental health institutions. During the study period of six months 46 assaulted staff members were reported and interviewed three times after the violent incident. In the baseline assessment eight subjects (17%) met criteria for PTSD. After two and six months three and four subjects still met diagnosis criteria. It is concluded that a significant minority suffers from PTSD for several months after a patient assault. These findings

Background

In recent years violence by patients against staff members in mental health institutions has become an important challenge for care providing institutions. However, the type of health outcomes among affected psychiatric employees that has been studied is mainly limited to somatic outcomes. But, violent attacks may not only cause somatic injuries but may also have posttraumatic consequences with high rates of stress and other sequelae for mental health staff (1-4). Only two studies have reported on posttraumatic stress disorder (PTSD) following a violent patient incident (5, 6). Only one of these has used an acknowledged PTSD-questionnaire (6) and both studies were cross-sectional

in design. Aim of the present study was to assess post-traumatic stress disorder among staff members of mental health hospitals after a patient assault over a time period of six months.

Methods

Nine state mental health institutions in the state of North Rhine-Westphalia (Germany) were recruited for this study and reported patient assaults on staff members over a 6-months-period. All affected staff members who consented in written form to participate in the study were interviewed three times by trained interviewers. A baseline face-to-face-interview was conducted after the report of an assault, follow-up interviews by phone were conducted two and six months after the initial report. Median time between assault and baseline assessment was 49 days. The study was approved by the Ethics Committee of the University of Münster, Germany.

At baseline a semi-standardised questionnaire was used to collect socio-demographic data, information about the circumstances of the assault as well as emotional and organizational reactions after the assault. At baseline and both follow-ups additional instruments were applied. The German version of the Impact of Event Scale-Revised (IES-R), a widely used PTSD-research instrument, was used to measure posttraumatic stress following the assault (7). The German version of the Posttraumatic Stress Disorder Checklist – Civilian (PCL-C) was used to identify subjects with a DSM-IV diagnosis of posttraumatic stress disorder (8).

Only at baseline the German version of the Symptom Checklist 90-Revised was used to collect information about non-PTSD mental health symptoms (9).

Results

A total of 46 assaulted staff members were subsequently included in the study, 23 of them being women, their mean age was 38 years and the majority were nurses (70%). Other professions involved were physicians, social workers and house keeping personnel. Participants had been working for an average of 13 years at the reporting mental health hospital.

At baseline PCL-C assessment revealed that 8 participants (17%) met criteria for PTSD diagnosis. IES-R-total score was highly correlated with the SCL 90R-subcales. We observed significant differences in overall posttraumatic stress (assessed by IES-R) according to the severity of physical lesions received

during the assault. Participants with a severe physical damage (e.g. lack of consciousness) had the highest IES-R-total score. However, subjects with no physical damage scored higher on the IES-R-total score than those with small physical lesions (e.g. scratches).

Nine individuals declined the follow-up interview, 2 additional participants rejected to answer the standardised questionnaires (IES-R, PCL-C). These 11 individuals were excluded from the prospective analysis. The only significant difference between follow-up participants and non-participants was absence from work. Non-participants reported significantly more days of sickness absence between the incident and baseline interview. Non-participants had non-significantly higher scores on the Impact of Event Scale-Revised (IES-R) total score and on the IES-R avoidance subscale.

Among the participants with follow-up ($n = 35$) the same proportion with a PTSD diagnosis was observed, but a slightly lower IES-R total score. In this group women reported higher IES-R total scores than men at all three assessments. At the two and six months follow-ups, the number of subjects with a PTSD diagnosis had decreased from 6 to 3 (9%) and 4 (11%), respectively. Three participants had a stable diagnosis at all three assessments. One subject who did not have a PTSD diagnosis at baseline and follow-up 1, but was severely re-assaulted afterwards, subsequently met criteria for the diagnosis at follow-up 2. The IES-R-total score and all three subscores decreased over time. The decrease was significant for all scores.

Discussion

This study reports the first prospective results on the frequency of PTSD among assaulted staff members of mental health institutions. Up to 6 months after the assault a considerable minority of about 10% of assaulted participating employees suffers from clinically relevant posttraumatic stress. Another important aspect is that posttraumatic stress had no dose-response relation with the severity of physical damage caused by the assault in the weeks following the incident. Staff with no physical injuries reported higher stress than those who suffered from minor lesions only. The largest decrease in mental stress was observed in the first two months after the assault. But slight further decreases occurred until six months. A small minority, however, still suffers from PTSD symptoms that fulfil the criteria for a diagnosis of PTSD after six months.

The small sample size and a high potential for selection bias are obvious limitations of this study. An important reason for non-participation might be the fear of getting stigmatized after assaults. In this case our results would overestimate

the frequency of PTSD. But non-participation might also be caused by the PTSD-symptoms itself, especially the avoidant behaviour that is associated with this disorder. In that case our findings would underestimate the incidence of PTSD.

Given the considerable number of patients' assault on staff members, posttraumatic stress needs to be addressed by organizational efforts to minimize work-related injuries. In most psychiatric institutions, however, the organizational response to occupational health injuries is still related to physical lesions only. The management of posttraumatic stress in health care institutions requires firstly a strategy to recognize and report possible psychological sequelae. In the light of the above reported and other research findings, this seems to be a difficult task because of the avoiding behaviour of affected staff. Secondly, post-incident management support has to be provided by the organization. Recent PTSD-management strategies from US-forces and UK-military stress the importance of peer support (10, 11). Such a strategy seems to be a manageable solution for psychiatric hospitals, too. Experience from German hospitals reveals that assault victims do not want to be supported by superior management staff, but accept support by colleagues. In the Westphalian Hospital Muenster, Germany, we have recently set up a peer support program in which experienced mental health nurses try to keep contact with severely assaulted staff over several months. This program aims at providing psychological first help, not at therapy. A crucial method in this project is to actively ask for needs and emotional states by the support team. However, the assaulted employee determines frequency and impact of the contacts. In accordance with the state of research literature, debriefing sessions are not provided. If the assaulted employee shows relevant PTSD-symptoms over several weeks, the support team suggests professional psychological therapy.

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1 – Autoaggressive Verhaltensweisen bei den psychischen Kranken

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Abstract

Nach zeitgemaessen Vorstellungen, ordnet der Begriff „Aggression“ zwei Varianten ein: Heteroaggression und Autoaggression (Steinert T., Wolfersdorf M., 1993). Die Grundform der Autoaggression ist suizidales Verhalten, das bei den psychisch Kranken oft entstanden ist (Blumenthal SJ, 1988; Beck AT et al., 1990). So bestanden in Russland im Jahre 1993 die Kennziffern der Haeufigkeit der Suizide in der allgemeinen Population - 38 Faelle pro 100 000 und in der Population der psychisch Kranken – 84.6 pro 100 000 (Anisskin DB, 1997). All das zeigt auf eine grosse sozial-medizinische Wichtigkeit der Praevention der Suizide bei den psychisch Kranken.

Vorschungsziel

Studium des suizidalen Verhaltens bei den psychisch Kranken. Mit diesem Ziel waren alle Faelle der Suizide (n = 80), welche die psychisch Kranken waehrend zwei Jahre (2002-2003) in Udmurtien (administratives Gebiet der Russischen Foederation) begangen sind, studiert.

Methoden

epidemiologische, “psychologische Autopsie”, offizielle Statistik, wissenschaftliche Literatur.

Ergebnisse

Die Differenzierung der suizidalen Patienten nach Diagnosen hat folgendes gezeigt: Schizophrenie – 25%, leichte Intelligenzminderung – 18.7%, vaskulaere Demenz – 12.5%, organische Persoehnlichkeitsstoerungen – 11.3%, Reaktionen auf schwere Belastungen – 8.8%. Patienten mit Stoerungen durch Alkohol sind in diesem Studium nicht eingeordnet. Zwischen den psychopathologischen Syndromen bei den suizidalen Patienten sind depressives Syndrom (50% aller Faelle), psychopathisches Syndrom (17.5%) und paranoid-halluzinatorisches Syndrom (15%) als haeufigste registriert. Es ist festgestellt, dass suizidaler Konflikt bei den Patienten in 43.8% eine wirkliche Grundlage und in 37.5% eine psychopathologische Grundlage hat. In 18.7% aller Faelle war die Grundlage nicht festgestellt. Zur verbreitendsten Motivationen der Suizide gehoeren: Eifersucht – 12.5%, eigene Schwaeche in irgendwelcher Lebenssphaere – 12.5% und Ungerechtigkeit, Erniedrigung – 11.3%. 36.3% aller Patienten sind den Selbstmord nach der Alkoholeinnahme begangen. Die fuehrenden Stellen zwischen den Arten der Suizide bei den Patienten sind das Erhaengen (68.8% aller Faelle) und die Vergiftung (16.3%) eingenommen.

Schlussfolgerungen

Autoaggressive (suizidale) Verhaltensweisen sind bei den psychisch Kranken 2,2 Mal mehr als in der allgemeinen Population verbreitet. Insbesondere bezieht das zu Patienten mit Schizophrenie, mit leichter Intelligenzminderung und auch mit depressiver Symptomatik. In der Praevention des suizidalen Verhaltens bei den psychisch Kranken muss man gemeinsam mit der Behandlung eine besondere Aufmerksamkeit auf wirkliche Konflikte in der Sphaere der mikrosozialen Umgebung der Patienten, die fast eine Haelfte der suizidalen Motive zusammensetzen, beachten.

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2 – Prävalenz und Charakteristika von psychiatrisch-stationären Patienten mit auto- und fremdaggressivem Verhalten (Prevalence and characteristics of psychiatric inpatients with self-directed and other-directed aggressive behaviour)

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Zusammenfassung

In dieser klinischen Studie wurden Prävalenz und ausgewählte Charakteristika von Patienten mit zugleich auto- und fremdaggressivem Verhalten untersucht. Geprüft werden sollte, inwieweit sich Patienten mit auto- und fremdaggressivem Verhalten von anderen Patienten unterscheiden. Charakteristika der untersuchten Patientengruppe waren jüngeres Alter, häufiger weibliches Geschlecht, betreute Wohnformen, Suizidversuche in der Vorgeschichte und Persönlichkeitsstörung und häufigere und längere stationäre Behandlungen. Im Vorfeld der Aufnahme waren Suizidalität, Suizidversuche und Bedrohlichkeit charakteristisch.

Stichwörter

Auto- und fremdaggressives Verhalten, psychiatrisch stationäre Patienten, Prävalenz, Charakteristika

Summary

Prevalence and characteristics of psychiatric inpatients with self- and other-directed aggressive behaviour were analysed in this clinical study. Characteristics of index inpatients were compared with those of non-index inpatients. Younger age, female gender, living under institutional conditions, higher frequency of admissions and

longer duration of treatment, a history of suicide attempts, suicidal ideas, suicide attempts and aggressive behaviours prior to admission and personality disorder were characteristics of index inpatients.

Keywords: Self- and other directed aggressive behaviour, psychiatric inpatients, prevalence, characteristics

Einleitung

Zur Prävalenz von sowohl auto- als auch fremdaggressivem Verhalten bei psychiatrisch stationär behandelten Personen liegen nur wenige Studien vor, die in forensischen, kinder- und jugendpsychiatrischen und akutpsychiatrischen klinisch stationären Bereichen für Erwachsene durchgeführt wurden. 9-20% aller dokumentierten aggressiven Vorfälle waren autoaggressiv (Nijman et al. 1999a, Vivona et al. 1995, Hillbrand 1992). Nur fremdaggressiv waren 49,3% -87,5 % der aggressiven Patienten (Nijman und à Campo 2002; Oulis et al. 1996; Vivona et al. 1995; Hillbrand 1992; Myers und Dunner 1984), nur autoaggressiv 2,9-38,1% (Nijman und à Campo 2002; Vivona et al. 1995; Myers und Dunner 1984) und 18,8-30,0% waren sowohl auto- als auch fremdaggressiv (Nijman und à Campo, 2002; Hillbrand 1992).

Autoaggressive Vorfälle finden häufiger in den Abendstunden statt (Nijman und à Campo 2002; Nijman et al. 1999a) mit einem Trend zu mehr Vorfällen am Wochenende (Nijman et al. 1999a) und signifikant häufiger in Patientenzimmern, während fremdaggressives Verhalten gehäuft im Aufenthaltsraum, im Dienstzimmer, in den Fluren oder im Essensraum beobachtet wird (Nijman und à Campo 2002).

Patienten, die sich sowohl auto- als auch fremdaggressiv verhielten, zeigten in verschiedenen Untersuchungen im Vergleich zu nur fremdaggressiven Patienten ein höheres Ausmaß und eine größere Schwere der Fremdaggression (Hillbrand 1995; Hillbrand 1992), waren jünger (Nijman und à Campo 2002; Hillbrand 1995; nicht bei Hillbrand 1992), waren häufiger weiblich und an einer Borderline - Persönlichkeitsstörung erkrankt (Nijman und à Campo 2002). Serper et al. (2005) fanden in ihrer Untersuchung klinische, kognitive und demografische Faktoren als Prädiktoren für unterschiedliche Aggressionsformen.

In einer psychiatrisch klinischen Gesamtpopulation existiert unseres Wissens keine prospektive Untersuchung zu Prävalenz und Charakteristika von Patienten mit sowohl auto- als auch fremdaggressivem Verhalten.

Ziel der dreijährigen Studie war die systematische prospektive Untersuchung aggressiven Verhaltens in einer klinischen Gesamtpopulation und der Prävalenz und Charakteristika von Patienten mit sowohl auto- als auch fremdaggressivem Verhalten. Geprüft werden sollte, inwieweit sich Patienten mit auto- und fremdaggressiven Verhalten von anderen Patientengruppen unterscheiden.

Methodik

Die Untersuchung wurde in der Klinik für Psychiatrie und Psychotherapie, Evangelisches Krankenhaus Bielefeld/ Bethel durchgeführt, die für die regionale psychiatrische Pflichtversorgung der Stadt Bielefeld mit 324.000 Einwohnern zuständig ist. Zum Einzugsgebiet gehören auch die Einrichtungen der von Bodelschwingschen Anstalten mit großen Heimbereichen für Patienten mit psychischen Störungen, Epilepsie und geistiger Behinderung.

Zwischen 2001 und 2003 wurden die von Patienten ausgehenden aggressiven Ereignisse der Klinik mit der Staff Observation Aggression Scale – Revised (SOAS-R) dokumentiert. Die Erhebung erfolgte auf allen 16 Stationen mit insgesamt 274 Betten. In den Jahren 2001-2003 wurden 5.595 Personen mit 13.357 Behandlungsepisoden aufgenommen.

Durchführung der Untersuchung

Nach Schulung der Mitarbeiter der Stationen wurden die aggressiven Vorfälle auf den Stationen mit der SOAS-R erfasst. Der Erfassungsbogen wurde durch das Teammitglied ausgefüllt, das aggressives Verhalten von Patienten beobachtet hatte.

Die Vorfalldaten der Jahre 2001-2003 wurden auf der Personenebene aggregiert und mit den ebenfalls auf der Personenebene aggregierten Falldaten der psychiatrischen Basisdokumentation (n=5.595) verknüpft. Im nächsten Schritt wurden vier Gruppen von Personen identifiziert: a) die Untersuchungsgruppe der Personen mit auto- und fremdaggressivem Verhalten und b) Personen mit nur fremdaggressivem Verhalten, c) Personen mit nur autoaggressivem Verhalten und d) ohne aggressives Verhalten als Vergleichsgruppen.

Als potentielle Prädiktoren für Patienten mit auto- und fremdaggressivem Verhalten wurden soziodemografische (Alter, Geschlecht, Berufstätigkeit, Staatsangehörigkeit und Wohnform), erkrankungsbezogene (Diagnose nach ICD-10, Rechtsstatus bei Aufnahme, Suizidalität und Bedrohlichkeit

im Vorfeld der Aufnahme, Suizidversuch im Rahmen der Aufnahme) und Verlaufsmerkmale (Anteil der Erstaufnahmen, Aufnahmehäufigkeit und kumulierte Behandlungsdauer in den Jahren 2001-2003, Suizidversuche in der Vorgeschichte) der Untersuchungsgruppe im Gruppenvergleich überprüft. Alle Variablen des CHI²-Tests wurden dichotomisiert. Für einige Variablen konnten wegen fehlender Daten nicht alle Personen in die Analyse mit einbezogen werden. Die Auswertung der Daten erfolgte mit SPSS, Version 12.01. Gruppenvergleiche wurden mittels Varianzanalyse (ANOVA) bzw. CHI²-Tests analysiert.

Instrumente

Die Staff Observation Aggression Scale (SOAS) ist ein reliables und valides Erfassungsinstrument für fremdaggressives Verhalten mit hoher Interraterreliabilität und einer mittlerweile häufigen Anwendung insbesondere im europäischen Raum (Nijman et al., 2005; Finzel et al., 2003; Nijman et al., 2002a; Nijman et al., 2002b; Omérov et al., 2002; Grassi et al., 2001; Soliman und Reza, 2001; Palmstierna und Wistedt, 1987). Die revidierte Version der SOAS, die SOAS-R (Nijman et al. 1999b), ermöglicht die zusätzliche Erfassung autoaggressiven Verhaltens. Der Schweregrad aggressiven Verhaltens wird aus dem Summenscore der einzelnen Spalten mit Werten zwischen 0 (leichteste Form der Aggression) und 22 (schwerste Form der Aggression) berechnet.

Bei der psychiatrischen Basisdokumentation (BADO) handelt es sich um ein von der DGPPN empfohlenes Instrument zur Qualitätssicherung im (teil-)stationären Bereich (Cording et al. 1995). Die soziodemografischen-, erkrankungsbezogenen- und verlaufsbezogenen Merkmale wurden mit einer leicht modifizierten Version der BADO erfasst. Die Daten wurden von den fallverantwortlichen Ärzten und Psychologen erhoben und dokumentiert.

Ergebnisse

1.849 Vorfälle von 509 Personen wurden erfasst, davon waren 91,2% (1.686) fremdaggressiv und 8,8% (163) autoaggressiv. Pro Bett und Jahr wurden 2,1 fremdaggressive und 0,2 autoaggressive Vorfälle beobachtet.

In der Abteilung Allgemeine Psychiatrie I mit einem Behandlungsschwerpunkt für psychotische Störungen (89 Betten) fanden 70,4% der Vorfälle statt, in der Abteilung Allgemeine Psychiatrie II mit einem psychotherapeutischem Behandlungsschwerpunkt für Patienten mit Depressionen, Angst- und

psychosomatischen Störungen und Persönlichkeitsstörungen (67 Betten) 8,4%, in der Abteilung für Abhängigkeitserkrankungen (76 Betten) 9,9 % und in der gerontopsychiatrischen Abteilung (50 Betten) 10,5%. 0,8% der Vorfälle wurden von aktuell nicht stationär behandelten Personen verursacht.

5.086 (90,9%) aller Personen zeigten kein aggressives Verhalten. Bei 440 Personen (8,6%) wurde nur fremdaggressives Verhalten mit 1.570 Vorfällen beobachtet, durchschnittlich $3,6 \pm 8,7$ pro Person (Range 1-164). 54 Personen (1,0%) verhielten sich nur autoaggressiv mit 90 Vorfällen, $1,7 \pm 1,7$ Vorfälle pro Person (Range 1-11). Bei 15 Personen (0,3%) wurden sowohl auto- als auch fremdaggressives Verhalten dokumentiert mit 116 fremd- und 73 autoaggressiven Vorfällen, durchschnittlich $12,9 \pm 10,0$ pro Person (Range 2-31). Von diesen Personen begingen $n=10$ (66,7%) häufiger fremd- als autoaggressive Handlungen, $n=3$ (20%) häufiger auto- als fremdaggressive und 2 (13,3%) gleich häufig auto- und fremdaggressive Handlungen.

Im Folgenden werden die Ergebnisse für die auto- und fremdaggressive Untersuchungs- und die Vergleichsgruppen (nur fremdaggressiv, nur autoaggressiv, nicht aggressiv) in dieser Reihenfolge wiedergegeben.

Die Personen mit auto- und fremdaggressivem Verhalten lebten häufiger in einer betreuten Wohnform der ambulanten oder stationären Eingliederungshilfe (46,7% zu 31,4% zu 33,3% zu 16,5%; $\text{CHI}^2=78,8$, $\text{df}=3$, $p<0,001$) als die nicht aggressiven und waren jünger ($31,2 \pm 11,2$ zu $44,8 \pm 18,4$ zu $35,9 \pm 14,0$, $48,6 \pm 19,2$; $F=15,0$, $p<0,001$) und häufiger weiblich (80% zu 40,5% zu 53,7% zu 45,5%; $\text{CHI}^2=13,4$, $\text{df}=3$, $p=0,004$) im Vergleich zur nur fremdaggressiven und nicht aggressiven Vergleichsgruppe.

Bezüglich klinischer Merkmale unterschied sich die Untersuchungsgruppe durch eine höhere Aufnahmehäufigkeit ($15,2 \pm 18,7$ zu $4,6 \pm 5,9$ zu $4,0 \pm 5,2$ zu $2,1 \pm 2,9$; $F=136,3$, $p<0,001$) und eine längere kumulierte Behandlungsdauer ($220,3 \pm 187,2$ zu $100,8 \pm 102,5$ zu $107,7 \pm 117,6$ zu $44,2 \pm 54,8$; $F=156,7$, $p<0,001$). Die Aufnahmen erfolgten seltener mit rechtlicher Grundlage (7,7% zu 34,4% zu 17,0% zu 11,4%; $\text{CHI}^2=131,5$ $\text{df}=3$, $p<0,001$) und es handelte sich seltener um eine Erstaufnahme (13,3% zu 17,3% zu 24,1% und 40,1%; $\text{CHI}^2=108,8$, $\text{df}=3$, $p<0,001$) im Vergleich zur nicht aggressiven Vergleichsgruppe. Kein Unterschied zeigte sich bei dem Anteil der Notaufnahmen.

Personen mit auto- und fremdaggressivem Verhalten hatten häufiger einen Suizidversuch in der Vorgeschichte (69,2% zu 31,7% zu 57,8% zu 23,6%; $\text{CHI}^2=46,1$, $\text{df}=3$, $p<0,001$) und im Rahmen der aktuellen Aufnahme (53,8% zu 9,0% zu 25,0% zu 7,4%; $\text{CHI}^2=60,1$, $\text{df}=3$, $p<0,001$) begangen oder waren häufiger suizidal im Vorfeld der Aufnahme (61,5% zu 14,5% zu 50,0% zu

19,7%; $\text{CHI}=49,6$, $\text{df}=3$, $p<0,001$) als die nur fremdaggressiven und nicht aggressiven Personen. Interessanterweise war auch die Bedrohlichkeit im Vorfeld der Aufnahme (46,2% zu 40,9% zu 12,8% zu 8,7%; $\text{CHI}=394,6$, $\text{df}=3$, $p<0,001$) häufiger als in der nur auto- und nicht aggressiven Vergleichsgruppe ohne Unterschied zu der nur fremdaggressiven.

Die Gruppe der auto- und fremdaggressiven Personen litt seltener an einer Schizophrenie (23,1% zu 53,1% zu 33,3% zu 17,8%; $\text{CHI}^2=227,1$, $\text{df}=3$, $p<0,001$) als die Gruppe der fremdaggressiven und häufiger an einer Persönlichkeitsstörung (53,8% zu 5,9% zu 25,0% zu 2,6%; $\text{CHI}^2=197,5$, $\text{df}=3$, $p<0,001$) im Vergleich zu den fremd- und nicht aggressiven Personen.

Diskussion

Der Anteil von 8,8% autoaggressiven Handlungen an allen aggressiven Verhaltensweisen entspricht dem Ergebnis von Nijman et al. (2002a) mit 9%. 2,9% aller aggressiven Patienten verhielten sich auto- und fremdaggressiv, dies liegt unter den Ergebnissen früherer Untersuchungen (19-30%, Nijman und à Campo, 2002; Hillbrand, 1992). Diese wurden allerdings auf ausgesuchten Stationen und nicht in einer klinischen Gesamtpopulation durchgeführt. Patienten mit sowohl auto- als auch fremdaggressivem Verhalten sind für einen relativ hohen Anteil der aggressiven Vorfälle verantwortlich, hier 2,9% aller aggressiven Patienten für 10,2% der Vorfälle. Diese Tendenz wird in der Untersuchung von Nijman und à Campo (2002) bestätigt. Methodisch ist einschränkend darauf hinzuweisen, dass die SOAS-R autoaggressives Verhalten nicht ebenso dezidiert erfasst wie fremdaggressives Verhalten. Daher ist eine Dunkelziffer autoaggressiver Vorfälle zu vermuten, zumal autoaggressives Verhalten eher in den Patientenzimmern durchgeführt wird und sich so der direkten Beobachtung entzieht.

Charakteristika sowohl auto- als auch fremdaggressiver Patienten sind jüngeres Alter, weibliches Geschlecht, Leben in einer betreuten Wohnform, häufigere und längere stationäre Behandlungen, häufigere Suizidversuche in der Vorgeschichte, Suizidalität, Suizidversuche, Bedrohlichkeit im Vorfeld der Aufnahme und die Diagnose einer Persönlichkeitsstörung. Hillbrand (1992) fand ebenfalls ein jüngeres Alter in der Untersuchungsgruppe und Nijman und à Campo (2002) das Vorliegen einer Persönlichkeitsstörung und weibliches Geschlecht. Insgesamt scheint die Untersuchungsgruppe durch einen ungünstigeren Krankheitsverlauf und kritischere Umstände mit Selbst- und Fremdgefährdung, die schließlich zur Aufnahme führten, charakterisiert

zu sein. Bei der Gruppe der jüngeren, häufiger weiblichen Patienten mit Persönlichkeitsstörung könnte ein höheres Ausmaß von Traumatisierung in der Vorgeschichte angenommen werden mit daraus möglicherweise folgender erhöhter Impulsivität, defizitärer Affektregulation und häufigerer dissoziativer Symptomatik. Zukünftige Studien sollten diese Einflussfaktoren und den Einfluss von Umgebungsfaktoren und Interaktionsmustern berücksichtigen mit dem Ziel, effektivere Interventionen zur Reduktion von insbesondere komplex aggressivem Verhalten zu entwickeln.

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3 – Violent Behavior of Psychiatric Inpatients. Frequencies and Risk Factors

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Summary

In the Psychiatric Hospital of Zurich the patient assaults were assessed during two 6 months periods between 1999 and 2001. Two hundred and five of 1937 inpatients (10.6%) were reported to have shown violent behavior. The following risk factors for aggressive behavior were identified: male gender, rehospitalization, and severity of mental illness. The risk of violent behavior rises at 0.5% per day of hospitalization time; it is lowered in case of voluntary entry to the hospital and slightly lowered for older age. Psychiatric diagnosis however was not related to aggressiveness.

Keywords: Patient assaults, aggressive behavior, risk factors, inpatient treatment, Psychiatry

Background

The interest in studies of aggressive behavior of psychiatric inpatients during hospitalization has grown over the last years. Although the risk of being confronted with violent behavior of mentally ill patients in public is quite low (1), there is a relatively high risk for people employed in a mental hospital to be confronted with aggressive Patients. One explanation for this is the fact that only a small group of inpatients are responsible for a large number of repeated aggressive assaults (2). Furthermore, patient assaults can cause severe consequences for the victims involved.

The present study has two main aims:

1. a situation focused perspective, where the aggressive behavior is examined in relation to the surrounding situation and
2. a person focused perspective, where the prognostic factors for aggressive behavior is situated in the person itself.

Methods

The data presented in this study are part of a larger prospective study assessing patient assaults in six psychiatric hospitals of the Swiss canton of Zurich. The evaluation is limited to data observed in the Psychiatric Hospital of Zurich, where the patient assaults were assessed during two 6 months periods from November 1999 to May 2000 and from February to July 2001 in 21 wards (acute-, geronto-, rehabilitation- and specialized-psychiatric).

The following behaviors were defined as aggressive and documented by the care-team on a self-developed questionnaire.

- Physical violence against people or objects
- Physical damage to people
- Verbal or gestural threats
- Strong or persistent insults

The used questionnaire provided detailed information about each case of violent behavior in terms of:

- Frequency, time
- Circumstances hints for aggression
- People involved
- Reaction of the care-team
- Risk factors

Results

Two hundred and five of 1937 inpatients (10.6%) were reported to have shown violent behavior during the two periods of assessment. The portion for male patients was higher at 12.9% (120 of 929) than for female patients 8.4% (85 of 1008; $\chi^2=10.27$; $df=1$; $p=0.001$).

The 549 reported violent assaults were committed by 205 inpatients. 46.1% of the aggressive Patients showed aggressive behavior more than once.

Tab. 1 Frequencies of Known Risks

Aggressive behavior shown before	84.5%
Sudden outbreak of anger	41.9%
Influence of other Patients	13.1%
Tendency to panic	8.8%
Patient has experienced abuse	2.7%

Tab. 2 Hints for Aggression in Advance

Irritability	59.3%
Motor restlessness	37.0%
Verbal announcement	29.7%
Not reachable verbally	28.0%
No hints in advance	13.9%
Anxiety	8.1%

Tab. 3 Type of Aggression

Assault of violence with hands and feet	55.0%
Strong or persistent insults	40.1%
Threat of physical violence	27.7%
Assault of violence with glass, bottle or weapon	11.3%
Assault of violence with chair, furniture	8.4%

Tab. 4 Consequences of the Aggressive Behavior

Victim feeling threatened	64.6%
Victim feeling angry	38.0%
Physical damage	29.9%
Necessity of non-medical support	7.8%
Necessity of medical treatment	7.8%

Tab. 5 Possible Avoidance of Aggressive Behavior

More medication	36.5%
Medication earlier	32.4%
More time for patient	26.4%
Early intervention	23.0%
Less disturbances	22.3%
Declare clear limits	16.9%
Possibility of retreat	12.8%
Firm agreements	6.8%
More self-responsibility	5.4%
Offering a “room of aggression”	4.7%

Tab. 6 Trigger for Aggressive Behavior

Conflict with the care-team	31.4%
Conflict with other patients	28.3%
Everyday actions	16.6%
Illness-caused state	16.3%
Request to take medication	11.0%
Refuse of private spare time	9.7%
Problems with language, culture or religion	6.4%
Refuse of medication	4.8%
Refuse of attention	4.6%
Refuse of admission to certain premises	4.2%
Holding back personal articles	1.1%

Risk factors

Accomplishing logistic regressions the following risk factors for aggressive behavior were identified: male gender (OR=1.52), re-hospitalization (OR=2.23), and severity of mental illness (OR=1.66). The risk of violent behavior rises at 0.5% (OR=0.005) per day of hospitalization time; it is lowered in case of voluntary entry to the hospital (OR=0.39) and lowered for older age at 1% per year (OR=0.99). Psychiatric diagnosis however was not related to aggressive behavior.

The Results from this Study confirm to a large extent the findings of earlier

Studies assessing violent behavior of psychiatric inpatients (3).

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4 – The organizational dimensions of keeping a unit safe

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Background

Aggression and violence on inpatient psychiatric units has been widely recognized as a significant problem in nursing. Although there has been research identifying the risk factors for aggression and violence and the characteristics of staff and patients that contribute to aggression and violence, researchers have been criticized for privileging a reactive rather than a proactive stance in the management of difficult psychiatric inpatients. Thus there continues to be a call for researchers to develop and test multidimensional models of prevention that reflect the complexity of how nurses structure and manage a unit with acutely symptomatic and potentially aggressive patients.

Purpose of the study

The main purpose of this study was to develop via observations and interviews a mid-range theory of the de-escalation process. However, it became clear from the observations and the interviews that preventing aggression and violence also entailed an understanding of the multidimensional aspects of unit organization that either enhanced or diminished the safety of both patients and staff on inpatient psychiatric units.

Methods

The methods used for this study were consistent with grounded theory methodology. After receiving approval from the institutions' Institutional Review

Boards, the authors spent approximately 250 hours observing staff and patients on two inpatient psychiatric units and interviewed 16 staff and 12 patients about what they thought helped patients who were escalating calm down. The data were analyzed using the constant comparative method recommended by Glaser and Strauss.

Findings

The basic social process that emerged from the data was Keeping the Unit Safe. Keeping the unit safe is not simply the endpoint of a linear process but rather is the outcome of a dynamic process that shapes and is shaped by the organizational dimensions of the unit. These dimensions are ideology, people, space and time. Although these dimensions will be discussed separately, the data from the study revealed a reciprocal relationship among the dimensions. Thus, changes in one dimension not only impacted the safety on the unit, but also required changes in the other dimensions if safety was to be restored. In other words, there is a dynamic balance between the four dimensions.

Implications

The findings from this study have implications for how leadership staff and managers assess and maintain safety on the unit. Although individual patients certainly have an impact on the safety on a unit, the findings from this study point to the importance of unit leadership taking a systems perspective when evaluating unit needs. The findings from this study provide leadership staff with a framework to use when making recommendations to administration regarding the changing needs on the unit.

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5 – Do preventative measures work? The correlation of alarms, security staff and training patient initiated aggression to New Zealand psychiatrists.

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Summary

We performed an anonymous postal survey of all consultant psychiatrists in New Zealand. We asked if they been attacked or harassed, by patients, in a variety of ways, We asked if their workplace environment had various staff, alarms. The rescence of security guards was associated with a decrease rate of attack. Other interventions were neutral, or associated with an increased rate of patient initiated aggression

Key Words: Postal survey, Self-protection, Management violence, Alarms Security Abuse, Assault, Harassment, Stalking, Complaints.

Background

Most of the research about patient initiated aggression is based in the inpatient ward. In New Zealand [1] the care of psychiatric patients has been moved to the community: there are now virtually no long term inpatient beds. A previous survey [2] of the managers of inpatient and community psychiatric units had shown that there was a variety of precautionary measures in place within workplaces.

Because of a paucity of data about the rates of aggression against psychiatrists and within the community, we surveyed the one year period prevalence of

various types of threats or assaults by patients against consultant psychiatrists. At the same time, we aimed to measure the association of the presence or absence of alarms, security teams, and training and the period prevalence of patient initiated aggression.

Method

We used an anonymous postal survey of all consultant psychiatrists in New Zealand. We asked if the psychiatrist had been verbally threatened, had their family threatened, been intimidated, had property damaged, been sexually harassed or touched in a sexually inappropriate manner, had been assaulted, injured, stalked, or persecuted by means of formal complaint. If the participant had such an event, we asked if it had occurred within the most recent year. We asked if their workplace environment had panic buttons, personal alarms. We asked if there were security guards present or an emergency management team. We asked if the psychiatrist was trained in self-protection, de-escalation or management of violence.

We then associated the interventions using Fisher's exact test, with R version 1.6.0 [3]

Results

We received responses from 197/308 consultant psychiatrists (63.9%). The presence of a security guard was associated with a significant decreased in the risk of assault to psychiatrists (OR 0.22 (0.04-0.82), $p=0.03$). No other intervention was shown to decrease the risk of adverse events. However, the use of personal alarms and training in self protection, de-escalation or management in violence were associated with an increased risk of assault; training in self-protection was associated with an increased risk of sexual harassment; training in de-escalation and management of violence was associated with an increased risk of family threat; and having a personal alarm was associated with an increased risk of verbal threat.

Discussion

The nature of this survey meant that we could identify associations, but we cannot make any comments on the timing of the introduction of any intervention.

We therefore cannot exclude the provision of any intervention after the event(s) described. We also cannot account for the interpersonal style, or coping style, of the participants.

However, these findings are similar to those in both a previous survey of the managers of mental services, and in a parallel survey of general practitioners. Although there is a literature on interventions within hospital environments, there is a paucity of research to date on the efficacy of any primary (or secondary) intervention in the community.

We suggest that managers and trainers ensure that there is a body of evidence before they undertake any measure to increase the safety of psychiatrists from assault, even if these interventions appear to be appropriate.

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6 – Preventing seclusion – what does this ask from a team?

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Summary

A description and the results of a 3 years project to abandon seclusion in a Dutch mental hospital will be presented. The results are very hopeful and the project changed the way of working within the team. The effects for the clinical team will be presented. Recommendations will be given for future teams that intend to start a similar project.

Keywords: Dutch healthcare, seclusion, autonomy, intensive care.

Introduction

While Dutch Healthcare has been highly-praised internationally, the frequent use of coercion, in the form of seclusion of psychiatric patients, is a phenomenon that in other countries has led to great incredulity (van der Werf, 2001). Although in the European countries adjoining the Netherlands coercion is being used in many different ways (Kasander et.al., 2002), nowhere else seclusion of patients accepted as in the Netherlands (Hrachovec, 2001), despite the fact that seclusion can be a traumatic experience to patients suffering from severe psychiatric illnesses (Fisher, 1994).

International studies have shown that the use of seclusion rooms is determined more by culture than by the patient's pathology and there are no controlled studies on the effect (Sailas, Fenton, 2005). The same cultural factor leads to coercion by means of fixation or forced medication in other countries (van der Werf, 2001)

In the Netherlands the use of coercion has been the subject of discussion. This has led to the laying down of a number of (quality-)conditions that should guarantee better care for psychiatric patients for whom coercion-methods are indicated (Berghmans et.al., 2001).

In addition, there is a discussion concerning the law “BOPZ” (Psychiatric Hospital Compulsory Admission-Act). This law offers psychiatric patients guarantees in the compulsory admission procedure and lays down a number of conditions for admission under coercion. (GIGV,1994) This law emphasizes the protection of the patient’s autonomy and self-determination, and forced interventions can only take place if the patient is a danger to himself or to his environment.

Enough reason for us to start a project aimed at the prevention of coercion - specifically seclusion - and the search for alternative treatments.

The targets for this project were formulated as follows:

Developing an admission unit where the central objective is to look for alternatives to coercion, and in particular to pay attention to the avoidance of seclusion. The final aim, a seclusion-free admission-unit where restraint measurements are being reduced by 50% in comparison to similar units, is to be achieved within a 3-year period (June 2002 – June 2005).

Necessary conditions are:

- To secure the safety of the patient, his/her environment and the employees
- Not to shift problems to other departments, institutions or care partners
- To increase treatment-satisfaction of the patient and his/her family
- To work within the restraints of the law (BOPZ)
- For scientific research to take place next to the project.

Results

The aims of the project were reached: separation is nearly abandoned and the use of other therapeutic forms of restrained are almost zero.

What has changed in the team?

First off all the view on the term ‘autonomy’ has changed: Autonomy of the patient is harmed when he is psychiatrically ill and dangerous and this autonomy must be compensated by his/her family and by evidence based professionalism.

Looking at the process of treatment the team has changed its procedures :*Outpatient treatment:*

In the first instance, when a risk of admission exists, a nurse from the clinical team attempts to stabilize the situation at the home of the patient. Secondly, therapy and admission is offered early in the process of the disease and not only at a crisis moment.

Intake:

Reassessment of the crisis criteria takes place. There is a different view on criteria for danger: danger in the society is different from danger on a clinical ward.

Both the family as well as the referring professional are present at the intake to provide complete information to help reinforce the position of the patient and to formulate adequate therapeutic goals. It gives guarantees for continuity of treatment.

Treatment process:

Treatment is according to treatment goals which are evaluated regularly. Both the family as well the referred patient are again present if necessary.

When coercion is at the horizon the team uses maximum persuasion and psycho-education in collaboration with family and outpatient care. There will be no seclusion without medication.

To prevent escalation, the team, especially the nursing staff, uses early signs of disrupting behaviour as targets for interventions.

A full day program is scheduled and different disciplines participate. Psychomotor and other non-verbal therapies are very useful.

The treatment is very individualised and the use of protocols is minimal.

Discharge and after care:

A seamless transition to day-care or outpatient treatment is guaranteed. The day-care program is the same for both in- and outpatients . For a short period of time it is possible to use the clinical staff for outpatient treatment, even a nurse at home.

Facilities

Each patient has his/ her own room. For disrupting patients there is a separate subunit for intensive care in construction..

The culture of the clinical team

The vision is established and shared at team days and peer supervision. Feedback is accomplished by qualitative and quantitative data (KWAZOP and CRF). Visiting and having guests to and from other hospitals gives continual feedback.

Within the team there is a shared final responsibility, instead of responsibility residing only with the doctor. The whole team is trained in handling aggression in a way that the relation with the patient is maintained.

In the presentation we will elaborate on the topics for the team members.

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7 – Workshop (1) – Dialectical Behavior Therapy (DBT) in a forensic psychiatric setting in the Netherlands

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Abstract

DBT is one of the few empirically validated treatment programs in the treatment of, especially so called “low level”, borderline patients (Linehan et al., 1991; Linehan, 1993; van den Bosch et al., 2005). There is growing evidence that DBT is effective in reducing (para) suicidal and self-destructive impulsive behavior. Also, adapted versions of DBT seem to be effective, in outpatient and residential settings (Bohus et al., 2004), in targeting other problem behavior, as drug abuse (Linehan et al., 1999, 2002), alcohol abuse (van den Bosch et al., 2005), and eating disorders (Telch et al., 2001).

There is some conviction among therapists that DBT could be beneficial in the treatment of anti-social personality disorder (McCann, 2000; Pfafflin, & Ross, 2004, Berzins & Trestman, 2004), but up till now no efficacy studies have been taken place. The Dutch forensic psychiatric hospital Oldenkotte has decided to prepare such an efficacy study.

Anti social personality disorder is, next to borderline, one of the disorders in which therapists experience difficulties in creating a good therapeutic alliance. The character of the problems, and the fact that the problem behaviour is often seen as not connected to the disorder, does not motivate therapists to create a good working alliance. DBT, therefore, is based on the assumption that the attitude of therapists towards patients and their disorders need to be changed into a transparent, understanding and compassionate one, in order to make treatment effective. Especially in a forensic psychiatric setting like Oldenkotte, normally a very judgmental attitude towards the patients is found. As a logical consequence, Oldenkotte first started with a training program for all their staff members.

The workshop will show some basic information on DBT. Exercises will give the attendants the opportunity to experience how all the professionals working in the hospital were trained. Hopefully some of the beneficial effect this training has had on the general attitude of the workers will be experienced. Finally we hope that the attendants will understand why the change in attitude of our mental health workers diminished the level of repression so often found in these kind of settings. The workshop will show that even if one doesn't implement DBT as a treatment program, the process of changing the attitude of the workers has an effect on the level of violence from and towards the patients.

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8 – Reducing clinical violence in mental health setting – a seven year study

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Abstract

This paper will review a longitudinal study of clinical violence within a medium secure forensic psychiatry unit. It builds upon published work undertaken by the author(s) (Green and Robinson, 2001), whereby all clinical violence was audited and reviewed to compare trends, and evaluate the effectiveness of clinical interventions. Using a clinical review and audit process all incidents of clinical violence were evaluated and reviewed. It was undertaken on a continuous annual cycle over seven years. During the period of the study violence and aggression was reduced by over 80%. The paper shares the outcomes of the study, including the relationship between a range of multi-professional clinical interventions targeted at, and reducing, both the frequency and impact of violence. Although the study was carried out in a forensic mental health unit the methodology and lessons learned can be transferred across a range of healthcare settings.

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9 – Nursing study of personal based “early recognition and early intervention” schemes in forensic care

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Summary

A forensic relapse prevention plan was elaborated aiming the prevention of violence of mentally ill patients. This plan emphasis on the method of ‘early recognition and early intervention’ i.e. on those signs of behaviour that appear before the patient becomes violent.

A ‘spaced introduction design’ is applied in order to implement the intervention stepwise in a forensic hospital. Comparative measures carried out between and within wards and on level op patients. Pivotal outcome for research is ‘inpatient incident behaviour’. Among others, effects of intervention on patients, nurses and ward culture are focus of attention in this study.

Keywords: Forensic nursing, early recognition, intervention, violent behaviour, relapse prevention.

