

# S3-Leitlinie „Verhinderung von Zwang: Prävention und Therapie aggressiven Verhaltens bei Erwachsenen“

(Leitlinienreport – Fassung vom 10.09.2018)

AWMF-Register Nr. 038-022

Herausgebende Fachgesellschaft:

Deutsche Gesellschaft für Psychiatrie und Psychotherapie,  
Psychosomatik und Nervenheilkunde e. V. (DGPPN)

## Steuerungsgruppe:

### Federführend

Prof. Dr. med. Tilman Steinert

ZfP Weissenau,  
Abteilung Psychiatrie I  
der Universität Ulm  
Ravensburg/Ulm

### Redaktion

Dr. med. Sophie Hirsch

ZfP Weissenau,  
Abteilung Psychiatrie I  
der Universität Ulm  
Ravensburg/Ulm

## Leitlinienreport

### 1. Geltungsbereich und Zweck

#### **Begründung für die Auswahl des Leitlinienthemas**

Aggressives Verhalten ist ein im Zusammenhang mit psychischen Erkrankungen im Vergleich zur Allgemeinbevölkerung gehäuft auftretendes Phänomen (Fazel et al. 2009a, Witt et al. 2013). Angesichts der Tatsache, dass der Beginn der Psychiatrie in den Geschichtsbüchern auf die Befreiung der Geisteskranken in der Pariser Salpêtrière aus ihren Ketten datiert wird, ist der Umgang mit Gewalt und Zwang wohl das älteste Problem psychiatrischer Institutionen. Während dies über lange Zeit weitgehend tabuisiert wurde, steht heute der Anspruch der psychisch erkrankten Menschen auf eine bestmögliche Versorgung unter den Aspekten sowohl der Sicherheit als auch der Menschenwürde und Überlegungen der Sicherheit für die Beschäftigten im Gesundheitswesen im Vordergrund. Damit wird der Umgang mit Aggressivität und Zwang heutzutage zu einem wichtigen Aspekt der Behandlungsqualität. Diese Herausforderung wird zeitgemäß mit der Erstellung von Leitlinien und deren Implementierung in die klinische Praxis angenommen. 2005 publizierte das britische National Institute of Clinical Excellence (NICE) nach umfangreichen Vorarbeiten die "Clinical Practice Guidelines for Violence: The short term management of disturbed/violent behaviour in psychiatric in-patient settings and emergency departments" unter Beteiligung von psychisch erkrankten Menschen, deren Angehörigen und zahlreichen professionellen Gruppen. Im Jahre 2015 erschien eine Aktualisierung dieser Leitlinie (NICE 2015). Andere Behandlungsleitlinien vergleichbaren Umfangs liegen bisher nicht vor. Die hier vorliegende S3-Leitlinie wurde im Auftrag der Deutschen Gesellschaft für Psychiatrie und Psychotherapie, Psychosomatik und Nervenheilkunde erstellt und stellt eine Aktualisierung und Erweiterung der im Jahre 2010 erschienenen S2-Leitlinie „Therapeutische Maßnahmen bei aggressivem Verhalten“ dar.

#### **Zielorientierung der Leitlinie**

Diese Leitlinie soll den Professionellen in Kliniken und gemeindepsychiatrischen Institutionen, den psychisch erkrankten Menschen und ihren Angehörigen gleichermaßen einen Überblick über den gegenwärtigen Stand des Wissens und eine gute klinische Praxis vermitteln. Letztere leitet sich einerseits aus den wissenschaftlichen Erkenntnissen, andererseits aus ethischen Überlegungen und den gesetzlichen Bestimmungen ab. Im Hinblick auf die unterschiedlichen Zielgruppen wurde versucht, eine möglichst allgemeinverständliche Sprache zu benutzen und unnötigen Einsatz von Fachterminologie zu vermeiden. Ein Ziel aller Leitlinien ist die Implementierung in die klinische Praxis und damit auch die Verbesserung dieser Praxis.

#### **Ziele der Leitlinie**

Ziel dieser Behandlungsleitlinie ist es, Empfehlungen zu Diagnose und Therapie von aggressivem Verhalten auf der Basis aktueller wissenschaftlicher Erkenntnisse und guter

Versorgungspraxis zur Verfügung zu stellen. Es soll damit die Grundlage geschaffen werden, Zwangsmaßnahmen und Zwangsunterbringungen zu reduzieren oder zu vermeiden. Falls deren Anwendung unumgänglich ist, ist die Menschenwürde zu wahren und Rechtssicherheit zu gewährleisten. Interventionen sind so kurz und so wenig eingreifend wie möglich zu halten und psychische oder physische Traumata zu vermeiden.

Den Mitarbeitenden der Leitliniengruppe war bei der Erarbeitung der Leitlinie bewusst, dass dieses Thema in der Öffentlichkeit, aber auch innerhalb der Psychiatrie außerordentlich kontrovers diskutiert wird. Sowohl die Psychiatrie-Erfahrenen selbst als auch deren Angehörige, politisch Verantwortliche auf verschiedenen Ebenen (CPT, Antwort der Bundesregierung 2005, Gesundheitsministerkonferenz 2007), die Vertreter verschiedener Medien kritisieren z. T. konstruktiv und fundiert, z. T. polemisch und wenig faktenorientiert, die in der psychiatrischen Versorgung tätigen Professionellen und die von ihnen praktizierten (Zwangs-)Behandlungen. Die vorliegende Leitlinie fasst das aktuell verfügbare, wissenschaftlich gesicherte Wissen zum Thema „Umgang mit aggressivem Verhalten in der Psychiatrie“ in verschiedene Evidenzgrade eingeteilt zusammen. Es sollte berücksichtigt werden, dass aus dieser Leitlinie abgeleitete Empfehlungen stets im Einzelfall zu überprüfen sind. Eine individuelle Behandlung, möglichst im Konsens mit dem Betroffenen, ist erstrebenswert. Beim Thema „Aggressives Verhalten“ sind Auslöser, Ursachen und Interaktionen komplex ineinander verwoben. Nicht nur psychisch erkrankte Menschen können sich aggressiv verhalten, auch psychiatrische Einrichtungen können im Sinne sog. „institutionelle Gewalt“ Zwang ausüben und Aggressionen hervorrufen. Auch kann es vorkommen, dass sich Mitarbeitende sowie Angehörige z. B. verbal aggressiv verhalten.

### **Patientenzielgruppe**

In der Leitlinie soll es um die Behandlung erwachsener Menschen vom 18. Lebensjahr mit psychischen Erkrankungen (Erkrankungen aus dem Kapitel F der ICD-10) gehen, die im Rahmen ihrer Erkrankung aggressiv oder gewalttätig werden oder die von Zwangsmaßnahmen betroffen werden. Die Situation bei Kindern und Jugendlichen wird in der Leitlinie nicht berücksichtigt. Die Leitlinie berücksichtigt verschiedene psychiatrische Settings (ambulant, teilstationär und stationär). Der Schwerpunkt liegt auf der Behandlung psychisch erkrankter Menschen außerhalb des Maßregelvollzugs. Wo Erkenntnisse aus forensischen Populationen hierfür relevant sind, werden sie aufgeführt.

### **Versorgungsbereich**

Die Problematik aggressiven Verhaltens ebenso wie die der Zwangsmaßnahmen betrifft in erster Linie psychiatrische Krankenhäuser. Mit zunehmender Deinstitutionalisierung ist aber immer deutlicher geworden, dass Krankenhausbehandlung nur einen vergleichsweise kleinen Ausschnitt der psychiatrischen Versorgung darstellt, die heute überwiegend als Gemeindepsychiatrie stattfindet. Demzufolge ist die Problematik des Umgangs mit Aggression und Gewalt genauso wie die sog. "institutionelle Gewalt" immer weniger auf Krankenhäuser beschränkt, sondern auch in sonstigen gemeindepsychiatrischen

Institutionen, in der ambulanten Versorgung und im häuslichen Bereich bzw. Wohnumfeld von Bedeutung. Die auch heute noch vielfach zu beobachtende Gewohnheit, dass aggressives Verhalten von psychisch erkrankten Menschen in betreuten Wohneinrichtungen als zwingender Grund für eine Krankenhauseinweisung angesehen wird und folglich auch allein das Krankenhaus der Ort ist, an dem institutionelle Gewalt stattfindet, erscheint fragwürdig und wird vermutlich angesichts künftiger unter Kostendruck stattfindender Veränderungen des Versorgungssystems so nicht mehr zu halten sein. Allerdings bezieht sich die gegenwärtig vorliegende wissenschaftliche Literatur entsprechend dem Schwerpunkt der Forschungskapazitäten noch unverhältnismäßig stark auf den stationären Bereich, weshalb auch diese Leitlinie unvermeidlich bzgl. der vorliegenden Evidenz dort ihren Schwerpunkt hat. Dennoch können unter Berücksichtigung der anderen rechtlichen und institutionellen Rahmenbedingungen eine Reihe von Ergebnissen und Empfehlungen auf den außerklinischen bis hin zum häuslichen Bereich übertragen werden.

### **Anwenderzielgruppe/Adressaten**

Zielgruppen der vorliegenden Leitlinie sind:

- die in der Versorgung psychisch erkrankter Menschen Tätigen (Psychiaterinnen und Psychiater, Nervenärztinnen und Nervenärzte, Allgemeinärztinnen und Allgemeinärzte, klinische Psychologinnen und Psychologen, ärztliche und psychologische Psychotherapeutinnen und Psychotherapeuten, Sozialarbeiterinnen und Sozialarbeiter, Pflegenden, Ergotherapeutinnen und Ergotherapeuten etc.)
- sich im Rahmen einer psychischen Störung aggressiv verhaltende Erwachsene und Menschen aus deren Umfeld.

Die Leitlinie dient außerdem der Information von politischen Entscheidungsträgern, den Medien und der allgemeinen Öffentlichkeit. Auswirkungen in der Rechtsprechung, der Finanzierungen von Leistungen im Gesundheitswesen und der Anwendungshinweise bei Medikamenten sind möglich und ggf. auch erwünscht.

## 2. Zusammensetzung der Leitliniengruppe: Beteiligung von Interessensgruppen

### Repräsentativität der Leitliniengruppe: Beteiligte Berufsgruppen **S2k** **S3**

Die Leitlinie wurde von der Leitliniensteuerungsgruppe bestehend aus Ärztinnen und Ärzten aus Fachkrankenhäusern, Universitätskliniken, den öffentlichen und ambulanten Gesundheitsdiensten sowie Psychologen, Pflegewissenschaftlern, Pflegenden und Fachpflegenden, Juristinnen und Juristen, psychisch erkrankten Menschen und ihren Angehörigen erarbeitet.

Prof. Dr. med. Tilman Steinert  
ZfP Weissenau, Abteilung Psychiatrie I der Universität Ulm  
Ravensburg/Ulm  
Federführend

Dr. med Sophie Hirsch  
ZfP Weissenau, Abteilung Psychiatrie I der Universität Ulm  
Ravensburg/Ulm  
Redaktion

Dr. Matthias Albers  
Bundesweites Netzwerk Sozialpsychiatrischer Dienste/Bundesverband der Ärztinnen und Ärzte des Öffentlichen Gesundheitsdienstes e. V.  
Abteilung Soziale Psychiatrie, Gesundheitsamt, Stadt Köln

Cornelia Brummer  
Deutsche Gesellschaft für Bipolare Störungen

Ruth Fricke  
Bundesverband Psychiatrie-Erfahrener e. V.  
Bochum

Dipl.-Psych. Gabriel Gerlinger, M.A.  
Wissenschaftlicher Dienst  
DGPPN e. V.  
Berlin

Prof. Dr. jur. Tanja Henking, LL.M.  
Hochschule für angewandte Wissenschaften  
Würzburg-Schweinfurt  
Fakultät Angewandte Sozialwissenschaften  
Würzburg

Dr. med. Felix Hohl-Radke  
Klinik für Psychiatrie, Psychosomatik und Psychotherapie  
Asklepios Fachklinikum  
Brandenburg

Dr. med. Regina Ketelsen  
Klinik für Psychiatrie und Psychotherapie in Bethel  
Evangelisches Klinikum Bethel

Michael Mayer, M.A.  
Allgäu-Akademie am Bezirkskrankenhaus  
Kaufbeuren

Prof. Dr. med. Jürgen L. Müller  
Universitätsmedizin Göttingen  
Schwerpunktprofessur für Forensische Psychiatrie;  
Asklepios Klinik für Forensische Psychiatrie Göttingen  
Prof. Dr. med. Oliver Pogarell  
Klinik und Poliklinik für Psychiatrie und Psychotherapie  
Klinikum der Universität München  
München

Prof. Dr. med. Thomas Pollmächer  
Klinik für Psychiatrie und Psychotherapie  
Klinikum Ingolstadt  
Ingolstadt

Daniela Schmid  
Bundesnetzwerk Selbsthilfe Seelische Gesundheit e. V. (NetzG), Kassel  
Journalistin Druckstudio GpZ Überlingen gGmbH  
Überlingen

Prof. Konrad Stolz  
Hochschule Esslingen (im Ruhestand)  
Stuttgart  
Prof. Dr. rer. medic. habil. Michael Schulz  
und André Nienaber  
Lehrstuhl Psychiatrische Pflege  
Fachhochschule der Diakonie Bielefeld

Prof. Dr. med. Dr. phil. Jochen Vollmann

Institut für Medizinische Ethik und Geschichte der Medizin  
Ruhr-Universität  
Bochum

Gernot Walter  
Zentrum für Seelische Gesundheit  
Kreiskliniken Darmstadt-Dieburg  
Groß-Umstadt

Christian Zechert  
Bundesverband der Angehörigen psychisch erkrankter Menschen –  
Familienselbsthilfe Psychiatrie e. V.  
Bonn

Die resultierenden Empfehlungen wurden in der Konsensusgruppe abgestimmt. In dieser waren die nachfolgend genannten wissenschaftlichen Fachgesellschaften und Organisationen (jeweils mit ihren Mandatsträgern und Berufszugehörigkeit aufgeführt) vertreten. Es wurden Organisationen und Verbände um Beteiligung gebeten, die nach Einschätzung der DGPPN Bezugspunkte zum Thema der Leitlinie haben. Einige antworteten nicht bzw. teilten mit, dass sie nicht teilnehmen könnten.

Nicht direkt in die Leitlinienerstellung einbezogene Experten aus der Betreuung geistig behinderter Menschen (Kurt Hoffmann) und aus dem gerontopsychiatrischen Bereich (Dr. Jochen Tenter) wurden beratend hinzugezogen und erhielten relevante Teile des Leitlinientexts mit Empfehlungen vorab zu einem Review.

### In der Konsensuskonferenz vertretene Organisationen und ihre Vertreter

a)

#### AWMF-Mitgliedsgesellschaften



Deutsche Gesellschaft für Psychiatrie und Psychotherapie, Psychosomatik und Nervenheilkunde e. V. (DGPPN) vertreten durch Professor Thomas Pollmächer, Arzt für Psychiatrie und Psychotherapie



Deutsche Gesellschaft für Gerontopsychiatrie und -psychotherapie (DGGPP) vertreten durch Dr. Jochen Tenter, Arzt für Psychiatrie und Psychotherapie



Deutsche Gesellschaft für Suchtforschung und Suchttherapie e. V. (DG-Sucht) vertreten durch Professor Oliver Pogarell, Arzt für Psychiatrie und Psychotherapie



Deutschsprachige Gesellschaft für Psychotraumatologie (DeGPT) vertreten durch Professor Ingo Schäfer, Arzt für Psychiatrie und Psychotherapie



Die Deutsche Gesellschaft für Pflegewissenschaft e.V. (DGP) vertreten durch Professor Markus Witzmann, Pflegewissenschaftler

## b) Weitere Organisationen



Betreuungsgerichtstag e. V.



Bundesnetzwerk Selbsthilfe seelische Gesundheit e.V. (Netz G)



Deutsche Alzheimer Gesellschaft e. V. Selbsthilfe Demenz



Deutsche Gesellschaft für Bipolare Störung e. V. (DGBS)



Bundesverband der Angehörigen psychisch Kranker e. V. (BAPK)



Berufsverband Deutscher Nervenärzte (BVDN)



Berufsverband Deutscher Psychologinnen und Psychologen e. V. (BDP)

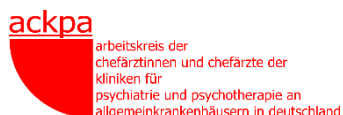




Berufsverband Deutscher Psychiater (BVDP)



Bundesdirektorenkonferenz Psychiatrischer Krankenhäuser e. V. (BDK)



Arbeitskreis der ChefarztInnen der Kliniken für Psychiatrie und Psychotherapie an Allgemeinkrankenhäusern (ACKPA)



Bundesfachverband Leitender Krankenpflegepersonen in der Psychiatrie e. V. (BFLK)



Bundesinitiative Ambulante Psychiatrische Pflege e. V. (BAPP)



Bundesverband der Berufsbetreuer/innen e. V. (BdB)



Deutsche Fachgesellschaft für Psychiatrische Pflege e. V. (DFPP)



Deutsche Gesellschaft für Soziale Psychiatrie e. V. (DGSP)



Aktion Psychisch Kranke e. V. (APK)



Bundesverband der Ärztinnen und Ärzte des Öffentlichen Gesundheitsdienstes e. V. (BVÖGD)

## Repräsentativität der Leitliniengruppe: Beteiligung von Patienten S2k S3

Patientenvertreterinnen waren von Anfang an als Mitglieder der Leitliniensteuerungsgruppe und Autoren an der Erarbeitung der Leitlinie beteiligt (Cornelia Brummer, Ruth Fricke,

Daniela Schmid), auch ein Angehöriger (Christian Zechert). So war es möglich, die Sicht psychisch erkrankter Menschen und ihrer Angehörigen bereits bei der Erstellung der Leitlinientexte und der Ableitung der Empfehlungen mit einfließen zu lassen.

In der Konsensuskonferenz waren vier Betroffenenverbände vertreten (Bundesnetzwerk Selbsthilfe seelische Gesundheit, Bundesverband Psychiatrie-Erfahrener e. V. (BPE), Bundesnetzwerk seelische Gesundheit, Aktion Psychisch Kranke e. V. (APK), die trialogische Deutsche Gesellschaft für Bipolare Störung (DGBS) wurde ebenfalls durch eine Betroffenenvertreterin vertreten und war an der Erarbeitung der Leitlinie beteiligt. Der Bundesverband der Angehörigen psychisch Kranker e. V. (BApK) war ebenfalls in der Konsensuskonferenz vertreten.

6 von 25 Stimmen (24 %) in der Konsensuskonferenz halten also Betroffene bzw. ihre Angehörigen, starker Konsens gegen psychisch erkrankte Menschen und ihre Angehörigen war nicht möglich. Gegenstimmen und Minderheitsvoten wurden in der Leitlinie aufgeführt.

Eine gekürzte, leicht verständliche Fassung der Leitlinie speziell für psychisch erkrankte Menschen, ihre Angehörigen und die Öffentlichkeit wird erstellt.

### 3. Methodologische Exaktheit

#### Recherche, Auswahl und Bewertung wissenschaftlicher Belege (Evidenzbasierung)

##### Formulierung von Schlüsselfragen

In mehreren vorbereitenden Treffen wurde die inhaltliche Struktur der Leitlinie mit der Task Force Patientenautonomie der DGPPN, Professor Falkai, Professor Maier und dem Koordinator dieser Leitlinie, Professor Steinert, diskutiert und abgestimmt.

##### Folgende Schlüsselfragen sollten mit dieser Leitlinie beantwortet werden:

Welcher Zusammenhang besteht zwischen psychischer Erkrankung, Aggression/Gewalt und Zwang? Wie häufig und unter welchen Bedingungen kommt aggressives Verhalten im Rahmen psychischer Erkrankungen vor?

Wie kann man Zwang im Rahmen psychischer Erkrankungen vermeiden? Welche Interventionen sind geeignet Zwang in psychiatrischen Institutionen zu reduzieren?

Wie kann man aggressives Verhalten und gewalttätige Übergriffe im Rahmen psychischer Erkrankungen vermeiden? Welche pharmakologischen und nicht-pharmakologischen Interventionen sind geeignet aggressives Verhalten im Rahmen psychischer Erkrankungen zu behandeln?

##### Verwendung existierender Leitlinien zum Thema **S2e S3**

Vor den eigenen systematischen Literaturrecherchen wurde eine Recherche nach anderen Leitlinien, die sich mit den Themen Zwang und Gewalt befassen, durchgeführt.

Berücksichtigt wurden psychiatrische Leitlinien, die sich mit aggressivem Verhalten beschäftigten. Ausgeschlossen wurden Leitlinien für Kinder- und Jugendliche, Leitlinien, die reines selbstschädigendes/suizidales Verhalten betrachteten und Leitlinien, welche nur Diagnostik/Evaluation aggressiven Verhaltens beinhalteten.

Dazu wurde die internationale Leitliniensammlung [guidelines.gov](http://guidelines.gov) mit den trunkierten Stichworten *aggress\** und *violen\** durchsucht. Die nachfolgend genannten Leitlinien wurden berücksichtigt. Internationale Evidenz und Expertenwissen wurde stets dann verwendet, wenn es vor dem Hintergrund des deutschen Rechts- und Versorgungssystems anwendbar erschien.

##### Großbritannien

National Institute of Clinical Excellence (NICE): NICE Guideline NG10 "Violence and Aggression Short-term management in mental health, health and community settings Updated edition", 2015.

## Frankreich

Troubles du Comportement chez les Traumatisés Crâniens: Quelles options thérapeutiques ?

Außerdem wurde die deutsche Leitliniensammlung auf AWMF.org durchgesehen. Alle psychiatrischen S3-Leitlinien, die Angaben zum Umgang mit aggressivem Verhalten enthielten, wurden berücksichtigt.

## Deutschland

Leitlinie Demenz AWMF-Registrierungsnummer: 038-013 S3

Leitlinie Bipolare Störung AWMF-Registernummer 038/018 S3

Leitlinie Psychosoziale Therapien bei schweren psychischen Erkrankungen

Registrierungsnummer: 038-020 S3

Alkoholbezogene Störungen: Screening, Diagnose und Behandlung AWMF Registernummer 076-001 S3

Zudem erfolgte eine Abstimmung der relevanten Empfehlungen in der noch nicht veröffentlichten S3-Leitlinie zur Schizophrenie mit den Autoren, um Widersprüche zwischen den Leitlinien zu vermeiden.

Wenn Leitlinienadaptationen durchgeführt wurden, ist dies bei den entsprechenden Hintergrundtexten und Empfehlungen in der Leitlinie explizit aufgeführt.

## Systematische Literaturrecherche **S2e S3**

Es wurde primär entschieden, zu insgesamt drei Themen systematische Reviews durchzuführen:

- Medikation zur Behandlung aggressiven Verhaltens (als Update der letzten Leitlinie)
- Reduktion von freiheitsbeschränkenden Zwangsmaßnahmen (neu)
- Mitarbeiterschulungen und Deeskalationstechniken (als Update der letzten Leitlinie).

Im Verlauf wurde entschieden, ein viertes systematisches Review durchzuführen zu häuslicher Gewalt gegen Angehörige psychisch erkrankter Menschen, da hier in der alten Leitlinie eine thematische Lücke entdeckt wurde.

**Zu den übrigen Themen wurde auf bereits bestehende Reviews zurückgegriffen und es wurden orientierende Suchen durchgeführt. Zusätzlich wurden die Experten der Leitliniensteuerungsgruppe und die externen Experten vor Beginn der Erstellung der jeweiligen Kapitel angeschrieben und gebeten, relevante Literatur aus ihren Forschungsgebieten einzureichen.**

Als methodische Unterstützung wurde das Recherchemanual der AWMF sowie die wissenschaftliche Bibliothek Weissenau und die Universitätsbibliothek der Universität Ulm mit einbezogen.

Für jedes der vier im Rahmen der Leitlinie erstellten Reviews und für jede jeweils abgefragte Datenbank wurde ein eigener Suchstring erstellt. Suchstrings konnten nicht einfach von einer auf die andere Datenbank übernommen werden, da die verschiedenen Datenbanken nicht auf die gleichen Thesauren zugreifen und nicht dieselben Operatoren verstehen.

Die systematische Suche wurde so geplant, durchgeführt und dokumentiert, dass sie jederzeit repliziert und nachvollzogen werden kann. Vor Beginn der Suche wurde das Review zentral registriert. Die neu durchgeführten Reviews wurde bei PROSPERO (<https://www.crd.york.ac.uk/PROSPERO/>) registriert (Registernummer Freiheitsbeschränkende Maßnahmen # 42016035541, Gewalt gegen Angehörige #).

### **Auswahl der Datenbanken**

Zu Beginn des systematischen Reviews wurde festgelegt, welche Datenbanken herangezogen und durchsucht werden sollen. Entsprechend der Empfehlungen des Deutschen Cochrane Zentrums, der Arbeitsgemeinschaft der Wissenschaftlichen Medizinischen Fachgesellschaften (AWMF) und des Ärztlichen Zentrums für Qualität in der Medizin (ÄZQ) wurden mindestens zwei unterschiedliche Datenbanken durchsucht: Medline und Cinahl (Deutsches Cochrane Zentrum 2013). Medline ist die Datenbank der US-amerikanischen National Library of Medicine und enthält Zitationen und Zusammenfassungen internationaler biomedizinischer Zeitschriftenartikel. Medline wurde über die Oberfläche Pubmed im Internet kostenlos abgerufen (US National Library of Medicine 2017a). Da es sich bei Zwangsmaßnahmen vor allem im angloamerikanischen Bereich um ein Thema handelt, das vorwiegend von pflegewissenschaftlicher und weniger von medizinischer Seite beforscht wird, wurde die Suche in Medline um eine Suche in Cinahl ergänzt. Die kostenpflichtige Datenbank Cinahl wurde über eine Lizenz des Universitätsklinikums Ulm über die Oberfläche EbscoHost verwendet. Bei Cinahl handelt es sich nach Angaben der Betreiber um die Datenbank mit der größten Sammlung an pflege- und gesundheitswissenschaftlichen Artikeln. Durch die Kombination dieser beiden Datenbanken soll eine möglichst umfassende Suche mit Ergebnissen von Wissenschaftlerinnen und Wissenschaftlern aus verschiedenen Disziplinen und Ländern erreicht werden.

Für das systematische Review über Gewalt gegen Angehörige wurden weitere psychologische Datenbanken (PsycINFO, PsycindexPLUS) sowie die mehr europäisch ausgerichtete Datenbank EMBASE einbezogen.

Neben Primärliteratur wurden bei der systematischen Suche auch systematische Reviews anderer Autoren gefunden. Die Literaturverzeichnisse der Reviews mit klar beschriebener

und gut nachvollziehbarer Methodik wurden durchgesehen und so weitere wichtige, durch die systematische Datenbankabfrage noch nicht erfasste Arbeiten eingeschlossen, eine für systematische Reviews ebenfalls empfohlene Methode („Referenzrecherche“, Horsley et al. 2011). Eingeschlossen wurde dann nur die jeweilige Primärliteratur aus der systematischen Datenbankabfrage und der Referenzrecherche. Das heißt, die Reviews selbst wurden ausgeschlossen, um zu vermeiden, dass eine Originalstudie zwei- oder mehrfach eingeschlossen wird, wenn sie in mehreren Reviews eingeschlossen wurde.

### **Auswahl des Literaturverwaltungsprogramms**

Zum Sammeln und Ordnen der Literaturstellen wurde das Literaturverwaltungs- und Wissensmanagementprogramm Citavi in der Version 5.3 mit einer Serverlizenz verwendet.

### **PICO-Schema und Suchstring**

Die Erstellung des Suchstrings erfolgte aus der formulierten Fragestellung und den vorab festgelegten Ein- und Ausschlusskriterien mit Hilfe des PICO-Schemas als Zwischenschritt (Liberati et al. 2009). PICO steht für Person, Intervention, Comparison (Vergleichsintervention bzw. -gruppe) und Outcome (Endpunkt). Die Ein- und Ausschlusskriterien, wurden danach sortiert, ob sie sich auf den zu untersuchenden Personenkreis P (z. B. erwachsene Menschen mit einer schweren psychischen Erkrankung), die zu untersuchende Intervention I (z. B. Interventionen zur Reduktion von Zwang) oder den gesuchten klinischen Endpunkt O (z. B. Zwangsmaßnahme) bezogen.

Nach Möglichkeit wurde jedes Ein- und Ausschlusskriterium mit einem oder mehreren Stichwörtern umschrieben. Diese Stichwörter waren in englischer Sprache, da die verwendeten Datenbanken vornehmlich englischsprachige Literatur bzw. Literatur, bei welcher zumindest Titel und Zusammenfassung („Abstract“) auf Englisch erschienen sind, enthalten. Die Stichwörter wurden trunkiert, um auch ähnliche Wörter finden zu können. Mit den Stichwörtern wurden der Titel und die Zusammenfassung eines Artikels durchsucht. Zusätzlich zu den Stichwörtern wurden Schlagwörter verwendet. Die Gesamtheit der Schlagwörter, die einem Artikel zugeordnet werden, skizziert das Thema des Artikels. Die Schlagwörter, die in einer bestimmten Datenbank verwendet werden, werden in einem sogenannten Thesaurus gesammelt. Für Medline sind dies die Medical Subject Headings (MeSH-Terms). Für den umfangreichen Thesaurus der MeSH-Terms wurde eine von der amerikanischen Nationalbibliothek für Medizin angebotene Suchmaschine verwendet (US National Library of Medicine 2017b). Durch die Eingabe der Stichwörter wurden die zugehörigen Schlagwörter gefunden. Ein Schlagwort befindet sich stets in einer logischen Ordnung innerhalb des Thesaurus, es gibt weitere Ober- und enger Unterbegriffe. Ober- und Unterbegriffe wurden durchgesehen und ebenfalls der Suche als Schlagwort hinzugefügt, sofern dies sinnvoll erschien.

Allgemeines Schema für die Sammlung von Stich- und Schlagworten zur Beschreibung der Ein- und Ausschlusskriterien nach dem PICO-Schema in einer Tabelle

Person	Intervention	Comparison	Outcome
Stichworte zu Person	Stichworte zur Intervention	Stichworte zur Vergleichsintervention	Stichworte zum Endpunkt
...	...	...	...
Schlagworte zu Person	Schlagworte zur Intervention	Schlagworte zur Vergleichsintervention	Schlagworte zum Endpunkt
...	...	...	...

Die einzelnen Stich- und Schlagwörter wurden zur Konstruktion des Suchterms mit Operatoren miteinander verbunden. Dabei wurden in dieser Dissertation die Booleschen Operatoren *AND* (und) und *OR* (oder) verwendet. Werden Wörter mit *AND* verknüpft, werden nur Artikel gefunden, die sowohl das eine als auch das andere Wort enthalten. Werden sie mit *OR* verknüpft, werden sowohl Artikel, die nur das eine, als auch solche, die nur das andere oder beide Wörter enthalten, gefunden. Auf ausschließende Operatoren wie *NOT* (nicht) oder *XOR* (entweder, oder) wurde entsprechend der Literatur zur Konstruktion von Suchen verzichtet, da so häufig fälschlicherweise Artikel ausgeschlossen werden, in welchen ein Wort oder ein Wortteil zufällig in anderem Zusammenhang erscheint (Deutsches Cochrane Zentrum 2013). Die Inhalte innerhalb der Spalten der PICO-Tabelle wurden mit *OR* verknüpft, die Spalten miteinander dann mit *AND*. Des Weiteren wurden Klammern gesetzt, damit *OR* vor *AND* Operatoren durchgeführt werden, wie für die Suche nach dem oben erstellten PICO-Schema erforderlich. Ohne Klammern werden *AND*- vor *OR*-Operatoren ausgeführt, ähnlich der Regelung „Punkt vor Strich“ in der Mathematik.

Suchstrategien und -terme wurden vor Beginn der Suchen im schriftlichen Umlaufverfahren konsentiert. Dazu wurden diese in einer Cloud und per E-Mail den Mitgliedern der Leitliniensteuerungsgruppe zur Verfügung gestellt. Pro Suche hatte die Steuerungsgruppe 4 Wochen Zeit zu kommentieren, eine Woche vor Ablauf der Frist erfolgte eine Erinnerung per E-Mail. Die Suchbegriffe wurden dazu übersichtlich dem PICO-Schema (PICO = Patient, Intervention, Comparison, Outcome, entsprechend den Ein- und Ausschlusskriterien unserer Leitlinie) zugeordnet, um zu vermeiden, dass lange, unübersichtliche Suchbefehle bewertet werden müssen. Stillschweigen wurde bei der Konsentierung der Suchterme ausnahmsweise als Zustimmung gewertet.

### Auswahl der Suchergebnisse

Nach Abschluss der Suche wurden die Ergebnisse in das Literaturverwaltungsprogramm Citavi importiert. Dubletten (hier Artikel, die sowohl über Cinahl als auch über Medline gefunden wurden) wurden mit Hilfe von Citavi entfernt. Das Ein- und Ausschließen der Artikel erfolgte anhand der Ein- und Ausschlusskriterien in drei Schritten. Im ersten Schritt

wurde der Titel des gefundenen Artikels gelesen und es wurde entschieden, ob der Artikel gleich anhand des Titels ausgeschlossen werden musste. Im zweiten Schritt wurde, wenn der Artikel nicht anhand seines Titels ausgeschlossen wurde, die Zusammenfassung geprüft. Im dritten Schritt wurde der ganze Artikeltext gelesen und abhängig von den Ein- und Ausschlusskriterien ein- oder ausgeschlossen (Fulltext-Screening“). Die Artikel wurden von zwei Personen unabhängig voneinander gelesen und ein- bzw. ausgeschlossen. Bei Uneinigkeit der Personen erfolgte der Ein- oder Ausschluss nach Diskussion zwischen beiden.

### **Ein- und Ausschlusskriterien, Suchstrategien und Suchterme, Suchzeitpunkte sowie Rater der einzelnen Reviews:**

#### **Medikamente (Rater: Sophie Hirsch, Tilman Steinert):**

##### **a) Rapid Tranquilisation**

Zuerst wurde eine Suche speziell nach Reviews ab 2006 durchgeführt, was einem Vorgehen entsprechend der alten S2 LL und somit einem Update entspricht. Durchsucht wurde die Datenbank Pubmed. Zudem wurde awmf.org und guidelines.gov zur Identifikation bereits bestehender Leitlinien durchsucht.

Wenn es nahezu zeitgleich mehrere Reviews zur selben Fragestellung gab, die sich in ihrer Literaturlauswahl zwar überschneiden, aber nicht völlig identisch waren, wurde folgendermaßen vorgegangen:

- Einzelstudien und Reviews dürfen nicht noch einmal mit bewertet werden, wenn sie schon in einem anderen Review enthalten sind. Teilweise wurden besonders wichtige Studien oder Studien mit zusätzlichen Outcomes und Informationen neben der Hauptfragestellung des Reviews erneut zitiert.
- Wenn mehrere Reviews zur gleichen Zeit erschienen sind, gilt es zu prüfen, ob diese genau die gleiche Fragestellung betreffen und dieselben Datenbanken/Suchstrategien bemüht wurden. In der Regel wird das methodisch beste Review gewählt und die übrigen nur mit dem Hinweis „Doppelpublikation“ aufgeführt. Die in dem Review nicht enthaltenen Einzelstudien, die evtl. in einem anderen Review aufgeführt sind, werden nach einer entsprechenden Handsuche einzeln zitiert. Im Zweifel sollen auch in diesem Fall lieber Originalstudien als Reviews verwendet werden.
- Wenn Reviews methodisch unzureichend sind, muss man sich im Zweifelsfall auf die einzelnen Zitationen beziehen und soll das Review als Hilfe nicht heranziehen.

Als Suchterm wurde vorerst lediglich

Rapid AND tranquil\*

verwendet. Im Laufe der Arbeit ergaben sich aber Sicherheitsbedenken bzgl. der inhalativen Applikationsform sowie der Kombination von Olanzapin und Benzodiazepinen, weswegen hier ergänzende Suchen durchgeführt wurden.



Inhaled AND loxapin

Olanzapine\* AND benzodiazepine\* AND safety

Im Verlauf des Leitlinienerstellungsprozesses wurde dann auf Wunsch der beteiligten Betroffenenvertreter eine weitere systematische Suche nach dem Vorbild der für diese Leitlinie erstellte systematischen Reviews (Zwangsmaßnahmen, Angehörigenarbeit, Deeskalation) nach folgendem Schema durchgeführt:

Textwörter [Titel/Abstract] und MeSH-Terms [MeSH]

P(erson)	I(intervention)	C	O(utcome)
mental*	rapid tranquil*		violen*
psychiatr*	adrenergic		aggress*
schizo*	anticonvuls*		anger*
autis*	neurolept*		agitat*
delir*	antipsychotic*		hostil*
dement*	mood stabili*		aggression[MeSH Terms]
intellect*	benzodiazepin*		violence[MeSH Terms]
brain injur*	lithium		anger[MeSH Terms]
bipolar	psychotrop*		psychomotor agitation[MeSH Terms]
Affective psychosis, bipolar[MeSH Terms]	adrenergic beta antagonists[MeSH Terms]		hostility[MeSH Terms]
Behavior disorder, disruptive[MeSH Terms]	anticonvulsants[MeSH Terms]		
Impulse control disorders[MeSH Terms]	anti dyskinesia agents[MeSH Terms]		
mood disorders[MeSH Terms]	central nervous system depressants[MeSH Terms]		
Neurocognitive disorders[MeSH Terms]	psychotropic drugs[MeSH Terms]		
Neurodevelopmental	Estrogenic		

disorders[MeSH Terms]	agents[MeSH Terms]		
Personality disorders[MeSH Terms]	Gestagenic agents[MeSH Terms]		
Paranoid Disorders[MeSH Terms]	Antiandrogens[MeSH Terms]		
Psychotic Disorders[MeSH Term]	neurotransmitter agents[MeSH Terms]		
Schizophrenia[MeSH Term]			
Post traumatic stress disorder[MeSH Terms]			

Diese Suche war erneut als Update der S2 LL angelegt und beinhaltete daher Ergebnisse ab 2006 bis hin zum Abfragezeitpunkt im September 2016. Daraus ergab sich folgender Suchstring:

(mental\*[Title/Abstract] OR psychiatr\*[Title/Abstract] OR schizo\*[Title/Abstract] OR autis\*[Title/Abstract] OR delir\*[Title/Abstract] OR dement\*[Title/Abstract] OR intellect\*[Title/Abstract] OR brain injur\*[Title/Abstract] OR bipolar[Title/Abstract] OR Affective psychosis, bipolar[MeSH Terms] OR Behavior disorder, disruptive[MeSH Terms] OR Impulse control disorders[MeSH Terms] OR mood disorders[MeSH Terms] OR Neurocognitive disorders[MeSH Terms] OR Neurodevelopmental disorders[MeSH Terms] OR Personality disorders[MeSH Terms] OR Paranoid Disorders[MeSH Terms] OR Psychotic Disorders[MeSH Term] OR Schizophrenia[MeSH Term] OR Post traumatic stress disorder[MeSH Terms]) AND (violen\*[Title/Abstract] OR aggress\*[Title/Abstract] OR anger\*[Title/Abstract] OR agitat\*[Title/Abstract] OR hostile\*[Title/Abstract] OR aggression[MeSH Terms] OR violence[MeSH Terms] OR anger[MeSH Terms] OR psychomotor agitation[MeSH Terms] OR hostility[MeSH Terms]) AND (rapid tranquil\*[Title/Abstract] OR adrenergic[Title/Abstract] OR anticonvuls\*[Title/Abstract] OR neurolept\*[Title/Abstract] OR antipsychotic\*[Title/Abstract] OR mood stabili\*[Title/Abstract] OR benzodiazepin\*[Title/Abstract] OR lithium[Title/Abstract] OR psychotrop\*[Title/Abstract] OR adrenergic beta antagonists[MeSH Terms] OR anticonvulsants[MeSH Terms] OR anti dyskinesia agents[MeSH Terms] OR central nervous system depressants[MeSH Terms] OR psychotropic drugs[MeSH Terms] OR Estrogenic agents[MeSH Terms] OR Gestagenic agents[MeSH Terms] OR Antiandrogens[MeSH Terms] OR neurotransmitter agents[MeSH Terms]) AND ("2006/01/01"[Date - Publication] : "3000"[Date - Publication])

Die Suche beschränkte sich hier ebenfalls auf die Pubmed-Datenbank. Erneut wurde von aggregierter Evidenz ausgegangen und erst alle systematischen Reviews gesichtet, dann noch die neuesten Einzelstudien ab 2016, die noch nicht in der ersten Suche enthalten gewesen waren.

### **b) Behandlung rezidivierenden aggressiven Verhaltens**

Zuerst wurde eine Suche speziell nach Reviews bezüglich der einzelnen Substanzen durchgeführt, was einem Vorgehen entsprechend der alten S2 LL und somit einem Update entspricht. Dann eine komplementäre Suche auch nach Primärliteratur zu den einzelnen Erkrankungen, bei denen wie folgt vorgegangen wurde: Bei Demenz ab 2005 gesucht, entspricht einem Update der S2-LL. Bei den übrigen Krankheitsbildern wurden die Kapitel neu erstellt. Suche wurde i.d.R. ab 2011 durchgeführt, entspricht einer Konzentration auf aktuelle Literatur. Das jeweilige Datum der Suche in eckigen Klammern angegeben. Durchsucht wurde die Datenbank Pubmed. Zudem wurde awmf.org und guidelines.gov zur Identifikation bereits bestehender Leitlinien durchsucht.

Wenn es nahezu zeitgleich mehrere Reviews zur selben Fragestellung gab, die sich in ihrer Literaturlauswahl zwar überschneiden, aber nicht völlig identisch waren, wurde folgendermaßen vorgegangen:

- Einzelstudien und Reviews dürfen nicht noch einmal mit bewertet werden, wenn sie schon in einem anderen Review enthalten sind. Teilweise wurden besonders wichtige Studien oder Studien mit zusätzlichen Outcomes und Informationen neben der Hauptfragestellung des Reviews erneut zitiert.
- Wenn mehrere Reviews zur gleichen Zeit erschienen sind, gilt es zu prüfen, ob diese genau die gleiche Fragestellung betreffen und dieselben Datenbanken/Suchstrategien bemüht wurden. In der Regel wird das am methodisch beste Review gewählt und die übrigen nur mit dem Hinweis „Doppelpublikation“ aufgeführt. Die in dem Review nicht enthaltenen Einzelstudien, die evtl. in einem anderen Review aufgeführt sind, werden nach einer entsprechenden Handsuche einzeln zitiert. Im Zweifel sollen auch in diesem Fall lieber Originalstudien als Reviews verwendet werden.
- Wenn Reviews methodisch unzureichend sind, muss man sich im Zweifelsfall auf die einzelnen Zitationen beziehen und soll das Review als Hilfe nicht heranziehen.

