Aggression Prevention Protocol

User Manual

Dr Tessa Maguire
Professor Brian McKenna
Professor Michael Daffern

Forensicare

Centre for Forensic
Behavioural Science

ABOUT THE AUTHORS

Tessa Maguire is a Senior Lecturer of Forensic Mental Health Nursing at the Centre for Forensic Behavioural Science at Swinburne University of Technology. She also has a joint appointment with the Victorian Institute of Forensic Mental Health (Forensicare).

Brian McKenna is Professor of Forensic Mental Health, which is a joint appointment between the Auckland University of Technology and the Auckland Regional Forensic Psychiatry Services in Aotearoa New Zealand. He is also an adjunct professor at the Centre for Forensic Behavioural Science at Swinburne University of Technology.

Michael Daffern is Professor of Clinical Forensic Psychology and Deputy Director of the Centre for Forensic Behavioural Science at Swinburne University of Technology. He is also Consultant Principal Psychologist with the Victorian Institute of Forensic Mental Health (Forensicare) and a Fellow of the Australian Psychological Society.

For further information, contact the authors at:

Centre for Forensic Behavioural Science
Swinburne University of Technology
Level 1, 582 Heidelberg Road
Alphington, VIC, 3078
Australia

T: (+61 3) 9214 3887

E: tjmaguire@swin.edu.au
or
mdaffern@swin.edu.au

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Orientation to this Manual

The Dynamic Appraisal of Situational Aggression (DASA) is an actuarial risk assessment instrument designed to assist in the appraisal of risk for violence within 24 hours following assessment. The Aggression Prevention Protocol (APP) was designed to be used in conjunction with the DASA, to provide staff with guidance about how to intervene to prevent violence for patients presenting with different levels of risk. This manual was written to describe the APP and the interventions that are incorporated. The first part of the manual provides a background description of the DASA and the rationale and development of the APP. After that there is a description of the APP interventions for each DASA risk band. There is also a discussion about implementation approaches for the eDASA + APP.

Use of language

Where possible we have used the terms person or individual throughout the manual. In some instances, we have used the term 'patient'. This is to respect the wishes of the Thomas Embling Hospital Consumer Advisory Group, who provide advice and leadership across Forensicare, as this is the term preferred by them.
We acknowledge that terms used across services will vary.

Introduction

Aggressive and violent behaviour is a concern for mental health services around the world. It can have a significant impact on the well-being of staff and patients. The presence of aggression and violence can also negatively influence the ward milieu *(Foster et al., 2007)*. Furthermore, there can be financial consequences for services as a result of inpatient aggression, related to injury and compensation, absenteeism and issues concerning recruitment and retention of staff *(Edward et al., 2016; LeBel & Goldstein, 2005)*.

Often, to prevent and manage aggression, staff may resort to using restrictive interventions, including physical restraint and seclusion. These are high-risk interventions that have the potential to cause harm (physical, emotional and psychological) to patients *(Berzlanovich et al., 2012; Kinner et al., 2017; Lewis et al., 2009)*. Staff are also vulnerable to negative outcomes during, and after use *(Bigwood & Crowe, 2008; Moyo & Robinson, 2012; Muir-Cochrane et al., 2018)*. From a human rights perspective, there are issues associated with the use of these practices, such as limits on freedom of movement *(Bergk & Steinert, 2007; Cleary et al., 2010)*. There is also the potential for these interventions to be used inappropriately, for example use of these interventions as a punitive measure, or when used as a strategy to manage the unit during staffing shortages *(Kumble & McSherry, 2010)*.

Internationally, the focus has shifted from reducing the use of restrictive interventions, to working towards elimination. The shift has occurred due to legislative changes, push for change from staff and organisations *(Gaskin et al., 2007; Kumble & McSherry, 2010; McKenna, 2016)*, and from consumers and their supporters *(Brophy et al., 2016)*. However, despite the desire to reduce or eliminate these practices, restraint and seclusion are still frequently relied upon when disruptive or aggressive behaviour occurs in healthcare settings *(Brophy et al., 2016; Maguire et al., 2012; Savarimuthu & Jung, 2021)*. While there are differences in definitions and oversight of these practices due to local legislation, the use of restrictive interventions are subject to a strict legal framework and monitored closely. These interventions should only be used after other less restrictive interventions have been tried, and used only as a last resort *(Cleary et al., 2010; Happell & Koehn, 2011)*.

There are several barriers to reducing the use of restrictive interventions. Nurses as a professional group are most often responsible for applying these interventions *(Mann-Poll et al., 2015)* and a study by Muir-Cochrane, and colleagues (2018) reported that nurses expressed fear about the removal of these interventions. This study recommended a need for careful consideration regarding elimination of these practices, and the provision of clear alternatives.

In a systematic review, Kynoch et al. (2011) found no studies that investigated patient aggression prevention strategies in acute care settings. The Royal Australian and New Zealand College of Psychiatrists (2010, p.2) identified a "lack of staff knowledge, or skills to prevent use and identify and use alternative interventions" and, a "lack of staff training and knowledge about early warning signs of agitation and aggression and effective interventions to prevent the use of seclusion and restraint". This lack of knowledge and skill has significant consequences for the prevention of violence since staff (most often nurses) are left with little guidance about how to best manage violent and aggressive behaviour without these restrictive strategies. There are also inconsistencies in the type, level and evaluation of aggression management training, and limited outcome data which could provide much needed direction in managing aggression *(Heckemann et al., 2015; Johnson, 2010)*.

A starting point for violence risk mitigation, and one strategy that does have an empirical evidence base, is the use of validated risk assessment instruments to identify who might be at risk of engaging in aggression, followed by the development of an intervention plan and the instigation of strategies. It should be highlighted however, that risk assessment by itself is unlikely to reduce aggression. Assessment of risk must be followed with strategies to prevent aggression *(Irwin, 2006; Maguire et al., 2018)*. We now turn to a description of risk assessment in inpatient mental health settings, before turning to a description of intervention strategies that may be indicated by dynamic risk assessment.