Introduction

Forensic nurses deal on a daily base with patients who are less capable handling their aggression. This is especially the case within in forensic care because nurses are most close and frequent in contact with less motivated and disturbing

patients. Foremost in forensic nursing one should expect evidence based risk management methods and instruments; however appears a lack on risk managing methods (Morrison 2002). The concept 'early recognition and early intervention' enables nurses and patients an approach to recognise disturbing behaviour in a very early stage of onset (Birchwood, 1992; Van Meijel et. al. 1998, 1999, 2000, 2002). 'Early recognition and early intervention' is a method in which early warnings signs of disturbing behaviour is detected en described in a relapse prevention plan. The purpose is to teach the patient to monitor his behaviour, to identify the early warning signs of disturbing behaviour and to carry out actions in order to prevent further deterioration. These interventions are the result of collaboration between the patient, family and nursing staff.

The metaphor of 'black box' explains the concept 'early recognition'. This metaphor captures the idea that patients can learn to recognize and reconstruct their behaviour like the 'blackbox' in aviation: patients have to find their 'mental black box'. Early warning signs of risk behaviour are especially interesting to recognize and centralize in relapse prevention. Another metaphor close to this concept is 'the signature' of the patient: each patient behaves regarding his particular profile.

The method 'early recognition and early intervention' is derived from these concepts. The purpose of it is teaching patient to monitor his behaviour, to identify the early warning signs of disturbing behaviour and to describe actions to prevent further deterioration. These interventions are the result of collaboration between the patient, nurse and the member(s) of the social network.

Early recognition and early intervention

In a forensic nursing study we elaborated a nursing protocol in which the method of 'Early recognition and early intervention' is described. 'Early signs' can be defined as: Subjective experiences, thoughts, and behaviours of the patient that occurs in de phase preceding a (e.g. psychotic) relapse (referring to Heinrichs & Carpenter 1985, Herz & Melville 1980, Meijel 2002). The nature of these signs can exist of psychotic or non-psychotic symptoms. In case of psychotic symptoms distinguish can be made between signs with and without severe violent behaviour (Humphreys 1992, Swanson 1998, Taylor 1998).

A model to point out the area on which we focus: figure 1 "The process of deterioration"

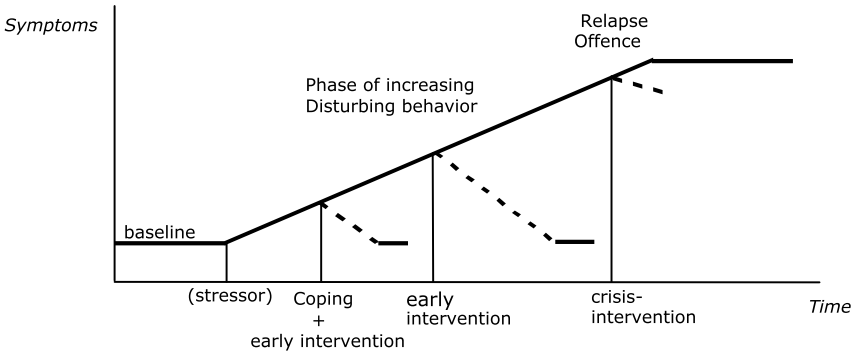


Figure 1: The process of deterioration

This model shows the process of increasing disruption towards crisis situations (Herz and Mellville 1980, Meijel et al 2003). On the baseline the behaviour occurs in stable conditions. The up going line shows when stress or symptoms of disorder increases, adjusting behaviour, coping, is necessary to recover to the baseline. When the symptoms and stress further increases, in the end no recovery is possible and severe violent behaviour is likely to occur.

In forensic care much attention is given to intervene when the patient is functioning in the upper part of the line, when the crisis is almost manifest or really happens. To put it otherwise: the disease is treated; the offence in which severe violent behaviour took place is often subject of relapse prevention plans. Less attention is given to that behaviour in which the patient functions relatively stable but in which the first signals of deteriorating behaviour develops. There are a lot of opportunities to mark those early signs in daily practice of e.g. forced admission. In that area we focus on applying 'early recognition and early intervention'. We call this the area of 'early signs'.

The advantage intervening in this area is that the patient is better capable to recognise his altering behaviour because he is not yet suffering from severe symptoms and so is better be able to participate in recovery (Birchwood 1992, Docherty et al 1978, Meijel 2003). Therefore self management of the patient will improve.

In training much attention is given to factors influencing originate violent behaviour. Hiday (1997) created a model explaining the influence of social

and personal factors influencing onset of severe violence e.g. victimisation, substance abuse, TCO symptoms, tense situation, stressful events. Especially nurses in forensics' care for patients influenced by these factors. Because most early warning signs are related to these interfering factors 'early recognition' contributes forensic nurses teaching patients gaining insight in occurrence of violent behaviour and encourage them to carry out preventive actions.

When applying 'early recognition and early intervention' attention has to be given to training nurses and support and monitoring the process of embedding of intervention within daily practise. For the training part, 'tailor made' training and package was developed.

The method 'early recognition and intervention' and protocol consists of four phases:

1. Preparatory phase
2. Listing early warning signs
3. Monitoring early signs
4. Preparing an actionplan.

In the preparatory phase theme 'working with a relapse prevention plan' is introduced to the patient and to the members of his social network. In addition the characteristics of the patient and his social network will be assessed and described. The purpose is to determine relevant factors that might interfere with the application of the protocol.

In the phase of 'listing early signs' the nurse, the patient and his social network evaluate which early signs were most characteristic in earlier episodes of relapse. When these early signs are determined they are classified into three levels of severity. The purpose of this classification is that the patient learns to recognise his behaviour in the range from stable to relapse characteristics.

In the phase of 'monitoring early signs' the patient learns to assess systematic the presence of early signs for the purpose of estimating the risk of relapse.

Finally in the action plan patient, nurse and members of the social network together determine actions that are useful to carry out in case of increase of early signs.

Research

In a Dutch Phd-study the method 'early recognition and early intervention' is applied to all the 180 patient of a forensic psychiatric hospital (Dr. S. Van Mesdagkliniek). All patients committed severe offences and stay under custody care. This study comprises three stages: further protocol

modification, implementation of the intervention protocol and a study on effectiveness of applying this intervention.

Method

Prior to the development of the forensic protocol literature review and qualitative nursing research strategies (interviews, case study and panel) were carried out in order to gain insight in the forensic characteristics when applying the protocol. (Munhall & Oiler 1993, Polit & Hungler 1999). Next the 'early recognition and early intervention' protocol was modified which lead to the 'early recognition' package: protocol, relapse prevention plan and training reader. (Fluttert et.al.2002).

In a follow up effect-study the method and 'early recognition' package was applied en studied for 30 months. 200 Patients and 190 nurses are involved in de study. A 'spaced introduction design' was applied existing 3 study groups. All the 16 wards of the hospital were hosted in one of three study groups. Consequently comparative measures within en between the study groups were generated. In the hospital each occurring incident was registered using the Staff Observation Aggression Scale (Revised) (Nijman et al. 2002).

Additional process of implementation was extensively studied. Every month at every nurse/patient level was registered to what degree the method really was applied. If application was not succeeded reason for it was registered with distinction between reasons of patient and nurses. This yielded knowledge about factors influencing embedding the method in daily practise.

Research question on ward level was whether ward culture would contribute to success applying intervention and embedding it in daily practice. For this purpose a culture assessment questionnaire was used (Quin & Cameron, 2000)

The method 'early recognition' demands great efforts and prolonging attention of nurses towards patients. Especially in forensic care contact between patient and nurse is very important and vulnerable at the same time because topics arising in nursing care are for patients often very personal and confronting. For this reason effects for nurses are determined on nearness – distance of nurses to patients. In a formerly Dutch study the 'V-Pacon' questionnaire (Betgem 2001) was elaborated. All 190 nurses filled in the 'V-Pacon' before, during and 6 months after applying 'early recognition'. In this questionnaire is determining how nurses' manage balancing between being interested and getting involved in patients world and at same time be aware of enough distance to patients in order keep a professional view.

Data monitoring and analyses

In order gaining inside in effects of intervention for patients all gathered data were filled in a 'research matrix'. This matrix with vertically all patients and horizontally 30 months contains the next data :

- Degree of application of intervention,
- Reason for not applying intervention,
- Occurring incident and weight of each incident (SOAS-R),
- Ward on which patient stays,
- Replacement of patients between wards and admissions and discharges.

Additional data was gathered addressed to characteristics of patients e.g. socio demographic data, diagnosis, PCL-R scores, nature of offence, first or re-offender, culture background, length of stay in forensic care.

Next data-analyses where carried out:

- Comparative measures of occurring incidents before, at start and during intervention.
- Correlation between degree of exposure and incident behaviour.
- Multi level analyses to gain insight in effects for patients on level of patient, ward, patient category (depending on offence and diagnosis) and research group (time and duration of exposure).

Results

The qualitative research so far yielded the most pivotal factors influencing application of the method and protocol. Key factor was the way nurses succeeded getting in contact with the patient and prolong this contact addressed to 'early recognition'. It is of great importance to agree with the patient about the terms to be used in the conversations and in relapse prevention plan. These terms must be bearable, understandable for the patient and acceptable to label certain behaviours.

It appears that the involvement of members of social network in this method has to be considered very precisely. A network analyses contributes the assessment of the influence of the social network and contribution to collaborate in 'early recognition'.

Regarding to overall effect or 30 months of 'early recognition' on incident behaviour (measured with SOAS-R) for wards applying intervention compared

to wards with 'care as usual' indicates that number of incidents decrease as well severity of incidents.

Next will be determined results of effect study for incident behaviour (number and severity) of patients exposed to interventions compared to patients intermitted and patient not exposed to intervention. Also will be determined whether exposure, in terms of compliance working with relapse prevention plan, correlates with characteristics of patient (diagnosis, offence, socio demographic data).

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10 – Aggressive behaviour of prisoners with psychiatric disorders

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Abstract

Various sources indicate that acts of aggression against prison staff occur frequently. However, very little detailed information is available about the nature, causes and severity of aggressive behaviour in Dutch prisons. **aim** To obtain insight into the nature and severity of the aggressive behaviour of prisoners with psychiatric disorders. **methods** The aggressive behaviour of all the prisoners residing in one of the seven sections of the foba (Forensic Observation and Supervision Departement) (which has 66 cells) between 1 October 2001 and 31 July 2002 (10 months) was recorded by means of an adapted version of the Staff Observation Aggression Scale-Revised (adapted for prison conditions). **results** Over the 10-month period 186 aggressive incidents were reported, which is equivalent to a frequency of about 3.4 incidents per cell per annum. About one in seven of the incidents reported had physical consequences for the victims and the aggression was generally directed against prison staff (79%). Patient-to-patient aggression, however, was rare in the foba (5%). The frequency of aggression was particularly high in the -Very Intensive Care - ward where the most disturbed and mainly acutely psychotic patients are detained (on average 9 incidents per cell per annum). Among this category of patients aggression significantly often seems to stem from by the patient's psychopathy. In the seven sections of the foba aggression frequently occurs in cell doorways. **conclusion** In spite of the structure and rest that foba offers to patients, overstimulation still seems to play a role in eliciting aggression, particularly among the most disturbed psychotic prisoners in the Very Intensive Care ward. In the light of the ongoing discussion in the Netherlands about placing more than one prisoner in a cell, it is interesting to note that of all the incidents that occurred in the various sections more than a quarter took place in cell doorways.

According to the prison staff a possible disadvantage of placing more than one prisoner in a cell is that dangerous situations often arise when cells are being locked or unlocked.[tijdschrift voor psychiatrie 46(2004)9, 609-618]key words aggression, imprisonment, psychiatric disorders, psychosis, violence

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11 – Workshop (2) – New perspectives on the origins and psychobiology of violence

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Summary

Studies on the origins of anger and violence usually focus on their cognitive underpinnings. This paper proposes that there are unique conditioned neuroendocrine patterns, also called conditioned emotional templates that drive the formation of five different types of anger as a response to perceived or actual violation. They are: justified anger, rage, resentment, hating anger, and helpless anger. The author suggests that in the state of helpless anger a neuroendocrine freeze occurs as an adaptive response to a life-threatening event in which the individual has no control. Hating anger is a protective psychophysiological mechanism that buries helpless anger and can produce violent behavior.

Key Words: aggression, anger, anger types, cellular memory, conditioned emotional template, declarative memory, fight-flight-freeze-or flow anger response, freeze, hating anger, helpless anger, justified anger, neurothymic integration, procedural memory, rage, reptilian dive reflex, resentment/hostility, shutting-down phenomenon, state emotion, survival aggression, trait emotion, violence

Compact Version of Presentation

This presentation describes my observations of physiologically-based responses to emotion in psychotherapy and proposes new hypotheses about the psychobiology of different types of anger and their relation to violence. These theories are based on the clinical use of a psychophysiological method called neurothymic integration. This method taps into the conditioned emotional

templates that carry the physiologic patterns of different emotional memories, including the types of anger that lead to violence.

My discoveries about anger and its biological origins began when I observed physical changes in new patients as they told their stories. As these individuals explained why they were entering psychotherapy there came a critical moment in their stories when they held their breaths and their breathing became shallow; their skin paled; their pupils became dilated. Often the person was unable to find the words to explain the memory she or he had just tapped into. I call this critical moment the freeze. The freeze is a shutting-down phenomenon that is currently recognized in the field of trauma (Barry, 2004, 1991; Levine 1997; Scaer, 2001; van der Kolk, 2000, 1994, 1989).

Through the 1990's this stunning physical and cognitive shutdown was not well-addressed in the clinical psychotherapy literature. Instead, the primary clinical interest in traditional mental health training and practice was the cognitive content of a patient's presentation and the predominant role of cognition in emotion activation and regulation (Clore, 1994; Schachter, 1996; Scherer, 1999; Scherer & Walbott, 1994).

For each patient in which I observed the freeze response there was a particular aspect of the memory that contained awareness of fear or shock, accompanied by a feeling of profound helplessness, the state that I call the freeze. Regardless of the original cause of the emotional freeze, the person felt cognitively and emotionally paralyzed. Most important, in each of these individuals, the memory, carried actively in the tissues of the body, appeared to be comprised of a set of unique physical patterns, also known as a conditioned emotional template. When activated, these conditioned emotional templates created a systemic effect that in the moment rendered the individual's cognition useless and the physical body powerless. What is this physical pattern? Why is it there? Is there a connection between anger and violence and the development of the freeze? Is the freeze reaction one of the elemental underpinnings of violence?

Violence and Its Relationship to Anger

In order to understand violence it is necessary to recognize its multiple presentations, beginning with the roles of anger and aggression. Casey's definition of anger as a reaction to violation (1998) appears to be a relevant description of the primal source of anger reactions. Aggression is behavior or an energetic act that ranges from assertive, bold, or enterprising to one that launches hostilities, violence or attacks (American Heritage Dictionary of the

English Language, 2000). Violence is defined as “the abusive or unjust exercise of power” (American Heritage Dictionary of the English Language, 2000, p.1507). Accordingly, violence is the result of a perceived or actual violation that initiates a unique type of anger response.

Different Perspectives on Anger

State or Trait characteristics

Examining anger and its different presentations, it is helpful to view anger through various lenses. One of the lenses is that of Scherer who describes five affective states paraphrased below:

1. Emotion-a relatively brief episode of synchronized responses by all or most organismic subsystems as a reaction to a significant internal or external event;
2. Mood-a diffuse affect state, often with no apparent cause, of low intensity, but long duration;
3. Interpersonal stance-an affective stance taken toward another person that colors the interpersonal exchange, e.g., distant, warm;
4. Attitude-relatively enduring, affectively colored beliefs, predispositions, etc., toward other persons and objects:
5. Personality traits-ongoing emotionally-laden personality dispositions and behavior tendencies (2000, pp. 140, 141).

Using these concepts to clarify the differences between state or trait anger types (Eysenck, 1983; Spielberger, 1972), Scherer’s definition of emotion in number 1 above will represent the state (S) anger responses described below and trait (T) anger responses fit into one or more of Scherer’s states number 2-5 above.

Neuroendocrine Patterns of Response to Anger

Another lens used in assessing anger responses is that of the underlying neuroendocrine patterns of fight, flight, freeze, or flow that occur either as new responses to novel anger-inducing events or are conditioned physiologic pattern, also known as emotional templates, that are driven by the autonomic nervous system as a response to familiar anger-inducing stimuli (Barry, 2004).

This paper proposes that there are five anger types of uniquely-occurring or conditioned neuroendocrine-driven anger responses possible within an individual as observed during ten years’ clinical findings using the neurothymic integration method described below. These anger types are described in the following section with two additional notations to indicate that the anger type is either a state (S) or a trait (T) emotion response and a neuroendocrine-generated flight, fight, freeze, or flow conditioned emotional template.

Types of Anger

1. Justified anger: A controlled physical and mental reaction to violation that results in productive, organized behavior to address and resolve the original violation. (S and T) (Fight and Flow).
2. Rage: A rapidly-occurring, uncontrolled and disorganized physical and mental reaction to violation that peaks rapidly and results in explosive and unproductive behavior. (S) (Fight).
3. Resentment/hostility: An enduring, controlled physical and mental reaction to violation that results in unproductive, guarded, antagonistic behavior and increased physical and mental tension. (T) (Fight).
4. Hating anger: An enduring, controlled physical and mental reaction to violation that results in heightened hostile focus on the hated object and guarded hostile behavior. The outcome of hating anger ranges from focused silent hatred to a controlled and powerful homicidal aggression directed toward the hated object. (T) (Fight).
5. Helpless anger: A rapidly-occurring, uncontrolled physical and mental reaction to violation that results in an unproductive physical state that subjectively “paralyzes” the physical, cognitive, and emotional functioning of the individual. This enduring conditioned neuroendocrine “freeze” state is at the heart of posttraumatic stress disorder and dissociative states (Scaer, 2001; Porges, 2001, 1995; van der Kolk, 2000). (S and T) (Freeze).

Formulations on the Development of Violence from Helpless Anger

In violent individuals, helpless anger appears to lead to repression of the perception of helplessness with a concurrent creation of the protective psychophysiologic defense mechanism of hating anger – the basis of violent behavior. I propose that helpless anger is an organismic response that has an immediate effect of shutting down the intellect and the physical organs so that the individual is unprepared to take action for self-defense from the violating situation. In some individuals, particularly those born with a Type A or cardiovascular-responding personality type (Smith, Glazer, Ruiz, & Gallo, 2004; Stemmler, Heldmann, Pauls, & Scherer, 2001), viewed by many as hostile or anger-prone (Rozanski, Blumenthal, & Kaplan, 1999; Smith & Gallo, 1999; Seigman & Smith, 1994), the toxic state of helpless anger appears to create a different reaction, hating anger. Hating anger is a psychophysiologic defense that buries the memory of helpless

anger in the unconscious and results in a cold, homicidal attitude toward the original aggressor. Violent attitudes and violent behavior toward specific groups occur when a subset of these individuals generalizes the homicidal attitude to a larger group that represents the original perpetrator of the actual or perceived violation.

The Psychophysiologic Origins of the Freeze

Each type of violation and its resulting anger appears to cause different autonomic nervous system responses that can manifest either as a fight, flight, freeze, or flow anger response within the same individual. For example, one person can respond to different types of anger-provoking, violating situations with several possible results. These anger responses can include, for example, a respectful, but firm statement that defuses the violating event (justified anger); or with a sudden, uncharacteristic rage; or the person can develop an obvious resentment or hostility toward another person or situation; or respond with a strong desire to attack. Yet another anger-inducing circumstance may cause the same person to withdraw and a different infuriating event may result in an automatic freeze or shutting-down reaction, depending on the precipitating violation,.

The sympathetic nervous system branch of the autonomic nervous system has been well documented as the source of the fight or flight response (Bernston & Cacioppo, 2002; Cannon, 1929; Nijenhuis, van der Hart, & Steele, 2004; van der Kolk, 2000). One of the most cogent explanations of the freeze response has been advocated by Porges (1995, 2001) who proposes that under life-threatening duress there is a freeze reaction in the human vagal nerve that originates in the primitive human nervous system. This response in the reptilian brain origins of the human central nervous system (CNS) is called the reptilian dive reflex. This primitive survival reflex from ancient reptilian ancestors causes the human cardiovascular and respiratory systems to shut down in order to conserve energy and reduce the need for oxygen (Ibid.).

The reptilian dive reflex appears to be the cause of the freeze at the heart of helpless anger. I believe that the effects of this reflex – the freeze response – occur when the human being is in a powerfully threatening situation, whether childhood abuse, warfare, or a natural disaster. As a response to the threat a survival aggression rises within the human being. Because of the overwhelming situation, the survival energy cannot be discharged and has no place to go. With no outlet, this survival aggression could overwhelm the individual's vital physical and emotional cores. Similar to an overloaded fuse shutting down an

electrical system rather than causing destruction of the electrical system, the human body reverts immediately to the primitive reptilian survival response, shuts down, and promotes survival (Porges, 1995, 2001; Scaer, 2001).

The initial freeze reaction can be regarded as adaptive. (Ibid.). What appears to happen as a result of the initial freeze response is that the unconscious mind, through a series of neurophysiologic events, creates a conditioned memory, an emotional template (Levine, 1997; Scaer, 2001; van der Kolk, 2000, 1994, 1989) that is retained in procedural memory, the memory held at the unconscious level in the body. Procedural memory, also known as implicit memory is held at a physiological level unknown to the conscious, cognitive declarative memory, also known as explicit memory (Nijenhuis, van der Hart, & Steele, 2004; van der Kolk, 1994).

My clinical observations over the past 10 years' use of the neurothymic integration method indicate that individuals have the potential to experience all four different types of reactions, fight, flight, freeze, or flow depending on the interactions of inherited neuroendocrine dispositions; the unique meaning of the anger-inducing event; and the presence of conditioned physiologic emotional templates resulting from previous exposure to different types of anger-inducing events. In other words, the assumption that there is a characterological style of anger response that occurs under all anger-inducing situations (Rosenfield, 1988) no longer seems to be an accurate view of anger response patterns in the human being.

Cellular Memory: A Foundation Concept of Psychoneuroimmunology

The notion of conditioned physiologic memory is a foundation of studies in psychoneuroimmunology (Ader & Cohen, 1993). Cellular memory is the concept that the smallest units of human tissue are able to retain memory of multiple and complex physiological patterns (Albrecht & Petty, 1998; Edelman, 1987; Jacobs & Lehuizen, 2002; Rosenfield, 1988; Turner, 2002). This concept is central to my formulations about the physiologic patterns, also called conditioned emotional templates of the different anger types, including the freeze response. These physiologic patterns are unique to each human being. It appears that the DNA-directed cellular replication of older cells by new cells maintains the original conditioned physiologic patterns (Ibid.), including those of the fight-flight-freeze-flow anger patterns.

In order to elicit the fight-flight-freeze-flow physiologic patterns of anger

initially observed in my clinical practice, I created the neurothymic integration method, an emotion induction method, by integrating three different hypnotherapy modalities to elicit the psychophysiological patterns associated with individuals' memories of their own unique anger episodes (Barry, 1991). The hypnotherapy modalities include: Eriksonian hypnotherapy (Erickson, 1980), David Grove's metaphor and symbolic therapy (Grove & Panzer, 1989), and Bandler and Grinder's hypnotic trance formation with neuro-linguistic programming (1981). I modified these approaches to elicit specific psychophysiological states associated with Pavlovian conditioning (Schafe, Nader, Blair, & LeDoux, 2001), sympathetic nervous system responses (Beauchaine, 2001a & b; Bernston & Cacioppo, 2002; Scaer, 2001), and PTSD physiologic reactivity patterns (Nijenhuis, van der Hart, & Steele, 2004; van der Kolk & van der Hart, 1991).

In developing this methodology I was particularly interested in eliciting the 'within-person' differentiation of fight, flight, freeze, and flow patterns associated with anger – not previously described in the literature. Following the recommendation of Dr. Steven Southwick, clinical director of the National Post-Traumatic Stress Disorder Center I created a verbal script that would be the same for each person experiencing the method. The purpose of the neurothymic integration script is to tap into the conditioned emotional templates of procedural memory.

Limitations of Current Anger and Emotion Research

The general assumption in most anger studies is that the individual has a consistent characterological pattern of anger response (Spielberger, Jacobs, Russell, & Crane, 1985). For example, anger response patterns in several recent studies have been described using Spielberger's (Forgays, Forgays, & Spielberger, 1997) concepts of characterological "anger in" or "anger out" (Bruehl, Burns, Chung, & Johnson, 2002; Gallacher, Yarnell, Sweetnam, Elwood & Stansfield, 1999; and Steptoe, Copley, Griffeth & Kirschbaum, 2000).

Currently researchers are studying anger and its physiologic effects primarily using emotion induction techniques in which participants view anger-inducing films (Christie & Friedman, 2004; Gross & Levenson, 1995); participate in deceptive anger-inducing situations (Harmon-Jones, Amodio, & Zinner, 2004); or experience emotion induction with an imagery script (Vermetten & Bremner, 2004; Sinha, 1996; Sinha, Catapano, & O'Malley, 1999). Although these induction procedures produce physiologic responses to the films, deception, or imagery they do not differentiate the types of anger experienced by the participants.

Humans experience different types of anger, depending on 1) the interactions of inherited neuroendocrine disposition and 2) the unique meaning applied to the cause of the anger-inducing violation, and 3) the development of conditioned autonomic nervous system patterns (Barry, 2004; Levine, 1997; Porges, 1995, 2001; Scaer, 2001; van der Kolk, 1987, 1994, 2000; van der Kolk & van der Hart, 1991) or conditioned emotional templates that are unique for each person and can result in either the fight, flight, freeze, or flow anger response (Barry, 2004). It is time for clinicians and researchers to understand the powerful role of the psychodynamics and psychophysiology of anger in violent behavior. Clinical interventions and research approaches that integrate these new concepts will be better equipped to investigate, address, and treat violence.

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Symposium (1) – Applying Theory and Practice in Working with Violent Conduct

Clive Hollin, Ruth M. Hatcher, David Jones & Louise Braham (UK)

12. Aggression Replacement Training: Theory into Practice
13. Aggression Replacement Training: Evaluation and new developments
14. Managing problematic anger in a high security psychiatric hospital
15. The development of a violence treatment program: issues in delivering a treatment program to violent mentally disordered offenders in a high security setting

The focus of this symposium is the application of theory and evidence to produce effective treatments for violent conduct. There are four papers in the symposium that cover a wide range of material.

1. Aggression Replacement Training: Theory into Practice
Clive R. Hollin & Ruth M. Hatcher
2. Aggression Replacement Training: Evaluation and New Developments Ruth M. Hatcher & Clive R. Hollin
3. Managing Problematic Anger In a High Security Psychiatric Hospital
David Jones
4. The Development of a Violence Treatment Programme: Issues in delivering a treatment programme to violent mentally disordered offenders in a high security setting.
David Jones & Louise Braham

12 – Aggression replacement training (ART): theory into practice

Clive R. Hollin & Ruth M. Hatcher

The development of Aggression Replacement Training marks a significant step in the formulation of evidence-based programmes for clinical work with violent people. Starting from the point of evidence-based practice, it is essential that effective interventions are soundly grounded in both theory and empirical evidence. This paper looks at the three components of Aggression Replacement Training -- Social Skills Training, Anger Control Training, and Moral Reasoning Training -- with a view to considering two questions.

First, what is the evidence that these three aspects of functioning -- i.e. social skills, anger control, and moral reasoning -- are in fact related to violent conduct? Second, what is the evidence that the techniques used by Aggression Replacement Training to change social skills, anger control, and moral reasoning are effective? By drawing on both theory and the literature relevant both to the study of violence and clinical approaches to violence, the case will be made that the theory and associated empirical evidence that underlies Aggression Replacement Training is substantial.

The conclusion is offered that practitioners can have confidence in the evidence base that informs Aggression Replacement Training. Given this strong base, the next step is to review the evidence for the effectiveness of ART itself and to look to at the case for broadening its application to a range of client groups, including forensic psychiatric patients.

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13 – Aggression replacement training (ART): evaluation & new developments

Ruth M. Hatcher & Clive R. Hollin

The previous paper looked at the theory and evidence base that underpins Aggression Replacement Training. The first part of this paper extends that discussion to look at the evidence that has evaluated the outcome of Aggression Replacement Training. Drawing on Goldstein's (2004) review, several evaluations have been carried out in a range of settings, based in both institutions and in the community, and with a range of client groups, including gang members and young offenders. We have recently reported an evaluation of Aggression Replacement Training as applied within the Probation Service in England and Wales and an overview of the findings is presented. In particular we focus on the issues of measurement of both process and outcome in a field evaluation. As the momentum behind Aggression Replacement Training grows, so work is underway to adapt it to new populations. The work of Hornsveld (2004) who has adapted Aggression Replacement Training to form a new programme, Aggression Control Therapy, for forensic psychiatric patients is of particular interest to this conference. The final part of this presentation looks in detail at the changes instigated by Aggression Control Therapy and how they try to connect the principles that inform Aggression Replacement Training with the clinical profile of forensic psychiatric patients.

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14 – Managing problematic anger in a high security psychiatric hospital

David Jones

Clinical Nurse Specialist

Applying psychological treatments to the management of violence in clinical settings is an important factor in the management of forensic patients. Anger mediated aggression is frequently cited as a major factor in offences involving violence. Standardised approaches to the treatment of anger involve a variety of techniques ranging from relaxation training and cognitive restructuring to social skills training. Such approaches however require high levels of motivation and cooperation, characteristics not readily found in forensic psychiatric patients. Notoriously difficult to treat, forensic patient populations present the clinician with a unique set of problems that in most instances render standardised cognitive-behavioural treatments ineffective. This problem has raised the question as to how standardised interventions can be adapted in order that they are responsive to the specific needs of forensic populations and thus improve treatment outcomes. The Managing Problematic Anger is a 36-week manualised treatment programme, that has been adapted from Novaco's stress inoculation approach (Novaco, 1975, 1983) and other anger treatments (Deffenbacher 1996). Intended specifically for forensic patient populations, the programme utilises motivational techniques in order to modify readiness for treatment, thus reducing patient drop out and maximising therapeutic engagement. The weekly sessions are also augmented by ward based-skills coaching and care plans to enhance and facilitate skills acquisition and transfer. The programme was initially piloted in a high security hospital with 10 patients, with a further 10 patients having now completed the programme. In terms of treatment outcome, data obtained using psychometric questionnaires and behavioural observations indicate reductions in the frequency and intensity of aggressive and anger related behaviours.

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15 – The Development of a Violence Treatment Programme: Issues in delivering a treatment programme to violent mentally disordered offenders in a high security setting.

David Jones Clinical Nurse Specialist & Louise Braham

Cognisant of the absence of programmes to treat mentally disordered violent offenders, and implemented an intervention aimed at reducing violent recidivism amongst mentally disordered offenders has been developed. The Violent Offender Treatment Programme (VOTP) is a modular-based cognitive-behavioural treatment programme intended for high-risk populations. It is delivered over a year (250 hours) using both individual and group work, utilising a variety of strategies focussing on criminogenic factors associated with violent offending. The influence of mental illness, substance misuse, and personality difficulties on behaviour are highlighted throughout. The VOTP is manualised and based on contemporary evidence-based treatment approaches within the psychological field. The integrity of the programme is shaped by adherence to pre-determined learning objectives, regular staff supervision, and observation of treatment sessions. Successful delivery of this programme requires facilitators to be highly trained in psychological treatment approaches and group facilitation skills. There is an education process running parallel to the treatment programme to allow facilitators to continue to develop the skills necessary for effective programme delivery. Preliminary findings suggest reduced institutional violence, high levels of attendance and a low drop-out rate, increased pro-social behaviours, coping skills and general interpersonal functioning, and a positive change in attitude towards offending.

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16 – A comparison between German and Swiss hospitals concerning the use of coercive measures

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Summary

The frequency and duration of mechanical restraint and seclusion is compared across 7 Swiss and 7 German psychiatric hospitals. Hospital structure characteristics and guidelines on coercive measures are analysed. The results show different patterns in the use of seclusion and restraint across Swiss and German hospitals. Associations of data on coercive measures with hospital structure characteristics and guidelines are significant. Data interpretation should consider confounding factors such as severity of illness and hospital structure characteristics. International comparisons on coercive measures allow for knowledge transfer and critical reflection of national traditions in the use of coercive measures.

Keywords: Coercive measures, mechanical restraint, seclusion, psychiatric hospital, Switzerland, Germany, comparison

Introduction

Across Europe there is a growing interest in data concerning coercive measures used in the treatment of the mentally ill. Data on the use of coercive measures in more than one institution in one country have been published in Finland (1), Germany (2), UK (3) and Switzerland (4). To date, no comparative data on the incidence of such interventions in European countries is available.

In 2004, two independent working groups in Germany (“Arbeitskreis zur Prävention von Zwang und Gewalt in der Psychiatrie”) and Switzerland (“Qualitätszirkel Benchmarking Zwangsmaßnahmen”) decided to compare the frequency and duration of coercive measures in standard psychiatric care across different psychiatric hospitals in Germany and Switzerland.

Additionally, hospital characteristics and guidelines should be determined and associations with the incidence of coercive measures be calculated. The objective was to establish an international knowledge transfer process in order to reduce the frequency and duration of coercive measures on a long-term basis to an extent of necessity.

Methods

The incidence and duration of mechanical restraint and seclusion was reliably recorded across 7 Swiss and 7 German psychiatric hospitals during the one year period of 2004. The Swiss hospitals are situated in the Northern parts of Switzerland (Deutsche Schweiz), the German hospitals in the South of Germany. The hospitals are each completely responsible for psychiatric inpatient care and continuously generate complete, reliable and comparable data concerning coercive measures.

Mechanical restraint was defined as the use of belts to tie patients to a bed. Seclusion was defined as bringing the patient into an empty room without possibility to leave. The incidence of involuntary medication by coercion was documented in both German and Swiss hospitals. Due to different national definitions it was not possible to compare the data concerning involuntary medication. In Germany involuntary medication is defined as the administration of medication by physical restraint or any kind of touching or holding the patient, whereas in Switzerland it is additionally defined as the use of pure psychological force by which the patient is overwhelmed. In all participating hospitals involuntary medication was documented reliably and completely with respect to the definitions used.

To compare the data, we generated indicators by using a programme “DoComP” (Documentation of Coercive measures in Psychiatry) developed specifically for this purpose. This programme evaluates hospital-based indicators in the respective ICD 10 F principal groups (F1 – F4 and F6). The indicators are related to cases treated (admissions) and cases affected by coercive measures.

The indicators reflect the frequency and duration of mechanical restraint and seclusion. The following indicators were used for comparison:

1. Percentage of cases exposed to mechanical restraint:
Number of cases exposed to mechanical restraint divided by number of cases treated
2. Percentage of cases exposed to seclusion:
Number of cases exposed to seclusion divided by number of cases treated
3. Number of mechanical restraints per affected case:
Total number of mechanical restraints divided by total number of cases affected by mechanical restraint
4. Number of seclusions per affected case:
Total number of seclusions divided by total number of cases affected by seclusion
5. Cumulative duration of mechanical restraints per affected case:
Total duration of mechanical restraints divided by number of cases exposed to mechanical restraint
6. Cumulative duration of seclusion per affected case:
Total duration of seclusions divided by number of cases exposed to seclusion
7. Mean duration of one mechanical restraint:
Total duration of mechanical restraints divided by total number of mechanical restraints
8. Mean duration of one seclusion:
Total duration of seclusions divided by total number of seclusions

Differences between German and Swiss hospitals concerning the indicators were tested for statistical significance using Mann-Whitney-U-tests. Associations between the indicator scores and both characteristics of hospital structure and variables reflecting the elaboration of hospital guidelines on coercive measures were analysed using correlational analysis (Spearman's rho).

Results

The following data represent the results (F2) concerning the indicators. The data are presented for the 7 German and the 7 Swiss hospitals separately.

Percentage of cases exposed to mechanical restraint

	Mean	MD	Min	Max	Range
CH (N=7)	5,1	2,1	0,0	14,4	14,4
D (N=7)	11,3	11,5	7,3	15,9	8,6

Percentage of cases exposed to seclusion

	Mean	MD	Min	Max	Range
CH (N=7)	17,8	14,2	8,2	38,3	30,1
D (N=7)	6,6	6,8	0,0	14,2	14,2

Number of mechanical restraints

	Mean	MD	Min	Max	Range
CH (N=7)	1,3	1,1	0,0	3,0	3,0
D (N=7)	3,2	3,2	2,2	4,3	2,1

Number of seclusions

	Mean	MD	Min	Max	Range
CH (N=7)	1,6	1,4	1,0	2,7	1,7
D (N=7)	3,6	3,3	0,0	7,5	7,5

Cumulative duration of mechanical restraints

	Mean	MD	Min	Max	Range
CH (N=7)	60,2	73,9	0,0	132,3	132,3
D (N=7)	36,5	30,3	22,0	58,1	36,1

Cumulative duration of seclusions

	Mean	MD	Min	Max	Range
CH (N=7)	77,4	91,4	40,3	110,2	69,9
D (N=7)	25,2	31,2	0,0	37,9	37,9

Mean duration of mechanical restraints

	Mean	MD	Min	Max	Range
CH (N=7)	41,8	44,1	0,0	75,6	75,6
D (N=7)	12,2	9,2	6,2	22,6	16,4

Mean duration of seclusions

	Mean	MD	Min	Max	Range
CH (N=7)	55,0	55,0	21,1	87,5	66,4
D (N=7)	6,8	5,2	0,0	14,6	14,6

The results of Mann-Whitney-U-tests showed, that significantly ($p < .05$) more cases (F2) were exposed to mechanical restraint in German than in Swiss hospitals, whereas in Swiss hospitals significantly ($p < .05$) more cases (F2) were exposed to seclusion. Also, mechanical restraints as well as seclusions were repeated significantly ($p < .05$) more often in German than Swiss hospitals (F2). The average duration of one seclusion (F2) as well as the cumulative duration of seclusions per affected case (F2) was significantly ($p < .05$) longer in Swiss than in German hospitals.

For Swiss as well as for German hospitals, correlations (Spearman's rho, $p < .10$) between indicator scores (F2) and variables reflecting guidelines showed significant associations. For Swiss hospitals (N=6) the correlational analysis (Spearman's rho, $p < .10$, N=6) between hospital characteristics and data on coercive measures showed amongst others the following significant associations: A higher percentage of cases exposed to seclusions was associated with a higher number of inhabitants in the catchment area and a higher cumulative duration of seclusions was associated with a higher number of beds in general psychiatry. For German hospitals the correlational analysis (Spearman's rho, $p < .10$, N=6) between hospital characteristics and data on coercive measures showed amongst others the following significant associations: A higher number of restraints was associated with a higher number of hospital beds for the treatment of addictions and a higher mean duration of one restraint was associated with a higher number of hospital beds per 100.000 inhabitants. Further results will be presented.

Discussion

For the first time, a European comparison concerning the frequency and duration of seclusion and restraint in psychiatric hospitals was realised. Furthermore, associations of the use of guidelines and hospital characteristics with data on coercive measures were analysed. The results clearly showed different patterns in the use of seclusion and mechanical restraint across Swiss and German hospitals: In German hospitals more schizophrenic patients were exposed to mechanical restraint than to seclusion, whereas in Swiss hospitals more patients were secluded than restrained.

The results also show, that restraints as well as seclusions of schizophrenic patients were repeated more often in the German than in the Swiss hospitals. The cumulative duration of seclusions and restraints per affected case and the mean duration of one restraint and one seclusion were higher in Swiss than in German hospitals. These different practice patterns raise the question, whether – from an ethical point of view – less but longer coercive measures should be preferred rather than more but shorter coercive measures.

Hospital structure characteristics as well as the use of guidelines on coercive measures were associated with the frequency and duration of coercive measures, in German as well as in Swiss hospitals. Because of the low hospital numbers, these associations should be interpreted with caution. This is also true for the data concerning the frequency and duration of coercive measures. The influence of important variables such as severity of illness or number of staff on duty could not be considered in the context of the statistical analysis. Therefore, differences in the data between the hospitals can not solely be attributed to different local traditions in the treatment of the mentally ill.

The data analysis also showed the problems that arise with international comparisons on coercive measures. Due to different definitions of involuntary medication across the countries, it was not possible to compare the data concerning restraint, seclusion and involuntary medication, thus to compare the total frequency and duration of coercive measures applied. Nevertheless, the power of international comparisons lies in the opportunity to critically reflect national traditions and to achieve transparency on an international level. International comparisons might be first steps towards the development of European standards concerning the use of coercive measures.

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17 – An interdisciplinary approach to the use of restraint and seclusion

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Reducing or eliminating restraint and seclusion for the violent patient in a mental health facility is a requirement of many regulatory agencies. Several barriers to this were identified by evaluation of 122 survey responses received from all levels of patient care employees in a state mental hospital with a forensics unit.

The descriptive survey asked about reducing/eliminating restraint and seclusion from the facility. Several barriers to this were identified. The staff reported feeling safer having restraint and/or seclusion available, feeling that only 20% or less of the violent episodes resulting with the use of these measures could have been avoided, feeling it was not possible to completely eliminate their use, and feeling that using these measures was not a degrading process to a patient's human rights.

Some procedures identified to assist with reducing or eliminating the use of restraint and seclusion during violent episodes were as follows: giving more authority to direct caregivers, include these caregivers in the care planning process, increase caregiver training regarding violent episodes, and being more consistent with the treatment of all patients.

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18 – Management strategies to keep the unit safe

Mary E. Johnson, PhD, RN, Kathleen R. Delaney, DNSc, RN (USA)

Background

Aggression and violence on inpatient psychiatric units continues to be a significant problem in nursing. In response to this problem, the recent trend has been toward increasing staff knowledge about de-escalation skills. Although these strategies are important, the authors contend that de-escalation is only one aspect of an overall effort toward violence prevention on inpatient psychiatric units.

Purpose of the study

The main purpose of this study was to develop via observations and interviews a mid-range theory of the de-escalation process. However, it became clear from the observations and the interviews that in addition to de-escalation strategies, preventing aggression and violence entailed an understanding of the complex day-to-day strategies that the staff use to prevent situations from escalating to violence. It is the authors' assertion that these day-to-day strategies have been taken for granted by clinicians and researchers and overlooked in psychiatric mental health nursing.

Methods

The methods used for this study were consistent with grounded theory methodology. After receiving approval from the institutions' Institutional Review Boards, the authors spent approximately 250 hours observing staff and patients on two inpatient psychiatric units and interviewed 16 staff and 12 patients about what they thought helped patients who were escalating calm down.

The data were analyzed using the constant comparative method recommended by Glaser and Strauss.

Findings

Given the acuity of symptoms presented by patients admitted to the unit and the reduced lengths of inpatient stays, the conditions on these units are constantly changing. The first step in responding to these changing conditions is awareness. Awareness entails awareness of self, the individual patient and the milieu and can vary in degree and change over time. The second step is the strategies used to respond to these changing conditions. These strategies are organized into individual and milieu strategies and day-to-day and episodic strategies. The keys to successfully managing changing conditions are (a) awareness of what is happening on the unit and (b) determining the most effective level of intervention in light of the specific situation.

Conclusions

The data from this study revealed that awareness is a salient concept in the process of preventing aggression and violence on inpatient psychiatric units. And yet, this concept has been taken for granted. Equally overlooked are the day-to-day management strategies. However, the day-to-day strategies are requisite to the staff becoming aware of changing conditions.

Lastly, although there has been more emphasis by researchers and clinicians on the episodic management of the escalating patient or milieu, the focus has centered on individual strategies rather than milieu strategies. The proposed model of management integrates these concepts.