Aggress\* AND adrenergic antagonist [-01.12.2015]

Aggress\* AND anticonvulsant [-01.12.2015]

Aggress\* AND antidepressant [-01.12.2015]

Aggress\* AND antipsychotic [-01.12.2015]

Aggress\* AND benzodiazepine [-01.12.2015]

Aggress\* AND drug intervention [-01.12.2015]

Aggress\* AND lithium [-01.12.2015]

Aggress\* AND psychotropic drugs [-01.12.2015]

Violen\* AND adrenergic antagonist [-01.12.2015]

Violen\* AND anticonvulsant [-01.12.2015]  
 Violen\* AND antidepressant [-01.12.2015]  
 Violen\* AND antipsychotic [-01.12.2015]  
 Violen\* AND benzodiazepine [-01.12.2015]  
 Violen\* AND drug intervention [-01.12.2015]  
 Violen\* AND lithium [-01.12.2015]  
 Violen\* AND psychotropic drugs [-01.12.2015]  
 Anger AND drug intervention [-01.12.2015]  
 Anger AND psychotropic drugs [-01.12.2015]  
 Hostility AND drug intervention [-01.12.2015]  
 Hostility AND psychotropic drugs [-01.12.2015]  
 Aggress\* AND autism\* [2011-02.02.2016]  
 Violen\* AND autism\* [2011-03.02.3016]  
 Aggress\* AND brain injury [2011-23.02.2016]  
 Violen\* AND brain injury [2011-23.02.3016]  
 Aggress\* AND delir\* [2011-24.02.2016]  
 Violen\* AND delir\* [2011-24.02.3016]  
 Aggress\* AND dementia [2005-15.12.2015]  
 Agitation AND dementia [2005-15.12.2015]  
 Aggress\* AND intellectual\* disab\* [2011-26.01.2016]  
 Violen\* AND intellectual\* disab \* [2011-02.03.3016]

Im Verlauf des Leitlinienerstellungsprozesses wurde dann auf Wunsch der beteiligten Betroffenenvertreter eine weitere systematische Suche nach dem Vorbild der für diese Leitlinie erstellte systematischen Reviews (Zwangmaßnahmen, Angehörigenarbeit, Deeskalation) nach folgendem Schema durchgeführt:

Textwörter [Titel/Abstract] und MeSH-Terms [MeSH]

P(erson)	I(intervention)	C	O(utcome)
mental*	rapid tranquil*		violen*
psychiatr*	adrenergic		aggress*
schizo*	anticonvuls*		anger*
autis*	neurolept*		agitat*
delir*	antipsychotic*		hostil*
dement*	mood stabili*		aggression[MeSH Terms]
intellect*	benzodiazepin*		violence[MeSH Terms]
brain injur*	lithium		anger[MeSH Terms]
bipolar	psychotrop*		psychomotor agitation[MeSH

			Terms]
Affective psychosis, bipolar[MeSH Terms]	adrenergic beta antagonists[MeSH Terms]		hostility[MeSH Terms]
Behavior disorder, disruptive[MeSH Terms]	anticonvulsants[MeSH Terms]		
Impulse control disorders[MeSH Terms]	anti dyskinesia agents[MeSH Terms]		
mood disorders[MeSH Terms]	central nervous system depressants[MeSH Terms]		
Neurocognitive disorders[MeSH Terms]	psychotropic drugs[MeSH Terms]		
Neurodevelopmental disorders[MeSH Terms]	Estrogenic agents[MeSH Terms]		
Personality disorders[MeSH Terms]	Gestagenic agents[MeSH Terms]		
Paranoid Disorders[MeSH Terms]	Antiandrogens[MeSH Terms]		
Psychotic Disorders[MeSH Term]	neurotransmitter agents[MeSH Terms]		
Schizophrenia[MeSH Term]			
Post traumatic stress disorder[MeSH Terms]			

Diese Suche war erneut als Update der S2 LL angelegt und beinhaltete daher Ergebnisse ab 2006 bis hin zum Abfragezeitpunkt im September 2016. Daraus ergab sich folgender Suchstring:

(mental\*[Title/Abstract] OR psychiatr\*[Title/Abstract] OR schizo\*[Title/Abstract] OR autis\*[Title/Abstract] OR delir\*[Title/Abstract] OR dement\*[Title/Abstract] OR intellect\*[Title/Abstract] OR brain injur\*[Title/Abstract] OR bipolar[Title/Abstract] OR

Affective psychosis, bipolar[MeSH Terms] OR Behavior disorder, disruptive[MeSH Terms] OR Impulse control disorders[MeSH Terms] OR mood disorders[MeSH Terms] OR Neurocognitive disorders[MeSH Terms] OR Neurodevelopmental disorders[MeSH Terms] OR Personality disorders[MeSH Terms] OR Paranoid Disorders[MeSH Terms] OR Psychotic Disorders[MeSH Term] OR Schizophrenia[MeSH Term] OR Post traumatic stress disorder[MeSH Terms]) AND (violen\*[Title/Abstract] OR aggress\*[Title/Abstract] OR anger\*[Title/Abstract] OR agitac\*[Title/Abstract] OR hostil\*[Title/Abstract] OR aggression[MeSH Terms] OR violence[MeSH Terms] OR anger[MeSH Terms] OR psychomotor agitation[MeSH Terms] OR hostility[MeSH Terms]) AND (rapid tranquil\*[Title/Abstract] OR adrenergic[Title/Abstract] OR anticonvuls\*[Title/Abstract] OR neurolept\*[Title/Abstract] OR antipsychotic\*[Title/Abstract] OR mood stabili\*[Title/Abstract] OR benzodiazepin\*[Title/Abstract] OR lithium[Title/Abstract] OR psychotrop\*[Title/Abstract] OR adrenergic beta antagonists[MeSH Terms] OR anticonvulsants[MeSH Terms] OR anti dyskinesia agents[MeSH Terms] OR central nervous system depressants[MeSH Terms] OR psychotropic drugs[MeSH Terms] OR Estrogenic agents[MeSH Terms] OR Gestagenic agents[MeSH Terms] OR Antiandrogens[MeSH Terms] OR neurotransmitter agents[MeSH Terms]) AND ("2006/01/01"[Date - Publication] : "3000"[Date - Publication])

Die Suche beschränkte sich hier ebenfalls auf die Pubmed-Datenbank. Erneut wurde von aggregierter Evidenz ausgegangen und erst alle systematischen Reviews gesichtet, dann noch die neuesten Einzelstudien ab 2016, die noch nicht in der ersten Suche enthalten gewesen waren.

### **Freiheitsbeschränkende Maßnahmen (Rater: Sophie Hirsch, Tilman Steinert, Erich Flammer (extern)):**

#### **Ein- und Ausschlusskriterien**

Eingeschlossen wurden alle Studien, welche Interventionen zur Reduktion von mechanischen Zwangsmaßnahmen bei erwachsenen Patientinnen und Patienten mit einer psychischen Erkrankung untersuchten. Es wurden nur Patientinnen und Patienten mit schweren psychischen Erkrankungen (im Sinne von „severe mental illness“, also Psychose/Schizophrenie, bipolare Störung), Suchterkrankungen und schweren Persönlichkeitsstörungen (vornehmlich Borderline-Persönlichkeitsstörung) eingeschlossen. Dabei wurde es als ausreichend erachtet, wenn die Diagnosen klinisch gestellt wurden, da bereits zu Beginn der Arbeit zu erwarten war, dass vor allem klinische Beobachtungsstudien gefunden würden. Ausgeschlossen wurden grundsätzlich alle Patientinnen und Patienten ohne psychische Erkrankung. Ausgeschlossen wurden daher Studien, die Patientinnen und Patienten, bei denen nur ein neurologisches, chirurgisches oder internistisches Krankheitsbild beschrieben war, beschreiben, also auch die Literatur über aggressives Verhalten im Rahmen epileptischer Anfälle bzw. in postiktalen Zuständen. Studien, in denen nur oder vornehmlich Kinder und Jugendliche unter 18 Jahren untersucht wurden, wurden

ebenso wenig eingeschlossen. In Ländern, in denen Kinder und Jugendliche in der Erwachsenenpsychiatrie mit behandelt werden, fanden sich teilweise Studien mit gemischten Populationen, die dann in die Arbeit aufgenommen wurden, wenn der Anteil der Kinder und der Anteil der Erwachsenen nachvollziehbar berichtet wurde und erwachsene Menschen überwogen. Grundsätzlich wurden nur Studien aufgenommen, die die Reduktion oder Vermeidung von mechanischen Zwangsmaßnahmen untersuchen (Fixierung, Isolierung, Festhalten). Nicht eingeschlossen wurden Studien, die sich mit der Häufigkeit von Zwangseinweisungen oder Zwangsbehandlungen beschäftigen. Es waren sowohl Studien geeignet, bei denen die Häufigkeit von Zwangsmaßnahmen als (primärer) Endpunkt untersucht wurde, als auch Studien, die die Dauer der einzelnen Zwangsmaßnahme oder die kumulierte Dauer aller Zwangsmaßnahmen als (primären) Endpunkt zum Inhalt hatten. Alle Interventionen auf pflegerischer, therapeutischer, organisatorischer und politischer Ebene (beispielsweise auch Gesetzesänderungen) wurden eingeschlossen. Wesentlich war, dass die Intervention auf die Reduktion von Zwangsmaßnahmen abzielte oder zumindest auf Aggression und Gewalt, wenn Zwangsmaßnahmen als Surrogatparameter verwendet wurden. Reine Medikamentenstudien wurden ausgeschlossen. Studien über Interventionen, die primär auf eine bessere Behandlung einer bestimmten Patientengruppe abzielten und in der Folge zu weniger Zwangsmaßnahmen führten, wurden nicht eingeschlossen. Häufig war dies bei Studien über delirante Zustände mit konsekutiver Fixierung der Fall. Ebenfalls ausgeschlossen wurden Studien, in denen mechanische Zwangsmaßnahmen als eine Nebenwirkung einer anderen, auf einen anderen Endpunkt abzielende Intervention mit gemessen wurden. Ein häufiges Beispiel hierfür war die Fragestellung, ob die Einführung eines Rauchverbots auf Station aufgrund strengerer Nichtrauchergesetze in Europa zu vermehrten Zwangsmaßnahmen führte. Artikel, die überhaupt keine Intervention beinhalteten, sondern lediglich den Verlauf über die Zeit beschrieben, wurden ebenfalls ausgeschlossen. Nicht eingeschlossen wurden zudem Untersuchungen reiner Assoziationen klinischer, soziodemographischer oder sonstiger Parameter mit der Häufigkeit von Zwangsmaßnahmen (wie Erkrankung der Patientinnen und Patienten, Besetzung der Schicht, Herkunft oder Alter der Beteiligten), ohne dass eine Intervention stattfand oder sich zumindest die äußeren Umstände, wie beispielsweise gesetzliche Vorgaben oder das politische System, bedeutsam änderten. Eingeschlossen wurden nur Studien, in denen mechanische Zwangsmaßnahmen als Sicherungsmaßnahmen im engeren Sinne verstanden wurden und aus Sicht der Durchführenden als „Ultima Ratio“ eingesetzt wurden. Ausgeschlossen wurden daher ebenso Studien, in denen Fixierung als „verhaltenstherapeutische Maßnahme“ gezielt eingesetzt und wieder ausgeschlichen wurde.

## PICO-Schema und Suchstring

Die zu untersuchende Vergleichsintervention C wurde bei diesem Review nicht extra abgebildet, da mit wenigen kontrollierten Studien mit Vergleichsinterventionen gerechnet wurde.

Die Tabelle 1 zeigt die Stich- und Schlagwörter, welche zur Suche verwendet wurden, nach dem PICO-Schema geordnet.

Tabelle: (Verkürztes) PICO-Schema. PICO steht für Person, Intervention, Comparison und Outcome (Person, Intervention, Vergleichsintervention und Endpunkt) und ermöglicht eine systematische, reproduzierbare Suche mit guter Sensitivität und Spezifität. Die Tabelle enthält trunkierte Stichwörter, mit denen Titel und Zusammenfassung der Artikel in den Datenbanken durchsucht wurden, sowie Schlagwörter, mit denen der Thesaurus von Medline, die Medical Subject Headings, durchsucht wurde.

<b>P</b>	<b>I</b>	<b>O</b>
mental*	Reduc*	Restrain*
psychiatr*	Eliminat*	Seclu*
schizo*	Prevent*	Coerci*
autis*	Human right*	containment
delir*	Crisis intervention	
dement*	De-escalat*	
intellect*		
brain injur*		
bipolar		
Affective psychosis, bipolar[MeSH Terms]	Human Rights[MeSH]	Restraint, physical[MeSH]
Behavior disorder, disruptive[MeSH Terms]	Patient Advocacy[MeSH]	Coercion[MeSH]
Impulse control disorders[MeSH Terms]		
mood disorders[MeSH Terms]		
Neurocognitive disorders[MeSH Terms]		
Neurodevelopmental disorders[MeSH Terms]		
Personality disorders[MeSH Terms]		
Paranoid Disorders[MeSH Terms]		
Psychotic Disorders[MeSH		



Term]		
Schizophrenia[MeSH Term]		
Post traumatic stress disorder[MeSH Terms]		

Folgende Suchstrings wurden verwendet:

Medline:

*(Reduc\*[Title/Abstract] OR Eliminat\*[Title/Abstract] OR Prevent\*[Title/Abstract] OR Human right\*[Title/Abstract] OR "Crises intervention"[Title/Abstract] OR De-escalat\*[Title/Abstract] OR Human Rights[MeSH] OR Patient Advocacy[MeSH]) AND (Restrain\*[Title/Abstract] OR Seclu\*[Title/Abstract] OR Coerci\*[Title/Abstract] OR containment[Title/Abstract] OR Restraint, physical[MeSH] OR Coercion[MeSH]) AND (mental\*[Title/Abstract] OR psychiatr\*[Title/Abstract] OR schizo\*[Title/Abstract] OR autis\*[Title/Abstract] OR delir\*[Title/Abstract] OR dement\*[Title/Abstract] OR intellect\*[Title/Abstract] OR brain injur\*[Title/Abstract] OR bipolar[Title/Abstract] OR Affective psychosis, bipolar[MeSH Terms] OR Behavior disorder, disruptive[MeSH Terms] OR Impulse control disorders[MeSH Terms] OR mood disorders[MeSH Terms] OR Neurocognitive disorders[MeSH Terms] OR Neurodevelopmental disorders[MeSH Terms] OR Personality disorders[MeSH Terms] OR Paranoid Disorders[MeSH Terms] OR Psychotic Disorders[MeSH Term] OR Schizophrenia[MeSH Term] OR Post traumatic stress disorder[MeSH Terms])*

Cinahl

*AB (Reduc\* OR Eliminat\* OR Prevent\* OR Human right\* OR "Crises intervention" OR De-escalat\*) AND (Restrain\* OR Seclu\* OR Coerci\* OR containment) AND (mental\* OR psychiatr\* OR schizo\* OR autis\* OR delir\* OR dement\* OR intellect\* OR brain injur\* OR bipolar) OR TI (Reduc\* OR Eliminat\* OR Prevent\* OR Human right\* OR "Crises intervention" OR De-escalat\*) AND (Restrain\* OR Seclu\* OR Coerci\* OR containment) AND (mental\* OR psychiatr\* OR schizo\* OR autis\* OR delir\* OR dement\* OR intellect\* OR brain injur\* OR bipolar)*

Die Suche wurde am 20.09.2016 durchgeführt.

*Erste Raterin war Sophie Hirsch (wissenschaftliche Mitarbeiterin), zweiter Rater Erich Flammer (extern).*

Die Suche bei Medline ergab am 20.09.2016 2446 Treffer, die bei Cinahl 469. Nach Entfernung der Dubletten verblieben 2578 Artikel zum Title-Abstract-Screening (Schritt 1 und 2 des Ein- und Ausschlussprozesses). Davon wurden noch 336 vollständig durchgelesen und letztendlich 71 der durch die systematische Datenbankrecherche identifizierten Artikel in das Review zur qualitativen Synthese eingeschlossen. Bei der Recherche in den Referenzlisten der Reviews wurden auch Artikel aus Zeitschriften gefunden, die nicht in Pubmed gelistet waren. Des Weiteren konnten so ältere Artikel gefunden werden, die teilweise keine oder nur eine sehr kurze oder unstrukturierte Zusammenfassung hatten,

sodass sie mit den heute üblichen Suchstrategien, die auf den Titel und die Zusammenfassung fokussieren, nicht sicher gefunden werden können. Hiervon wurden weitere 14 Artikel eingeschlossen, sodass dieses Review insgesamt 85 Artikel einschließt, welche 78 unterschiedliche Studien beschreiben. Recherche, Screening und Ein- und Ausschluss sind in Abbildung XXX dargestellt.

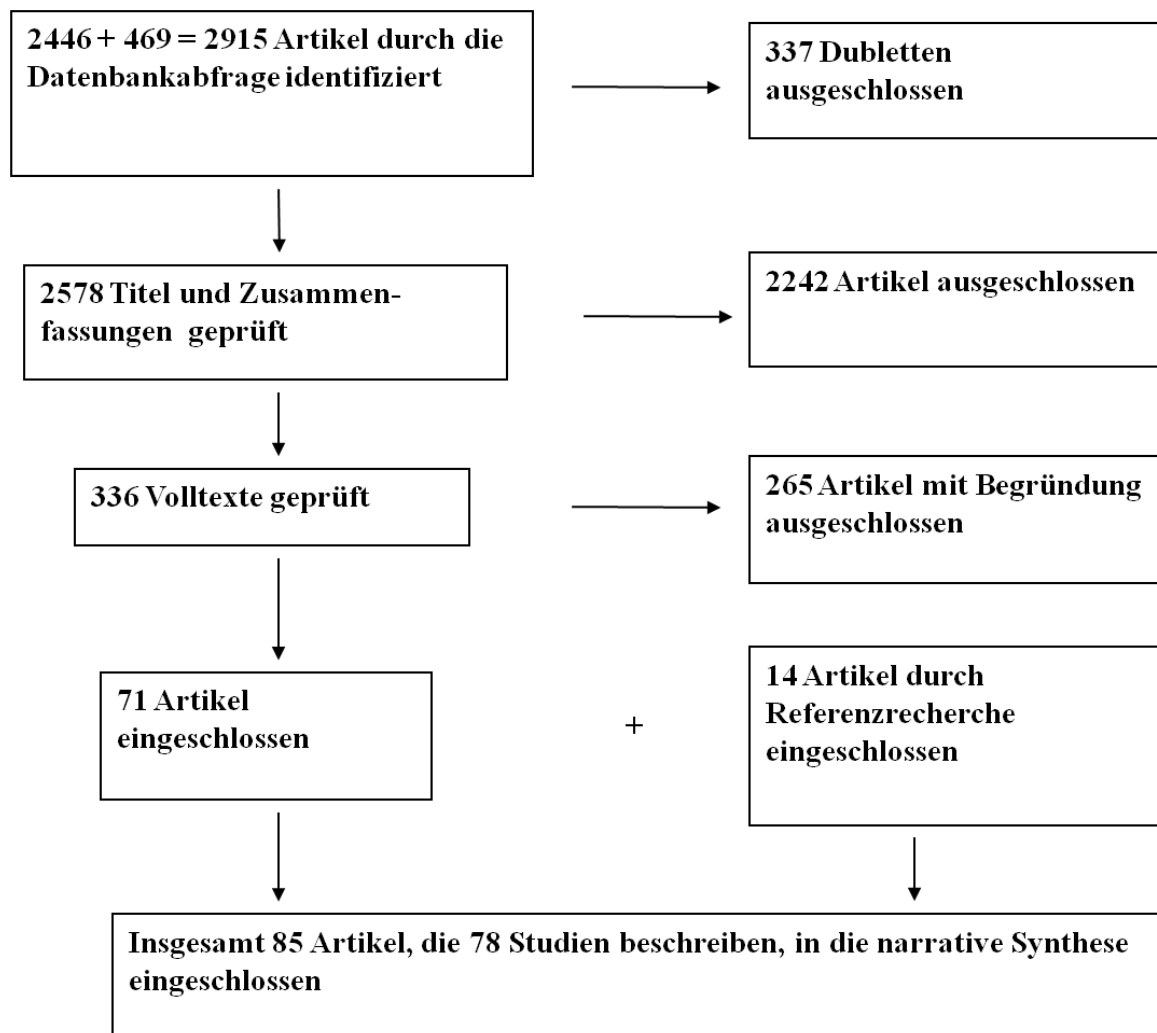


Abbildung: Das Flow-Chart beschreibt den zur Erstellung des systematischen Reviews durchgeführten mehrstufigen Ein- und Ausschussprozess. Die Anzahl der gefunden, ein- und ausgeschlossenen Artikel sowie der von ihnen beschriebenen Studien sind aufgeführt.

Alle 337 Artikel, die das Fulltext-Screening durchlaufen haben, sind im Anhang aufgeführt. Die eingeschlossenen Artikel werden im Anhang in Evidenztabellen aufgeführt. Insgesamt wurden 265 im Fulltextscreening Artikel ausgeschlossen.

Tabelle: Häufige Ausschlussgründe beim Fulltext-Screening. Die linke Spalte enthält häufige Ausschlussgründe, die rechte Spalte enthält die Anzahl der Artikel, die deshalb ausgeschlossen wurden, sowie deren Anteil an allen ausgeschlossenen Artikeln in Prozent. Die Differenz zu 100 Prozent ist durch Rundungen bedingt.

Ausschlussgrund	Anzahl Artikel ( %)
keine Daten zur Reduktion von mechanischen Zwangsmaßnahmen berichtet	52 (19,6)
Reduktion von Zwang nicht als primäres Outcome oder Surrogatparameter für die Reduktion von Gewalt definiert, sondern als Teil der Intervention, Nebenwirkung oder Outcome einer Sekundäranalyse	44 (16,6)
Reviews oder andere Sekundärliteratur	42 (15,8)
unpassende Personengruppe, vor allem Kinder, Menschen mit geistiger Behinderung, hirnorganischer Störung oder Demenz	36 (13,6)
keine klar umschriebene Intervention berichtet	32 (12,1)
Einzelfallberichte oder rein qualitative Studien ohne Daten zur Häufigkeit/Dauer von Zwangsmaßnahmen	26 (9,8)
mangelnde Datenqualität, d.h. weder Baseline noch Follow-up, kein sinnvoller Vergleich zwischen Intervention und fehlender Intervention (Standardbehandlung) bzw. vor und nach Intervention möglich	12 (4,5)
nicht mit dem deutschen Versorgungssystem kompatibles Setting, wie amerikanische Emergency Rooms oder ambulante Zwangsbehandlung in Großbritannien und Skandinavien	9 (3,4)
Sonstiges	12 (4,5)
$\Sigma$	265 (99,9)

**Deeskalation und Mitarbeiterschulungen (Rater: Christine Wichmann (Doktorandin), Sophie Hirsch):**

**PICO-Schema und Suchstring**

PICO-Schema und Suchstring

Anhand des (bereits erwähnten) PICO-Schemas wurde (ebenfalls) ein Suchstring erstellt, dessen Schwerpunkt *evidenzbasierte* Trainingsprogramme und Mitarbeiterschulungen zum Umgang mit aggressivem Verhalten bei Menschen mit psychischen Erkrankungen sein sollten. Zur besseren Vergleichbarkeit der Personengruppen der einzelnen Reviews des Updates der S2 Leitlinie wurden sowohl für das Review zu Trainingsprogrammen, als auch im Rahmen der Reviews zur Reduktion freiheitsbeschränkender Massnahmen und Medikation zur Behandlung aggressiven Verhaltens dieselben trunkierten Such- und Schlagwörter zur

Beschreibung des gesuchten Personenkreises verwendet. Dies entspricht dem „P“ („Person“) gemäss PICO- Schema.

Weiter wurde anstelle der zu untersuchenden Vergleichsintervention „C“ („Comparison“) das PICO-Schema modifiziert und um englischsprachige Trainingsbegriffe und MeSH-Terms (Medical Subject Headings) diesbezüglich erweitert. Auf diese Weise entstand folgende Tabelle XX mit Stich- und Schlagworten:

<b>P (Person)</b>	<b>I (Intervention)</b>	<b>C (Comparison)</b>	<b>O (Outcome)</b>	<b>Trainings- begriffe</b>
mental*	hold*		violen*	train*
psychiatr*	restrain*		aggress*	teach*
schizo*	seclu*		anger*	educat*
autis*	self-defen*		agitat*	learn*
delir*	self-protec*		hostil*	
dement*	defen*		injur*	
intellect*	breakawa*		seclu*	
brain injur*	conflict-resol*		coerci*	
bipolar*	conflict solv*		restrain*	
	de-escalat*		sick*	
	coerci*		distress*	
	prevent*			
<b>MeSH-Terms (Medical Subject Headings) als Thesauren von <i>Medline</i></b>				
affective psychosis, bipolar	physical restraint		aggression	education [Subheading]
behavior disorder, disruptive			violence	
impulse control disorders			anger	
mood disorders			psychomotor agitation	
neurocognitive disorders			hostility	
neurodevelopmental disorders			physical restraint	
personality disorders				
paranoid disorders				
psychotic disorders				
Schizophrenia				



### Suchterm Cinahl:

*(TI (mental\* OR psychiatr\* OR schizo\* OR autis\* OR delir\* OR dement\* OR intellect\* OR brain injur\* OR bipolar\*) OR AB (mental\* OR psychiatr\* OR schizo\* OR autis\* OR delir\* OR dement\* OR intellect\* OR brain injur\* OR bipolar\*)) AND ( TI (hold\* OR coerci\* OR de-escalat\* OR conflict solv\* OR conflict-resol\* OR breakawa\* OR defen\* OR self-protec\* OR self-defen\* OR seclu\* OR restrain\*) OR AB (hold\* OR coerci\* OR de-escalat\* OR conflict solv\* OR conflict-resol\* OR breakawa\* OR defen\* OR self-protec\* OR self-defen\* OR seclu\* OR restrain\*) ) AND ( TI (violen\* OR prevent\* OR distress\* OR sick\* OR restrain\* OR coerci\* OR seclu\* OR injur\* OR hostil\* OR agitat\* OR anger\* OR aggress\*) OR AB (violen\* OR prevent\* OR distress\* OR sick\* OR restrain\* OR coerci\* OR seclu\* OR injur\* OR hostil\* OR agitat\* OR anger\* OR aggress\*) ) AND (TI (train\* OR learn\* OR educat\* OR teach\*) OR AB (train\* OR learn\* OR educat\* OR teach\*))*

### Auswahl der Suchergebnisse

Im nächsten Schritt wurden mit Hilfe dieser konfigurierten Suchstrings die Datenbanken Medline und Cinahl durchsucht und die gefundenen Ergebnisse in das Literaturverwaltungsprogramm Citavi (Version 5.3) importiert und übernommen. Mittels Citavi konnten Publikationen, welche durch den Suchstring sowohl in Medline, als auch Cinahl gefunden wurden, als doppelt vorkommende Publikationen erkannt und als sogenannte Dubletten ausgeschlossen. Anschliessend erfolgte unter Berücksichtigung der bereits im Vorfeld festgelegten Ein- und Ausschlusskriterien zunächst die Durchsicht der Titel und Zusammenfassungen der Suchergebnisse (Title/Abstract-Screening). Konnte so eine Publikation nicht eindeutig für passend oder unpassend erklärt werden musste im nächsten Schritt der gesamte Artikel im sogenannten Volltext-Screening gelesen und erneut anhand der Ein- und Ausschlusskriterien als geeignet oder ungeeignet bewertet werden.

### Ein- und Ausschlusskriterien

Eingeschlossen wurden alle Studien, welche mindestens eine Trainings-/Schulungsmaßnahme des Personals als Intervention zum Management von aggressivem Verhalten bei Patientinnen und Patienten mit einer psychischen Erkrankung beinhalteten. Dabei wurden rein präventive Maßnahmen beispielsweise im Sinne von Beruhigung des aggressiven Patienten durch äußere Einflüsse wie dem Offen-stehen-lassen einer Türe, einer bestimmten Wandfarbe oder bestimmten Gegenständen im Umfeld des Patienten, ohne einen aktiven Trainingsaspekt der Mitarbeiter ausgeschlossen. Weiter wurden reine Medikamentenstudien zum Management bei aggressivem Verhalten ausgeschlossen. Eingeschlossen wurden nur Patientinnen und Patienten, welche unter einer psychischen Erkrankung gemäß internationaler Klassifikation psychischer und Verhaltensstörungen der ICD-10-WHO (World Health Organisation) Version 2016 leiden (vgl. Horst Dilling: *Internationale Klassifikation psychischer Störungen. ICD-10 V (F). Klinisch-diagnostische Leitlinien*. 10. Auflage. Hogrefe, 2015, ISBN 978-3-456-85560-8). Zu diesen Patientinnen und

Patienten mit psychischen Störungen wurden unter anderem Menschen mit einer Psychose/Schizophrenie und bipolaren Störung gezählt. Weiter gehörten Menschen mit Verhaltensauffälligkeiten und Persönlichkeitsstörungen (beispielsweise Borderline-Persönlichkeitsstörung) dazu, ebenso wie neurokognitive Störungen, um so nicht zuletzt auch den geriatrisch-psychiatrischen Personenkreis mit abzudecken. Da im Vorfeld des systematischen Reviews davon auszugehen war, dass veröffentlichte Publikationen insbesondere auf Daten aus Beobachtungsstudien beruhen würden, wurde bezüglich des Formenkreises der psychischen Störungen eine klinische Diagnosestellung als ausreichend erachtet. Folglich war eines der Ausschlusskriterien Patientinnen und Patienten, bei denen keine psychische Störung gemäß internationaler Klassifikation vorlag. Ein weiteres Ausschlusskriterium waren Studien und Publikationen, in welchen insbesondere oder ausschließlich Kinder und Jugendliche vor Vollendung des 18. Lebensjahres als Patienten Klientel untersucht wurden. Hierbei galt es jedoch zu beachten, dass Veröffentlichungen, in welchen sowohl Kinder und Jugendliche, als auch Erwachsene zum Patienten Klientel gehörten, klar und nachvollziehbar der Anteil der erwachsenen Patienten gegenüber dem Anteil minderjähriger Patienten überwiegen musste. Ausgeschlossen wurden in diesem Sinne auch Publikationen welche aggressives Verhalten in Tieren/ Tierversuchen zum Thema hatten.

Weiter wurden nur Studien eingeschlossen, die örtlich klar einer psychiatrischen/medizinischen Institution zuzuordnen waren, sowie Orte im Sinne einer Betreuungseinrichtung und des gesundheitlichen Versorgungssystems. Ausgeschlossen wurden daher Studien, welche beispielsweise aggressives Verhalten unter Soldaten in militärischen Lagern untersuchten.

Darüber hinaus wurden lediglich Studien berücksichtigt, welche neben dem Titel und der Zusammenfassung auch in der Publikation selbst in deutscher oder englischer Sprache veröffentlicht wurden. D. h. ausgeschlossen wurde alle nicht-deutsch- und nicht-englischsprachige Literatur.

Nicht mit eingeschlossen wurden zudem Veröffentlichungen im Sinne vom Leserbriefen, Kommentaren und Zeitschriftenaufsätzen, welche beispielsweise lediglich eine Empfehlung zur Einführung einer Trainingsmaßnahme abgaben, ohne jedoch konkret eine Intervention zu beschreiben oder deren Wirksamkeit zu messen.

Ausgeschlossen wurden außerdem Peer-Reviews zur Fragestellung, um so Wiederholungen der einzelnen Studien zu vermeiden und das Risiko der internen Bias zu vermindern.

### **Freie Frage:**

Lassen sich Prediktoren finden, die Gewalt psychisch Erkrankter gegen ihre Angehörigen voraussagen?

Was für Auswirkungen/Konsequenzen/Outcome hat die Gewalt psychisch Erkrankter auf die Angehörigen?

Fragekomponenten	Einschlusskriterien	Ausschlusskriterien
<b>-Die Population:</b>		
Freitext-Suche/Trunkierung:	-mental*	
	(mental disorders, mental illness,...) NICHT mental health	
	-psychiatr*	
	-schizo*	
	-autis*	-Autismus ja, aber meistens
handelte		es sich um Kinder,
Ausschluss Youth,		Child, <18 years old
	-delir*	-Drogen- und Alkohol Abusus als
		Co-Erkrankung ja, ABER NICHT
		Alkoholismus oder Drogen
alleine	-dement*	
	(jede Art von Demenz, meistens Alzheimer D.)	
	-intellect*	
	-brain injur*	-KEIN Schlaganfall
	-bipolar	
Thesaurus-Suche:	-Affective psychosis, bipolar	-keine unipolare Depression, keine
		post-partum Depression
	-Behavior disorder, disruptive	
	-Impulse control disorders	
	-Mood disorders	
	-Neurocognitive disorders	
	-Personality disorders	-Aber NICHT Compulsive
personality		disorder ->meistens Kinder,
		NICHT Borderline personality
disorder	-Paranoid Disorders	
	-Psychotic Disorders	
	-Schizophrenia	
	u.a. auch „First episode psychosis“	
	-Post-traumatic stress disorder	
<b>-Die Interventionen:</b>		
	<b>-Prädiktoren, die zur Gewalt führen,</b>	
	NUR solche GEGEN Angehörige, Z.B:	



„Practitioners“, staff“, andere den psychisch selbst	Family, relative, informal caregiver	NICHT formal caregiver NICHT: gegen „nursing Patienten, Kranken Patienten (NICHT victimisation)
<b>-Der Endpunkt:</b>	<b>-Setting:</b> community, outpatient setting at home	NICHT inpatient clinic NICHT hospital
	<b>-Gewalt:</b>	!: elder abuse: meistens Gewalt der Angehörigen gegen die älteren, kranken Menschen !: intim partner violence: meistens ist die psychische Erkrankung ein Prädiktor dafür ein Gewaltopfer zu werden.
etc.)	<b>-Outcome für den Angehörigen</b> meistens durch den Begriff „Burden“	NICHT Outcome des Patienten (Rückfall
<b>-Die Studiendesigns:</b>	-Befragung von Angehörigen oder Patienten (mit quantitativen Angaben)	<b>-NICHT,</b>
wenn es keine quantitativen Angaben zu den Gruppen gab		<b>-KEINE</b> Editorials, Briefe, Bucheinträge <b>-KEINE</b> Einzelfallberichte, -serien <b>-KEINE</b> Sekundäranalysen*, Auswertungen von medizinischen Akten <u>*Ausnahme:</u> wenn Primär- studie Thema behandelt, dann Einschluss

**-KEINE Reviews**Durchführung der Suche in Medline und Cinahl

**Die Suche erfolgte am 22. Oktober 2017 und lieferte 1467 Treffer bei Medline und 523 Treffer bei Cinahl. Nach Entfernung der doppelten Publikationen (n= 276) verblieben 1715 Artikel. (Fortsetzung folgt)**

**Gewalt gegen Angehörige (Rater: Hannah Rafalski (Doktorandin), Sophie Hirsch):**

Für dieses Review, das im Rahmen einer Dissertation erstellt wurde, wurden folgende Datenbanken für die folgenden Zeiträume über die Suchoberfläche Ovid durchsucht.

- MEDLINE <1946 to Present> (diese Version enthält alle Treffer bis zum aktuellsten Fund): enthält vor allem angloamerikanische Journale
- Embase <1974 to x.x.x> (hier die Version, die bis zum vorherigen Tag aktuell ist): hat eine europäische Ausrichtung (und pharmakologischen Schwerpunkt).
- PsycINFO <1806 to x.x.x> (hier die Version, die bis zum geltenden Monat aktuell ist): Verzeichnis der Literatur zu Psychologie, Verhaltens- und Sozialwissenschaften
- PsynDEXPLUS -Literature and Audiovisual Media <1977 to x.x> (Version, die bis zum geltenden Vormonat aktuell ist, Version mit Tests für meine Fragestellung nicht zielführend): Schwerpunkt auf deutschsprachigen Ländern

In einem vorgelagerten Schritt wurde eine Pilotsuche mit der Funktion „Basic Search“ durchgeführt, um den Suchterm zu optimieren. Im nächsten Schritt wurde dann wie bei den anderen Suchen mit der Funktion „Advanced Search“ nach trunkierten Stichworten und nach Schlagworten (neben Medical Subject Headings für Medline auch mit Subject Headings für Embase) gesucht.

Da in diesem Review epidemiologische Fragestellungen beantwortet werden sollten (Was sind Risikofaktoren für häusliche Gewalt/Gewalt gegen Angehörige durch psychisch erkrankte Menschen? Wie häufig ist sie? Welche Folgen hat sie?), wurde nicht auf das auf Interventionsstudien ausgelegte PICO-Schema zurückgegriffen. Stattdessen wurde das MIP-Schema verwendet.

M-Methodology

I-Issue

P-Participants

Dann wurde entsprechend vorgegangen, d.h. innerhalb der Spalten wurde mit dem Bool'schen Operator OR verknüpft, die Spalten untereinander wurden mit AND verknüpft.

## Suchstrategie

### Database:

Ovid MEDLINE(R) Epub Ahead of Print, In-Process & Other Non-Indexed Citations, Ovid MEDLINE(R) Daily and Ovid MEDLINE(R) <1946 to Present>, Embase <1974 to 2017 Augst 07>, PsycINFO <1806 to July Week 5

### Search Strategy: 08.08.2017

- 1 Risk Factors/ (1247403)
- 2 Prevalence/ (794779)
- 3 „Survey and Questionnaires“/ (930526)
- 4 predict\*.ti. or predict\*.ab. (3319044)
- 5 „Outcome and Process Assessment (Health Care)“/ (740394)
- 6 burd\*.ti. or burd\*.ab. (423959)
- 7 consequen\*.ti. or consequen\*.ab. (1317384)
- 8 1 or 2 or 3 or 4 or 5 or 6 or 7 (7739036) (*alles zu M*)
- 9 Domestic Violence/ or Violence/ or Intimate Partner Violence/ (128317)
- 10 Spouse Abuse/ or Elder Abuse/ or Physical Abuse/ (32020)
- 11 Expressed Emotion/ (85537)
- 12 violent\*.ti. or violent\*.ab. (180575)
- 13 aggressi\*.ti. or aggressi\*.ab. (490950)
- 14 abus\*.ti. or abus\*.ab. (392959)
- 15 9 or 10 or 11 or 12 or 13 or 14 (1109873) (*alles zu I-violence*)
- 16 Family/ (202837)
- 17 Family Relations/ (52353)
- 18 Caregivers/ (91275)
- 19 caregiv\*.ti. or caregiv\*.ab. (162211)
- 20 16 or 17 or 18 or 19 (422960) (*alles zu I-family*)
- 21 mental\*.ti. or mental\*.ab. or psychiatr\*.ti. or psychiatr\*.ab. or schizo\*.ti. or schizo\*.ab. or autis\*.ti. or autis\*.ab. or delir\*.ti. or delir\*.ab. or dement\*.ti. or dement\*.ab. or intellect.ti. or intellect.ab. or brain injur\*.ti. or brain injur\*.ab. or bipolar.ti. or bipolar.ab. (2552958)
- 22 mental disorders/ or bipolar disorders/ or „disruptive, impulse control, and conduct disorders“/ or mood disorders/ or neurocognitive disorders/ or personality disorders/ or affective disorders, psychotic/ or paranoid disorders/ or psychotic disorders/ or schizophrenia/ or „trauma and stressor related disorders“/ (809606)
- 23 21 or 22 (*alles zu P-patients*)
- 24 8 and 15 and 20 and 23 (4674)(*Suche in Medline*)
- 25 prediction/ (311999)
- 26 emotional abuse/ or sexual abuse/ (41897)

- 27 caregiver burden/ or caregiver support/ (203762)  
 28 mental disease/ or attitude to mental illness/ (203763)  
 29 8 or 25 (7766642) (*alles zu M*)  
 30 15 or 26 (1118286) (*alles zu I-violence*)  
 31 20 or 27 (425061) (*alles zu I-family*)  
 32 23 or 28 (2825092) (*alles zu P-patients*)  
 33 29 and 30 and 31 and 32 (4859) (Suche mit Anpassung zusätzlich in Embase)  
 34 24 or 33 (4859) (*endgültiger Suchterm, da es keiner Anpassung in PsycINFO bedurfte*)  
 35 remove duplicates from 34 **(3755) (Endtreffer)**

### Anmerkungen:

**M – Methodology**

**I – Issue: Family & Violence**

**P – Paticipants: patients with mental disorders**

Suchstrategie

Database: **additional** PSYNDEXplus Literature and Audiovisual Media <1977 to July 2017>

Auszug:

...

34 Gewalt\*.ti. or Gewalt.ab. (7438)

35 psychi\*.ti. (296543)

36 Famil\*.ti. (551687)

.... (Verknüpfung mit den Blöcken I-violence, I-family und P)

44 37 or 39 or 43 (8477) (alle Suchen zusammen: angepasste Medline, Embase und PSYNDEXplus Suche, in PsycINFO ist keine Anpassung erfolgt)

### Problem und Handhabung:

Durch die Anpassung der Suchstrategie an PSYNDEXplus (deutsche Verschlagwortung) wurde die Suche für PSYNDEXplus genauer und erreichte eine größere Trefferzahl, für die anderen Datenbanken wurde die Suche aber zu offen, zu vage. Es ergab sich hierdurch eine Trefferzahl von 8477, statt 3664.

Deshalb wurden von Schritt 44 die Dubletten entfernt und anschließend die Treffer in PSYNDEXplus, an der Zahl 161, exportiert. Die Hauptsuche wurde dann ohne PSYNDEXplus und ihre Anpassung durchgeführt.

Anmerkung zur Dublettenentfernung: Da in OVID die Dublettentfernung nur bis 6000 Treffern möglich ist, wurde eine Dublettenentfernung einzeln in der Medline- und Embase-Suche durchgeführt. In einem zweiten Schritt dann:

50 44 (=8477) not (37 (Medline Anpassung) or 39 (Embase Anpassung)): (5520)

51 remove duplicates from 50 (4449)

52 46 (Medline ded.) or 47 (Embase ded.) or 51 **(6759) (Endtreffer)**

- ➔ Embase
- ➔ Medline
- ➔ PsycINFO

→ PSYNDXplus: 161 Treffer

**Suchstrategie CINAHL EBSCO HOST: 21.08.2017**

**S1** (MH „Surveys“) OR (MH „Risk Factors“) (231,487)

**S2** (MH „Prevalence“) (64,374)

**S3** (MH „Outcome Assessment“) (39,443)

**S4** S1 OR S2 OR S3 (*Thesaurus (MH) für M*)

**S5** (MH „Homicide“) OR (MH „Violence“) OR (MH „Domestic Violence“) OR (MH „Exposure to violence“) OR (MH „Verbal Abuse“) OR (MH „Aggression“) (30,989) (*Thesaurus für I-violence*)

**S6** (MH „Family“) OR (MH „Patient-Family Relations“) OR (MH „Family Functioning“) (35,763) (*Thesaurus für I-family*)

**S7** (MH „Caregiver Burden“) (7,492) (*Thesaurus für I-family*)

**S8** (MH „Mental Disorders“) OR (MH „Neurotic Disorders“) OR (MH „Affective Disorders“) OR (MH „Dissociative Disorders“) OR (MH „Impulse Control Disorders“) OR (MH „Psychotic Disorders“) OR (MH „Affective Disorders, Psychotic“) OR (MH „Bipolar Disorders“) OR (MH „Dementia“) OR (MH „Paranoid Disorders“) OR (MH „Schizoaffective Disorders“) OR (MH „Schizophrenia“) OR (MH „Acting Out“) (110,580) (*Thesaurus für P*)

**S9** TI (mental\* OR psychiatr\* OR schizo\* OR delir\* OR dement\* OR intellect\* OR brain injur\* OR bipolar\*) OR AB (mental\* OR psychiatr\* OR schizo\* OR delir\* OR dement\* OR intellect\* OR brain injur\* OR bipolar\*) (240,715) (*Freitextsuche mit Trunkierung in Title (TI) und Abstract (AB) für P*)

**S10** S8 OR S9 (277,690) (*Thesaurus und Freitextsuche für P zusammen*)

**S11** S6 OR S7 (41,405) (*Thesaurus für I-family zusammen*)

**S12** TI (violen\* OR aggressi\* OR abus\*) OR AB (violen\* OR aggressi\* OR abus\*) (93,236) (*Freitextsuche mit Trunkierung für I-violence*)

**S13** S5 OR S12 (105,266) (*Thesaurus und Freitextsuche mit Trunkierung für I-violence zusammen*)

**S14** TI caregiv\* OR AB caregiv\* (35,053) (*Freitextsuche mit Trunkierung für I-family*)

**S15** S11 OR S14 (69,058) (*Thesaurus und Freitextsuche mit Trunkierung für I-family*)

**S16** S13 AND S15 (3,222) (*„I-violence“ UND „I-family“ zusammen*)

**S17** TI (predict\* OR burd\* OR consequen\*) OR AB (predict\* OR burd\* OR consequen\*) (329,728) (*Freitextsuche mit Trunkierung für M*)

**S18** S4 OR S17 (590,775) (*Thesaurus und Freitextsuche mit Trunkierung für M*)

**S19** S10 AND S16 AND S18 (390) (*„P“ AND „I“ AND „M“*)

**Annotation:** M (= Methodology), I (= Issue), P (= Participants)

Gesucht wurde am 12.07.2017. **Insgesamt ergaben sich nach Entfernung der Dubletten 4226 Treffer, davon wurden 223 Artikel nach dem Title-Abstract-Screening in das Fulltext-Screening aufgenommen und letztendlich 27 Studien in die Leitlinie eingeschlossen (s Anhang).**

### Auswahl der Evidenz **S2e S3**

Grundsätzlich wurden alle Studientypen außer Einzelfallberichte eingeschlossen. Nicht eingeschlossen wurden ferner rein theoretische Abhandlungen, normative Stellungnahmen oder Gerichtsurteile. Ebenfalls ausgeschlossen wurde graue Literatur wie beispielsweise unveröffentlichte Dissertationen. Bezüglich der Sprachen wurden primär keine Einschränkungen gemacht (im Verlauf mussten eine japanische und eine türkische Studie wegen Übersetzungsproblemen ausgeschlossen werden). Alle Artikel, die inhaltlich und methodisch den Einschlusskriterien entsprachen, wurden eingeschlossen. Jeweils die methodisch am höchsten bewerteten Studie (s. u. „Bewertung der Evidenz“) wurde für die Ableitung der Empfehlung verwendet. Widersprüchliche Ergebnisse wurden im Hintergrundtext dargestellt. Die jeweiligen die Empfehlung begründenden Literaturstellen und die Begründungen für die Ableitung einer entsprechenden starken Empfehlung/Empfehlung/eines Vorschlags finden sich direkt bei den entsprechenden Empfehlungen in der Leitlinie.

### Bewertung der Evidenz **S2e S3**

Die Evidenz-Ebenen werden in Anlehnung an die Empfehlungen des Oxford Centre for Evidence-Based Medicine wie folgt definiert:

**Evidenzgrad 1:** Systematisches Review, das mehrere randomisierte kontrollierte Studien (RCTs) einschließt

**Evidenzgrad 2:** Randomisierte kontrollierte Studie oder Beobachtungsstudie mit dramatischem Effekt

**Evidenzgrad 3:** Nicht-randomisierte kontrollierte Studie

**Evidenzgrad 4:** Vorher-Nachher-Vergleiche, Fall-Kontroll-Studien, Fallserien

**Evidenzgrad 5:** Theoretisch hergeleitete Empfehlungen, Expertenmeinungen

Das Bewertungssystem ist im Internet unter <http://www.cebm.net/wp-content/uploads/2014/06/CEBM-Levels-of-Evidence-2.1.pdf> abrufbar.

### Erstellung von Evidenztabelle **S2e S3**

Tabellen mit den einzelnen im Rahmen der systematischen Evidenzrecherche und -bewertung eingeschlossenen Studien finden sich im Anhang dieses Leitlinienreports.

### **Formulierung der Empfehlungen und strukturierte Konsensfindung**

Die einzelnen Kapitel wurden vom Koordinator und der Redakteurin bzw. beauftragten Experten aus der Leitliniensteuerungsgruppe erstellt. Die Autoren stellten die aktuellen wissenschaftlichen Daten zusammen und formulierten die Entwurfstexte.

**Anhand der Texte wurden vom Leitlinienkoordinator Vorschläge für Empfehlungen gemacht.** Die Entwürfe wurden allen Mitgliedern der Leitliniensteuerungsgruppe mit Hilfe einer Cloud online sowie per E-Mail zur Kommentierung zur Verfügung gestellt. Die Kommentare und Korrekturvorschläge wurden von der Redakteurin eingearbeitet. **So entstanden in einem mehrstufigen Prozess im Sinne eines Delphiverfahrens Texte und Empfehlungen, die dann in zwei Treffen der Leitliniensteuerungsgruppe diskutiert, mittels Handzeichen abgestimmt und zur Vorstellung bei der Konsensusgruppe verabschiedet wurden.** Sowohl in der Leitliniensteuerungsgruppe als auch in der Konsensusgruppe waren sowohl Experten (Forschende aus den Bereichen Sozialpsychiatrie, Patientenautonomie, Pflegewissenschaften, Medizinethik und –recht) als auch Anwender (Ärztinnen und Ärzte, Psychologinnen und Psychologen, Pflegende, gesetzliche Betreuer) sowie Patientinnen und Patienten und ihre Angehörigen beteiligt.

Die Treffen der Leitliniensteuerungsgruppe fanden am 07.07.2016 und 28.06.2017 in Berlin und am 12.12.2017 in Frankfurt am Main statt. Die Konsensuskonferenz fand am 12.02.2018 in Berlin statt. Die Treffen wurden vorab mittels des Onlinetools doodle festgelegt und die Teilnehmenden per E-Mail eingeladen.

### **Formale Konsensfindung: Verfahren und Durchführung** S2k S3

Die so von der Leitliniensteuerungsgruppe erarbeiteten Empfehlungen wurden dann der Leitlinienkonsensusgruppe online (mittels der Plattform SurveyMonkey) zur Vorabstimmung zur Verfügung gestellt. Mitglieder der Konsensusgruppe, die einer Empfehlung nicht zustimmten, konnten online Alternativvorschläge für diese Empfehlung einreichen. Insgesamt gaben 18 der 22 Mandatsträger ihre Stimme ab.

Die Empfehlungen, bei denen online kein Konsens erzielt werden konnten, wurden dann im Rahmen der Konsensuskonferenz diskutiert und ggf. geändert. Diese Empfehlungen und die jeweiligen Alternativvorschläge aus der Onlineumfrage wurden dann in der Konsensuskonferenz erneut mittels Handzeichen im Sinne **eines nominalen Gruppenprozesses** abgestimmt. Zusätzlich wurden Empfehlungen mit knappem Konsens oder vielen Enthaltungen nach Beratschlagung mit der AWMF in der Konferenz diskutiert und teilweise ebenfalls erneut abgestimmt. An der Konferenz nahmen 25 Expertinnen und Experten, davon 20 Mandatsträger, die insgesamt 21 Stimmen hatten (Herr Thomas Pollmächer stimmte wegen des kurzfristigen Ausfalls von Herrn Felix Hohl-Radke doppelt ab, für BDk und DGPPN), teil.

Durch dieses Vorgehen sollte verhindert werden, dass in der Konsensuskonferenz ein zu hoher Zeitdruck entsteht, insbesondere den strittigen Punkten zu wenig Zeit eingeräumt wird und Standpunkte der verschiedenen Parteien nicht geklärt werden.

Sowohl der nominale Gruppenprozess in der Konsensuskonferenz als auch die Diskussionen und Abstimmungen in der Leitliniensteuerungsgruppe wurden von Frau Dr. Nothacker als erfahrene und neutrale Mitarbeiterin der AWMF moderiert.

Die Stärke des Konsenses ist bei den jeweiligen Empfehlungen direkt in der Leitlinie vermerkt.

Starker Konsens	> 95 % der Teilnehmenden	Annahme der Empfehlung
Konsens	> 75 %-95 %	
Mehrheitliche Zustimmung	> 50 %-75 %	Ablehnung der Empfehlung
Kein Konsens	<= 50 %	

Ab mindestens 16 Zustimmungen wurde ein Konsens, ab mindestens 20 Zustimmungen ein starker Konsens erreicht.

### **Berücksichtigung von Nutzen, Nebenwirkungen-relevanten Outcomes**

#### **Klinische Relevanz**

Die klinische Relevanz kann die Einstufung einer Empfehlung beeinflussen. Als Resultat eines Expertenkonsenses kann zum Beispiel eine Empfehlung auch ohne hierarchisch hochstehende Evidenzklasse einem hohen Empfehlungsgrad zugeordnet werden, wenn dies die Lösung eines Versorgungsproblems erfordert ([www.versorgungsleitlinien.de](http://www.versorgungsleitlinien.de)).

Entsprechende Herauf- und Herabstufungen finden sich direkt bei den jeweiligen Empfehlungen.

### **Formulierung der Empfehlungen und Vergabe von Evidenzgraden und/ oder Empfehlungsgraden**

**S2k S3**

**Starke Empfehlung, Soll- Empfehlung, Empfehlungsgrad A:** Eine Behandlungsmethode erhält die Empfehlungsstärke A, wenn zu der Methode Studien der Kategorie 1 oder 2 vorliegen (s. o. „Evidenzgrade“).

**Empfehlung, Sollte-Empfehlung, Empfehlungsgrad B:** Eine Behandlungsmethode erhält die Empfehlungsstärke B, wenn zu der Methode Studien der Kategorie 3 oder 4 vorliegen. (Wenn eine Studie der Kategorie 1 oder 2 vorliegt, aus der die Empfehlung für eine Methode extrapoliert werden muss, bspw. weil andere Populationen oder Settings untersucht wurden, dann erhält sie ebenfalls die Empfehlungsstärke B)

**Vorschlag, Kann-Empfehlung, Empfehlungsgrad 0:** Eine Behandlungsmethode erhält die Empfehlungsstärke C, wenn zu der Methode Studien der Kategorie 5 vorliegen. (Wenn Studien der Kategorie 3 oder 4 vorliegen, aus der die Empfehlung für eine Methode



extrapoliert werden muss, dann erhält sie ebenfalls die Empfehlungsstärke C)

**Abweichungen sind bei entsprechendem Expertenkonsens möglich, wobei hier ethische, kulturelle, wirtschaftliche Aspekte sowie Sicherheit und Patientenpräferenzen mit einbezogen werden.**

### **Expertenkonsens**

Wenn es für eine Behandlungsmethode keine experimentellen wissenschaftlichen Studien gibt, diese nicht möglich sind oder nicht angestrebt werden, das Verfahren aber dennoch allgemein üblich ist und innerhalb der Konsensusgruppe eine Übereinkunft über das Verfahren erzielt werden konnte, so erhält diese Methode die Empfehlungsstärke Expertenkonsens.

### **Statement**

Allgemeine Begriffsdefinitionen, Studienergebnisse, Expertenmeinungen und deren Erklärung, die aber nicht direkt in eine Empfehlung münden.

## 4. Externe Begutachtung und Verabschiedung

### Pilottestung

Auf eine Pilotierung wurde verzichtet, da es sich bei der Leitlinie um ein Update und Upgrade einer bestehenden Leitlinie handelt und Expertinnen und Experten, die bereits bei der letzten Version beteiligt waren und die Umsetzbarkeit in der Praxis bereits erprobt hatten, einbezogen wurden.

### Verabschiedung durch die Vorstände der herausgebenden

### Fachgesellschaften/Organisationen **S2k S2e S3**

Nach der Konsensuskonferenz und einer vierwöchigen Frist zur Prüfung des Textes durch die Mandatsträger, wurde die Endversion erneut an die Mandatsträger verschickt zur Vorlage bei und der Verabschiedung der Texte durch die Vorstände ihrer Fachgesellschaften.

Der Bundesverband der Psychiatrie-Erfahrenen (BPE) hat der Endfassung der Leitlinie nicht zugestimmt. Der offenen Brief des Verbandes findet sich am Ende dieses Leitlinienreports.

## 5. Redaktionelle Unabhängigkeit

### Finanzierung der Leitlinie **S2k S2e S3**

Die Leitlinie wurde von der Deutschen Gesellschaft für Psychiatrie und Psychotherapie, Psychosomatik und Nervenheilkunde (DGPPN) in Auftrag gegeben. Es wurden eine halbe Stelle für eine wissenschaftliche Mitarbeiterin über 3 Jahre (insgesamt 90.000 Euro plus MwSt) und Reisekosten (insgesamt 3000 Euro) bezahlt. Die DGPPN war durch Herrn Gerlinger und Herrn Professor Pollmächer in der Leitliniensteuerungsgruppe und durch Herrn Professor Pollmächer in der Konsensusgruppe mit einfacher Stimme vertreten. Ansonsten erfolgte keine Einflussnahme der finanzierenden Gesellschaft auf Inhalte der Leitlinie. Andere Geldgeber gab es nicht. Die Expertinnen und Experten der Leitliniensteuerungsgruppe arbeiteten ehrenamtlich bzw. verrichteten ihre Aufgaben im Rahmen ihrer hauptberuflichen Tätigkeit. Reisekosten trugen die entsendenden Organisationen, nur für Psychiatrieerfahrene wurden Reise- und Übernachtungskosten von der DGPPN bzw. dem ZfP Südwürttemberg übernommen.

### Darlegung von und Umgang mit Interessenkonflikten **S2k S2e S3**

Die Interessenkonflikte wurden schriftlich mit Hilfe des von der AWMF angebotenen Musterformulars erhoben. Die Erhebung fand zu Beginn (2016) und zum Ende (2017) der Leitlinienerstellung unter den Mitgliedern der Leitliniensteuerungsgruppe (incl. Koordinator und wissenschaftlicher Mitarbeiterin) und vor Abstimmung der Empfehlungen unter den Mitgliedern der Konsensusgruppe (2018) statt. Folgende Interessenskonflikte wurden dabei erhoben.

Nr.	Erklärung
1	Berater- bzw. Gutachtertätigkeit oder bezahlte Mitarbeit in einem wissenschaftlichen Beirat eines pharmazeutischen, biotechnologischen bzw. medizintechnischen Unternehmens
2	Honorare für Vortrags- und Schulungstätigkeiten oder bezahlte Autoren- oder Koautorenschaften im Auftrag pharmazeutischer, biotechnologischer, medizintechnischer Unternehmen
3	Finanzielle Zuwendungen (Drittmittel) für Forschungsvorhaben, direkte Finanzierung von Mitarbeitenden der Einrichtung von Seiten kommerziell orientierter (pharmazeutischer, biotechnologischer bzw. medizintechnischer Unternehmen bzw. Auftragsinstitute) oder anderer Förderer
4	Eigentümerinteresse an Arzneimitteln/Medizinprodukten (z. B. Patent, Urheberrecht, Verkaufslizenz)

5	Besitz von Geschäftsanteilen, Aktien, Fonds mit Beteiligung pharmazeutischer, biotechnologischer bzw. medizintechnischer Unternehmen
6	Familiäre oder persönliche Beziehungen zu einem Vertretungsberechtigten eines pharmazeutischen, biotechnologischen bzw. medizintechnischen Unternehmens
7	Mitglied von in Zusammenhang mit der Leitlinienentwicklung relevanten Fachgesellschaften/ Berufsverbänden, Mandatsträger im Rahmen der Leitlinienentwicklung
8	Politische, akademische (z. B. Zugehörigkeit zu bestimmten therapeutischen „Schulen“) oder privat/persönliche Beziehungen, die Interessenskonflikte begründen könnten
9	Gegenwärtiger Arbeitgeber, relevante frühere Arbeitgeber der letzten 3 Jahre

Es wurde vom Leitlinienkoordinator nach Prüfung der Formulare empfohlen, dass Mitglieder mit finanziellen Verbindungen in die pharmazeutische Industrie bzw. in kommerzielle Deeskalations-/Sicherheitsschulungs- und Trainingsprogramme sich bei Abstimmungen zu den jeweiligen Themen enthalten. Dies wurde im nominalen Gruppenprozess bei der Konsensuskonferenz auch so umgesetzt. In der Online-Abstimmung im Vorfeld zur Konsensuskonferenz konnte die Umsetzung der Empfehlung durch die Mandatsträger nicht überprüft werden, da aus technischen Gründen nur eine anonyme Abstimmung möglich war. Die Interessenskonflikte des Leitlinienkoordinators und der wissenschaftlichen Mitarbeiterin wurden zudem von der DGPPN überprüft.

Die angegebenen Interessenskonflikte sind in den untenstehenden Tabellen aufgeführt (N= Nein, es besteht kein Interessenkonflikt in diesem Bereich, J= Ja, es bestehen Interessenskonflikte). Wenn Interessenskonflikte bestehen, sind diese am Ende der Tabellen genauer erläutert.

## Deklarierte Interessensgruppe der Leitliniensteuerungsgruppe 2016 beim ersten Treffen

Name	1	2	3	4	5	6	7	8	9
Tilman Steinert	N	N	J	N	N	N	J	N	Zentrum für Psychiatrie Südwestfalen
Sophie Hirsch	N	N	N	N	N	N	J	N	Zentrum für Psychiatrie Südwestfalen
Matthias Albers	N	N	N	N	N	N	J	N	Stadt Köln
Ruth Fricke	N	N	N	N	N	N	J	N	Seit 2002 pensioniert, Bundesverband Psychiatrie- Erfahrener
Franziska Gaese	J	N	N	N	N	N	J	N	Isar Amper Klinikum München Ost
Gabriel Gerlinger	N	N	N	N	N	N	N	N	DGPPN
Reinhard Gielen	N	N	N	N	N	N	J	N	Asklepios Westklinikum/Zentrum für seelische Gesundheit
Tanja Henking	N	N	N	N	N	N	N	N	Hochschule für angewandte Wissenschaften Würzburg- Schweinfurt
Knut Hoffmann	N	N	N	N	N	N	J	N	LWL-Universitätsklinikum Bochum
Felix Hohl-Radke	N	N	N	N	N	N	J	N	Asklepios Fachklinikum Brandenburg
Regina Ketelsen	N	N	N	N	N	N	N	N	Evangelisches Klinikum Bethel, Klinik für Psychiatrie und Psychotherapie Bethel
Martin Kolbe	N	J	N	N	N	N	J	N	DGBS e. V.
Michael Mayer	N	N	N	N	N	N	J	J	Bezirkskrankenhaus Kaufbeuren, Allgäu- Akademie
Jürgen L. Müller	J	N	J	N	N	N	J	N	Uni Göttingen, Asklepios GmbH
Oliver Pogarell	J	J	N	N	N	N	J	N	Uniklinik München
Thomas Pollmächer	N	N	N	N	N	N	J	N	Klinikum Ingolstadt
Michael Schulz	J	J	N	N	N	N	J	N	Fachhochschule der Diakonie
Konrad Stolz	N	N	N	N	N	N	N	N	NN.
Jochen Vollmann	N	J	N	N	N	N	J	N	Ruhr-Universität Bochum
Christian Zechert	N	N	N	N	N	N	J	N	Evangelisches Krankenhaus Bielefeld (bis 02/2014), BApK e. V.

Tilman Steinert

3. Forum für Gesundheitswirtschaft, Bremen.. Finanzierung von Forschung zur  
Personalbesetzung in psychiatrischen Kliniken

7. Mitglied der DGPPN, European Violence in Psychiatry Research Group

→ Keine Stimme bei Konsensuskonferenz

Sophie Hirsch:

7. Mitglied bei DGPPN, European Violence in Psychiatry Research Group

→ Keine Stimme bei Konsensuskonferenz

Matthias Albers

7. BVÖGD, DGSP

→ Keine bedeutsamen Interessenskonflikte

Ruth Fricke

→ Keine bedeutsamen Interessenskonflikte

Gabriel Gerlinger

→ Keine bedeutsamen Interessenskonflikte

Reinhard Gielen

→ Leitliniensteuerungsgruppe vorzeitig verlassen aus persönlichen Gründen, keine Stimme in der Konsensuskonferenz

Tanja Henking

→ Keine bedeutsamen Interessenskonflikte

Knut Hoffmann

Leiter des Referats „Geistige Behinderung“ der DGPPN

→ Keine bedeutsamen Interessenskonflikte

Felix Hohl Radke:

7. Vorstandsmitglied der BDK, in diesem Rahmen z.B. Teilnahme an der Task Force Patientenautonomie

→ keine bedeutsamen Interessenskonflikte

Regina Ketelsen:

→ keine bedeutsamen Interessenskonflikte

Martin Kolbe

→ Leitliniensteuerungsgruppe vorzeitig verlassen aus persönlichen Gründen, keine Stimme in der Konsensuskonferenz

Michael Mayer

7. DGPPN / DFPP / DG Pflegewissenschaft

8. Entwicklung eines nicht-kommerziellen Deeskalationstrainings

→ Empfehlung: Stimmenthaltung bei Deeskalation, Trainings/Fortbildungen

Jürgen Müller

1. Dr. Pfleger Pharma, Advisory Board Schizophrenie
  3. Asklepios, Projekt PSM
  7. DGPPN
- Empfehlung: Stimmenthaltung bei Medikamenten

Oliver Pogarell

1. Advisory Board Vortioxetin (Lundbeck), beendet 2016
  2. Vorträge für Lundbeck, Desitin, Otsuka
  7. Leiter des Arbeitskreises im Auftrage des Bayerischen Staatsministeriums für Gesundheit und Pflege zum Thema Unterbringung und Zwangsmaßnahmen
- Empfehlung: Stimmenthaltung bei Medikamenten

Thomas Pollmächer

7. DGPPN, BDK
- Keine bedeutsamen Interessenskonflikte

Michael Schulz

1. Einmalige Teilnahme als Berater an einem Schizophrenieprojekt der Firma Janssen-Cilag im September 2013. Es sollte ein Projekt zu Minussymptomatik aufgelegt werden. Habe von dem Projekt aber nichts mehr gehört. Es wurden damals 1500 € vergütet. Dafür war ich einen Tag in Berlin und habe dann noch einiges geschrieben.
  2. Firma ABBVIE am 3.-5. Oktober. Fortbildungsveranstaltung für Pflegemitarbeiter, die mit Morbus-Chron Patienten arbeiten. Geschult wurden Techniken, um die Adhärenz der Medikamenteneinnahme zu verbessern.  
Gezahlt wurden für drei Tage in Wien plus An- und Abreisetag 3500 €.
  7. Ich bin Präsidiumsmitglied der Deutschen Fachgesellschaft für Psychiatrische Pflege (DFPP) und des Bundesverbandes der Leitenden Krankenpfleger in der Psychiatrie (BFLK)
- Empfehlung: Stimmenthaltung bei Medikamenten

Konrad Stolz

- Keine bedeutsamen Interessenskonflikte

Jochen Vollmann

2. Fortbildungsveranstaltungen in zahlreichen Krankenhäusern
  7. DGPPN, Akademie für Ethik in der Medizin
- Keine bedeutsamen Interessenskonflikte

Christian Zechert

7. Bundesverband der Angehörigen psychisch erkrankter Menschen

→ Keine bedeutsamen Interessenskonflikte

Deklarierte Interessenskonflikte der Leitliniensteuerungsgruppe 2017 beim Abschlusstreffen

Name	1	2	3	4	5	6	7	8	9
Tilman Steinert	N	N	J	N	N	N	J	N	ZfP Südwürttemberg
Sophie Hirsch	N	J	N	N	N	N	J	J	ZfP Südwürttemberg
Matthias Albers	N	N	N	N	N	N	J	N	Stadt Köln
Cornelia Brummer	N	N	N	N	N	N	J	N	Diakonie Hessen
Ruth Fricke	N	N	N	N	N	N	J	N	Seit 2002 pensioniert
Gabriel Gerlinger	N	N	N	N	N	N	N	N	DGPPN e. V.
Tanja Henking	N	N	N	N	N	N	N	N	Hochschule für angew. Wissenschaften Würzburg- Schweinfurt
Felix Hohl-Radke	N	N	N	N	N	N	J	N	Asklepios Fachklinikum Brandenburg
Regina Ketelsen	N	N	N	N	N	N	N	N	Evangelisches Klinikum Bethel, Klinik für Psychiatrie und Psychotherapie
Michael Mayer	N	N	N	N	N	N	J	J	Bezirkskrankenhaus Kaufbeuren
Jürgen L. Müller	N	N	N	N	N	N	J	N	Uni Göttingen, Asklepios GmbH
André Nienaber	N	J	N	N	N	N	J	N	LWL-Klinikum Gütersloh, Fachhochschule der Diakonie Bielefeld
Oliver Pogarell	J	J	N	N	N	N	J	N	Klinikum der Universität München (KUM)
Thomas Pollmächer	N	N	J	N	N	N	J	N	Klinikum Ingolstadt
Daniela Schmid	N	N	N	N	N	N	N	N	NetzG e. V. / Journalistin Druckstudio GpZ Überlingen gGmbH
Michael Schulz	N	J	N	N	N	N	J	N	Fachhochschule der Diakonie Bielefeld
Konrad Stolz	N	N	N	N	N	N	N	N	Hochschullehrer im Ruhestand
Jochen Vollmann	N	J	N	N	N	N	N	N	Ruhr-Universität Bochum
Gernot Walter	N	J	N	N	N	N	J	N	Zentrum für Seelische Gesundheit an den Kreiskliniken Darmstadt Dieburg
Christian Zechert	N	N	N	N	J	N	J	N	1.1.2016–31.12.2017 neben der Vorstands-tätigkeit auch Wissenschaftlicher Mitarbeiter eines vom BMG geförderten Projekts in Trägerschaft des BApK.



Tilman Steinert

3. Forum für Gesundheitswirtschaft, Bremen. Finanzierung von Forschung zur Personalbesetzung in psychiatrischen Kliniken

7. Mitglied der DGPPN

Sophie Hirsch

2. Vortrag über häusliche Gewalt bei einer Fortbildung für Psychiaterinnen und Psychiater des kommerziellen Fortbildungsinstituts FomF

7. Mitglied bei DGPPN, EViPRG

8. Wissenschaftliche Mitarbeiterin der LLStG

→ Keine Stimme bei Konsensuskonferenz

Matthias Albers

7. BVÖGD, Netzwerk Sozialpsychiatrischer Dienst, DGSP

→ Keine bedeutsamen Interessenskonflikte

Cornelia Brummer

7. DGBS

→ Keine bedeutsamen Interessenskonflikte

Ruth Fricke

7. Mitglied im geschäftsführenden Vorstand des Bundesverbandes Psychiatrie-Erfahrener (BPE e.V.)

→ Keine bedeutsamen Interessenskonflikte

Gabriel Gerlinger

→ Keine bedeutsamen Interessenskonflikte

Tanja Henking

→ Keine bedeutsamen Interessenskonflikte

Felix Hohl Radke

7. Vorstandsmitglied der BDK, in diesem Rahmen z.B. Teilnahme an der Task Force Patientenautonomie

→ keine bedeutsamen Interessenskonflikte

Regina Ketelsen:

→ keine bedeutsamen Interessenskonflikte

Michael Mayer

7. DGPPN / DFPP / DG Pflegewissenschaft

8. Mitwirkung bei Entwicklung eines Deeskalationstrainings

→ Empfehlung: Stimmenthaltung bei Deeskalation, Trainings/Fortbildungen

Jürgen Müller

7. DGPPN

→ Empfehlung: Stimmenthaltung bei Medikamenten (s.o.)

André Nienaber

2. Janssen Cilag GmbH Vortragstätigkeit

7. Mitglied in der DFPP und der DGPPN

→ Empfehlung: Stimmenthaltung bei Medikamenten

Oliver Pogarell

1. Advisory Board Vortioxetin (Lundbeck), beendet 2016

2. Vorträge für Lundbeck, Desitin, Otsuka

7. Leiter des Arbeitskreises im Auftrage des Bayerischen Staatsministeriums für Gesundheit und Pflege zum Thema Unterbringung und Zwangsmaßnahmen

→ Empfehlung: Stimmenthaltung bei Medikamenten

Thomas Pollmächer

3. Projekt „Schlafbezogene nächtliche Atmungsstörungen bei psychiatrischen Patienten“

7. DGPPN (VS-Mitglied), BDK (Vorsitzender)

→ Keine bedeutsamen Interessenskonflikte

Michael Schulz

2. 2014 Projekt zur Schulung von MA in Adherence Therapie an der Forensischen Klinik Nettgut in Andernach, incl. Evaluation. Gesamtvolumen des Projekts 60.000 €.

7. DFPP

→ Keine bedeutsamen Interessenskonflikte

Konrad Stolz

→ Keine bedeutsamen Interessenskonflikte

Jochen Vollmann

2. Vorträge bei Medac GmbH in Berlin 2015 und 2017, bei KWHL GmbH in Bochum 2016, bei Berlin Chemie in Bocuham 2016 und beim Verband der Ersatzkrankenkassen Sachsen 2015.

→ Empfehlung: Stimmenthaltung bei Medikamenten

Gernot Walter

2. Schulungen und Beratungen für die Bereiche Aggressions- und Sicherheitsmanagement für Einrichtungen und Verbände des Gesundheitswesens, Herausgabe Fachbuch und diverse Buchkapitel zu oben genanntem Thema

7. DFPP, ENTMA

→ Empfehlung: Stimmenthaltung bei Deeskalation, Training/Fortbildung

Christian Zechert

5. Der BApK ist Miteigentümer des Psychiatrie-Verlags, Köln. Formal ist der Verlag ein „Unternehmen der Gesundheitswirtschaft“ und nicht gemeinnützig.

→ Keine bedeutsamen Interessenskonflikte

Deklarierte Interessenskonflikte der Konsensusgruppe 2017 vor Abstimmung

Name	1	2	3	4	5	6	7	8	9
Stephan Debus	N	N	N	N	N	N	J	N	Med. Hochschule Hannover, Klinik für Psychiatrie, Sozialpsychiatrie und Psychotherapie
Helga Füßmann	N	N	N	N	N	N	J	N	NN
Sabine Jansen	J	J	N	N	N	N	J	N	Deutsche Alzheimergesellschaft e.V. Selbsthilfe Demenz
Annette Loer	N	N	N	N	N	N	J	N	Oberlandesgericht Celle/ Amtsgericht Hannover
Heidrun Lundie	N	N	N	N	N	N	J	N	St. Alexius/St. Josefs-Krankenhaus
Inge Neisser	N	N	N	N	N	N	J	N	NN
Klaus Obert	N	N	N	N	N	N	N	N	Gemeindepsychiatrisches Zentrum Stuttgart
Iris Peymann	N	N	N	N	N	N	J	N	
Oliver Pogarell	J	J	N	N	N	N	J	N	Klinikum der Universität München (KUM)
Christa Roth-Sackenheim	N	N	N	N	N	N	J	N	NN
Ingo Schäfer	N	J	N	N	J	N	J	N	Klinik für Psychiatrie und Psychotherapie Universitätsklinikum Hamburg-Eppendorf
Jochen Tenter	N	N	N	N	N	N	J	N	ZfP Südwürttemberg
Roland Urban	N	N	N	N		N	J	N	NN
Egberth Wienforth	N	N	N	N	N	N	J	N	NN

Markus Witzmann	N	N	N	N	N	N	J	N	Klinikum des Bezirks Oberbayern und Staatl. Hochschule München
Christian Zechert	N	N	N	N	J	N	J	N	Seit 1.1.2018 nur Altersrente 01.01.2016 – 31.12.2017 (Arbeitnehmer und Altersrentenbezieher) 01.03.2014 – 31.12.2015 Freier Mitarbeiter beim BApK e.V und Altersrente Bis 28.02.2014 Wissenschaftlicher MA des Ev. Krhs. Bethel / ab 1.3.2014 Altersrente
Martin Zinkler	N	N	N	N	N	N	J	N	Kliniken Landkreis Heidenheim gGmbH

Stephan Debus

7. Entsendung durch DGSP, Mitglied der DGSP und im DGSP-FA-Forschung

→ Keine bedeutsamen Interessenskonflikte

Helga Füßmann

7. Vorsitzende des VPP und des BDP

Sabine Jansen

1. 250 Euro Novartis, 1500 Euro Lilly (jeweils 2015, nicht persönlich erhalten)

2. Fa. Lilly 1100 Euro für einen Vortrag (11/2016, nicht persönlich erhalten)

7. Mandatsträgerin für Deutsche Alzheimergesellschaft

→ Empfehlung: Stimmenthaltung bei Medikamenten

Annette Loer

7. Betreuungsgerichtstag (ehrenamtlicher Vorstand und hier als Mandatsträgerin für LL entsandt)

→ Keine bedeutsamen Interessenskonflikte

Heidrun Lundie

7. Mitglied in der Bundesfachvereinigung für leitende Pflegenden in der Psychiatrie

→ Keine bedeutsamen Interessenskonflikte

Inge Neisser

7. Berufsverbnd Deutscher Psychologinnen und Psychologen

→ Keine bedeutsamen Interessenskonflikte

Iris Peymann

7. Bundesverband der Berufsbetreuer/Innen, Vorstand

→ Keine bedeutsamen Interessenskonflikte

Oliver Pogarell

1. Advisory Board Vortioxetin (Lundbeck), beendet 2016

2. Vorträge für Lundbeck, Desitin, Otsuka

7. Leiter des Arbeitskreises im Auftrage des Bayerischen Staatsministeriums für Gesundheit und Pflege zum Thema Unterbringung und Zwangsmaßnahmen

→ Empfehlung: Stimmenthaltung bei Medikamenten

Jochen Tenter

7. DGPPN, DGGPP, DAGPP

→ Keine bedeutsamen Interessenskonflikte

Christa Roth-Sackenheim

7. Vorsitzende des Berufsverbandes Deutscher Fachärzte für Psychiatrie und Psychotherapie

→ Keine bedeutsamen Interessenskonflikte

Ingo Schäfer

2. Zentrum für Psychotraumatologie Hamburg

5. Zentrum für Psychotraumatologie Hamburg

7. DGPPN, DeGPT (Mandatsträger), DGSucht, NS

→ Keine bedeutsamen Interessenskonflikte

Roland Urban

7. DGPPN, BVDN, BVDP

→ Keine bedeutsamen Interessenskonflikte

Egberth Wienforth

7. DGPPN, BVDN, BVDP

→ Keine bedeutsamen Interessenskonflikte

Markus Witzmann

7. Sektion Psychiatrische Pflegeforschung der DGP e.V.

→ Keine bedeutsamen Interessenskonflikte

Christian Zechert

5. Der BApK ist Miteigentümer des Psychiatrie-Verlags, Köln. Formal ist der Verlag ein „Unternehmen der Gesundheitswirtschaft“ und nicht gemeinnützig.

7. Vorstand BApK e.V., Mitglied DGSP

→ Keine bedeutsamen Interessenskonflikte

Martin Zinkler

7. DGPPN; ACKPA

→ keine bedeutsamen Interessenskonflikte

## 6. Verbreitung und Implementierung

### Konzept zur Verbreitung und Implementierung

Die Leitlinie soll im Internet auf der Seite der AWMF und der DGPPN frei zugänglich sein. Zudem soll sie in Printform vertrieben werden (s. u. Unterstützende Materialien) und in Rundschreiben verbreitet werden.

Die Leitlinie wurde bereits auf verschiedenen internationalen psychiatrischen Kongressen vorgestellt.

Alle bisherigen Erfahrungen (6-Core-Strategies, Safewards) ergaben, dass es nicht ausreicht, Wissen und Materialien zur Verfügung stellen, um Zwang und Gewalt wirksam zu reduzieren. Stattdessen sind strukturierte Programme erforderlich, die auf verschiedenen Ebenen des Versorgungssystems ansetzen.

Aus den Empfehlungen der Leitlinie soll daher ein Interventions-Plan abgeleitet werden, der i.S. einer Fidelity-Skala überprüfbar ist, z. B.

- Festlegen von individuellen Verantwortlichkeiten, Einbezug der Klinikleitung
- Angemessene Gestaltung von Stationen
- Einführung von Sprach- und Kulturmittlern
- Einbeziehung von Peers
- Einführung eines Konzepts zur Reduktion geschlossener Stationstüren und Ausgangsbeschränkungen, Möglichkeiten zum begleiteten Ausgang
- Standardisierte Risikoeinschätzung und standardisierte Frühinterventionen
- Einführung von Sensory Modulation, Time-Out-Räume, 1:1-Betreuung und individualisierten Notfallpläne für Patienten auf Station
- Einführung individualisierter Behandlungspläne
- Angebot von verhaltenstherapeutischen Einzel- und Gruppentherapien
- Verpflichtende Schulungen und Trainings für Mitarbeitende und psychisch erkrankte Menschen
- Einführung alternativer freiheitsbeschränkender Maßnahmen wie Festhalten
- Verkürzung der Überprüfungsintervalle bzw. Einführung einer lückenlosen 1:1 Betreuung bei freiheitsbeschränkenden Maßnahmen
- Menschliche Gestaltung von freiheitsbeschränkenden Maßnahmen, bei länger andauern Maßnahmen mit therapeutischen Angeboten und Möglichkeiten zu Besuchen
- LL-gerechte Pharmakotherapie in der Akutsituation
- LL-gerechte Pharmakotherapie in der Langzeitbehandlung
- Standardisierte Erfassung von Aggression, Gewalt und Zwangsmaßnahmen
- Einführung von Nachbesprechungen
- Einführungen von Vorausverfügungen nach Unterbringungen und nach freiheitsbeschränkenden Maßnahmen auf Station

Angestrebt wird eine Forschung zur Wirksamkeit der Implementierung mit einer multizentrischen randomisierten kontrollierten Studie.

### **Unterstützende Materialien für die Anwendung der Leitlinie**

Die Leitlinie soll in einer Langfassung, in einer Kurzfassung, die die Empfehlungen für den klinischen Alltag enthält sowie in einer Fassung für psychisch erkrankte Menschen und ihre Angehörigen erscheinen, die die wichtigsten Erkenntnisse aus Hintergrundtext und Empfehlungen in verständlicher Sprache zusammenfasst, erscheinen. Eine Übersetzung der Empfehlungen und der Nutzerfassung ins Englische ist geplant.

### **Diskussion möglicher organisatorischer und/oder finanzieller Barrieren gegenüber der Anwendung der Leitlinienempfehlungen**

Neben zeitlichen und finanziellen Barrieren (Personal, Schulungen, Gebäude) spielen bei Zwang und Gewalt ganz besonders das Sicherheitsgefühl des Einzelnen und die Verantwortlichkeiten in der Gruppe eine Rolle. Hier müssen Strategien entwickelt werden, um Zwang und Gewalt gleichermaßen zu reduzieren und psychisch erkrankte Menschen und Mitarbeitende vor Verletzungen und Traumatisierungen zu bewahren. Neben Aufklärungsarbeit spielen Schulungen und Trainings sowie ideelle, finanzielle und praktische Unterstützungen durch das operative und das strategische Management eine wichtige Rolle.

### **Messgrößen für das Monitoring: Qualitätsziele, Qualitätsindikatoren**

Prozessqualität: Die Einführung des oben genannten XXX Punkte Plan kann mit Audits überprüft werden. Es soll eine Fidelity-Skala entwickelt werden. Geplant ist ein multizentrisches RCT.

Ergebnisqualität: Zusätzlich sollten aggressive und gewalttätige Übergriffe sowie Zwangsmaßnahmen erfasst und standardisiert ausgewertet werden, bspw. Fixierungen, Isolierungen oder Übergriffe pro 1000 Patiententage, Dauer der Zwangsmaßnahmen pro 1000 Patiententage etc.



## 7. Gültigkeitsdauer und Aktualisierungsverfahren

### Datum der letzten inhaltlichen Überarbeitung und Status

Diese Leitlinie wurde am 12.02.2018 in der Konsensuskonferenz zuletzt inhaltlich überarbeitet und verabschiedet. Die Leitlinie ist bis Februar 2023 gültig.

### Aktualisierungsverfahren

Die Leitlinie soll bis 2023 aktualisiert werden.

Ansprechpartner ist die DGPPN (sekretariat@dgppn.de).

Dabei sollen Updates für die vier systematischen Reviews erstellt werden.

Folgende bisher noch nicht vollständig untersuchte Bereiche sollen dann besondere Berücksichtigung finden, ggf. müssen in der Zwischenzeit Untersuchungen diesbezüglich durchgeführt und Daten gesammelt werden:

- Neue Datenlage komplexe/strukturierte Behandlungsprogramme zur Reduktion von Zwangsmaßnahmen
- Neue Datenlage zu Mitarbeitertrainings,
- Sicherheitsdienste in Krankenhäusern

## Anhang – Evidenztabellen

### Medikamente

Bibliographic citation	
National Collaborating Centre for Mental Health (UK): Violence and Aggression: Short-Term Management in Mental Health, Health and Community Settings: Updated edition. London: British Psychological Society; 2015.	
Study type	Guideline
Evidence level	I-IV
Results / Effect size	
Source of Funding	

Bibliographic citation	
Steinert T, Hamann K: External Validity of Studies on Aggressive Behavior in Patients with Schizophrenia: Systematic Review. Clin Pract Epidemiol Ment Health. 2012; 8: 74–80.	
Study type	Review
Evidence level	
Results / Effect size	In most of the studies, aggression or violence, respectively, were poorly defined. Only 5 (15.2 %) studies used a cut-off score on an aggression scale. Only 6 studies (18.2 %) reported the number of patients who refused to participate, and 16 (48.5 %) reported the number of drop-outs. Only 3 studies (9.1 %) reported a systematic comparison of participants and non-participants. We found that data which allow for the assessment of representativeness of the investigated samples are poorly reported. For most studies, doubts regarding external validity seem justified and generalisability is questionable due to possible selection bias.
Source of Funding	Not reported

Bibliographic citation	
Belgamwar RB, Fenton M: Olanzapine IM or velotab for acutely disturbed/agitated people with suspected serious mental illnesses. Cochrane Database of Systematic Reviews 2005; Issue 2. Art. No.: CD003729.	
Study type	Review
Evidence level	Ia
Results / Effect size	Four trials compared olanzapine IM with IM placebo (total n=769, 217 allocated to placebo). Fewer people given olanzapine IM

had 'no important response' by 2 hours compared with placebo (4 RCTs, n=769, RR 0.49 CI 0.42 to 0.59, NNT 4 CI 3 to 5) and olanzapine IM was as acceptable as placebo (2 RCTs, n=354, RR leaving the study early 0.31 CI 0.06 to 1.55). When compared with placebo, people given olanzapine IM required substantially fewer additional injections following the initial dose (4 RCTs, n=774, RR 0.48 CI 0.40 to 0.58, NNT 4 CI 4 to 5). Olanzapine IM did not seem associated with extrapyramidal effects (4 RCT, n=570, RR experiencing any adverse event requiring anticholinergic medication in first 24 hours 1.27 CI 0.49 to 3.26).

Two trials compared olanzapine IM with haloperidol IM (total n=482, 166 allocated to haloperidol). Studies found no differences between olanzapine IM and haloperidol by 2 hours for the outcome of 'no important clinical response' (2 RCTs, n= 482, RR 1.00 CI

0.73 to 1.38) neither was there a difference for needing repeat IM injections (2 RCTs, n=482, RR 0.99 CI 0.71 to 1.38). More people on haloperidol experienced akathisia over the five day oral period compared with olanzapine IM (1 RCT, n=257, RR 0.51 CI 0.32 to 0.80, NNT 6 CI 5 to 15) and fewer people allocated to olanzapine IM required anticholinergic medication by 24 hours compared with those given haloperidol IM (2 RCTs, n= 432, RR 0.20 CI 0.09 to 0.44, NNT 8 CI 7 to 11).

Two trials compared olanzapine IM with lorazepam IM (total n=355, 119 allocated to lorazepam). For the outcome of 'no important clinical response' , there was no difference between people given olanzapine IM and those allocated to lorazepam at 2 hours (2 RCTs, n=355, RR 0.92 CI 0.66 to 1.30) but fewer people allocated to olanzapine IM required additional injections by 24 hours compared with those on lorazepam IM (2 RCTs, n=355, RR 0.68 CI 0.49 to 0.95, NNT 10 CI 6 to 59). People receiving IM olanzapine were less likely to experience any treatment emergent adverse events, than those on lorazepam (1 RCT, n=150, RR at 24 hours 0.62 CI 0.43 to 0.89, NNT 5 CI 4 to 17) and over the same time period there were no clear differences in the use of anticholinergic medication between groups (1 RCT, n=150, RR 1.16 CI 0.38 to 3.58).

No studies reported outcomes related to hospital and service use. Nor did any report on issues of satisfaction with care or suicide, selfharm

	or harm to others. No studies evaluated the oro-dispersable form of olanzapine.
Source of Funding	All studies are funded by a company with a pecuniary interest in the result.

Bibliographic citation	
Gilles D, Sampson, S, Beck A, Rathbone J: Benzodiazepines for psychosis-induced aggression or agitation. Cochrane Database of Systematic Reviews 2013; Issue 4. Art. No.: CD003079.	
Study type	Review
Evidence level	Mixed Ia, IV
Results / Effect size	<p>We included 21 trials with a total of n = 1968 participants. There was no significant difference for most outcomes in the one trial that compared benzodiazepines with placebo, although there was a higher risk of no improvement in people receiving placebo in the medium term (one to 48 hours) (n = 102, 1 RCT, RR 0.62, 95 % CI 0.40 to 0.97, very low quality evidence).</p> <p>There was no difference in the number of participants who had not improved in the medium term when benzodiazepines were compared with antipsychotics (n = 308, 5 RCTs, RR 1.10, 95 % CI 0.85 to 1.42, low quality evidence); however, people receiving benzodiazepines were less likely to experience extrapyramidal effects (EPS) in the medium term (n = 536, 8 RCTs, RR 0.15, 95 % CI 0.06 to 0.39, moderate quality of evidence). Data comparing combined benzodiazepines and antipsychotics versus benzodiazepines alone did not yield any significant results.</p> <p>When comparing combined benzodiazepines/antipsychotics (all studies compared haloperidol) with the same antipsychotics alone (haloperidol), there was no difference between groups in improvement in the medium term (n = 155, 3 RCTs, RR 1.27, 95 % CI 0.94 to 1.70, very low quality evidence) but sedation was more likely in people who received the combination therapy (n = 172, 3 RCTs, RR 1.75, 95 % CI 1.14 to 2.67, very low quality evidence). However, more participants receiving combined benzodiazepines and haloperidol had not improved by medium term when compared to participants receiving olanzapine (n = 60, 1 RCT, RR 25.00, 95 % CI 1.55 to 403.99, very low quality evidence) or ziprasidone (n = 60, 1 RCT, RR 4.00, 95 % CI 1.25 to 12.75 very low quality</p>

	evidence). When haloperidol and midazolam were compared with olanzapine, there was some evidence the combination was superior in terms of improvement, sedation and behaviour.
Source of Funding	Several trials were funded by pharmaceutical companies. Other sources of funding include support from the National Alliance for Research on Schizophrenia and Depression; a postgraduate scholarship from the National Health and Medicine Research Council and a research grant from the Australasian College for Emergency Medicine; a grant from the Gralnick Foundation, High Point Hospital, Port Chester, NY; funding from Fundação Oswaldo Cruz, the British Council, CAPES (Coordenação de Aperfeiçoamento de Pessoal de Nível Superior) and FAPERJ (Fundação de Amparo à Pesquisa do Estado do Rio de Janeiro); funding by intramural research grants from Fluid Research Fund (Christian Medical College, Vellore), and the Cochrane Schizophrenia Group general fund.