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19 – Seminar (1) – Safe supportive observations v seclusion in the management of violence and aggression

Mary Love, Tam Ndhlovu & U. Nyandoro (UK)

Definition of Seclusion

“The supervised confinement of a patient in a room, which may be locked to protect others from significant harm”(1999 Mental Health Act Code of Practice)

Definition of “Observations”

“To watch the patient attentively whilst attempting to minimise the extent to which the patient feels that he/she is under surveillance” (1999 SNMAC)

Aims of the study

This project explored the views of patients and staff of a women only secure hospital to different techniques employed to achieve safe calming of highly agitated female patients, in the context of recent debates and differences of view between the hospital and regulatory bodies.

Introduction

A variety of techniques are currently used in UK hospitals to enable the safe calming of highly aroused patients. There is however limited research and evidence to answer the questions ‘What works?’, ‘What doesn’t work?’ and ‘What is (potentially) harmful? Seclusion is one of the methods employed but, following an extensive literature search and review, it is clear that there are strong

and conflicting views about its employment and efficacy. Various commentators have argued strongly that it should not be used. The Mental Health Act Code of Practice states clearly that ‘seclusion should not be used.... Where there is any risk of suicide or self-harm’, a particular issue with female patients with mental health problems.

Into the Mainstream’ (DOH 2003), a UK government guidance document, argued for the need to provide gender-sensitive care and treatment for women and to provide ‘relational security’. However it also recognised that women also found enhanced observations to be an invasion of their privacy, which in turn could increase violence and aggression.

Study setting and population

The Dene Hospital, a Medium secure unit for women who can present with extreme challenging behaviours, was built in 2001, without a seclusion room.

Many of the women cared for in The Dene have a primary diagnosis of Borderline Personality Disorder or Complex Post Traumatic Stress Disorder. Many have spent a great deal of their lives in some form of an institution; some have experienced ‘seclusion’ as well as being nursed in a ‘low stimulus environment’ (their bedroom) on ‘enhanced observations’.

The UK regulatory bodies (the Healthcare Commission (HCC) and the Mental Health Act Commission (MHAC)) have stated that it is their view that the current practice of The Dene when managing violence and agitation amounts to seclusion. The current practice employed at the hospital is to remove any woman who is highly aroused to a quiet room or occasionally to manage them in their bedroom, supported by staff who employ de-escalation therapeutic interventions throughout the procedure. The hospital argues that this does not amount to seclusion.

Because of this difference of view, it was felt that the issue needed to be explored further and that we needed to obtain the views of staff and service users as to whether supportive observations were a humane and effective technique or whether a seclusion room/crisis intervention suite was needed to support our ethos that engagement and early intervention is likely to lead to a reduction of violent and aggressive behaviour.

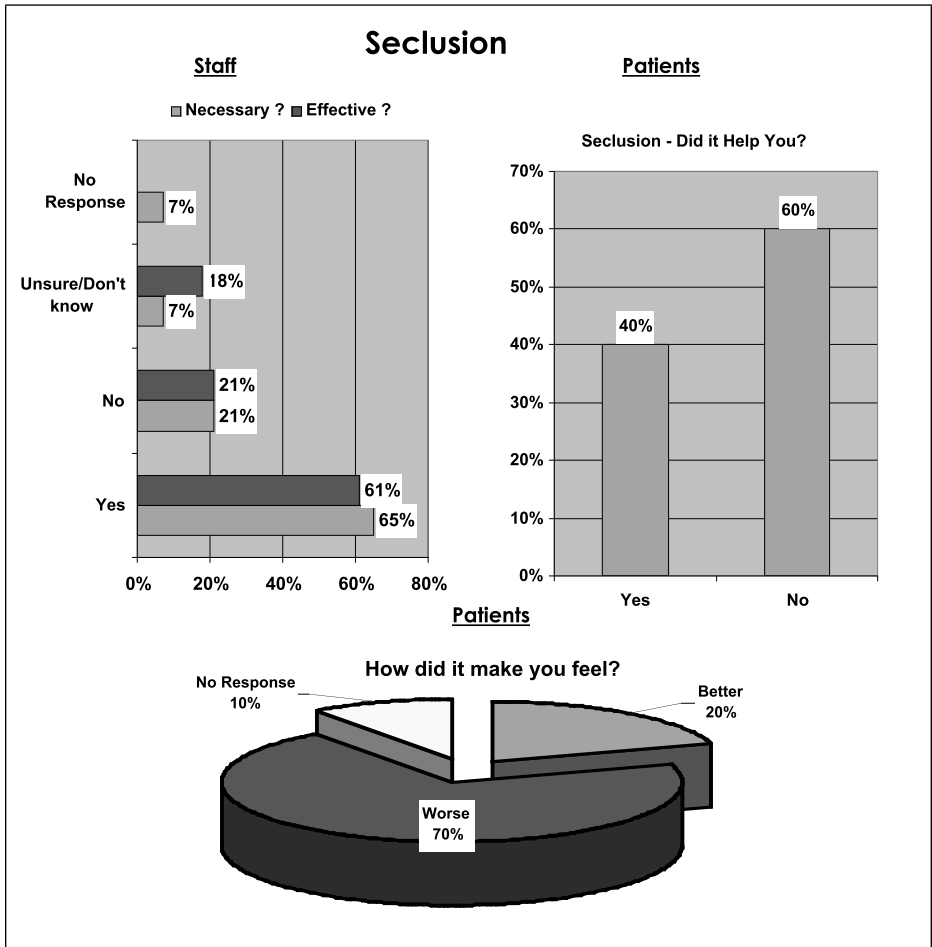
Consultation began with an open debate in July 2005, attended by service users, the Mental Health Act Commission, Mental Health Nurses, Psychiatrists, Psychologists and other professionals.

From this debate, nursing staff expressed the view that there were times when a person needed to be removed to a quiet area. Service users indicated that at

times they had felt being nursed in their rooms was beneficial, if the nursing staff observing them interacted with them and they felt supported.

In order to support this, further evidence was required and, in agreement with the hospital Research, Ethics and Academic Development group, (a sub-group of the clinical governance process at the Dene), a standard questionnaire was devised, asking staff and patients their views on seclusion and enhanced observations. In total 50 questionnaires were sent to patients and 107 to staff. This elicited a patient response rate of 24% (12/50), a staff response rate of 29%. It was agreed that a Thematic Analysis approach would be used to collate views.

Results



This paper will discuss the responses received, areas identified for improvement, how are we measuring the effectiveness of the work we do and future plans.

With the management of self-harm, enhanced observations are more effective in reducing the risk. In previous employment staff report that they had secluded patients because of self-harming behaviour, yet isn't seclusion to prevent harm to others?

Many of the staff said they would use seclusion to control violence, as they felt reassured.

Discussion

Savage & Salib (1999) suggest that, although seclusion of some patients may be a safe and effective intervention in controlling incidents, a therapeutic alternative, whether a bedroom or intensive care area is more humane. From the debate and questionnaires received back, most staff and service users agree with this.

It has been identified that women do need an environment where they can safely explore relationships, where they feel empowered and are treated with respect and dignity. Bloom (1998) stated that women's needs should be addressed in a safe and trusting environment and that the treatments offered should build on women's strengths, and promote independence and self-reliance.

Although we support the use of safe and supportive observations, we need to continue measuring if they are effective and, if not, what alternative is there?

Recent audits undertaken at the Dene indicate that many of the observations are carried out by unqualified staff. The patient's views are that some staff do not interact with them. Enhanced observations currently require a high staff ratio; difficulties with recruiting lead to the use of agency staff. This can increase the risk of violence as these staff are unfamiliar with the patients needs. They also do not receive the training required. We would agree that staff training is needed to develop and utilize strategies in place of restraint or enhanced observations are paramount.

Structured programmes for the women that are not just Monday-Friday that include socialisation as well as rest. Involving them in their risk assessment – Advance Directives, what keeps them calm? On admission asking about previous experiences they have had.

The American Psychiatric Association (2003) recommended that by having mature staff, the appropriate skill mix can deliver quality care and develop a culture where patients needs and interests are clearly focused. The focus needs to be on prevention, not reaction.

In light of the work carried out so far we would recommend that further studies be carried out, as this has raised more questions than answers.

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20 – Identifying risk in palliative care settings: dealing with cancer patients with mental health problems

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Keywords: Cancer, palliative care, mental disorder, dual diagnosis, risk management.

Introduction

The Highland Hospice is a Specialist Palliative Care Unit comprising a 10 bedded in-patient unit and a range of day care services. The client group have complex palliative care needs, which usually include ‘difficult to manage’ pain and symptom control.

In addition to the usual care management issues of patients in the late stage of progressive terminal disease, mental health problems have become a key concern. Nursing staff have identified problems in managing the increasing numbers of patients being admitted with mental health problems, who may exhibit violent and aggressive behaviors.

The Philosophy of Hospice Palliative Care

“supports the long term objective of creating a personalized experience with each patient at the end of life, whereby in the face of suffering there is opportunity for growth and quality end-of-life closure for both patient and family. Promoting quality of life and death with dignity emphasises that the patient and the family

live each day as fully as possible with the hope of making the very best of today when tomorrows are limited". (Egan & Labyak 2001, p8)

The nurses who provide hospice care must constructively respond to nursing situations that are, by definition, highly emotive. The principles that direct the team are the patient's values, choices, wishes and needs for the remainder of their life and death. Patients and families are encouraged to take the lead in determining the care goals that are appropriate, given these circumstances. Some patients may be sad, anxious and distressed but compliant. However, sometimes patients are confused, agitated and non compliant. It is when clients find themselves unable to make rational choices that hospice nurses find it difficult to set boundaries and change their egalitarian approach to care.

Cancer and Mental Disorder

Currently one in three people in Scotland will contract cancer and of this number 150.6 people per 100,000 of population will die from it (Scottish Executive 2003). The incidence of cancer continues to rise and recent World Health Organisation reports predict that cancer rates will rise by 50% by 2020 (Scottish Executive 2003). The corollary is also true for people suffering from mental health problems. These continue to rise and the WHO estimates rates of lifetime prevalence of mental disorders among adults to range from 12.2% to 48.6% (WHO 2000). The statistics suggest that the overlap in mental health issues in palliative care settings are likely to increase in number and significance.

An early study by Derogartes et al (1983) looked at the psychiatric profile of cancer patients. They found that, of the two hundred and fifteen randomly accessed cancer patients who were new admissions to three collaborating cancer centres, only 53% of the study participants had "a normal response to cancer". The remaining 47% had a psychiatric diagnosis, namely: 32% of these patients had adjustment disorders and symptoms of depression; 6% suffered from major depression; 4% had organic mental disorders, such as dementia, delirium or psychosis; and the remaining 5% had pre-existing psychiatric disorders composing of personality disorders (3%) and anxiety disorders (2%). Later studies have reported that 14% to 31% of cancer survivors have a diagnosis of a mental disorder (Kornblith 1998). It is possible that the statistics have changed in the last 5-7 years (in line with WHO studies), but more recent and/or comprehensive data are lacking. For this reason it was determined that

Derogartes 1983 study could provide a useful framework for discussion.

Applying Derogartes data, the potential for violence in palliative care settings can be estimated to come from two groups: 1) the 3% of cancer patients with personality disorder, and 2) the 4% of cancer patients who suffer from organic mental disorders associated with the degenerative progression of the disease process in cancer. The problem of violence in palliative care environments can therefore be predicted to be from a very small percentage of cancer patients. Yet the threat of even a small scale predicted problem is a source of major concern for the hospice staff. This is because they feel that they lack experience in this more specialised area of mental health, and in dealing with patients who are uncooperative and violent. The atmosphere of co-operation and harmony within the hospice setting is not amenable to the disruptive influence of even a few clients.

The Experience of Highland Hospice

In line with the findings of the study by Derogartes et al (1983), in Highland Hospice the potential for aggression has stemmed predominantly from diagnoses of the two groups of dual diagnosis cancer patients discussed previously:

Organic mental disorders (e.g., brain or dural metastases and dementia. Presenting symptoms: delirium, psychosis, confusion and agitation, especially in the terminal phases). Pre existing psychiatric disorders (e.g., personality disorder, manic depression).

Case Study 1 – organic psychosis. The patient had no previous history of mental disorder.

A 65 year old man with a diagnosis of prostatic cancer, bone metastases and an extensive leptomeningeal tumour (tumour of the dura). The patient was admitted to the hospice because of left leg and sacro-iliac rib pain, nausea and vomiting, constipation, anaemia and very low mood.

The patient's physical symptoms settled, but he presented with increasing anxiety and confusion and scored a significantly depressed-score of 22 on the Edinburgh Depression Scale.

Suffering from restlessness his anxiety increased. Self-flagellation grew and he became obsessed by 'sins'; real or imaginary. He experienced negative thoughts and visual hallucinations. He became increasingly paranoid about the nursing staff and was agitated if they smiled or even blinked. This in turn triggered

aggression. He had bizarre thoughts and heard the voices of his wife and friends 'talking about him'. The patient refused all medication. He was seen by the psychiatrist who diagnosed organic psychosis. However the psychiatrist felt that the psychiatric unit would be unable to cope with the specialist palliative care needs of this patient. The patient was not detained under the Mental Health Act.

There did not appear to be any pattern of sensitivity for this patient, and any kind of stimulus triggered an aggressive response in him. Having absconded from the ward after dropping and breaking a cup he was considered to be at significant risk for suicide because of his depressed state and the location of the hospice, which was situated on the banks of a fast flowing river. He was followed by one member of staff but became aggressive and violent when approached, refusing to return to the hospice. His family and the hospice doctor were contacted by mobile phone and they came to assist the nurse. The patient was eventually persuaded to return to the hospice and take his medications. He ultimately settled on a regime of Olanzapine which is an atypical antipsychotic, Lorazepam at night and Dexamethazone to reduce the tumour swelling

Case Study 2 – manic depression. The patient had a previous history of mental disorder.

A 52 year old woman with a diagnosis of cancer of the appendix with metastatic spread to both ovaries and the perineum. Following a recurrent history of bowel obstruction a loop ileostomy was performed, but this leaked constantly. She was admitted to the hospice for pain and symptom control, along with management of the ileostomy and obstructions. The patient had a previous long-standing psychiatric history of manic depression. She was very aggressive towards her husband and staff when manic. Her anxiety levels increased in response to the pain and problems with the stoma, which could not be resolved surgically because there was very little bowel remaining. An extremely demanding patient, she made constant and unreasonable requests for increasing amounts of opioids, yet still continued to complain of pain following analgesic administration. If her demands were not met immediately she became violent and aggressive, and on several occasions pushed and hit out at staff. The patient was a very large and strong woman and presented a very real threat to staff.

Having complained of feeling trapped and depressed, she insisted upon managing her own medications and then on going home. She was readmitted 48 hours later, unconscious and opioid toxic. The patient was deemed unsuitable for

psychiatric admission because of her palliative care problems. The psychologist, after a full review, challenged her behaviour, and the patient then refused any further contact for psychological support. Finally lapsing into terminal agitated delirium as a progression of the physical illness she was sedated with very large doses of Haloperidol, Midazolam and Phenobarbitone until she died.

Feelings of the Nursing Staff in Managing Care

The nurses expressed fear for their own safety and felt ill equipped and ‘out of their depth’ to cope with what they regarded as ‘mental health’ patients. Although very skilled in communication techniques they normally dealt with sad, anxious, depressed, but compliant patients. The staff experienced great difficulty in trying to set boundaries and enforce codes of behaviour for patients who were demanding, manipulative and difficult to deal with, but who were also distressed, suffering and at the end of their lives. They were concerned that the environment and staffing levels were not ‘set up’ to manage violent and aggressive patients, and were unsure of their ethical and legal position.

Ethical/Legal Considerations

The ethical and legal difficulties identified were in relation to the detention, restraint and administration of drugs to patients within the hospice setting; particularly in situations where the patient refuses medications, is aggressive and/or violent, or decides to leave the premises.

There is an underlying presumption in the law that it is wrong to interfere with the actions of another adult without lawful excuse, but neither the civil nor the criminal law in Scotland is set out in a precise code. There is no specific legislation dealing with “restraint” that sets out what is lawful in a care settings and what is not. The two pieces of legislation that have the most relevance are the Mental Health (Scotland) Act 1984 and the Adults with Incapacity (Scotland) Act 2000. The impact of the European Convention on Human Rights has also to be taken into account.

Within a general adult care setting health care professionals can normally use the provision of the Mental Health Scotland Act 1984, which requires assessment by a psychiatrist. The Adults with Incapacity Act 2000, can also be invoked by the medical practitioner primarily responsible for the medical treatment, if it is

deemed that a patient is incapable of making rational decisions on their own behalf. Under this legislation it is acceptable for a member of staff to use force to restrain someone if : There is reason to believe that s/he is about to cause the member of staff harm. A person's actions may put other vulnerable people at risk. A vulnerable person needs to be prevented from self-harming (duty of care).

Notwithstanding, the House of Lords has said that such powers should only be used where someone has "run amok and is a manifest danger either to her/himself or others" (Mental Welfare Commission Scotland 2005, p23), and then the force should be the minimum necessary and for the least time possible. Practitioners exercising restraint will have to justify their policies and the use of such policies in individual circumstances, should an action for assault be initiated.

In the hospice setting it can be difficult for staff to identify at what point physical restraint would be necessary, and realistically it is doubtful if staffing levels would permit any kind of radical physical enforcement. The hospice is set in a tranquil peaceful environment, but is isolated, has no security services, and employs only two male nurses who are seldom on duty at the same time.

Management

As highlighted in the case studies, it is difficult to manage dual diagnoses and to identify the most appropriate place of care for these patients. In the initial stages of a dual diagnosis the patient may "see-saw" between the care provided in a palliative care setting and a mental health unit. If the palliative care patient becomes mentally disturbed and the staff feel unable to deal with them, they may be transferred to a mental health unit. However the mental health staff often feel challenged by the complexity of the cancer and palliative care treatment the patient is receiving and may deem that the best place for care is back in the palliative care unit.

In the palliative care setting all dimensions of care must be managed simultaneously. When behavioural manifestations result from organic disorders, then these must be addressed in order to resolve the problem, but the extreme elements of the behaviour have to be managed well enough to allow palliative treatments to take place. Bruera et al (1992) identified cognitive failure in 80%-90% of patients studied prior to death and a noted reversible cause of delirium in 44% of these patients. The complications prevent dual diagnosis

patients from responding to cognitive therapeutic approaches .

Interventions

- Full multi-professional assessment, including physical, psychological, social and spiritual dimensions, and a plan of care developed based upon this assessment which should include meeting the family's needs.
- Thorough evaluation of medications to identify reversible pharmacological causes of mental disorder from drugs such as opioids, sedatives, anticholinergics and steroids.
- Complete blood count, electrolytes, urea, creatinin and calcium levels to rule out hypoxia, dehydration and metabolic causes such as hypercalcaemia, hypoglycaemia, and paraneoplastic syndrome.
- Consideration of palliative radiotherapy or chemotherapy to shrink tumour growth enough to alleviate symptoms.
- Risk assessments carried out for patients with mental health issues who may harm themselves or others.
- Increase staffing levels in line with risk assessment
- Care plans and Care protocols developed
- Protocol for dealing with patients who are at risk of going Absent Without Leave (AWOL) developed
- Review of policies on restraint and administration of medicines.

Preparation of Staff

The majority of staff in the hospice are generalist trained. Only two have a dual mental health and general qualifications, but they have worked outside of the mental health environment for a number of years. It was, therefore, decided to introduce some mental health workshops to support staff in decision making using critical incident analyses and education on legal and ethical issues, and to then work through the policies and protocols being introduced. Staff in the hospice explored issues relating to risk assessment and the individualization of care for patients with dual diagnosis, having reflected on recent cases within the hospice. Staff were helped to plan care for future eventualities.

All staff are now trained in: advanced communications; management of aggression and violence; use of non restrictive methods of care and in methods of restraint. Seeking additional support for the hospice staff, the local psychiatric

hospital was approached to recruit a community Registered Mental Nurse (RMN) for one day per week to strengthen multi-professional working relationships. It is anticipated that this person will provide additional mental health consultancy regarding approaches to care outwith the framework of the formal educational initiatives that have been established.

Conclusions

Patients presenting with a dual diagnosis of terminal cancer and mental disorder within a palliative care environment present a series of unique challenges for the staff working within the hospice environment. Staff who are used to working in harmony with patients in a co-operative relationship often find it difficult to deal with the potential for violence and aggression within the peaceful environs of the hospice setting.

Issues relating to management of the hospice with regard to manpower and the lack of appropriately qualified staff, along with the restrictions imposed by the legal system, require that the problems presented by violent patients within a hospice setting not be addressed in the manner that such patients would be handled in a “traditional” mental health unit. The management team within the hospice have attempted to overcome the care limitations placed upon the hospice staff by sponsoring a series of initiatives. The goal has been to provide care for people who may be extremely challenging but who are experiencing perhaps the ultimate need for compassion.

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21 – Security rules and banned items on psychiatric acute admission wards in Athens – Greece: The role of the nurse

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Summary

Nurses are increasingly expected to predict and prevent the suicidal and violent / homicidal impulses of their clients on psychiatric acute admission wards.

Keywords: psychiatric nurse, acute ward, ward safety, patient safety, banned items

Objective

The purpose of this study was to evaluate the preventive measures that are taken by nurses on admission and during admission of patients as it regards to items being banned and of course safety and security policies that exist and are currently administered on acute psychiatric wards.

Introduction

Safety and security in hospitals has become a major issue of concern in our country. There is a need to protect vulnerable patients from other patients, patients, property and staff from outsiders, patients from themselves, the staff from violent patients, and, at times, the public from patients.

Hospitals tend to have a wide range of policies and procedures that address the issues pointed. These policies raise concerns about the human rights of patients and make it difficult for mental health professionals to keep a balance between the safety and security of patients, staff and public and respect of the rights and choices of individuals. This can produce a diversity of opinion on levels and

types of psychiatric ward safety and security required (confiscation of property, locking of ward doors, restrictions on freedom, use of security guards).

Increasing violence in various hospital settings, the high risk of physical assault faced by mental health professionals as well as the literature regarding to violence management and prevention have led us to research the current safety and security procedures on acute psychiatric wards in Athens – Greece.

The majority of the available literature refers to the need for increased safety and security in hospitals and for well-planned units from the outset.

Subjects and methods

The study was conducted on three major hospitals in greater Athens area: Eginition hospital, Dromokaition hospital and Dafni hospital. A hundred and sixty four nurses of different educational level who were working in psychiatric acute care settings, were randomly selected.

Assessment instrument

The assessment instrument was the Ward Safety and Security Rules Survey by Seamus Cowman. This instrument was translated for the Greek population by Giannouli, 2003, and standardized by Giannouli, Koukia, Gonis, Douzenis, 2003.

Data Analysis

We used a descriptive study given that there is no other research concerning this subject in Greece and particularly in Athens area. The purpose of the study was only to describe the security rules and the ward safety in the three major psychiatric hospitals of Athens.

Results

Demographic results

The sample consisted of 146 nurses. 71 (48.6%) were male and 75 (51.4%) were female. 22 (13.4%) of nurses were working at Eginition, 37 (22.6%)

at Dromokaition and 105 (64.0%) at Dafni. We interviewed nurses from 14 different wards. The number of beds was varying between 20 and 35. No ward reported the presence of a Seclusion Room.

Banned items

We noticed that there are items banned from the total or the majority of group of nurses like alcoholic drinks, medications, drugs, penknives, weapons, solvents, flexes. For the majority of other items nurses reported various opinions. A number of items are sometimes or never banned like batteries, pencils, perfume. We surprisingly saw a small number of nurses permit items like solvents (9.8%), lighters and matches (25.6%) and batteries (42.1%). (table 1)

Ward safety rules

1. Searching on admission

The most common search on psychiatric patient by the nurse was bag search (92.1%) and pocket search (76.8%). “Rub-down” search was sometimes or never practiced. Nurse never use detectors or practice strip search. (table 2)

2. Searching during admission

In this section we found different results e.g. patients’ property is always (30.5%), sometimes (50.6%), or never (18.9%) searched on return from leave. (table 3)

3. Ward safety

Concerning the ward safety it looks like every nurse has a different approach. We reported all kinds of results for bathrooms, taps, plastic crockery, cutlery, glasses and boiled water. (table 4)

4. Illegal drug testing and control

The most frequent testing on admission was urine or blood (90.2%). Only the 48.8% of nurses report to the police if drugs discovered. For urine or blood testing on return from leave as well as a random testing, it seems that every nurse has a different approach. The 59.8% of nurses reported that they sometimes perform these tests and the 31.1% never. Only if there is a reasonable ground for suspicion, the 89.6% of nurses ask the patient to give urine or blood for testing. (table 5)

5. Alcohol testing and control

The majority of nurses never program breath or blood testing to the patient on admission (42.7%) or on return from leave (39.0%). If they have a suspicion for alcohol use, the 42.7% of nurses perform breath or blood testing on the patient. (table 6)

Security features

We noted only a minimum number of security features in the wards. Only one out of fourteen wards has an intercom system and in four exists a rapid response team on call. In nine wards there is a panic alarm in the office only and in eight an emergency response telephone extension. Nurses from ten wards reported that they have an access to security guards at all times. Finally all nurses noted that they refuse entry on visitors if a problem occurs.

Locking Ward Door

Eleven Wards has been locked always in the last six months and the rest three wards have been locked at least once a day.

Table 1: Banned item

Item	Always banned N(%)	Sometimes Banned N(%)	Never banned N(%)
Alcoholic drinks	164 (100)		
Batteries		95 (57.9)	69 (42.1)
Disposable razors	79 (48.2)	85 (51.8)	
Flexes/cables	152 (92.7)	12 (7.3)	
Illegal drugs	164 (100)		
Lighters/matches	37 (22.6)	85 (51.8)	42 (25.6)
Medications/tables	164 (100)		
Nail files	133 (81.1)	31 (18.9)	
Pencils/pens	5 (3.0)	87 (53.0)	72 (43.9)
Penknives	164 (100)		
Perfume/after-shave	6 (3.7)	101 (61.6)	57 (34.8)
Plastic bags	18 (11.0)	34 (20.7)	112 (68.3)
Razor blades	159 (97.0)	5 (3.0)	
Scissors	164 (100)		
Solvents	139 (84.8)	9 (5.5)	16 (9.8)
Weapons	164 (100)		

Table 2: Searching on admission

Practice	Always N(%)	Sometimes N(%)	Never N(%)
Bag search	151 (92.1%)	13 (7.9%)	
Pockets search	126 (76.8%)	32 (19.5%)	6 (3.7%)
'rub-down' search		36 (21.9%)	128(78.0%)
Strip search			164 (100%)
Check with fixed point or hand held metal detector			164 (100%)

Table 3: Searching during admission

Practice	Always N (%)	Sometimes N (%)	Never N (%)
Patients' property is searched on return from leave	50 (30.5%)	83 (50.6%)	31 (18.9%)
Patients' bed spaces searched (e.g. lockers, under beds etc.)	130 (79.3%)	34 (20.7%)	
Visitors searched	48 (29.3%)	102 (62.2%)	14 (8.5%)

Table 4: Ward safety

Practice	Always N (%)	Sometimes N (%)	Never N (%)
Bathrooms are kept locked when not in use	57 (34.8)	8 (4.9)	99 (60.4)
Taps/plugs removed from bath (state either or both)	48 (20.3)	42 (25.6)	74 (45.1)
Plastic crockery is used	35 (21.3)	85 (51.8)	44 (26.8)
Plastic cutlery is used	26 (15.9)	75 (45.7)	63 (38.4)
Plastic glasses/tumblers are used	51 (31.1)	73 (44.5)	40 (24.4)
Cleaning cupboard locked (mop, bleach etc.)	124 (75.6)	40 (24.4)	
Patients do not have access to boiling water for drinks	21(12.8)	11 (6.7)	132 (80.5)
Cutlery counted after use	129 (78.7)	22 (13.4)	13 (7.9)

Table 5: Illegal drug testing and control

Practice	Always N (%)	Sometimes N (%)	Never N (%)
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Urine or blood testing on admission	148 (90.2)	16 (9.7)	
Reporting to the police if drugs discovered	25 (15.2)	59 (36.0)	80 (48.8)
Urine or blood testing on return	16 (9.8)	117 (71.3)	31 (18.9)
Random urine or blood testing	15 (9.1)	98 (59.8)	51 (31.1)
Urine or blood testing upon reasonable grounds for suspicion	147 (89.6)	17 (10.4)	

Table 6: Alcohol testing and control

Practice	Always N (%)	Sometimes N (%)	Never N (%)
Breath or blood testing on admission	40 (24.4)	54 (32.9)	70 (42.7)
Breath or blood testing on return from leave		100 (61.0)	64 (39.0)
Random breath or blood testing		69 (43.1)	95 (57.9)
Breath or blood testing upon reasonable grounds for suspicion	70 (42.7)	43 (26.2)	51 (31.1)

Conclusion

In many of the results a significant percentage is in sometimes banned, which indicates that there is no protocol or given policy as to what should or should not be banned in an acute mental ward. Nurses learn how to administer the safety and security rules by their senior colleagues or they decide individually. As a result this administration differs greatly and is related to the nurse as a personality, his/her education level, the ward he works in, the status of the patient, his/her diagnosis, etc.

We have noticed significant differences in relation with searching the patient on admission and during hospitalization, ward safety, alcohol and drug testing and control. There is a critical deficiency on security features like swipe card system, intercom system, CCTV or metal detectors. The majority of nurses depend only on security guards, panic alarm and emergency response telephone for coping with situations at risk. It was quite surprising to realize that there are

minimum security measures taken in many of the wards researched. We hope that his research will stimulate open debate and sharing of views around what is appropriate, efficacious, ethical and legal in the practice of acute care.

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22 – Development of a method to predict and prevent violent and aggressive inpatient behaviour: working with an aggression prevention plan

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Summary

With the help of a number of colleagues, I developed an aggression prevention plan for managing aggressive inpatient behaviour, based on patient knowledge and experience. The aggression prevention plan focuses on the way a person exhibits self-control, and makes use of an interactive model (a so called crisis development model). We found that most important signals of aggression are dependant on the individual coping style of the patient.

This knowledge makes it possible not only to assess the fear and tension building up in a patient, but also between the patient and health care worker. By understanding this interaction and taking the appropriate action, the ability to prevent aggressive behaviour can be increased. A plan is drawn up for each individual patient which is called an “aggression prevention plan”. Aggression prevention plans are now commonly used within Dutch psychiatry and are known as “signaleringsplannen”. The method was recently published in the professional Dutch Mental Health Care magazine “PsychoPraxis” (no. 4, August 2005).

Keywords: Aggression prevention plan, Prevention, Aggressive behaviour, Crisis-Development-Model, Self-control, Coping style, Development Experience

Presentation

1. Project

Problem

How to convert the intuitive experience we had with managing aggressive behaviour into a useful tool.

Purpose

A purpose-built model is easy to teach. It is quickly understood which increases the ability to prevent aggressive behaviour in patients when a new colleague joins the team, or when a patient is transferred to a new hospital.

Method

After 10 years the method is now finely tuned and well integrated into working procedures. It has certainly helped to reduce aggressive behaviour.

Conclusion

We have developed a tool that works well and has proven itself in a demanding, forensic hospital, the GGzE, located in Eindhoven, the Netherlands. After 10 years of development with good results, it was considered worthwhile to communicate this method to others.

2. Explanation of the aggression prevention plan

The aggression prevention plan looks at the way a person exhibits self-control, and makes use of an interactive model. This makes it possible to assess fear and tension building between the patient and health care worker. By understanding this interaction and taking the appropriate action, the ability to prevent aggressive behaviour is increased. The aggression prevention plans can be applied to patients with a psychotic disorder or a personality disorder. The use of aggression prevention plans for patients with a personality disorder may be new to many people.

Crisis Development Model

The crisis development model is an interactive model focussed on the different phases leading to the loss of control. The loss of self-control can lead to violent and aggressive behaviour. For every phase of losing control there is a corresponding recommended intervention that the health care worker should initiate. The model can also be used to explain a patient's behaviour to the patient himself, enabling him to stop escalation before things get out of hand.

Table 1 – Stages of Crisis and Corresponding Recommended Interventions

Phase	Description of Stage of Crisis	Recommended Intervention
0	Stable behaviour	Follow normal routine
1	Fear of losing control	Be supportive, communicative
2	Losing control	Take control
3	Violent behaviour	Physically intervene
4	Tension release	Allow cool-off time before evaluating

Prevention of Aggressive Behaviour

In adapting this model to aggression prevention plans, we became aware that the crucial stage of the process for preventing aggressive behaviour involved recognizing the transition from phase one to two, and taking the correct action. Health care workers are often good communicators who prefer to use talking as their method of intervention. However, continuing to be supportive and discussing the issue over and over when the crisis develops to the stage of losing control is not effective and it increases the risk of violence.

The crisis development model can be applied to the patient, but can also be applied to the health care worker. Experience taught us that for psychotic patients, the aggression prevention plan must focus on the behaviour and the loss of control of the patient himself. This is how existing prevention plans work. However, for patients with a personality disorder the aggression prevention plan must focus on the behaviour and the loss of control of both the patient and the health care worker. In these cases, we often see that either the patient or the health care worker or both lose control during the crisis period.

Coping style

Through working with the aggression prevention plans for many years, I have found that the most important signals of aggression are dependant on the individual coping style of the patient. The individual's coping style often comprises one or more of the following coping mechanisms:

Ineffective coping:

Common lack of skills in dealing with stress and strong emotions. When the patient can no longer cope with the problems, he is likely to lash out. The ensuing aggression is mostly focussed on things, not on people.

Not coping within the family:

Within families there are often very complicated patterns of interaction, with high expectations from relationships. Seemingly minor occurrences can cause very emotional responses. A simple telephone call or visit from a family member may cause an upheaval. The resulting aggression is mostly focussed on things, or is directed verbally to people in general.

Increased need for control:

The patient deals with his fears by trying to control the other person, without considering that person's needs or feelings. It can manifest itself as inappropriate

behaviour and lead on to person-focused aggression. The aggressor attacks the person who refuses to accept his need to keep control.

Project and identify:

When a person is not able to cope with his own feelings of anger or fear, he rejects these feelings and projects them on to another person. The perpetrator will deny doing this. The other person feels wrongly accused and reacts by feeling powerless, indignant or angry. This may in turn anger the perpetrator, who reacts more defensively, which can lead to a cycle of deteriorating interaction, and ultimately to person-focused aggression.

Changeable sense perception:

Sense perception can be affected by exhaustion and stress. As a result, sense perception can be seriously impaired (resulting in such impairments as tunnel vision, an autistic fixation on dots and lines, epileptic twilight state, psychotic hallucinations etc.)

This mostly results in aggressive behaviour towards the patient himself or his surroundings; very rarely is it directed towards other people, and certainly not directly.

Disturbed thinking:

In this coping strategy a person's perception is impaired. The person involved acts strangely, acting on his warped perception. The response is not that of a 'normal' person. It can eventually lead to aggression directed towards a person.

Defensive coping:

With defensive coping, the patient's fears and feelings of insignificance are overridden. The person develops an inflated self-image that is not easily corrected. The person comes into conflict with others who do not concur with this self-image. In an attempt to cope, this person comes more and more into conflict and the possibility of aggression increases. The aggression is often directed toward the person who threatens the inflated self-image of the offender. Quite often the ensuing aggression is unheralded and unexpected.

By detecting which coping mechanisms the individual exhibits, it becomes easier to develop an effective aggression prevention plan.

To conclude:

In my presentation I have tried to show you how we work to prevent or predict aggressive behaviour. Of course medication is also an important tool in this prevention. Our experience has taught us that aggression often starts within relationships and that these relationships are therefore the most important tools to use when it comes to prevention. This is also why it is very important to have an interactive model that explains the mechanisms underlying possible escalation.

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23 – The pharmacological management of aggression in the acute situation: a systematic review

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Background

Aggression is an important issue in mental health departments. Several interventions and coercive measures are used in daily clinical practice to manage aggression. One of the interventions used in psychiatry to manage aggression is the administration of psychotropic drugs. Whereas chemical restraint is frequently used to manage acute aggression, the evidence is scarce.

Objectives

In this systematic review we investigated the evidence for the drugs currently used in the management of acute aggression in a general adult psychiatric population.

Methods

We searched Medline, Embase, Psycinfo and the Cochrane library for meta-analyses and randomized controlled trials on the pharmacotherapy of aggression. We excluded those studies referring to specialized psychiatric settings and non-psychiatric settings.

Studies were judged to their internal validity and generalizability to daily clinical practice.

Results

As well as for antipsychotic agents including haloperidol, droperidol and zuclopenthixol, promethazine as for benzodiazepines including lorazepam and midazolam evidence for effectiveness was found. Study limitations comprised small study populations - which might result in a lack of power to show superiority of one drug above another- short study duration, and poor generalizability to daily clinical practice.

Conclusion

On the basis of the evaluated studies and taking into account the study limitations, droperidol appears to be first choice if tranquillisation is required as soon as possible. Furthermore the combination of haloperidol and lorazepam is fast acting and appears to be more sedating than monotherapy. If a calming down effect is more desired than sedating the patient, monotherapy of haloperidol or olanzapine appears to be appropriate.

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24 – The pharmacological management of aggression as an ongoing problem: evidence-based?

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Background

Whereas aggression influences well being of patients and staf, prevention of aggression should have high priority in psychiatry. Pharmacotherapy is frequently used for the management of aggression, both for aggression in the acute situation as for aggression as an ongoing problem.

Objectives

In this systematic review we evaluated the evidence for pharmacological maintenance therapy in the case of aggression in “general adult psychiatry”.

Methods

We searched Medline, Embase, Psycinfo and the Cochrane library for meta-analyses and randomised controlled trials on the pharmacotherapy of aggression.

We excluded those studies applying to specialised psychiatric settings and non-psychiatric settings. Internal validity and generalizability of the articles was assessed by two independent authors.

Results

One meta-analysis and 30 randomised controlled trials were evaluated. The use of numerous scales in and insufficient data reporting the individual studies hampered the assessment of efficacy across studies. Using a best-evidence synthesis model, weak evidence for the anti-aggressive effect of several drugs was found. Limitations of the RCTs included small sample sizes, short study duration and poor generalizability to daily clinical practice.

Conclusion

Weak evidence for effectiveness was found for antidepressants, atypical antipsychotics, beta adrenergic blocking drugs and anticonvulsants but not for typical antipsychotics. For future research firstly consensus about the use of aggression measurement scales should be reached. Furthermore we recommend to conduct pragmatic trials instead of randomised controlled trials with strict in- and exclusion criteria in order to obtain results which are generalisable to daily clinical practice.

25 – The pharmacological treatment of aggression in acquired brain injury

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Background

Aggressive and impulsive behaviour are amongst the most frequent neuropsychiatric symptoms in acquired brain injury (ABI). Medication is one of the most used interventions to treat these symptoms. No guideline exists to help the clinician making rational, evidence-based choices. For example, no RCT's are known on the effect of anti-psychotics in the rehabilitation of traumatic brain injury in general. However, this medication is frequently prescribed. Personal experience is an important 'decision-maker' in the medication-strategy of many clinicians. For this reason the evaluation of the scientific literature is an important step to improve a systematic medication-strategy in the treatment of aggression ABI.

Objectives

Evaluation of the psychopharmacological literature in the treatment of aggression in ABI.

Method

We searched Medline, Embase, Psycinfo and the Cochrane library for any studies looking at the management of aggression in ABI.

Results

The evaluation-process is currently running. The first results show that there are only a few studies with evidence-level of RCT's or higher (Evidence-class A1, A2 or B) and the conclusions are inconsistent. For example, in their review Richard et al ('02) analysed 29 studies and found that mood-stabilizing antiepileptics, and specially carbamazepine constitute together with SSRI antidepressants the first choices. In the Cochrane-review of Fleming ('03) the best quality of evidence is for beta-blockers, but large doses were used and many clinicians would not prescribe this.

Conclusion

Final conclusions are yet to be made, but the first conclusions show a precarious picture of prescribing various medications without strong evidence that this has a proven effect. Better research evaluations of drugs for the management of agitation and/or aggression in ABI are required. Recommendations for future research are given

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26 – Institutional violence: towards situational management

David J. Cooke, Lorraine Johnstone & Lisa Gadon (UK)

Violence in institutions is influenced by both institutional factors and situational institutional factors. Individual factors include, for example, the presence of personality disorder, major mental illness, employment and relationship difficulties. Situational factors include, for example, staff experience, training and morale, the presence of clear management structures etc.

Developments in systematic risk management have focused on individual factors. It is argued that situational management is required in any comprehensive approach to reducing institutional violence, not least because institutional factors may be more amenable to change than certain individual factors.

Two studies will be described. First, a systematic review of the empirical literature on situational factors will be provided. Second, a qualitative analysis of interviews carried out with mental health and prison professionals will be described. Both studies provided complementary information about the importance of situational risk factors in mental health and prison settings.

Information from both studies has been used to develop a structured approach to the assessment of situational risk factors. The method the PRISM will be described.

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27 – Thinking, feeling and acting : emergency department nurses responses to violence

Frances E. Brinn (New Zealand)

Keywords: Attributions, emotions, violence, intervention, emergency nursing

Abstract

Little existing literature predicts the actions health care staff will use to manage incidents utilising theoretically derived approaches to violence. This study explored the applicability of Weiner's (1980) model of helping behaviour to 76 emergency department nurses to determine if attributions predicted the type of behaviour undertaken to reduce the violence. Key elements of Weiner's model (causal attributions, affective responses and helping behaviour) were assessed using self report questionnaires.

The sample reported high levels of exposure to verbal and physical violence from patients in the six months preceding the study (96% and 66% respectively). Limited support was found for the overall applicability of Weiner's model to this sample. However, support was demonstrated for the application of the model in the prediction of diffusion of violent incidents. It is suggested that further research may provide valuable evidence for the observed relationships between cognitions, emotions and behaviour which may be used to inform current violence management training programmes and encourage the use of diffusion techniques in the management of violent incidents.

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28 – The role of powerlessness in violence

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Summary

This presentation will discuss the role of powerlessness in violence with emphasis on adolescent behaviors and domestic violence. Powerlessness is a nursing diagnosis that deserves more attention. It is underutilized and needs more empirical research. It is a characteristic that is predominantly manifested in perpetrators and victims way before the act of violence occurs. It is the purpose of this presentation to do a literature search on powerlessness and violence, to raise the health professionals' awareness of the role of powerlessness in violence, and to discuss prevention and management strategies related to powerlessness and violence.

Keywords: Powerlessness, Violence, Adolescent Health. Domestic Violence

Objectives

To provide an extensive literature search on powerlessness and violence experienced by perpetrators as well as the victims of violence.

To provide an analysis of the role of powerlessness on current treatment modalities of clients experiencing violence.

To discuss management strategies as they relate to powerlessness and violence.

Powerlessness

Powerlessness is a major nursing diagnosis that is underutilized in the prevention

and assessment of violent clients or victims of violence in the community. Due to aggressive behaviors openly manifested by clients or patients, powerlessness is not clearly identified as one of the underlying factors that contribute to violence. Stanhope & Knollmueller (2001) wrote that feelings of powerlessness and helplessness are factors that contribute to forming gangs (p. 414). Abused children who engage in vicarious victimization feel powerless and “grow up feeling unloved and worthless” (Stanhope & Lancaster (1992, p. 417). In the descriptive correlational study (Heraldo Gacad, 2002) of powerlessness and its relationship to health-promoting behaviors, college students’ perception of powerlessness was found to be significantly and inversely predictive of their engagement in health-promoting behaviors ($p < .001$). This study classified violence according to the Center of Disease Control and Prevention’s health risk behaviors and therefore, not health-promoting but very compromising to health.

Powerlessness is theoretically defined as the state in which an individual or group perceives a lack of control over certain events or situations that affects outlook, goals, and lifestyle (NANDA Definition in Carpenito, 2001). It is considered to be a negative predictor of a health promoting lifestyle. The sense of powerlessness has been repeatedly correlated with negative health behaviors (Kaplan, 1997; Shapiro, Siegel, Scovill, & Hays, 1998).