Bibliographic citation	
Andrezina R, Josiassen RC, Marcus RN, Oren DA, Manos G, Stock E, Carson WH, Iwamoto T: Intramuscular aripiprazole for the treatment of acute agitation in patients with schizophrenia or schizoaffective disorder: a double-blind, placebo-controlled comparison with intramuscular haloperidol. <i>Psychopharmacology</i> (2006) 188:281–292	
Study type	RCT
Evidence level	Ib
Number of Patients	448
Patient characteristics	All patients suffered from schizophrenia and agitation All patients > 18 years All patients in-patients Patients were also required to have Positive and Negative Syndrome Scale (PANSS) Excited Component (PEC) scores of $\geq 15$ and $\leq 32$ , and a score of $\geq 4$ (moderate) on at least two of the five PEC items Give informed consent Exclusion criteria: other psychiatric or neurologic diseases, seizures, abnormal EEG, stroke, head trauma, significant risk of committing suicide, substance dependence, use of benzodiazepines, anticholinergic agents
Intervention	IM aripiprazole 9.75 mg

Comparison	IM haloperidol 6.5 mg or IM placebo
Length of Follow up	22 h
Outcome measures	Reduction from baseline on the PEC-score at 2h Secondary Outcomes: CGI-I, CGI-S, ACES, CABS, BPRS
Results / Effect size	Mean improvement in PEC at 2 h was significantly greater for IM aripiprazole (-7.27) vs placebo (-4.78; $p < 0.001$ ); IM aripiprazole was noninferior to IM haloperidol (-7.75) on PEC. All secondary efficacy measures showed significantly greater improvements at 2 h for IM aripiprazole and IM haloperidol over placebo. Mean number of injections/patient and percentage of patients requiring benzodiazepines were significantly lower for IM aripiprazole vs placebo ( $p < 0.01$ ). IM aripiprazole was well tolerated. Extrapyramidal symptom-related adverse events were similar for aripiprazole (1.7 %) and placebo (2.3 %) and lower than with haloperidol (12.6 %).
Source of Funding	Pharmaceutical companies: Bristol-Myers Squibb Company(Princeton, NJ) and Otsuka Pharmaceutical Co., Ltd. (Tokyo, Japan)

Bibliographic citation	
Zimbhoff DL, Marcus RN, Manos G, Stock E, McQuade RD, Auby P, Oren DA: Management of Acute Agitation in Patients With Bipolar Disorder Efficacy and Safety of Intramuscular Aripiprazole. Journal of Clinical Psychopharmacology Volume 27, Number 2, April 2007.	
Study type	RCT
Evidence level	Ib
Number of Patients	301
Patient characteristics	All patients suffered from bipolar I disorder (manic or mixed episodes) and agitation All patients > 18 years All patients in-patients Patients were also required to have Positive and Negative Syndrome Scale (PANSS) Excited Component (PEC) scores of $\geq 15$ and $\leq 32$ , and a score of $\geq 4$ (moderate) on at least two of the five PEC items Give informed consent Exclusion criteria: other psychiatric or neurologic diseases, first manic episode, non-responder on other antipsychotics, significant medical history exposing patients to undue risk of significant adverse events (AEs) or interfering with safety/efficacy assessments, use of

	benzodiazepines, anticholinergic agents
Intervention	IM aripiprazole 9.75 mg per injection (n = 78), IM aripiprazole 15 mg per injection (n = 78)
Comparison	IM lorazepam 2 mg per injection (n = 70), or IM placebo (n = 75)
Length of Follow up	24 h
Outcome measures	Reduction from baseline on the PEC-score at 2h Secondary-Outcomes: CGI-I, CGI-S, ACES, CABS, YMRS, SAS, and BARS
Results / Effect size	<p>Mean improvements in Positive and Negative Syndrome Scale Excited</p> <p>Component score at 2 hours were significantly greater with IM aripiprazole (9.75 mg, <math>-8.7</math>; 15 mg, <math>-8.7</math>) and IM lorazepam (<math>-9.6</math>) versus IM placebo (<math>-5.8</math>; <math>P_{0.001}</math>). For all other efficacy measures, all 3 active treatments showed significantly greater improvements over IM placebo at 2 hours (<math>P &lt; 0.05</math>), with similar improvements across the active treatments. Significant differences over IM placebo were seen by 45 to 60 minutes for several efficacy parameters. Both</p> <p>IM aripiprazole doses were well tolerated; the safety profile was similar to oral aripiprazole. Oversedation (Agitation–Calmness Evaluation Scale score of 8 or 9) during 2 hours after first injection was less frequent with IM aripiprazole 9.75 mg (6.7 %) and IM placebo (6.8 %) versus IM aripiprazole 15 mg (17.3 %) and IM lorazepam (19.1 %). IM aripiprazole 9.75 and 15 mg are effective and well tolerated for acute agitation in bipolar disorder, although the low incidence of oversedation suggests a risk–benefit profile for</p> <p>IM aripiprazole 9.75 mg.</p>
Source of Funding	Source of funding: none, conflicts of interests: yes

Bibliographic citation	
Tran-Johnson, TK; Sack, DA et al.: Efficacy and Safety of Intramuscular Aripiprazole in Patients With Acute Agitation: A Randomized, Double-Blind, Placebo-Controlled Trial. The Journal of Clinical Psychiatry 2007.	
Study type	RCT
Evidence level	Ib
Number of Patients	357
Patient characteristics	patients with acute agitation with a DSM-IV diagnosis of

	schizophrenia, schizoaffective disorder, or schizo-phreniform disorder
Intervention	IM aripiprazole 1 mg, 5.25 mg, 9.75 mg, or 15 mg
Comparison	IM haloperidol 7.5 mg; or placebo
Length of Follow up	24 h
Outcome measures	Reduction from baseline on the PEC-score at 2h Secondary Outcome ACES, CABS, CGI-S, CGI-I, BPRS
Results / Effect size	Intramuscular aripiprazole 5.25 mg, 9.75 mg, and 15 mg and IM haloperidol 7.5 mg demonstrated significantly greater reduction in the primary efficacy measure versus placebo. These changes were statistically significant as early as 45 minutes for the IM aripiprazole 9.75-mg group, with a trend toward significance ( $p = .051$ ) at 30 minutes. Intramuscular haloperidol 7.5 mg first showed a significant reduction in PEC score versus placebo at 105 minutes. At 30 minutes, significantly more patients responded (defined as a greater than or equal to 40 % reduction in PEC score) to IM aripiprazole 9.75 mg versus placebo (27 % vs. 13 %, $p = .05$ ). Intramuscular aripiprazole 9.75 mg significantly improved agitation, without oversedation, as measured by change in ACES score from baseline to 2 hours versus placebo ( $p = .003$ ). No patient discontinued the study because of treatment-emergent adverse events. Extrapyramidal symptoms occurred most frequently in the IM haloperidol group. The most common adverse event in IM aripiprazole recipients was headache.
Source of Funding	Pharmaceutical companies: Bristol-Myers Squibb Company(Princeton, NJ) and Otsuka Pharmaceutical Co., Ltd. (Tokyo, Japan)

Bibliographic citation	
Citrome, L.: Comparison of Intramuscular Ziprasidone, Olanzapine, or Aripiprazole for Agitation: A Quantitative Review of Efficacy and Safety. The Journal of Clinical Psychiatry 2007.	
Study type	Review
Evidence level	Ib
Results / Effect size	Using the a priori definitions of response at 2 hours after the first injection, NNT for response versus placebo (or placebo equivalent) in treating agitation for the pooled data at the recommended dose of ziprasidone 10-20 mg was 3 (95 % CI = 2 to 4), for olanzapine 10 mg was 3 (95 % CI = 2 to 3), and for aripiprazole 9.75 mg was 5 (95 % CI = 4 to 8). Treatment-emergent adverse events occurring during the pivotal trials revealed



	statistically significant NNH versus placebo (or placebo equivalent) for aripiprazole for headache (NNH = 20, 95 % CI = 11 to 170) and nausea (NNH = 17, 95 % CI = 11 to 38), for ziprasidone in the treatment of headache (NNH = 15, 95 % CI = 8 to 703), and for olanzapine in treatment-emergent hypotension (NNH = 50, 95 % CI = 30 to 154). Olanzapine and aripiprazole had a more favorable extrapyramidal side effect profile compared to haloperidol. (There was no haloperidol treatment arm in the ziprasidone studies.)
Source of Funding	Source of funding: none, conflicts of interests: yes

Bibliographic citation	
Kittipeerachon M, Chaichan W. Intramuscular olanzapine versus intramuscular aripiprazole for the treatment of agitation in patients with schizophrenia: A pragmatic double-blind randomized trial. <i>Schizophr Res.</i> 2016 Oct;176(2-3):231-8. doi: 10.1016/j.schres.2016.07.017. Epub 2016 Jul 25.	
Study type	RCT
Evidence level	Ib
Number of Patients	80
Patient characteristics	adult patients (18-65years old) with schizophrenia experiencing agitation in a psychiatric hospital in Thailand, patients with a PANSS-EC score range of 22-35 entered the study, of whom 13 % had a medical comorbidity and 40 % a history of active substance abuse
Intervention	9, 75 mg Aripiprazole i.m. or 10 mg Olanzapine i.m.
Comparison	
Length of Follow up	24 h
Outcome measures	Excited Component of the Positive and Negative Syndrome Scale (PANSS-EC).
Results / Effect size	The 40 patients receiving IM olanzapine showed greater improvement than the 40 patients receiving IM aripiprazole in PANSS-EC scores at 2h after the injection (p=0.002) but not at 24h. The two treatments were well tolerated. Patients receiving IM olanzapine experienced greater somnolence than those receiving IM aripiprazole. There were no clinically relevant changes in vital signs in either group.
Source of Funding	All authors declare that they have no conflicts of interest.

Bibliographic citation	
Pratts M, Citrome L, Grant W, Leso L, Opler LA: A single-dose, randomized, double-blind, placebo-controlled trial of sublingual asenapine for acute agitation. <i>Acta Psychiatr Scand.</i> 2014 Jul;130(1):61-8.	
Study type	RCT
Evidence level	Ib
Number of Patients	120
Patient characteristics	Agitated adults 18–65 years (any diagnosis) presenting for treatment in an emergency department and found to have a score of $\geq 14$ on the Positive and Negative Syndrome Scale-Excited Component (PANSS-EC)
Intervention	a single dose of a sublingual 10 mg tablet of asenapine
Comparison	placebo
Length of Follow up	None
Outcome measures	Reduction from baseline on the PEC-score at 2h
Results / Effect size	A total of 120 subjects were randomized, 60 each to sublingual asenapine or placebo. Mean (SE) baseline PANSS-EC scores for the asenapine-treated and placebo-treated subjects were $19.4 \pm 0.66$ and $20.1 \pm 0.61$ , respectively. Mean PANSS-EC scores at endpoint (LOCF) was $7.4 \pm 0.65$ for the asenapine-treated subjects and $14.7 \pm 0.98$ for the placebo-treated subjects. Change in PANSS-EC score at 2 h was statistically significantly greater for the asenapine-treated subjects compared with the placebo-treated subjects. NNT for response vs. placebo was 3 (95 % CI 2–4).
Source of Funding	Investigator-initiated trial grant 39230 from Merck & Co., Inc.

Bibliographic citation	
Dorevitch A, Katz N, Zemishlany Z, Aizenberg D, Weizman A: Intramuscular flunitrazepam versus intramuscular haloperidol in the emergency treatment of aggressive psychotic behavior. <i>American Journal of Psychiatry</i> 1999; 156:142-144	
Study type	RCT
Evidence level	Ib
Number of Patients	28

Patient characteristics	actively psychotic inpatients, aged 20-60 years, who were under treatment with neuroleptic agents 13 men and 15 women 19 schizophrenia, seven schizoaffective disorder, and two bipolar disorder Inclusion Criteria: presence of active psychosis; disruptive or aggressive behavior, pronounced psychomotor agitation, or violent outbursts; and hospitalization in an acute ward
Intervention	1 mg i.m. of flunitrazepam
Comparison	5 mg i.m. of haloperidol
Length of Follow up	2 h
Outcome measures	OAS Measurements were made at baseline and at 15, 30, 45, 60, 90, and 120 minutes. All ratings were completed by the same rater, who was blind to the study medications. Overall response to treatment was defined as a reduction of at least 50 % in Overt Aggression Scale score at 90 minutes. The BPRS and the CGI scale were also administered at baseline to assess the severity of psychotic symptoms.
Results / Effect size	Both flunitrazepam and haloperidol exhibited acute antiaggressive activity. This beneficial effect was obtained within 30 minutes.
Source of Funding	Not reported

Bibliographic citation	
Powney MJ, Adams CE, Jones H: Haloperidol for psychosis-induced aggression or agitation (rapid tranquillisation). Cochrane Database of Systematic Reviews 2012; Issue 11. Art. No.: CD009377. DOI: 10.1002/14651858.CD009377.pub2.	
Study type	Review
Evidence level	Ia
Results / Effect size	We included 32 studies comparing haloperidol with 18 other treatments. Few studies were undertaken in circumstances that reflect real world practice, and, with notable exceptions, most were small and carried considerable risk of bias. Compared with placebo, more people in the haloperidol group were asleep at two hours (2 RCTs, n = 220, risk ratio (RR) 0.88, 95 % confidence interval (CI) 0.82 to 0.95). Dystonia was common (2 RCTs, n = 207, RR 7.49, CI 0.93 to 60.21). Compared with aripiprazole, people in the haloperidol group required fewer injections than those in the aripiprazole group (2 RCTs, n = 473, RR 0.78, CI 0.62 to 0.99). More people in the haloperidol group experienced dystonia (2 RCTs, n = 477, RR 6.63, CI 1.52 to 28.86). Despite three larger trials

	<p>with ziprasidone (total n = 739), data remain patchy, largely because of poor design and reporting. Compared with zuclopenthixol acetate, more people who received haloperidol required more than three injections (1 RCT, n = 70, RR 2.54, CI 1.19 to 5.46). Three trials (n = 205) compared haloperidol with lorazepam. There were no significant differences between the groups with regard to the number of participants asleep at one hour (1 RCT, n = 60, RR 1.05, CI 0.76 to 1.44). However, by three hours, significantly more people were asleep in the lorazepam group compared with the haloperidol group (1 RCT, n = 66, RR 1.93, CI 1.14 to 3.27). There were no differences in numbers requiring more than one injection (1 RCT, n = 66, RR 1.14, CI 0.91 to 1.43). Haloperidol's adverse effects were not offset by addition of lorazepam (e.g. dystonia 1 RCT, n = 67, RR 8.25, CI 0.46 to 147.45; required antiparkinson medication RR 2.74, CI 0.81 to 9.25). Addition of promethazine was investigated in one larger and better graded trial (n = 316). More people in the haloperidol group were not tranquil or asleep by 20 minutes (RR 1.60, CI 1.18 to 2.16). Significantly more people in the haloperidol alone group experienced one or more adverse effects (RR 11.28, CI 1.47 to 86.35). Acute dystonia for those allocated haloperidol alone was too common for the trial to continue beyond the interim analysis (RR 19.48, CI 1.14 to 331.92).</p>
Source of Funding	Not reported

Bibliographic citation	
<p>Bieniek SA, Ownby RL, Penalver A, Domingues RA: A double-blinded study of lorazepam versus the combination of haloperidol and lorazepam in managing agitation. <i>Pharmacotherapy</i> 1998; 18:57-62</p>	
Study type	RCT
Evidence level	Ib
Number of Patients	20
Patient characteristics	<p>Men and women age 18-50 years who were seen on the PES with acutely agitated behavior, and who had met clinical criteria for the use of chemical restraints, were considered for the study. Patients were also required to show psychometric evidence of aggressive or agitated behavior, as defined by a minimum score of 4, with score of 2 or more on at least one item, of the Overt Aggression Scale (OAS). Additionally, a rating of at least 50 on a 100-point visual analog</p>

	scale reflecting agitation and hostility from none to extreme was also required. Subjects were medically healthy, with no overt evidence of physical illness. Those known to be pregnant, positive for the human immunodeficiency virus, or had a history of seizures or severe head trauma were excluded. Also excluded were those with psychopathology due to a suspected general medical condition, or whose symptoms were initially judged to be solely related to alcohol or substance abuse.
Intervention	Lorazepam 2 mg i.m.
Comparison	Combination of haloperidol 5 mg i.m. and lorazepam 2 mg i.m.
Length of Follow up	180 minutes
Outcome measures	The Overt Aggression Scale (OAS), visual analog scales reflecting agitation and hostility, and the Clinical Global Impressions (CGI) severity scale were administered at baseline and 30, 60, 120, and 180 minutes after the injection. Planned data comparisons included categoric assignment of patients as improved, as defined by decreases in outcome measures 60 minutes after the injection, as well as continuous variables up to 180 minutes after the injection.
Results / Effect size	A significantly greater percentage of subjects receiving combined treatment improved on the specific measures 60 minutes after dosing ( $p < 0.05$ ). Kaplan-Meier survival analyses showed significant between-group differences in survival curves plotted for the entire study period ( $p < 0.05$ ). Repeated measures analyses of variance studying group differences showed that both groups improved over time, but between-group differences were not significant. The powers of these analyses were low due to the small sample. No serious adverse effects occurred in either treatment group.
Source of Funding	Not reported

Bibliographic citation	
Huf G, Alexander J, Gandhi P, Allen MH. Haloperidol plus promethazine for psychosis-induced aggression. <i>Cochrane Database of Systematic Reviews</i> 2016, Issue 11. Art. No.: CD005146. DOI: 10.1002/14651858.CD005146.pub3.	
Study type	Review
Evidence level	Ia
Results / Effect size	We found two new randomised controlled trials (RCTs) from the 2015 update searching. The review now includes six studies, randomising 1367 participants and presenting data relevant to six

comparisons.

When haloperidol plus promethazine was compared with haloperidol alone for psychosis-induced aggression for the outcome not

tranquil or asleep at 30 minutes, the combination treatment was clearly more effective (n=316, 1 RCT, RR 0.65, 95 % CI 0.49 to 0.87, high-quality evidence). There were 10 occurrences of acute dystonia in the haloperidol alone arm and none in the combination group.

The trial was stopped early as haloperidol alone was considered to be too toxic.

When haloperidol plus promethazine was compared with olanzapine, high-quality data showed both approaches to be tranquillising. It

was suggested that the combination of haloperidol plus promethazine was more effective, but the difference between the two approaches

did not reach conventional levels of statistical significance (n=300, 1 RCT, RR 0.60, 95 % CI 0.22 to 1.61, high-quality evidence).

Lower-quality data suggested that the risk of unwanted excessive sedation was less with the combination approach (n=116, 2 RCTs, RR 0.67, 95 % CI 0.12 to 3.84).

When haloperidol plus promethazine was compared with ziprasidone all data were of lesser quality. We identified no binary data for

the outcome tranquil or asleep. The average sedation score (Ramsay Sedation Scale) was lower for the combination approach but not

to conventional levels of statistical significance (n=60, 1 RCT, MD - 0.1, 95 % CI - 0.58 to 0.38). These data were of low quality and it

is unclear what they mean in clinical terms. The haloperidol plus promethazine combination appeared to cause less excessive sedation

but again the difference did not reach conventional levels of

statistical significance (n=111, 2 RCTs, RR 0.30, 95 % CI 0.06 to 1.43).

We found few data for the comparison of haloperidol plus promethazine versus haloperidol plus midazolam. Average Ramsay Sedation

Scale scores suggest the combination of haloperidol plus midazolam to be the most sedating (n=60, 1 RCT, MD - 0.6, 95 % CI -1.13

to -0.07, low-quality evidence). The risk of excessive sedation was considerably less with haloperidol plus promethazine (n=117, 2

RCTs, RR 0.12, 95 % CI 0.03 to 0.49, low-quality evidence).

Haloperidol plus promethazine seemed to decrease the risk of needing

restraints by around 12 hours (n=60, 1 RCT, RR 0.24, 95 % CI 0.10 to 0.55, low-quality evidence). It may be that use of midazolam

with haloperidol sedates swiftly, but this effect does not last long.

When haloperidol plus promethazine was compared with lorazepam, haloperidol plus promethazine seemed to more effectively cause

sedation or tranquillisation by 30 minutes (n=200, 1 RCT, RR 0.26, 95 % CI 0.10 to 0.68, high-quality evidence). The secondary

outcome of needing restraints or seclusion by 12 hours was not clearly different between groups, with about 10 % in each group needing

this intrusive intervention (moderate-quality evidence). Sedation data were not reported, however, the combination group did have

less 'any serious adverse event' in 24-hour follow-up, but there were not clear differences between the groups and we are unsure exactly

what the adverse effect was. There were no deaths.

When haloperidol plus promethazine was compared with midazolam, there was clear evidence that midazolam is more swiftly tranquillising

	<p>of an aggressive situation than haloperidol plus promethazine (n=301, 1 RCT, RR 2.90, 95 % CI 1.75 to 4.8, high-quality evidence). On its own, midazolam seems to be swift and effective in tranquillising people who are aggressive due to psychosis. There</p> <p>was no difference in risk of serious adverse event overall (n=301, 1 RCT, RR 1.01, 95 % CI 0.06 to 15.95, high-quality evidence).</p> <p>However, 1 in 150 participants allocated haloperidol plus promethazine had a swiftly reversed seizure, and 1 in 151 given midazolam</p> <p>had swiftly reversed respiratory arrest.</p>
Source of Funding	<p>All studies were undertaken by researchers and clinicians who were</p> <p>already receiving support from their home institutions. Industry funding was not involved.</p>

Bibliographic citation	
<p>Barbui C. Intramuscular haloperidol plus promethazine is more effective and safer than haloperidol alone for rapid tranquillisation of agitated mentally ill patients. Evidence-Based Mental Health 2008;11(3):86–7.</p>	
Study type	RCT
Evidence level	Ib
Number of Patients	316
Patient characteristics	<p>316 adults presenting to the psychiatric emergency room with agitation or dangerous behaviour requiring intramuscular sedation, for whom an attending doctor was available to record the diagnosis and severity of the episode.</p>
Intervention	<p>Single intramuscular injection of haloperidol (5 or 10 mg) or haloperidol (5 or 10 mg) plus promethazine (up to 50 mg). In the haloperidol alone group, 29 % received 5 mg and 71 % received 10 mg. In the haloperidol plus promethazine group 50 % received 5 mg haloperidol and 50 % received 10 mg.</p>
Comparison	
Length of Follow up	20 min for primary outcomes, 2 weeks for secondary outcomes
Outcome measures	<p><i>Primary outcome:</i> proportion of patients tranquil (calm and non-agitated with no threatening behaviour) or asleep at 20 min.</p> <p><i>Secondary outcomes included:</i> tranquil or asleep at 40, 60 and 120</p>



	min; need for further medical attention within 24 h; adverse events.
Results / Effect size	Haloperidol plus promethazine increased the proportion of patients tranquil or asleep at 20 min compared with haloperidol alone (proportion tranquil or asleep: 72 % with combined treatment vs 55 % with haloperidol alone; RR 1.30, 95 % CI 1.10 to 1.55). The combined treatment increased the proportion of patients asleep at 20 min (19 % with combined treatment vs 8 % with haloperidol alone; RR 2.33, 95 % CI 1.26 to 4.27). There was no difference between interventions in the proportion of patients tranquil or asleep after 20 min (40 min: RR 1.07, 95 % CI 0.95 to 1.20; 60 min: RR 1.07, 95 % CI 0.97 to 1.17; 120 min: RR 1.03, 95 % CI 0.96 to 1.11). Haloperidol plus promethazine increased the proportion of patients who did not need to have a doctor recalled (77 % with combined treatment vs 65 % with haloperidol alone; RR 1.18, 95 % CI 1.02 to 1.36). Haloperidol alone increased the risk of serious adverse events compared with haloperidol plus promethazine (1 % with combined treatment vs 7 % with haloperidol alone; RR 0.09, 95 % CI 0.01 to 0.68). Most of the serious adverse events in the haloperidol alone group were acute dystonia (10 cases vs none with haloperidol plus promethazine).
Source of Funding	Brazilian Research Council.

Bibliographic citation	
Baldaçara L, Sanches M, Cruz Cordeiro D, Parolin Jackowski A: Rapid tranquilization for agitated patients in emergency psychiatric rooms: a randomized trial of olanzapine, ziprasidone, haloperidol plus promethazine, haloperidol plus midazolam and haloperidol alone. Revista Brasileira de Psiquiatria 2011; vol 33 nº 1 mar2011	
Study type	RCT
Evidence level	Ib
Number of Patients	150
Patient characteristics	Patients with agitation caused by psychotic or bipolar disorder
Intervention	intramuscular olanzapine, ziprasidone, haloperidol plus promethazine, haloperidol plus midazolam and haloperidol alone
Comparison	
Length of Follow up	12 h
Outcome measures	Overt Agitation Severity Scale, Overt Aggression Scale and Ramsay Sedation Scale
Results / Effect size	All medications produced a calming effect within one hour of

	administration, but only olanzapine and haloperidol reduced agitation by less than 10 points, and only olanzapine reduced aggression by less than four points in the first hour. After twelve hours, only patients treated with haloperidol plus midazolam had high levels of agitation and aggression and also more side effects. Ziprasidone, olanzapine and haloperidol alone had more stable results for agitation control, while ziprasidone, haloperidol plus promethazine and olanzapine had stable results for aggression control.
Source of Funding	Funding: no. Conflicts of Interest: yes.

Bibliographic citation	
Huang CL, Hwang TJ, Chen YH, Huang GH, Hsieh MH, Chen HH, Hwu HG: Intramuscular olanzapine versus intramuscular haloperidol plus lorazepam for the treatment of acute schizophrenia with agitation: An open-label, randomized controlled trial. J Formos Med Assoc. 2015 May;114(5):438-45. doi: 10.1016/j.jfma.2015.01.018. Epub 2015 Mar 17.	
Study type	RCT
Evidence level	Ib
Number of Patients	67
Patient characteristics	Acutely agitated patients with schizophrenia or schizoaffective disorder
Intervention	10 mg IM olanzapine
Comparison	5 mg IM haloperidol plus 2 mg IM lorazepam
Length of Follow up	24 h
Outcome measures	Agitation was measured with Positive and Negative Syndrome Scale Excited Component (PANSS-EC) and Agitation Calmness Evaluation Scale (ACES) during the first 2 hours and at 24 hours after the first injection. Safety was assessed using the Simpsons Angus Scale and Barnes Akathisia Rating Scale and by recording adverse events at 24 hours following the first injection. The Clinical Global Impression-Severity scale was also rated.
Results / Effect size	The PANSS-EC scores decreased significantly at 2 hours after the first injection in both groups (olanzapine: -10.2, $p < 0.001$ ; haloperidol + lorazepam: -9.9, $p < 0.001$ ). Haloperidol plus lorazepam was not inferior to olanzapine in reducing agitation at 2 hours. There were no significant differences in PANSS-EC or ACES scores between the two groups within 2 hours following the first injection. The frequencies of adverse events and changes in Clinical Global Impression-Severity, Simpsons Angus Scale, and Barnes Akathisia Rating Scale scores from baseline to 24 hours

	showed no significant differences between the groups.
Source of Funding	The study was supported by a grant from Mr Ya-Jen Cheng's Foundation, Taipei, Taiwan. The preparation of this manuscript was supported by a grant from National Science Council (97-2314-B-002-129-MY3). Eli Lilly and Company supplied short-acting injectable olanzapine. The authors also acknowledge statistical assistance provided by the Taiwan Clinical Trial Bioinformatics and Statistical Center, Training Center, and Pharmacogenomics Laboratory (which was founded by the National Research Program for Biopharmaceuticals at the Ministry of Science and Technology of Taiwan; MOST 103-2325-B-002-033).

Bibliographic citation	
Walther S et al. Rapid Tranquilization of Severely Agitated Patients With Schizophrenia Spectrum Disorders. A Naturalistic, Rater-Blinded, Randomized, Controlled Study With Oral Haloperidol, Risperidone, and Olanzapine. J Clin Psychopharmacol 2014;34: 124Y128	
Study type	RCT
Evidence level	Ib
Number of Patients	43
Patient characteristics	severely agitated patients at acute care psychiatric units  From February 2004 until September 2005, all patients admitted to the acute care inpatient units of the University Hospital of Psychiatry Bern, Switzerland, were screened for schizophrenia, schizoaffective, or schizophreniform disorder according to the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition criteria. Diagnoses were made based on psychiatric examination and review of all case files. Only subjects aged between 18 and 55 years were further evaluated. Subjects with relevant medical or neurological disorders, who were pregnant, or who had ongoing intake of illicit drugs and alcohol were excluded.
Intervention	Participants were randomly assigned to receive either daily haloperidol 15 mg, olanzapine 20 mg, or risperidone 2 to 6 mg over 5 days.
Comparison	
Length of Follow up	96 h
Outcome measures	Symptom severity was assessed using the Positive and Negative Syndrome Scale (PANSS). <sup>18</sup> We used the PANSS psychotic agitation subscale (PANSS-PAS) including PANSS items hallucinatory behavior (P3), excitement (P4), hostility (P7),

	uncooperativeness (G8), and poor impulse control (G14) to select subjects who were highly agitated. The PANSS-PAS was used in previous studies <sup>10</sup> and is similar to the PANSS excitement subscale used in comparable studies on agitation with a range of 5 to 35 points. Further assessments included the Abnormal Involuntary Movement Scale (AIMS) the Simpson Angus Scale for Parkinsonism (SAS) and the Barnes Akathisia Rating Scale (BARS).
Results / Effect size	All drugs were effective for rapid tranquilization within 2 hours. Over 5 days, the course differed between agents (P < 0.001), but none was superior. Dropouts occurred only in the risperidone and olanzapine groups. Men responded better to treatment than did women during the initial 2 hours (P = 0.046) as well as over the 5-day course (P < 0.001). No difference between drug groups was observed regarding diazepam or biperiden use.
Source of Funding	Source of funding: none, conflicts of interests: yes

Bibliographic citation	
Lavania S, Praharaj SK, Bains HS, Sinha V, Kumar A. Efficacy and Safety of Levosulpiride Versus Haloperidol Injection in Patients With Acute Psychosis: A Randomized Double-Blind Study. Clin Neuropharmacol. 2016 Jul-Aug;39(4):197-200. doi: 10.1097/WNF.0000000000000161.	
Study type	RCT
Evidence level	Ib
Number of Patients	60
Patient characteristics	drug-naïve patients having acute psychosis
Intervention	intramuscular haloperidol (10-20 mg/d) or levosulpiride (25-50 mg/d) for 5 days
Comparison	
Length of Follow up	5 d
Outcome measures	All patients were rated on Brief Psychiatric Rating Scale (BPRS), Overt Agitation Severity Scale (OASS), Overt Aggression Scale-Modified (OAS-M) scores, Simpson Angus Scale (SAS), and Barnes Akathisia Rating Scale (BARS).
Results / Effect size	Repeated-measures ANOVA for BPRS scores showed significant effect of time (P < 0.001) and a trend toward greater reduction in scores in haloperidol group as shown by group × time interaction (P = 0.076). Repeated-measures ANOVA for OASS showed significant effect of time (P < 0.001) but no group × time interaction. Repeated-measures ANOVA for OAS-M scores

	showed significant effect of time ( $P < 0.001$ ) and greater reduction in scores in haloperidol group as shown by group $\times$ time interaction ( $P = 0.032$ ). Lorazepam requirement was much lower in haloperidol group as compared with those receiving levosulpiride ( $P = 0.022$ ). Higher rates of akathisia and extrapyramidal symptoms were noted in the haloperidol group.
Source of Funding	Conflicts of Interest and Source of Funding: The authors have no conflicts of interest to declare.

Bibliographic citation	
Garza-Trevino ES, Hollister LE, Overall JE, Alexander WF: Efficacy of combinations of intramuscular antipsychotics and sedative-hypnotics for control of psychotic agitation. American Journal of Psychiatry 1989; 146:1598-1601	
Study type	RCT
Evidence level	Ib
Number of Patients	68
Patient characteristics	22 manic patients, 16 schizophrenic patients, 16 atypical psychotic patients, and 14 patients with miscellaneous diagnoses. All had baseline agitation ratings (100-mm scale) of 50 or greater; however, the median baseline score was 60.
Intervention	a combination of haloperidol, 5 mg, and lorazepam, 4 mg; 5 mg of haloperidol alone; or 4 mg of lorazepam alone.
Length of Follow up	Not reported for the RCT, 210 minutes in the pilot study
Outcome measures	100-mm scale
Results / Effect size	These analyses confirmed that the combination treatment was significantly ( $p < 0.05$ ) superior to each of the components in producing rapid tranquilization after statistical correction for differences in baseline severity of agitation. In addition, these analyses confirmed that patients with higher baseline agitation scores were significantly ( $p < 0.05$ ) less likely to reach the tranquilization criterion in 30 minutes.
Source of Funding	Not reported

Bibliographic citation	
Battaglia J MS, Rush J, Kang J, Mendoza R, Leedom L, Dubin W, McGlynn C, Goodman L: Haloperidol, lorazepam, or both for psychotic agitation? A multicenter, prospective, double-	

blind, emergency department study. The American Journal of Emergency Medicine 1997; 15:335-340	
Study type	RCT
Evidence level	Ib
Number of Patients	98
Patient characteristics	psychotic, agitated, and aggressive patients (73 men and 25 women)
Intervention	intramuscular injections of lorazepam (2 mg), haloperidol (5 mg), or both in combination (1 to 6 injections of the same study drug within 12 hours, based on clinical need)
Length of Follow up	At least 12 h after last injection
Outcome measures	ABS, MBPRS, CGI, Alertness Scale
Results / Effect size	Effective symptom reduction was achieved in each treatment group with significant ( $P < .01$ ) mean decreases from baseline at every hourly ABS evaluation. Significant ( $P < .05$ ) mean differences on the ABS (hour 1) and MBPRS (hours 2 and 3) suggest that tranquilization was most rapid in patients receiving the combination treatment. Study event incidence (side effects) did not differ significantly between treatment groups, although patients receiving haloperidol alone tended to have more extrapyramidal system symptoms. The superior results produced by the combination treatment support the use of lorazepam plus haloperidol as the treatment of choice for acute psychotic agitation.
Source of Funding	Supported in part by a grant from Wyeth-Ayerst Research.

Bibliographic citation	
Foster S, Kessel J, Berman ME, Simpson GE: Efficacy of lorazepam and haloperidol for rapid tranquillisation in a psychiatric emergency room setting. International Clinical Psychopharmacology 1997; 12:175-179	
Study type	RCT
Evidence level	Ib
Number of Patients	37
Patient characteristics	highly agitated patients exhibiting psychotic symptoms presenting at a psychiatric emergency room service
Intervention	Lorazepam (either intramuscular injection or oral concentrate)
Comparison	Haloperidol (either intramuscular injection or oral concentrate)
Length of Follow up	4 h
Outcome measures	BPRS, CGI
Results / Effect size	Both medications reduced symptom ratings on the Brief

	Psychiatric Rating Scale and Global Clinical Impression of Overall Symptom Severity Scale. Global Clinical Impression scores for the two medication groups did not differ significantly either at baseline or at 4 h after entry into the study. However, Global Clinical Impression scores of patients in the lorazepam group were less severe at intermittent ratings. The groups did not differ on the Brief Psychiatric Rating Scale at any rating time. No differences were found either in the number of doses administered or in the administration route selected.
Source of Funding	National Alliance for Resaearch in Schizophrenia and Depression.

Bibliographic citation	
Alexander J, Tharyan P, Adams CE, John T, Mol C, Philip J: Rapid tranquilisation of violent or agitated patients in a psychiatric emergency setting: a pragmatic randomised trial of intramuscular Lorazepam versus haloperidol plus promethazin. British Journal of Psychiatry 2004; 185:63-69	
Study type	Pragmatic, randomised clinical trial.
Evidence level	Ib
Number of Patients	200
Patient characteristics	Consecutive patients were assessed and were eligible for trial entry if the attending physician felt that intramuscular sedation was clearly indicated because of agitation, aggression or violent behaviour, and if the physician did not feel that either one of the interventions posed an additional risk for the patient. In keeping with prevailing clinical practice in this country, consent was obtained from a responsible relative if patients refused, or lacked capacity to consent to treatment by virtue of severe mental illness. For this trial relatives were fully informed and their written consent obtained; patients without a responsible relative were excluded.
Intervention	intramuscular lorazepam (4 mg)
Comparison	intramuscular haloperidol (10 mg) plus promethazine (25-50 mg) mix
Length of Follow up	2 weeks
Outcome measures	Patients were rated at each assessment point on whether they were tranquil or asleep; in addition, the time of onset of tranquillisation and sleep were noted. Participants were considered to be tranquil when they were calm and not exhibiting agitated, aggressive or dangerous behaviour. They were considered to be asleep if, on inspection, they appeared to be sound asleep and were not aroused by ambient disturbances; the

	<p>depth of this apparent slumber was not assessed further. They were also rated on the Clinical Global Impression – Severity (CGI–S) scale at entry, and the CGI–Improvement (CGI–I) scale with respect to aggression and violence, the Simpson–Angus extrapyramidal side-effects rating scale and the Barnes Akathisia Scale at each assessment point; any other clinically important adverse effect, especially dystonia, was also noted. These assessments were conducted only on participants who were awake, as extrapyramidal symptoms are usually not apparent during sleep or, in the case of dystonia or akathisia, are likely to prevent sleep. Other outcomes within the first 4 h were the use of additional medication for control of agitated or aggressive behaviour, the use of physical restraints, the need for further medical attention and numbers absconding. Participants were also followed up 2 weeks later to check for adverse effects or adverse outcomes and compliance with oral medication. The primary outcome was ‘tranquil or asleep by 4 h’.</p>
Results / Effect size	<p>At blinded assessments 4 h later (99.5 % follow-up), equal numbers in both groups (96 %) were tranquil or asleep. However, 76 % given the haloperidol-promethazine mix were asleep compared with 45 % of those allocated lorazepam (RR=2.29, 95 % CI 1.59-3.39; NNT=3.2, 95 % CI 2.3-5.4). The haloperidol-promethazine mix produced a faster onset of tranquillisation/sedation and more clinical improvement over the first 2 h. Neither intervention differed significantly in the need for additional intervention or physical restraints, numbers absconding, or adverse effects.</p>
Source of Funding	<p>This trial was funded by intramural research grants from the Fluid Research Fund of the Christian Medical College, Vellore and the Cochrane Schizophrenia Group general fund.</p>

Bibliographic citation	
Allen MH, Feifel D, Lesem MD et al (2011) Efficacy and safety of loxapine for inhalation in the treatment of agitation in patients with schizophrenia: a randomized, double-blind, placebo-controlled trial. <i>J Clin Psychiatry</i> 72:1313–1321	
Study type	RCT
Evidence level	Ib
Number of Patients	129
Patient characteristics	agitated patients with schizophrenia or schizoaffective disorder
Intervention	inhalation of 5 or 10 mg of loxapine
Comparison	placebo



Length of Follow up	6 d
Outcome measures	The primary efficacy measure was change on the Positive and Negative Syndrome Scale-excited component (PANSS-EC) 2 hours following treatment. Secondary outcomes included the Clinical Global Impressions-Improvement scale (CGI-I), Behavioral Activity Rating Scale (BARS), and time to first rescue medication.
Results / Effect size	Differences were statistically significant ( $P < .05$ ) between placebo and both 5-mg and 10-mg doses on the CGI-I and the CGI-I responder analyses at 2 hours and in time to first rescue medication, and they were statistically significant ( $P < .05$ ) between placebo and 10-mg loxapine on the PANSS-EC 20 minutes after administration continuing through 2 hours and in change from baseline BARS. Three serious adverse events occurred at least 6 days after treatment, but none were judged related to study treatment. The most common adverse events were sedation and dysgeusia (22 % and 17 %, respectively, in the 10-mg group, and 14 % and 9 %, respectively, in the placebo group).
Source of Funding	Alexza Pharmaceuticals, Inc.

Bibliographic citation	
Kwentus J, Riesenbergr RA, Marandi M et al (2012) Rapid acute treatment of agitation in patients with bipolar I disorder: a multicenter, randomized, placebo-controlled clinical trial with inhaled loxapine. <i>Bipolar Disord</i> 14:31–40	
Study type	RCT
Evidence level	Ib
Number of Patients	314
Patient characteristics	agitated patients with bipolar I disorder (manic or mixed episodes)
Intervention	inhaled loxapine 5 mg or 10 mg
Comparison	Inhaled placebo
Length of Follow up	24 h
Outcome measures	The primary efficacy endpoint was change from baseline in the Positive and Negative Syndrome Scale-Excited Component (PANSS-EC) score two hours after Dose 1. The key secondary endpoint was the Clinical Global Impression-Improvement score at two hours after Dose 1. Additional endpoints included the changes from baseline in the PANSS-EC from 10 min through 24 hours after Dose 1. Safety was assessed by adverse events, vital signs, physical examinations, and laboratory tests.

Results / Effect size	For the primary and key secondary endpoints, both doses of inhaled loxapine significantly reduced agitation compared with placebo. Reduced agitation, as reflected in PANSS-EC score, was evident 10 min after Dose 1 with both doses. Inhaled loxapine was well tolerated, and the most common adverse events were known effects of loxapine or minor oral effects common with inhaled medications (dysgeusia was reported in 17 % of patients receiving active drug versus 6 % receiving placebo).
Source of Funding	Alexza Pharmaceuticals

Bibliographic citation	
Lesem MD, Tran-Johnson TK, Riesenbergr RA et al (2011) Rapid acute treatment of agitation in individuals with schizophrenia: multicentre, randomised, placebo-controlled study of inhaled loxapine. Br J Psychiatry 198:51–58	
Study type	RCT
Evidence level	Ib
Number of Patients	233
Patient characteristics	Males and females 18-65 years old Schizophrenia and agitation PANSS > 14 and a score of >4 on at least one item Good general health Non-pregnant, non-lactating
Intervention	One, two or three doses of loxapine (5 or 10 mg)
Comparison	placebo
Length of Follow up	24 h
Outcome measures	Change from baseline in PANSS-EC 2h after dose one, CGI-I 2 h after dose one
Results / Effect size	Inhaled loxapine (5 and 10 mg) significantly reduced agitation compared with placebo as assessed by primary and key secondary end-points. Reduced PANSS-EC was evident 10 minutes after dose one with both 5 and 10 mg doses. Inhaled loxapine was well tolerated, and the most common adverse events were known effects of loxapine (e.g. sedation) or minor oral effects common with inhaled medications. Three people had wheezing or bronchospasm, one experienced severe sedation and one neck dystonia and oculogyration.
Source of Funding	Alexza Pharmaceuticals

Bibliographic citation	
Kishi T, Matsunaga S, Iwata N: Intramuscular olanzapine for agitated patients: A systematic review and meta-analysis of randomized controlled trials. <i>J Psychiatr Res.</i> 2015 Sep;68:198-209. doi: 10.1016/j.jpsychires.2015.07.005. Epub 2015 Jul 6.	
Study type	Review
Evidence level	Ia
Results / Effect size	We identified 13 RCTs (19 comparisons) as follows: 7 comparisons with 1059 patients for OLA-IM versus placebo; 5 comparisons with 613 patients for OLA-IM versus haloperidol (HAL)-IM; 2 comparisons with 108 patients for OLA-IM versus ziprasidone (ZIP)-IM; 2 comparisons with 110 patients for OLA-IM versus HAL-IM plus midazolam; and 3 comparisons with 412 patients for OLA-IM versus HAL-IM plus promethazine, 2 comparisons with 355 patients for OLA-IM versus lorazepam-IM (LOR-IM); and 1 comparison with 67 patients for OLA-IM versus HAL-IM plus LOR-IM. OLA-IM was superior to placebo in both Positive and Negative Syndrome Scale-Excited Component (PANSS-EC) and Agitation Calmness Evaluation Scale (ACES) scores 2 h after first injection, and had a comparable side effect profile, including over sedation, extrapyramidal symptoms, akathisia, and anticholinergic use. While there was no significant difference in PANSS-EC scores after 2 h between OLA-IM and HAL-IM, OLA-IM outperformed HAL-IM in ACES after 2 h. Compared with HAL-IM, OLA-IM was associated with fewer side effects, including anticholinergic use, akathisia, extrapyramidal symptoms, and dystonia, and marginally less QT prolongation compared with HAL-IM.
Source of Funding	No funding sources were received for this study.

Bibliographic citation	
Marder SR1, Sorsaburu S, Dunayevich E, Karagianis JL, Dawe IC, Falk DM, Dellva MA, Carlson JL, Cavazzoni PA, Baker RW: Case reports of postmarketing adverse event experiences with olanzapine intramuscular treatment in patients with agitation. <i>J Clin Psychiatry.</i> 2010 Apr;71(4):433-41. doi: 10.4088/JCP.08m04411gry. Epub 2010 Feb 9.	
Study type	Review of Case reports
Evidence level	III
Results / Effect size	The estimated worldwide patient exposure to olanzapine IM from January 1, 2004, through September 30, 2005, was 539,000; 160 cases containing AEs were reported from patients with schizophrenia (30 %), bipolar disorder (21 %), unspecified

	<p>psychosis (10 %), dementia (8 %), and depression (5 %). Many reported concomitant treatment with benzodiazepines (39 %) or other antipsychotics (54 %). The most frequently reported events involved the following organ systems: central nervous (21 %), cardiac (12 %), respiratory (6 %), vascular (6 %), and psychiatric (5 %). Eighty-three cases were considered serious, including 29 fatalities. In these fatalities, concomitant benzodiazepines or other antipsychotics were reported in 66 % and 76 % of cases, respectively. The most frequently reported events in the fatal cases involved the following organ systems: cardiovascular (41 %), respiratory (21 %), general (17 %), and central nervous (10 %). The majority of fatal cases (76 %) included comorbid conditions and potentially clinically significant risk factors for AEs.</p>
Source of Funding	Eli Lilly.

Bibliographic citation	
<p>Wilson MP, MacDonald K, Vilke GM, Feifel D: A comparison of the safety of olanzapine and haloperidol in combination with benzodiazepines in emergency department patients with acute agitation. <i>J Emerg Med.</i> 2012 Nov;43(5):790-7. doi: 10.1016/j.jemermed.2011.01.024. Epub 2011 May 20.</p>	
Study type	structured retrospective chart review
Evidence level	III
Number of Patients	96
Patient characteristics	<p>The only inclusion criteria, aside from having received parenteral haloperidol, was documentation in the chart of vital signs and oxygen saturation monitoring before medication administration and within 4 h afterwards. Patients were excluded if they received haloperidol orally instead of intramuscularly, or if they received a long acting haloperidol decanoate injection. Patients who received multiple doses of haloperidol during an ED visit were entered in the analysis only once for the first dose of this medication.</p>
Intervention	parenteral haloperidol either with or without benzodiazepines
Comparison	parental olanzapine either with or without benzodiazepines
Length of Follow up	4 h
Outcome measures	measurement of vital signs and ethanol levels
Results / Effect size	<p>There were 96 patients (71 haloperidol, 25 olanzapine) who met inclusion criteria. No patient in the olanzapine + benzodiazepine group had hypotension, although one patient in the olanzapine-only group did (6.7 %); 2 patients in the haloperidol +</p>

	benzodiazepines group (5.1 %) and 2 patients in the haloperidol-only group (6.3 %) had hypotension. In alcohol-negative (ETOH-) patients, neither olanzapine alone nor olanzapine + benzodiazepines was associated with decreased oxygen saturations. In ETOH+ patients, olanzapine alone was not associated with decreased oxygen saturations, but olanzapine + benzodiazepines were associated with lower oxygen saturations than haloperidol + benzodiazepines.
Source of Funding	Source of funding: none, conflicts of interests: yes

Bibliographic citation	
Currier GW, Chou JC, Feifel D, Bossie CA, Turkoz I, Mahmoud RA, Gharabawi GM: Acute treatment of psychotic agitation: A randomized comparison of oral treatment with risperidone and lorazepam versus intramuscular treatment with haloperidol and lorazepam. <i>Journal of Clinical Psychiatry</i> 2004; 65:386-94	
Study type	RCT
Evidence level	Ib
Number of Patients	162
Patient characteristics	patients exhibiting agitation associated with active psychosis
Intervention	oral treatment with 2 mg of risperidone plus 2 mg of lorazepam
Comparison	intramuscular treatment with 5 mg of haloperidol plus 2 mg of lorazepam
Length of Follow up	
Outcome measures	The change scores on a 5-item acute-agitation cluster from the Positive and Negative Syndrome Scale (hallucinatory behavior, excitement, hostility, uncooperativeness, and poor impulse control) were the main outcome measure.
Results / Effect size	Mean acute-agitation cluster scores were similar in the 2 groups at baseline. Mean score improvements at 30, 60, and 120 minutes after dosing were significant at each timepoint in both groups ( $p < .0001$ ) and were similar in both groups ( $p > .05$ ). Both treatments were well tolerated.
Source of Funding	Janssen Pharmaceutica Products, L.P., Titusville, N.J.

Bibliographic citation	
Barak Y, Mazeh D, Plopski I, Baruch Y: Intramuscular ziprasidone treatment of acute psychotic agitation in elderly patients with schizophrenia. <i>American Journal of Geriatric Psychiatry</i> 2006; 14:629-633	

Study type	Prospektive Studie ohne Vergleichsgruppe
Evidence level	III
Number of Patients	21
Patient characteristics	elderly patients (60 years of and older) admitted to a psychogeriatric ward for acute psychotic agitation six male and 15 female mean age 71.4 +/- 1.3 years (range: 60-81 years)
Intervention	three days of flexible-dose i.m. ziprasidone, after an initial dose of 10-20 mg, a subsequent dose of 10-20 mg could be given after 12 hours if needed (maximum daily dose: 40 mg)
Comparison	
Length of Follow up	3 d
Outcome measures	All treatment emergent side effects and adverse events along with the investigators' assessments of severity were systematically recorded as the primary outcome. The Brief Psychiatric Rating Scale (BPRS) and the Behavioral Activity Rating Scale (BARS) were the secondary outcomes.
Results / Effect size	There was one adverse event in a patient with untreated benign prostatic hypertrophy who developed urinary retention. Two side effects of mild severity that resolved spontaneously were observed: blurred vision and sedation. The BPRS decreased by 26.8 points after three days of treatment ( $p = 0.001$ ). The BARS score, reflecting agitation, decreased significantly after each injection, reaching maximal decrease of 2.14 points at completion of study ( $p = 0.001$ ).
Source of Funding	This study was supported with an independent research grant from Pfizer, Inc.

Bibliographic citation	
Kohen I, Preval H, Southard R, Francis A: Naturalistic study of intramuscular ziprasidone versus conventional agents in agitated elderly patients: retrospective findings from a psychiatric emergency service. American Journal of Geriatric Pharmacotherapy 2005; 3:240-245	
Study type	Naturalistic study
Evidence level	III
Number of Patients	35
Patient characteristics	Patients aged > 65 years who received a single 20 mg dose of IM ziprasidone for the treatment of acute agitation.
Intervention	a single 20-mg dose of IM ziprasidone
Comparison	IM haloperidol, with or without lorazepam

Length of Follow up	
Outcome measures	In some patients in the ziprasidone group, the effects of the drug on agitation were assessed prospectively by blinded psychiatrists using the Behavioural Activity Rating Scale (BARS) (1--difficult or unable to arouse to 7--violent, requires restraint). Also included in the analysis were data concerning use of rescue medication (oral or parenteral) other than the study drug within 2 hours of initial treatment, restraint time, and adverse events (changes in vital sign measurements and electrocardiography [ECG]).
Results / Effect size	The database revealed 15 patients who received ziprasidone (9 men, 6 women; age range, 65-87 years) and 20 patients who were included in the CT sample (13 men, 7 women; age range, 65-88 years). In the 6 cases rated on the BARS, the mean (SE) baseline score was high (6.8 [0.1]), with a decrease to 4.0 (0.4) ( $P < 0.05$ ) at 45 minutes after study drug administration and to 2.8 (0.4) ( $P < 0.01$ ) at 120 minutes. Rescue medication was needed in 4 ziprasidone cases and 2 CT cases ( $P = NS$ ), and mean (SE) restraint times did not vary significantly between groups (ziprasidone [ $n = 12$ ], 85 [15] minutes; CT [ $n = 17$ ], 83 [12] minutes). No clinically significant effects on blood pressure or heart rate were noted, and no cardiac or other adverse events were reported. ECG results with ziprasidone ( $n = 3$ ) or CT ( $n = 6$ ) were unremarkable.
Source of Funding	Not reported

Bibliographic citation	
Greco KE, Tune LE, Brown FW, Van Horn WA: A retrospective study of the safety of intramuscular Ziprasidone in agitated elderly patients. Journal of Clinical Psychiatry 2005; 66:928-929	
Study type	retrospective study
Evidence level	III
Number of Patients	23
Patient characteristics	complaint of dementia (DSM-IV) with agitation
Intervention	intramuscular Ziprasidone
Outcome measures	QTc-Intervalls
Results / Effect size	There was no significant difference in the QTc interval between the baseline and the post-ziprasidone values. One patient had a QTc greater than 500 ms and 25 % over baseline, and therefore the medication was discontinued. The mean prolongation of the QTc interval was only 0.5 ms. There were no episodes of torsades de pointes. Other medications that the patients were taking did

	not appear to affect the QTc interval in an expected manner.
Source of Funding	This study was supported by a fellowship from Summer Training on Aging Research Topics-Mental Health, San Diego, Calif., and a grant from the National Institute of Mental Health, Bethesda, Md.

Bibliographic citation	
Citrome L, Volavka J, Czobor P, Brook S, Loebel A, Mandel FS: Efficacy of ziprasidone against hostility in schizophrenia: Post hoc analysis of randomized, open-label study data. Journal of Clinical Psychiatry 2006; 67:638-642	
Study type	a randomized, rater-blinded, 6-week, open-label study
Evidence level	Ib
Number of Patients	572
Patient characteristics	inpatients diagnosed with DSM-IV schizophrenia or schizoaffective disorder
Intervention	sequential intramuscular and oral ziprasidone
Comparison	haloperidol
Length of Follow up	42 d
Outcome measures	The Brief Psychiatric Rating Scale (BPRS) was the principal outcome measure. To determine the effect of ziprasidone on hostility, post hoc analyses of scores on the hostility item from the BPRS were conducted. Introducing positive symptoms and akathisia as covariates tested specific antihostility effect.
Results / Effect size	Ziprasidone demonstrated specific antihostility effects over time throughout the 42-day study period and statistically significant superiority to haloperidol on this measure in the first week of treatment ( $p = .0149$ at first evaluation [day 1, 2, or 3]; $p = .0358$ at day 7).
Source of Funding	Pfizer Inc., New York, N.Y., supported this work. The data were provided by Pfizer, Inc., to Dr. Citrome, and Dr. Czobor performed the statistical analyses independent of Pfizer, Inc.

Bibliographic citation	
Pascual JC, Madre M, Soler J, Barrachina J, Campins MJ, Alvarez E, Perez V: Injectable atypical antipsychotics for agitation in borderline personality disorder. Pharmacopsychiatry 2006; 39:117-118	
Study type	Naturalistic-open-label study, Case reports
Evidence level	III
Number of Patients	20



Patient characteristics	Patients with borderline personality disorder attended at the psychiatric emergency service
Intervention	10 mg Olanzapine, 20 mg Ziprasidone
Comparison	Patients with Psychotic disorder
Length of Follow up	6 h
Outcome measures	PANSS-EC, ACES Need for physical restraint, other medications Vital signs Spontaneously reported adverse effects
Results / Effect size	PANSS-EC scores in BPD-patients decreased significantly and they decreased significantly more than in the psychosis group. No serious adverse effects were observed. Two psychotic and one BPD-patient experienced over-sedation, one BPD-patient experienced well tolerated hypotension.
Source of Funding	Not reported.

Bibliographic citation	
Jayakody K, Gibson RC, Kumar A, Gunadasa S. Zuclopenthixol acetate for acute schizophrenia and similar serious mental illnesses. Cochrane Database of Systematic Reviews 2012, Issue 4. Art. No.: CD000525. DOI: 10.1002/14651858.CD000525.pub3.	
Study type	Review
Evidence level	Ia
Results / Effect size	We found no data for the primary outcome, tranquillisation. Compared with haloperidol, zuclopenthixol acetate was no more sedating at two hours (n = 40, 1 RCT, RR 0.60, 95 % CI 0.27 to 1.34). People given zuclopenthixol acetate were not at reduced risk of being given supplementary antipsychotics (n = 134, 3 RCTs, RR 1.49, 95 % CI 0.97 to 2.30) although additional use of benzodiazepines was less (n = 50, 1 RCT, RR 0.03, 95 % CI 0.00 to 0.47). People given zuclopenthixol acetate had fewer injections over seven days compared with those allocated to haloperidol IM (n = 70, 1 RCT, RR 0.39, 95 % CI 0.18 to 0.84, NNT 4, CI 3 to 14). We found no data on more episodes of aggression or harm to self or others. One trial (n = 148) reported no significant difference in adverse effects for people receiving zuclopenthixol acetate compared with those allocated haloperidol at one, three and six days (RR 0.74, 95 % CI 0.43 to 1.27). Compared with haloperidol or clotiapine, people allocated zuclopenthixol did not seem to be at more risk of a range of movement disorders (< 20 %). Three studies found no difference in the proportion of people getting blurred vision/dry mouth (n = 192, 2 RCTs, RR at 24 hours 0.90, 95

	<p>% CI 0.48 to 1.70). Similarly, dizziness was equally infrequent for those allocated zuclopenthixol acetate compared with haloperidol (n = 192, 2 RCTs, RR at 24 hours 1.15, 95 % CI 0.46 to 2.88). There was no difference between treatments for leaving the study before completion (n = 522, RR 0.85, 95 % CI 0.31 to 2.31). One study reported no difference in adverse effects and outcome scores, when high dose (50-100 mg/injection) zuclopenthixol acetate was compared with low dose (25-50 mg/injection) zuclopenthixol acetate.</p>
Source of Funding	Not reported.

**Freiheitsbeschränkende Maßnahmen**

Artikel-Nr.	Studien-Nr.	Sub-nummer	
1	1	1	Abderhalden, C.; Needham, I.; Dassen, T.; Halfens, R.; Haug, H. J.; Fischer, J. E. (2008): Structured risk assessment and violence in acute psychiatric wards: randomised controlled trial. In: The British journal of psychiatry: the journal of mental science 193 (1), S. 44–50. DOI: 10.1192/bjp.bp.107.045534.
2	2	1	Ala-Aho, S.; Hakko, H.; Saarento, O. (2003): Reduction of involuntary seclusions in a psychiatric ward. In: Duodecim; laaketieteellinen aikakauskirja 119 (20), S. 1969–1975.
3	3	1	Ash, David; Suetani, Shuichi; Nair, Jayakrishnan; Halpin, Matthew (2015): Recovery-based services in a psychiatric intensive care unit - the consumer perspective. In: Australas Psychiatry 23 (5), S. 524–527. DOI: 10.1177/1039856215593397.
4	4	1	Belanger, S. (2001): The 'S&R challenge': reducing the use of seclusion and restraint in a state psychiatric hospital. In: Journal for healthcare quality: official publication of the National Association for Healthcare Quality 23 (1), S. 19–24.
5	5	1	Bell, A.; Gallacher, N. (2016): Succeeding in Sustained Reduction in the use of Restraint using the Improvement Model. In: BMJ quality improvement reports 5 (1). DOI: 10.1136/bmjquality.u211050.w4430.
6	6	1	Blair, E. W.; Woolley, S.; Szarek, B. L.; Mucha, T. F.; Dutka, O.; Schwartz, H. I. et al. (2016): Reduction of Seclusion and Restraint in an Inpatient Psychiatric Setting: A Pilot Study. In: The Psychiatric quarterly. DOI: 10.1007/s11126-016-9428-0.
7	7	1	Blair, M.; Moulton-Adelman, F. (2015): The Engagement Model for reducing seclusion and restraint: 13 years later. In: Journal of psychosocial nursing and mental health services 53 (3), S. 39–45. DOI: 10.3928/02793695-20150211-01.
7b	7	2	Murphy, Bennington-Davis (2005): Restraint and seclusion: The model for eliminating their use in healthcare.
8	8	1	Hardesty S; Borckardt JJ; Hanson R; Grubaugh AL; Danielson CK; Madan A et al. (2007): Evaluating initiatives to reduce seclusion and restraint. In: J Healthc Qual 29 (4), S. 46–55.
8a	8	2	Borckardt, J. J.; Madan, A.; Grubaugh, A. L.; Danielson, C. K.; Pelic, C. G.; Hardesty, S. J. et al. (2011): Systematic investigation of initiatives to reduce seclusion and restraint in a state

Artikel-Nr.	Studien-Nr.	Sub-nummer	
			psychiatric hospital. In: Psychiatr Serv 62 (5), S. 477–483. DOI: 10.1176/ps.62.5.pss6205_0477.
8b	8	3	Borckardt, Jeffrey J.; Grubaugh, Anouk L.; Pelic, Christopher G.; Danielson, Carla Kmett; Hardesty, Susan J.; Frueh, B. Christopher (2007): Enhancing patient safety in psychiatric settings. In: Journal of psychiatric practice 13 (6), S. 355–361. DOI: 10.1097/01.pra.0000300121.99193.61.
8c	8	4	Madan, Alok; Borckardt, Jeffrey J.; Grubaugh, Anouk L.; Danielson, Carla Kmett; McLeod-Bryant, Stephen; Cooney, Harriet et al. (2014): Efforts to reduce seclusion and restraint use in a state psychiatric hospital: a ten-year perspective. In: Psychiatr Serv 65 (10), S. 1273–1276. DOI: 10.1176/appi.ps.201300383.
9	9	1	Boumans, Christien E.; Egger, Jos I. M.; Souren, Pierre M.; Hutschemaekers, Giel J. M. (2014): Reduction in the use of seclusion by the methodical work approach. In: Int J Ment Health Nurs 23 (2), S. 161–170. DOI: 10.1111/inm.12037.
10	10	1	Bowers L; Brennan G; Flood C; Lipang M; Oladapo P (2006): Preliminary outcomes of a trial to reduce conflict and containment on acute psychiatric wards: City Nurses. In: J Psychiatr Ment Health Nurs 13 (2), S. 165–172. DOI: 10.1111/j.1365-2850.2006.00931.x.
11	11	1	Bowers L; Flood C; Brennan G; Allan T (2008): A replication study of the city nurse intervention: reducing conflict and containment on three acute psychiatric wards. In: J Psychiatr Ment Health Nurs 15 (9), S. 737–742. DOI: 10.1111/j.1365-2850.2008.01294.x.
12	12	1	Cibis, M. L.; Wackerhagen, C.; Muller, S.; Lang, U. E.; Schmidt, Y.; Heinz, A. (2016): Comparison of Aggressive Behavior, Compulsory Medication and Absconding Behavior Between Open and Closed door Policy in an Acute Psychiatric Ward. In: Psychiatrische Praxis. DOI: 10.1055/s-0042-105181.
13	13	1	Clarke DE; Brown A; Griffith P (2010): The Brøset Violence Checklist: clinical utility in a secure psychiatric intensive care setting. In: J Psychiatr Ment Health Nurs 17 (7), S. 614–620. DOI: 10.1111/j.1365-2850.2010.01558.x.
14	14	1	Cummings, Kathleen S.; Grandfield, Sylvia A.; Coldwell, Craig M. (2010): Caring with comfort rooms. Reducing seclusion and restraint use in psychiatric facilities. In: Journal of psychosocial

Artikel-Nr.	Studien-Nr.	Subnummer	
			nursing and mental health services 48 (6), S. 26–30. DOI: 10.3928/02793695-20100303-02.
16	16	1	Donat, D. C. (1998): Impact of a mandatory behavioral consultation on seclusion/restraint utilization in a psychiatric hospital. In: Journal of behavior therapy and experimental psychiatry 29 (1), S. 13–19.
73	16	1	Donat, Dennis C. (2002a): Employing Behavioral Methods to Improve the Contaxt of Care in an Public Psychiatric Hospital: Reducing Hospital Reliance on Seclusion/Restraint and Psychotropic PRN Medication. In: Cognitive and Behavioral Practice 9, S. 28–37.
74	16	1	Donat, Dennis C. (2002b): Impact of improved staffing on seclusion/restraint reliance in a public psychiatric hospital. In: Psychiatric rehabilitation journal 25 (4), S. 413–416.
15	16	1	Donat, Dennis C. (2003): An analysis of successful efforts to reduce the use of seclusion and restraint at a public psychiatric hospital. In: Psychiatr Serv 54 (8), S. 1119–1123. DOI: 10.1176/appi.ps.54.8.1119.
17	17	1	D'Orio, Barbara M.; Purselle, David; Stevens, Debbie; Garlow, Steven J. (2004): Reduction of episodes of seclusion and restraint in a psychiatric emergency service. In: Psychiatr Serv 55 (5), S. 581–583. DOI: 10.1176/appi.ps.55.5.581.
18	18	1	Espinosa, L.; Harris, B.; Frank, J.; Armstrong-Muth, J.; Brous, E.; Moran, J.; Giorgi-Cipriano, J. (2015): Milieu improvement in psychiatry using evidence-based practices: the long and winding road of culture change. In: Archives of psychiatric nursing 29 (4), S. 202–207. DOI: 10.1016/j.apnu.2014.08.004.
19	19	1	Fisher, W. A. (2003): Elements of successful restraint and seclusion reduction programs and their application in a large, urban, state psychiatric hospital. In: Journal of psychiatric practice 9 (1), S. 7–15.
20	20	1	Flutters, F. A.; van Meijel, B.; Nijman, H.; Bjorkly, S.; Grypdonck, M. (2010): Preventing aggressive incidents and seclusions in forensic care by means of the 'Early Recognition Method'. In: Journal of clinical nursing 19 (11-12), S. 1529–1537. DOI: 10.1111/j.1365-2702.2009.02986.x.
21	21	1	Forster, P. L.; Cavness, C.; Phelps, M. A. (1999): Staff training decreases use of seclusion and restraint in an acute psychiatric hospital. In: Archives of psychiatric nursing 13 (5), S. 269–271.

Artikel-Nr.	Studien-Nr.	Subnummer	
22	22	1	Godfrey, Jenna L.; McGill, Amanda C.; Jones, Nicole Tuomi; Oxley, Stephen L.; Carr, Robyn M. (2014): Anatomy of a transformation: a systematic effort to reduce mechanical restraints at a state psychiatric hospital. In: <i>Psychiatr Serv</i> 65 (10), S. 1277–1280. DOI: 10.1176/appi.ps.201300247.
23	23	1	Gonzalez-Torres, Miguel Angel; Fernandez-Rivas, Aranzazu; Bustamante, Sonia; Rico-Vilademoros, Fernando; Vivanco, Esther; Martinez, Karmele et al. (2014): Impact of the creation and implementation of a clinical management guideline for personality disorders in reducing use of mechanical restraints in a psychiatric inpatient unit. In: <i>The primary care companion for CNS disorders</i> 16 (6). DOI: 10.4088/PCC.14m01675.
24	24	1	Guzman-Parra, J.; Aguilera, Serrano C.; Garcia-Sanchez, J. A.; Pino-Benitez, I.; Alba-Vallejo, M.; Moreno-Kustner, B.; Mayoral-Cleries, F. (2016): Effectiveness of a Multimodal Intervention Program for Restraint Prevention in an Acute Spanish Psychiatric Ward. In: <i>Journal of the American Psychiatric Nurses Association</i> 22 (3), S. 233–241. DOI: 10.1177/1078390316644767.
25	25	1	Guzman-Parra, Jose; Garcia-Sanchez, Juan A.; Pino-Benitez, Isabel; Alba-Vallejo, Mercedes; Mayoral-Cleries, Fermin (2015): Effects of a Regulatory Protocol for Mechanical Restraint and Coercion in a Spanish Psychiatric Ward. In: <i>Perspectives in psychiatric care</i> 51 (4), S. 260–267. DOI: 10.1111/ppc.12090.
26	26	1	Hamilton, Bridget; Love, Anna (2010): Reducing reliance on seclusion in acute psychiatry. In: <i>Australian nursing journal</i> (July 1993) 18 (3), S. 43.
27	27	1	Hellerstein, D. J.; Staub, A. B.; Lequesne, E. (2007): Decreasing the use of restraint and seclusion among psychiatric inpatients. In: <i>Journal of psychiatric practice</i> 13 (5), S. 308–317. DOI: 10.1097/01.pra.0000290669.10107.ba.
28	28	1	Hoch, Jeffrey S.; O'Reilly, Richard L.; Carscadden, Judith (2006): Relationship management therapy for patients with borderline personality disorder. In: <i>Psychiatr Serv</i> 57 (2), S. 179–181. DOI: 10.1176/appi.ps.57.2.179.
29	29	1	Jones, D. W. (1997): Pennsylvania hospital continues to reduce seclusion and restraints. In: <i>Joint Commission perspectives. Joint Commission on Accreditation of Healthcare Organizations</i> 17 (2), S. 17.

Artikel-Nr.	Studien-Nr.	Subnummer	
30	30	1	Jonikas, J. A.; Cook, J. A.; Rosen, C.; Laris, A.; Kim, J. B. (2004): A program to reduce use of physical restraint in psychiatric inpatient facilities. In: <i>Psychiatr Serv</i> 55 (7), S. 818–820. DOI: 10.1176/appi.ps.55.7.818.
31	31	1	Jungfer, Hermann-Alexander; Schneeberger, Andres R.; Borgwardt, Stefan; Walter, Marc; Vogel, Marc; Gairing, Stefanie K. et al. (2014): Reduction of seclusion on a hospital-wide level: successful implementation of a less restrictive policy. In: <i>Journal of psychiatric research</i> 54, S. 94–99. DOI: 10.1016/j.jpsychires.2014.03.020.
32	32	1	Keski-Valkama, A.; Sailas, E.; Eronen, M.; Am Koivisto; Lonnqvist, J.; Kaltiala-Heino, R. (2007): A 15-year national follow-up: legislation is not enough to reduce the use of seclusion and restraint. In: <i>Social psychiatry and psychiatric epidemiology</i> 42 (9), S. 747–752. DOI: 10.1007/s00127-007-0219-7.
33	33	1	Khadivi, Ali None; Patel, Raman C.; Atkinson, Angela R.; Levine, Jeffery M. (2004): Association between seclusion and restraint and patient-related violence. In: <i>Psychiatr Serv</i> 55 (11), S. 1311–1312. DOI: 10.1176/appi.ps.55.11.1311.
34	34	1	Khazaal, Y.; Chatton, A.; Pasandin, N.; Zullino, D.; Preisig, M. (2009): Advance directives based on cognitive therapy: a way to overcome coercion related problems. In: <i>Patient education and counseling</i> 74 (1), S. 35–38. DOI: 10.1016/j.pec.2008.08.006.
35	35	1	Laker C; Gray R; Flach C (2010): Case study evaluating the impact of de-escalation and physical intervention training. In: <i>J Psychiatr Ment Health Nurs</i> 17 (3), S. 222–228. DOI: 10.1111/j.1365-2850.2009.01496.x.
36	36	1	Lewis M; Taylor K; Parks J (2009): Crisis prevention management: a program to reduce the use of seclusion and restraint in an inpatient mental health setting. In: <i>Issues Ment Health Nurs</i> 30 (3), S. 159–164. DOI: 10.1080/01612840802694171.
37	37	1	Lorenzo, R. D.; Miani, F.; Formicola, V.; Ferri, P. (2014): Clinical and organizational factors related to the reduction of mechanical restraint application in an acute ward: an 8-year retrospective analysis. In: <i>Clinical practice and epidemiology in mental health: CP &amp; EMH</i> 10, S. 94–102. DOI: 10.2174/1745017901410010094.

Artikel-Nr.	Studien-Nr.	Subnummer	
38	38	1	Lykke, J.; Austin, S. F.; Morch, M. M. (2008): Cognitive milieu therapy and restraint within dual diagnosis populations. In: Ugeskrift for laeger 170 (5), S. 339–343.
39	39	1	MacDonald, A. (1989): Reducing seclusion in a psychiatric hospital. In: Nursing times 85 (23), S. 58–59.
40	40	1	Maguire, T.; Young, R.; Martin, T. (2012): Seclusion reduction in a forensic mental health setting. In: J Psychiatr Ment Health Nurs 19 (2), S. 97–106. DOI: 10.1111/j.1365-2850.2011.01753.x.
41	41	1	McCue, R. E.; Urcuyo, L.; Lilu, Y.; Tobias, T.; Chambers, M. J. (2004): Reducing restraint use in a public psychiatric inpatient service. In: The journal of behavioral health services & research 31 (2), S. 217–224.
42	42	1	Needham, I.; Abderhalden, C.; Meer, R.; Dassen, T.; Haug, H. J.; Halfens, R. J.; Fischer, J. E. (2004): The effectiveness of two interventions in the management of patient violence in acute mental inpatient settings: report on a pilot study. In: Journal of psychiatric and mental health nursing 11 (5), S. 595–601. DOI: 10.1111/j.1365-2850.2004.00767.x.
43	43	1	Noorthoorn, E. O.; Voskes, Y.; Janssen, W. A.; Mulder, C. L.; van de Sande, R.; Nijman, H. L. et al. (2016): Seclusion Reduction in Dutch Mental Health Care: Did Hospitals Meet Goals? In: Psychiatr Serv, appips201500414. DOI: 10.1176/appi.ps.201500414.
44	44	1	Novak, T.; Scanlan, J.; McCaul, D.; MacDonald, N.; Clarke, T. (2012): Pilot study of a sensory room in an acute inpatient psychiatric unit. In: Australasian psychiatry: bulletin of Royal Australian and New Zealand College of Psychiatrists 20 (5), S. 401–406. DOI: 10.1177/1039856212459585.
45	45	1	Ohlenschlaeger, Johan; Nordentoft, Merete; Thorup, Anne; Jeppesen, Pia; Petersen, Lone; Christensen, Torben O. et al. (2008): Effect of integrated treatment on the use of coercive measures in first-episode schizophrenia-spectrum disorder. A randomized clinical trial. In: International journal of law and psychiatry 31 (1), S. 72–76. DOI: 10.1016/j.ijlp.2007.11.003.
46	46	1	Olver, James; Love, Mervyn; Daniel, Jeffrey; Norman, Trevor; Nicholls, Daniel (2009): The impact of a changed environment on arousal levels of patients in a secure extended rehabilitation facility. In: Australasian psychiatry: bulletin of Royal Australian and New Zealand College of Psychiatrists 17 (3), S. 207–211.



Artikel-Nr.	Studien-Nr.	Subnummer	
			DOI: 10.1080/10398560902839473.
47	47	1	Petrakis, M.; Penno, S.; Oxley, J.; Bloom, H.; Castle, D. (2012): Early psychosis treatment in an integrated model within an adult mental health service. In: <i>European psychiatry: the journal of the Association of European Psychiatrists</i> 27 (7), S. 483–488. DOI: 10.1016/j.eurpsy.2011.03.004.
48	48	1	Phillips, D.; Rudestam, K. E. (1995): Effect of nonviolent self-defense training on male psychiatric staff members' aggression and fear. In: <i>Psychiatr Serv</i> 46 (2), S. 164–168. DOI: 10.1176/ps.46.2.164.
49	49	1	Pollard, R.; Yanasak, E. V.; Rogers, S. A.; Tapp, A. (2007): Organizational and unit factors contributing to reduction in the use of seclusion and restraint procedures on an acute psychiatric inpatient unit. In: <i>The Psychiatric quarterly</i> 78 (1), S. 73–81. DOI: 10.1007/s11126-006-9028-5.
50	50	1	Prescott, David L.; Madden, Lynn M.; Dennis, Marilyn; Tisher, Paul; Wingate, Carrie (2007): Reducing mechanical restraints in acute psychiatric care settings using rapid response teams. In: <i>The journal of behavioral health services &amp; research</i> 34 (1), S. 96–105. DOI: 10.1007/s11414-006-9036-0.
51	51	1	Putkonen, A.; Kuivalainen, S.; Louheranta, O.; Repo-Tiihonen, E.; Ryyanen, O. P.; Kautiainen, H.; Tiihonen, J. (2013): Cluster-randomized controlled trial of reducing seclusion and restraint in secured care of men with schizophrenia. In: <i>Psychiatr Serv</i> 64 (9), S. 850–855. DOI: 10.1176/appi.ps.201200393.
52	52	1	Richmond I; Trujillo D; Schmelzer J; Phillips S; Davis D (1996): Least restrictive alternatives: do they really work? In: <i>J NURS CARE QUAL</i> 11 (1), S. 29–37.
53	53	1	Rohe, T.; Dresler, T.; Stuhlinger, M.; Weber, M.; Strittmatter, T.; Fallgatter, A. J. (2016): Architectural modernization of psychiatric hospitals influences the use of coercive measures. In: <i>Der Nervenarzt</i> . DOI: 10.1007/s00115-015-0054-0.
54	54	1	Schepelern, E. S.; Aggernaes, K. H.; Stender, A. K.; Raben, H. (1993): Use of restraints in a psychiatric department, Frederiksberg Hospital, before and after introduction of the new psychiatric law. Restraining devices. In: <i>Ugeskrift for laeger</i> 155 (50), S. 4091–4095.
55	55	1	Smith, S.; Jones, J. (2014): Use of a sensory room on an intensive care unit. In: <i>Journal of psychosocial nursing and</i>

Artikel-Nr.	Studien-Nr.	Subnummer	
			mental health services 52 (5), S. 22–30. DOI: 10.3928/02793695-20131126-06.
56	56	1	Stead, Karen; Kumar, Saravana; Schultz, Timothy J.; Tiver, Sue; Pirone, Christy J.; Adams, Robert J.; Wareham, Conrad A. (2009): Teams communicating through STEPPS. In: The Medical journal of Australia 190 (11 Suppl), S128-32.
57	57	1	Steinert, Tilman; Zinkler, Martin; Elsasser-Gaissmaier, Hans-Peter; Starrach, Axel; Hoppstock, Sandra; Flammer, Erich (2015): Long-Term Tendencies in the Use of Seclusion and Restraint in Five Psychiatric Hospitals in Germany. In: Psychiatrische Praxis 42 (7), S. 377–383. DOI: 10.1055/s-0034-1370174.
58	58	1	Sullivan, Ann M.; Bezmen, Janet; Barron, Charles T.; Rivera, James; Curley-Casey, Linda; Marino, Dominic (2005): Reducing restraints: alternatives to restraints on an inpatient psychiatric service--utilizing safe and effective methods to evaluate and treat the violent patient. In: The Psychiatric quarterly 76 (1), S. 51–65.
59	59	1	Sullivan D; Wallis M; Lloyd C (2004): Effects of patient-focused care on seclusion in a psychiatric intensive care unit...including commentary by Holmes D and Perron A. In: International Journal of Therapy & Rehabilitation 11 (11), S. 503–508.
60	60	1	Taxis, J. Carole (2002): Ethics and praxis: alternative strategies to physical restraint and seclusion in a psychiatric setting. In: Issues in mental health nursing 23 (2), S. 157–170.
61	61	1	Teitelbaum, A.; Volpo, S.; Paran, R.; Zislin, J.; Drumer, D.; Raskin, S. et al. (2007): Multisensory environmental intervention (snoezelen) as a preventive alternative to seclusion and restraint in closed psychiatric wards. In: Harefuah 146 (1), 11-4, 79-80.
62	62	1	Templeton L; Gray S; Topping J (1998): Seclusion: changes in policy and practice on an acute psychiatric unit. In: J MENT HEALTH 7 (2), S. 199–202.
63	63	1	van de Sande, R.; Nijman, H. L. I.; Noorthoorn, E. O.; Wierdsma, A. I.; Hellendoorn, E.; van der Staak, C.; Mulder, C. L. (2011): Aggression and seclusion on acute psychiatric wards: effect of short-term risk assessment. In: The British journal of psychiatry: the journal of mental science 199 (6), S. 473–478. DOI: 10.1192/bjp.bp.111.095141.

Artikel-Nr.	Studien-Nr.	Subnummer	
64	64	1	Vruwink, F. J.; Mulder, C. L.; Noorthoorn, E. O.; Uitenbroek, D.; Nijman, H. L. (2012): The effects of a nationwide program to reduce seclusion in the Netherlands. In: BMC psychiatry 12, S. 231. DOI: 10.1186/1471-244X-12-231.
65	65	1	Wale, Joyce B.; Belkin, Gary S.; Moon, Robert (2011): Reducing the use of seclusion and restraint in psychiatric emergency and adult inpatient services- improving patient-centered care. In: The Permanente journal 15 (2), S. 57–62.
66	66	1	Whitecross, Fiona; Seear, Amy; Lee, Stuart (2013): Measuring the impacts of seclusion on psychiatry inpatients and the effectiveness of a pilot single-session post-seclusion counselling intervention. In: Int J Ment Health Nurs 22 (6), S. 512–521. DOI: 10.1111/inm.12023.
67	67	1	Wieman, Dow A.; Camacho-Gonsalves, Teresita; Huckshorn, Kevin Ann; Leff, Stephen (2014): Multisite study of an evidence-based practice to reduce seclusion and restraint in psychiatric inpatient facilities. In: Psychiatr Serv 65 (3), S. 345–351. DOI: 10.1176/appi.ps.201300210.
68	68	1	Yang, Chin-Po Paul; Hargreaves, William A.; Bostrom, Alan (2014): Association of empathy of nursing staff with reduction of seclusion and restraint in psychiatric inpatient care. In: Psychiatr Serv 65 (2), S. 251–254. DOI: 10.1176/appi.ps.201200531.
69	69	1	Ashcraft, Lori; Anthony, William (2008): Eliminating seclusion and restraint in recovery-oriented crisis services. In: Psychiatr Serv 59 (10), S. 1198–1202. DOI: 10.1176/appi.ps.59.10.1198.
70	70	1	Corrigan P, Holmes PE, Luchins D, Basit A, Buican B. (1995): The effects of interactive staff training on staff programming and patient aggression in a psychiatric inpatient ward. In: Behavioral Interventions 10 (1), 17-32.
71	71	1	Craig, C.; Ray, F.; Hix, C. (1989): Seclusion and restraint: decreasing the discomfort. In: Journal of psychosocial nursing and mental health services 27 (7), S. 17–19.
72	72	1	Currier, Glenn W.; Farley-Toombs, Carole (2002): Datapoints: use of restraint before and after implementation of the new HCFA rules. In: Psychiatr Serv 53 (2), S. 138. DOI: 10.1176/appi.ps.53.2.138.
75	75	1	Goodness, Kelly R.; Renfro, Nancy S. (2002): Changing a culture: a brief program analysis of a social learning program on a

Artikel-Nr.	Studien-Nr.	Sub-nummer	
			maximum-security forensic unit. In: Behavioral sciences & the law 20 (5), S. 495–506. DOI: 10.1002/bsl.489.
76	76	1	Kostecka, M.; Zardecka, M. (1999): The use of physical restraints in Polish psychiatric hospitals in 1989 and 1996. In: Psychiatr Serv 50 (12), S. 1637–1638. DOI: 10.1176/ps.50.12.1637.
77	77	1	Lloyd C, King R, Machingura T. (2014): An investigation into the effectiveness of sensory modulation in reducing seclusion within a acute mental health unit. In: Advances in Mental Health 12, S. 93–100.
79	79	1	Morales, E.; Duphorne, P. L. (1995): Least restrictive measures: alternatives to four-point restraints and seclusion. In: Journal of psychosocial nursing and mental health services 33 (10), S. 13–16.
80	80	1	O'Malley J, Frampton C, Wijnveld AM et al. (2007): Factors influencing seclusion rates in an adult psychiatric intensive care unit. In: Journal of Psychiatric Intensive Care 3 (2), S. 93–100.
81	81	1	Smith, Gregory M.; Davis, Robert H.; Bixler, Edward O.; Lin, Hung-Mo; Altenor, Aidan; Altenor, Roberta J. et al. (2005): Pennsylvania State Hospital system's seclusion and restraint reduction program. In: Psychiatr Serv 56 (9), S. 1115–1122. DOI: 10.1176/appi.ps.56.9.1115.
82	82	1	Steinert T, Eisele F, Göser U, Tschöke S, Solmaz S, Falk S. (2009): Quality of Process and Results in Psychiatry: Decreasing Coercive Interventions and Violence among Patients with Personality Disorder by Implementation of a Crisis Intervention Ward. In: Gesundh ökon Qual manag 14, S. 44–48.

## Evidenztabellen

<b>Nummer</b>	<b>1</b>
<b>Studie</b>	Abderhalden, C.; Needham, I.; Dassen, T.; Halfens, R.; Haug, H. J.; Fischer, J. E. (2008): Structured risk assessment and violence in acute psychiatric wards: randomised controlled trial. In: The British journal of psychiatry : the journal of mental science 193 (1), S. 44–50. DOI: 10.1192/bjp.bp.107.045534.
<b>Institution</b>	University of Bern, Center of Psychiatry Rheinau
<b>Studientyp</b>	Cluster randomised controlled trial plus preference arm
<b>Kontrollgruppe ja/nein</b>	yes
<b>Komplex ja/nein</b>	no
<b>Interventionstyp</b>	Early Interventions// Structured Risk Assessment, BVC
<b>n Patienten</b>	2364
<b>Effekt ja/nein auf S/R</b>	yes
<b>Beschreibung Intervention</b>	Risk Assessment with BVC-CH, scores from 7-9 measures from a list, scores 10 or above interdisciplinary team meeting
<b>Beschreibung Kontrolle</b>	TAU
<b>Beschreibung Patienten</b>	acute psychiatric wards, psychiatric incl. Substance abuse, less personality disorders
<b>Beschreibung Outcomevariablen</b>	aggressive events (SOAS-R), coercive measures (dichotomous)
<b>Beschreibung Ergebnisse</b>	Coercive measures + 10 % in control condition, -27 % in intervention condition, - 60 % in preference group
<b>Dauer Baseline/Intervention/Follow-up</b>	3 month baseline, 3 month intervention
<b>Funding</b>	Swiss National Science Foundation
<b>Qualitätsbemerkung</b>	no follow-up, no sample size calculation, just descriptive statistics, differences at baseline, no masking, no reporting about interventions done if risk assessment scores high

<b>Nummer</b>	<b>2</b>
<b>Studie</b>	Ala-Aho, S.; Hakko, H.; Saarento, O. (2003): Reduction of involuntary seclusions in a psychiatric ward. In: Duodecim; laaketieteellinen aikakauskirja 119 (20), S. 1969–1975.
<b>Institution</b>	Oulu University Hospital
<b>Studientyp</b>	Pretest-posttest-design
<b>Kontrollgruppe ja/nein</b>	no
<b>Komplex ja/nein</b>	yes
<b>Interventionstyp</b>	Complex
<b>Effekt ja/nein auf S/R</b>	yes
<b>Beschreibung Intervention</b>	Incidents discussed in team meetings, crises peaks linked to weekend leaves were reduced, de-escalation methods, continuous observation and structured week schedules for suicidal patients, pair of responsible nurses, personal treatment plan for every patient, better interdisciplinary interaction
<b>Beschreibung Patienten</b>	closed semi-acute wards, most patients suffered from psychosis
<b>Beschreibung Outcomevariablen</b>	Number of seclusion (mechanical restraint) events, reported by reason, month, day, time
<b>Beschreibung Ergebnisse</b>	No. Of restraint events decreased from 1.0 % per treatment days in 1999 to 0.5 in 2000 and 0.4. in 2001.
<b>Dauer</b>	
<b>Baseline/Intervention/Follow-up</b>	2 years planning, 1 year team assessment, 2 further years complex intervention

<b>Nummer</b>	<b>3</b>
<b>Studie</b>	Ash, David; Suetani, Shuichi; Nair, Jayakrishnan; Halpin, Matthew (2015): Recovery-based services in a psychiatric intensive care unit - the consumer perspective. In: AUSTRALAS PSYCHIATRY 23 (5), S. 524–527. DOI: 10.1177/1039856215593397.
<b>Institution</b>	Central Adelaide Local Health Network
<b>Studientyp</b>	Pretest-posttest-design
<b>Kontrollgruppe ja/nein</b>	no
<b>Komplex ja/nein</b>	yes
<b>Interventionstyp</b>	Complex, Recoverybased
<b>n Patienten</b>	725?? (admissions)
<b>Effekt ja/nein auf S/R</b>	yes
<b>Beschreibung Intervention</b>	Recovery practices: meet and greet services, respectful communication, peer specialist, interdisciplinary team meetings, carer consultant, culturally sensitive care, collaborative care, sensory modulation, exercise facilities, group activities, safety-care plans, de-escalation strategies, debriefing, information about medication, exit-interview
<b>Beschreibung Patienten</b>	PICU, patients who are a risk to themselves or others, common diagnosis were schizophrenia, drug induced psychosis, mania
<b>Beschreibung</b>	Number of seclusion, admissions affected by seclusion, duration of

<b>Outcomevariablen</b>	seclusion events (average)
<b>Beschreibung Ergebnisse</b>	admissions affected by seclusion decreased from 28 % in 2011-2012 to 15 % in 2012-2013 ( $p < 0.001$ ), number of seclusion decreased from 261 to 125, duration of seclusion events increased slightly from 4 to 4.2h
<b>Dauer Baseline/Intervention/Follow-up</b>	2 years during which the recovery-based interventions were introduced step by step
<b>Funding</b>	Not reported

<b>Nummer</b>	<b>4</b>
<b>Studie</b>	Belanger, S. (2001): The 'S&R challenge': reducing the use of seclusion and restraint in a state psychiatric hospital. In: Journal for healthcare quality : official publication of the National Association for Healthcare Quality 23 (1), S. 19–24.
<b>Institution</b>	Colorado Mental Health Institute at Pueblo
<b>Studientyp</b>	interrupted time series
<b>Kontrollgruppe ja/nein</b>	no
<b>Komplex ja/nein</b>	yes
<b>Interventionstyp</b>	Complex, S&R Challenge
<b>Effekt ja/nein auf S/R</b>	yes
<b>Beschreibung Intervention</b>	Leadership, implementing quality improvement teams, Debriefing after S/R event, new Documentation form, Training, stricter definition (time-out = seclusion, even just sitting in a chair in the dayhall),
<b>Beschreibung Patienten</b>	whole psychiatric hospital including adult, adolescent and forensic patients
<b>Beschreibung Outcomevariablen</b>	S/R hours per 1000 patient days, Number of S/R episodes, average length of S/R episodes, distribution of length of episodes
<b>Beschreibung Ergebnisse</b>	the number of S&R hours per 1000 patient days decreased by more than 90 % (ca. 325 -> 25), episodes fell from ca. 9 to ca. 4 per day, average length of S/R episodes declined from 17.6 to 3.5 hours, high number of short episodes (< 1 hour) in adolescent unit
<b>Dauer Baseline/Intervention/Follow-up</b>	9 month baseline, 9 month intervention
<b>Funding</b>	not reported
<b>Qualitätsbemerkung</b>	unsufficient reporting about patient population, no sufficient pause between baseline and intervention data collecting

<b>Nummer</b>	<b>5</b>
<b>Studie</b>	Bell, A.; Gallacher, N. (2016): Succeeding in Sustained Reduction in the use of Restraint using the Improvement Model. In: BMJ quality improvement reports 5 (1). DOI: 10.1136/bmjquality.u211050.w4430.