Powerlessness is defined as a perceived lack of personal or internal control of certain events or in certain situations (Bush, 1988; Johnson, 1967; Minton, 1967). It is an expectancy or probability held by the individual that his own behavior cannot determine the occurrence of the outcomes or reinforcement he seeks (Bush, 1988; Chung & Pardeck, 1997; Seeman, 1959). It is also the perception of the individual that one’s own actions will not significantly affect an outcome (Gage, 1997; Gilbert, 1992; Miller, 1999; Phares, 1976).

Indicators of powerlessness are those signs and symptoms that lead nurses to conclude that powerlessness exists. The defining characteristics of powerlessness (Carpenito, 2001) can be major (must be present), i.e., overt or covert [anger, apathy] expressions of dissatisfaction over inability to control a situation that is negatively affecting outlook, goals, and lifestyle. It can be minor (may be present), i.e., lack of information-seeking behaviors, apathy, anxiety, anger, violent behavior, depression, unsatisfactory dependence on others, acting-out behavior, uneasiness, resignation and passivity.

The concepts or manifestations of powerlessness have both subjective and objective dimensions (Wallerstein, 1992). It is a perceived phenomenon (Seeman, 1959). Stein (1991) emphasized that the individual perception of powerlessness was the key factor in determining powerlessness. Most often, powerlessness is related to the political and economic system suggesting an environmental or social component. Powerlessness can be pathologic as well as situational which is related to personal or environmental factors. Trait powerlessness is more pervasive affecting general outlook, goals, lifestyle, and relationships (Stephenson, 1979).

With daily stressors and perceived lack of social support, a sense of powerlessness in adolescents leads to negative behavior patterns (Beyth-Marom & Fischhoff, 1997). Harlow (1986) found that feelings of meaninglessness and lack of purpose were important intervening variables in relating depression in youth with both suicidality and substance abuse. He showed that depression and associated psychic pain and self-derogation often occur first among adolescents, and are followed by a sense of meaninglessness and lack of purpose in life. This process, in turn, may lead to substance abuse or suicidality. The sense of meaninglessness usually is preceded by feelings of powerlessness (Carpenito, 2001).

Lerner (1986) emphatically states in his book that “powerlessness is bad for [one’s] health” (p.8). It causes unhappiness. People who feel powerless do not feel safe. Lerner points out that “there is no escape from the consequences of living in a society shaped by powerlessness – that even when it doesn’t show up in the more obvious ways, it shows up in the ways that we die” (p.10). This is one more manifestation of the devastating consequences of living in a society where powerlessness results in the accommodation of things that are destructive and harmful including violence in families and communities. When people feel powerless for any extended length of time, they tend to become more willing to “accept parts of the world they would otherwise reject” (Lerner, p. 8). This means that people who feel powerless tend to lower their expectations and may even engage in an activity that they would not normally adopt. They act in ways that go against their best visions of who they are and who they can and want to be.

Powerlessness also “corrupts” (Lerner, 1986, p. 2) in a very direct way. It changes, transforms, and distorts people. It makes them different from how they would otherwise want to be. They look at the world and their own behavior, and tell themselves that, although they are not living the lives they want to live, there is nothing they can do about it. They are powerless.

Lerner also claims that high and chronic levels of stress, which violence is a consequence or an aftermath, is a manifestation of powerlessness (p.18). Stress itself is increasingly accepted as an inevitable fact about our society. Society emphasizes the development and application of external power and is overly concerned with achievement, possession, domination and competition. People's lives have been so attuned to external control that when they look inward they find an "empty" sign (p. 189). They, most especially our young people, do not have the slightest notion of how to relax or how to use, let alone develop their internal resources. This lack of resources is distressing as they feel powerless against the onslaught of various stressors. As a substitute for internal power and in an effort to numb their alienation (oftentimes caused by a feeling of powerlessness), they may turn to legal and illegal substances such as alcohol, prescriptive drugs, cocaine, marijuana, caffeine, nicotine, many other mood-altering substances as well as violent behaviors.

Studies on powerlessness in the adolescent are scarce. Stein (1991) examined the relationship between the adolescent's report of life events to which he or she has been exposed within the past year, the adolescents' perception of powerlessness, and their self-esteem. The results revealed that feelings of powerlessness and an increased incidence of significant life events predicted low levels of self-esteem. Desirable and undesirable family life events, in addition to feelings of powerlessness, served as better predictors of self-esteem than powerlessness and one total life event score. Adolescents of lower socioeconomic status experienced lower levels of self-esteem and greater feelings of powerlessness than their counterparts of higher socioeconomic status. It is found that perpetrators of violence are found to have low self-esteem (Stanhope & Lancaster, 1992).

Powerlessness is a component of alienation. Calabrese and Adams ((1990) investigated differences in alienation between incarcerated and non-incarcerated adolescents with the hypothesis that incarcerated adolescents would have significantly higher levels of isolation, normlessness, powerlessness, and total alienation than would non-incarcerated adolescents. Results indicated that incarcerated adolescents had significantly higher levels of alienation. This investigation provides evidence that alienation is expressed in feelings of powerlessness and, therefore, may be a construct associated with delinquent behavior of adolescents in combination with other factors.

Powerlessness, according to Roy (1981), is the individual's perceptions

of a lack of individual or personal control over events in a given situation. Roy states that the person's perceptions of powerlessness may result from situational events and circumstances. Similarly, perceptions of loss may result in feelings of powerlessness. When eighth and tenth graders were surveyed, 34% girls and 15% boys reported being sad and hopeless; 18% girls and 9% boys felt they had nothing to look forward to in their future. Adolescents abusing drugs have often adopted the use of substances as a means of coping with feelings of boredom or emptiness (Burge, Felts, Chenier & Parrillo, 1995). Denial from both the adolescent and the health professionals contributes to lack of awareness of this problem. This finding is important for health professionals to consider because adolescents exhibit powerlessness at an earlier period of their lives and feel they have nothing to look forward to. This may also mean that they are feeling hopeless. In many of these cases, powerlessness is an antecedent (Miller, 1999) of hopelessness

People who experience powerlessness are psychologically damaged and internalize problems as their fault rather than a response to system-wide discrimination. Related concepts include (a) alienation (Calabrese & Adams, 1990; Sankey & Huon, 1999), (b) external locus of control (Bearinger & Blum, 1997), (c) oppression (Chung & Pardeck, 1997; Freire, 1970), (d) loneliness (Buchholz & Catton, 1999; Mahon, Yarcheski & Yarcheski, 1993), and (e) self-concept or self-esteem (Dishion, Capaldi & Yoerger, 1999; Gage, 1997; Howard & Jenson, 1999) or self-efficacy (Gillis, 1994; Martinelli, 1999) or self-image (Rew, Resnick, & Blum, 1997).

Powerlessness: a construct of locus of control

Powerlessness is a construct of locus of control (Stein, 1991). Stein emphasizes that the individual's perception of powerlessness is key in determining powerlessness and integral in locus of control. The concept of powerlessness can not be discussed without a discussion of its opposite – power or empowerment. Miller (1999) states that power is a resource for living that is present in all individuals.

The sense of internal power is a vital component of self-concept or self-image where one learns how to improve internal control (control feelings, thoughts, and internal abilities) thereby thinking, feeling, and behaving in an effective manner (Howard & Jenson, 1999). Many adolescents are unaware that they

have the power within that can help them in any undertaking. They tend to rely on outside sources for recognition and self-esteem (Spreitzer, 1995) instead of knowing that they already have it. They perceive the world as not supportive, and therefore, feel powerless. This is synonymous to the “societal alienation” that Sankey & Huon (1999) mentioned in their study. Powerlessness is oftentimes related to a low self-esteem or self-concept. Powerlessness is on the opposite continuum of self-efficacy. In health promotion, self-efficacy is considered to be a positive factor in influencing health-promoting behavior. Powerlessness is a negative feeling or perception and therefore is theorized as to possibly impede a health-promoting behavior. There is no empirical evidence to support this hypothesis. There is even a possibility that powerlessness in some cases may cause an individual to engage in health-promoting behavior.

Powerlessness is also closely related to loneliness in the adolescent population. Buchholz & Catton (1999) and Huff (1999) reviewed theories and research on loneliness and aloneness with adolescent perspectives. They found that adolescents were able to distinguish between the two states. Loneliness, as anticipated, was viewed negatively, being coupled with sadness and hopelessness. Prolonged powerlessness may lead to hopelessness (Carpenito, 1997). Aloneness was viewed as a neutral state. Loneliness was differentiated from depression. With loneliness, there is the hope of reacquiring the love object, whereas with depression there is an irreversible feeling of loss.

Alienation

Alienation is a construct that is significantly correlated to powerlessness. Sankey & Huon’s (1999) multi-component model of delinquency was developed to explore the interrelationships of psychosocial variables and their relationships to delinquent behavior. Alienation was tested for its ability to act as a core mediator predictor variable. A sample of 152 adolescents, 78 females and 74 males completed a battery of questionnaires designed to assess each of the variables in the proposed model. Salient pathways to delinquency were identified. They include environmental and person-centered factors. Alienation was not found to be a necessary mediating predictor variable. “Societal” alienation, on the other hand, was shown to have important explanatory power. This finding is significant because it supports the observation that society dictates people to experience powerlessness. Twemlow & Sacco (1998) described gangs offering power, which leads to social status, access to money and members of the

opposite sex, and a sense of security. Power is gained by participating in criminal activities. Alienated, bored youth may participate in violent activities to pass time. Criminal street gangs fill this void and the real feeling of powerlessness is masked.

Ugarizza & Fallon (1994) state that homelessness represents the ultimate powerlessness and oppression. Constant victimization is a reality that homeless individuals face everyday. Chung & Pardeck (1997) addressed the issue that certain conditions help create a sense of powerlessness observed in the lives of Korean American children and suggested an ecosystem intervention aimed at their empowerment. It is important to note here that powerlessness is perceived by adolescents in poverty and minority status and may contribute to their engaging in health risk behaviors including violent or aggressive acts.

Violence

It is defined as a “nonaccidental acts that result in physical or emotional injury” (Maurer & Smith, 2005). In fact, violence has become so commonplace that it is unusual to find anyone who has not been exposed to violence either by personal experience or by acquaintance with a victim. In some communities, violence is so prevalent that residents are desensitized to it. Community members feel powerless to stop it and instead concentrate on efforts to ensure safety and that of their family members (Maurer & Smith, 2005, p. 517).

According to the theories on assaultive and homicidal behavior, perpetrators can not tolerate separation. They feel powerless and cannot manage on their own. They feel abandoned, angry and depressed. Rage is behind the depression. They consider rejection as an attack on their ego.

The attachment theory explains violent acts as related to the emergence of a sense of self. As early as 18 months, the infant develops consolidation of one’s self. He or she has the ability to soothe one’s self and social bonding is most active at this time. However, the child who witness or experiences violence in the home or community will become a child who lacks protection. He or she will live with strong personal anxiety and may survive by dissociating from trauma of witnessing or experiencing abuse. The child will feel numb and powerless. The trauma and violence will inhibit a sense of connectedness to other persons and the outside world. These may be manifested in episodes of cruelty to animals, siblings,

friends, parents or grandparents. This child will acquire a lack of sensitivity to the pain of others as well as a distorted association of pain with various events.

Social isolation

Social isolation was identified as a characteristic that increases the risk for physical and sexual abuse. It leads to the feeling of shame experienced by the child. Powerlessness is evidently present in children who witness intimate partner violence or live in an abusive home environment.

Responsibility of health care professionals

The health care professionals have a responsibility to look at our domestic, national as well as global communities as they relate to powerlessness and violence. This can be done by the following: (1) Recognition and Assessment of clients in the hospital settings as well as the nearby communities we serve, (2) Education and training of health care workers in the management of violent and aggressive behaviors, and (3) Specific and comprehensive discussions will be provided during the actual presentation.

Acknowledgments

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Note: A comprehensive list of references will be available during the conference.

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Symposium (2) – Prevention of aggression and coercion on Dutch psychiatric wards

Joost Jan Stolker, H.L.I. Nijman, P.H. Zwanikken, M. Overdijk, J. Vandeninden, L.E. Goedhard, E.R. Heerdink & A.C.G. Egberts (Netherlands)

29. Are patients' views on seclusion associated with lack of privacy on the ward?
30. The 'aggression-coach program' as measure to increase safety in a forensic psychiatric hospital
31. Prevention of seclusion on an acute psychiatric care unit

29 – Are patients' views on seclusion associated with lack of privacy on the ward?

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Background

Seclusion is one of the most used strategies to cope with severe inpatient aggression. It may have deleterious physical and psychological effects on patients and staff members. Therefore, it is important to reduce the number of episodes of seclusion.

Objectives

In this study, we sought to investigate whether residing on single versus multiple bedrooms influences patients' opinions about seclusion.

Methods

We prospectively collected data over March 1999 until October 2000 from a consecutive sample of 78 secluded patients of 18 years or older. The patients were hospitalized on a 20-bed locked ward of a psychiatric hospital in the south of the Netherlands. Data included gender, age, main psychiatric diagnosis as

established by the psychiatrist of the ward and duration of seclusion. Furthermore, patients were asked to rate nine possible views of seclusion on a 5-point scale.

Results

Fifty-four patients provided informed consent. We found an average score of 3.1 on items in which positive aspects of seclusion were addressed, whereas on negative items the mean score was 2.4. This difference was significant ($p < 0.05$). We subtracted the mean score of patients on the negative items from their mean score on the positive ones, which resulted in an overall score that reflected the 'satisfaction' (or dissatisfaction) with seclusion. We found that seclusion is perceived as a less negative experience after having resided with fellow patients in a multiple bedroom prior to it ($p < 0.05$).

Conclusion

The way patients are housed prior to seclusion may have an impact on how seclusion is perceived. Aggressive behavior may be reinforced by a lack of privacy and rest on the multiple bedrooms of wards like these.

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30 – The ‘aggression-coach program’ as measure to increase safety in a forensic psychiatric hospital

M. Overdijk

Background

Aggression may lead to physical and psychological harm of patients and nurses. However, according to Morrison et al.¹, it is possible to reduce violence and injuries even in a forensic setting. Inspired by these authors, we started our ‘aggression-coach project’.

Objectives

In this study we wanted to investigate possibilities to increase safety of nurses by focussing on their skills to prevent aggression and to closely coach them after aggressive incidents.

Methods

The project was started in November 2002 at a 40 beds-forensic psychiatric hospital in the centre of the Netherlands. A nurse consultant (aggression-coach) asked all the nurses to fill in a questionnaire after dealing with an aggressive incident. After studying the questionnaire the aggression-coach discussed (traumatic) experiences with the nurses. Furthermore, we introduced aggression-management plans for all patients which made it possible for the multidisciplinary team to be alert on early aggression signs and plan interventions if needed. These plans and alternatives for coercive and restrictive measures were discussed with the patients. To monitor aggressive incidents, we started measuring aggressive incidents of six most aggressive patients with the SOAS-R, during one year as a pilot.

Results

The most important finding of our study was that nurses felt more safe and capable of finding the right mix of security with clinical treatment. In addition, we found that the number of aggressive incidents during one year decreased with 30%. The total number of days patients were secluded also decreased with 30%.

Conclusion

In our experience it is possible to make a forensic psychiatric hospital more safe with a broad spectrum of measures focussing on the prevention of aggression.

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31 – Prevention of seclusion on an acute psychiatric care unit

J. Vandeninden

Background

Compared to most other European countries in Dutch psychiatric hospitals seclusion is a frequently used measure. The general opinion in the Netherlands is that seclusion as a coercive measure to reduce aggression and violence should be avoided.

Objectives

In our hospital, we wanted to lower the number of days on which seclusion was used by 30% in a 2 year period.

Methods

On basis of a literature review, in 2003 a comprehensive program to prevent seclusion on an acute psychiatric care ward was introduced. This ward includes 17 beds. Most patients are suffering from psychotic disorders and personality disorders. We received a grant for this project which allowed us to add a nurse to the day and evening shift. The main goal was to change the view of the team: seclusion is not a solution for challenging behaviour. Individual seclusion prevention programs for high risk patients were introduced.

If patients were secluded, individual programs to leave the seclusion room as soon as possible were started and subsequently seclusion was evaluated with the patients.

The seclusion prevention program was weekly discussed with colleagues. We compared the total number of seclusion days in 2004 with the number of days in 2000-2002. We also compared duration of seclusions during these years.

Results

Compared with the years 2001 (492 days) and 2002 (595 days), in 2004 a 40-50% reduction of seclusion days was reached. The duration of seclusion was also reduced with 50%. Nurses feel more safe and have more time to coach patients, to talk with them and to discuss important themes with colleagues.

Conclusion

It is possible to significantly decrease the prevalence and duration of seclusion on acute wards. Seclusion must not be seen as a solution, but as a problem which needs a different solution.

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32 – The association between as-needed medication and aggressive incidents in psychiatric long stay patients

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Background

Aggressive behavior of patients in mental health care institutions can have serious consequences, including staff injury and high costs. In daily clinical practice several interventions, including pharmacotherapy, are used to manage aggressive behavior. Previous studies showed that not only the use of regular medication, but also the use of psychotropic pro re nata (p.r.n., or as-needed) medication is increased in aggressive patients compared to non-aggressive patients. However, these studies were retrospective and based upon hospital records without the use of validated aggression scales.

Objectives

To determine the association between the administration of oral benzodiazepines and antipsychotics, used as p.r.n. medication used as as-needed medication and aggressive incidents in psychiatric long stay patients.

Methods

Design and setting

In the period between September 2004 and May 2005 a prospective observational study was conducted in four Dutch psychiatric long-stay wards, specialized in patients with externalizing behavior disorders. All patients admitted during the nine-month study period were included. The frequency and severity of aggressive incidents was recorded by ward personnel using the validated Staff Observation Aggression Scale-Revised (SOAS-R). SOAS-R scores range from 0 (no aggression) up to 22 (extremely severe aggression). Pharmacy and hospital records of the wards were used to obtain information about patient characteristics and the administered p.r.n. medication.

Analysis

The association between aggressive incidents and the use of oral benzodiazepines and antipsychotics as p.r.n. medication was assessed using logistic regression analysis and was expressed as an odds ratio (OR). In a crossover design, the difference in administered numbers of p.r.n. medications within 48, 24, and 12 hours before an aggressive incident was compared with the difference of administered numbers of p.r.n. medications within the 48, 24, and 12 hours after an aggressive incident, using the Wilcoxon signed ranks test.

Results

The study population comprised 198 patients. In the study period, 1,074 aggressive incidents, caused by 107 patients, were recorded. The odds ratio for the use of any p.r.n. medication among patients with aggressive incidents was 2.4 (95% CI 1.3- 4.3) compared to patients without incidents. Using the Wilcoxon signed ranks test it was found that p.r.n. medication was statistically significant more frequently administered after an aggressive incident than before such an incident. Subgroup analyses indicated that the use of p.r.n. medication following an aggressive incident was increased after severe but also after mild aggressive incidents.

Conclusion

Aggressive psychiatric patients used more p.r.n. medication as compared to non-aggressive patients. In addition, p.r.n. medication is more frequently administered following an aggressive incident than before an aggressive incident. Therefore, we conclude that in the management of aggression, p.r.n. medication is predominantly used to prevent further escalation but not for the prevention of aggression. The question remains whether p.r.n. medication is effective in preventing further escalation. In a future study this question will be investigated.

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33 – Workshop (3) – Managing aggressive behaviour with psychotic patients: from practice to research

Symposium of Bert van der Werf, Ph.D.

Clinical psychologist and researcher, De Geestgronden Psychiatric Centre, Bennebroek, The Netherlands

Abstract

Aggression and violence by patients and subsequent enforced constraintive measures by nursing staff are among the main problems in clinical psychiatry, not to mention the impact of long-lasting threats. Much research has been done on either aggression and violence or on the impact on patients of the use of constraint. Less research projects have focused upon the impact of specific psychotic symptoms such as confusion, paranoia and hearing command voices and the suitability of specific nursing strategies in order to reduce these main problems. And there is hardly any research on the relationship between aggression and staff coping styles; on the impact of the dominant strategies of nursing staff on preventing and managing aggression and violent behaviour.

This is the main focus of two research projects called: From constraint to collaboration; the implementation of Early Warning Plans (EWP) and: Patients' views on aggressive incidents in clinical psychiatry.

The author's experience in these two projects is that aggression as well as the frequent coercion of constraint strongly reflect both staff and patient attitudes. Future research therefore should focus more upon the interaction between psychotic patients and staff and the mutual beliefs and attitudes of both parties.

The aim of this session is to make the delegates aware of the close relationship between aggression and the use of constraint in relation to (specific) psychotic symptoms.

First I will give an example of an aggressive incident, followed by two dominant strategies in which staff tend to manage aggression and threatening crises with psychotic patients.

Then I will discuss the contrast in opinion, in staff attitudes on what is seen as important aspects of diagnosing aggression and what nurses subsequently focus upon: exerting external control or promoting self control.

These differences in focus will be illustrated by an EWP on the one hand and a plan focussing on exerting external control on the other hand. Consequences for future research questions derived from these two projects are discussed as well as some general consequences of the relationship with specific psychotic symptoms such as paranoia and confusion.

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34 – Effectiveness of training interventions in the management of violence in health care: systematic review

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I. Needham (School of Health Sciences, Fribourg, Switzerland)

Background

Many psychiatric institutions provide training programs for their staff in order to prevent or to cope with assaults by aggressive patients. Little is known about the effectiveness of such programs.

Method

A systematic review of all published and ‘grey’ research studies on the evaluation of aggression management training programs in health care has been conducted. The studies have been reviewed for their results concerning following issues: Incidents, work absenteeism, injuries, coercive measures, knowledge, confidence, and skills.

Results

We identified 48 studies that have been published from 1976 to 2005. Most studies have been done in psychiatry/mental health, few have been conducted in other fields (e.g., intellectual disabilities, emergency care). Content of the evaluated trainings were mainly combinations of psychological de-escalation with physical techniques. Pure de-escalation interventions or physical technique-interventions were less often evaluated. Up to date only one randomised controlled trial has been done, most studies have case-control-designs and before-and-after-designs. Independent of setting and design, most studies on knowledge and confidence show that trained staff gains in knowledge about

violence and in confidence about dealing with difficult situations. Less clear is the outcome on incidents, injuries etc. Several studies find less incidents and their consequences, but several studies find no differences or even increasing numbers between control conditions or before and after trainings.

Discussion

The finding that trained staff knows more about aggression and is more confident about handling difficult situations is a worth in its own. The background of the conflicting findings on the number of incidents etc. remains obscure. One reason might be the sensitization and vigilance to aggressive incidents that is happening while staff is trained. Although the results about the number of incidents reveal no clear tendency, it is concluded that training programs for staff in health care should be provided.

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35 – Mental health nurses’ attitudes on the reasons of patient aggressions and its management: the effect of a training course

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Introduction

Increasing aggression within the health system is a growing problem for nurses, because they are the most susceptible to suffer violence. Studies about nurses’ attitudes towards the motives of patients’ aggression in psychiatric nursing care show different inner attitudes influencing nurses’ behaviour regarding patient aggression. Training programmes are one possibility to disseminate new knowledge into practise. These programmes can positively change nurses’ attitudes about prevention and intervention of patients’ aggression. However, there is a lack of controlled studies measuring their assets on attitudes and their effect on the nurses’ behaviour.

Methods

To judge the effect of the training on mental health nurses’ attitudes about the reasons for patients’ aggression and on its management, we conducted a quasi-experimental pre- and post-test study with two groups - the intervention and

the control group. The sample covered 63 nurses (intervention group $n = 29$, control group $n = 34$). The intervention was an one-week education programme about the management of patients' aggression and violence. The attitude of the participants of the training course was recorded by the German version of the Management of Aggression and Violence Attitude Scale developed by Duxbury (2002).

Results

The results show that nurses' attitudes about the reasons for patient aggression are underpinned by three models. Internal inherent characteristics of the patients, external reasons focusing on environmental factors and situational-interactional sources referring to the overall context in which aggressive incidents occur, including staff-patient interaction. The adherence to external reasons of patient aggression was the strongest one. Remarkable is that at post-test, there were no significant attitude changes triggered by the intervention to be shown .

Conclusion

Different explanations are discussed regarding the lack of effect of the training programme on nurses' attitudes. The training programme is possibly not strong enough to have an effect, the attitudes of the respondents may be too stabile to be affected by the training. It is also possible that the stable attitudes are attributable to professional socialisation. Moreover, it remains questionable to what extent a single instrument of measurement can record attitude changes.

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36 – Locating training within a comprehensive organizational strategy to manage aggression & violence in health and social care

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Relevant Conference Themes:

- Organisational and environmental measures for reducing / managing workplace related violent and aggressive inpatient behaviour
- Policies, Guidelines and Standards with regard to the management of violent and aggressive inpatient behaviour
- Education and training of health care workers in the management of violent and aggressive inpatient behaviour

Abstract

Work related violence is a serious problem within healthcare that diminishes the quality of working life for staff, compromises organisational effectiveness and ultimately impacts negatively on the provision of services. Extensive international reports from professional literature and regulatory agencies have identified the magnitude of the problem, and have concluded that all healthcare staffs may be affected irrespective of work location, occupation, or department.

Recognition of this indisputable risk places professional, statutory, and moral imperatives upon employers to provide staff with safe and effective training in the management of work-related violence. While evidence suggests that training reduces risks to staff, improves their clinical effectiveness, and results in cost savings from reduced injuries and related expenses, efforts to provide training are seriously hindered by the absence of research evidence or clear guidelines as to what constitutes safe, effective, and acceptable practice. This absence of

evidence and guidelines, has been identified by professional and regulatory bodies internationally, to be a matter of concern that requires urgent attention.

Furthermore, while the provision of training to staff diminishes this risk, the erroneous assumption that training alone can address this issue is now increasingly acknowledged. The effective management of violence, requires that training be embedded within an integrated organisational matrix that adequately and equally acknowledges the concerns and meets the needs of all stakeholders including

- clinical practitioners,
- health and safety departments,
- organisational risk management agents and be compliant with
- corporate policy.

This paper will present the Matrix of Training Effectiveness (MoTE), an organizational structure which has been developed to integrate training in the management of aggression and violence into a shared vision of organizational effectiveness and excellence in practice and care.

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37 – Post traumatic stress disorder: clinical features and treatment for women sexually abused as children

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Abstract

Women who are survivors of childhood sexual abuse (CSA) have higher rates of Post Traumatic Stress Disorder (PTSD) in adulthood than any other trauma survivors. Often these women are also categorized as being severely and persistently mentally ill (SPMI) because of their severe dysfunction. Usually medications and supportive services are the preferred therapies offered, within mental health agencies, denying the need for dealing with past trauma issues.

Few research studies have related to the effectiveness of group therapy with women who have a core issue of CSA, especially when the women are labeled SPMI. The goal of this research study was to evaluate the outcomes of cognitive behavioral group therapy for adult survivors of CSA who were labeled SPMI. The research instruments used were: 1) demographic and negative coping history, 2) the Beck Depression Inventory (BDI), 3) the Symptoms Checklist 90 – Revised, 4) the Rosenberg Self-Esteem Scale (RSI), and 5) the Childhood Incest Questionnaire (CIQ). Measurement intervals included the initial group session and the final group session (50 weeks).

A quasi-experimental design was used for this study. The control group (n = 65) was composed of women with a CSA history who did not have a label of SPMI. The study group (n = 56) was also composed of women with a CSA history who did have a label of SPMI.

Results of the study indicated that the percentage of those in each study group who completed the year-long group were exactly the same (64%). Initial scores on the testing instruments indicated greater pathology in those women labeled SPMI. Final scores, at the completion of group therapy, indicated that abused women who were labeled SPMI improved in self-esteem and decreased symptom scores at the same rate as the abused women who were not labeled SPMI. It was also found that both groups achieved significant improvement on all outcome

variables. Based on two-sample t-tests there were no significant differences in demographic variables, abuse history, and negative coping patterns between the two groups.

Non-SPMI women improved on the BDI scale, as their mean score decreased from 21.4 to 14.4 (from moderate to mild depression). The scores for SPMI-labeled women decreased from 30.9 to 23.8 (from severe to moderate depression). For the SCL-90-R, non-SPMI subjects showed improvement by decreasing from a mean score of 1.9 to 1.06 during the year. Women labeled SPMI decreased symptom means from 2.0 to 1.69. For the CIQ, SPMI subjects decreased from a mean score of 3.05 to a mean of 2.59, and non-SPMI subjects moved from 2.57 to 2.13. The non-SPMI subjects improved on the RSE scale from a mean score of 2.78 to a mean of 3.66. The SPMI subjects moved from a mean score of 1.70 to 2.55. Both groups had significant scoring decreases in the PTSD scales of the CIQ and the SCL 90-R.

The study suggested then, that women who are labeled severely and persistently ill and are diagnosed with PTSD resulting from CSA can benefit from time-limited, cognitive-behavioral group therapy.

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38 – Inpatient trauma study – an examination of the aftermath of untoward incidents in mental health inpatient settings

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Abstract

Restraint is frequently used as an intervention to manage violence and aggression; however the application of restraint differs worldwide. For example, mechanical restraints are used in America whereas physical hands on approaches are used within the UK. There is a growing body of qualitative literature which considers the effects of antecedents and the escalation of violent and aggressive situations. These studies are beginning to inform and shape training programmes in the management of violence and aggression, particularly in the prevention of incidents which may require restraint. Despite these improvements, it is unlikely that violence will be eliminated and restraint is likely to continue to be used for a small proportion of incidents which involve aggression and violence. While understanding related to managing antecedents continues to develop, there is a lack of clarity as to the management of the aftermath of restraint in mental health settings both within the UK and internationally.

There is a paucity of published studies related to this aspect of management of violence and an urgent need to consider this aspect of mental health care further, particularly in relation to the traumatic effects of restraint. Some US studies indicate that up to 40% of inpatients meet criteria for PTSD although few of these patients have case note diagnoses (Meuser et al 1998; McFarlane et al 2001). These studies have far reaching implications in relation to inpatient care in general as well as the more discrete area of restraint. A number of complex factors may exist in relation to restraint and PTSD in mental health settings. The effects of restraint may compound existing PTSD in this group; the effects of

restraint on undiagnosed PTSD patients are unknown; there is the potential that PTSD may develop as a result of the experience of restraint. There are no current published studies which examine these complex factors.

Bonner et al's (2002) pilot study examined both staff and patients' experiences of untoward incidents involving restraint, using a semi-structured questionnaire to elicit what each group found both helpful and unhelpful in the management of these incidents. The results highlighted that untoward incidents generated strong and disturbing emotional reactions for patients and staff, particularly in the aftermath of the event. The study established a possible connection between experiences of restraint and the reawakening of previous exposure to traumatic encounters. Aspects of post incident support were identified as being helpful although not implemented routinely or formally.

This presentation aims to share the development of a wider study, built upon Bonner et al's (2002) earlier pilot study. The current study is being undertaken within an NHS Trust in the UK and will examine further the aftermath of restraint and the traumatic impact, if any, of the incident. The study will evaluate a post incident consultation which will be used following untoward incidents involving restraint in mental health care in-patient settings. The consultation is a review of the incident which includes considering antecedents, factors related to the event itself, as well as management of the aftermath of the incident. Follow up interviews of the staff and patients involved in the post incident consultations aim to establish a more comprehensive understanding of the links between restraint and the reawakening of previous traumatic encounters, as well as screening for potential early indicators for PTSD within the study group.

The aim of the presentation is to share work in progress in relation to the Congress theme of post incident responses after violent and aggressive inpatient behaviour: coping with trauma. Preliminary results of some aspects of the study will be presented.

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39 – The lasting effects of domestic homicide

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Background

The effect on children of the murder of a parent by the other parent, uxoricide, is immediate and devastating. Usually in a single act the child loses both parents. The victim is dead and the other parent is either also dead as in the case of homicide/suicide, a fugitive, or in the custody of the police. Although seemingly rare, the authors will present evidence indicating the incidence of uxoricide is similar to childhood leukemia. If one assumes that the lives of children of uxoricide are disrupted nearly as much as those with cancer, the extent of the problem is obvious. Yet any comparison of the attention given these two groups of vulnerable children by researchers demonstrates a significant disparity.

Specific Object of Study

The purpose of this study is to add to the understanding of the experience of uxoricide from the perspective of an adult who had this experience as a child.

Method

Data were collected with two interviews from 47 informants. Interviews were transcribed and analyzed using hermeneutic phenomenology.

Findings

The themes that have emerged include violence prior to the homicides, substance abuse, experiences of intimate partner abuse in later personal relationships, a surprising lack of anger regarding the perpetrator, the homicide or their later life circumstances and a beginning description of paths to recovery. The participants struggled with ways to make sense of the event that changed their childhoods. They relied on religion, a strong sense of family and family continuity, and a belief that alcoholics and mentally ill people are not responsible for what they do. In general these adult survivors have an in-depth thoughtful perspective as the result of living through this trauma and their subsequent childhood, that sometimes continued to be traumatic.

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40 – Seminar (2) – The American Psychiatric Nurses Association seclusion and restraint standards: a platform for creating safety for patients and staff

Lynn Clark DeLacy, PhD(c) , RN, CNAA & Marlene Nadler-Moodie, MS, APRN, BC (American Psychiatric Nurses Association)

Summary

This seminar is proposed to describe the process used by an American Psychiatric Nurses Association task force that integrated diverse thinking into a single set of documents articulating a position paper and standards of practice on seclusion and restraint use. These documents will be reviewed in detail. Since the presenters have reduced seclusion and restraint use in their own clinical settings, examples of successful use of the standards while serving persons with violent and aggressive behavior will also be discussed.

Abstract

Background

Following reports of deaths occurring in seclusion and restraints, regulatory changes were enacted to limit the use of these measures. Intended to improve patient safety, the changes also unleashed fear and resistance among mental health treatment providers facing growing potential for violence.

In response, the American Psychiatric Nurses Association (APNA) established a task force charged to produce a position statement on seclusion and restraint as well as professional standards of practice to guide the profession through a period of significant change.

Project and Method

At the association's annual meeting in Toronto, Canada in 1999, a panel informed APNA membership about emerging regulatory changes and heard their perspectives prior to task force work. Emotional testimonies about violence in inpatient settings emphasized the challenges the Seclusion and Restraint Task Force would face. Fifteen individuals, from varied geographic regions and practice settings, were selected for the task force. Task force members included staff nurses, administrators, advanced practice nurses, and university faculty from public, private, forensic, and academic settings. This diversity brought breadth of thinking and experience to embrace the complex issues surrounding the limitation and safe use of seclusion and restraint. The diversity also challenged the group to find common ground to address issues that seemed to have incompatible values and priorities.

Results

The task force produced a position statement and standards that have been subsequently used to reduce or eliminate seclusion and restraint use without increasing patient and staff injuries. The position statement articulated eight principles that provided the foundation for Standards of Practice that addressed both performance and care. Standards of Professional Performance were developed for leadership, staff training and performance improvement. Standards of Care addressed collaborative work with clients and families, as well as treatment plans and interventions to minimize seclusion and restraint use. Recognizing the responsibility for safety when seclusion or restraint are used, the standards described requirements to initiate seclusion or restraint as well as to monitor and assess clients' readiness for release. Debriefings and documentation requirements were included. The standards provide a basis for dialogue and action around the full range of issues that health care organizations must address in order to safely limit and safely use seclusion or restraint.

At the annual association meeting following the promulgation of the position statement and standards, and at each annual meeting since, interactive sessions involving up to 200 nurses reflected that psychiatric-mental health nurses across the United States continue to provide creative leadership for a wave of change in the management of patients at risk for or during violent or aggressive events. The enthusiastic testimonies of success, and the willingness to engage

in productive, professional dialogue about remaining challenges, fuel a cycle of confidence in our collective learning. The standards provided psychiatric mental health nurses with a platform on which they could stand individually and collectively to call for and create the required administrative and clinical structure and process changes necessary to support patient and staff safety with minimal seclusion and restraint.

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41 – A typology of early vs late starters among French Canadians with major mental disorder

Mathieu Cynthia M.Ps.

Côté Gilles Ph.D. (Canada)

Abstract

A number of studies have assessed the level of violence of individuals suffering from major mental disorder. Some researchers have found that within the population suffering from such disorders, there is a higher risk of committing violent crimes than in the general population. Literature demonstrates that offenders suffering from major mental disorder do not represent a homogeneous population on a variety of different characteristics. Recent research has shown that there are two groups of mentally disordered persons: early starter (early onset of behavioural problems) and late starters (behaviour problems that started during adulthood).

The present study was designed to achieve a better understanding of the differences between persons suffering from major mental disorder who are early versus late starters. The sample was recruited within the province of Quebec, Canada. It is composed of 137 men who have received a diagnosis of major mental disorder (bipolar disorder, major depression, schizo-affective disorder, schizophrenia, schizophreniform disorder, delirious disorder, non-specified psychotic disorder).

Participants were recruited and separated in three distinct status following legal criteria. Participants in the first group were convicted and incarcerated. In the second group, participants have been found non criminally responsible on account of mental disorder. Individuals in the third group were involuntary inpatients found dangerous for themselves or other. Participants came from four administrative regions of Quebec.

Results indicate that there are interesting and important differences between early and late starters. The prediction of early versus late starters group differences on etiological variables was explained mainly by the fact that participants who

were early starters were more likely to have a brother or sister who were abusing drugs and family member who was incarcerated than late starters. As far as symptomatology, it seems that the group differentiation was explained by the fact that early starters scored higher at impulsivity and substance abuse scales. Early starters were less educated than the late starters. The two groups also differed on antisocial behaviour, early starters had perpetrated more violence and more severe forms of violence than late starters. These findings have implications for future treatment programs, prevention and risk assessment for persons with major mental disorders.

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42 – Schizophrenia and crime: a relationship in doubt

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A relationship exists between mental disorder and offending behaviours but the nature and extend of the association remains in doubt.

Aim

To present a critical review of the present knowledge about the relationship between schizophrenia and crime and highlight the difficulties that arise from the confounding factors that are present in the study of violent behaviour.

Method

Literature review studies from the MEDLINE with special mention will be made on national surveys that attempted to clarify this relationship.

Results

Based on a computerised search of the literature on schizophrenia and crime, studies in this area can be divided in three main categories. 1) Studies of offending behaviour among schizophrenic patients. 2)Studies of the prevalence of psychotic disorder amongst offenders. 3) Epidemiological community based studies (including national surveys)

Conclusions

Schizophrenic disorder although closely associated with the violent crime in the public perception has only a weak association as far as the scientific research can prove. The most common “risk” factors (age, sex, concomittant drug or alcohol use) are very similar to the risk factors for violence in the general population. This association is strengthened with the presence of comorbid antisocial personality disorder.

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43 – Violent crime and substance abuse: a medico-legal comparison between deceased users of anabolic androgenic steroids and abusers of illicit drugs

Fia Klötz, A. Petersson, D. Isacson & I. Thiblin (Sweden)

Abstract

Several case reports and survey studies have indicated that abuse of anabolic androgenic steroids (AAS) often leads to increased aggression and feelings of hostility that occasionally may trigger violent behaviour. However, there are also observations indicating that many users of AAS also are involved in abuse of alcohol and/or various illegal substances. Since substance abuse is a well known risk factor for violent behaviour, one may suspect that the observed violence among AAS users might in many cases have been confounded by drug abuse. In the present study, the criminal history, in terms of incidence of registered offences, of deceased users of AAS with and without signs on abuse of other illegal substances, and the criminal history of deceased users of illicit substances but not AAS were compared, trying to further elucidate this possible association between AAS use and violence.

The risk of being convicted for a crime against property was significantly higher among deceased substance abuse-positive AAS-negative males than in either of the AAS-positive substance abuse-negative or the AAS-positive substance abuse-positive groups (RR 20.866 resp 8.516), whereas the risk of being convicted for a crime of violence was at least as high in the two AAS-positive groups as in the AAS-negative group.

In conclusion the findings of the present study indicate that a positive test for AAS in connection with autopsy could be regarded as an indicator of possible previous violent criminality at the same rate as a positive test for one or more illicit substance(s), but that the cause as well as the type of violence might differ between these two groups. This observation also suggests that the observed violent criminality among AAS users is not systematically confounded by abuse of other drugs.

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44 – Seminar (3) – The EQUIP Program

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Summary

The Equip-program, or ‘EQUIP’, is an evidence based multi-component group treatment program for antisocial youngsters with behaviour problems. This presentation contains a very clear explanation of EQUIP, the theoretical background of the EQUIP, a short video demonstration and also a short life demonstration. The similarities and differences between EQUIP and A.R.T. (Goldstein, 1998) will be discussed, especially the differences in the mutual help meetings and in the more cognitive basis of the aggression management part by focusing on the correcting of the Thinking Errors of the youngsters.

Introduction

Several cognitive behavioral interventions for aggressive and delinquent youth have been developed. EQUIP is one of them. But first we want to look at some theory.

Why does one adolescent become aggressive while others do not? Social cognitive processes can explain aggressive and delinquent behavior in adolescents. Currently one of the most influential approaches to the study of social cognitive processes and aggression is the Social Information Processing theory (SIP, Crick & Dodge, 1994; Lemerise & Arsenio, 2004). Besides social information processing there is a lot of theory about moral development, the so called ‘domain model’ of moral development. Despite the fact of a historical

split in the two major fields within developmental psychology that focus on this topic, namely research on children's aggression and research on children's moral development, we think that these approaches can be integrated: "Many acts of aggression are clear moral transgressions, and, in turn, many moral transgressions involve either physical or verbal aggression." (Lemerise & Arsenio, 2004).

In this seminar we will present the integration of SIP and moral domain models (Lemerise & Arsenio, 2004), because in EQUIP the intervention is also focused on both aggression and on moral development. It is our opinion that this is one of the major strengths of EQUIP.

EQUIP is multicomponential primarily in the sense that it integrates two basic approaches to treating antisocial behavior: the mutual help approach and the skills training approach. The skills curriculum is in itself also multicomponential by focusing on the subjects of moral judgment development, anger management and social skills training. This 'helping skills' curriculum of EQUIP is partly based on the Aggression Replacement Training (ART, Goldstein & Glick, 1987; Goldstein, 1998). The similarities and differences between EQUIP and A.R.T. will be discussed. We could see the EQUIP program also as some kind of step further than ART. To quote John Gibbs from his "new perspectives on Aggression replacement training" (page 69): 'You should definitely consider using EQUIP if you are implementing ART in a long-term residential facility where you have an opportunity to develop an effective culture of caring –as Arnie (Goldstein et al., 1988) put it, "to capture a major portion of the youth's environment and turn it in a pro-social direction" (p. 203)'.

F.C. Teylingereind chose for the 'Equip' program because of its vision. Communication is the most important thing in Teylingereind, the cork on which this institution is floating.

'Respect is the basis of our communication'. Respect for every particular individual, client or employee. In a justice institution in most of the cases you can see a regression in moral development. Scientific research showed that it is possible with specific programs to enhance the moral development of the adolescents. The EQUIP Program is one of these programs.

An institution with a stimulating moral climate is – according to Kohlberg- an institution characterized by a strong feeling for community and a fair decision making. (A fair decision is a decision through arguments, that does justice to someone –or a group of persons- after fair unbiased weighting out the rights

and arguments of all people involved). In such a community there is also time for a discussion about the norms and moral considerations based upon the equivalence of every individual. EQUIP wants to stimulate this discussion and certainly also the moral development.

In the Teylingereind situation the EQUIP-sessions are done 3 to 5 times a week (depending on the schedule and the group). Of course there are in the daily routine, besides the EQUIP sessions, enough possibilities to refer to and to translate that what is learned into practice.