<b>Institution</b>	NHS Fife Scotland
<b>Studientyp</b>	interrupted time series
<b>Kontrollgruppe ja/nein</b>	no
<b>Komplex ja/nein</b>	yes
<b>Interventionstyp</b>	Complex, PDSA Improvement model, staff patient feedback (after Scalan 2010, D'Orio et al 2007, Huckshorn 2014, Hellerstein 2007)
<b>n Patienten</b>	(593 occupied bed day per month)
<b>Effekt ja/nein auf S/R</b>	yes
<b>Beschreibung Intervention</b>	policy change, data use (changing existing incident report tool), implement debriefs, training, involvement, increase the use of seated restraint, improvements were implemented in four steps (PDSA-cycles)
<b>Beschreibung Intervention II</b>	Staff and patient feedback
<b>Beschreibung Patienten</b>	acute admission ward
<b>Beschreibung Outcomevariablen</b>	restraints per 1000 bed days
<b>Beschreibung Ergebnisse</b>	Baseline (including the 4 PDSA-cycles) 4.18 restraints per 1000 patient days, after implementing staff and patient feedback 1.97 (= ca. 50 % reduction)
<b>Beschreibung sekundäre Ergebnisse</b>	Baseline 22 % of restraint incidents resulted in a staff debrief, after implementing staff and patient feedback 60 %
<b>Dauer</b>	
<b>Baseline/Intervention/Follow-up</b>	before baseline 1 year (bad reporting), baseline with PDSA 1-4 24 months, after implementing feedback 12 months
<b>Funding</b>	Not reported
<b>Qualitätsbemerkung</b>	contamination due to the 4 PDSA before implementing staff and patient feedback, high variability of S/R events, insufficient reporting about patient population, no sufficient pause between baseline and intervention data collecting

<b>Nummer</b>	<b>6</b>
<b>Studie</b>	Blair, E. W.; Woolley, S.; Szarek, B. L.; Mucha, T. F.; Dutka, O.; Schwartz, H. I. et al. (2016): Reduction of Seclusion and Restraint in an Inpatient Psychiatric Setting: A Pilot Study. In: The Psychiatric quarterly. DOI: 10.1007/s11126-016-9428-0.
<b>Institution</b>	Institute of Living/Hartford Hospital, Burlingame Center for Psychiatric Research and Education/Institute of Living
<b>Studientyp</b>	Pretest-posttest-design
<b>Kontrollgruppe ja/nein</b>	no
<b>Komplex ja/nein</b>	yes
<b>Interventionstyp</b>	Complex, incl. Trauma-informed care
<b>Untersuchungseinheit</b>	episode of hospitalisation
<b>n Patienten</b>	11913?? (admissions, 3884 during baseline, 8029 during intervention)
<b>Effekt ja/nein auf S/R</b>	yes
<b>Beschreibung Intervention</b>	routine use of BVC, education in crises intervention and trauma-



	informed care, increased frequency of physician reassessment of need for S/R, formal administrative review of S/R events, environmental enhancements (e.g. comfort rooms to support sensory modulation)
<b>Beschreibung Patienten</b>	psychiatric inpatient service of a large urban hospital, including 4.9 % children < 12 y and 9.2 % adults > 66 y
<b>Beschreibung Outcomevariablen</b>	seclusion/restraint events per 100 admissions, duration of mean seclusion and restraint events
<b>Beschreibung Ergebnisse</b>	statistical significant reduction in seclusion events (9.2 -> 4.4/100 = 52 % reduction), not significant reduction of 6 % in restraint events, significant increase in seclusion (337.7 -> 516.2 min) and restraint (286.0-> 445.0 min) duration.
<b>Beschreibung sekundäre Ergebnisse</b>	Most common behavior in BVC associated with S/R irritability (96 %), boisterousness (78 %), verbal threats (63 %), confusion (50 %)
<b>Dauer Baseline/Intervention/Follow-up</b>	baseline one year, intervention period 2 years
<b>Funding</b>	Research Committee of the facility
<b>Qualitätsbemerkung</b>	insufficient reporting about patient population

<b>Nummer</b>	<b>7</b>
<b>Studie</b>	Murphy, Bennington-Davis (2005): Restraint and seclusion: The model for eliminating their use in healthcare.
<b>Institution</b>	Salem (OR) Hospital, Evolutions in Healthcare
<b>Studientyp</b>	interrupted time series
<b>Kontrollgruppe ja/nein</b>	no
<b>Komplex ja/nein</b>	yes
<b>Interventionstyp</b>	complex, engagement model
<b>Effekt ja/nein auf S/R</b>	yes
<b>Beschreibung Intervention</b>	Physical plant (new wallpaper was installed, comfortable and inviting common-room furniture replaced institutional pieces, warning or "no" signs were replaced with inspirational posters and pictures, comfort room was conceived), Staff deployment (Staff members were given incentives to be among patients rather than behind the counters of the nursing station or in offices, the unit paid for meals when staff members chose to eat alongside the patients, normalizing conversation during mealtimes was encouraged and adopted), Leadership and customer service (interactions among staff are as important and orchestrated as interactions between staff and patients), Language and vocabulary (Less stigmatizing, less judgmental alternatives replaced words and phrases like noncompliance, time-out, training, case management, denies, alleges, claims, and refuses), Rituals and traditions (organization became data-driven, financial and performance indicators were distributed to all staff, and the organization developed a shared

	<p>vision), Community meeting for staff, physicians and patients together twice a day. Every episode of seclusion or restraint was treated as a system's issue. Staff notified the medical director and administrative director in the moment, any time, 24/7 who then apologized in person to the patient. Trauma-informed care (reduction of the revved-up autonomic nervous system, including tone of voice...), Admission process (decrease fear and anxiety, offer service rather than making demands, and put people at ease instead of increasing their need for defense), Physicians involved in the model, meetings and meals.</p>
<b>Beschreibung Intervention II</b>	
<b>Beschreibung Kontrolle</b>	
<b>Beschreibung Patienten</b>	<p>Salem Hospital is a nonprofit regional hospital with approximately 280 beds in operation. The psychiatry inpatient unit is housed in a free-standing building three blocks from the main hospital. Inpatient psychiatry is an acute adult and geriatric, locked, secure unit of 24 beds, with an average length of stay of eight days and a census that is nearly always at capacity. One-third of people admitted are experiencing their first psychiatric hospitalization. People are admitted acutely from emergency departments at Salem Hospital and other hospitals from around the state, med-surg floors, jail, therapist and physician offices, crisis centers, and directly from home or the streets. There are no exclusionary admitting criteria except for acute and active severe physical illness or acute intoxication requiring medical intervention. Primary diagnoses are schizophrenia or other psychosis and mood disorders. Of people admitted, 50 % have coexisting substance abuse conditions. Payers include Medicaid, Medicare, and private insurance, and some patients have no means of payment.</p>
<b>Beschreibung Outcomevariablen</b>	<p>Seclusion events per year, annual hours of locked seclusion</p>
<b>Beschreibung Ergebnisse</b>	<p>Seclusion events fell from about 200 in 2000 to about 50 in 2001 (after implementation of Engagement Model), and further decreased to about 10 in 2002 and less than that in 2003 and 1 event in 2004 and 0 in 2005. Annual hours of locked seclusion fell from over 1400 in 2000 to about 250 in 2001, 36,9 in 2002, 2,25 in 2003 and 10 minutes in 2004.</p>
<b>Beschreibung sekundäre Ergebnisse</b>	<p>Employee injuries also decreased dramatically from over 60 in 2000 to about 30 in 2001 and 2(?) in 2005. Cost of workers compensation claims were about 5000\$ in 2001 and 2002 each and then fell to zero and remained zero.</p>
<b>Dauer Baseline/Intervention/Follow-up</b>	<p>6 years baseline for seclusion events, one year for annual hours, 5 years post-intervention</p>
<b>Funding</b>	<p>not reported</p>

<b>Nummer</b>	<b>8</b>
<b>Studie</b>	Borckardt, J. J.; Madan, A.; Grubaugh, A. L.; Danielson, C. K.; Pelic, C. G.; Hardesty, S. J. et al. (2011): Systematic investigation of initiatives to reduce seclusion and restraint in a state psychiatric hospital. In: Psychiatric services (Washington, D.C.) 62 (5), S. 477–483. DOI: 10.1176/ps.62.5.pss6205_0477.
<b>Institution</b>	Medical University of South Carolina
<b>Studientyp</b>	interrupted time series, variable baseline design
<b>Komplex ja/nein</b>	yes
<b>Interventionstyp</b>	Complex, Engagement model
<b>n Patienten</b>	(89783 patient days)
<b>Effekt ja/nein auf S/R</b>	yes
<b>Beschreibung Intervention</b>	engagement model: 1. trauma informed care , 2. languages and rules, including a team for every unit reviewing and modifying rules 3. therapeutic environment, painting, furniture, decoration etc. 4. patient involvement in treatment planning; the different steps were implemented randomly in different order in the different units
<b>Beschreibung Intervention II</b>	parallel AIDET to improve patient satisfaction and staff-patient communication
<b>Beschreibung Kontrolle</b>	
<b>Beschreibung Patienten</b>	high-acuity adult unit, geriatric unit, general adult unit, substance abuse unit, child and adolescent unit
<b>Beschreibung Outcomevariablen</b>	seclusion/restraint rate per patient day
<b>Beschreibung Ergebnisse</b>	A significant reduction of 82.3 % ( $p=.008$ ) in the rate of seclusion and restraint was observed between the baseline phase (January 2005 through February 2006) and the follow-up, postintervention phase (April 2008 through June 2008). After control for illness severity and nonspecific effects associated with an observation-only phase, changes to the physical environment were uniquely associated with a significant reduction in rate of seclusion and restraint during the intervention rollout period.
<b>Beschreibung sekundäre Ergebnisse</b>	patient ratings of the quality of care questionnaire improved after the interventions "environment", "involvement in treatment planning", but noch in trauma sensitivity trauma-informed care intervention, language and rules)
<b>Dauer Baseline/Intervention/Follow-up</b>	baseline 14 month, implementation phase 13 months, follow up period 3 months
<b>Funding</b>	none

<b>Nummer</b>	9
<b>Studie</b>	Boumans, C. E.; Egger, J. I. M.; Hutschemaekers, G. J. M. (2016): Could you please reduce your seclusion rates? To structure patient care by the methodical work approach. In: Tijdschrift voor psychiatrie 58 (2), S. 140–144.
<b>Institution</b>	Center for Psychosis and Substance Use Disorder, Centre for Excellence for Neuro Science/Vincentvan Gogh Intitute/Venray
<b>Studientyp</b>	Clinical Controlled trial
<b>Kontrollgruppe ja/nein</b>	yes
<b>Komplex ja/nein</b>	yes
<b>Interventionstyp</b>	Treatment planning wirth the Methodical Work Approach
<b>n Patienten</b>	678 (134 intervention, 544 control)
<b>Effekt ja/nein auf S/R</b>	yes
<b>Beschreibung Intervention</b>	Translation from problems into goals, search for means to reach the goals, treatment plan ist set up with interdisciplinary team to match nursing and treatment plans, patient and his family, implementation of plan, evaluation readjustment
<b>Beschreibung Intervention II</b>	normal nursing and treatment plans, multidisciplinary team sessions
<b>Beschreibung Patienten</b>	combination of psychosis and substance abuse disorders, specialized intensive care for people with dangerous behaviour or non-response to treatment, almost all involuntarily, some had already been in forensic settings
<b>Beschreibung Outcomevariablen</b>	number of seclusion episodes per 1000 patient days, hours of seclusion per 1000 patient days, available from an electronic registration system, data available per quarter
<b>Beschreibung Ergebnisse</b>	the number of seclusion incidents per 1000 patient days decreased from 15 in the first quarter of the study period to three in the last quarter of the study period. The number of hours spent in seclusion by the patients of the experimental ward decreased from 934 hours/1000 patient days at the first measurement in 2008 to 62 hours/1000 patient days at the last measurement in 2010. On the control wards, the number of seclusion incidents per 1000 patient days was 11 during the first quarter of the study and 12 during the last quarter of the study. The first measurement in 2008 showed 398 hours spent in seclusion, whereas the last measurement in 2010 showed 356 hours spent in seclusion. There was a wide range, with 1016 hours spent in seclusion in the third quarter of 2009. The control wards showed no statistically-significant changes over time in the number of incidents or in the hours of seclusion. In contrast, the experimental ward differed statistically significantly from the control wards by a reduction in e number of seclusion incidents ( $P < 0.01$ ) and a reduction in the number of seclusion hours ( $P < 0.01$ ).
<b>Dauer</b>	
<b>Baseline/Intervention/Follo</b>	baseline 3 quaters, intervention 6 quarters

<b>w-up</b>	
<b>Funding</b>	not reported
<b>Qualitätsbemerkung</b>	no randomisation, no follow-up, no sample size calculation, no masking, nothing about individual treatment plans reported, construction of a artificial control group
<b>Nummer</b>	<b>10</b>
<b>Studie</b>	Bowers L; Brennan G; Flood C; Lipang M; Oladapo P (2006): Preliminary outcomes of a trial to reduce conflict and containment on acute psychiatric wards: City Nurses. In: J PSYCHIATR MENT HEALTH NURS 13 (2), S. 165–172. DOI: 10.1111/j.1365-2850.2006.00931.x.
<b>Institution</b>	St. Bartholomew School of Nursing and Midwifery, City University
<b>Studientyp</b>	Pretest-posttest-design
<b>Kontrollgruppe ja/nein</b>	no
<b>Komplex ja/nein</b>	no
<b>Interventionstyp</b>	Supervision/Carer Consultant, City Nurses
<b>n Patienten</b>	(284 shift reports at baseline, 1315 during the intervention, this represents a respond rate of 56 %)
<b>Effekt ja/nein auf S/R</b>	no
<b>Beschreibung Intervention</b>	City nurses work three days per week with the team on the wards, using the working model (Positive appreciation, emotional regulation, effective structure...) to reach low-conflict, low-containment and high-nursing standards
<b>Beschreibung Patienten</b>	acute psychiatric wards
<b>Beschreibung Outcomevariablen</b>	Patient–staff Conflict Checklist Shift Report (PCC-SR, This tick box checklist is completed at the end of each shift, and consists of 21 conflict behaviour items and 9 containment measures, for which definitions are provided.), Ward Atmosphere Scale (WAS), Attitude to Personality Disorder Questionnaire (APDQ), Maslach Burnout Inventory (MBI), Ward Structure Questionnaire (WSQ), Interaction–Observation Checklist (IOC)
<b>Beschreibung Ergebnisse</b>	At the level of main outcomes, conflict significantly decreased, but containment did not. The more detailed information on individual items shows that significant falls in aggression, absconding and self-harm were achieved. There was no significant alteration in medication-related conflict. The picture in relation to general rule breaking was more mixed, with refusal to get out of bed decreasing, but refusal to attend to personal hygiene increasing. With respect to containment measures, use of intermittent observation decreased. However, a new Trust policy released in 2003 discouraged the use of intermittent observation, therefore this fall cannot be credited to the intervention. Door locking increased during the intervention. Seclusion and restraint did not change significantly.

<b>Beschreibung sekundäre Ergebnisse</b>	There were no significant changes in the APDQ, MBI, MSQ and WSQ before and after the intervention. The WAS showed improvements in: the amount of support patients gave to each other and staff gave to patients; the degree of autonomy and independence of patients in making their own decisions; how much patients were orientated towards leaving hospital; and how much patients were expected to be concerned with their personal problems and feelings. Interaction rates significantly altered before and after the intervention. Positive interaction between staff and patients increased from a mean rate of 0.065 to 0.139 per observation ( $z=-3.19, P=0.001$ ), as did interactions rated as neutral (before=0.142, after=0.237, $z=-3.98, P < 0.001$ ).
<b>Dauer</b>	
<b>Baseline/Intervention/Follow-up</b>	3 month baseline, 1 year intervention
<b>Funding</b>	Square Smile Appeal and Henry Smith Charity
<b>Qualitätsbemerkung</b>	many scales, tests, nothing reported about adjustment for multiple testing, vague description

<b>Nummer</b>		11
<b>Studie</b>	Bowers L; Flood C; Brennan G; Allan T (2008): A replication study of the city nurse intervention: reducing conflict and containment on three acute psychiatric wards. In: J PSYCHIATRIC MENT HEALTH NURS 15 (9), S. 737–742. DOI: 10.1111/j.1365-2850.2008.01294.x.	
<b>Institution</b>	St. Bartholomew School of Nursing and Midwifery, City University	
<b>Studientyp</b>	Clinical Controlled trial	
<b>Kontrollgruppe ja/nein</b>	yes	
<b>Komplex ja/nein</b>	no	
<b>Interventionstyp</b>	Supervision/Carer Consultant, City Nurses	
<b>n Patienten</b>	?? (630 shift reports during baseline on experimental and 550 on control wards, 1444 during the intervention on experimental wards and 2692 on controls, this represents a response rate of 58 %)	
<b>Effekt ja/nein auf S/R</b>	no	
<b>Beschreibung Intervention</b>	City nurses work three days per week with the team on the wards, using the working model (Positive appreciation, emotional regulation, effective structure...) to reach low-conflict, low-containment and high-nursing standards	
<b>Beschreibung Patienten</b>	acute psychiatric wards	
<b>Beschreibung Outcomevariablen</b>	Patient–staff Conflict Checklist Shift Report (PCC-SR, This tick box checklist is completed at the end of each shift, and consists of 21 conflict behaviour items and 9 containment measures, for which definitions are provided.), Ward Atmosphere Scale (WAS), Attitude to Personality Disorder Questionnaire (APDQ), Maslach Burnout Inventory (MBI), Ward Structure Questionnaire (WSQ), Interaction–Observation Checklist (IOC)	
<b>Beschreibung Ergebnisse</b>	On the primary outcome measures of total conflict and total	

	containment, no significant change occurred on the experimental or control wards. The majority of conflict and containment items were also unchanged.
<b>Beschreibung sekundäre Ergebnisse</b>	Conflict and containment events both fell significantly between during the intervention period, the former by 20 % and the latter by 18 %.
<b>Dauer Baseline/Intervention/Follow-up</b>	3 month baseline, 1 year intervention
<b>Funding</b>	Square Smile Appeal and Henry Smith Charity
<b>Qualitätsbemerkung</b>	many scales, tests, nothing reported about adjustment for multiple testing, vague description

<b>Nummer</b>	12
<b>Studie</b>	Cibis, M. L.; Wackerhagen, C.; Muller, S.; Lang, U. E.; Schmidt, Y.; Heinz, A. (2016): Comparison of Aggressive Behavior, Compulsory Medication and Absconding Behavior Between Open and Closed door Policy in an Acute Psychiatric Ward. In: Psychiatrische Praxis. DOI: 10.1055/s-0042-105181.
<b>Institution</b>	Charité, UPK Basel
<b>Studientyp</b>	Pretest-posttest-design, retrospektiv
<b>Kontrollgruppe ja/nein</b>	nein
<b>Komplex ja/nein</b>	no
<b>Interventionstyp</b>	Türöffnung
<b>n Patienten</b>	980, davon 163 untergebracht
<b>Effekt ja/nein auf S/R</b>	no
<b>Beschreibung Intervention</b>	Türöffnung
<b>Beschreibung Patienten</b>	allgemeinpsychiatrische Patienten, u-a- mit Schizophrenie, affektiver Psychose, Sucht; > 50 % unfreiwillig nach PsychKG oder BGB)
<b>Beschreibung Outcomevariablen</b>	Entweichung, Zwangsmedikation, aggressive Übergriffe, Fixierung, besondere Sicherheitsmaßnahmen nach §29a (Isolierung)
<b>Beschreibung Ergebnisse</b>	Keine signifikante Reduktion von S/R
<b>Dauer Baseline/Intervention/Follow-up</b>	baseline: 8 Jahre (1995, 2002), Intervention 2 Jahre (2012, 2013)
<b>Funding</b>	keine Interessenskonflikte
<b>Qualitätsbemerkung</b>	Daten durch zweiszenzeitliche Änderung des Stationskonzepts kontaminiert (bspw. Trennung Männer Frauen aufgehoben, baseline enthält nur Männer, Intervention gemischt), andere Änderungen innerhalb von fast 20 Jahren wahrscheinlich

<b>Nummer</b>	13
<b>Studie</b>	CLARKE DE; BROWN A; GRIFFITH P (2010): The Brøset Violence Checklist: clinical utility in a secure psychiatric intensive care setting. In: J PSYCHIATR MENT HEALTH NURS 17 (7), S. 614–620. DOI:

	10.1111/j.1365-2850.2010.01558.x.
<b>Institution</b>	University of Manitoba, Health Science Center Winnipeg
<b>Studientyp</b>	interrupted time-series
<b>Kontrollgruppe ja/nein</b>	no
<b>Komplex ja/nein</b>	no
<b>Interventionstyp</b>	Early Interventions// Structured Risk Assessment, BVC
<b>N Patienten</b>	48
<b>Effekt ja/nein auf S/R</b>	yes
<b>Beschreibung Intervention</b>	BVC completed for each patient, each shift for the first 72h
<b>Beschreibung Patienten</b>	PICU (11 beds) of an acute psychiatric ward, PICU for most unstable and dangerous patients, 40/48 were involuntarily
<b>Beschreibung Outcomevariablen</b>	seclusion incidents (absolute count per month)
<b>Beschreibung Ergebnisse</b>	Using a modified case study approach, use of seclusion decreased dramatically for the duration of the 3-month trial. In the 2 months before the implementation of the BVC, there was an average of 30 episodes of seclusion per month. During the trial, the rate dropped to 12 per month, while after completion of the trial, the rate again increased, but only to 22 episodes per month.
<b>Dauer</b>	
<b>Baseline/Intervention/Follow-up</b>	baseline 2 months, intervention 3months, follow-up 2 months, for follow-ups after 1 and 5 years no data for S/R
<b>Funding</b>	Workers' Compensation Board of Manitoba
<b>Qualitätsbemerkung</b>	missing follow-up for seclusion an restraint data

<b>Nummer</b>	14
<b>Studie</b>	Cummings, Kathleen S.; Grandfield, Sylvia A.; Coldwell, Craig M. (2010): Caring with comfort rooms. Reducing seclusion and restraint use in psychiatric facilities. In: Journal of psychosocial nursing and mental health services 48 (6), S. 26–30. DOI: 10.3928/02793695-20100303-02.
<b>Institution</b>	New Hampshire Hospital, Concorde, New Hampshire/ Edith Nourse Rogers Memorial Veterans Hospital, Bedford, Massachusetts
<b>Studientyp</b>	Clinical Controlled trial
<b>Kontrollgruppe ja/nein</b>	yes
<b>Komplex ja/nein</b>	no
<b>Interventionstyp</b>	Sensory modulation// Comfort Rooms
<b>Effekt ja/nein auf S/R</b>	No (just after exclusion of high users)
<b>Beschreibung Intervention</b>	light blue painted room, photo wallpaper, light dimmer, multisensory reclining chair, television, DVD, CD, calming music, books, puzzles, weighted blankets, stress balls, magazines
<b>Beschreibung Patienten</b>	one unit in a big psychiatric hospital, in the hospital: adults, children, primary direct receiving facility, > 2000 involuntarily admitted people annually
<b>Beschreibung</b>	frequency, duration and variance of seclusion and restraint (measures



<b>Outcomevariablen</b>	not further specified)
<b>Beschreibung Ergebnisse</b>	ANOVA showed no significant changes, after excluding 11 high utilizers (2 % of admissions) accounting for 15 % of episodes, 14 % of seclusion hours and 56 % of restraint hours, SPC (statistical process control) showed decrease in frequency, duration, variation in S/R
<b>Beschreibung sekundäre Ergebnisse</b>	89 % of patients reported a reduction in distress, nobody an increase in distress, 88 % of comfort room interventions did not progress to S/R
<b>Dauer Baseline/Intervention/Follow-up</b>	baseline plus intervention 9 months??
<b>Funding</b>	None
<b>Qualitätsbemerkung</b>	Outcome measures not specified, length of baseline and intervention period not specified, nothing about absolute episodes/durations and their relative declines, no sufficient data

<b>Nummer</b>	16
<b>Studie</b>	Donat, D. C. (1998): Impact of a mandatory behavioral consultation on seclusion/restraint utilization in a psychiatric hospital. In: Journal of behavior therapy and experimental psychiatry 29 (1), S. 13–19.
<b>Institution</b>	Western State Hospital, University of Virginia/School of Medicine Charlottesville
<b>Studientyp</b>	interrupted time-series//pre-posttest design
<b>Kontrollgruppe ja/nein</b>	no
<b>Komplex ja/nein</b>	yes
<b>Interventionstyp</b>	Behavioral therapy// Behavioral treatment plans
<b>n Patienten</b>	(inpatient census went from 319 - 245)
<b>Effekt ja/nein auf S/R</b>	yes
<b>Beschreibung Intervention</b>	Patients who exceeded the monthly criteria (a.o. 6x 72h) receive a behavioral treatment plan from the Behavior Management Committee
<b>Beschreibung Patienten</b>	adult psychiatric inpatients with severe and persistent psychiatric impairment in a state hospital, unclear if it is a longterm care facility
<b>Beschreibung Outcomevariablen</b>	mean S/R use per person
<b>Beschreibung Ergebnisse</b>	The data were analyzed by ANOVA utilizing a within-subjects design with repeated measures. This analysis revealed a significant effect for the before-after condition (seclusion/restraint utilization during the 6 months after approval of the treatment plan compared to seclusion/restraint use during the 6 months prior to approval of the plan), $F(52, 1)=11.03, p<0.01$ . There was significantly less seclusion/restraint utilization during the 6 months after approval of the plan. The analysis also revealed a significant interaction between the serial effect across months during the before period and the serial effect of months during the after period, $F(260, 5)=4.77,$

	p<0.01. The serial trend across the 6 months prior to approval of the plan was for increasing use of seclusion/restraint. The serial trend across the 6 months after approval of the treatment plan was for decreasing seclusion/restraint use.
<b>Dauer</b>	
<b>Baseline/Intervention/Follow-up</b>	6 months baseline, 6 months after implementation of the intervention
<b>Funding</b>	Not reported
<b>Qualitätsbemerkung</b>	insufficient reporting about patient population, especially setting, LOS, setting

<b>Nummer</b>	17
<b>Studie</b>	D'Orio, Barbara M.; Purselle, David; Stevens, Debbie; Garlow, Steven J. (2004): Reduction of episodes of seclusion and restraint in a psychiatric emergency service. In: Psychiatric services (Washington, D.C.) 55 (5), S. 581–583. DOI: 10.1176/appi.ps.55.5.581.
<b>Institution</b>	Emory University, Grady Memorial Hospital Atlanta
<b>Studientyp</b>	Pretest-posttest-design, retrospective
<b>Kontrollgruppe ja/nein</b>	no
<b>Komplex ja/nein</b>	yes
<b>Interventionstyp</b>	complex, comprehensive plan for early identification and management of problem behaviors
<b>n Patienten</b>	(1327 patient contacts per month, 484 were admitted to the observation area)
<b>Effekt ja/nein auf S/R</b>	yes
<b>Beschreibung Intervention</b>	response team for behavioral emergencies, two-way radios on the wards, verbal de-escalation training, identification of prodromal behaviors with a rating scale and management with verbal de-escalation, medication, time-outs, increasing existing video surveillance
<b>Beschreibung Patienten</b>	Approximately 38 percent of psychiatric emergency service patients are admitted to the observation area. At any given time, there are seven to 22 patients in the observation unit. The most common diagnoses seen in psychiatric emergency services are substance use disorders (35 percent), psychotic disorders (25 percent), unipolar mood disorders (13 percent), bipolar disorders (11 percent), adjustment disorders (6 percent), and anxiety disorders (2 percent). The remaining 8 percent of the diagnoses each have an occurrence of less than 2 percent.
<b>Beschreibung Outcomevariablen</b>	Number of S/R episodes per month, compliance rate with performance improvement measures
<b>Beschreibung Ergebnisse</b>	The mean±SD for the number of episodes of seclusion and restraint per month was 65.2±9.4 before implementation and 38.1±12 after implementation (F=28.5, df=1, 16, p< .001), which represents a 39 percent reduction in the number of episodes of seclusion and

	restraint. New joint commission regulations instituted in January 2001 did not significantly alter the postintervention levels of seclusion and restraint. Implementation was associated with greater compliance with performance improvement measures for seclusion and restraint. ( $F=890.5$ , $df=1, 16$ , $p<.001$ ).
<b>Beschreibung sekundäre Ergebnisse</b>	Before implementation, the mean monthly compliance rate was $96\pm.22$ percent, and after implementation, it was $100\pm.23$ percent
<b>Dauer</b>	
<b>Baseline/Intervention/Follow-up</b>	9 months baseline, 9 months after implementation of the intervention
<b>Funding</b>	Not reported

<b>Nummer</b>	18
<b>Studie</b>	Espinosa, L.; Harris, B.; Frank, J.; Armstrong-Muth, J.; Brous, E.; Moran, J.; Giorgi-Cipriano, J. (2015): Milieu improvement in psychiatry using evidence-based practices: the long and winding road of culture change. In: Archives of psychiatric nursing 29 (4), S. 202–207. DOI: 10.1016/j.apnu.2014.08.004.
<b>Institution</b>	New York-Presbyterian Hospital
<b>Studientyp</b>	time series
<b>Kontrollgruppe ja/nein</b>	no
<b>Komplex ja/nein</b>	yes
<b>Interventionstyp</b>	Complex
<b>n Patienten</b>	(big hospital with 350 patients)
<b>Effekt ja/nein auf S/R</b>	yes
<b>Beschreibung Intervention</b>	Interventions were multiple, including intensive multi-modal staff education based on the literature review and starting in orientation, introduction of comfort rooms, changes in debriefing practices, careful review of all seclusion and restraint episodes, introduction of integrative modalities (activities, nursing presence, early identification and management, communication, shared tea time), and careful review of all 1:1 observation and review of unit structure (vital signs later in the morning), reminders/posters on the ward.
<b>Beschreibung Patienten</b>	facility is treating children, adolescents and adults with a wide variety of psychiatric diagnoses on 15 separate inpatient units
<b>Beschreibung Outcomevariablen</b>	S/R incidents per year, patient and staff satisfaction on a 0-100 % Likert Scala
<b>Beschreibung Ergebnisse</b>	As the most restrictive intervention, restraints declined (from 282 in 2005 to 16 in 2014), and seclusion rates increased temporarily (from 28 in 2005 to 435 in 2006) and then began to decline (to 53 in 2014). Initially we found that only 50 % of the incidents were judged to have been unpreventable. Now, 6 years into the project, there are fewer than 5 % in which our reviewers felt that an alternative intervention might have been successful.
<b>Beschreibung sekundäre</b>	Patient satisfaction and staff scores have improved.

<b>Ergebnisse</b>	
<b>Dauer</b>	
<b>Baseline/Intervention/Follow-up</b>	10 years reported, time of intervention not clear
<b>Funding</b>	Not reported
<b>Qualitätsbemerkung</b>	not reported when which interventions were implemented
<b>Nummer</b>	19
<b>Studie</b>	Fisher, W. A. (2003): Elements of successful restraint and seclusion reduction programs and their application in a large, urban, state psychiatric hospital. In: Journal of psychiatric practice 9 (1), S. 7–15.
<b>Institution</b>	Creedmoor Psychiatric Center
<b>Studientyp</b>	time series ??
<b>Kontrollgruppe ja/nein</b>	no
<b>Komplex ja/nein</b>	yes
<b>Interventionstyp</b>	Complex, Especially shorter duration of physicians S&R order, new training programs, new dual debriefing process
<b>n Patienten</b>	(Creedmoor admits approximately 50 recipients per month. The hospital operates 19 wards with a typical census of 26 recipients per ward (fewer on its Secure Care ward).)
<b>Effekt ja/nein auf S/R</b>	yes
<b>Beschreibung Intervention</b>	the performance improvement workgroup administered an identical survey to both staff and recipients, new staff training curriculum (this curriculum put greater emphasis on increasing staff sensitivity to situations which may lead to violence and training staff in noncoercive measures of de-escalating potentially violent situations), 8-hour curriculum entitled “Creating A Respectful Environment”, use of two types of post-event discussions: 1. “post-event analysis” which takes place immediately after the application of restraint or seclusion and involves the staff members who participated in the intervention along with supervisory staff who review the concrete handling of the situation while it is still fresh in their minds, look at what might have been done differently to avoid restraint or seclusion, and make a short-term plan to avoid a repetition of the intervention. 2. “debriefing” that includes the recipient and his or her regular treatment team and involves a more detailed behavior analysis, from both the recipient’s and the team’s points of view, of the events leading up to the intervention and more long-range planning to avoid a repetition of the restraint or seclusion, data usage and Benchmarking, better treatment interventions (DBT, avoid psychopharmacologic complacency, aggressive use of clozapine), reduction of physician’s of S/R order duration from 4 to 2 and then 1 hour.
<b>Beschreibung Patienten</b>	Creedmoor’s inpatient division provides intermediate and extended psychiatric hospitalization to mentally ill individuals over 18 years of

	age who remain dangerous to others or actively or passively dangerous to self despite acute treatment (averaging 3–6 weeks in duration) in the psychiatric units of local general hospitals. Creedmoor also admits mentally ill individuals from the New York City jail system.
<b>Beschreibung Outcomevariablen</b>	S/R orders per 1000 recipient days, combined hours of S/R per 1000 recipient days
<b>Beschreibung Ergebnisse</b>	Creedmoor experienced a 67 % decline in its rate between 1999 and 2001 and went from being 46 % above the average state rate to 44 % below it. Since virtually 100 % of recipients were spending the full 4 hours in restraint or seclusion during 1999, the decrease in combined hours of restraint and seclusion per 1,000 recipient days between 1999 and 2001 was approximately 92 %.
<b>Beschreibung sekundäre Ergebnisse</b>	QUAL: Among the actions that substantial numbers (> 35 %) of both staff and recipients felt would have a positive impact were increased staff politeness, more explanations of staff actions, fewer rules, more individualized expectations for participation in treatment activities, and the availability of more concrete de-escalation strategies (e.g., taking a shower or a walk) as opposed to verbal interventions and medication. Both staff and recipients (> 90 %) endorsed the value of post-restraint debriefings in preventing repeat occurrences. A large majority of both staff and recipients (> 85 %) endorsed the value of having staff, as part of their training, hear presentations from recipients who had a history of being restrained. In addition, about half of staff and recipients endorsed the value of staff experiencing restraint or seclusion as part of their training.
<b>Dauer Baseline/Intervention/Follow-up</b>	3 years observation ??
<b>Funding</b>	Not reported
<b>Qualitätsbemerkung</b>	No clear baseline, different interventions implemented step by step, contamination from former intervention-steps, where do effects come from??
<b>Nummer</b>	20
<b>Studie</b>	Flutters, F. A.; van Meijel, B.; Nijman, H.; Bjorkly, S.; Grypdonck, M. (2010): Preventing aggressive incidents and seclusions in forensic care by means of the 'Early Recognition Method'. In: Journal of clinical nursing 19 (11-12), S. 1529–1537. DOI: 10.1111/j.1365-2702.2009.02986.x.
<b>Institution</b>	Utrecht University/Department of Nursing Science, InHolland University, Radboud University, Ullevål University Hospital, Oslo
<b>Studientyp</b>	one-way case-crossover design
<b>Interventionstyp</b>	Early Interventions// Early Recognition Method (incl. collaborative care)

<b>n Patienten</b>	168
<b>Effekt ja/nein auf S/R</b>	yes
<b>Beschreibung Intervention</b>	ERM was conducted in 4 phases: 1. information of the patient, 2. extended list of early signs of aggression set up by the patient and his nurse-staff mentor, 3. collaborative monitoring the patient's behaviour and detecting early signs of loss of emotional equilibrium, 4. preventive actions are discussed with the patient and described in the early detection plan. When warning signs emerged, if possible, these actions were carried out to help the patient regain his self-control. ERM sessions between a patient and his staff mentor generally took approximately 30 minutes/week. The intervention was implemented as part of already existing weekly evaluations between patients and their mentors. All staff members working with patients on ERM-wards were trained (1-d-training) in applying this intervention
<b>Beschreibung Kontrolle</b>	TAU
<b>Beschreibung Patienten</b>	Of a total of 189 patients who were eligible to be included, 168 (88,9 %) actually were involved in the intervention and 21 (11,1 %) persistently refused to get involved. All of these 189 patients were males, involuntarily admitted and convicted of serious offences. The mean admission duration, as assessed in the middle of the 30 months study period, was 51 months (SD 35; range 3–176 months). main diagnosis: schizophrenia, anti-social PD, ASD, sexual deviation.
<b>Beschreibung Outcomevariablen</b>	the main outcome measures were the number of seclusions and the severity of incidents that led to these seclusions, as rated on the SOAS-R
<b>Beschreibung Ergebnisse</b>	For the involved patients (n = 168), a significant decrease in seclusions from 219 in TAU to 104 in ERM, [Chi-squared (1) = 22,82 p < 0,001] was found. The ERM observation period showed substantially lower aggression in comparison to the TAU period . To be more specific, the seclusion rate per patient per month decreased from a mean of 0,13 (SD 0,33, median = 0,000)–0,05 (SD 0,13, median = 0,000) (z = -4,264, p < 0,001, r = -0,23). The severity of the incidents, calculated by the incident-severity-index, decreased from 1,38 (SD 4,18, median = 0,000)–0,50 (SD 1,75, median = 0,000) (z = -4,071, p < 0,001, r = -0,22).
<b>Beschreibung sekundäre Ergebnisse</b>	Significant decreases in seclusions as well as severity of incidents were also found in the following patient subgroups: patients with schizophrenia patients with anti-social personality disorder and patients with substance abuse In patients (n = 58) who in TAU, at least had one incident with a SOAS-R-severity-score of 13 or higher a significant decrease in seclusions and a significant decrease of severity of incidents was also found. Patients convicted of sexual offences, on the other hand, did not show significant improvement after participation in the intervention. The intervention resulted in a small effect size for the total sample. A medium effect size was found

	for the subgroup of patients with substance abuse problems. This suggests that this last subgroup may have benefited most from the intervention. Finally, we found a negative correlation between the age of the patient and the decrease of the incident-severity-index.
<b>Dauer Baseline/Intervention/Follo w-up</b>	baseline: 2396 patient-months in total, post-intervention: 1995 patient-months in total
<b>Funding</b>	Not reported

<b>Nummer</b>	21
<b>Studie</b>	Forster, P. L.; Cavness, C.; Phelps, M. A. (1999): Staff training decreases use of seclusion and restraint in an acute psychiatric hospital. In: Archives of psychiatric nursing 13 (5), S. 269–271.
<b>Institution</b>	San Francisco Country Community Mental Health Services, John George Psychiatry Pavillon, Gateway Psychiatric Services
<b>Studientyp</b>	pretest-posttest-design
<b>Kontrollgruppe ja/nein</b>	no
<b>Komplex ja/nein</b>	no
<b>Interventionstyp</b>	Staff training
<b>n Patienten</b>	(2000 admissions for inpatient treatment per year)
<b>Effekt ja/nein auf S/R</b>	yes
<b>Beschreibung Intervention</b>	Management of Assaultive Behavior workgroup (multidisciplinary committee, recommend policy changes, leadership, developing a mandatory full-day-training), Training (3 goals: increase awareness of the factors leading to patient aggression, promote knowledge about less restrictive measures, increase safe staff reactions to violence; every staff member experienced 5-point restraint, administrative personal present during the training, explain goals especially staff members safety), weekly discussion items about S/R during team meetings, hospital-wide publicity charting the ongoing process
<b>Beschreibung Patienten</b>	acute-psychiatric hospital: 4 locked wards, 1 emergency service, LOS decreased during the study period from 16 to 9,14
<b>Beschreibung Outcomevariablen</b>	number and duration of seclusion and restraint episodes, number of staff injuries incurred during physical containment
<b>Beschreibung Ergebnisse</b>	The total annual rate of restraint decreased 13,8 % overall, from 2379 episodes per 2560 admissions in 1995, to 2380 episodes per 3010 admissions in 1996. The average duration of seclusion or seclusion and restraint per episode was reduced 54,6 %, from 13,9 hours/episode in 1995 to 6,3 hours/episode in 1996. Staff injuries were reduced 18,8 % from 48 incidents in 1995 to 39 in 1996.
<b>Dauer Baseline/Intervention/Follo w-up</b>	1 year baseline, 1 year post-intervention
<b>Funding</b>	Not reported
<b>Qualitätsbemerkung</b>	Contamination due to other changes (LOS decreases, admissions

	increase), all staff injuries should have been counted, not just those linked to containment
--	--