The EQUIP program and the different aspects of it

The first step in EQUIP is to learn the youngsters in some Mutual Help Meetings the Thinking errors and the Problem names. This is very important, because the Thinking errors and Problems names are used in all the EQUIP sessions. In this mutual help meetings the clients learn that they are making these thinking errors and that, because they are making these thinking errors they do things they should not do. The Thinking errors are:

1. Self centered (main thinking error)
2. Minimizing/Mislabeling
3. Assuming the worst
4. Blaming others.

When advancing in EQUIP the clients learn that they can think differently and that by thinking differently they also can act differently. For instance: when you get pushed by someone they learn not to think: 'I have to defend myself' (which is the thinking error 'assuming the worst') but instead: 'I am not going to die when someone pushes me'. This last form of thinking can prevent you from getting into fights.

The EQUIP method says that you get problems by making one or more of these thinking errors. These problems are subsequently classified as 1 of the 12 problem names as defined by the method:

1. Low self image
2. Inconsiderate of Self
3. Inconsiderate of others
4. Authority Problem
5. Easily Angered
6. Aggravates others

7. Misleads Others
8. Easily Misled
9. Alcohol or Drug Problem
10. Stealing
11. Lying,
12. Fronting.

When the youngsters know that their problems can be classified this way we can work towards changing them. After this first step, the mutual help meetings are supplemented with the training skills program. But still the mutual help meetings should also be continued. After this first step, the EQUIP program continues with the next meetings:

1. The mutual help meetings

In this mutual help meetings the emphasis is on group members' helping potential. The clients can bring in their problems and talk about it. The mutual help meetings are an important part of the Equip program. Already in the mutual help meetings the youngsters can, besides helping each other, correct their thinking errors. During the 'helping skills' curriculum the mutual help meetings will also continue.

2. Training the 10 most important social skills

The ten most useful social skills for these 'criminal' youngsters are also shortly explained by the steps they are divided into.

Expressing a Complaint Constructively Think ahead, make a constructive suggestion.

Caring for someone Who is Sad or Upset Think ahead, start a conversation.

Dealing Constructively with Negative Peer Pressure Think, 'Why?' Think ahead etc.

Keeping Out of Fights Stop and think. Think ahead to consequences. Handle it.

Helping Others Think, 'is there a need?' Think ahead how to help, when, etc.

Preparing for a Stressful Conversation: Imagine ahead the other's person's feelings.

Dealing Constructively with Someone Angry at You Listen openly and patiently.

Expressing Care and Appreciation Think is the person would like to know you care.

Dealing Constructively with Someone Accusing You of Something Think of how.

Responding Constructively to Failure. Decide, plan to try again.

These are the ten social skills (from the Goldstein list of 50 social skills) from which these youngsters with conduct disorders are profiting the most.

The youngsters learn to do these social skills in different (3, 4 or 5) steps. For instance when the social skill is expressing a complaint constructively:

1. Identify the problem
2. Think ahead what you'll say
3. Express your complaint
4. Make a constructive suggestion.

3. Moral education by social decision making

The goal of these meetings is to train the youngsters in making a grown-up, moral fair group decision. By doing so the members help each other in their moral development, following the theory of Kohlberg, that through good, positively directed discussions youngsters can take a step forward in their moral development. They do so by talking about different problem situations. This talking starts by answering questions about the different problem situations. This discussion about moral dilemma's will, like Kohlberg stated, lead to higher stages of moral development following the idea's of six stages of moral development according to Kohlberg here quoted by Robert N. Barger: (Sometimes there are stated 7 stages as Kohlberg himself also did earlier by describing a stage 0: the infant is egoistic)

Level	Stage	Social orientation
Preconventional	1	Obedience and Punishment
	2	Individualism/Instrumentalism
Conventional	3	'Good boy/girl'/mutual respect
	4	Law and order/rules of society
Postconventional	5	Social Contract
	6	Principled Conscience

Most of the boys in Teylingereind are measured to be somewhere in between stage 1 and 2, but there are exceptions, and the boys in a peer group who are at a higher level can indeed stimulate the 'moral reasoning' of the other boys.

For instance:

Alonzo is walking along a side street with his friend Rodney. Rodney stops in front of a beautiful new sports car. Rodney looks inside and then says excitedly, "Look! The keys are still in this thing! Let's see what it can do! Come on, let's go!"

What should Alonzo say or do?

Should Alonzo try to persuade Rodney not to steal the car?
Should persuade/ should let steal/ can't decide (circle one)

What if Rodney says to Alonzo the keys were left in the car, that anyone that careless deserves to get ripped off? Then should Alonzo try to persuade Rodney not to steal the car?

Should persuade/ should let steal/ can't decide (circle one) Etc.

The youngsters should answer these questions for themselves and then talk about why they answer differently, if they answer differently. The experience with the EQUIP Program in America is that the clients in the EQUIP-group often in majority, at least most of the times, give the right answers. When in this example 4 out of 6 say that Alonzo should convince Rodney not to steal the car then this is the base to have a discussion. With an example like this it is easy to see that the clients will correct each other, because the majority has the right idea. As an EQUIP-trainer you are there to lead the discussion the way the majority can convince the minority. Of course the youngsters sometimes do not think in majority right, so then the minority has to convince the majority (with your support as a trainer).

In this discussion it is not only the answer the clients give, but the argumentation is maybe even more (following Kohlberg) important! Sometimes a client can give an unfair answer for an understandable and sometimes moral very high level reason. In an EQUIP-situation where the family is poor and the son deals drugs to give the family a better income one of the youths in an EQUIP-group can say for instance:

‘It is not that bad he is dealing because his family depends on his money, he is giving them a living’. Or when choosing for a ‘bad planet’ to go to as a ‘man from Mars’ a youngster can say: ‘I want to make a better society of this planet and turn it into a good planet, that is why I will choose the bad planet’.

Given these kinds of arguments the clients can have a discussion where you'll find most of the time that the majority of the group can convince the minority with good arguments. (Or again: the rightful minority can convince the majority.) The idea is also that once back in the society the clients are strong enough to withstand peer pressure and keep their just opinion. The goal of the meetings to make a just social decision is to make this decision as unanimously as possible.

4. Anger management and correcting thinking errors

More mature development of moral judgment will only reduce aggressive or antisocial behavior in actual social situations if certain other problems of the youngsters are also addressed in treatment. In this seminar we will also

give special attention to the theoretical background and practice of this anger management sessions. And we will watch some video. This part from EQUIP is different from ART.

Beck (1999) was right to characterize self-centeredness (the key problem of the reactive offender) as “the eye (‘I’) of the storm” of anger in antisocial behavior.

The interventions in EQUIP are focused on the cognitive deficiencies (lack of self-control and inner speech) and the cognitive distortions (the thinking errors). In these sessions the youngsters learn the role and use of verbal thoughts in mediating actions and making constructive social behavior. Skills for remediating cognitive deficiencies should reduce arousal and buy time that is needed if constructive social skills are to be used. Skills for remediating cognitive distortions should tap the positive potential of antisocial adolescents.

Anger management consists of ten steps during ten different meetings of which here are given in some very short forms:

Evaluating anger/aggression: re-evaluating, anger management (not eliminating anger.)

Anatomy of anger (AMBC) Self talk (mind) as a source of anger. Early warning signs.

Monitoring/correcting thinking errors Gary’s Thinking Errors exercise. Daily logs.

More anger reducers Deep breathing, backward counting, peaceful imagery.

Thinking ahead to consequences. TOP (Think of the Other Person)

Using ‘I’ statements for constructive consequences ‘

Self-evaluation Self-evaluation, self-reflection. Talking back to thinking errors.

Reversing things you do that make other people angry.

Self as victimizer: you are sometimes a victim, mostly a victimizer

Victimizer and grand review: chose a just life

This 10 sessions are designed to remediate deficiencies and distortions in both reactive and proactive aggression. Session 1 through 7 address anger and aggression in response to provocation from others (reactive aggression), and session 8 through 10 address anger and aggression initiated against others (proactive aggression).

Research about the effectiveness of EQUIP

EQUIP turned out to be, according to some scientific studies (Leeman e.a. 1993; Nas, 2005), a very effective treatment for these 'antisocial' groups of youngsters. The promotional study of drs. C. Nas in cooperation with the university of Utrecht, the Netherlands, will be presented. Dr. C. Nas did her scientific promotion research in the FC Teylingereind to tell us more of the effectiveness of the EQUIP Program. (C. Nas, 2005) She found out that indeed there was a change: youths who followed the Equip meetings made significantly less thinking errors after the EQUIP meetings than a comparable group of youngsters who did not follow the EQUIP Program. The same was true for their opinion about criminal behavior. Youngsters who followed the EQUIP Program thought afterwards significantly more negative about criminality.

Conclusion

So we can conclude that these are very encouraging results and that we should continue to support the EQUIP Program and the scientific research for its effects.

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Internet:

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For more information about the Equip Program:

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45 – Acceptable and compounded risk in working with assaultive patients: strategies for risk management

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Keywords: clinical violence in psychiatry, psychiatric nursing, clinical crisis management, assault risk management in psychiatry, clinical risk assessment

Abstract

Over past decades, patient neglect and abuse in clinical psychiatric settings at the hands of improperly trained professionals, unethical caregivers, and archaic systems has been well documented in scholarly literature, popular literature, and even depicted in cinema. Gratefully, such documentation has given birth to widespread reform in patients rights and legal avenues to exercise such rights, rigorous personnel selection and training, institutional standardization and accreditation, and extensive renovation in policies, procedures, and therapeutic modalities. Due to past decades of such documentation, however, when patient assault against mental health nurses and psychiatric staff is now more recently brought to light as a current occupational health hazard, it unfortunately necessitates in the minds of many an uncomfortable paradigm shift which views patients in the role of perpetrator instead of the more traditional role of victim. The result has been underscoring the problem of psychiatric staff being assaulted, blaming staff for assaultive patient behavior, and subsequent underreporting by staff of such incidents. The paradigm shift, however, of patients moving from victims to perpetrators in the context of clinical violence is erroneous and unwarranted.

In today's highly scrutinized, post-standardized contemporary clinical psychiatric setting, the real perpetrator of clinical violence is neither patient nor staff member. The real perpetrator and enemy is psychopathology which leaves in its wake victims of clinical violence who are both patients and staff. The goal is to address psychopathology clinically and administratively in such a way as to promote the mutual benefit and safety of both psychiatric patients

and caregivers. After all, mental health nurses and psychiatric staff who are in a state of ongoing worry about their own safety are reported as not being able effectively to attend to the health, safety, and general well being of their patients.

One of the two purposes of this paper is to explore and distinguish two critical phenomena described by mental health nurses working with assaultive psychiatric patients. Mental health nurse participants in a previous phenomenological study conducted by this author, poignantly shed light on acceptable risk of assault (inherent in the nature of the work) and compounded risk of assault (created extraneously to the nature of the work). Both phenomena are faced by nurses and staff on a continual basis in the clinical psychiatric setting. The other purpose of this paper is critically to examine strategies aimed at minimizing the risk of assault that is inherent in acceptable risk, and correctively addressing the risk of assault that is created in compounded risk.

Introduction

Mental health nurses and psychiatric staff find themselves in a position where the risk of injury from assault has become an occupational health hazard. It is reported to be even more hazardous than commonly thought of dangerous occupations such as mining, lumber, and construction work (Love and Hunter, 1996). Again, the goal in clinical psychiatry is not to color patients in the light of perpetrators, but critically to examine the phenomenon and to address psychopathology in such a way as to promote the mutual benefit and safety of both psychiatric patients and caregivers.

Acceptable Risk

Lanza (1996) corroborates that injury to mental health nurses in psychiatric settings due to assault carries a greater risk than many occupations. This is consonant with an earlier assertion by Lusk (1992) concerning nursing injury rates from patient assault actually surpassing the injury rates for highly dangerous occupations. Only in the past decade has injury from patient assault been framed as an occupational problem to mental health nursing staff (Dubin and Lion, 1992; Lanza, 1996; Lipscomb and Love, 1992, Love and Hunter, 1996; Lusk, 1992). Carlsson, Dahlberg, and Drew (2000) identify assault in the clinical environment as an ongoing problem. "Nurses are physically assaulted,

threatened, and verbally abused more often than other professionals” (Carlsson, Dahlberg, and Drew, 2000, p.533). Mental health nurses acknowledge (cognition) and accept (volition) the dangerous nature of the job and the inherent risk involved in it despite clinical skill sets and administrative safeguards (Schultz, 2002).

“That’s my job. I am to put myself physically and direct in harm’s way in order to prevent other people from being hurt. And if I’m hurt in the process of it, that’s part of my job”(participant) (Schultz, 2002, p.141).

“But I figure it kind of goes with the job to a degree...if a staff gets hurt, it kind of falls in with the territory of working in that kind of environment”(participant) (Schultz, 2002, p.142).

Compounded Risk

Even though mental health nurses do acknowledge and accept the inherent risk involved in the very nature of the work, they also identify risk of assault that is sometimes created extraneously to the nature of the work by willful neglect or indifference of administration. Such nurses express an awareness of what is right in trying to protect patients and themselves, but are frustrated and indignant by their inability to do so when that inability is created by a mental health administration placing them in unreasonably dangerous situations (Schultz, 2002). Such unreasonably dangerous situations include but are not limited to overcrowding of units especially with high acuity, cutting of staffing numbers, overburdening existing staff, failure to provide adequate training opportunities, and a greater concern with overall clinical statistics than case by case therapeutics.

“I saw the potential for someone really getting hurt...That should never happen...So, I mean... I told her (administrator) this was going to happen. She didn’t seem to really care”(participant) (Schultz, 2002, p.174).

“I just felt set up...Basically they need you here to run this unit, but you’re expendable enough – you can afford to get hit...No real action was taken until after the attack and after I pressed charges”(participant) (Schultz, 2002, p.174).

“In essence, no one is accountable or responsible, and I’m not talking about

patients...When doctors or nurses hurt their clientele by neglect or not caring, we are held accountable and responsible. When mental health administration hurts their clientele – their internal customers – their staff by neglect or not caring, who’s accountable?”(participant) (Schultz, 2002, p.175).

Strategic Risk Management and Implications

The importance of differentiating acceptable risk of assault and compounded risk of assault is that it enables mental health nurses far more astutely to discriminate and address risk in a way other than simplistically attributing it all to either luck or administrative negligence, and being able to do nothing about either. To discriminate is the first step in addressing types of risk properly in either minimizing them or alleviating them. Concerning acceptable risk of assault, even the most skillful practitioner may be assaulted.

“The most clinically skilled nurse was pummeled”(participant) (Schultz, 2002, p.154).

Even though the risk of assault always exists no matter what is employed, developing a skill set in therapeutic engagement allows mental health nurses and staff to have the tools to work always toward the best possible outcome while at least being prepared for the occasionally inevitable worst possible outcome. Remaining unskilled in an attitude that it does not matter anyway, creates compounded risk in the sense that a risk of assault is now present that has no business being there. Being skillful in therapeutic engagement involves empathic listening, recognition of paraverbal communication, understanding of proxemics of personal space and kinesics of body language, and overall cue visibility in being alert to behavioral escalation (Crisis Prevention institute, 1987).

Being alert to diagnostic history, particularly a history of violence, is also strategic in assault risk management from a predictive point of view. This can be a double-edged sword, however, since it can be used to stereotype patients and disengage from them. Fisher (1995) points to the ethical dilemma of distancing vs. therapeutic engagement. Providing nursing care carrying with it the risk of injury to the caregiver is a frequently experienced ethical issue for mental health nurses (Grace, Fry, and Schultz, 2003). Furthermore, inversely, a lack of a history of violence can lull caregivers into letting down their guard. A patient’s history of violence has to begin somewhere. It can begin with the unsuspecting

caregiver. As Tanke and Yesavage (1985) report, a large number of assaultive patients do not even give cues, so it is critical in risk management always to be a practitioner of vigilance.

Teamwork is an operationally pivotal element of assault risk management. Mental health nurses describe balancing the duty to do good/avoid harm to the patient with the duty to do good/avoid harm to the self by therapeutically engaging patients, but with greater safeguards for the self in the process – safeguards that only trusting teamwork could provide (Schultz, 2002). Phrases such as “staff presence,” “staff back-up,” “peer protection,” “show of force,” “strength in numbers,” “knowing where your help is,” “a group acting as one,” “open door procedures,” “non-isolative practices,” “same page teaming” are all lifted up as the standard.

Concerning compounded risk of assault, as stated, compounded risk needs not to be created only by administration. It can be created by reckless and uninformed practice. After all, compounded risk of assault is any created risk extraneous to the nature of the work which should not be present. Ongoing staff education looms large in assault risk management. In regard to mental health nursing administration, administrative analysis of compounded risk is very important, especially when staffing cuts affect the operational element of teamwork on units with high acuity. Workplaces are required to develop accountability concerning workplace related violence (White, 1996). Administrative measures to alleviate compounded risk are important to the mutual benefit and safety of both psychiatric patients and caregivers.

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46 – Involuntary commitment – a qualitative study of the interaction between the nurse and the threatening and violent patient

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Summary

This study investigates the interaction of the nurse and the threatening and violent psychiatric patient. The investigation is based on the fundamental belief that this interaction influences the possible later use of restraint. The study problem is approached by investigating a critical act i.e. the admission of involuntary hospitalized psychiatric patients. The interaction is investigated and described through the use of qualitative interviews and passive (non-participant) observation of the nurse and her working environment. The study findings compile the strategies used by the nurse in her practical reality. The strategies include preparation, protection, and introduction strategies as well as management and environment strategies.

Keywords: Nursing strategies, violent patients, restraint, nurse-patient interaction.

Introduction

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 (CPT 2002). This report creates an image problem for Danish nurses. Judgements like this emphasises the need for research into the interacting of the nurse and the violent patient

No empirical evidence exists regarding the management of violent situations without the use of coercion (restraint). Restraint is a well known technique

required, when managing violence and threats, and clinicians feels that this is the only choice albeit of a poor selection (Berring).

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 tell others about what kind of strategies they are using.

In order to reduce the use of restraint and develop alternative deescalating strategies, it is a priority for nurses working in the health care settings to articulate the strategies for managing violence without the use of coercion.

Prediction of violence has been shown repeatedly to be a clinical difficult task, and the accuracy of such predictions has usually been deemed poor. The prediction of violence is often a team effort (Morrison 1993 a) and the decisions are often made after input from professionals with a variety of differing perspectives.

The influence of the nurse on the occurrence of violence and the later use of restraint is noticeable absent from the literature. Morrison (Harris D. & Morrison, Morrison 1990, 1992a, 1992b, 1993a, 1993b) suggests that there is a connection between the nurse's education and the kind of deescalating technique she is using. Often researchers connect the behaviour of the nurse with the behaviour of the patient e.g. qualitative studies shows that violence is a common response to a non-emphatic limit setting style (Lancee et al, Lowe et al).

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.

Thereby the research problem is: "How is the interaction between the nurse and the violent and threatening patient?"

The study problem was investigated through a critical act i.e. the admission of involuntary hospitalized psychiatric patients. This act is especially critical because coercion is a strong predictor for violence (Morrison 1992). The admission is explored before, during and after the admission, and the focus is on the nurse and the environment.

Material and methods

An inductive study was conducted to explore the interaction between the nurse and the patient. The interaction was investigated and described through the use of qualitative interviews and passive (non-participant) observation of the nurse and her working environment. Data were analyzed using the grounded theory

approach. The outcome of the analyses is a theory based in the empirical reality of the nurse in the field (Bunch 1983).

The study and the setting

The setting for the study was a forensic psychiatric unit located at a university hospital in the capital of Denmark. The unit has 10 beds and admits patients with all kind of psychiatric diagnosis. The average of involuntarily admitted patient is 10 %. Only patients who posed a significant risk to themselves or others were confined to the locked ward. Data collection took place over a two-month period.

After the admission the nurse were interviewed. The author followed a specially designed schedule with questions that made it easy for the participant to tell about the situation, and remember similar situations. Field notes were written and interviews were tape-recorded.

Sampling was purposive; the informant was chosen if she was responsible for the admittance (n 4). The informants were from 27 to 58 years of age, male and female, all RNs and all had psychiatric nursing experience between two and twenty years.

The data were analyzed using the grounded theory approach (Bunch, Glaser) using open coding, where simple concepts were identified. The coding was then compared and a complete list of concepts produced. Concepts sharing similarities at a more abstract level were combined to form categories, which then were given suitable names. The categories were grouped to provide core themes. Two expert nurses validated the data.

Result

The study findings compile the strategies used by the nurse in her practical reality. The strategies consist of: preparation, protection, and introduction strategies and management and environment strategies.

Table 1 give an overall picture of the interaction between the violent and threatening patient and the nurse and the environments.

Themes	Categories	Codes
The Act	Preparation strategy	Practical and mental preparation, surroundings, the admission, placing, risk taking
	Protection strategy	Securing, manifestation, searching
	Introduction strategy	Confidence, comfort, relationship, cooperating
The Scene	Management strategy	Management responsibility, structure and organisation
	Environments strategy	Ward atmosphere, coping, milieu therapy

Table 1: The themes, categories and codes of the nurse strategies

Table 2 give a detail picture of the nursing strategies

Themes	Categories	Codes
The Acts	Nursing strategies	Passive: Waiting, listening, containing, observing, and slipping of. Active: Prediction, preventing, informing, interpreting, deflecting, guiding, protecting, correcting, medicating, restraining.

Table 2: The detailed codes of the nursing strategies

A qualitative study is only an initial exploration of a topic area, and this study is an analysis of only one unit and four admissions. In spite of this limitation this study findings indicate that the nurse in the act of admission at this unit, as a whole does not provoke violent behaviour in the patient. The admission seems appropriate and deserves recognition. Her preparation is scares; the protection strategies contain controlling actions, but the introduction part of the strategies compensate. However, a patient declared free of risk during the admission is afterwards left on his own and at the mercy of the environment without equivalent caring support. The environment is dominated by difficult and threatening working conditions. Insufficient staffing, unpredictable working hours, and a threatening environment strain the nurse. The management accepts this strain wordlessly. Known by the management the nurse prioritises administrative tasks over individual and planned nursing of the patients. The nurses do not realise the lack of involvement of the management, and therefore cannot change the situation. The nurses comply with

and expect the difficult working conditions, and therefore the strain is invisible to the public. But the patients are witnesses to the conditions and therefore are double strained. They face the problems of the nurses as well as their own.

Conclusion and recommends

In the act of admission as a whole the nurse is using strategies, which seem to calm down the patient. Prepare, keeping safety, and introducing as a hole does not provoke violent behaviour in the patient. These strategies combined with the nursing strategies accurately outline the events in the interacting with the violent and threatening patient.

This study shows that the nurse is able to manage violence in the interaction without the use of coercion (at least in the first encounter). The nurse is using personal strategies to calm down the patient, but it is uncommon for her to communicate these strategies verbally.

Prediction of violence is a clinical difficult task, this study shows that the nurse is using her physical senses when she is judging the risk; but she hasn't the vocabulary to describe her deescalating techniques.

When the patient is declared free of risk he is left on his own and at the mercy of the environment. The environment is dominated by difficult and threatening working conditions: insufficient staffing, unpredictable working hours, and a threatening environment that strain the nurse also. After the first encounter the patient is left alone. Known by the management the nurse prioritises administrative tasks over individual and planned nursing of the patients.

This study's compilation of the strategies gives an initial nursing vocabulary to explain the large efforts actually performed in the nursing of the violent patient. Thereby the role of the nurse in the caring for violent patient can be explained to the public, and the image of the nurse improved. But the working conditions are mistreating the nurses, and the management allow the nurses to prioritise administrative task over individual and planned nursing.

Psychiatric nurses are challenged to update their practice and search for new solutions to this serious problem, but the solution requires a leadership that can develop a vision for managing violence without the use of restraint.

The strategies identified in this study must be integrated in educating programs, nurses in psychiatric units have to be taught them and the strategies have to be integrated in to clinical practice.

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47 – The interface between legal interventions and the therapeutic relationship in responses to violence in mental health services

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Abstract

Factors relevant to an analysis of this interface include:

1. The parameters of the therapeutic contract
2. The role of capacity assessments in formulating a proportionate response to aggressive and abusive behaviour
3. The development of a formalised approach for reporting crime, engaging with police investigations and prosecutions
4. The hospital's role in supporting individuals who are the victims of crime
5. The withdrawal of services in extremis

Therapeutic, social and legal duties

A provider of mental health services owes a duty of care to its service users to ensure that they are treated to an appropriate standard. However, it also has a duty to provide a safe environment for its staff, service users and visitors. At times, the conduct of individual service users compromises the safety of staff, service users and visitors. In many cases it will be possible to manage an individual's behaviour through the use by skilled staff of proper de-escalation or intervention techniques. However, there will be occasions where an individual's conduct cannot be managed in a safe way because of the individual's propensity to disregard the rules governing acceptable behaviour. Sometimes service users will, through their actions, be guilty of criminal offences characterised by physical and non-physical violence.

When considering measures to deal with violent and/or aggressive service users, the provider must act within a legal framework. It must also measure

its response against the circumstances of particular cases. Policies and procedures should outline the range of options available for managing violence and aggression which can be applied on an operational basis at differing levels depending upon the severity of the behaviour in question and taking risk factors into consideration.

Remedial action

A range of actions are available when dealing with violent or aggressive behaviour. Some of these are administrative - i.e. verbal warnings, Acknowledgment of Responsibility Agreements and the withdrawal of treatment - which are all decisions exercisable by the provider in respect of ongoing treatment. The others require the intervention of the Police or the Courts. The administrative remedies should be seen in terms of a tariff of escalating responses. All illustrate the existence of an interface between therapy and the threat of law.

The Effect of Mental Disorder and the Role of Capacity Assessments

In principle, the mere existence of a mental disorder does not prevent any of the actions set out above from being taken to deal with the conduct of an individual service user. However, where the service user lacks mental capacity to understand his actions or the consequences of those actions, then the available remedies will be more limited.

Where the service user's culpability for his actions is negated by a lack of capacity it would not be appropriate to deny all treatment. However, this does not remove alternative legal remedies.

Conclusion

The law can be a useful tool for dealing with violence in a clinical setting, but it should be used wisely and proportionately if it is to enable effective treatment and provide adequate protection.

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48 – Aggression from the inside: a qualitative study to discover nurses' experiences regarding patient aggression in psychiatric inpatient settings

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Summary

Patient aggression towards nursing staff is a prominent problem in psychiatric settings. Little research has been conducted on nurses lived experiences of patient violence. This qualitative study endeavoured to discover nurses' lived experience regarding patient violence in in-patient settings and to discover their explicit and implicit knowledge on the management patient aggression. Six psychiatric nurses participated and a tentative dynamic model was developed from the data. The main categories are: Explaining the act of violence, living in tension, defining and tolerating different types of violence, experiencing and managing emotions and feelings, and mobilising resources in the situation.

Keywords: Violence, in-patient psychiatry, nurses, qualitative research

Introduction

This research work was instigated by the Northern Centre of Psychiatry in the Swiss Canton of Vaud due to the occurrence of in-patient violence in the care centres and was conducted in collaboration with the University of Applied Sciences in Lausanne and Fribourg, Switzerland. In spite of nurses having been trained in the management of patient violence nursing personnel is still faced with difficulties in handling the problem. The responsible psychiatrist for the Canton of Vaud, Dr.

Quinche, remarked on the problem: “Many courses have been administered and there are numerous protocols on patient violence in psychiatry. However, every time violent incidents occur emotional reactions are important and one has the impression that such reactions are being studied for the first time”.

Rationale of the study

Many studies on the management of violence point to the necessity of ameliorating its prevention, of developing nurses’ communicative competence, and of methods of de-escalation. However, little attention has been placed on nurses’ conception of violence and their relevant knowledge. Furthermore, most studies in psychiatric institutions have been conducted utilising quantitative methods with the focus on the issue of violence, physical consequences, and the reactions of personnel [1-4]. By contrast, this qualitative research project endeavours to discover the dynamics between different elements of the phenomenon (conceptions, knowledge, emotions, attitudes, reactions etc.).

Research question and methodology

The aims of this study were to discover the:

- conceptions of nurses regarding patient violence,
- emotions experienced by nurses and their management of these emotions,
- attitudes of nurses viz a viz patient aggression,
- theoretical knowledge of nurses regarding the management of patient violence, practice of nurses regarding patient violence, their means of handling such situations, nurses’ comprehension of violent situations, and the phenomenon of violence between nurses and the nursed in psychiatric in-patient settings utilising a phenomenological approach. Six semi-structured interviews were conducted with nurses working on acute psychiatric wards where violence is a common occurrence. In the interviews the nurses were requested to report in detail an incident of violence they had experienced. The interviews were transcribed ad-verbatim and analysed using the method of employing the system of categorisation according to Paillé and Mucchielli [5]. The data analysis led to a tentative dynamic model which is to be tested in the second phase of the study. It was assumed that the results of this study may have an influence on the education of nurses regarding the management of violence.

³In : Courrier du m_decin vaudois, m_decine et violence, oct. 2003, p.9

Categorisation

The analysis of 400 narrative entities in the six in-depth interviews led to the emergence of 34 codes and five categories.

Explaining the act of violence

The nurses reported in a spontaneous manner the reasons for the emergence of the vio-lent incident. Very often they sought to justify the act of violence. The principal reasons are the following – in the order of importance:

- The attitude of the nurse, her/his position, her/his intrusion in the intimate zone of the patient.
- Psycho-pathology as a reason for the patient's violence.
- Frustration and emotionnaly disturbed behaviour
- Symptoms of delusion or hallucination.
- Symptoms of anxiety or fear.

Living in tension

Nurses experience numerous types of contradictions or tensions in situations where vio-lence occurs. Here are the main findings on this theme:

- Tension and the lack of agreement between the patient's expectations and the therapeutic regime e.g. involuntary referral to hospital or seclusion is the most predominant source reported by the nurses. If the nurses are not convinced of the value therapeutic regimen this may lead to considerable tension.
- Violence as a paradoxically unacceptable but an indispensable situation part of the *conditio humana*.
- Tensions related to divergent opinions relating to the therapeutic regimen especially between physicians and nurses.
- Other tensions such as the role of the nurse vs their own violent feelings towards patients or between nursing knowledge, techniques, or security protocols which are difficult to apply.

Defining and tolerating different types of violence

This category relates to the interviewees' comprehension of violence and their views on the tolerability of such events.

Defining violence: The interviewees define violence as a physical (e.g. hitting), verbal (e.g. insult, threat), or as a behavioural (e.g. contempt, passivity) event. Nurses were asked whether they perceived some types of violence as more severe or as more tolerable than others. The following results emerged

- The type of violence is greatly influences nurses' tolerance. Great variation exists with some nurses perceiving physical violence as the most severe whilst others regard verbal violence as the most severe form. Probably nurses' individual experiences may account for such differences. Non-white nurses for example may experience racist remarks as the most difficult to tolerate.
- The origin of the act of violence plays an important part in the perception of nurses. If violence occurs as a result of illness it seems more tolerable. Often the first impulse of nurses after being subjected to a violent situation is to try to discover any possible the meaning of the act in order to establish its tolerability. We found no evidence for any ty-pology of the severity of violence in the eyes of the nurses.
- The object of the act of violence also influences its tolerability. Violence directed towards objects is the most tolerable form and the least tolerable type is violence towards the patients family, and the patient her or himself is deemed as very difficult to tolerate. However, when nurses are the object of violence this seems more tolerable: "Nurses are there when violence occurs, and although we are not used to it, we can extract the message it is trying to transmit".

Experiencing and managing emotions and feelings

For the purpose of this study feelings are defined as the "combination of physical sensa-tions, of gesticulations, and of cultural meanings learned in the process of social rela-tions" [c.f. 6, p. 132] and comprise of entities such as hate or love. Emotions are re-sponses to current, past, or future real or imagined events which emanate from a spe-cific cause [c.f. 6, p. 132].

- Nurses' emotions on dealing with violence are fear and consequently anger and sadness.
- Nurses' feelings are humiliation, culpability, denigration, frustration, powerlessness, inse-curity, and sometimes hatred.

Interestingly, the nurses did not spontaneously report on their emotions and feelings but only after prompting. However, when they started to talk of their emotions and feelings it was as though the "door of the sluice" had opened for they spoke extensively and poignantly on this theme. Emotions and feelings affect nurses for a long period with some interviewees reporting on encounters

of violence which happened a long time ago.

We discovered the following – partially contradictory - strategies of nurses' to manage their emotions:

- Banalisation: Nurses acted as if the violence had never happened – “I just carried on”, “I forgot... after a couple of minutes, it didn't exist any more”
- Verbalisation: Most nurses needed to talk about the incident with colleagues, physicians, patients or during supervision.
- Reflection: Pondering on the incident is related to the category “explaining the act of violence”.

Mobilising resources in the situation

During data analysis we looked for resources – knowledge, attitudes, or capacities at the disposition of the nurses – for managing violence.

β Internal resources: Three types of internal resources were identified: tacit experiential knowledge (the most prominent), explicit knowledge (less prominent) and physical capabilities (marginal).

- External resources: The nursing team is perceived as a potential institutional resource: “One is never alone in such situations”. Physicians and nursing management are part of this structure and the police is also mentioned as a civil resource.
- The lack of resources: Numerous nurses reported not being able to manage certain violent incidents and referred to their lack of resources without being able to pinpoint exactly what was lacking. Other nurses remarked on inadequate framework, or on the lack of physical or staffing resources.

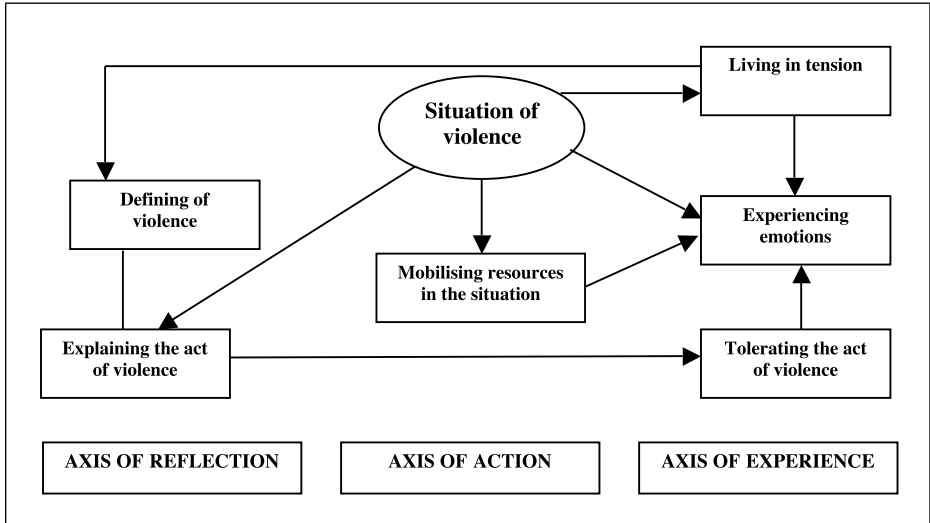
Interestingly reports on physical resources were almost inexistent. Not a sole nurse described physical competencies or techniques to handle the situation. When reporting on violent incidents nurses seem more preoccupied with fleeing or with survival.

Towards a tentative model of experiencing violence

A dynamic model of nurses' experience in handling violence comprising of the axis of reflection (the definition of violence and the explanation of the genesis of the violent act), the axis of lived experience (emotions and feelings and resulting tension and tolerating the act of violence), and the axis of action (mobilising resources in the situation and the management of emotions).

Figure 1 demonstrates the interrelationship between the various elements of the lived experience of violence.

Figure 1: A tentative dynamic model of nurses' lived experience of violence



Discussion

The aim of this preliminary study was to discover how nurses experience the phenomenon of patient violence in in-patient settings and to discover their explicit and implicit knowledge on the management patient aggression. We found that nurses were very eager to explain violent acts and that they had great difficulties expressing their implicit experiential knowledge. Only after prompting did the participants report their emotions on handling violent situations.

Nurses' feelings and emotions – such as fear, anger, sadness, or culpability are corroborated by other studies [e.g. 4, 7]. Interestingly nurses only reported on the physical management of violence in a marginal manner. This may point to the nurses' preoccupation with the emotional aspects of their lived experiences of violence or with the "basic" necessity of survival. In the emerging tentative dynamic model various interactions between the elements are postulated. For example on the axis of reflection nurses definitions of violence may help to explain the violent act. Explanation then becomes a function of tolerating the violence. However, these dynamics must be validated data emanating from

further interviews. In spite of the small number of interviewees a large amount of variability arose which points to the complexity of the theme.

Conclusion

In educating nurses to handle patient violence we conclude that more emphasis should be placed on equipping them to express their implicit and experiential knowledge and on the emotional impact in dealing with patient violence. Furthermore physical aspects of managing violence should be addressed.

Limitations

Certain limitations apply to the present study. Because of the small number of inter-viewees we could not reach data saturation. Also, the analysis has not yet been presented to the interviewees to test validation (especially the dynamic model of experiencing violence). Because it is not clear if our findings are transferable to psychiatric nurses in other regions the results should be treated with caution. Finally, a further study is planned with a greater number of participants in order to validate our preliminary findings.

Acknowledgements

We thank the nurses who participated in this study and who gave their approval to utilise their experiences.

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49 – The process of response of mental health nurses to the experience of assaults by patients: a qualitative study using grounded theory methods.

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Abstract

This paper will discuss a research project conducted in a mental health service in regional New South Wales, Australia, as a part of PhD studies. The researcher firstly engaged in non-participant observation of nurses at work in several in-patient units and then prospectively interviewed 16 nurses about their experiences in recovering from assaults by patients. Data were analysed using grounded theory methods. Interim results show that nurses were routinely engaged in ‘responding to others in an ad hoc manner’ in mental health care settings and were less inclined towards planned nursing care. It is proposed that this passivity extends to the way in which nurses respond to the experience of patient assault in that they tend to downplay and even ignore their personal needs, despite personal hardship, whilst engaging less with their patients.

Keywords: assault, nurses, responses, qualitative research, grounded theory

Introduction

The problem of violence in health care settings has become significant in the past two decades and as a consequence there has been much research activity, including studies concerned with the responses of nurses to the experience of being assaulted by patients. This latter phenomenon has been studied previously in mental health contexts but there are gaps in the information about how mental health nurses respond when they are assaulted by their patients. In particular, the researcher wondered about the source and nature of the anger and emotional distress reported by assaulted nurses (Lanza, 1983; Poster & Ryan 1989;

Needham, et al 2004) as well as the relevance of the victim's work environment in shaping their responses post-assault. The researcher was also interested in whether the employment of post-assault coping strategies such as avoidance and denial (Wykes & Whittington, 1991) created difficulties for nurses with respect to their ability to engage therapeutically with their patients. In response to the above the researcher designed a study in which there was a prospective examination of the responses of mental health nurses to the experience of patient-initiated assault using mixed methods but primarily employing a grounded theory method.

Research questions

The researcher commenced this study with two research questions. In keeping with the grounded theory method, the initial questions were broad but sufficiently focused to permit enquiry (Strauss and Corbin, 1998 p. 40):

- i. What is the process of response of mental health nurses to 2assaults by patients? and*
- ii. What is the effect of a recent (patient-initiated) assault upon the ability of the mental health nurse to engage therapeutically with her/his patients?*

Contexts and procedures

The research project was conducted in two main phases within the inpatient units of a mental health service located in regional New South Wales, Australia. During phase one (December 2002 to March 2003) the researcher observed nurses at work for twelve hours in each of three participating inpatient units and recorded their activities using field notes and sociograms.

²For the purposes of this study patient assault was defined as:

- i. any interaction between a nurse and a patient that results in a staff member feeling personally threatened and distressed (e.g. where the nurse is verbally threatened) OR
- ii. any interaction between a nurse and a patient where there is unwanted physical contact and the nurse sustains an injury (such as where the nurse is injured following a physical attack or during a restraint procedure) or where there is an exchange of body fluid (e.g. where the nurse is spat upon).

During phase two of the project (July 2003 to August 2004), sixteen volunteer nurses were interviewed within three weeks of their assault by a patient using: the Assault Response Questionnaire (ARQ) which measures a range

of responses (such as anger and anxiety) on a five-point scale from ‘none’ to ‘slight’ through to ‘severe’ (Poster & Ryan, 1989); the Perceived Stress Scale (PSS) (Cohen, Kamarck and Mermelstein, 1983); and a demographic data form (interview one). Follow-up interviews were also conducted with this sample of nurses at three months (interview two) and six months (interview three) post-assault. Interviews two and three were broadly scripted to explore the following dimensions: working conditions; the nurse’s ongoing responses to assault; changes in response over time; moderating factors which might affect coping; individual coping strategies; & relationships with patients and colleagues. Questions were posed broadly: “Tell me, how you have been coping since your assault?” and “Have you experienced any difficulties in the way in which you relate to patients since the assault?” In accordance with the method the researcher refined the schedule of interview questions, during the research project, according to the increased sensitivity gained as data collection progressed.

Procedures and data analysis using a grounded theory approach

Data were analysed as they were collected using the grounded theory approach outlined by Strauss and Corbin (1998) in which the raw data were ‘broken up’ via a process known as open coding and then placed into interim level one categories on the basis of shared characteristics. The data were then ‘reassembled’ during processes known as axial coding and selective coding with the aim of constructing categories with greater levels of abstraction and, hence, greater capacity to explain variation within the data. These activities were facilitated by the basic processes of memo writing, questioning the data and making theoretical comparisons with the dual aims of facilitating categorisation of the data and verification of the procedures. Interviews progressed until it became clear that there was saturation, the point at which there is redundancy in the development of categories according to their properties and dimensions. Ultimately the goal of this approach is to use deductive as well as inductive processes in order to create a sub-stantive theory, grounded in the specific data, which has the power to explain what is going on for the particular environment.

Findings during phase one of the project (see Figure 1) revealed that nurses’ activities were directed towards the core process of responding to others in an ad hoc manner. Accordingly the individual nurse was engaged with her/his

patients on a priority basis depending upon the level of crisis in the unit at any given time. Under ordinary conditions nurses balanced house-keeping activities with tasks associated with everyday caring for patients and therapeutic nursing (i.e. planned nursing interventions based upon nursing assessment). Extremes of disorganised, ‘entitled’ patient behaviour, abuse by patients and frank violence often plunged the unit from a state where the nurses could maintain order into a state of chaos. Under these chaotic conditions the nurses were consumed with the task of defusing crises which was characterised by nurses: catering for contingencies as they arose; solving related housekeeping problems; and engaging in everyday caring as a response to the imperative to calm and placate. Chaos also occurred when large numbers of doctors and allied health entered the nurses’ station to conduct business hence disrupting nursing activities or making demands upon resources. Sometimes, chaos was anticipated and ‘nipped in the bud’. Generally speaking, however, the main feature of responding to others in an ad hoc manner was that nurses were simply reacting to situations rather than engaging in the process of planning patient care on the basis of adequate nursing assessment.

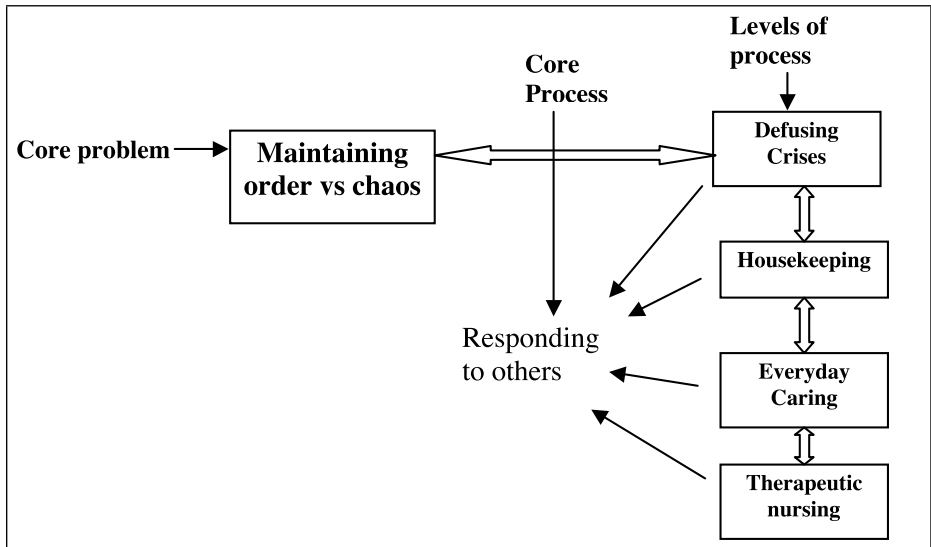


Figure: 1: Representation of nursing levels of process in relation to the core process Responding to others in an ad hoc manner

Excerpt from field notes (Feb. 2003): ‘Terry’ -hits the windows on the nurses’ station repeatedly; pushes other patients; abuses nurses on-and-off for 4 hours

in close cycles of escalation: “I’m gunna smash your face in ... If I meet you on the outside I’m gunna kill you and your trash family” .

The staff lock themselves in the nurses’ station for a time before venturing out to placate this patient.

Data analysis from phase two of the project is ongoing. Thus far the researcher has analysed the data from interviews one and two but analysis of the data from interview three is in progress at the time of writing. Of the sixteen nurses interviewed for phase two of the project, eleven were males and five were females. Ages ranged from 26 to 55 years of age and eleven of the nurses were aged between 45 and 55 years. Nursing experience ranged from one year to 25 years and, whilst one nurse reported experiencing his first assault, ten of the nurses reported 50 or more previous assaults during their careers. The most common form of assault reported for this study was a single punch although three nurses reported that they had been verbally threatened. One nurse reported a broken thumb whilst another experienced a broken tooth but the remainder of the nurses suffered no serious physical injury. Five of the nurses reported experiencing a severe level of threat during their assault whilst six reported experiencing a moderate level of threat and five reported experiencing a mild or negligible level of threat.

Initial responses to the experience of being assaulted by a patient, as recorded on the ARQ, ranged from one nurse who had reported just one ‘mild’ response (anger) to another nurse who had reported three ‘severe’ responses, five at a ‘fairly intense level’, nine at a ‘moderate’ level and ten at a ‘mild’ level. As a general statement, however, responses tended to be reported mostly at ‘mild’ and ‘moderate’ levels with most participants recording at least one response in the ‘fairly intense’ or ‘severe’ categories. Responses typically included feelings of anger, anxiety and disbelief that the assault had occurred. The main purpose of using the initial questionnaires was to provide baseline data and to establish a common ‘language’ that might facilitate the description of feelings during the latter interviews.

During the second interview at three months post-assault one nurse reported that he “was over it” after just one hour post-assault despite reporting a moderate level of threat experienced during the assault. Five of the nurses reported that they took two-to-three weeks to recover whilst two nurses reported taking a longer time (seven and eight weeks respectively). Another three nurses were able to identify that they had ongoing responses and two of this group were contemplating a change of employment. Many of the nurses commented that they only thought about their assault when they were interviewed by the researcher. Of the fourteen

participants who initially reported that they had recovered from the effects of their assault and had subsequently “moved on”, however, nine participants later recalled experiencing ongoing responses ranging from anger and frustration to assault-related dreams and re-experiencing the event. Significantly, the most common coping strategies apart from talking it over with colleagues included: not thinking about the assault; minimising the effects of the assault (“it wasn’t as bad as it could have been”); avoidance and denial; being philosophical (“it could have been anyone”); engaging in ‘gallows humour’ with colleagues; and distancing from patients. These nurses also reported changed relationships with their patients viz: being wary of patients; decreased ability to engage with patients; generalising (“all patients are as bad as one another”) and a compromised ability to provide optimal patient care. In addition to the above the nurses also reported a sense of futility associated with their perceptions that; patients were being inadequately medicated; medical staff were not listening to the nursing staff; and that nursing administration staff (i.e. those not located in the immediate health care environment) were ignoring them.

Analysis of the second interview data resulted in the emergence of several level one categories including: Responses post-assault (emotional, social, etc); Perception of recovery; Coping strategies; Futility; and Coping mediators. Higher levels of abstraction lead to subsequent categories: Minimising/having feelings minimised, and Churning. As part of the development of a substantive theory, the following preliminary relational statements have been constructed to explain what is happening:

1. When mental health nurses are assaulted by their patients they may experience a range of emotional, social and cognitive responses. As a consequence these nurses tend to engage in ‘passive’ coping strategies such as ignoring and minimising their responses to alleviate distress. Responses and coping strategies may also be enhanced or diminished by a range of coping mediators such as the perception of interaction with others (e.g. whether support is offered from nursing administration) and the perception of patient factors (e.g. whether there is the belief that the patient intended to attack them).
2. Minimising/ having feelings minimised describes the main process by which the nurses deal with their distress intra-personally as well as their perception of how they are dealt with by people outside their immediate peer group. Whilst close colleagues are perceived as providing support, the assaulted nurse believes that he/she is ignored by nursing administration as well as medical and allied staff.
3. Nurses appear to have a general optimism about the outcome of their assault and tend to return to work without taking time off to recover. However many

are surprised to find that they are not over it. This group of nurses tend to develop ongoing anxiety related to: a sense of futility about their jobs; and assault reminders which occur with exposure to assault-related places or events, re-experiencing the assault via intrusive thoughts, and/or assault-related dreams. The ongoing anxiety related to futility and assault reminders appears to have a cyclical pattern referred to here as churning and yet affected nurses continue to apply little in the way of problem-solving or active coping mechanisms to alleviate distress.

Discussion

The author will discuss the findings of this study in relation to previous research including more recent qualitative studies (e.g. Chambers, 1998; Hislop & Melby, 2003). In particular the nurses' responses to assault will be discussed in relation to their practice and occupational health and safety needs. In addition it is hypothesised that the nurses' apparent passivity in the workplace and their less than assertive coping strategies may be adaptive strategies given the highly volatile environment in which they work.

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50 – Violence and mental health in Northern Ireland: exploring effectiveness of therapeutic services

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In the past most psychiatrists and psychologists argued that people affected by community violence in Northern Ireland (locally known as the “Troubles”) generally reacted with astonishing resilience to the continuing violence. It was not until the beginning of the Peace Process in the mid 1990’s, more specifically the Good Friday Agreement in 1998, that substantial attention was paid to developing interventions and researching the actual impact of the Troubles on the people of Northern Ireland. In addition, previous evidence of significant long-term effects and psychological suffering due to the conflict was confirmed. Many voluntary groups were formed to help people affected by sectarian violence by offering a wide range of therapeutic services. However, little is known about the effectiveness of the services offered by these groups.

This paper describes **PAVE (People Affected by ViolencE)**, an on-going research project that explores the availability, capacity, and effectiveness of services for people affected by violence in Northern Ireland. It comprises two main phases. In phase one, a survey of therapeutic services that are available to those affected by the Troubles in Northern Ireland is reported. 49 voluntary groups were included in the study.

This paper focuses in phase two of the project, which involves an in-depth exploration of the effectiveness of these services in regard to achieving their set aims/goals. Some of the groups are contacted and meetings are held to negotiate practicalities of application of the assessment tool, number of participants, etc. Utilising single-system, time series research methodology, the individual measurement protocol for each participant includes General Health Questionnaire (GHQ), Beck Depression Index (BDI) and Posttraumatic Stress Diagnostic Scale (PDS) as pre-treatment measures, intra-treatment

measures, and post-treatment measures. Data collection is ongoing and this paper reports on the initial analysis of results.

Measuring the effectiveness of therapeutic services offered to people is increasingly being adopted as a practice to offer the most effective treatment bearing in mind the individual differences. Conclusions drawn from the research reported here can and will inform future strategy, policy, and practice in Northern Ireland and further afield. Practice and policy implications will be addressed.

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51 – Recording situational vulnerability as precursors of inpatient aggression: an introduction to the REFA

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Introduction

This paper reports on the basis and clinical application of the Report Form for Aggressive Episodes (REFA). The REFA was originally developed to cope better with the issues of obtaining precise operational definition of aggression, of including situational variables, and of reducing rates of underreporting.

The purpose of the present paper is to present the:

- theoretical base
- design
- psychometric properties, and
- clinical application of the REFA.

Theoretical base

The interactional approach of REFA explicitly focuses on detailed situational analyses of aggression and dangerousness. Aggression is understood as a personality characteristic manifesting itself as a function of the triggering qualities of each situation or interaction. Situation is defined as the actual situation is perceived, interpreted and assigned meaning. It is proposed that detailed reports of patients' situational vulnerability may prove useful in the diagnosis and treatment of aggression and dangerousness. Situational vulnerability is defined as increased probability of behaving aggressively towards others given certain classes of interactions.

Design

REFA is a behavioural rating scale which measures the actual aggressive behaviour and its situational determinant(s) according to a list of 30 potential precipitants to aggression, grouped in seven main categories. The REFA is based on generally accepted definitions of aggression as they are found in the literature. There are six vertical sections for the recording of characteristics of aggressive episodes: one for verbal threats, one for physical threats and four sections for physical assaults.

Psychometric properties

Studies of measures of validity and inter-rater reliability indicate that the psychometric properties of the instrument are very good. Findings from these studies will be presented in some detail.

Clinical application

There are three clinical domains where this instrument has proven to be of clinical worth: (1) To develop specific coping strategies in relation to individual vulnerability situations, (2) To form a base for individually adopted security routines for each patient, and (3) To inform the risk assessment process in general, and in particular the rating of the R2 and R5 items in the HCR-20. To conclude a brief case illustration is presented.

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52 – Testing a new tool: the management of aggression and violence attitude scale (MAVAS)

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Background

Studies that explore the views of service users about the causes and management of aggression and violence are still relatively scarce. Those that have been conducted largely focus upon specific interventions such as seclusion and/or restraint as opposed to more holistic approaches. Furthermore, the use of structured questionnaires targeting the attitudes of this population is rare.

Object of project

In order to address this deficit and elicit the views of users in mental health settings about a variety of factors pertaining to aggression, the Management of Aggression and Violence Attitude Scale (MAVAS) was developed. The piloting, implementation and testing of MAVAS will be discussed.

Method

MAVAS is a visual analogue scale comprising 27 statements that pertain to the causes of aggression and violence and its management. This scale can be administered to both staff and patients alike allowing comparisons to be made. Using a small sample of nursing staff (n=16) and patients (n=20) MAVAS was administered and later re-administered and responses analysed using t tests and factor analysis. Comments on the use of the scale were also collated.

Results

Results revealed that MAVAS is quick and easy to use and therefore likely to attract a high response rate. A test-retest demonstrated a strong degree of reliability achieving a correlation co-efficient of 0.89. Factor analysis was used to examine validity and four factors were clearly evident, three of which highlighted recognised models of causation (internal, external and situational/ interactional) and a final factor that reflected management approaches. Each factor loaded at 0.8 and above. It is concluded therefore that this tool is both valid and reliable although it is recognised that further testing is required using larger sample sizes and that transferability may be problematic in some instances. Furthermore, some guidance on terminology is required when using MAVAS with service users and the determination of perceptions and values is not tested using this scale. Further work in these areas is warranted particularly with a view to the development and evaluation of staff training on the management of aggression and violence and subsequent performance.

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53 – Gender differences in aggressive behaviour at admission to a psychiatric hospital

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Summary

As aggressive behaviour has a negative impact in general psychiatry, its influence specifically from a gender related point of view in an in-patient population of a psychiatric clinic was assessed at the time of admission. A group of 521 successively-admitted psychiatric inpatients was investigated at admission with the help of the “Social Dysfunction and Aggression Scale” (SDAS). A slightly higher frequency and intensity of “verbal aggressive behaviour” was observed in males. Within the other categories of aggressive behaviour (“tension”, “physical violence to things”, and “assaults”), however, the percentages and intensities of gender-related aggressive behaviour did not differ significantly. Furthermore, under the covarying impact of various psychiatric diagnoses the gender related differences concerning the intensity of “verbal aggressive behaviour” disappeared. When comparing male and female subgroups, it was notable that male schizophrenic patients were younger than females when displaying comparable risks of showing at least one kind of aggressive behaviour. In addition in the female subgroup “self-injurious behaviour” was more strongly correlated to the category “tension” than in the male subgroup.

Keywords: Aggressive behaviour – gender – time of admission – psychiatry

Introduction

Gender differences in the quality and intensity of aggressive behaviour are

described in a variety of fields for example: biology, environmental or social contexts, and individual experiences [e.g. Lansford et al. 2003; Cyrulnik et al. 2003; Smith, Brain 2000; Rohde-Dachser 1996; Rubin, Hubbard 2003; Krug et al. 2002; Eichelman 2003; Rubinow, Schmid 1996; Bergeman, Montpetit 2003; Turner, Mc Clure 2003; Ernst 2001; Martin, Bryant 2001; Brain 1994]. Most of the studies come to the conclusion that in general population male gender is more often associated with various types of overt aggressive behaviour and violence than female counterparts.

Among patients with major psychiatric disorders, the results of studies on gender differences in aggressive behaviour are much more inconsistent: The gender ratio in clinical studies of intermittent explosive disorders is typically reported to be three males to one female [Coccaro 2003]. In some investigations, psychiatric in-patients male gender is seen as an additional risk indicator for aggressive behaviour besides diagnosis, intoxication and comorbidity [Steinert 1998, Soyka 2000, Ruesch et al. 2003, Finzel et al. 2003]. In other studies neither gender was associated with more aggressive behaviour [Barlow et al. 2000, Mellesdal 2003] or female inpatients showed more aggressive behaviour under a variety of intervening variables [Kho et al. 1998; Krakowski, Czobor 2004]. The results concerning rate and severity of physical injuries inflicted to the victims by inpatient assaults show inconsistency as well: in one study female patients contributed to more injuries than male inpatients [Mellesdal 2003], in other studies a higher proportion of male patients were responsible for more physical injuries to their victims [Steinert 1998, Finzel et al. 2003; Krakowski, Czobor 2004].

Aims of the study

An attempt was made to assess whether, at the time of admission, frequency and intensity of various types of “overt” aggressive behaviour are different in the genders of psychiatric in-patients.

Method

Aggressive behaviour was investigated in a group of 521 successively-admitted psychiatric inpatients at the time of admission over a four month period. Within the defined catchment area of the western section of Frankfurt (a population

of about 190,000 inhabitants), there is a requirement to treat all who need hospitalisation without exception. A range of psychopharmacological agents, electro convulsion therapy, sleep-deprivation, and detoxification etc. were applied to the patients, according to their diagnoses. The Psychotherapy used had a psychoanalytic or a behaviouristic orientation.

The caseload of the hospital was very heterogeneous, and diagnoses were classified based on clinical judgements according to the DSM-IV- and ICD-10-system. In order to include all information available, as many collateral sources as possible, (e.g. relatives, neighbours, nurses, and police-officers) were interviewed directly or by telephone. They provided their observations on any aggressive behaviour that the patient demonstrated 6 hours before and 6 hours after admission. A decision was made to limit the period of observation to a total of 12 hours because clinical experience suggested that the maximum of overt aggressiveness towards others (directly associated with the severity of the psychiatric disorders) occurs during this time. Furthermore it was expected that pre- and post-admission violence displayed during this short time span would be a direct expression of the psychiatric disorders. Consequently they were examined together, even if there were cases with evidence of only pre- or post-admission aggressive behaviour.

The study required an instrument allowing the separate assessment of different categories of aggressive behaviour from self-injurious and suicidal behaviour. The “Social Dysfunction and Aggression Scale” (SDAS) [Wistedt et al. 1990] fulfils all the requirements mentioned above and contains 11 items with anchoring-definitions of five grades (0 = not present, 1 = doubtful or very mild, 2 = mild to moderate, 3 = severe, 4 = extremely severe). It consists of 9 items covering overt aggression (non-directed verbal aggressiveness, directed verbal aggressiveness, irritability, negativism, dysphoric mood, socially disturbed behaviour, physical violence to personnel, physical violence to others, physical violence to things) and 2 items covering inward aggression (suicidal behaviour vs. self-injurious behaviour). The categories have clear operational definitions: for example a verbal provocation towards a nurse was rated as mild to moderate directed verbal aggressive behaviour and an assault with a bottle as a weapon against another patient as an example of a severe physical violent act towards others. The reliability of this scale is high (interclass coefficient: .97, Cronbach’s alpha: .79) [Wistedt et al. 1990]. The validity of the SDAS is high as well: the sumscores of the scales MOAS [Kay et al. 1988], SDAS, and SOAS [Palmstierna, Wistedt 1987] correlate highly (r between .78 and .91) [Steinert et al. 2000]. Furthermore the SDAS is the scale with the highest sensitivity

concerning aggressive behaviour (91%) in comparison to the afore mentioned scales [Steinert 2001]. For the purpose of the study, the intensity of the mental illnesses was measured by use of the Clinical Global Impression Scale (CGI) [NIMH 1970].

Description of the group

The diagnosis were: 187 substance related disorders, 163 schizophrenia, 70 depressive disorders, 50 dementia and psycho organic disorders, and 51 personality disorders and neuroses. The group consisted of 222 (42.6%) females and 299 (57.4%) males. The rate of voluntary admissions was 408 (78.3%); the rate of emergency admissions was 261 (50.1%). The mean CGI score (severity of the mental disorder) was 5.67 (sd: 0.77, range: 4 – 7, median: 6). The mean age was 44.6 yrs (sd:15.6, range: 16 - 89 yrs, median: 43 yrs). Male patients were significantly younger than female patients (mean age males: 42.18 yrs, sd: 13.58; mean age females: 47.97 yrs, sd: 17.45; T-test: $T = -4.258$; $p=.000$). In the male subgroup, 53.8% continued in-patient treatment for the purpose of crisis intervention for at least one week in comparison to 55.0% in the female subgroup.

Results

Entire group (N=521): 127 (24.4%) patients showed at least one type of aggressive behaviour. Emergency admissions showed increased frequencies of aggressive behaviour for both subgroups (odds-ratio: 2.420; $c_df1=17.712$; $p=.000$; 95%C.I.: 1.593 – 3.674, male subgroup: odds-ratio = 3.677; $c_df1=15.497$; $p=.000$; 95%C.I.: 1.881 – 7.187; female subgroup: odds-ratio = 1.786; $c_df1=4.541$; $p=.033$; 95%C.I.: 1.044 – 3.056). Aggressive behaviour was also closely associated with involuntary admissions (odds-ratio: 12.709; $c_df1=132.293$; $p=.000$; 95%C.I.: 7.837 – 20.610; male subgroup: odds-ratio = 10.043; $c_df1=45.430$; $p=.000$; 95%C.I.: 4.792 – 21.051; female subgroup: odds-ratio = 14.995; $c_df1=86.666$; $p=.000$; 95%C.I.: 7.893 – 28.487) which was to be expected. Among the different types of aggressive behaviour only “verbal aggressive behaviour” showed a slightly increased percentage within the male subgroup: 19.4% for males vs. 13.5% for females (odds-ratio for male gender = 1.541; $c_df1=3.143$; $p=.076$). There were no significant gender-related differences concerning the other qualities of aggressive behaviour:

tension, physical violence to things, and assaults. Furthermore, gender-related differences in frequency and intensity of suicidal or self-injurious behaviour were not evident.

Age seemed to be an intervening variable in the interaction between gender, aggressive behaviour and diagnostic subgroup: In contrast to the other diagnostic subgroups, male schizophrenic patients were significantly younger than female counterparts (means: 51 vs. 60 yrs.) when they showed comparable levels of at least one type of aggressive behaviour (log-rank test: 8.65, df_1 , $p=.0033$).

Only in the male subgroup did patients exhibiting “verbal aggressive behaviour” show a significant association with the variable “continuing in-patient treatment for at least one week for the purpose of crisis intervention” (males: 70.7% crisis intervention following verbal aggressive behaviour vs. females: 60.0%; male patients: coefficient of contingency $\phi = .166$, $p = .004$; female patients: coefficient of contingency $\phi = .040$, $p = .550$). This result was confirmed in covariance with diagnoses, involuntarily admissions, emergency admissions, and CGI-score.

Results

Subgroup of patients exhibiting aggressive behaviour ($N=127$): In the subgroup of patients exhibiting at least one type of aggressive behaviour, the males showed a significantly higher intensity of “verbal aggressive behaviour” (Mann-Whitney U-test: $Z = -1.976$; $p=.048$). This result covaries with the impact of diagnoses on “verbal aggressive behaviour” with the highest score found among schizophrenic patients and the lowest score among depressed patients (Kruskal-Wallis test: mean rank depressed patients = 32.67 vs. mean rank schizophrenic patients = 73.54 vs. mean rank addicted patients = 69.32 vs. mean rank demented and organic psychotic patients = 53.81 vs. mean rank neurotic and personality disordered patients = 57.57; $c_{df4} = 15.078$; $p=.005$). No other single variables of interest were identified that were significantly correlated to “verbal aggressive behaviour”. In an ordinal regression model only the diagnoses schizophrenia and addiction showed an impact on the dependent variable “verbal aggressive behaviour” in contrast to gender. Correlated with both diagnoses the risk of behaving verbally aggressive was increased statistically as a trend.

In the female subgroup self-injurious behaviour was correlated to the aggressive behaviour “tension” (Spearman-rho: $r = .536$, $p=.000$, estimation of variance =

.284); in the male subgroup this correlation was weaker (Spearman-rho: $r = .431$, $p = .000$, estimation of variance = .186). This qualitative aspect of female aggressive behaviour with a correlation of “tension” to “self-injurious behaviour” can be demonstrated in a two-dimensional solution of a multidimensional scaling model. The euclidian distances of this multidimensional scaling model are rather small between “tension”, “self-injurious behaviour”, and “female gender” in comparison to “tension”, “self-injurious behaviour”, and “male gender”.

Discussion

The present findings indicate similarities in the frequency and intensity of overt aggressive behaviour between the subgroups of male and female psychiatric in-patients at the time of admission. One possible explanation may be that female as well as male psychiatric in-patients manifest comparable amounts of aggressive potential in overt aggressive behaviour at admission. As a consequence the power of the aggressive potential in females as well as in males may decrease possible gender related differences in the frequency or intensity of aggressive behaviour either before or subsequent to the time of admission. The results corroborate with the findings of Steinert 1998, Soyka 2000, Ruesch et al. 2003, and Finzel et al. 2003: the presence of male gender can be interpreted as an additional risk indicator for “verbal aggressive behaviour” at admission, covarying with diagnoses concerning the intensity of “verbal aggressive behaviour”. The present findings concerning a short time period of 12 hours only, are different from the findings of Kho et al. 1998 and Krakowski and Czobor 2004 who found more aggressive behaviour in female in-patients under a variety of intervening variables, for example, the length of treatment, the temporal course of aggression, and several ward characteristics. In contrast to the afore mentioned studies only the potential of aggressiveness was assessed which represents the psychopathological “culmination point” of different mental disorders which necessitated admission into a hospital.

In keeping with this interpretation, the higher frequency of in-patient-crisis-intervention following verbal aggressive behaviour only in the male subgroup can be viewed as the result of males appearing more dangerous than females when exhibiting comparable levels of aggressive behaviour at admission [Steinert 1998, Finzel et al. 2003; Krakowski, Czobor 2004]. As a consequence crisis-intervention may be offered more often to male than to females patients. In the course of a mental disorder the frequency and intensity of the different

kinds of aggressive behaviour may also correlate with the changes in hormone levels in the female subgroup (premenstrual time period). Unfortunately this factor could not be controlled for.

The present results concerning the younger age of schizophrenic males showing at least one kind of aggressive behaviour may represent the age distribution of the general population of the catchment area: for example only 39.65% out of the 65 through 85 year old inhabitants of the western Frankfurt area are males. In addition this finding may be interpreted as the impact of the earlier first manifestation of schizophrenia in males [Häfner et al. 1989, Riecher et al. 1990]. As a consequence male schizophrenic patients may have a higher chance of showing at least one kind of aggressive behaviour at a younger age compared to the group of female patients with schizophrenic disorders. Patients at high risk for displaying aggressive behaviour in general were identified as those of young age and being actively psychotic [Barlow et al. 2000].

The finding of a slightly higher association between “tension” and “self-injurious behaviour” in the female subgroup could indicate that females may bodily harm themselves while experiencing their aggressive potential as “tension”. Replication of a stronger association of tension and self-injurious behaviour in female patients in further studies, could contribute to establishing additive gender-related therapeutical possibilities [Riecher-Rössler, Rohde 2001]: If females are able to direct their aggressiveness outwardly by acting it out physically in a therapeutical context for example with the help of expressive media [Hartwich, Fryrear 2002] they may not resort to bodily self-harm as an extraneous projection of aggression.

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54 – Supporting the implementation of a national guideline for effective prevention and management of violence in services for people with mental health problems and learning disability

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Abstract

Between December 2003 and March 2005, 265 mental health and learning disability units took part in a national audit programme that supported them to gather systematic data about the ways in which they maximised safety and minimised risk in relation to the prevention and management of violence. Standards for the audit were drawn from national guidelines 1 2, and the audit programme was fully funded by the Healthcare Commission – an inspectorate body for English and Welsh health services. The audit focused on individual wards/units and data were gathered from the whole constituency – staff of all types, service users, and visitors. Information collected included more than 6500 anonymised questionnaire returns, which contained over 20,000 lines of comments.

The audit findings revealed that both the factors that cause violence, and potential solutions, are highly individualised. Participating units obtained an insight into the particular factors that were influencing the likelihood that violence would happen in their services, and whether it would be managed effectively if it did. Common problems included the following.

- **Unsafe environments:** the design of many of units failed to meet many basic safety standards.
- **Inadequate staffing:** nationally, many services of all types were operating with vacancy factors. This was commonly linked to the on-going drain of experienced staff into higher paid, and often more highly-regarded, community posts. Many in-patient services were being left reliant upon inexperienced leaders. Additionally, many services were experiencing problems recruiting

staff and were overly-reliant upon bank and agency staff. Under either or both of these circumstances, the adoption of a proactive approach to the prevention and management of violence was impossible.

- Client mix and over-crowding: many acute mental health services were ‘fire fighting’ - struggling to work with an increasingly unwell population, many with a dual diagnosis. For many, faced with high bed occupancy figures and inadequate staffing, the delivery of a therapeutic service appeared to have become impossible. Sizeable inequities in staffing levels and skills mix across the country were also evident.

¹Royal College of Psychiatrists (1998) Clinical Practice Guidelines for the Management of Imminent Violence. College Research Unit, Royal College of Psychiatrists, London

²National Institute for Clinical Excellence (2005) Violence: The short term management of disturbed/violent behaviour in inpatient psychiatric settings and emergency departments. Clinical guideline 25, National Institute for Clinical Excellence, London UK.

- Substance misuse was identified as the most common trigger for violence. Problems associated with the use of alcohol and illegal drugs were more common in mental health services.
- High levels of boredom: many wards/units were unable to offer service users a structured and therapeutic system of care. This was linked to low staffing levels and high volumes of paperwork. As well as the obvious link between ‘boredom’ and ‘violence’, this was seen to have an impact on recovery rates for service users, and on job satisfaction for staff.
- Staff training in the prevention and management of violence: significant numbers of staff reported dissatisfaction with the timing, content, or quality of the training they received. Additionally, and perhaps more concerning, many felt unable to apply the training in real life situations.

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55 – The national institute for clinical excellence (NICE) guideline on the short term management of disturbed/violent behaviour in psychiatric inpatients and emergency departments / Guideline development – going beyond the evidence

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Summary

The National Institute of Clinical Excellence (NICE) published in February 2005 a guideline on the prevention and short-term management of violence in adult psychiatric in-patient settings and emergency departments for use in the UK. This guideline was developed simultaneously alongside an inquiry into the death of a African Caribbean psychiatric service user who died whilst being restrained in a secure setting. Both documents reached markedly different decisions on crucial aspects of care in managing violence. Future consideration needs to be given to how separate but parallel decision-making processes should function in relation to one another.

Keywords: violent, disturbed, guideline, David Bennett, African Caribbean, inquiry, guideline, restraint.

Background

The National Collaborating Centre for Nursing and Supportive Care based at the Royal College of Nursing was commissioned by the National Institute of Clinical Excellence (NICE) to develop evidence-based guidelines on the prevention and short-term management of violence in adult psychiatric in-patient settings and emergency departments for use in the UK.

The guideline was launched and published in February 2005.

A NICE guideline provides a systematic review of all the evidence in a given area, which is then considered by a guideline development group (GDG) of multi-professional experts including two service user members. Where evidence is limited, as it was for this guideline, additional measures for validating the recommendations were sought. These included seeking advice from external experts, a peer review process, and a stakeholder consultation. Focus groups were also conducted with African Caribbean service users. Clinically relevant recommendations were then drafted by the group using a modified formal consensus technique.

An independent inquiry into the death of David Bennett (an African Caribbean psychiatric service user who died whilst being restrained in a secure setting in 1998) was published in December 2003. As with the guideline, the inquiry made specific recommendations relating to the use of physical intervention (restraint) and the prone position, managing the head during restraint, the number of people who should restrain and the deliberate use of pain. This inquiry examined the evidence surrounding the care and treatment of one individual and considered whether procedural compliance was compromised or whether the procedure required review. A panel of five health and legal experts considered the evidence of 18 expert witnesses and on the basis of this drew up clinically relevant recommendations. Many of these recommendations fall outside the scope of the NICE guideline. The David Bennett inquiry was clear that it intended its findings to inform the work of relevant parties. It names the NICE guideline as one such party.

The two processes reached notably different conclusions. In particular, the inquiry set a time limit of three minutes for postural (prone) restraint. This time limit was not recommended in the NICE guideline. Instead an emphasis was placed on the proper management of factors which may contribute to sudden death (e.g pressure on the neck, pelvis or torso). The presentation will focus on the extent to which the differing processes and rationale underpinning the decision-making of the two bodies resulted in these divergent positions.

Concurrence between the guideline and the inquiry

In light of the inquiries expectations and as a matter of NICE policy the guideline development group gave due consideration to the report before publishing its own recommendations. A number of key areas coincided where both parties were in

agreement. There were also recommendations in the inquiry that the guideline development group utilised in the guideline. The following are some examples: The inquiry highlighted the importance of including awareness and acknowledgement of a service user's spiritual needs. The GDG concurred and included the term alongside other key terms in a number of recommendations e.g

- All service users, regardless of culture, gender, diagnosis, sexual orientation, disability, ethnicity or religious/spiritual beliefs should be treated with dignity and respect.'

The inquiry recommended that mental health trusts should set out a written policy dealing with racist abuse, and that this policy should be disseminated to all staff and displayed prominently in all public areas. The GDG again concurred with this recommendation as shown below.

- All services should have a policy for preventing and dealing with all forms of harassment and abuse. Notification of this policy should be disseminated to all staff and displayed prominently in all clinical and public areas.

In the event of any form of alleged abuse, the matter should be dealt with by staff as soon as is practicable in accordance with relevant policies of the service.'

The inquiry recommended that control of the head should be maintained at all times and that the person controlling the head should control the physical intervention procedure. The GDG formed the following recommendation.

'During physical intervention, one team member should be responsible for protecting and supporting the head and neck, where required. The team member who is responsible for supporting the head and neck should take responsibility for leading the team through the physical intervention process, and for ensuring that the airway and breathing are not compromised and vital signs are monitored.'

The inquiry throughout their report refer to the need for staff to be trained in resuscitation techniques, sufficient staff are required in an emergency and references are made for wards to have access to resuscitation equipment. The following recommendation in the guideline is considered a key priority for implementation by the GDG.

All staff involved in administering or prescribing rapid tranquillisation, or

monitoring service users to whom parenteral rapid tranquillisation has been administered, should receive ongoing competency training to a minimum of Immediate Life support (ILS – Resuscitation council UK) (covers airway, cardio-pulmonary resuscitation [CPR] and use of defibrillators).

Staff who employ physical intervention or seclusion should as a minimum be trained to Basic Life support (BLS – Resuscitation council UK)

Key areas of divergence between the guideline and the inquiry

There were, however, areas where due consideration was given and the guideline development group were not in accord with the panel in the David Bennett inquiry. The following are the most sensitive examples.

The inquiry recommended one black/ethnic minority trainer for race awareness as a ‘one-off’ course. The GDG were of the opinion that the NICE guideline in its recommendations needed to instil a culture of awareness in the NHS to produce a workforce who are aware of a range of issues relating to black and ethnic minority people. This practice of cultural awareness is to be demonstrated by all trusts within an ongoing program of competency training on the prevention and management of violence. Such training should not be an ‘add-on’ but be integrated within training. The purpose of the NICE guideline is not to perpetuate the view that black people are more prone to violence.

One of the more contentious issues was the stipulation by the inquiry that a service user should not be restrained in the prone position for longer than 3 minutes, which the guideline did not recommend. This was raised in the subsequent media attention after the launch of the guideline in February in 2005. David Bennett had been held face down for 25 minutes. The GDG discussed the prone position and agreed it was not the position that is relevant in sudden death, but other contributing factors. The key factors are pressure being placed upon the abdomen and thorax. It was noted that struggling in any position would produce lactic acid that can cause irregularities resulting in the cessation of heartbeat. The meeting was informed that 9/10 restraint events end up on the floor as it is natural to fall forward and that the supine position is more likely to result in pain.

Furthermore the GDG was informed that the 5 minute rule in the Prison

Service Manual, quoted in the inquiry, was removed on the grounds that it was not practical and that it is safer to recommend that the shortest time possible is desirable. It was also stated that the prone position is defined differently in different contexts and that for the police authority it usually refers to a hogtie position. This position is when hands are brought round to the back and the feet are pulled back to meet them.

One of the key attributes of the guideline is that it has a legal preface setting out clearly for healthcare professionals their legal obligations under Common and European law. The following key point emphasizes the appropriate level of response and is extracted from the legal preface.

‘Failure to act in accordance with the guideline may not only be a failure to act in accordance with best practice, but in some circumstances may have legal consequences. For example, any intervention required to manage disturbed behaviour must be reasonable and proportionate response to the risk it seeks to address.’

Another extremely sensitive area of concern raised by the inquiry was the use of deliberate pain to control a service user during restraint, and stated whatever the circumstances this technique should not be permitted. This matter was extensively discussed by the GDG and the final recommendation was also influenced by the consultation process. The safety of the service user and staff member is paramount. The wording under went many revisions to ensure there was no ambiguity about the key message.

A number of physical skills may be used in the management of a disturbed/violent incident.

The level of force applied must be justifiable, appropriate, reasonable and proportionate to a specific situation and should be applied for the minimum possible amount of time. Every effort should be made to utilise skills and techniques that do not use the deliberate application of pain. The deliberate application of pain has not therapeutic value and could only be justified for the immediate rescue of staff, service users and/or others.

Two further examples of divergence between the guideline and the inquiry illustrate the different starting positions of the guideline and inquiry. However, both their recommendations are generalised to the same target population of inpatient psychiatric services. Firstly, the inquiry was against the use of

mechanical restraint. The GDG acknowledged that they are used sparingly and are more sophisticated than the strait jacket. For some patients mechanical restraint is preferable to constant restraint or rapid tranquillisation. The recommendation does not seek to approve their use and ensures that a strict protocol on an individual case by case basis is adhered to before use.

Secondly, the inquiry is clear about adherence to BNF (British National Formulary) limits when prescribing medication as this was a factor, although not the cause, in David Bennett's death. The BNF consider the use of a medicine for unlicensed indication or in an unlicensed dose is acceptable, if there is a pressing clinical need and there is sufficient evidence to support the use of the medicine in an unlicensed way. This is most likely to be the case with the use of the recommended medication lorazepam for rapid tranquillisation. It will examine the guideline's evidence before acknowledging any unlicensed use of medication. The inquiry, however, was rightly concerned with the over medication of service users and medications of the same class being given. The guideline makes recommendations on both these points. The inquiry has limited space or structure to deal effectively with these issues and reports on the events of a single case. The guideline had a wider brief and a structure that allowed it more in-depth analysis of the issues. It had the capacity to make more detailed sequential recommendations to guide healthcare professionals through their clinical decisions, as required to address the varied clinical pathways of individuals in their care.

Conclusion

The decisions and deliberations shown above indicate that the NICE guideline overlaps considerably with the expectations and recommendations of the David Bennett inquiry. In several places, the NICE guideline is able to elaborate more fully on the use of certain interventions. For example, the issue of BNF limits in relation to rapid tranquillisation is more fully covered by the NICE guidelines. Also there are points where the NICE guideline does not fully concur with the inquiry recommendations for the reasons specified above, for example, prone restraint, use of mechanical restraints, and pain compliance. Two review processes reached markedly different decisions on a crucial aspect of care in managing violence. Arguably, the relative weight of the more evidence-based, stakeholder consultation and wide ranging peer review process does however provide a stronger guide for clinical practice. Future consideration needs to be given to how these separate but parallel decision-making processes should

function in relation to one another.

Acknowledgements

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56 – Violent patients in forensic treatment in Czech Republic – Need of the standards, law, and detection

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Abstract

From the legislative point of view the in-patient forensic treatments (FT) are the most problematic part of the Czech psychiatric care, because those treatments are commanded and carried out practically always against the will of the patient. In Czech Republic (CR) there are no standards or laws delimiting the execution of the FT. There is only criminal law delimiting conditions of imposition of the FT. There is even no detention institution in CR. Thus all those FT's are carried out in civil psychiatric hospitals (provided according to the medical law from 1966), usually among the voluntary patients, which causes many problems – violence, bullying, and then the necessity of restriction from medical staff.

According to the criminal law FT can be ordered only by court. Obligatorily FT is ordered to the crime offender who is found (by legal expert - psychiatrist) insane and dangerous for society. Optionally FT is ordered (together with sentence to the prison) to the crime offender who's criminal responsibility was found reduced (and FT is recommended as meaningful). Cooperation with patients ordered to FT by these law-paragraphs is usually well. But very problematic patients are those who were ordered to the FT according to the paragraph about "the crime offenders who abuse drugs". These offenders (practically all have gross dissocial personality disorder) are brought to the FT from the prison and they consider FT to be the second punishment.

By the criminal law the FT should be carried in prison, but it is realized only in one prison of 36 in CR in the case of sexual offenders. The length of FT is no limited in CR – according to the law "FT lasts until it fulfills its purpose".

FT can be terminate (or changed to out-patient form) by court (on proposal of offender or medical institution). The time between the proposal and legal proceedings takes usually 2 months – 2 years in CR. Such a long time the personality disorder must be cured (even though it is incurable).

Psychiatric Hospital Prague – Bohnice is the only one in CR with separate department for FT's. There are 80 beds, 45 employees, 4 units in 2 buildings. Unfortunately it is not possible to separate psychiatric patients from addicted and sexual offenders. There is established the regime treatment based on Skala's antialcoholic program. Problem is that there is no legal support for that. Problem is that according to the medical law the medical secrecy must be kept. Problem is that payment of FT is provided from health insurance and thus FT of foreigner is not paid. Problem is that medical staff is not able to prevent the offenders from escaping. Problem is that the time between committing a crime and offending the obligator FT is several months.

Some of these problems are solved in proposition of new criminal law. But there is no operational parliament in CR to accept the proposal. There is e.g. a proposal of a detention institution in the new law, but there is no project for building it.

On the casuistic examples the lecture will discuss the need of standards (if not a law) delimiting the execution of the FT's and will propose them. The lecture will summarize the legal situation in psychiatry in CR. The necessity of a detention institution for preventing violence in psychiatric institution will be discussed, based on the experiences from civilized countries (e.g. USA, Holland). The legal proposal of the detention institution in CR can be discussed.

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57 – Workshop (4) – The level of reflection in clinical teams on violence management

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Abstract

The participants of the workshop are invited to reflect on the way their teams are evaluating violent incidents on the wards. In case of imminent danger physical restraint techniques and seclusion interventions are widely used in psychiatric wards. However the question rises how healthcare workers appraise violent behaviour, when is the best moment to canalise aggression and are we able to work on a pro-active way combined with a learning attitude on retrospective analysis of violent incidents? Transparency on emergency decision-making seems to be missing. This problem is often due to the lack of objective risk terms and our acceptance that violence is a part of the job. From this perspective we will briefly discuss some theoretical frameworks on violence in psychiatry. Secondly we will demonstrate some typical examples of therapeutic management of aggression in our hospital. Later in the workshop program the participants will be challenged to reflect on their own transparency in the therapeutic management of aggression.

In our hospital progress is made on the integration of cognitive behavioural strategies in the therapeutic climate of the psychiatric wards. We will discuss how these strategies match with the biological vulnerability and the social background of our patients in stable and emergency situations. In the workshop some video examples are showed and we will discuss the decision making process and the therapeutic management of violent behaviour. In cognitive behavioural approaches detection and changing misbelieves of patients is an important issue. Influencing misbelieves of patients about their aggressive behaviour demand a staff attitude of permanent self-reflection on moral reasoning and misbelieves about the factors causing aggressive incidents. In the workshop we will work out

some practice examples. The participants are challenged to discuss the pitfalls, timing and limitations on reflective practice in the therapeutic management of violence. The purpose of this workshop is to learn from experiences on pro-active strategies on the management of violence.

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58 – Inpatient aggressive behaviour in short term psychiatric units

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Abstract

The hospitalised inpatients with psychiatric problems run risks of developing aggressive behaviour against others and against themselves, especially in short time psychiatric units, where those behaviours are a relatively prevalent phenomenon. Those are behaviours understood by the staff, through their relationship, thus influencing the psychiatric nursing care direct or indirectly. The dimension of this phenomenon remains however unknown and we don't have systematized information, which enables characterization.

Method

It was decided to make an exploratory study "Impatient Aggressive Behaviour in short term psychiatric units" with the following goals:

- Evaluate the prevalence of the aggressive behaviours;
- Characterize the aggressive incidents occurred in the short term psychiatric units of acute inpatients;
- Identify characteristics of the inpatients who have developed aggressive behaviours;
- Describe the contexts where they occurred.

The exploratory work was done between January of 2003 and December of 2003 in six psychiatric units of three public hospitals in the area of Coimbra.

It was used the Staff Observation Aggression Scale – SOAS-R – (Nijman, 1999), a Visual Analogue Scale – VAS and a questionnaire of characterization to register and characterize the aggressive incidents. The data obtained were treated and analysed with the support of the SPSS 11.0 programme.

Results

During twelve months, from January to December of 2003, 185 incidents were monitorized in the selected units. In the different units the average incident per bed was of 1,2 per year, resulting in a prevalence of approximately 10%, that is, 10 in a hundred inpatients had aggressive behaviours. The SOAS- R and WAS scales showed a positive Pearson correlation (.483) at the level of .001. The majority of the monitorized incidents were evaluated at the moderate level (74). In 68 incidents the precipitant of the aggression wasn't identified. However, in the 117 inpatients left the precipitant identification was possible, being the "Patient denial of something by the staff" (in 43 incidents) the most relevant. The most used means by the inpatients to aggression was the verbal aggression, thus being observed in 137 incidents, although the parts of the body have also been observed in 127 incidents. The nurses were the main target of the incidents.

The consequences were especially centred in "People" (occurred in 107 incidents). In 53 incidents the staff was able to control the inpatients' aggressive behaviours through non-restrictive measures. The nursery and the canteen were the places where there were more incidents, in 55 and 52 incidents, respectively. The time distribution of the aggressive incidents wasn't uniform along the 24 hours. A high frequency during the period from 9 a.m. to 12 a.m. (59 incidents) was observed. The 135 inpatients, who developed the aggressive behaviours, were in average 40 years old; they are predominantly male; they were admitted to the urgency in a voluntary way and in open regime; they are mainly schizophrenic and have other psychotic disorders. The men developed more aggressive behaviours than women.