<b>Nummer</b>	22
<b>Studie</b>	Godfrey, Jenna L.; McGill, Amanda C.; Jones, Nicole Tuomi; Oxley, Stephen L.; Carr, Robyn M. (2014): Anatomy of a transformation: a systematic effort to reduce mechanical restraints at a state psychiatric hospital. In: PSYCHIATR SERV 65 (10), S. 1277–1280. DOI: 10.1176/appi.ps.201300247.
<b>Institution</b>	Central Regional Hospital, Butner, South Carolina
<b>Studientyp</b>	pretest-posttest-design
<b>Kontrollgruppe ja/nein</b>	no
<b>Komplex ja/nein</b>	yes
<b>Interventionstyp</b>	staff training and response team / policy change requires upper-management approval for S/R
<b>n Patienten</b>	2244
<b>Effekt ja/nein auf S/R</b>	yes
<b>Beschreibung Intervention</b>	Nonviolent Crises Intervention (NVCi) training program in deescalation techniques, forming a response team to assist in crises situations
<b>Beschreibung Intervention II</b>	S/R requires upper-management approval
<b>Beschreibung Patienten</b>	acute adult unit and community transition unit
<b>Beschreibung Outcomevariablen</b>	patients put in S/R per patients on the unit that day, manual holds, PRN, assaults on staff or consumers
<b>Beschreibung Ergebnisse</b>	After implementing training and crises response teams R was reduced in both units, after the additions policy change the number of R was again decreased on the admission ward, no decrease on the CTU because R were already eliminated, R decreased by 98 % on the AAU and by 100 % on the CTU, CTU had not used the intervention for 559 days. S and PNR decreased on AAU and increased in CTU, assaults and injuries were reduced in both units, manual holds stayed the same).
<b>Dauer</b>	
<b>Baseline/Intervention/Follow-up</b>	1 year baseline, 1 year after 1 intervention, 1 year after 2. intervention
<b>Funding</b>	No competing interests
<b>Qualitätsbemerkung</b>	Contamination of the 2. intervention by the first

<b>Nummer</b>	23
<b>Studie</b>	Gonzalez-Torres, Miguel Angel; Fernandez-Rivas, Aranzazu; Bustamante, Sonia; Rico-Vilademoros, Fernando; Vivanco, Esther; Martinez, Karmele et al. (2014): Impact of the creation and implementation of a clinical management guideline for personality disorders in reducing use of mechanical restraints in a psychiatric inpatient unit. In: The primary care companion for CNS disorders 16



	(6). DOI: 10.4088/PCC.14m01675.
<b>Institution</b>	University of the Basque-Country/Department of Neuroscience, Basurto University Hospital/Psychiatry Service, Granada University/Neuroscience Institute
<b>Studientyp</b>	Pretest-posttest-design, retrospective
<b>Kontrollgruppe ja/nein</b>	no
<b>Komplex ja/nein</b>	no
<b>Interventionstyp</b>	Specialized therapy for personality disorders// implementation of a guideline for the management of personality disorders
<b>n Patienten</b>	199 (87 baseline, 112 intervention=
<b>Effekt ja/nein auf S/R</b>	yes
<b>Beschreibung Intervention</b>	treatment guideline focussing on cluster B disorders and follows a psychodynamic perspective, guideline was developed and implemented collaboratively with key staff, guideline focusses on treatment plans, interpersonal interaction, reduction of conflicts NOT coercive measures
<b>Beschreibung Patienten</b>	young inpatients with a clinical diagnosis of personality disorder, mostly cluster b/Bordeline, only a minority had a stable partner or were employed
<b>Beschreibung Outcomevariablen</b>	patients with restraint use, relative and absolute risk reduction
<b>Beschreibung Ergebnisse</b>	Restraint use was reduced from 38 of 87 patients with personality disorders (43.7 %) to 3 of 112 (2.7 %), for a relative risk of 0.06 (95 % CI, 0.02–0.19) and an absolute risk reduction of 41 % (95 % CI, 29.9 %–51.6 %). Restraint use in patients with other diagnoses was also reduced to a similar extent.
<b>Beschreibung Nebenwirkungen</b>	The risk of being discharged against medical advice increased after the intervention, with a relative risk of 1.84 (95 % CI, 0.96–3.51).
<b>Dauer Baseline/Intervention/Follow-up</b>	1 year baseline, 1 year post-intervention
<b>Funding</b>	No fundings or conflicts of interest reported.
<b>Qualitätsbemerkung</b>	No. Of S/R per patient and duration of S/R not reported

<b>Nummer</b>	24
<b>Studie</b>	Guzman-Parra, J.; Aguilera, Serrano C.; Garcia-Sanchez, J. A.; Pino-Benitez, I.; Alba-Vallejo, M.; Moreno-Kustner, B.; Mayoral-Cleries, F. (2016): Effectiveness of a Multimodal Intervention Program for Restraint Prevention in an Acute Spanish Psychiatric Ward. In: Journal of the American Psychiatric Nurses Association 22 (3), S. 233–241. DOI: 10.1177/1078390316644767.
<b>Institution</b>	University regional hospital of malaga/department of mental health, biomedical research institute of malaga
<b>Studientyp</b>	Pretest-posttest-design, retrospective
<b>Kontrollgruppe ja/nein</b>	no

<b>Komplex ja/nein</b>	yes
<b>Interventionstyp</b>	Complex, Six Core Strategies
<b>n Patienten</b>	(1575 admissions, 158 required mechanical restraint, 249 restraining episodes in 2 years)
<b>Effekt ja/nein auf S/R</b>	yes
<b>Beschreibung Intervention</b>	4/6 Cores strategies: 1. Leadership and organizational changes - developing discussion groups, analyze data, review and update of the coercive-measures-protocol, reduction of frequency and duration of seclusion beomes quality indicator; 2. registration and monitoring of risk patients, 3. Nursing staff Training: de-escalation techniques and prevention (10 hours course, and weekly 1-hour-sessions), involvement of patients in the treatment program
<b>Beschreibung Patienten</b>	acute psychiatric ward
<b>Beschreibung Outcomevariablen</b>	probability of being restrained, total number od restraint and mean number of monthly incidents per 1000 patient days, mean duration of each episode of restraint, resasons for restraint
<b>Beschreibung Ergebnisse</b>	The probability of mechanical restraint use in a hospital admission decreased (year 2013 vs. 2012; adjusted odds ratio = .578), the total percentage of restrained patients fell from 15.07 % to 9,74 %, the total number of restraint hours was reduced from 2514 in 2012 to 1559 in 2013. There was a significant difference between the mean number of monthly incidents per 1000 patient days in 2012 (18.54 +-8.78) and in 2013 (8.53 +- 7.00; P= 0.005). However the mean duration of each episode increased from 15.33 to 18.35 (p= 0.03).
<b>Dauer</b>	
<b>Baseline/Intervention/Follow-up</b>	1 year baseline, 1 year post-intervention
<b>Funding</b>	None

<b>Nummer</b>	25
<b>Studie</b>	Guzman-Parra, Jose; Garcia-Sanchez, Juan A.; Pino-Benitez, Isabel; Alba-Vallejo, Mercedes; Mayoral-Cleries, Fermin (2015): Effects of a Regulatory Protocol for Mechanical Restraint and Coercion in a Spanish Psychiatric Ward. In: Perspectives in psychiatric care 51 (4), S. 260–267. DOI: 10.1111/ppc.12090.
<b>Institution</b>	University regional hospital of malaga/department of mental health, biomedical research institute of malaga
<b>Studientyp</b>	Pretest-posttest-design, retrospective
<b>Kontrollgruppe ja/nein</b>	no
<b>Komplex ja/nein</b>	no
<b>Interventionstyp</b>	institutional changes// Regulatory Protocol for Mechanical Restraint
<b>Effekt ja/nein auf S/R</b>	No??
<b>Beschreibung Intervention</b>	every episode ist registered centrally, indications for use are restricted, maximal duration 4hr, extension must be orderd by psychiatrist, nurse assesement every 15 minutes plus video

	monitoring instead of 30 minutes, medical assessment after 1 hour instead of 2 hours after beginning, staff received no training but written information
<b>Beschreibung Patienten</b>	acute psychiatric ward
<b>Beschreibung Outcomevariablen</b>	date and time of immobilization, reasons for restraint, patient cooperation, medication, staff involvement, time of suspending the measure, diagnosis
<b>Beschreibung Ergebnisse</b>	In 2005, 100 patients were restrained (accounting for 148 restraint episodes), and in 2012, a total of 82 patients were restrained (accounting for 164 restraint episodes). The percentage of patients restrained in 2005 was 18.2 %, compared to 15.1 % in 2012 ( $\chi^2 = 1.90$ , $p = .17$ ), with an odds ratio (OR) (2012 vs. 2005) of 0.80 (CI = 0.58–1.01; 95 %). The mean duration of each mechanical restraint episode decreased from 27.91 hr in 2005 to 15.33 hr in 2012 ( $Z = -0.52$ , $p < .01$ ), and the total number of restraint hours was also reduced from 4,131 to 2,514 in 2005 and 2012, respectively. The mean of restraint episodes per patient increased from 1.5 to 2 episodes in 2012 ( $Z = -2.10$ , $p < .05$ ).
<b>Beschreibung sekundäre Ergebnisse</b>	In 2012, there was an increase in using medication together with mechanical restraint measures ( $\chi^2 = 9.99$ , $p < .01$ ).
<b>Dauer Baseline/Intervention/Follow-up</b>	1 year baseline, 1 year post-intervention (7 years later)
<b>Funding</b>	None

<b>Nummer</b>	26
<b>Studie</b>	Hamilton, Bridget; Love, Anna (2010): Reducing reliance on seclusion in acute psychiatry. In: Australian nursing journal (July 1993) 18 (3), S. 43.
<b>Institution</b>	St. Vincent's Mental Health (SVMH)
<b>Studientyp</b>	time series?? Pre-post??
<b>Kontrollgruppe ja/nein</b>	no
<b>Komplex ja/nein</b>	yes
<b>Interventionstyp</b>	complex, local seclusion reduction plan
<b>Effekt ja/nein auf S/R</b>	yes
<b>Beschreibung Intervention</b>	commission of a working group, one-day-training-program "Creating Safety", changing seclusion policies, piloting a Emergency Response Team made up of senior clinicians and managers
<b>Beschreibung Patienten</b>	acute unit
<b>Beschreibung Outcomevariablen</b>	seclusion events
<b>Beschreibung Ergebnisse</b>	the rate of seclusion declined markedly over the course of the project, from 474 events in 2006 to 186 in 2008 and 200 in 2009
<b>Dauer Baseline/Intervention/Follow-up</b>	4 years observation?

<b>w-up</b>	
<b>Funding</b>	NHMRC NICS Fellowship
<b>Qualitätsbemerkung</b>	unsufficient reporting about patientst, admissions, development of S/R rates over time, e.g. in 2007

<b>Nummer</b>	27
<b>Studie</b>	Hellerstein, D. J.; Staub, A. B.; Lequesne, E. (2007): Decreasing the use of restraint and seclusion among psychiatric inpatients. In: Journal of psychiatric practice 13 (5), S. 308–317. DOI: 10.1097/01.pra.0000290669.10107.ba.
<b>Institution</b>	New York State Psychiatric Institute, Columbia University College of Physicians and Surgeons
<b>Studientyp</b>	pretest-posttest-design
<b>Kontrollgruppe ja/nein</b>	no
<b>Komplex ja/nein</b>	yes
<b>Interventionstyp</b>	Complex
<b>Untersuchungseinheit</b>	
<b>n Patienten</b>	
<b>Effekt ja/nein auf S/R</b>	yes
<b>Beschreibung Intervention</b>	duration of physicians S/R order declined from 4 to 2 hours, staff training, clinical director has to ecaluate all patientst with 2 or mor consecutive S/R episodes, relaxing off-unit privilegues, Coping Agreement Questionnaire is filled out from patient and nurse together
<b>Beschreibung Patienten</b>	patients suffering from schizophrenia, schizoffective disorder, mood disorders, anxiety disorders, substantial abuse, eating disorders, two research and one general units
<b>Beschreibung Outcomevariablen</b>	number of individuals secluded, restrained per number of individuals admitted during reporting unit, number of hours al clients spent in S, R per number of inpatient hours in the reporting period, patient-related staff-injuriy, fights/assaults, elopments
<b>Beschreibung Ergebnisse</b>	The number of patients placed in restraints did not change (from $0.35 \pm 0.6$ to $0.32 \pm 0.5$ patients/month), although there was a numerical (but not statistically significant) decrease in the number of hours that patients were restrained (from $1.7 \pm 1.2$ to $1.0 \pm 2.4$ hours/month). However, all seclusion variables showed a dramatic and statistically significant decrease. After September 1, 2000, the number of patients secluded dropped from $3.1 \pm 1.4$ to $1.0 \pm 1.1$ patients/month and the number of hours in seclusion dropped from $41.6 \pm 52$ to $2.7 \pm 4.5$ hours/month.
<b>Beschreibung Nebenwirkungen</b>	Two of the three secondary outcomes—number of elopements per month and number of patient-related staff injuries per month—demonstrated significant decreases during the course of our follow-up . There was also a numerical (although not statistically significant) decrease in fights and assaults. Elopements averaged

	1.05 ± 1.2 per month in the 20 months prior to the project, 1.0 ± 0.95 per month in the first year following the implementation of the project, and then decreased to 0.58 ± 0.67, 0.43 ± 0.67, 0.0 ± 0, 0.0 ± 0, and 0.17 ± 0.39 per month in the following years after improved off-unit escort staffing.
<b>Dauer Baseline/Intervention/Follow-up</b>	20 months baseline, 67 months after starting interventions
<b>Funding</b>	not reported
<b>Qualitätsbemerkung</b>	interventions were introduced over time, no reporting about this, no clear interventions point, not reported in 1000 patient hours

<b>Nummer</b>	28
<b>Studie</b>	Hoch, Jeffrey S.; O'Reilly, Richard L.; Carscadden, Judith (2006): Relationship management therapy for patients with borderline personality disorder. In: Psychiatric services (Washington, D.C.) 57 (2), S. 179–181. DOI: 10.1176/appi.ps.57.2.179.
<b>Institution</b>	Center for Research on Inner City Health at St. Michael's Hospital in Toronto, Ontario, department of health policy, management and evaluation at the University of Toronto, Regional Mental Health Care in London, Ontario, Department of Psychiatry at the University of Western Ontario in London, Ontario
<b>Studientyp</b>	pretest-posttest-design, retrospective
<b>Kontrollgruppe ja/nein</b>	no
<b>Komplex ja/nein</b>	no
<b>Interventionstyp</b>	Specialized therapy for personality disorders// Relationship Management Therapy
<b>n Patienten</b>	27
<b>Effekt ja/nein auf S/R</b>	yes
<b>Beschreibung Intervention</b>	With relationship management therapy, patients choose their own treatment, limited only by the availability of resources and by professional standards of practice. A fundamental, and perhaps counterintuitive, aspect of this type of therapy is that a patient who requests hospitalization will be admitted if a bed is available. Patients are always admitted on a voluntary status, allowed to leave if they request discharge, and given full privileges throughout their hospital stay. The model requires that patients who engage in or threaten self-harm or aggressive behavior are discharged from the inpatient part of the program for 24 hours, S/R are not allowed.
<b>Beschreibung Patienten</b>	patients aged 18-64 years, meeting DSM-IV criteria for borderline personality disorder
<b>Beschreibung Outcomevariablen</b>	incidents of self-harm, hours of S, R, constant nursing observation
<b>Beschreibung Ergebnisse</b>	No differences were seen in the mean number of hours in

	seclusion (from 12±34 hours in the year before enrollment to 9±36 hours in the year during enrollment). Sizeable and statistically significant differences were seen in the mean annual number of hours in restraints (from 33±135 hours to 1±3 hours; $p < .01$ for Wilcoxon signed-rank test) and constant nursing observation (from 95±342 hours to 4±14 hours; $p < .001$ for Wilcoxon's signed-rank tests). Overall, self-harm incidents declined significantly, from 2±3 per year before enrollment in the relationship management therapy program to none during the time that patients were enrolled in this program ( $p < .001$ for Wilcoxon's signed-rank tests).
<b>Dauer Baseline/Intervention/Follow-up</b>	at least 12 months baseline per patient, and 12 months for the intervention
<b>Funding</b>	Financial support from career scientist award from the ontario ministry of health and long term care
<b>Qualitätsbemerkung</b>	insufficient reporting over time??

<b>Nummer</b>	29
<b>Studie</b>	Jones, D. W. (1997): Pennsylvania hospital continues to reduce seclusion and restraints. In: Joint Commission perspectives. Joint Commission on Accreditation of Healthcare Organizations 17 (2), S. 17.
<b>Institution</b>	Haverford State Hospital in Harverford, Penn
<b>Studientyp</b>	pre-post-design
<b>Kontrollgruppe ja/nein</b>	no
<b>Komplex ja/nein</b>	no
<b>Interventionstyp</b>	Staff training
<b>Effekt ja/nein auf S/R</b>	yes
<b>Beschreibung Intervention</b>	The staff development instructos (leadership?) on the treatment units are reinforcing our process by education direct care staff in methods of effectively managing critical situations/aggressive behaviors (cultural change?)
<b>Beschreibung Patienten</b>	seriously, persistently mentally ill inpatients, longterm care?
<b>Beschreibung Outcomevariablen</b>	S/R patients/incidents/Hours for 1000 inpatient days
<b>Beschreibung Ergebnisse</b>	secluded patients (per 1000 inpatient days, 1995 vs. 1996) 0.76 -> 0.2, seclusion incidents 1.24 -> 0.20, seclusion hours 1.92 -> 0.19, restrained patients 0,78-> 0.34, restraint incidents 1.64 -> 0.45, restraint hours 3.72 -> 1.44
<b>Dauer Baseline/Intervention/Follow-up</b>	2 consecutive years during changes that happened during many years
<b>Funding</b>	not reported
<b>Qualitätsbemerkung</b>	insufficient reporting about interventions and changes, anderes

	Versorgungssystem (eher wie Heim??)
<b>Nummer</b>	30
<b>Studie</b>	Jonikas, J. A.; Cook, J. A.; Rosen, C.; Laris, A.; Kim, J. B. (2004): A program to reduce use of physical restraint in psychiatric inpatient facilities. In: Psychiatric services (Washington, D.C.) 55 (7), S. 818–820. DOI: 10.1176/appi.ps.55.7.818.
<b>Institution</b>	Department of Psychiatry at the University of Illinois at Chicago, Center on Mental Health Services Research and Policy
<b>Studientyp</b>	pre-post-design
<b>Komplex ja/nein</b>	yes
<b>Interventionstyp</b>	Patient interviewing, staff training
<b>n Patienten</b>	1910 adult patients treated during this time
<b>Effekt ja/nein auf S/R</b>	yes
<b>Beschreibung Intervention</b>	One component of the program involved interviewing patients (in the first 24 h after intake) to determine their stress triggers and personal crisis management strategies. So patients personal strategies can be used during hospitalization if these techniques are documented before agitation or anger occurs. The second consisted of training staff members in crisis deescalation and nonviolent intervention.
<b>Beschreibung Patienten</b>	youths (not relevant to the review), general psychiatric unit and research unit where people generally suffer from psychotic and mood disorders.
<b>Beschreibung Outcomevariablen</b>	The rate was defined as the total number of patient-hours in restraints that quarter, divided by the number of patient-days (the daily patient census summed for all days of the quarter). This number was then multiplied by 24 and then by 1,000.
<b>Beschreibung Ergebnisse</b>	The general psychiatry unit experienced an 85 percent decrease in restraint rate one quarter after the training and a 99 percent decrease two quarters after the training. Once again the rate remained low during the final two quarters of the evaluation period. The clinical research unit experienced a 51 percent decrease in the restraint rate in the quarter after crisis management training and a 49 percent decrease in the quarter after nonviolent crisis intervention training. In the two quarters after both trainings had occurred, the rate declined by 98 percent and remained low (at zero) for the final two quarters.
<b>Dauer Baseline/Intervention/Follow-up</b>	4-5 quarters baseline, 1-2 quarters implementation of intervention, 4 quarters postintervention/follow up
<b>Funding</b>	This study was funded by the National Institute on Disability and Rehabilitation Research, U.S. Department of Education, and the Center for Mental Health Services, and by cooperative agreement H-133B-000700 from the Substance Abuse and

	Mental Health Services Administration.
<b>Nummer</b>	31
<b>Studie</b>	Jungfer, Hermann-Alexander; Schneeberger, Andres R.; Borgwardt, Stefan; Walter, Marc; Vogel, Marc; Gairing, Stefanie K. et al. (2014): Reduction of seclusion on a hospital-wide level: successful implementation of a less restrictive policy. In: Journal of psychiatric research 54, S. 94–99. DOI: 10.1016/j.jpsychires.2014.03.020.
<b>Institution</b>	Universitäre psychiatrische Klinik, Universitätsklinikum Hamburg-Eppendorf, Psychiatrie Dienste Graubünden
<b>Studientyp</b>	pre-post-design, 2 y longitudinal hospital wide observational study
<b>Kontrollgruppe ja/nein</b>	no
<b>Komplex ja/nein</b>	no
<b>Interventionstyp</b>	Türöffnung
<b>n Patienten</b>	Phase 1: 573 cases (!) on closed wards, 674 cases on closed wards that were newly opened in phase 2, 99 on open wards. Phase 2: 926 for closed wards, 353 for newly opened wards, 193 for open wards.
<b>Effekt ja/nein auf S/R</b>	yes
<b>Beschreibung Intervention</b>	Opening 2 of 4 closed wards, This step was prepared through an extensive planning period and supported by strong, constant top-down leadership. In the two previously closed wards, which were permanently opened during the study period, no specific changes concerning the therapeutic setting and/or personnel were implemented. However, in the whole hospital (open and closed wards) one-to-one care was increased in crisis situations, personnel was trained in deescalation strategies, psychotherapeutic approaches were implemented, and crisis management for suicidality and aggression was standardized.
<b>Beschreibung Patienten</b>	Psychiatric University Hospital with 6 general admissions wards, patients whose inpatient treatment was completed in Phase 1 or 2
<b>Beschreibung Outcomevariablen</b>	Change in patients subjected to seclusion and change in patients subjected to forced medication on a hospital-wide level was defined as main outcome criterion. Chi-square tests were performed to compare the percentage of seclusions and forced medications during the two analysis periods.
<b>Beschreibung Ergebnisse</b>	On a hospital-wide level, the percentage of patients with at least one seclusion during AP2 was significantly lower than during AP1 ( $\chi^2(1)=5.8; p=.016$ ), while there was no significant change in forced medication ( $\chi^2(1)=.08; p=.775$ ).
<b>Beschreibung sekundäre Ergebnisse</b>	On a ward-type level, there were no significant changes regarding the percentage of patients with at least one seclusion on closed (AP1: 75 (13.1 %); AP2: 151 (16.3 %); $\chi^2(1)=2.9; p=.091$ ) and open (AP1: 0 (0 %); AP2: 4 (2.1 %); $\chi^2(1)=2.1; p=.149$ ) wards. For newly opened wards, the number of patients with at least one seclusion changed significantly from 110 (15.9 %) in AP1 to 1 (3 %) in AP2



	( $c2(1)=59.8;p<.001$ ). The number of forced medications increased significantly on closed wards (AP1: 17 (3.0 %); AP2: 50(5.4 %); $c2(1)=4.9;p=.027$ ) and decreased significantly on newly opened wards (AP1: 34 (4.9 %); AP2: 0 (0 %); $c2(1)=17.9;p<.001$ ).There were no significant changes regarding open wards (AP1:0 (0 %); AP2: 2 (1.0 %); $c2(1)=1.0;p=.309$ ).
<b>Dauer Baseline/Intervention/Follo w-up</b>	1 year baseline, 1 year postintervention
<b>Funding</b>	none
<b>Qualitätsbemerkung</b>	contamination through the other programs, nothing reported on changed admission policies (patients not randomized)

<b>Nummer</b>	32
<b>Studie</b>	Keski-Valkama, A.; Sailas, E.; Eronen, M.; Am Koivisto; Lonqvist, J.; Kaltiala-Heino, R. (2007): A 15-year national follow-up: legislation is not enough to reduce the use of seclusion and restraint. In: Social psychiatry and psychiatric epidemiology 42 (9), S. 747–752. DOI: 10.1007/s00127-007-0219-7.
<b>Institution</b>	Vanha Vaasa Hospital, National Research Center for Welfare and Health, Helsinki, Finland, Kellokoski Hospital, Tampere University, University of Helsinki...
<b>Studientyp</b>	repeated survey
<b>Kontrollgruppe ja/nein</b>	no
<b>Komplex ja/nein</b>	no
<b>Interventionstyp</b>	Legislative changes
<b>Effekt ja/nein auf S/R</b>	no
<b>Beschreibung Intervention</b>	Finland joined the European Convention of Human Rights in 1990 and implemented the fundamental rights in 1995. The restriction of patients' freedom and the use of coercion in psychiatry are regulated by the Finnish Mental Health Act. In relation to using coercion, the Finnish Mental Health Act has been revised three times during three decades so that it has become more specific each time. However, the Mental Health Acts in 1978 and in 1991 did not include explicit regulations about the seclusion and restraint practices. In practice, local instructions regulated the use of seclusion and restraint at the hospital level until the partly revised Mental Health Act went into effect in 2002. Since then, the Act has focused on regulating the use of coercive measures during inpatient care. The intent of the reform was to specify the reasons for limiting the fundamental rights of the involuntarily treated patient as well as to clarify and standardise coercive practices.
<b>Beschreibung Patienten</b>	patients from psychiatric hospitals in Finland
<b>Beschreibung Outcomevariablen</b>	Number of secluded patients, secluded patients of all psychiatric inpatients, number of restrained patients, restrained patients of all

	psychiatric in-patients
<b>Beschreibung Ergebnisse</b>	The total number of seclusion and restraint incidents during the study week was 263 in 1990, 242 in 1991, 217 in 1994, 161 in 1998 and 129 in 2004. The total number of all hospitalised patients and the total number of the secluded and restrained patients decreased, but the risk for being secluded did not change during the study time when compared to the first study year. In the use of restraint, there was a slight decrease from index year 1990 to 1991, 1998 and 2004, but no linear trend was formed.
<b>Beschreibung sekundäre Ergebnisse</b>	The duration of the seclusions events increased over time, the duration of restraint events did not change.
<b>Dauer Baseline/Intervention/Follow-up</b>	15 years observation period
<b>Funding</b>	not reported
<b>Qualitätsbemerkung</b>	different legislative changes put together, some of them very inconcrete, not specific for Psychiatry (e.g. human rights)

<b>Nummer</b>	33
<b>Studie</b>	Khadivi, Ali None; Patel, Raman C.; Atkinson, Angela R.; Levine, Jeffery M. (2004): Association between seclusion and restraint and patient-related violence. In: Psychiatric services (Washington, D.C.) 55 (11), S. 1311–1312. DOI: 10.1176/appi.ps.55.11.1311.
<b>Institution</b>	department of psychiatry at Bronx-Lebanon Hospital Center and with Albert Einstein College of Medicine
<b>Studientyp</b>	pre-post-design, retrospective
<b>Kontrollgruppe ja/nein</b>	no
<b>Komplex ja/nein</b>	yes
<b>Interventionstyp</b>	complex
<b>Effekt ja/nein auf S/R</b>	yes
<b>Beschreibung Intervention</b>	The intervention was compatible with the mandates of JCAHO and included staff education, the addition of the history of inpatient violence to admission forms, continuous nursing monitoring to minimize the duration of episodes of seclusion and restraint, postepisode debriefing of the staff and the patient, and a review of each episode by the senior nurse and a physician. The intervention centered on early recognition of signs of agitation among patients and early clinical intervention.
<b>Beschreibung Patienten</b>	Patients in this hospital tend to be poor; are insured primarily through Medicaid or Medicare; tend to have severe and persistent mental illness, most often in the context of dual diagnosis; and are frequently admitted involuntarily.
<b>Beschreibung Outcomevariablen</b>	total number of episodes of S/R in the 12 months before and after the intervention examining the 2000 and 2001 central nursing books, episodes of violence against patients and staff and episodes of self-

	destructive behavior were determined from incident report files, other-directed violence was defined as any event in which there was unwanted physical contact with intent to harm
<b>Beschreibung Ergebnisse</b>	A significant decrease (52 percent reduction) was seen in the total number of episodes of seclusion and restraint from the 12 months before to the 12 months after the intervention ( $\chi^2=37.01$ , $df=2$ , $p<.001$ ).
<b>Beschreibung Nebenwirkungen</b>	The number of episodes of assaults on staff increased significantly, from 31 in the preintervention period to 83 in the postintervention period ( $\chi^2=31.9$ $df=2$ , $p<.001$ ). The number of episodes of assaults on patients also increased significantly, from 67 in the preintervention period to 85 in the postintervention period ( $\chi^2=5.52$ $df=2$ , $p<.05$ ).
<b>Dauer Baseline/Intervention/Follow-up</b>	1 year baseline, 1 year post-intervention
<b>Funding</b>	not reported
<b>Qualitätsbemerkung</b>	year 2000 seems to be baseline, 2001 post-intervention, unclear in which period this complex intervention was implemented

<b>Nummer</b>	34
<b>Studie</b>	Khazaal, Y.; Chatton, A.; Pasandin, N.; Zullino, D.; Preisig, M. (2009): Advance directives based on cognitive therapy: a way to overcome coercion related problems. In: Patient education and counseling 74 (1), S. 35–38. DOI: 10.1016/j.pec.2008.08.006.
<b>Institution</b>	Geneva University Hospitals; Department of Psychiatry/University Hospital Center and University of Lausanne
<b>Studientyp</b>	pre-post design
<b>Kontrollgruppe ja/nein</b>	no
<b>Komplex ja/nein</b>	no
<b>Interventionstyp</b>	Advance directives based on cognitive therapy
<b>n Patienten</b>	18
<b>Effekt ja/nein auf S/R</b>	no (not for seclusion but for hospitalization, compulsory admissions, LOS)
<b>Beschreibung Intervention</b>	Specific therapeutic sessions (mean = 4 sessions; S.D. = 1.6; range of 2–8) were dedicated to help patients to prepare ADs. Cognitive therapy sessions based on a Socratic exploration of what is happening attempt to enhance the patients' skill to write their ADs and to improve coping with their disorder. The intervention is divided into seven phases: (1) legal information about ADs, (2) exploration of cognitive representation of illness, (3) concerns about previous treatments including compulsory admission procedures (patients' experiences with treatments, restraint and seclusion procedures. Explore the cases in which specific measures are considered acceptable or not by the patient), (4) elaboration of long-term prevention strategies, including the conception of how to cope

	with prodroms of mania or depression in the future, (5) establishment of the ADs, obligatory signed and approved by the patient, (6) application of the ADs during the next crisis and (7) re-evaluation of the suitability of the ADs.
<b>Beschreibung Patienten</b>	12 suffering from bipolar disorder, 6 from schizophrenia, average age 40 year, 61 % women, time since first contact with psychiatric services 9 years (SD 5,2 years), 22.2 % active substance abuse dependence, 13 hospitalizations (SD 7.5), duration of hospitalizations 21.9 months (SD 4.3) time since the first ADDs 29.2 months (SD 4.2), subjects have a past history of compulsory admissions (4.9, SD 3.4), During the year preceding ADBCT, all patients revealed non-adherence or irregular compliance to treatment. The following mood stabilizing or antipsychotic agents were prescribed prior to ADBCT: lithium (8), valproate (12), carbamazepine (1), lamotrigine (2), clozapine (3), olanzapine (6), quetiapine (4).
<b>Beschreibung Outcomevariablen</b>	(Hospitalizations, Compulsory admissions), days spent in a locked room, (days spent in psychiatric hospital)
<b>Beschreibung Ergebnisse</b>	The number of hospitalizations and compulsory admissions, as well as the number of days spent in a psychiatric hospital decreased significantly after ADs, whereas the diminution of the number of days spent in a locked room was not statistically significant.
<b>Dauer Baseline/Intervention/Follow-up</b>	Number and duration of psychiatric hospitalizations for a mood or a psychotic episode as well as compulsory admissions and seclusion procedures were recorded for each patient 2 years before ADBCT and during a follow-up period of at least 24 months.
<b>Funding</b>	not reported

<b>Nummer</b>	35
<b>Studie</b>	Laker C; Gray R; Flach C (2010): Case study evaluating the impact of de-escalation and physical intervention training. In: J PSYCHIATRIC MENTAL HEALTH NURS 17 (3), S. 222–228. DOI: 10.1111/j.1365-2850.2009.01496.x.
<b>Institution</b>	Health Service & Population Research Department, Institute of Psychiatry, King's College/London; Faculty of Health, Nursing and Midwifery, University of East Anglia
<b>Studientyp</b>	pre-post design
<b>Kontrollgruppe ja/nein</b>	no
<b>Komplex ja/nein</b>	no
<b>Interventionstyp</b>	Staff training
<b>n Patienten</b>	195 patients (96 pre and 103 post training, 3 patients available in both periods) admitted to the PICU during this timeframe and 266 incidents by 86 different service users
<b>Effekt ja/nein auf S/R</b>	no
<b>Beschreibung Intervention</b>	physical intervention training about restraint but with emphasis on prevention and de-escalation

<b>Beschreibung Patienten</b>	PICU-patients, majority was male and from ethnical minorities, had schizophrenia, bipolar disorder or substance dependence, some were in hospital involuntarily
<b>Beschreibung Outcomevariablen</b>	incident rate ratio (IRR) pre and post training, severe IRR, IRR for RT and hands on
<b>Beschreibung Ergebnisse</b>	1. The pre- and post-training groups were similar by the characteristics analysed. 2. The incident rates after training were not significantly lower than before training (IRR = 0.986, 95 % CI = 0.75–1.29, P = 0.920). 3. The odds of a severe incident were not significantly lower after training than before training (Odds Ratio = 0.58, 95 % CI 0.32–1.03, P = 0.064). 4. Adjustment for demographics made no difference to the conclusions drawn and had little impact on the estimates.
<b>Dauer Baseline/Intervention/Follow-up</b>	6 months baseline, 6 months after training
<b>Funding</b>	not reported
<b>Qualitätsbemerkung</b>	seclusion events not mentioned

<b>Nummer</b>	36
<b>Studie</b>	Lewis M; Taylor K; Parks J (2009): Crisis prevention management: a program to reduce the use of seclusion and restraint in an inpatient mental health setting. In: ISSUES MENT HEALTH NURS 30 (3), S. 159–164. DOI: 10.1080/01612840802694171.
<b>Institution</b>	Department of Psychiatric Nursing/John Hopkins Hospital Baltimore
<b>Studientyp</b>	time series?, retrospective for 2004-6, prospective for 2007
<b>Kontrollgruppe ja/nein</b>	no
<b>Komplex ja/nein</b>	yes
<b>Interventionstyp</b>	complex, Crisis Prevention Management
<b>n Patienten</b>	(88 beds for psychiatric inpatients in a 900 bed hospital)
<b>Effekt ja/nein auf S/R</b>	yes
<b>Beschreibung Intervention</b>	Structured risk assessment (Phipps Aggression Screening Tool), Personal Safety Plan (including early warning symptoms, specific actions to decrease stress), Daily Safety Focused Community Meeting, Family Style Meals Program, leisure activities, staff made a concerted effort to be in patient environment rather than in nurses' station, Milieu Rounds (staff meetings to discuss patients or safety issues), expansion of yearly staff education, use the least restrictive alternative, Patient Support Sheet (incl patient's target symptoms, effective interventions, instances when it will be imperative to report to the nurse) for one-to-one observers, Comfort Carts and Comfort Rooms, patient debriefing after S/R
<b>Beschreibung Patienten</b>	Patients may have voluntary or involuntary status. A large percentage of the population served by the department has a comorbid Axis I substance abuse diagnosis. A significant number of

	patients, over 20 % in the clinic, selfreport a history of recent aggression including making threats or hitting someone in the hospital. Twenty percent have been secluded, restrained, or required constant observation during past hospitalizations.
<b>Beschreibung Outcomevariablen</b>	total hours of seclusion and restraint, seclusion and restraint per 1000 patient hours a year, repeated restraints/seclusion
<b>Beschreibung Ergebnisse</b>	Each unit experienced a decrease in the use of restraint ranging from 20–97 %. Three of the four units had a decrease in the use of seclusion ranging from 30–63 %. Seclusion and restraint per 1000 patient hours a year also decreased (at least at a hospital wide level).
<b>Beschreibung Nebenwirkungen</b>	There was one moderate injury, defined as requiring suturing, steristrips, fracture, or splinting, of both a staff member and a patient during an aggressive event between 2004 and 2006. There was an increase in minor injuries, requiring application of a dressing, ice, cleaning of a wound, limb elevation, or topical medication for staff. Focus groups addressing this issue felt that was due to improved reporting.
<b>Dauer Baseline/Intervention/Follow-up</b>	about 2-3 years baseline and 1-2 years post intervention
<b>Funding</b>	not reported
<b>Qualitätsbemerkung</b>	insufficient reporting of outcome data, outcomes just shown in diagrams; program pilots implemented step by step, time lag of effects

<b>Nummer</b>	37
<b>Studie</b>	Lorenzo, R. D.; Miani, F.; Formicola, V.; Ferri, P. (2014): Clinical and organizational factors related to the reduction of mechanical restraint application in an acute ward: an 8-year retrospective analysis. In: Clinical practice and epidemiology in mental health : CP & EMH 10, S. 94–102. DOI: 10.2174/1745017901410010094.
<b>Institution</b>	Mental Health department SPDC-Modena Centro, NOCSAE
<b>Studientyp</b>	retrospective analysis, Fall-Kontroll-Studie?? time series??
<b>Kontrollgruppe ja/nein</b>	no
<b>Komplex ja/nein</b>	no
<b>Interventionstyp</b>	institutional changes
<b>n Patienten</b>	305 (all restrained inpatients admitted from 1-1-2005 to 31-12-2012 =560 cases, =1224 restraints)
<b>Effekt ja/nein auf S/R</b>	yes
<b>Beschreibung Intervention</b>	change of medical staff (2008), increase of nurses per shift and ward relocation in 2009, implementation of more restricted guidelines in 2011
<b>Beschreibung Patienten</b>	This retrospective study was conducted in the 15-bed public psychiatric ward, Servizio Psichiatrico di Diagnosi e Cura (SPDC) of Modena Centro, located in General Hospital (NOCSAE of Az-USL-

	Modena), where patients (catchment area of about 250,000 people) affected by acute psychiatric disorders are hospitalized in voluntary or compulsory treatment, as required by Italian Law 180. Majority of patients had schizophrenia/psychosis, organic psychosis or bipolar disorder.
<b>Beschreibung Outcomevariablen</b>	number of (Mechanical?) restraints
<b>Beschreibung Ergebnisse</b>	The number of restraints per year progressively declined during the 8-year period (Fig. 2). The reduction of restraints was statistically significantly related to all the institutional changes that occurred in the observation period: the change of medical staff in 2008 (Pearson $\chi^2 = 157.0559$ , $p < .001$ ), the increase in nurses per shift and the ward relocation in 2009 (Pearson $\chi^2 = 112.0902$ , $p < .001$ ) and the implementation of more restricted guidelines for restraint application in 2011 (Pearson $\chi^2 = 157.0559$ , $p < .001$ ).
<b>Dauer Baseline/Intervention/Follow-up</b>	8 years observation period
<b>Funding</b>	none declared
<b>Qualitätsbemerkung</b>	retrospective, institutional changes are not described in detail

<b>Nummer</b>	38
<b>Studie</b>	Lykke, J.; Austin, S. F.; Morch, M. M. (2008): Cognitive milieu therapy and restraint within dual diagnosis populations. In: Ugeskrift for laeger 170 (5), S. 339–343.
<b>Institution</b>	Sct. Hans Hospital, Center for Kognitiv Terapi
<b>Studientyp</b>	tim-series
<b>Kontrollgruppe ja/nein</b>	no
<b>Komplex ja/nein</b>	yes
<b>Interventionstyp</b>	Behavioral therapy// kognitive Milieuthherapie
<b>n Patienten</b>	70
<b>Effekt ja/nein auf S/R</b>	yes (just for restraint, not for seclusion, forced medication)
<b>Beschreibung Intervention</b>	Kognitives milieutherapeutisches Programm mit Psychoedukation, sozialem Kompetenztraining, kognitiver Verhaltenstherapie, Debriefing mit Personal und in der Patientengruppe (Erkennen externer und interner Auslöser für Krisensituationen und erarbeiten von Alternativen)
<b>Beschreibung Patienten</b>	Patienten mit Doppeldiagnose (F20-F34) plus Substanzmissbrauch Sucht (F10-19), bei denen Erkrankung so schwer ausgeprägt ist, das aktuell stationäre Behandlung indiziert ist
<b>Beschreibung Outcomevariablen</b>	Anzahl der von S/R, Zwangsmed betroffenen Patienten, Anzahl von S/R, Zangsmedikationsereignissen, Anteil von stationären Patienten, die von Zwangs betroffen sind
<b>Beschreibung Ergebnisse</b>	Der Anteil der fixierten Patienten nahm über die Jahre signifikant ab: 2002 9,33 %, 2003 9,08 %, 2004 5,31 %, 2005 1,18 %. Jährliche Odds

	ratio 0,64, $p > 0.0001$ . Keine signifikanten Änderungen ergaben sich beim Anteil der isolierten oder zwangsmedizierten Patienten.
<b>Dauer Baseline/Intervention/Follo w-up</b>	4 Jahre Beobachtungszeitraum
<b>Funding</b>	Not reported
<b>Qualitätsbemerkung</b>	sprachliche Schwierigkeiten meinerseits, da dänisch

<b>Nummer</b>	39
<b>Studie</b>	MacDonald, A. (1989): Reducing seclusion in a psychiatric hospital. In: Nursing times 85 (23), S. 58–59.
<b>Institution</b>	Royal Shrewsbury Hospital/Shelton
<b>Studientyp</b>	pre-post design, retrospective
<b>Kontrollgruppe ja/nein</b>	no
<b>Komplex ja/nein</b>	yes
<b>Interventionstyp</b>	Complex
<b>Effekt ja/nein auf S/R</b>	yes
<b>Beschreibung Intervention</b>	changing ward's concept (long stay, locked -> short stay, intensive care, open), improving of staff's skills mix, introduction of a stringent seclusion policy, staff education in incident prevention strategies; phase 2: redecorating and refurnishing the ward, shifting control from doctors to nurses, a primary nursing concept (Bezugspflege??) was installed
<b>Beschreibung Patienten</b>	psychiatric ward (changing from a long-stay secure = locked to a short-stay intensive care = open ward)
<b>Beschreibung Outcomevariablen</b>	seclusion events per week
<b>Beschreibung Ergebnisse</b>	Seclusion went down from 22.3 seclusion events per week to 2 seclusion events per week in phase one, and continued to decrease to 0.6 events per week in phase 2
<b>Funding</b>	Not reported
<b>Qualitätsbemerkung</b>	the two phases aren't specified, when did they occur? Contamination?, the concept of the ward changed, it's not clear if patient population stayed the same

<b>Nummer</b>	40
<b>Studie</b>	Maguire, T.; Young, R.; Martin, T. (2012): Seclusion reduction in a forensic mental health setting. In: J PSYCHIATR MENT HEALTH NURS 19 (2), S. 97–106. DOI: 10.1111/j.1365-2850.2011.01753.x.
<b>Institution</b>	Victorian Institute for Forensic Mental Health
<b>Studientyp</b>	interrupted time series
<b>Kontrollgruppe ja/nein</b>	no
<b>Komplex ja/nein</b>	yes
<b>Interventionstyp</b>	Complex, Six Core Strategies
<b>n Patienten</b>	(116 beds)



<b>Effekt ja/nein auf S/R</b>	yes
<b>Beschreibung Intervention</b>	<p>6CS: Reduction of seclusion identified as a priority in Corporate Plan. Establishment of a project management structure that included consumer consultants, managers, clinicians and academics of all disciplines. A project officer was employed. The Seclusion Policy and Procedure was rewritten to reflect changes to practice. Staff training sessions introduced the project and the new initiatives, and during induction new recruits to the hospital were introduced to the organizational commitment to reduce seclusion. Existing management of aggression training was revised to incorporate learnings from the project and to strengthen the focus on early intervention and prevention of aggression, trauma-informed care and sensory modulation. Regular updates were provided to unit staff through newsletters, emails and team meetings. A consumer consultant was a member of the Project Management Group. Consumer consultants liaised with the Consumer Advisory Group representatives on each unit to collate personal experiences of seclusion practices. The unit community meetings were used to promote and discuss the Beacon Project and new initiatives. Patients were invited to inspect the seclusion suites with unit managers to suggest refurbishment ideas. Consumer consultants and Consumer Advisory Group were involved in development of the Safety Plan. Consumers delivered content in the staff training. Staff and patients collaborated to review the unwritten and arbitrary 'unit rules' that often are sources of conflict. Revision of the admission procedures to reflect a more therapeutic introduction to the hospital. On admission patients were no longer taken to the seclusion area to be searched – the search occurred during the required physical examination conducted by the doctor and nurse. Implementation of Safety Plans, a collaborative document completed by the patient with the staff that recorded stressors and triggers, warning signs, calming strategies, and communication and de-escalation strategies. Safety Plans focus on early intervention. Sensory approaches were introduced (aroma therapeutic sprays, massage chairs, weighted blankets and rocking chairs. Occupational therapists provided sensory assessments. Establishment of Sensory Modulation Rooms that were designed to promote emotional control and to facilitate the learning and practice of stress management. Introduction of Seclusion Plans for patients secluded for longer than 4 h. In addition to documenting the care to be delivered, the plan identified the conditions and interventions that were required to end seclusion – this allowed transparency for the patient and consistency for the clinical team. Introduction of the Structured Day to provide a coherent approach to the programmes and activities undertaken by patients and reduce boredom – a frequent contributor to aggression. Risk assessment for imminent patient aggression was strengthened</p>

	<p>through revision of the use of the Dynamic Assessment of Situation Aggression: Inpatient Version. Improved documentation of incidents with staff more clearly describing early intervention and prevention strategies, a justification for seclusion and plans for ongoing treatment of aggression. Reduction in number of seclusion rooms at the hospital – previously there were 15 seclusion rooms, perhaps reinforcing a complacent use of the rooms. Collected and distributed widely the seclusion data. Data were regularly sent to units to inform practice. Case file entries were audited to examine practice. Other data (admission patterns, staff injuries, sick leave) were also reviewed. Introduction of a seclusion review process in which a senior nurse met with the treating team to reflect on the seclusion episode and make recommendations for practice. Strengthening of the existing post-seclusion debriefing to be more than an opportunity to discuss ongoing treatment. The debriefing was to assist the patient to process the experience of seclusion.</p>
<b>Beschreibung Patienten</b>	The patient population consists of male and female patients found not guilty by reason of mental impairment, sentenced and remanded prisoners, as well as patients referred from area mental health services that are deemed to be a risk to others. The most commonly identified risk for patients at TEH is interpersonal violence.
<b>Beschreibung Outcomevariablen</b>	seclusion events per month, patients secluded per month, total hours of seclusion per month
<b>Beschreibung Ergebnisse</b>	At the conclusion of the project, there was a demonstrable reduction of seclusion events and the hours of seclusion but a lesser reduction in the number of patients that were secluded. Peaks in seclusion events or hours of seclusion generally indicate the admission of a persistently aggressive patient. Peaks in numbers of patients being secluded can often indicate the presence of patients whose aggressive behaviour influences others to also be aggressive for various motivations. The reduction in the use of seclusion is evident during the Beacon Project but appears to increase post the project, but not to the pre-Beacon levels. Seclusion reduction in a forensic setting.
<b>Dauer Baseline/Intervention/Follow-up</b>	2 years baseline, 2 years intervention, 1 year follow up
<b>Funding</b>	Commonwealth-funded National Mental Health Seclusion and Restraint Project
<b>Nummer</b>	41
<b>Studie</b>	McCue, R. E.; Urcuyo, L.; Lili, Y.; Tobias, T.; Chambers, M. J. (2004): Reducing restraint use in a public psychiatric inpatient service. In: The journal of behavioral health services & research 31 (2), S. 217–224.