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59 – In-patients' violence in the psychiatric hospital in Maribor, Slovenia

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Objectives

Violent behaviour among individuals with severe mental disorders has become an important focus of treatment and management care in psychiatric hospitals. There have been no studies on violence and mental health among hospitalised psychiatric patients in Slovenia. The aim of this study was therefore to examine the frequency and the type of violent acts that were committed by patients in the Department of Psychiatry of the Teaching Hospital Maribor, Slovenia, in the period between 01.01.2004 – 31.03.2005.

Method

All violent acts, committed by the hospitalised patients during this period (n=1614), were assessed with the Overt Aggression Scale. They were also analysed with regard to the age, gender, diagnosis and duration of hospitalisations in the observed time period. Violent acts at the time of admission were not included. Descriptive statistics, and Pearson correlation coefficient for evaluating the correlation between female and male patients' number of incidents and number of hospitalisation days in the observed period, were used in the study.

Results

Two hundred and nine recorded violent acts were committed by 47 male (58.7%) and 33 female (41.3%) patients, with 107 (51.2%) and 102 (48.8%) incidents, respectively. Forty patients (50%) committed only one violent act, and contributed

with 19.1% of all the violent acts. The other half of the patients were repeaters responsible for 80.9% of all the acts. A trend towards the statistical significance in the correlation between number of incidents and number of hospitalisation days was observed in the female group. Quantitative data according to the type and severity of violence, diagnosis and age are discussed.

Conclusions

Organic, psychotic and personality disorders in all in-patients, as well as the time spent in the hospital by female patients, may signal a higher risk of violent acts. Reduction of risk of violent behaviour may require carefully targeted interventions, including integrated mental health treatment. There is also the need for the education of all active participants in violence reduction and prevention. Unfortunately, in Slovenia there are no comprehensive programmes for violence reduction yet. The present study may be regarded as the first step towards the establishment of such programmes.

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60 – Principles of family intervention, and their applicability in relation to the management of aggression in the inpatient setting

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Introduction

That nursing staff play a pivotal role in the assessment and management of risk, including in the area of violence and aggression, is undeniable (Doyle & Dolan, 2002). An increasing amount of literature concerns the complex range of skills required in recognition and de-escalation, and the need for ongoing development is acknowledged (Lewis, 2002). In tandem, focus is being directed towards contributory factors associated with aggression such as environmental factors, poor communication, inflexible attitudes and negative interactions (NIMHE, 2004).

It is in this context that the authors wish to draw attention to the possible merits of adopting some of the principles of Family Interventions when giving consideration to the complex processes and mechanisms occurring at the interpersonal level.

Family Intervention

Family Intervention is not a new concept and has been developed over recent decades. Research has consistently demonstrated that the home environment may significantly impact - positively or negatively - upon relapse rates and prognosis for those with severe mental health problems (Brown et al., 1962, 1972). This impact appears to be dependent to a large extent upon family members' attitudes and responses to symptoms and behaviour (Leff & Vaughan, 1985; Barrowclough & Tarrier, 2000) - more formally conceptualised as 'Expressed Emotion' or 'E.E.' (Kuipers et al., 2002).

A basic assumption is that psychotic illness such as schizophrenia can place substantial burden and stress on some families, resulting in an emotionally charged atmosphere or 'high E.E.'. Such families are characterised by overly critical or hostile attitudes towards individuals and / or emotional over involvement.

Thornicroft (1991) observed that care staff face many of the same problems as families in caring for people with enduring mental health problems. In working with people who present challenging behaviours, it appears natural that staff may experience powerful emotions common to family experiences (eg. envy, loss, blame, anger and guilt; Kuipers et al 1992). Subjective emotional experiences, in combination with the many varied attitudes, beliefs and values which present themselves within staff groups inevitably lead to even more complex dynamics. Just as families may argue and negotiate their role, identity and position within the family, it comes as no surprise that staff and patients may do the same (by examining the content of fractious interactions we notice that many staff assume a 'parental' role – expressed emotion may in such situations be reminiscent of the negative, critical parent). The clinical implications and need to understand such dynamics are considerable. Severe mental health problems are characterised by impairment and difficulties in relation to interpersonal functioning; these same interpersonal difficulties may serve to further exacerbate symptoms, increase distress and destabilize behaviour - sometimes culminating in violent or aggressive responses.

Zubin and Spring's Stress Vulnerability Model (1977) suggests psychological disorders arise when stress exceeds the individuals ability to cope. The model points to contributory factors within the individual, the environment, and in the interplay between the two. Levels of ambient stress connected with E.E. clearly contribute within this model to the exacerbation of disorders, disturbed behaviours and possible anger.

Averill (1983) goes further to suggest that the emotion or experience of anger results from a combination of external events, and related appraisals and expectations.

Those who, with great regularity, resort to verbal and physical abuse when their desires are not met are often characterised by deficiencies in those skills necessary to correctly appraise situations or resolve interpersonal problems. As a result, situations may appear threatening and encounters may be converted

into duels or violent struggles for survival. Such individuals may typically lack self-confidence and self-esteem and tend to rehearse grievances, slights, and injustices. In doing so, they maintain high levels of anger and hostility. Typically their aggressive reactions are directed towards immediate satisfaction and they make limited or highly distorted assessments of future consequences of their aggressive behaviours.

Like all of us, people with psychosis are trying to make sense of the world and their experiences (Fowler et al 1998). Under stress it is natural for people to resort to ways of coping which they have previously utilised, regardless of how maladaptive they might actually be (for example, becoming abusive, angry or disruptive).

The key in effective working with individuals, suggest Cutcliffe and Barker (2002), is the process of engagement - forming a relationship, a human – human connection, conveying acceptance and tolerance, and hearing and understanding. Birchwood et al (2000) agree that it is fostered by a search for common ground with the client, flexibility, and avoidance of a premature confrontation of their explanatory model of illness.

An integrated psycho-educational approach aimed at tackling unrealistic expectations, addressing communication difficulties, promoting effective problem solving, and encouraging reflection can only be of benefit to staff in this area. And, ultimately, patients for whom care is provided.

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61 – Seminar (4) – University Trainer Course Management of Aggression

Hans Fleury & Nico Oud (Netherlands) and Harald Stefan & Martina Saidy (Austria / Österreich)

Abstract

During this seminar the newly developed University Trainer Course “Management of Aggression” will be presented. The course is developed in the Netherlands and Switzerland by CONNECTING, and is now presented as the “Universitätslehrgang TrainerIn für Deeskalationsmanagement” at the Donau-Universität Krems, Zentrum für Management und Qualität im Gesundheitswesen, Krems, Austria.

Trainers are being taught to carry out more or less standardised aggression management training courses of five days in their in own institute. For this they follow a program within the university of 29 days practical and theoretical education, and a supervised 5 days training course adapted for their own institute. The total program consists of 34 days teaching, and a total of 450 study hours, including self study, a written self reflexion report, and a written thesis about a relevant theme regarding the management of aggression.

The five day aggression management course has been the subject of the study be Ian Needham (2004) (Keynote 4), and he wrote about this course the following:

“The general approach is a skill-oriented, action-centered and problem-centred participating learningpackage (Oud 1997). Numerous aspects of aggression management such as the nature and prevalence of aggression, violence and sexual harassment, the use of aggression scales, preventive measures and strategies , de-escalation techniques, ethical aspects of violence management and safety management (Oud 1997) are being presented to the participants. The primary goal of the course is to prevent patient aggression in psychiatric

practice. However, sometimes patients become aggressive in spite of preventive and de-escalation techniques. In order to deal with such contingencies the participants receive instructions in limiting freedom of aggressive patients, in break-away techniques, in control and restraint, and in post-incident care. One important part of the course is the coordination and concertation of nurses or other carers in cases where patients have been engaged in aggressive behaviour. Another important assumption of the training course is the role of the patient enacting in aggressive behaviour.

The “classical” role allocation of perpetrator and victim is rejected throughout the training course. The participants engaging in aggressive behaviour – the patients and carers – are deemed actors in social interaction. Hence, the carers as representatives and enforcing agents of institutional psychiatry also play their part in the origin of aggressive behaviour. They are thus actively encouraged to reflect their own contribution to the genesis, the prevention, the management, and the aftermath of aggression. Course participants are introduced to the concept of “actors” in social interaction in order to avoid the “perpetrator versus victim” dichotomy.

The training course corresponds by and large to a recently suggested core curriculum (Lee, Wright et al. 2001)”, the NICE guidelines (Keynote 8, paper presentation 54 and 55, and the poster presentation 7), and the recommendations regarding the content and duration of (basic) trainings in the recognition, prevention, post-incident care and therapeutic management of aggression, violent behaviour and sexual harassment in health care, and about the regulation, content and duration of training trainers for such courses by ENTMA (2005).

The training course is recommended to help to reduce some forms of aggression and coercion. It is also recommended to nursing (students) and other professional carers to help to boost their confidence, their feelings of safety, and their ability to render safer and more therapeutic care to their patients.

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Keynote 7 – Safety and Security in acute psychiatric services – the need for an European Agenda

Prof.Dr. Seamus Cowman (Ireland)

Abstract

Violence and assaultive behaviour is manifested in many different directions including patient violence and assault on staff; patient violence and assault on other more vulnerable patients; violence and assault from outsiders; patient violence towards visitors and the public generally. Violent death by suicide is also occurring with increasing frequency and within the hospital setting environmental dangers must be reduced including the need for security precautions to protect suicidal patients from themselves.

Despite the concerns of organisations such as the Health & Safety Authorities about violence and assault in healthcare, there is an alarming lack of clarity on matters of procedure and policy pertaining to ward safety and security in hospitals. Across the psychiatric services there is a bewildering array of practices ranging from an open door policy to locked wards and doors and confiscation of patients clothing and personal property, some of which borders on the infringement of human rights, liberty and the rights and choices of patients.

Generally across EU member states there is a distinct lack of discussion documents and position papers or clarification on safety and security issues in nursing. Meanwhile all mental healthcare staff, in particular psychiatric nurses, continue to express a high degree of concern about safety and security. The prevailing situation is that healthcare staff must continue to provide nursing services in the absence of standardised approaches to safety and security policy and procedure on wards.

This paper will discuss the background issues and the importance of safety & safety measures in mental health services. The paper will also report on the

findings of a comparative study involving the UK and Irish mental health services

The findings of the study demonstrate a distinct lack of agreement on safety and security procedures. The requirement for a strong EU agenda on safety and security is well supported. The EU agenda must determine the prevailing situation across EU member states and then progress towards the development of best practice guidelines to be implanted across the EU.

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Keynote 8 – The National Institute for Clinical Evidence (NICE) guidelines for the management of disturbed (violent) behaviour, and other national UK initiatives – their relevance for Europe

Mr. Rick Tucker

NHS Counter Fraud and Security Management Services (UK)

Introduction

The years 2005 and 2006 should prove to be highly significant benchmarks in the history of the management of violence in mental health and learning disability settings, not only within England, but throughout the United Kingdom and Europe, as for the first time national agencies within England will have issued guidance and training in response to the urgent need for a consistent approach to this phenomenon.

In this presentation, Rick Tucker will firstly contextualise current national policy and guidance by describing the recent history of the management of violence in mental health and learning disability settings in the UK, up to and including the Independent Inquiry into the Death of David Bennett, published in 2004. He will then describe the subsequent national initiatives, policy and guidance.

Abstract

The Independent Inquiry into the Death of David Bennett exposed shortfalls and inconsistencies, familiar to most service users, clinicians and managers, in management of violence training and practice. It also concluded that the National Health Service (NHS) is institutionally racist, in that it fails, particularly in mental health services, to meet the needs of service users from black and minority ethnic groups. Government sensitivity to the expected outcome of the inquiry and its recommendations meant that there was a political will to demonstrate a proactive approach on its part to tackle the issue of violence in health care settings and how it was managed. Although the subsequent initiatives

were arguably driven by political expediency, there was a genuine will, with the accompanying authority, to initiate positive change in response to the growing disquiet among service users, professionals and the general public.

Before the inquiry had concluded its proceedings the National Institute for Health and Clinical Excellence (NICE) was charged with the development of guidelines in relation to the short-term management of disturbed (violent) behaviour in adult psychiatric settings and in relation to service users attending emergency departments for mental health assessments. The guidance applies to adults aged 16 years and older and covers the following interventions and related topics:

- environment, organisation and alarm systems;
- prediction (antecedents, warning signs and risk assessment);
- training;
- service user perspectives, including those relating to ethnicity, gender and other special concerns;
- searching;
- de-escalation techniques;
- observation;
- physical intervention;
- seclusion;
- rapid tranquillisation;
- post-incident reviews and
- emergency departments.

At around the same time a cross-government group, co-ordinated by the National Institute of Mental Health (England) (NIMHE), the mental health branch of the Department of Health (England), was established to consider all aspects of the management of violence in mental health care and to recommend ways forward, particularly in relation to physical interventions, police liaison and the accreditation and regulation of trainers. This group includes in its membership representation from the Home Office, the NHS Security Management Service (NHS SMS), the Police Force, the Prison Service, MIND, the National Patient Safety Agency, service users and other stakeholders. This group is due to conclude its work and publish its guidance in 2006.

Between 2003 and 2004 the Royal College of Psychiatrists Research Unit undertook an audit of violence in 265 mental health and learning disability in-patient units to determine antecedents and causative factors of violence in these settings. The findings were published in 2005.

The NHS SMS was established by the Government as a Special Health Authority in 2003 with a remit to develop guidance and policy in relation to the security of NHS personnel and property, with a specific remit to tackle violence against staff, replacing the Government's 'zero tolerance' initiative. With the legal authority, via Secretary of State Directions, to direct health bodies to comply with their guidance, the SMS established a number of key directives to tackle violence, including:

- that each health body in England will nominate an executive director to take responsibility for security management issues, including tackling violence;
- that each health body will nominate a non-executive director to support all security management work, including tackling violence;
- that each health body will have in place a trained and accredited Local Security Management Specialist (LSMS) to carry out local security management work to national standards, especially in relation to tackling violence;
- that 750,000 staff across the NHS will receive conflict resolution training (non-physical interventions) by 2008, including a specific syllabus for mental health and learning disability staff, entitled 'Promoting Safer and Therapeutic Services', to be launched in October 2005;
- a memorandum of understanding with the Association of Chief Police Officers (England) to facilitate effective lines of communication between the NHS SMS and local police services; also, to facilitate effective exchange of information, investigation of offences and joint working practices with the objective of maximising the prevention and detection opportunities for all forms of crime against NHS staff and property, including violent incidents in mental health settings;
- the establishment of a Legal Protection Unit to advise health bodies regarding appropriate prosecutions of perpetrators of violence against NHS staff and to take up private prosecutions on their behalf as necessary.

The recently published National Audit of Violence, which was carried out by the Royal College of Psychiatrists' Research Unit on behalf of the Royal College of Psychiatrists and the Healthcare Commission, demonstrated irrefutably that the reasons for violence occurring in mental health and learning disability settings are complex and multi-faceted. Importantly, however, clinical pathology and clinical presentation were not shown to be the main causative factors, whereas a number of environmental, managerial, educational and practice issues were.

All of the above initiatives demonstrate that a truly holistic, consistent and multi-agency approach is required to bring about a reduction in the incidence of violence in mental health and learning disability settings. Throughout the western world, much effort and many resources over recent years have been spent in developing ways to react to and contain violence rather than to examine the reasons why it occurs and so develop policy and practice aimed at preventing it. In order for positive and lasting cultural change to take place there needs to be positive and energised international leadership that has the authority and resources to achieve multi-agency consensus as to the best way forward. For the first time in England the key national agencies are sending out a consistent message, creating a unique opportunity in the history of mental health and learning disability care to bring about the cultural change that needs to take place across the board in order to bring about not only a true and lasting reduction in the incidence of violence, but also an overall improvement in care provision.

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Keynote 9 – Coercive practices in acute mental health care: psychological, social and professional dilemmas

Dr. Richard Whittington (University of Liverpool, UK)

Abstract

Effective mental health care sometimes involves physically or verbally coercing the patient in some way. For the patient, being coerced is at least objectionable and at worst can be fatal. The decision by staff to use coercive measures is often made rapidly and under highly stressful conditions in which personal safety is felt to be endangered. This presentation will examine the notion of coercion and explore the process of decision-making ‘under fire’ by reference to a variety of relevant theoretical perspectives and recent research in psychology and sociology. When the human nature of decision-making is better understood it becomes possible to evaluate the validity of professional expectations in this area.

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Poster 1 – Impulsive violent behaviour: a review and operationalisation of factors

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Keywords: arousal, impulsiveness, violence, review

Background

In every day life people are confronted with impulsive violent behaviour that is out of context and proportion.

Aim

To identify the neurobiological, cognitive and social psychological factors related to impulsive violent behaviour. Is impulsive violent behaviour a separate psychopathological phenomenon? Is there evidence for sudden arousal chances in relation to impulsive aggressive behaviour? Operationalisation of factors found in the literature.

Method

Review

Results

The factors we found were only associated with the subject and did not discriminate for impulsive aggressive behaviour. There was evidence to regard impulsive violent behaviour as a separate psychiatric syndrome. Our postulated

arousal jump thesis in relation to impulsive violent behaviour found some ground for further investigation. The factors found are operationalised in a new instrument.

Conclusion

Impulsive aggressive behaviour is a psychiatric syndrome related to a multifactor and complex risk-profile. An arousal jump following provocation seems to be the neurobiological basis. Further research will focus on the differentiation of patients and non-patients with regard to the variables included in the risk-profile.

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Poster 2 – Strategies how to manage violent attacks

*U. Busch-Wübbena, R. Kuckelsberg, J. Hinrichs, C. Kick & Z. Zala
Max Planck Institute of Psychiatry, München, Germany*

Objective

The subjects violence and aggression are usually discussed under the aspect of treatment of patients against their own will. What is considered hardly ever is the fact, that violence can also be directed against employees in psychiatric wards – or social professions in general.

Methods

A poll among seven psychiatric hospitals received 99 responds. It turned out that 50% of the employees in secure wards have been victims of violent attacks. 40% pointed out that they were not prepared for violent situations. “Where do you feel most insecure?” received the following answers: 50% replied: “Fear to be left alone by the colleagues”, “fear to be injured”, “fear to injure the patient”, “fear not to be able to cope with the situation”. We established a team to examine the relevant basic conditions and to optimize the requirements with the help of a self-defence strategy and an emergency handbook.

Results

The handbook is about the management of violence emanating from patients. It is subdivided into: In-depth knowledge of the location, technical equipment, individual requirements; How to act in an emergency situation; Basic rules; Follow-up treatment of the patient, other patients, employees; Follow-up evaluation; Documentation/Standards; Legal implications.

PAP2001 (Patient-orientated aggression and violence management in psychiatry) is an easy to learn self-defence strategy which is in line with ethical aspects.

Conclusion

With this additional skill set the competence and the self-confidence of the staff are increased, as well as the therapeutical capabilities to communicate and to act. The required human and respectful contact with the patient is definitely given.

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Poster 3 – Changing the culture: successful restraint use reduction

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Abstract

The interim ruling put forth by Centers for Medicare and Medicaid (CMS) in 1999 included many new requirements of substantial impact for both acute care medical surgical general hospital units and particularly for behavioral health/psychiatric hospital units. Since that time, while some facilities and organizations continue to protest the stringency of these rulings they have become set in place nationally. The ruling is broad enough in scope to affect interdisciplinary clinical staff providing point of service care for patients as well as administration regarding staffing and financial issues. The challenge to provide best practice psychiatric health care for patients with behavioral problems which excluded the routine use of restraints as an intervention needed champions.

The Clinical Nurse Specialist took the lead in performance improvement activities which assisted the interdisciplinary staff in making great strides towards significant reduction in the use of restraints on the forty-six (46) bed behavioral health unit of a large general hospital. The need to “change the culture” regarding the use of restraints was our mission. No longer could staff think of restraint use as a method of assisting patients in obtaining behavioral control, restraint use would only be used for extreme dangerousness to self or others.

Quality assurance monitoring measures had been in place regarding restraint and seclusion use but the need to work towards serious restraint reduction required multiple projects. Under the guidance and direction of the leadership team, process action teams were established to work on policy making,

procedural changes, staff education, patient assessment, documentation tools and equipment use. All members of the interdisciplinary staff were included in some aspect to ensure a safe and effective model of delivery of care for patients who might require behavioral management for extremely dangerous behaviors to themselves or others.

Work in this area these past five (5) years has produced dramatic results in the reduction in the use of restraint or seclusion. Prior to the implementation of the “culture shift” in 1999, this acute unit had as many as twenty-five (25) restraints per month at times. In the recent years, rarely are restraints used and when absolutely necessary for the safety of patients and personnel only in situations of extreme dangerousness. In the calendar year from January, 2004-2005, only two (2) instances have occurred- therefore averaging less than one (1) per month. Currently the unit has proudly and successfully achieved one year restraint free.

As evidenced by the success of this average unit the practice change of restraint use reduction can occur on any unit when importance is given to the multiple tasks that are needed to change the “culture” of the unit. The early and subsequently continued success inspired staff to continually improve the process and maintain low use of restraints. The leadership team guided by the Clinical Nurse Specialist has been instrumental in shepherding the ongoing vigilance and providing continual support, education and monitoring. All of the practice and process changes which were used on this unit can be replicated elsewhere to assist others in making similar changes and having successful outcomes regarding reduced restraint use.

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Poster 4 – Community violence in Northern Ireland: categorisation of services and therapies for people affected by violence

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Background

Community violence in Northern Ireland, locally known as the “Troubles”, caused the death of more than 3600 people (Fay, Morrissey, & Smyth, 1999). This is just one example of recent man-made or natural disasters that caused large-scale traumatic death. Today, there is a previously unmatched awareness of the physical and psychological impact of violence. Health and welfare professionals have become aware that the experience of violent, conflict related physical and psychological injury and bereavement is much more complex than previously thought. A range of theories has been developed in an effort to explain the psychological health consequences of the Troubles (Dillenburger & Keenan, 2001) and a large number of voluntary groups have been formed aiming to help those affected by the Troubles.

The Research

The project detailed in this poster established a comprehensive and detailed overview and categorisation of therapeutic services offered to people affected by sectarian violence in Northern Ireland; and explores the availability and capacity of services available to them.

The project comprises two main phases. In phase one we conducted a survey on forty-nine voluntary groups using a questionnaire. In the questionnaire we requested information about the groups, the people seeking their services, and the range of intervention methods offered. To date 16 questionnaires have been

returned. In total an estimated number of 3,500 people used the services of the respondent groups. The majority of service users were females although most of the groups worked with men as well (n=12). The most frequently used services were befriending, advice and information, support and self-help groups, although a substantial number of groups also offered complementary therapies and narrative work. Fewer groups offered structured therapeutic services such as counselling or psychotherapy.

By-and-large, service provision can be categorised into five groups: (1) Psychology-based, (2) Medicine-based, (3) Philosophy-based, (4) Education-based, and (5) Community-based.

A database and categorisation of the services offered by voluntary groups has been created that allows for mapping of availability, capacity, viability, staff training, and uptake of services.

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Poster 5 – Ethical and methodical solutions for conducting a randomized controlled trial comparing seclusion and restraint

Jan Bergk & Tilman Steinert

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Objective

Is there any difference between seclusion and restraint? In guidelines the “least restrictive alternative” is recommended, but a Cochrane Review did not find any articles that could meet the minimal inclusion criteria of a RCT. While planning the study ethical and methodical problems had to be solved and will be discussed.

Methods

Possible outcome measures and different study designs with their advantages and drawbacks are presented.

Results

A cohort study with optional randomization combines a high internal with a high external validity. As the patients are not competent before the intervention, we acquire the informed consent in accordance to emergency medicine not for the coercive intervention but for subsequent participation in interviews and data recording. Main objective is the human DIGNITY during COercive Procedure (DICOP), a score that sums up different aspects of human rights from the patients’ point of view.

Conclusion

RCTs on coercive interventions in psychiatry are feasible and will be helpful in decision making on “least restrictive alternatives” and establishing ethical guidelines.

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Poster 6 – A randomized controlled trial comparing seclusion and restraint in psychiatry: preliminary results

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Objective

Seclusion and restraint are widely used for people with serious mental disorders. In most countries one intervention is preferred while the other is considered as inhuman or not sufficiently safe, but identical arguments refer to different preferences. There is a lack of evidence from well-designed studies on compulsory measures in psychiatry. In a Cochrane Review on seclusion and restraint no articles could be found that met the minimal inclusion criteria of a RCT. At present we conduct the first RCT comparing seclusion and restraint.

Methods

As principle outcome variable we chose the restriction to human rights in the patients' point of view. To assess the subjective violation of human rights we constructed a score summing up different aspects of human rights (human Dignity during COercive Procedure, DICOP-Score). As design we chose a cohort study with optional randomization. Mann Whitney Rank Test was used to compare the data of seclusion and restraint.

Results

Preliminary Results: 8 months after starting the study n=39 patients were included, 12 patients were randomized. As the sample size of randomized patients yet was too small for statistical analysis we did not make a difference

between randomized and non randomized patients for each intervention. The duration of coercive treatment was longer in the group of patients with restraint. The patients treated with restraint were more agitated and hostile. Significant differences in the DICOP-score between seclusion and restraint could not be found. Apart from the measure performed, and assuming that some type of measure was necessary, the patients thought seclusion would have been the most adequate intervention. Main stressors during seclusion were: “I feared the measure would last forever”, “I felt my dignity was taken away” and “others made decisions on me”. Main stressors during restraint were: “restriction of ability to move”, “others made decisions on me” and “I didn’t know what to expect”.

Conclusion

Randomized controlled trials on coercive interventions in psychiatry are feasible. The preliminary results did not yet differentiate between randomized and non randomized group due to small sample size. There were no significant differences between seclusion and restraint in the reduction of human rights.

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Poster 7 – The National Institute for Clinical Excellence (NICE) guideline on the short term management of disturbed/violent behaviour in psychiatric inpatients and emergency departments / Guideline development – going beyond the evidence

J.M. Chandler-Oatts, RN, RMN, BSc, MSc & Nelstrop L., Phd

On behalf of the Guideline Development Group and the National Collaborating Centre for Nursing and Supportive Care, Royal College of Nursing Institute, Oxford, England.

Aim

To compare the clinical value of recommendations made in an evidence based guideline on managing violence with recommendations from an independent public inquiry into the death of a service user restrained after a violent incident.

Background

The National Collaborating Centre for Nursing and Supportive Care based at the Royal College of Nursing was commissioned by the National Institute of Clinical Excellence (NICE) to develop evidence-based guidelines on the prevention and short-term management of violence in adult psychiatric in-patient settings and emergency departments for use in the UK. The guideline was launched and published in February 2005.

An independent inquiry into the death of David Bennett (an African Caribbean psychiatric service user who died whilst being restrained in a secure setting in 1998) was published in December 2003. As with the guideline, the inquiry made specific recommendations relating to the use of physical intervention (restraint) and the prone position, managing the head during restraint, the number of people who should restrain and the deliberate use of pain.

A NICE guideline provides a systematic review of all the evidence in a given area, which is then considered by a group of multi-professional experts including two service user members. Where evidence is limited, as it was for this guideline, additional measures for validating the recommendations were sought. These included seeking advice from external experts, a peer review process, and a stakeholder consultation. Focus groups were also conducted with African Caribbean service users. Clinically relevant recommendations were then drafted by the group using a modified formal consensus technique.

The David Bennett Inquiry examined the evidence surrounding the care and treatment of one individual and considered whether procedural compliance was compromised or whether the procedure required review. A panel of five health and legal experts considered the evidence of 18 expert witnesses and on the basis of this drew up clinically relevant recommendations.

The two processes reached notably different conclusions. In particular, the inquiry set a time limit of three minutes for postural (prone) restraint. This time limit was not recommended in the NICE guideline. Instead an emphasis was placed on the proper management of factors which may contribute to sudden death (e.g pressure on the neck, pelvis or torso). The presentation will focus on the extent to which the differing processes and rationale underpinning the decision-making of the two bodies resulted in these divergent positions.

Conclusion

Two review processes reached markedly different decisions on a crucial aspect of care in managing violence. Arguably, the relative weight of the more evidence-based process does however provide a stronger guide for clinical practice. Future consideration needs to be given to how these separate but parallel decision-making processes should function in relation to one another.

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Poster 8 – Veränderung durch Kooperation

H. Klinitz, R. Ketelsen, H. Schmidt & C. Zechert

Abstract

Psychiatrie hat einen Behandlungs- und einen Ordnungsauftrag. Auch Zwangsmaßnahmen tragen das Doppelgesicht einer „Hilfe wider Willen“. Neben Unterbringung, Isolierung und Zwangsmedikation ist die Fixierung eine der heikelsten Maßnahmen des psychiatrischen Alltags, beinhaltet sie in der Regel doch die körperliche Überwältigung des Patienten. Nur ausnahmsweise und eher im

Nachhinein scheint sie von Patienten als therapeutische Intervention erlebt zu werden, während sie für Ärzte unter die Maßnahmen des psychiatrischen Notfalls fällt. Systematische Studien zu diesem noch immer tabuisierten Aspekt psychiatrischen Handelns liegen mittlerweile auch für den deutschsprachigen Raum vor – das tatsächliche Ausmaß dieser Form von Gewalt ist allerdings nicht zuverlässig einzuschätzen. Wir berichten über die knapp 10jährige Erfahrungen und Ergebnisse einer überregionalen, interdisziplinären (Pflegekräfte, Ärzte, Psychologen) Kooperation als Mittel der Veränderung. Auf einer Fachtagung zu Qualitätssicherung haben 1996 Mitarbeiter aus Berlin, Bielefeld und Bremen vereinbart, sich regelmäßig (alle 3-4 Monate) über Zwangsmaßnahmen zunächst mit dem Ziel auszutauschen, die „Schmuddelecken“ der jeweiligen Klinik transparent zu machen. Wesentliche Voraussetzung hierfür war eine differenzierte und valide Dokumentation, die allein schon einen bewußteren und restriktiveren Umgang mit Zwangsmaßnahmen förderte. Die Erwartung war, über die Diskussion therapeutischer Konzepte und Erfahrungen in diesem sensiblen Bereich in den einzelnen Kliniken Veränderungen anzustoßen. So wurden Leitlinien bzw. „Behandlungspfade“ für eine fachgerechte Durchführung von Zwangsmaßnahmen entwickelt, eingeführt und einem Prozeß ständiger Revision unterworfen. Eine konkrete Folge war z.B., dass eine Sitzwachenpflicht für fixierten Patienten eingeführt wurde, wodurch sich die Dauer der Maßnahme

in einzelnen Häusern im Durchschnitt halbierte! Als entscheidend erwies sich, wie hoch in der Abteilungshierarchie die Wahrnehmung von Zwangsmaßnahmen angesiedelt ist - ob durch die Leitung bzw. durch den ärztlichen Direktor eine regelmäßige Kontrolle und Bewertung erfolgt; dies beeinflusst sowohl die Vollständigkeit ihrer Dokumentation als auch Häufigkeit und Dauer von Zwangsmaßnahmen. Eine wichtige Rolle spielt die routinemäßige Thematisierung auf Abteilungskonferenzen ebenso wie die Nachbesprechung jeder Zwangsmaßnahme mit dem betroffenen Patienten und, idealerweise, auf einer Stationsversammlung. Täglich über stattgefundene Zwangsmaßnahmen in der Ärztekonzferenz berichten zu müssen, unterstützt die Entwicklung von Standards in der Indikationsstellung. Bauliche Voraussetzungen (z.B. Schaffung von Akutbereichen auf einer offenen Station), therapeutische Konzepte wie Heterogenität vs. Spezialstationen, offene Tür trotz untergebrachter Patienten, Medikationsregime, Pflege Traditionen bzw. -konzepte, die Alternative Isolierung vs. Fixierung u.a. werden in Hinblick auf ihr Potential, die Rate von Zwangsmaßnahmen zu senken, diskutiert. In Vorbereitung einer neuen multizentrischen Studie wird die Validität der zu erhebenden Daten offen hinterfragt und z.B. als Missstand eingeordnet, wie unzureichend in der gerontopsychiatrischen Versorgung Bettgitter und Bauchgurt als Ausdruck professioneller Gewalt wahrgenommen werden. Aus der vertrauensvollen Zusammenarbeit der mittlerweile 6 beteiligten Kliniken sind eine Reihe von Publikationen entstanden oder angeregt worden, deren wesentliche Ergebnisse vorgestellt werden.

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Poster 9 – Calming the storm

Andreen L. Smith & C. Nichols***

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Abstract

Physical techniques to combat violence and aggression have been developed over the past 20 years, from original use in prison services, and adapted in response to increasing episodes of violence and aggression within health care settings. The challenge therefore has been to develop an improved service with emphasis on duty of care and maintenance of dignity. This poster will outline the development, components, approach and integration of a program of therapeutic management of violence and aggression training within Dorset Health Care NHS Trust.

The program aims to enhance existing staff skills, introduce new skills, share best practice and improve confidence in the recognition, early intervention and management of violent and aggressive situations. The program has developed beyond ‘just’ the teaching of physical techniques to a whole systems approach to the in-patient management of violence and aggression. Completion of the course offers staff a system of working both individually and in teams which will enable them to safely contain patients where necessary. Emphasis is placed on good communication, maximising the safety of all concerned, maintaining client dignity, avoidance of unnecessary force, and stresses therapeutic interventions as a first course and the use of physical, ‘hands on techniques’ as a last resort.

Elements incorporated into the program include: engagement strategies, de-escalation skills, breakaway and physical techniques, legal, ethical, cultural and gender considerations, risk assessment, basic life support, report writing,

complications related to drug and alcohol abuse, adaptation of techniques for use within adolescent, elderly, forensic and learning disability environments, debriefing of staff and patients and carers where appropriate. The course draws on the expert skills of specialist lead clinicians throughout the trust to deliver these components and is ever evolving learning lessons from practice.

Since this program was introduced in 2000 the numbers of staff trained in the therapeutic management of violence and aggression has risen from 28% to 99+%, staff report increased confidence in managing violent and aggressive incidents, audit has shown that there has been a dramatic increase in the use of de-escalation techniques and a 60% reduction in the use of actual 'hands on' physical interventions. Once trained, staff attend twice yearly updates to ensure standards and competencies are maintained. Breakaway and de-escalation training is also mandatory for all non-clinical staff. Training across all disciplines, and the provision of training for non-trust organisations e.g. local public, private and charitable organisations, ensures a consistent approach is used across services.

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Poster 10 – Aggression in forensic patients – is it possible to reliably categorize three basic forms?

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Helge Hoff

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Clinical psychologist

Abstract

In a ten patient high security ward aggressive episodes are routinely assessed by SOAS. A common asked question is about variations in aggression forms. This study investigates a hypothesis about three basic forms; irritable, defensive and predatory (instrumental), Nussbaum, 1997. For a period of one year aggressive behaviour has been assessed by three observers (ward psychologists).

The main issue so far is how reliably episodes can be classified based upon this categorization. Interrater reliability, both for assessment of primary and mixed forms, is calculated using Kappa and ICC. There is a moderate overall interrater reliability, with substantial variations between observers, patients and aggression forms.

Main patterns in aggressive behaviour among the patients are described. Irritable aggression is the most common type, followed by defensive and instrumental. Irritable aggression has the highest reliability score while defensive seems to have the lowest.

Different problems in the classification are discussed: multiple causation and changing forms during aggression course - punctuation problems for episodes

- possible overlapping categories and definition problems. Different knowledge about patients and different focus between observers may also be a factor in reducing reliability.

The results suggest that the following topics may be of interest in further studies:

- interventions to increase reliability.
- possible treatment and risk management implications of the categorization
- validating issues: comparing the individual profiles with diagnosis and symptoms and personality patterns.

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Poster 11 – Nurses dealing with traumatic events – does this happen only in psychiatric wards?

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Abstract

Nursing is a difficult and demanding field. Nursing practitioners have to confront and overcome a lot of occupational stress on an everyday basis. Numerous studies examine the way that the nursing staff copes with their stress. Some of them explore the way that nurses cope with critical incidents. These incidents have been defined as traumatic events. They cause the experience of emotional responses of such strength, that the usual coping skills of the personnel are insufficient. The stress reactions resulting from a traumatic event have both acute and delayed emotional, cognitive, physical and behavioural aspects.

Among the health-care professionals exposed to such events, nurses formulate the largest group. Psychiatric patient assaults on the staff members have reportedly increased. A literature review on the frequent occurrence of traumatically stressful events among psychiatric clinical nurses as well as non psychiatric ones and the high incidence of Post Traumatic Stress Disorder (PTSD) among staff victims of patients' violence will be presented.

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Poster 12 – Development of early intervention and symptom management plan for the mentally ill offenders

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Key words: prodromal signs, early intervention, forensic patient care

Background

Early interventions to prevent a recurrence of illness are important. To enable early intervention, nurses have to recognize the particular signs of an individual patient's recurrence. It is particularly important that a multidisciplinary team catch the prodromal signs to be able to deal with aggression of forensic psychiatric patients adequately. In addition, it is necessary that a patient understand his own subjective signs and objective signs and learn how to manage and cope with those signs.

Object

To look for individual prodromal sign of the hospitalized forensic psychiatric patients. On the basis of that, to aim at developing symptom management methods of the patient, and find a particular plan focused on early intervention.

Methods

Five patients participated in a psycho-education program. The symptoms and signs that the patient noticed during program participation were recorded. An investigator reviewed five patient's charts.

Result

Prodromal signs could be classified at three levels. (a) self control (early intervention by patient themselves), (b) need for advice by another person; key person and medical staff and so on (early intervention by another), (c) need for medical intervention or intervention by a little force (early intervention by medical staff). Furthermore, the early intervention was divided into four phases if we could include preventive intervention before prodromal signs developed in early intervention. The violent behavioral outbreak source, prodromal sign (subjective sign / objective sign), coping style were characteristic by a diagnostic difference.

Case of undifferentiated schizophrenia

They were almost able to recognize a subjective sign, but to make it a language was rare, and it was difficult to find an objective sign. Impulsiveness became stronger when they had a feeling of anxiety and irritation. Also they took a destructive action to deny the situation that was a weak point. Even if patient notices his own signs, he can not deal with adequately. Also there is the case where the coping style is violent. For example, shouting, hitting, and so on. With these cases, we required an educational approach about “impulsive behavior control” and “appropriate coping with stress”.

Case of paranoid: When they took an aggressive action for oneself and another person, it was caused by the fact that hallucination and delusion was experienced as direct. Recognition of prodromal sign was indistinct. There are cases where the patient cannot notice his own signs. In such a case, it is important that we manage the symptom and require that a plan of preventive intervention and early intervention is prepared.

Case of atypical schizophrenia: Prodromal sign itself is violent and aggressive. For example, getting angry easily and/or become highhanded. In this case intervention of all phases has to be substantial. We put weight on particularly preventive intervention, and it is necessary to continue carrying out an effective plan. Because there was understanding about subjective signs and objective signs, it was easy to get cooperation about drafting of a plan.

Acknowledgements

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Poster 13 – The relationship between patient – nursing staff ratio and patient violence

Mei-Bih Chen, RN, MS & Sling-Ling Tsai, RN, Phd

Abstract

Patient-staff ratios in psychiatric hospitals are the focus of policy-makers' attention for cost-effectiveness. The relationship between patient-nursing staff ratio and the prevalence of patient violent incidents, was examined at a medical center in Northern Taipei City. Data were collected from 102 beds of three acute inpatient wards. Each violent incident was recorded from an incident report form. Patient-staff ratios during work shifts when incidents occurred were compared with ratios during shifts when no incidents occurred. Pearson Correlation was used to analyze 8785 shifts in three inpatient units, sample periods for three months were examined. At least one violent incident occurred during 15 shifts (.17 percent). More violent incidents occurred on the day shift, confirming previous findings of a relationship between violent incidents and time of day as well as patient characteristics and milieu. However, the relationship between patient-nursing staff ratio and the occurrence of violent incidents was significant. This finding suggests that modifications in patient-staff ratios may affect the prevalence of patient violent incidents, staff may become overworked and demoralized and may no longer provide adequate patient supervision or treatment.

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Poster 14 – Rapid tranquilization in severe agitated patients with schizophrenic psychosis: a randomized clinical trial

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Introduction

Disturbed behavior is frequent in patients suffering from schizophrenia and related disorders. A number of psychotic phenomena like hearing imperative voices, fear and persecutory delusions are often associated with aggressive or even destructive actions. For decades, a combination of haloperidol and diazepam was the standard medication for rapid tranquilization. However, a variety of side-effects is known leading to poor compliance, lower quality of life, stigmatization and an increased number of hospitalizations. There are very few studies on new neuroleptics for rapid tranquilization, anxiety reduction and fast relief from acute psychotic symptoms, . in particular, of highly aggressive, agitated patients.

Methods

Five-days study inclusion criteria were a diagnosis of schizophrenia or related disorder and a PANSS Psychotic Agitation Subscore (PANSS-PAS) of ≥ 20 . Patients were randomized to orally applied haloperidol, risperidone or olanzapine. If necessary, diazepam up to 60 mg/24h was given. Assessment included CGI and PANSS on day 1 and 5, PANSS-PAS on day 2, 3 and 4. SAS and BARS were used to assess medication side effects on day 5. Due to the severity of psychotic symptoms no patient was able to give an informed consent on day 1. Patients who met inclusion criteria were additionally seen by a neutral physician and gave informed consents later.

Results

Not all of the 41 patients (25 male, 16 female) who met the inclusion criteria could be investigated due to dropout or to lack of informed consent leaving a sample of 21 patients (5 male, 6 female, mean age 35.2 yrs) During the five days of observation aggression and general severity of illness were substantially reduced (PANSS-PAS score decreased by 17.0 ± 5.70 , CGI by 1.86 ± 0.65 $p < 0,01$). Neither the respective antipsychotic medication shows an effect on the course of global PANSS reduction nor the cumulative diazepam. ($p > 0,5$). However, the risperidone group showed twice as much dropouts as the other two groups. One reason could be the lower sedative effect of risperidone as compared to olanzapine or haloperidol. The most common side effects were extrapyramidal symptoms in the haloperidol ($M_{SAS} = 3.87$) and risperidone ($M_{SAS} = 5.0$) group. The olanzapine group ($M_{SAS} = 0.66$) showed significantly less extrapyramidal side-effects than the other two groups ($p < 0.01$).

Conclusions

Haloperidol, risperidone and olanzapine show no difference in rapid tranquilization. Thus, atypical neuroleptics with more favorable side-effects could equally be used as “first-line” medication for rapid tranquilization of most acutely agitated schizophrenic patients. Due to the small sample size the results are preliminary and further investigations are needed.

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Poster 15 – Six year follow-up of violence management program with computer-assisted multi-media instruction

Sling-Ling Tsai, RN, Phd & Mei-Bih Chen, RN, MS

Abstract

The attack from a violent patient is always threatening for the psychiatric nurses. In order to enhance the nurse's ability in managing violence and alleviate the tense work environment by violent incidence, the in-service education of violent management must be provided. The main purpose of this study was to evaluate the outcome of the violence management program with computer-assisted multi-media instruction. The content of this program was validated by 54 psychiatric nurses in a medical center with 102 acute psychiatric beds in 1998. After the violence management program was constructed, the nurses were evaluated by a knowledge questionnaire of violence management pre and post the program. The knowledge score of violence management for psychiatric nurses was significant improved by paired t-test. The outcomes showed that the multi-media computer-assisted program was helpful in the learning process and recommend it to the medical discipline staffs. The nursing staffs renewed their violence management knowledge by this multi-media computer-assisted program each year thereafter. The violence rate of this medical center decreased .106 percent from .255 percent (1998) to.149 percent (2004). Thus, the study suggests that the violence management program with multi-media computer instruction could promote to other hospital, or put it into the Internet for staff's self learning of violence management knowledge.

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Poster 16 – Putting a psychiatric patient under restraint in relation to the way of his admission to the mental hospital and in relation to the nursing staff

Varda Paraskevi & Mougia Vasiliki (Greece)

Introduction

The outbreak of violence during the treatment of a patient to the mental hospital is the result of many factors that they effect the patient's behavior.

Objectives of the research

To determine the relation of the psychiatric patient with the way of his admission to the mental hospital.

To ascertain if there is a relation between restraint and nursing shift

Population of the research

717 patients that had been hospitalized unintentional or intentional in a public mental hospital in Athens compose the sample of the research.

Methods

For the attainment of the objectives of the study was formed a questionnaire with questions that concerned patients who had been put under restraint. The variables that had been studied are:

- The way of the patient's admission (unintentional or intentional)
- The reason witch the restraint happened
- The timing that the restraint happened and
- The nursing shift that the restraint happened.

The completion of the questionnaires was done by interviews while the medical files and the nursing staff's reports were used for the typical of the restraint.

Results

(1) From the total of 717 patients, 68 of them (9,5%) had been put under restraint, while 67 of 68 patients (98,5%) had been unintentional hospitalized. That means that over 25% of them were put under restraint. (2) 25% of the restraint had been in the morning shift, which is the most less rate while in the noon and the evening shift the rate of the restraint was 38,2% and 36,8% respectively.

The duration of the restraint in relation with the shift does not present statistical significant difference.

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Poster 17 – The effectiveness of the multimedia violence management education program in the emergency department

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Abstract

Aggression and violence are recognized as significant occupational risk for health care staff. In emergency departments, nursing staffs feel particularly vulnerable because of the added stress associated with having to contend with managing the violent, aggressive and demanding patients. It is the responsibility of nursing administrators to provide educational program and help nurses increase the knowledge and ability of violence management.

The multimedia violence management education program was developed by the psychiatry department as a training course for the new psychiatry nursing staffs with a very well effectiveness. All emergency nurses were included in this program. The nurses had to fill out the questionnaire with 28 questions before and after watching the program. The data were collected and analyzed by SPSS 12.0.

45 emergency nurses (43 female and 2 male nurses) were completed with the training program. The average of working experience was 10 years and six months. Most of the nurses were in the competency level of N2. There were 11 nurses had seen this program two years ago and 37 of them were never seen this multimedia education program before. The result showed that multimedia education program as an intervention could increase nurses knowledge of violence management significantly by using pair-t test ($p=0.000$) may contribute to helping emergency nurses in dealing with aggressive patients and violent incidents in the first step.

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Poster 18 – Aggression in a psychiatric clinic for acquired brain injury – incidence, nature and determinants

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Background

Many people with acquired brain injury have a dysfunctional stress response or suffer from aggression regulation disorders, often giving rise to referrals for clinical treatment. Adequate treatment of these patients requires knowledge as regards incidence, nature and determinants of aggressive behaviour. As far as we know, whilst quite common in other psychiatric patient groups, no epidemiologic studies have been conducted into aggression among patients of this particular group (Nijman et al., 2005).

Objectives

We investigated the incidence, nature and possible determinants of aggression in a group of patients with acquired brain injury.

Method

A 17-week prospective, observational study was conducted in a closed setting (45 beds) for adult inpatients with acquired brain injury. Data collected on the patients included gender, age, involuntary admission, freedom of movement, duration of stay, and data on aggression incidents using the Staff Observation Aggression Scale-Revised (SOAS-R).

Results

The incidence of aggression was 388 (= 28.9 incidents/bed/year; 3 incidents/day). We found that 24 patients were involved in one or more incidents, but 85.5% of the total number of incidents was caused by a small group only (n=8). The mean incident severity was 6.3, which is low (Nijman et al., 2005). Most incidents (233; 60%) occurred after patient-staff interactions. In 349 incidents (90%) the aggression was subject-directed, with a staff member being the target in 77% of the instances. Although it appeared that a victim felt threatened or sustained physical injuries because of an aggression incident on almost a daily scale, 255 incidents (65%) went by without any negative consequences being reported. In 230 incidents (59%) no or only verbal interventions were used to stop aggression. After 7 incidents, staff used seclusion to restrain the patient. No significant correlation was shown between aggressiveness and age, or freedom of movement outside the clinic. Gender however, showed a significant correlation with aggression. Male patients were significantly more often involved in aggression incidents. Involuntary admission and aggression showed also a significant correlation.

Conclusion

The incidence rate of aggression in this study is high compared to other studies, but the severity of the incidents is low (Nijman et al., 2005). Most incidents were related to patient-staff interactions, which may give an indication for future treatment. To continue our analysis of aggression incidents we are planning to compare this patient group with other groups, including forensic and intellectually disabled patients. A systematic registration of aggression incidents using the SOAS-R is recommended in daily routine.

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Poster 19 – Associated factors to physical restraint in psychiatric hospitalization in Spain

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Background

Physical restraint is a method for behavior control when treatment measures results inapplicable by reason of patient agitation or aggressiveness. Currently, prevalence of this measure among inpatients is estimated about 7-20%. Unless stringently indicated, this method represents a potential degrading experience for patients. All efforts regulating and reducing inappropriate interventions must be encouraged.

Objectives

Describe the characteristics of physical restraint in adult psychiatric wards in our Hospital. Identify associated factors to physical restraint. Purpose interventions for controlling these factors and reduce the use of physical restraint

Material and Methods

Data from paper registries filled by nursing staff every time a patient is physically restrained in our Hospital (gender, length of restraint, cause motivating intervention, preventive methods employed previously, injuries for patient or staff) along with a series of other variables retrieved from medical records (age, diagnosis, length of admission, drug abuse) were included in a database built by the authors.

Our sample was randomly compared with a group of 140 inpatients who had not been restrained along the same period.

Results

Data about 453 physical restraint incidents (136 patients) were collected. The mean age was 33.1 years, and 73% were male. The mean length of admission was 42.4 days. The mean length of restraint was 10.3 hours. Prevalence of physical restraint was 7.3%. Major causes motivating physical restraint were: aggressive behavior (49%), self-injuring (20%) and agitation (35%). Preventive strategies avoiding physical restraint were verbal contention (75%), activity distraction (34%), oral medication (45%) and intramuscular medication (16%). As several strategies can be used in the same episode, percentages overlap. Patients undergoing physical restraint held the following diagnoses: schizophrenia (41.4%), personality disorder (15%), non-schizophrenic and non-manic psychotic episode (12.80%) and manic episode (12%). Drug abuse was present in the 64% of our sample. Significant differences ($p < 0.01$) were found among physical restraint rates according nursing shifts (16% during morning shift; 50% during evening shift and 34% during night shift).

When comparing restraint inpatients with non-restraint ones significant differences ($p < 0.01$) were found as regards gender, age, diagnosis and drugs abuse.

To be a young male inpatient, diagnosed under schizophrenia label and abusing or being dependent to any substance, predicts a greater probability ($p < 0.05$) for being physically restrained during hospitalization.

Conclusions

Several factors in our sample increase the risk for a physical restraint. Male inpatients undergo physical restraint significantly more often than female.

“Schizophrenia” diagnosis also increases significantly the risk of inpatient to be physically restraint, as well as the presence of a “drug misuse” diagnosis as a comorbid condition. Physical restraint doesn’t occur randomly along all the day. The most of physical restraints occur during the evening and the night shifts. A broader knowledge about factors associated to being physically restraint during psychiatric hospitalization would help care givers to early identify high-risk patients and design preventive interventions addressed the reduction of this traumatic and potentially humiliating measure to essential levels.

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Poster 20 – Workplace Violence in Psychiatric Hospital: A case study in Thailand

Patraporn Tungpunkom, Kasara Kripichyakan, Bungorn Supavititpatana

Abstract

This is part of a large study entitled “Workplace Violence in the Health Sector: A case study in Thailand”. It was conducted in Chiang Mai, a region of northern Thailand, its aim was to explore the situation, consequences, and management of workplace violence in the psychiatric hospital. Quantitative and qualitative data were collected through questionnaires as well as individual and focus group interviews. Descriptive statistics and content analysis techniques were employed for data analysis.

The sample consisted of 48 personnel from various professional groups. It was found that in the last 12 months at the workplace, 17 personnel (35.4%) were physical attacked and 23 (47.9%) have witnessed incidents of physical violence. Twenty-two personnel (45.8%) have been verbally abused, 7 personnel (14.6 %) have been bullied, 4 personnel (8.3%) have been sexually harassed, and 1 personnel (2.1 %) has been racially harassed. Patients were the perpetrators for all types of violence but relatives of patients were also the perpetrator for verbal abuse and bullying. Based on the qualitative data, the causes of the violence are related to the characteristics of the personnel, the symptoms of the patients, conflict between the colleagues, misunderstanding, the feeling of an unsafe work status, the change of policy, accumulated stress, miscommunication, and loaded work. Moreover, stimulated factors also included the rotation of personnel from one unit to another and the exacerbation of symptoms of patients. The consequences could be divided towards to victims and abusers. After the violence occurred, the victims received support or treatment. They may get medical leave, compensation for medical expenses or praise from colleagues and superiors. As for the abuser, if they were patients, they received PRN medication, if they were the general public, investigations and subsequent

punishments would be pursued. The prevention strategies included training on the aggressive symptom management, skill for assessment, and self-defended technique.

The results of this study indicated that working with psychiatric patients is one of risk factors related to workplace violence. Raising awareness among health personnel as well as workplace violence prevention programs should be emphasized. Health services for both victims and perpetrators should be provided.

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Poster 21 – Techniques for Preventing Aggressive Behavior with Adolescent Clients

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Keywords: Aggression, Violent Behavior, Seclusion Room, Restraints, and Safety.

Definition

Any purposeful action which includes but is not limited to an attempt to injure self, others and/or destruction of property.

Causes

Societal pressure and other compounding variables cause adolescents to act upon ill-equipped and maladaptive developmental skills by becoming agitated, aggressive, destructive and violent in an attempt to adapt to normalcy.

Adolescent Psychiatric Unit: APU is a 12 bed inpatient short-term acute care unit, with a multidisciplinary treatment team. The unit is highly structured, with privileges tied to progress in treatment. The unit offers individualized psychiatric assessments, diagnosis, evaluation and crisis intervention for patients with

history or the potential for aggressive and/or violent behavior with the objective of providing intensive Individualized Treatment Plans (ITP).

Intervention

Interventions are based on milieu management techniques adopted from the Triangle of Choices. The Triangle of Choices offers different levels of care from the least restrictive to most restrictive. In addition staff education, patient debriefing, staff debriefing, staff competencies and staff levels have led to a substantial decline in the use of seclusion and restraints.

Results

A substantial decline in the use of seclusion and restraints on the adolescent psych unit.

Abstract

Due to societal pressure and other compounding variables, adolescents may act upon ill-equipped and maladaptive developmental skills by becoming agitated, aggressive, destructive and violent in an attempt to adapt to normalcy. These behaviors may be compounded due to poor coping skills related to being exposed to violence and abuse in various settings including their home, school and social circles.

Some of the behaviors portrayed by adolescent patients include, but are not limited to, homicidal ideation, suicidality and thoughts of hurting others. On the Adolescent Psychiatry Unit (APU), our objective is to use cutting-edge strategies and evidenced-based practice to stabilize the client and demonstrate functionality outside the acute care setting. The core values and mission statement of APU are to maintain client safety in light of the potential for aggressive behavior.

The mantra is to “De-escalate before the patient escalates,” by making amends to maladaptive behavior. It involves tackling internal and external factors that contribute to the psychological conflict. Some of the techniques, such as anger management, problem solving, stress reduction and psycho-education are

necessary and paramount to alleviate more restrictive interventions such as the use of seclusion room and/or restraints.

This poster will outline examples of the strategies utilized on APU, including a triangle of choices, awareness of triggers to aggression, and alternatives to violence when dealing with difficult feelings. Staff training will also be highlighted, including pointers on how to prevent aggressive behavior as well as how to safely de-escalate an aggressive patient.

A representative of APU will be available to explain how these interventions have been effective through examples of individualized choices created by clients, as well as graphs showing a declining trend in using seclusion and/or restraint. In addition other interventions such as debriefing techniques from patients' as well as care providers' perspectives will also be highlighted.

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Poster 22 – Attitudes towards domestic violence and help services among Slovenian adolescents

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Keywords: domestic violence, adolescents, help services, health professionals, victims, attitudes

Background

The role of the medical sector has expanded with increasing recognition that domestic violence is also a public health problem that can be prevented by addressing its underlying causes. Recent suggestions of World Health Organization have clearly stated that health ministry and medical services should have a focal point for the prevention of domestic violence.^{1,0} Although it has been estimated that domestic violence is wide spread in Slovenia, the lack of empirical data of domestic violence prevalence and its consequences, aggravate the precise knowledge on the extension of the phenomenon at the moment.⁰ Unfortunately, there is no widespread awareness of how violent behaviour looks like, which often leads to confusion, formation of taboos and stereotypes and passive tolerance to violent forms of behaviour in community. Beyond all the cost consequences that domestic violence causes each year, there are also enormous health, psychological and social consequences, inflicting not only intimate partners in families, but the most vulnerable parts of the family systems – children, as well. Therefore the routine system that would screen for such abuses should be implemented in health system^{0,0}. In this regard, the understanding of domestic violence awareness and attitudes towards support of domestic violence victims among the population is crucial in designing the effective prevention and intervention programmes in Slovenia.

Aim

The aim of our study was to estimate the extensiveness of domestic violence and the evaluation of attitudes towards different help services among Slovenian adolescents.

Methods

The questionnaire for screening the domestic violence behaviour and attitudes towards different help services was applied on the sample (N=1297) of young adolescents (age 13-15 years), which included 47,5% of males and 52,5% of females from 65 Slovenian primary schools from urban (46%) and from the rural area (54%). Data were analyzed with descriptive statistics, t-tests, ANOVA and chi-square tests with SPSS 13.0 tool.

Results

Attitudes towards domestic violence: Different forms of physical punishment (battering, slapping, pushing, grabbing), psychological punishment (shouting, calling names, insulting, swearing, threatening, not speaking), sexual abuse (forcing into sexual intercourse, rape, forcing to watch intimate parts of a body or erotic pictures), witnessing violent behaviour (between family members, against animals) and witnessing suicidal or auto-aggressive behaviour by family members were mostly recognised among adolescents as patterns of violent behaviour. Nevertheless, males believed, that domestic violence occurs less frequently ($t = -6,2$; $p < 0,05$) and they also found it more acceptable than females ($t = -4,2$; $p < 0,05$). Males were more tolerant to sexual abuse in families than females ($t = -3,6$; $p < 0,05$). Compared to non-victims, the victims of domestic violence believed that domestic violence occurs more frequently ($t = 2,1$; $p < 0,05$).

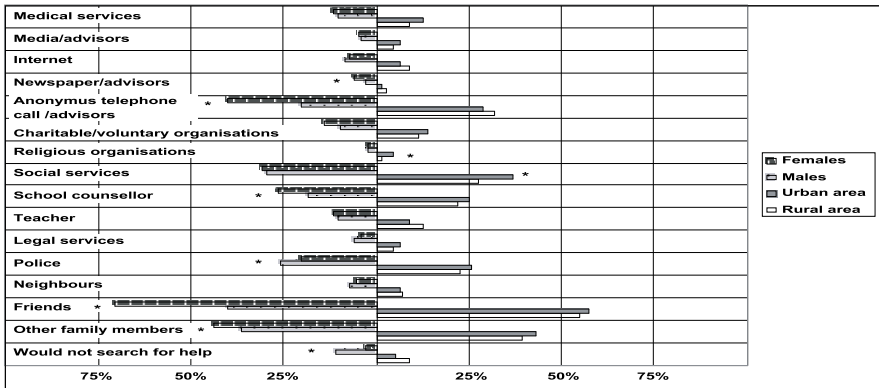
Victims of domestic violence: Analysis of answers to question: ‘Which family member was psychically or physically victimized?’ showed, that 18,7% of all adolescents experienced violence in their own family (38,3% males and 61,7% females). Two groups were excluded from further analysis: adolescents who did not respond to the question (28,5%) and those who answered inconsistently (1,2%). Calculations that were made on remaining sample revealed that 16,8%

of adolescents experienced violence themselves and 9,9% viewed other family members while being violated by family member(s). Female adolescents reported more victims that were close relatives than males (FEMALES: mother: 6,2%; father: 2,3%; MALES: mother: 3,9%; father: 1,9%), while male adolescents recognised more victims in distant family members (grandmother, grandfather, aunt, uncle, other children who were not brothers or sisters). Adolescents from rural area reported approximately twice as much victims of domestic violence when compared with those who lived in urban area, i.e.: URBAN: I was: 4,3%; mother: 3,5%; father: 2,8%; RURAL: I was: 8,2%; mother: 6,5%; father: 1,4%.

Attitudes towards help services: Attitudes towards organisations or individuals that could help juvenile adolescent victims of domestic violence (family members, neighbours, friends, social service, school teachers, school counsellors, medical service, police, country, legal system, volunteers and media) were in general positive among adolescent victims from rural and urban area. Adolescents found them helpful. Significantly different attitudes towards help services were found among victims when compared to non-victims regarding to gender (t-test, $p < 0,05$). When compared to females, males in both groups thought that support from friends, social services, school, medical services and police could be less helpful.

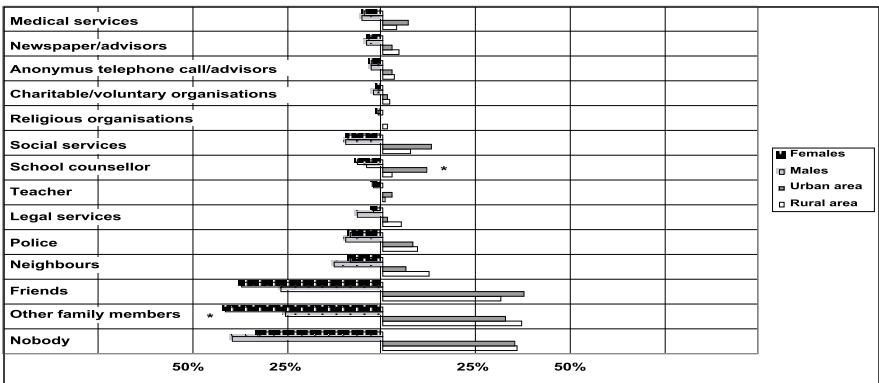
Potentially used help services: To the question: ‘Suppose that you became a victim of any form of violence in your family and that you experienced physical, psychological or material damage. Would you report it?’ 49% of non-victims and 34% of victims answered, that they would report the violence. Male non-victims would be less prepared to report the violence to other family members, friends, school counsellors or anonymous telephone-calls than female non-victims, but more prepared to report it to the police or to the legal services (Picture 1). 13,4% of adolescents would not search for assistance and approximately 20% of adolescents would probably seek assistance by medical service if they were victims of domestic violence. Adolescents from the urban area would use social and also religious services more often than those, who lived in the rural area, whereas adolescents from rural area found social services and mass media more helpful.

Picture 1: Percentages of non-victim adolescents who would probably seek help by different organisations or people, if they were victims of domestic violence (N=670). (- χ^2 ; $p < 0,05$; females vs. males and urban vs. rural area).*



Received help from help services in the case of domestic violence: The support was mostly offered by friends and by other family members, while approximately 70% of adolescents claimed not to receive any assistance (Picture 2). Assistance by health professionals was reported in approximately 10% of adolescent victims. Regarding to gender, females more often received assistance from other family members than males. 2,5% of victims who lived in the rural area and 12% of those who lived in the urban area, received the school counsellor support. However, there were no significant differences between victims who received support from health professionals in the rural and the urban area.

Picture 2: Percentages of adolescent victims of domestic violence who sought help by different organisations or people (N=243). (*- χ^2 ; $p < 0,05$; females vs. males and urban vs. rural area).



Discussion

Our study confirmed some estimation from non-governmental organisations, which deal with domestic violence. Approximately one fifth (18,7%) of adolescents experienced domestic violence. 16,8% of them were victims themselves, whereas 9,9% were witnesses when other family members WERE being violated. Interestingly, the research also revealed, that females were more sensitive to domestic violence which occurred between close family members and were also less tolerant to sexual abuse. The evaluation of victims' attitudes towards different help services showed, that the actual behaviour of adolescents, when faced with the problem of domestic violence, differed from their attitudes. While more than 20% of adolescents, who had never been victims of domestic violence, thought that they would seek assistance by any of cited help services, less than 20% of adolescents, who had really been victims, did so. Although adolescents mostly sought assistance by 'other family members' and 'friends', there were almost 40% of males and more than 30% of females, who did not receive any assistance at all, which should be another matter of community concern. For example, 20% of adolescents would seek for assistance by medical services in the case of domestic violence, whereas 10% of victims actually sought help by health professionals, which clearly shows that there is a recognizable gap between attitudes towards medical services and their practice policies.

Conclusions

The gap between attitudes towards medical support and the actually given support could be the orientation for developing better prevention strategies, i.e.: routine-screening procedures in medical practice for domestic violence in the future. The intervention and protection of a victim by health professionals is especially important when the victim is a child or an adolescent person, since such actions can effectively prevent the outburst of depression, suicide, behavioural problems and, of course, the never-ending story of spreading the violence to the future generations.

Acknowledgements

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Poster 23 – Personality traits and help strategies of women who are victims of domestic violence

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Keywords: domestic violence, help-seeking, help services, personality traits, aggression.

Background

Interpersonal violence occurs in enormous range of contexts and is ranked among the leading causes of death and disability¹. Despite current awareness of its causes and consequences, we are still lacking data on violence prevalence and occurrence. Particularly the domestic violence against women is often hidden and women are still at high risk of being injured or killed in courses of domestic violence, among them intimate partner violence being most common³. This significant public health problem does not result only in immediate injury, but also leaves health, social and economic consequences³. Therefore there is a strong need of some state-based interventions. However, to obtain establishment of necessary preventive programs the capacity for collecting data on violence should be increased¹. Moreover, following recommendations of World Health Organization¹ health ministry and medical services should take an active part in implementing successful preventive and intervention strategy. In our research we studied some basic information on prevalence of domestic violence, help strategies of its victims and their personality characteristics, aiming to support further researches providing preventive and intervention programs in Slovenia.

Aim

In the applied study we analysed the personality traits of women who were victims of domestic violence. Furthermore, the core aim of our study was to establish what sources of help the victims addressed.

Methods

Data were collected on sample of 81 women, aged between 20 and 78 years. The participants completed a General Domestic Violence Questionnaire for violence exposure and help seeking screening and two personality traits tests (Buss-Perry Aggression Questionnaire; 1992 and Plutchick's Inventory of Emotions; 1974). Using SPSS 13.0 tool we calculated descriptive statistics and t-tests.

Results

Frequency of domestic violence: On the basis of collected data we divided participants in two groups, regarding their answer to question "whether they had ever taken part or witnessed at least one of the following behaviour patterns that could be regarded as violent": battering, slapping, pushing, grabbing, shouting, insulting, swearing, threatening, not speaking, forcing into sexual intercourse, rape, forcing to watch intimate parts of a body or erotic pictures, suicidal or auto-aggressive behaviour by family members. Those who confirmed the question were further analysed regarding on answers to question "who was the victim of violent actions". The results showed that 25,9% of women stated that they were victims of domestic violence themselves. Surprisingly, 46,9% participants reported taking part or witnessing in violent situations mentioned above but they did not recognize themselves or others as victims of domestic violence. Women that declared themselves as victims estimated domestic violence to be more frequent than non-victims imagined. Difference in their views was significantly important ($t = -2,8$; $p < 0,05$). Victims felt that domestic violence against women was "unacceptable in all circumstances but not always punishable by law" whereas non-victims agreed with unacceptability of violence but tended to think that it is "always punishable by law".

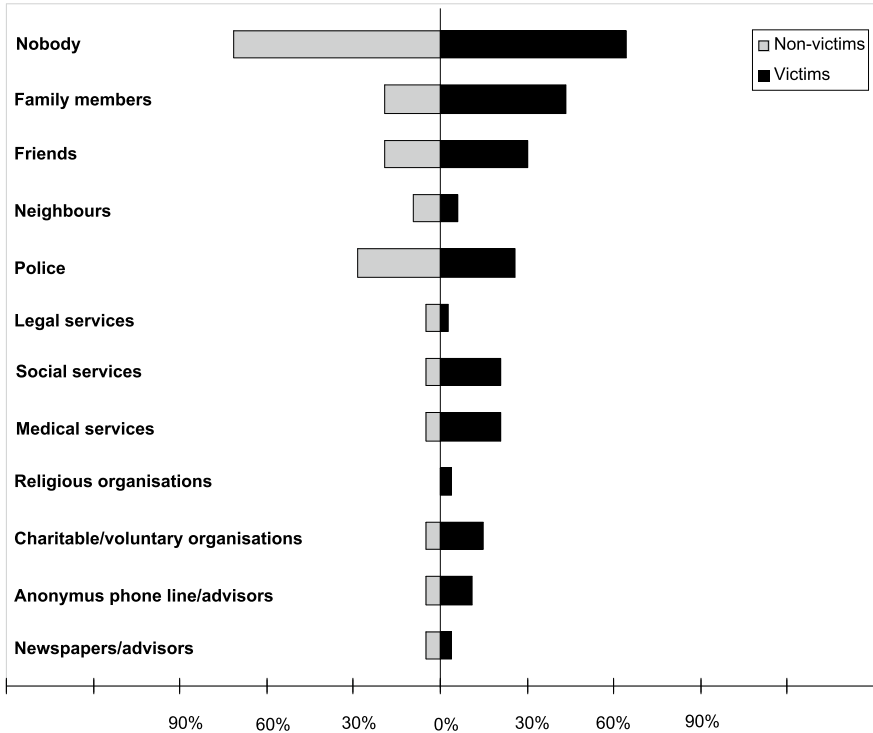
Participants also estimated different behaviour patterns as violent. The only significant difference appeared in consideration of abusive sexual behaviour since victims have reported this behavior pattern as violent more often than non-victims ($t = 2,6$; $p < 0,05$).

Help strategies of victims: In our study we were particularly interested in attitudes towards help services and help-seeking strategies of victims. Respondents were asked: “Whether family and friends, social services, medical services, the police, the state, charitable and voluntary organizations, religious organizations and the media could help women who are victims of domestic violence?” There were no significant differences between groups of victims and non-victims in their view on abovementioned entities as having a legitimate interest in the problem of domestic violence, family members, social services and friends scored highest, whereas the media and religious organizations were estimated with lowest scores. However, a weak tendency was revealed when victims reported that these entities could help more often comparing to responses of non-victims.

Furthermore, the participants were asked: “Whether each of instruments proposed (free phone number, tougher laws, tougher enforcement of existing laws, teaching young people about mutual respect, campaigns to raise public awareness, punishing perpetrators and rehabilitating perpetrators) was useful in combating domestic violence against women?” The answers showed the opposite tendency, non-victims scored usefulness of all the instruments higher than victims with significant difference in case of teaching young people ($t = -1,1$; $p < 0,05$), raising public awareness ($t = -1,9$; $p < 0,05$) and punishing perpetrators ($t = -3,1$; $p < 0,05$). Regarding help-seeking strategies, only 28,6% of women who described themselves as victims tried seek for help either by themselves or someone else did that. Results showed that in most cases the police (28,6%), family (19%), friends (19%) and neighbours (9,5%) helped victims of domestic violence. Other sources of help: social services, medical services, solicitors, barristers, charitable or voluntary organisations, religious organisations were named in minority.

In the hypothetical case being victim of domestic violence 35,8% of all participants answered that they would seek for help, preferably within the family (43,2%), at the police (25,9%), at friends (21%) or in humanitarian organizations (14, 8%).

Picture 1: Comparison between used help services in the group of victims (N=21) and potentially used help services in the group of non-victims (N=60) if they were victims of domestic violence.



Personality traits of victims: Women who reported being victim of domestic violence scored significantly higher on dimension hostility of Buss/Perry Aggression Questionnaire ($t = 3,0$; $p < 0,05$) but significantly lower on dimension aggression of Plutchick's Inventory of Emotions ($t = -2,1$; $p < 0,05$) comparing to women that had not experienced or witnessed domestic violence. Results on other dimensions of applied personality tests did not show significant differences. We also examined if these two groups of women differ in their estimations of relationships with their relatives. Victims estimated relationships with their parent's significantly worse than non-victims ($t = -5,3$; $p < 0,05$), but there were insignificant differences in estimation of relationship with partner, children and partners parents.

Discussion

Our estimate of victimization among women is comparable with studies that used the similar survey methodology⁴. Our results revealed the significant gap in the group of women who experiences or witnesses domestic violence and

who recognise these behaviour patterns as violent and those who do not address them so. Despite of all the efforts to raise awareness of this insidious and frequently deadly social problem, it still remains unrecognized and therefore uncovered in many cases, particularly concerning abusive sexual behaviour. It seems that general public tends to think that domestic violence is less wide spread and moreover, it is always recognized and punished. These data suggest the necessity of implementing public awareness campaigns, teaching people to recognize and deal with violent behaviour. Furthermore, special awareness should be addressed to families as our results show that quality of relationships within the family plays an important role, especially relationship with parents. Regarding help services in support to victims of domestic violence we should be concerned of the very low score of both, those who think they would seek for help when being victim of domestic violence and those who really do so. Moreover, there is a gap between these two groups, suggesting that not only that there is very small share of women who would intend to report domestic violence, in real-life situation there is a great possibility that they would remain silent. These data again supports the idea of taking necessary steps in designing of effective preventive approach to problem of domestic violence.

Conclusions

This study, based on self-report data, provides some baseline estimates to prospective evaluation of prevention programs. However, for enhanced understanding of domestic violence information from different data sources should be combined.

Acknowledgements

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Poster 24 – The impact of different coercive measures setting on pharmacotherapy use in a psychiatric intensive care unit

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Purpose

In patients with psychiatric disorders, admitted to a Psychiatric Intensive Care Unit (PICU), two types of pharmacological treatment are in use. Patients are given regular pharmacotherapy according to the diagnosis and “pro re nata” or “as required” therapy to control disturbed behavior. In patients presenting with agitation, violence or self-harm apart from “as required” therapy which is also called “chemical restraint” (antipsychotics and benzodiazepines), different physical coercive measures are in use (net-beds, bed-belts, non-coercive types of supervision). The aim of our prospective naturalistic study was to assess the possible differences in pharmacotherapy following the reduction of physical safety measures, e.g. the abandonment of net-beds and the use of bed-belts only.

Methods

all patients admitted in two time intervals – February - March in 1998 (when net-beds were still in use) and in 1999 (when only bed-belts were used) to PICU of University Psychiatric Hospital in Ljubljana, Slovenia, were evaluated. The collected data were: socio-demographic characteristics, ICD-10 diagnosis, Clinical Global Impressions, Global Assessment Scale and coercive measures. All prescribed medication, on regular basis or as chemical restraint, was thoroughly collected and doses calculated in chlorpromazine equivalents (in mg) for antipsychotics and benzodiazepine equivalents for benzodiazepines.

Results

332 patients (173 men) in 1998 and 312 (168 men) in 1999 were admitted to PICU, with mean CGI 4.6 and GAS 35.6 in 1998, and mean CGI 4.9 and GAS 29.0 in 1999. Around 60% of all admissions were patients with psychosis, and 30% with organic disorders or substance abuse in both years. 95 patients had a sort of coercive measure, among them 24 were restraint in a net-bed in 1998. In 1999, 44 patients had a safety measure (16 were restraint with bed-belts), 66.8% of patients received antipsychotics in average dose 696.3 mg (SD=736.2) on regular basis in 1998 vs 64.7% (average dose 569.1mg; SD=622.1) in 1999. Among the 95 patients in which safety measures were used in 1998, the average dose of antipsychotics used on as required basis was 78.0mg (SD=70.2) vs 149.2mg (SD=127.8) in 44 coerced patients in 1999 ($p=0.05$). The doses of benzodiazepines were higher in 1999 as well. Although the difference in prescribed doses of antipsychotics is small, a tendency toward the use of higher doses of antipsychotics and BZD has been observed after the change in physical coercive measures setting.

Conclusions

A difference in psychopharmacotherapy use has been observed after the change in the coercive measures setting in PICU. We speculate that the reduced availability of coercive measures might affect the use of complementary chemical restraint. However other factors may be of importance, like the change in the attitude of staff towards patients' disturbed behavior.

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Poster 25 – Assessment and prediction of violence risk of psychiatric inpatients and consequences on treatment approach, coercive measures and staff work place security and satisfaction

V. Pfersmann, Kramer B., Bayer F., Spoerk I. & Haushofer M.

Abstract

Violent incidents are a common risk for staff working at psychiatric wards. At the psychiatric department of a regional hospital in Vienna, Austria, about 35 to 50 % of the admitted patients present a risk of self- harm or harm other persons in relation to their psychiatric illness.

Aim

The aim of this study was 1. to better assess the risk of violence of these patients at admission and during treatment, 2. to optimise the therapeutic strategies, medical and nursing interventions, 3. to reduce the number of coercitive measures, 4. to reduce the number of violent incidents, 4 to optimise staff security and work place satisfaction.

Hypothesis

On setting the focus on the assessment and prediction of violent behaviour of the patients and focussing on methods of deescalation of risk situations and optimising therapeutic interventions, the necessity and the form of coercitive treatment methods and of violent acting out should be reduced and lead to a better work place quality and security of staff. The patients should be more satisfied with the treatment.

Methods

Within an observation period of six months all admitted patients were diagnosed by psychiatrist following ICD- 10 Criteria, psyopathology was assessed with BPRS (Brief psychiatric rating scale) and CGI (Clinical Global Impression) scale. The patients evaluated their satisfaction with the treatment and the staff. At the beginning and the end of the study the staff of the admission ward assessed their work place satisfaction and intensity of burn-out with the MBI (Maslach Burnout Inventory).

The risk of violence of the patients was assessed with the SOAS- R scale (Staff Observation of Aggression) twice a day during the first three days after admission and BVC-CH (Broset violence Checklist) and during further hospitalisation after a violent incident.

Therapeutic interventions such as therapeutic speech, talk down, medication and the necessity of coercitive measures were documented.

Results

As the observation period is still ongoing until november, 2005, first results: the frequency of violent incidents, the impact on patient and staff satisfaction will be presented.

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Poster 26 – Violence among patients with schizophrenia from year 1949 to 2000

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Objectives

To determine prevalence and characteristics of violence among schizophrenic patients in the years 1949, 1969, 1989, and 2000 in Prague (CR).

Methods

Follow back of four independent Prague samples from 1949, 1969, 1989, and 2000. A total of 404 rediagnosed patients from who met the DSM IV criteria for schizophrenia were screened for violence (defined as 3 points on MOAS) from the first observed psychotic symptoms until the time of latest information available.

Results

Logistic regressions revealed a marginally significant increase in violence only in the 2000 cohort. Overall, violence was 41.8% for men and 32.7% for women, with no association found between substance abuse and violence. Patients from first cohort who received pharmacotherapy treatment have lower duration of total hospitalization 1.74 (s.d. 4.04) years, than patients who never received antipsychotics - 9.23 (s.d. 11.54) years.

Analysis of victims of violent offenders (from 1989 and 2000 only) shows that family members were involved in the half of assaults committed by male as well as female offenders. Strangers were attacked in 17% of assaults.

Conclusions

The violence rate found in our sample is expected to remain stable over time under stable conditions. Substance abuse is not the leading cause for violence among schizophrenics. Pharmacotherapy on itself does not lead to decrease in violence. Preventing patients from substance abuse is not sufficient for reducing violence. Strategies aimed to the disordered impulse control and psychopathic characteristics together with antipsychotic therapy could decrease violence among patients with schizophrenia. Family members form the majority of victims

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Poster 27 – Decrease in P300 amplitude in Violent Impulsive offenders

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Introduction

Event-Related Potentials are a simple non-invasive neurophysiological method enabling to comprehend certain aspects of the cognitive processing of information in humans. The best-known component of Event-Related Potentials is the P300 wave. Alterations in the parameters of wave P300 have been observed in certain personality disorders and in persons with aggressive behavior. Aggressive behavior can be divided into three fundamental types. Firstly, aggression caused by a disease, namely under the influence of psychotic symptoms, delusions and hallucinations; secondly, premeditated aggression, non-impulsive, without any concomitant affect; and impulsive aggression without premeditation. To the latter group can be included the intermittent explosive disorder classified in DSM IV. In the group of impulsive aggressors amplitude lowering was reported.

Purpose

The purpose of this study is to investigate changes of the amplitude and latency at the Pz electrode site in impulsive aggressive individuals.

Methods

We examined 15 persons with impulsive aggressive behavior and compared them with the normal population matched for age, gender, and approximate educational status.

We used auditory P300 component of Event-Related Potentials and a neuropsychological battery Eysenck IVE.

Results

Group of impulsive aggressive offenders has significantly lower amplitudes of the P300 wave than control non-offenders group ($P < 0.001$). Group of impulsive aggressive offenders has not statistically significant longer latency of the P300 wave. Group of impulsive aggressive offenders has significant differences in I subscale of Eysenck IVE ($P < 0.001$). Impulsivness in Eysenck IVE doesn't correlate with the amplitude of the P300 wave.

Conclusion

The study confirms the hypothesis on the existence of a specific deficit in the processing of external stimuli in subjects manifesting an impulsive pattern of behavior. A decrease in amplitude points to a defect in attention. The results showed that in impulsive aggressive subjects we have found significantly lower amplitudes in comparison with the control group. In the latency of P 300 wave there were no significant differences.

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Poster 28 – Preventing and managing of aggressive behaviour of psychiatric patients

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Abstract

Patients admitted to inpatient psychiatric unit are usually in crisis so during this time acts of violence and physical aggression may occur. Nurses spend more time with patients on an inpatient unit than any other mental health professional. Thus they are more likely to be involved in preventing and managing aggressive behavior and they are in greater risk for being victims of acts of violence by patients. It is critical that psychiatric nurses be able to intervene effectively with patients before, during and after the aggressive episode.

Predicting aggressive behavior

Although researchers have made progress in determining reliable predictors of violence, there isn't accurate prediction. In general, research indicates that there are two populations of patients that are at increased risk of aggressive behavior:

- Patients with active psychotic symptoms
- Patients with substance abuse disorders

Nursing assessment

It is important for psychiatric nurses to be alert for symptoms of increasing agitation that could lead to violent behavior. Another critical factor in the assessment is affect associated with escalating behaviors. Violence assessment can help nurse to: establish therapeutic alliance with the patient; assess a

patient's potential for violence; develop and implement the plan of care; prevent aggression and violence. If the patient is believed to be potentially violent the nurse should:

- Implement the appropriate clinical protocol to provide patient and staff safety.
- Notify co-workers
- Obtain additional security
- Assess the environment and make necessary changes
- Notify the physician and assess the need for medications

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Poster 29 – Code White Pilot Project: Evaluation of Training in a Team Response to Higher Levels of Physical Aggression in a Tertiary Care Psychiatric Hospital

Margaret Moreau, Joseph Noone & Glenn Haley
Riverview Hospital, British Columbia, Canada

Abstract

Initiatives to improve the safety of patients in health care settings are a priority of Health Canada, the Canadian Council on Health Services Accreditation, and the British Columbia Ministry of Health. “Code White” addresses this need by providing a trained team response to higher risk behavioural emergencies using interventions that maintain a therapeutic relationship with the patient. The values of Code White training are: Staff and patient safety is the first priority; an underlying philosophy of respect and professionalism (not power and control); use of the least restrictive and most appropriate alternative; a focus on prevention and de-escalation (voluntary compliance is the goal); and restraint and seclusion as a last resort (prevention is the best intervention).

During the Code White Pilot Project, two days of training were provided to 65 multidisciplinary treatment team members of the Adult Tertiary Psychiatric Program at Riverview Hospital in British Columbia, Canada. Day 1 of training covered personal safety techniques; Day 2 focused on the discussion and practice of team interventions with an aggressive patient. At the conclusion of Day 2, a physical exam was used to determine whether each participant qualified as a Code White Leader, a Code White Team Member, or a Code White Auxiliary.

The evaluation data provided strong evidence that Code White training provides the groundwork for an effective and therapeutic response to the aggressive behaviour of patients with serious and persistent mental illness. The hospital administration has endorsed Code White training as essential for staff of the treatment units with the highest level of aggression (i.e., the intensive care unit, the secure care unit, and the refractory psychosis unit).

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Poster 30 – Against All Odds: A Successful Psychiatric Intensive Care Unit in a Tertiary Care Psychiatric Hospital

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Abstract

Riverview Hospital in British Columbia, Canada admits individuals with severe and persistent mental illness who require a level of assessment and treatment that cannot be provided by the secondary psychiatric care system of the province of British Columbia, which has a population of 4.2 million. The intensive care unit of Riverview Hospital provides treatment to patients with a high level of physical aggression.

The literature on psychiatric intensive care units emphasizes the importance of the physical environment in the prevention and management of the aggressive behaviour of patients with psychiatric illnesses. Single rooms, adequate living space, natural light, and access to a secure outdoor garden area are thought to facilitate the treatment of psychiatric aggression. In contrast, Riverview Hospital's intensive care unit is a 20-bed ward housed on the fourth floor of a 90-year old building. Patients sleep in four- to six-bed dormitories. The nursing station, which is located where the entry hall opens on to the day room, provides visibility through the use of plexiglass. Data from Riverview Hospital's psychiatric intensive care unit indicate that despite these environmental constraints, the unit provides effective and efficient treatment for patients with higher levels of physical aggression. The data that will be presented include patients' level of psychiatric symptomatology and aggression at intake and at discharge; use of "as needed" psychiatric medication and seclusion; medication profile at discharge, and patients' length of stay on the unit.

The successful functioning of the unit can be attributed to the social and psychological culture of the unit. Interactions with patients are characterized

by respect, honesty, and empathy. This promotes the development of a therapeutic alliance and foster the patients' belief that they can gain control over their behaviour and their lives. Psychiatric medication is prescribed and carefully monitored with the goal of reducing psychotic symptoms without creating debilitating sedation. The use of "as needed" medication is carefully monitored and seclusion is used for as limited a period of time as possible. Mechanical restraints are not utilized. Physical interventions avoid any use of pain compliance (for example, painful joint locks or pressure points). Many of the nursing staff have worked together on the unit for a number of years and have developed trust and confidence in their ability to function as a team. New staff on the unit are mentored by the unit's more experienced staff.

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- European Violence In Psychiatry Research Group (EVIPRG) (Europe)
- Connecting, partnership for consultancy & training (The Netherlands)
- Division of Forensic Psychiatry, Neurotec Department, Karolinska Institute (Sweden)
- Wiener Krankenanstalten Verbund (KAV) (Austria)
- Donau-University Krems – Universität für Weiterbildung (Austria)
- Haute école de santé Fribourg – Ecole du personnel soignant / Hochschule für Gesundheit Freiburg – Krankenpflegeschule (Switzerland)
- Nursing & Social Education Research Unit – University Berne Psychiatric Services (Switzerland)
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- Norwegian University of Science and Technology (NTNU), Section for Forensic Psychiatry, Brøset Hospital (Norway)
- Synopsis (The Netherlands)

Tom Palmstierna – Henk Nijman - Nico Oud

**“Good clinical, evidence-based practice
for understanding and managing
aggressive and violent behaviour”**

This book reflects the proceedings of the 4th European Congress on violence in clinical psychiatry, which was being held from 20 – 21 October 2005 in Vienna – Austria.

Violent and aggressive behaviour is a complex phenomenon of great importance as violence is one of the major obstacles for effective treatment and rehabilitation of patients, and with regard to health care workers, violence is the major occupational health hazard. The purpose of the congress was to promote and disseminate current knowledge within relevant areas of the recognition, assessment, prevention, treatment, interventions, post-incident interventions, and therapeutic safety management of violence in mental health care within clinical psychiatry. For that matter this congress offered 9 keynote plenary lectures, 10 symposia / seminars / workshops, 45 concurrent lectures, and 30 poster presentations by experts from 23 different countries.

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