<b>Institution</b>	Woodhull Medical and Mental Health Center
<b>Studientyp</b>	pre-post-design, prospective
<b>Kontrollgruppe ja/nein</b>	no
<b>Komplex ja/nein</b>	yes
<b>Interventionstyp</b>	Complex
<b>Effekt ja/nein auf S/R</b>	yes
<b>Beschreibung Intervention</b>	better identification of restraint-prone patients, a stress/anger management group for patients (4 sessions patient education!), staff training on crisis intervention, development of crises response team, daily review of all restraints, incentive system for staff
<b>Beschreibung Patienten</b>	psychiatric inpatients from a economically disadvantaged urban population
<b>Beschreibung Outcomevariablen</b>	number of restraints; patient-to-patient assaults; patient-to-staff-assaults; suicidal acts; self-inflicted injuries per 1000 patient-days
<b>Beschreibung Ergebnisse</b>	There was a significant decrease in the rate of restraint use after the restraint reduction initiatives were implemented.
<b>Beschreibung Nebenwirkungen</b>	No change in patient-to-patient-assualts or suicide attempts, decrease in self inflicted injuries, but significant increase in patient-to-staff-assults (but due to one peak)
<b>Dauer Baseline/Intervention/Follow-up</b>	3 years pre-intervention, 2 years post intervention
<b>Funding</b>	Not reported
<b>Qualitätsbemerkung</b>	when did the complex interventions occur? No pause between pre and post

<b>Nummer</b>	42
<b>Studie</b>	Needham, I.; Abderhalden, C.; Meer, R.; Dassen, T.; Haug, H. J.; Halfens, R. J.; Fischer, J. E. (2004): The effectiveness of two interventions in the management of patient violence in acute mental inpatient settings: report on a pilot study. In: Journal of psychiatric and mental health nursing 11 (5), S. 595–601. DOI: 10.1111/j.1365-2850.2004.00767.x.
<b>Institution</b>	School of Nursing/Fribourg, University of Bern, Humboldt University Berlin
<b>Studientyp</b>	pre-post-design, prospective
<b>Kontrollgruppe ja/nein</b>	no
<b>Komplex ja/nein</b>	no
<b>Interventionstyp</b>	Early Interventions// Structured Risk assessment (BVC-R), training course
<b>n Patienten</b>	576 patients accounting for 721 admissions and 7732 patient days (two 12-bed acute mental health care inpatient settings (one urban, one rural))
<b>Effekt ja/nein auf S/R</b>	yes
<b>Beschreibung Intervention</b>	The risk prediction was conducted using an extended version of the

	<p>Brøset Violence Checklist (BVC). The extended version – the BVC-R – requires nurses to rate six patient behaviours (confused, irritable, boisterous, verbally threatening, physically threatening and attacking objects) and to perform an overall assessment of the risk for imminent violence using a slide-rule-VAS. These combined ratings produce a score between 0 (very low risk) and 12 (high risk). All patients are consecutively assessed at admission and twice daily for the three following days. A natural frequency interpretation of the scoring results is provided comprising the following risk categories for a physical patient attack against staff: &lt; 1 in 100 (score 0–3), 1 in 100 (score 4–6), 1 in 10 (score 7–9) and 1 in 4 patients (score 10–12). For patients obtaining scores above 7, a discussion on preventive measures used in general practice (e.g. observation, relaxation) was recommended, and for patients with scores of 10 or more, we suggested considering immediate measures after multidisciplinary discussion.</p>
<b>Beschreibung Intervention II</b>	<p>The nurses were trained in the aggression management training course. The 5-day course (35 lessons) is a skill-oriented, action-centred, and problem-oriented educational programme incorporating experiential- and knowledge-based elements such as 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. Another main element of the course is the acquisition of practical ‘hands-on’ skills such as holding methods, breakaway techniques, and control and restraint. The approach includes the use of a team of three persons with clearly assigned roles (similar to the unambiguous role definition in cardiac arrest resuscitation) when dealing with aggressive patients.</p>
<b>Beschreibung Patienten</b>	<p>41,3 % females, mean age 38, range 15-88 years, 61,5 % involuntarily, diagnosis: Schizophrenia, schizo-type and delusional disorders, mood disorders, mental and behavioral disorders due to psychoactive substance use, neurosis, personality disorders; LOS: 1-367 days (median 5, mean 11.3)</p>
<b>Beschreibung Outcomevariablen</b>	<p>aggressive events (SOAS-R), attacks against persons, coercive measures (with or without prior aggression)</p>
<b>Beschreibung Ergebnisse</b>	<p>The crude analysis including all patients and using hospitalization days as the unit of analysis showed 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. However, the rates of coercive measures per 100 hospitalization days significantly declined from 4.0, to 2.9, and to 2.3 over the three study periods (<math>\chi^2</math>-test <math>P=0.0008</math>, Mantel–Haenszel trend-test <math>P=0.0002</math>).</p>
<b>Beschreibung sekundäre</b>	<p>It should be noted, that the two participating wards showed</p>

<b>Ergebnisse</b>	considerable differences as to the effects of the interventions. In one ward, we observed a significant decline in the percentage of days with occurrence of attacks against persons from 17.8 %, to 13.8 %, to 5.7 % (trend-test $P=0.005$ ), while the percentage of days with implementation of coercive measures remained similar (trend-test $P=0.24$ ). On the other ward, the days with occurrence of coercive measures declined (42.2 % to 28.7 %, trend-test $P=0.03$ ), while the percentage of days with attacks against persons remained unchanged (trend-test $P=0.72$ ). The severity of all aggressive incidents as assessed by the SOAS-R remained unchanged across the three study periods (mean score 9.8 vs. 10.1 vs. 10.5, $P = 0.59$ ). The SOAS-R score of those incidents identified as attacks against persons also remained unchanged (mean 12.9 vs. 13.2 vs. 11.8, $P = 0.35$ ). However, the subjective perception of severity as indicated on the visual analogue scale significantly declined after the training (mean 42.3 vs. 41.5 vs. 27.8, $\chi^2$ -test $P = 0.005$ ).
<b>Dauer Baseline/Intervention/Follow-up</b>	3 months baseline, 3 months post risk-assessment, 3 months post training (Both interventions implemented)
<b>Funding</b>	This study was supported by research grant BK 361/01 of the Swiss Academy of Medical Science.
<b>Qualitätsbemerkung</b>	units are not the same, different moderators in action?

<b>Nummer</b>	43
<b>Studie</b>	Noorthoorn, E. O.; Voskes, Y.; Janssen, W. A.; Mulder, C. L.; van de Sande, R.; Nijman, H. L. et al. (2016): Seclusion Reduction in Dutch Mental Health Care: Did Hospitals Meet Goals? In: Psychiatric services (Washington, D.C.), appips201500414. DOI: 10.1176/appi.ps.201500414.
<b>Institution</b>	Forensische Psychiatrie de Boog, Dutch Information Center for Coercive Measures, department of Medical Humanities, EMGO Institute for Health and Care Research/VU University Medical Center Amsterdam...
<b>Studientyp</b>	interrupted time series, pre post design?
<b>Kontrollgruppe ja/nein</b>	no
<b>Komplex ja/nein</b>	no
<b>Interventionstyp</b>	political/legislative changes
<b>n Patienten</b>	316064
<b>Effekt ja/nein auf S/R</b>	yes
<b>Beschreibung Intervention</b>	In 2006, GGZ Nederland (Dutch Association of Mental Health and Addiction Care) set a seclusion reduction target of 10 % per year.
<b>Beschreibung Patienten</b>	psychiatric inpatients
<b>Beschreibung Outcomevariablen</b>	seclusion incidents, patients secluded, patients secluded as percentage of those admitted, seclusion duration in hours (Mean, Median)

<b>Beschreibung Ergebnisse</b>	Both the seclusion rate (2008: 11.3 % -> 2013: 7 %) and the duration (median 2008: 92 hours -> 2013: 16 hours) of seclusion incidents decreased during this period. At the level of the individual hospital, absolute changes varied between a decrease of 93 % and an increase of 112 %. A greater than tenfold difference was found between hospitals in the duration of seclusion incidents per admission duration. After 2011 93 % of all admitted patients were included in the register, allowing a more sound comparison, which showed a mean and median reduction in seclusion rates of 9 % and a reduction in mean and median duration of seclusion hours of 8 and 32 %. -> a significant decrease in seclusion incidents per 1000 admission hours
<b>Beschreibung Nebenwirkungen</b>	forced medication increased by 81 %, -> significant increase in forced medication incidents per 1000 admission hours, the total number of coercive measures increased significantly
<b>Dauer Baseline/Intervention/Follow-up</b>	6 years observation period
<b>Funding</b>	This study was supported by grants 5159 and 5162 from the Dutch Ministry of Health, Welfare and Sports during 2013 and 2014. Between 2007 and 2012, the study was supported by several grants to each separate hospital by the Dutch Health Authority.
<b>Qualitätsbemerkung</b>	no complete reporting in the first years, selection bias?

<b>Nummer</b>	44
<b>Studie</b>	Novak, T.; Scanlan, J.; McCaul, D.; MacDonald, N.; Clarke, T. (2012): Pilot study of a sensory room in an acute inpatient psychiatric unit. In: Australasian psychiatry : bulletin of Royal Australian and New Zealand College of Psychiatrists 20 (5), S. 401–406. DOI: 10.1177/1039856212459585.
<b>Institution</b>	Missenden Psychiatric Unit, Mental Health Services, Sydney and South Western Sydney Local Health Districts, University of Sydney
<b>Studientyp</b>	pre-post-design
<b>Kontrollgruppe ja/nein</b>	no
<b>Komplex ja/nein</b>	no
<b>Interventionstyp</b>	sensory room
<b>n Patienten</b>	75
<b>Effekt ja/nein auf S/R</b>	no
<b>Beschreibung Intervention</b>	An existing interview room was converted into a sensory room. The design followed best practice principles and included a homely environment with scenic pictures, comfortable furnishings and a range of sensory modulation items (weighted blanket, listen to music, read magazine/book, rocking chair, scents, fitball). Staff were educated about the room and encouraged to offer time in the room to consumers at the first sign of distress or agitation. Over 80 % of nursing and allied health staff and 40 % of medical staff attended

	these sessions. Consumers were also routinely educated about the room and encouraged to use it when they felt distressed or needed 'time-out.'
<b>Beschreibung Patienten</b>	40-bed acute-psychiatric unit in the inner city of Sydney. 82,7 % female, 12 % Under 20 years, 64,7 20-39 years, 13.3 % 40-59 years. Diagnosis: Schizophrenia/other psychoses, Manic episode or bipolar affective disorder, Depresiom. Borderline, 25.3 % diagnosis missiing!
<b>Beschreibung Outcomevariablen</b>	self rated dsitress, Behavior, Episodes of Seclusion, Aggression incidents
<b>Beschreibung Ergebnisse</b>	No changes were noted in the rates of seclusion or aggression
<b>Beschreibung sekundäre Ergebnisse</b>	Changes in self rated distress and some problem behaviours (pacing, loud, irritable, intrusive, elevated, anxious). No interaction effects for gender. There were between-subjects interaction effects for medication and diagnosis and within-subjects effects of self-rated distress.
<b>Dauer Baseline/Intervention/Follo w-up</b>	12 months prior to and following intervention
<b>Funding</b>	no conflicts of interest, funding not reported??

<b>Nummer</b>	45
<b>Studie</b>	Ohlenschlaeger, Johan; Nordentoft, Merete; Thorup, Anne; Jeppesen, Pia; Petersen, Lone; Christensen, Torben O. et al. (2008): Effect of integrated treatment on the use of coercive measures in first-episode schizophrenia-spectrum disorder. A randomized clinical trial. In: International journal of law and psychiatry 31 (1), S. 72–76. DOI: 10.1016/j.ijlp.2007.11.003.
<b>Institution</b>	Sct. Hans Hospital, Bisbebjerg Hospital, Psychiatric Hospital Arhus
<b>Studientyp</b>	RCT
<b>Kontrollgruppe ja/nein</b>	yes
<b>Komplex ja/nein</b>	yes
<b>Interventionstyp</b>	integrated treatment
<b>n Patienten</b>	167 patients integrated treatment, 161 standard treatment
<b>Effekt ja/nein auf S/R</b>	no
<b>Beschreibung Intervention</b>	Integrated treatment consisted of assertive community treatment, psycho-educational multi-family groups, social skills training
<b>Beschreibung Patienten</b>	inpatients and outpatients with first-episode schizophrenia-spectrum disorder
<b>Beschreibung Outcomevariablen</b>	[number and duration of involuntary admission, detainment, involuntary treatment,] restraint with leather belt, straps and gloves, and number of physical restraints/use of force, isolation (locked door), [involuntary medication with sedatives] (all measuers restriceted to use only during hospitalization)
<b>Beschreibung Ergebnisse</b>	No significant difference in mechanical or physical restraint between integrative and standard treatment, no statistics on seclusion applied

	due to small numbers
<b>Beschreibung sekundäre Ergebnisse</b>	other coercive measures also not significant
<b>Dauer Baseline/Intervention/Follow-up</b>	1 year
<b>Funding</b>	The OPUS-trial was funded by grants from The Danish Ministry of Health and The Danish Medical Research Council. The Copenhagen Hospital Corporation funded the first author during the study period.
<b>Qualitätsbemerkung</b>	Secondary analysis of OPUS study??

<b>Nummer</b>	46
<b>Studie</b>	Olver, James; Love, Mervyn; Daniel, Jeffrey; Norman, Trevor; Nicholls, Daniel (2009): The impact of a changed environment on arousal levels of patients in a secure extended rehabilitation facility. In: Australasian psychiatry : bulletin of Royal Australian and New Zealand College of Psychiatrists 17 (3), S. 207–211. DOI: 10.1080/10398560902839473.
<b>Institution</b>	University of Melbourne, Mental Health Clinical Service Unit/Austin Health/Heidelberg/Australia
<b>Studientyp</b>	pre-post-design
<b>Kontrollgruppe ja/nein</b>	no
<b>Komplex ja/nein</b>	no
<b>Interventionstyp</b>	changes of the physical ward environment
<b>n Patienten</b>	15
<b>Effekt ja/nein auf S/R</b>	yes
<b>Beschreibung Intervention</b>	moving from a temporary, refurbished medical ward to a large, light-filled, purpose built facility
<b>Beschreibung Patienten</b>	the majority were male (80 %), had a diagnosis of schizophrenia (53 %) or schizoaffective disorder (13 %)
<b>Beschreibung Outcomevariablen</b>	seclusion episodes, extended seclusion episodes, staff report of aggressive incidents and Brief Psychiatric Rating Scale
<b>Beschreibung Ergebnisse</b>	There were statistically significant reductions in the mean number of seclusion episodes, (24 -> 11,7; d= 3.6) mean number of extended episodes (> 4h; 11.3 -> 4; d= 4.4) and BPRS total score following the move. There were non statistically significant reduction in aggressive incidents reported by staff. There were statistically significant increases in ambient light conditions in the new unit.
<b>Dauer Baseline/Intervention/Follow-up</b>	3 months baseline, 3 months after the move
<b>Funding</b>	Not reported
<b>Qualitätsbemerkung</b>	very few staff members participated



<b>Nummer</b>	47
<b>Studie</b>	Petrakis, M.; Penno, S.; Oxley, J.; Bloom, H.; Castle, D. (2012): Early psychosis treatment in an integrated model within an adult mental health service. In: European psychiatry : the journal of the Association of European Psychiatrists 27 (7), S. 483–488. DOI: 10.1016/j.eurpsy.2011.03.004.
<b>Institution</b>	St. Vincent's Mental Health Service (SVMHS), Monash University, University of Melbourne
<b>Studientyp</b>	comparison between a recent and a historic cohort
<b>Komplex ja/nein</b>	no
<b>Interventionstyp</b>	integrated treatment, Early Psychosis Program
<b>n Patienten</b>	62 (historic cohort) and 0 (recent cohort)
<b>Effekt ja/nein auf S/R</b>	no (not for seclusion)
<b>Beschreibung Intervention</b>	<p>Early Psychosis Program: A clinical programme, utilising an integrated model of management of early psychosis clients, commenced in 2006 with dedicated consultant psychiatrist time and a project officer to carry out program establishment tasks. Over time the project officer position was replaced by a senior clinician, employed in the service to both hold a clinical load and act as a resource for secondary consult, monitoring and training of other case managers regarding work with EPP clients. Program implementation was further enhanced after the introduction of a specific early psychosis nurse in the inpatient unit setting, to support acute service staff in identification of early psychosis cases and assist in timely referral to community and completion of care pathway documentation. The consultant psychiatrist had active involvement in the development of the service-based Early Psychosis Clinical Guidelines to facilitate a clinical programme, and ensured the guidelines were updated according to current best practice. The consultant developed the clinical pathway tool in association with other staff to maintain high clinical standards within the programme, and was also involved in all modifications to the pathway tool. All case managers who saw early psychosis patients clinically reported to the early psychosis consultant, and clinically worked with the early psychosis consultant and/or early psychosis registrar. The consultant reviewed cases within programme as clinically required, and closely supervised the early psychosis registrar to provide care according to current best practice guidelines. Early engagement with the patient and family was identified as an important priority. Providing continuity, familiarity and support at an early stage throughout all settings in the health service would facilitate trust, reduce distress and trauma. A comprehensive physical examination and investigations were encouraged. This ensured appropriate review of any biological contributors to the presentation and comorbid conditions. Physical illness assessment was a focus and reinforced by other processes and protocols within the service which included physical health and metabolic monitoring. A previous study indicated that there was solid fidelity to Guidelines 2 years after the implementation of the integrated model of</p>

	service delivery for an EPP within a metropolitan area mental health service.
<b>Beschreibung Patienten</b>	psychotic spectrum disorders, 55 %/57 % male, mean age 27/31 years, range 17 /18 - 62 Years, DUP 15/24 months
<b>Beschreibung Outcomevariablen</b>	[Duration of untreated psychosis,] admission to hospital (incl seclusion), [CTO, Family care involvement, discharge]
<b>Beschreibung Ergebnisse</b>	use of seclusion declined non significantly from 22 % to 15 %
<b>Funding</b>	no conflicts of interest, funding not reported??
<b>Qualitätsbemerkung</b>	willkürliche Auswahl Kohorten, Zeitraum 2006-2008 wird mit Zeitpunkt (2001) verglichen, starke Veränderungen der Diagnoseverteilung, der Versorgungslandschaft, unklar auf welche Grundgesamtheit sich die Isolierungszahlen beziehen.

<b>Nummer</b>	48
<b>Studie</b>	Phillips, D.; Rudestam, K. E. (1995): Effect of nonviolent self-defense training on male psychiatric staff members' aggression and fear. In: Psychiatric services (Washington, D.C.) 46 (2), S. 164–168. DOI: 10.1176/ps.46.2.164.
<b>Institution</b>	Fielding institute
<b>Studientyp</b>	CCT
<b>Kontrollgruppe ja/nein</b>	yes
<b>Komplex ja/nein</b>	no
<b>Interventionstyp</b>	staff training (nonviolent self-defense skills)
<b>n Patienten</b>	(24 self-selected male mental health staff)
<b>Effekt ja/nein auf S/R</b>	yes (for the group with both didactic and physical skills training)
<b>Beschreibung Intervention</b>	Training using didactic materials for 4h20 minutes over 2 sessions
<b>Beschreibung Intervention II</b>	didactic training and physical skills training for the same total time over 2 sessions
<b>Beschreibung Kontrolle</b>	no training
<b>Beschreibung Patienten</b>	psychiatric state hospital
<b>Beschreibung Outcomevariablen</b>	Buss-Durkee Hostility-Guilt Inventory (Judges rated physical skills pre- and posttraining during a role play; and self-rated); number of assaults and episodes of restraint
<b>Beschreibung Ergebnisse</b>	Subjects in the group who received only didactic training reported that during the two-week period they were involved in 18 assaultive encounters, resulting in ten episodes of restraint and three minor staff injuries. Subjects who received both didactic and physical training reported 13 assaults, resulting in five episodes of restraint and no injuries. The group who received no training reported 15 assaults, leading to eight episodes of restraint and one staff injury. Thus subjects trained in physical and didactic skills were involved in 23 percent fewer assaults than those who received only didactic training and 20 percent fewer assaults than the control group. They reported no injuries and 50 percent fewer episodes of restraint than the

	didactic group and 30 percent fewer than the control group.
<b>Beschreibung sekundäre Ergebnisse</b>	Judges rating showed significant differences between group 2 (didactic and physical skills training) and group 1 and 3
<b>Beschreibung Nebenwirkungen</b>	self-rating was not different between groups
<b>Dauer Baseline/Intervention/Follow-up</b>	2 weeks
<b>Funding</b>	not reported
<b>Qualitätsbemerkung</b>	insufficient reporting about patients, small sample, not test statistics about coercive measures

<b>Nummer</b>	49
<b>Studie</b>	Pollard, R.; Yanasak, E. V.; Rogers, S. A.; Tapp, A. (2007): Organizational and unit factors contributing to reduction in the use of seclusion and restraint procedures on an acute psychiatric inpatient unit. In: The Psychiatric quarterly 78 (1), S. 73–81. DOI: 10.1007/s11126-006-9028-5.
<b>Institution</b>	VA Puget Sound Health Care System/American Lake Division/Mental Health Service; department of Psychiatry and Behavioral Science/University of Washington
<b>Studientyp</b>	pre-post-design
<b>Kontrollgruppe ja/nein</b>	no
<b>Komplex ja/nein</b>	no
<b>Interventionstyp</b>	political/legislative changes
<b>Effekt ja/nein auf S/R</b>	yes
<b>Beschreibung Intervention</b>	The introduction of JCAHO 2000 standards for utilization of S/R occurred at month 28. This involved a series of formal and informal interventions implemented by the senior unit leadership and facility leadership, including discussions regarding alternatives to the use of S/R, exploration of staff concerns about the new standards through both informal discussion and focus groups, and positive feedback to staff from both senior unit management and facility leadership for the use of alternatives. Videotapes were also prepared, the intent of which was to serve as stimuli for discussions regarding risks of restraint, alternatives to restraint, and the senior leadership commitment to a restraint free environment. In addition, facility policies and procedures for the use of S/R were updated to reflect the emphasis on expanded leadership involvement in restraint and seclusion usage. As part of this, mental health and nursing leadership were tasked with the responsibility of reviewing all episodes of behavioral restraints for appropriateness and for meeting specified documentation requirements on an ongoing basis. In addition, the committee was tasked with identifying opportunities for improvement of care and patient safety. Aggregated and trended

	data were presented and discussed monthly at the facility clinical executive committee meeting.
<b>Beschreibung Patienten</b>	VA facility with a secured acute mental health unit that accepts voluntarily and involuntarily committed patients
<b>Beschreibung Outcomevariablen</b>	S/R hours per month, S/R hours per patient
<b>Beschreibung Ergebnisse</b>	T-test analysis revealed significantly fewer hours of restraint or seclusion in the months after the implementation of JCAHO standards compared to the months prior to this implementation, $t(44) = 4.59, P < .001$ . Similarly, there was a significant reduction in the hours of S/R use per patient following the implementation of the new JCAHO policy, $t(44) = 4.02, P < .001$ . Moreover, the difference in restraint or seclusion hours between the months prior to and after policy implementation remained significant even when changes in environmental variables were controlled using ANCOVA procedures, all $F_s(1,43) > 4.55, P_s < .05$ .
<b>Dauer Baseline/Intervention/Follow-up</b>	28 months baseline, 18 months post-intervention
<b>Funding</b>	Institutional support for this study was provided by the Mental Illness Research Education and Clinical Center (MIRECC) of the VA Puget Sound Health Care System, Tacoma and Seattle, WA.
<b>Nummer</b>	50
<b>Studie</b>	Prescott, David L.; Madden, Lynn M.; Dennis, Marilyn; Tisher, Paul; Wingate, Carrie (2007): Reducing mechanical restraints in acute psychiatric care settings using rapid response teams. In: The journal of behavioral health services & research 34 (1), S. 96–105. DOI: 10.1007/s11414-006-9036-0.
<b>Institution</b>	Acadia Hospital, APT Foundation Inc.
<b>Studientyp</b>	pre-post-design
<b>Kontrollgruppe ja/nein</b>	no
<b>Komplex ja/nein</b>	no
<b>Interventionstyp</b>	debriefing// Rapid response teams (= debriefing with staff)
<b>n Patienten</b>	(3702 patient bed days baseline, 3479 patient bed days post-intervention)
<b>Effekt ja/nein auf S/R</b>	yes
<b>Beschreibung Intervention</b>	Following any instance of mechanical restraint, a restraint response team was activated, consisting of (1) the medical director or assistant medical director, (2) the clinical supervisor, and (3) the nurse manager from the service where the restraint occurred. Within 24 h of the restraint episode, the restraint response team met with the receiving team, consisting of the restrained patient's attending physician, the charge nurse from the patient's program area, and the master's level clinician working with the patient. These consultations

	<p>were specifically designed to be brief (15–20 min) and to address the question, "What can be done to reduce the likelihood that an additional restraint will occur with this patient?" No limitations were placed on potential treatment options or strategies. The response team physician had the option of writing medication orders or modifications to the treatment plan if he/she desired. As the response team was required to meet within 24 h of the restraint episode, a 7-day-a-week coverage was arranged. Members of the change team rotated a call schedule for staffing the response team on weekends and holidays. Senior-level managers had historically been present in the hospital, or available for consultation, during weekend hours and thus were involved 7 days/week. Patients were not directly involved in the team meetings. Meeting format typically involved a brief review of the restraint incident (led by the receiving team), development of hypotheses about the cause of behaviors that led to restraint (all team members), and identification of specific treatment changes that were hypothesized to reduce the likelihood of further restraints. The nurse or master's level clinician from the receiving team documented recommended changes in treatment on a one-page form developed specifically for this purpose.</p>
<b>Beschreibung Patienten</b>	<p>Acadia Hospital is a nonprofit psychiatric and chemical dependency treatment facility providing inpatient treatment, partial hospital and intensive outpatient programs, an outpatient clinic, and extensive substance abuse services (methadone clinic, wet shelter). Hospital services include 22 adult inpatient beds, 21 young adult inpatient beds, 18 adolescent inpatient beds, 18 inpatient pediatric beds, and a 14-bed observation service.</p>
<b>Beschreibung Outcomevariablen</b>	<p>total no. Of restraint, no. Of physical/mechanical restraints (per 1000 patient days), total patients receiving restraint, patients receiving physical/mechanical restraint</p>
<b>Beschreibung Ergebnisse</b>	<p>The total number of mechanical restraints declined to 36.4 %, from 77 during the baseline period to 49 during the first 6 weeks of using the restraint response team. The total number of patients who received a mechanical restraint declined to a lesser degree, by 12 % (25 during baseline; 21 during change phase). The number of physical restraints also decreased during the change period by 44.3 % (79 during baseline; 44 during the change period). The total number of patients who received a physical restraint declined to a lesser degree, by 21.4 % (28 during baseline; 22 during change phase). The number of mechanical restraints per thousand patient bed days during baseline was 20.8, and during the change period was 14.1, which is a 32.2 % reduction. The number of physical restraints during baseline was 21.3 per thousand patient bed days, declining to 12.6 during the change period—a 40.8 % reduction. Thus, the reduction in both types of restraints was still evident when restraints were examined in relation to total patient bed days. Although the</p>

	overall rate of mechanical and physical restraints decreased during the 6-week intervention period, the number of patients receiving either a mechanical or physical restraint did not appear to significantly change. These findings seem predictable, given that the focus of the response teams was on patients who had already received at least one restraint episode, as opposed to reducing the likelihood of restraint for "high-risk" patients.
<b>Dauer</b>	
<b>Baseline/Intervention/Follow-up</b>	6 weeks baseline, (1 year extended baseline), 6 weeks post-intervention
<b>Funding</b>	not reported
<b>Qualitätsbemerkung</b>	short intervention, no follow up

<b>Nummer</b>	51
<b>Studie</b>	Putkonen, A.; Kuivalainen, S.; Louheranta, O.; Repo-Tiihonen, E.; Ryyanen, O. P.; Kautiainen, H.; Tiihonen, J. (2013): Cluster-randomized controlled trial of reducing seclusion and restraint in secured care of men with schizophrenia. In: Psychiatric services (Washington, D.C.) 64 (9), S. 850–855. DOI: 10.1176/appi.ps.201200393.
<b>Institution</b>	Department of Forensic Psychiatry/University of Eastern Finland (UEF), Niuvanniemi Hospital/Kuopio, Department of Clinical Neuroscience/Karolinska Institutet Stockholm...
<b>Studientyp</b>	Cluster-RCT
<b>Kontrollgruppe ja/nein</b>	yes
<b>Komplex ja/nein</b>	yes
<b>Interventionstyp</b>	Complex, Six Core Strategies
<b>n Patienten</b>	(During the intervention year, the two intervention wards accounted for 1,306–1,400 patientdays per month, with 50 beds (24 and 26 beds). The two control wards accounted for 930–1,003 patientdays per month, with 38 beds (17 and 21 beds))
<b>Effekt ja/nein auf S/R</b>	yes
<b>Beschreibung Intervention</b>	Between January and June 2009 the researchers assisted staff of the intervention wards to initiate the new practices, and they assisted again between July and December to maintain the intervention. The leaders of the intervention wards were supported with individual and group counseling (one hour per week) and in daily postevent analyses with the senior nurse or counselor (30 minutes per day). Staff critically reviewed problems, rules, and practices and received information on the risks and traumas associated with seclusion-restraint, the prevention of crises, and the new tools (one hour per week). The cultural anthropologist–psychotherapist-counselor used participation-observation methods to help the counseling processes and helped the wards to develop individual preventive strategies and alternatives to seclusion (one hour per week). The service users

	<p>educated the project workers in consumer specialist meetings (one hour per week) about their own experiences with violence and coercion, individual triggers of violence, and effective calming activities. They also suggested new ways and practices to decrease fear, violence, and coercion and brainstormed with staff and doctors about the ward rules and practices during weekly community meetings (45 minutes). According to the patients' request for activities, some patients and staff volunteered to work together one hour per week on building projects in the courtyard. Because many patients and staff found it difficult to discuss their experiences of coercion and violence, they wrote, photographed, and illustrated a book together, titled <i>Behind Locked Doors</i>. Statistics on coercion and violence were used to guide the practices in many ways. Intervention wards used a progress sheet to record and track daily the number of seclusion/restraint incidents observed, and staff discussed the monthly figures with the senior nurse (30 minutes per month). The statistics were also discussed in the monthly steering group and at two general information meetings. Individual graphics of violence and seclusion were used in counseling and crisis planning. Crisis prevention tools were tailored with input from staff and patients to aid in individual crisis prevention, deescalation of tense situations, and coping with crises. The tools included a questionnaire of traumatic experiences and violent behavior and a list of common triggers, warning signs, calming activities, and daily activities. The individual crisis plan, which was an agreement on the calming activities to be used if the warning signs of violence appeared, was revised and developed after each crisis. Each morning the project senior nurse and cultural anthropologist–psychotherapist-counselor discussed with staff the violent incidents that occurred and reported on the practices, restrictions, and alternative methods used, according to the postevent analysis sheet. These meetings identified and praised successful interventions and otherwise helped the staff to improve their practices.</p>
<b>Beschreibung Kontrolle</b>	TAU
<b>Beschreibung Patienten</b>	<p>About 86 % of the inpatients were men, 97 % of whom had schizophrenia spectrum disorder or a delusional disorder. The patients having the highest risk for violence and seclusion were admitted to the highsecurity wards that had the highest staff-to-patient ratios. Practically all patients used second-generation antipsychotics—primarily clozapine— and many received antiepileptics and mood stabilizers as adjuvants. In the four high-security units, with the exception of a small number of Asians, the clients were Finnish-speaking Caucasians. The mean±SD age of the patients was 40.26±10.6 in the intervention cluster and 38.46±10.6 years in the control cluster.</p>
<b>Beschreibung</b>	The monthly incidence rate ratios (IRRs) between the intervention

<b>Outcomevariablen</b>	<p>and control wards during the stabilized intervention (between July and December 2009) consisted of the following three parameters, all divided into 100 patient-days: seclusion, restraints, or roomobservation days (the number of patient-days when any seclusionrestraint or room observation was used); seclusion-restraint time (the patient-hours spent in seclusion or restraint); and violence (the number of incidents of physical violence against any person, including selfharm). In addition, the number of injuries to patients and staff during the intervention year was compared with data for the previous year.</p>
<b>Beschreibung Ergebnisse</b>	<p>Seclusion-restraint and observation days decreased during the supported intervention from 30 % to 15 % of the total patient time for intervention wards (IRR over time=.88, CI=.86-.90, p,.001) versus a decrease from 25 % to 19 % for control wards (IRR=.97, CI=.93-1.01, p=.056). The difference between the groups was significant (p=.001), despite the significantly lower rate in December than in July for both intervention wards (IRR=.51, CI=.43-.60, p,.001) and control wards (IRR=.77, CI= .63-.94, p=.009). Seclusion-restraint time decreased from 110 to 56 hours per 100 patientdays for intervention wards (IRR over time=.85, CI=.78-.92, p,.001), yet increased from 133 to 150 hours for control wards (IRR=1.09, CI=.94-1.25, p=.24). The difference between the groups was significant (p=.001). The difference between July and December was significant for intervention wards (IRR=1.14, CI=1.05-1.23, p=.001) and for control wards (IRR=.77, CI= .63-.94, p,.001). Violence decreased for both groups, from 1.1 % to .4 % of patient-days for intervention wards (IRR over time=.92, CI=.79-1.05, p=.23) versus from .1 % to .01 % for the control wards (IRR=.90, CI=.64-1.23, p=.51).The difference between intervention and control wards was not statistically significant (p=.91). The severity of violence diminished in the intervention wards. Patient-to patient violence or self-harm resulted in a broken bone for one patient during the intervention year (versus one suicide and one restraint death before the intervention in 2008). For the control wards patient injuries remained minor, consisting of superficial wounds. The consequences of patient-to-staff violence remained minor for both groups and consisted of superficial wounds and bruises.</p>
<b>Beschreibung sekundäre Ergebnisse</b>	<p>Monthly seclusion-restraint time had increased before the project (2006- 2007) but declined during both project years. The IRR for annual seclusion-restraint time, compared with 2007, was .75 (CI=.73-.78) in 2008 and .49 (CI=.47-.51) in 2009. More reports of patient-to-staff violence were recorded at the entire hospital: 18 reports during the information year (2008) and 22 reports during the intervention year (2009), compared with 13 reports before the project (2007). However, patientassociated injuries to staff resulted in 75 % and 65 % fewer sick days, respectively, during the</p>



	<p>information and intervention years, compared with the year before the project (29 days in 2008 and 40 days in 2009, versus 114 days in 2007). The mean duration of a sick leave resulting from patients was 80 % shorter during the project (1.6 days per injury for 2008 and 1.8 days per injury for 2009, versus 8.8 days per injury in 2007). The only patient-to-staff injury at the hospital occurred on a nonproject ward and resulted in a mild contusion. Surprisingly, monthly staff physical violence management training with colleagues resulted in a three- to fourfold higher number of sick days compared with sick days resulting from patient violence (89 sick days from staff training versus 29 days from patient-related incidents for 2008, and 165 sick days from colleague-related incidents versus 40 days from patient-related incidents for 2009). Compared with patient-to-staff injuries, these staff-to-staff injuries also resulted in longer sick leaves: mean 6.4 days per injury from colleagues versus 1.6 days per injury from patients for 2008 and 12.7 days per injury from colleagues versus 1.8 days per injury from patients in 2009.</p>
<b>Dauer Baseline/Intervention/Follow-up</b>	6 months
<b>Funding</b>	<p>This project was funded by the Finnish Ministry of Health through the developmental fund for Niuvanniemi Hospital. Dr. Tiihonen is a member of the AstraZeneca and Janssen-Cilag advisory boards. He also reports serving as a consultant for or receiving fees for expert opinions or lectures from AstraZeneca, Bristol-Myers Squibb, Eli Lilly, F. Hoffman–La Roche, GlaxoSmithKline, Janssen-Cilag, Lundbeck, Novartis, Organon, and Pfizer. The other authors report no competing interests.</p>
<b>Nummer</b>	52
<b>Studie</b>	Richmond I; Trujillo D; Schmelzer J; Phillips S; Davis D (1996): Least restrictive alternatives: do they really work? In: J NURS CARE QUAL 11 (1), S. 29–37.
<b>Institution</b>	Veterans Administration Medical Center Fort Lyon, VA Western New York Health Care System Buffalo/New York
<b>Studientyp</b>	pre-post-design
<b>Kontrollgruppe ja/nein</b>	no
<b>Komplex ja/nein</b>	no
<b>Interventionstyp</b>	staff training
<b>Effekt ja/nein auf S/R</b>	yes
<b>Beschreibung Intervention</b>	Staff training focussing on prevention and management of disturbed behavior, early assessment of disruptive behavior, interventions using least restrictive alternatives, and a team approach to using physical restraint if least restrictive alternatives are ineffective
<b>Beschreibung Patienten</b>	psychiatric inpatients and nursing home residents, including many

	veterans, having difficulty functioning in an unstructured environment and so requiring long term management
<b>Beschreibung Outcomevariablen</b>	seclusion and restraint hours in the psychiatric service per year
<b>Beschreibung Ergebnisse</b>	1991: 3388 restraint and 396 seclusion hours -> 1992: 1812 restraint and 788 seclusion hours. Total S/R hours declined by 31 percent, and restraint hours by 47 percent. But 2 of 3 wards showed an increase in seclusion only hours.
<b>Beschreibung sekundäre Ergebnisse</b>	during the 12 month study period 873 incidents of disruptive behavior occurred, 75 resulted in restraint, 25 in seclusion, 773 were managed using least restrictive alternatives
<b>Dauer Baseline/Intervention/Follow-up</b>	1 year baseline, 1 year post-intervention
<b>Funding</b>	not reported

<b>Nummer</b>	53
<b>Studie</b>	Rohe, T.; Dresler, T.; Stuhlinger, M.; Weber, M.; Strittmatter, T.; Fallgatter, A. J. (2016): Architectural modernization of psychiatric hospitals influences the use of coercive measures. In: Der Nervenarzt. DOI: 10.1007/s00115-015-0054-0.
<b>Institution</b>	Klinik für Psychiatrie und Psychotherapie/Uni Tübingen
<b>Studientyp</b>	pre-post-design // interrupted time series??
<b>Kontrollgruppe ja/nein</b>	no
<b>Komplex ja/nein</b>	no
<b>Interventionstyp</b>	changes of the physical ward environment
<b>Effekt ja/nein auf S/R</b>	yes
<b>Beschreibung Intervention</b>	Die früheren zehn Stationen im Altbau besaßen Zwei- bis Vierbettzimmer und umfassten für jeweils 16 bis 18 Patienten insgesamt eine Grundfläche von ca.200m <sup>2</sup> , mit nur zwei Duschen und Toiletten pro Station. Die neun Neubaustationen (je 17 Patienten, insgesamt ca. 400m <sup>2</sup> ) bieten Ein-und Zweibettzimmer mit jeweils einer barrierefreien Nasszelle. Die Zimmer haben einen eigenen Bereich für jeden Patienten (mit Bett, Schrank und Schreibplatz) und sind suizidpräventiv eingerichtet (z.B. Sicherheitsglasscheiben, Metallspiegel und verdeckte Kabel).
<b>Beschreibung Patienten</b>	verschieden psychiatrische Patienten
<b>Beschreibung Outcomevariablen</b>	Anzahl der Fixierungen, Anzahl der Tage mit Fixierungen, Anzahl der fixierten Patienten, durchschnittliche Dauer von Fixierungen
<b>Beschreibung Ergebnisse</b>	Vor dem Umzug im Jahre 2011 lag die Anzahl der Fixierungen mit durchschnittlich 7 % aller belegten Betten pro Monat sogar tendenziell niedriger als in anderen psychiatrischen Kliniken in Südwestdeutschland, in denen bis 2007 im Durchschnitt 9,5 % aller behandelten Patienten Zwangsmaßnahmen unterlagen. Nach dem Umzug reduzierte sich der monatliche, an der durchschnittlichen

	Bettenbelegung normierte Umfang der Zwangsmaßnahmen um 48–84 %. Die Anzahl der fixierten Patienten reduzierte sich um 50 % (0.069 -> 0.035; t37 = 5,968; p < 0,001; d = 1.96), die Anzahl der Tage mit Fixierung um 64 % (0.222 -> 0.081; t37 = 5,509; p < 0,001; d= 1,81), die durchschnittliche Dauer der Fixierungen um 52 % (2.015 -> 0.962; t37 = 3,195; p = 0,003; d= 1,05).
<b>Beschreibung Nebenwirkungen</b>	Der Einsatz von Zwangsmedikation reduzierte sich um 84 % (t37 = 6,669; p < 0,001). Auch die Anzahl fürsorglicher Zurückhaltungen reduzierte sich um 48 % (t37 = 3,491; p = 0,001). Der gleichzeitige Abfall der Zwangsmaßnahmen und -medikationen zeigt, dass die abnehmenden Fixierungen nicht durch zusätzliche Zwangsmedikationen kompensiert wurden.
<b>Dauer Baseline/Intervention/Follow-up</b>	baseline 24 Quartale, post-intervention 15 Quartale
<b>Funding</b>	T.Rohe, T. Dresler, M. Stuhlinger, M. Weber und A. J. Fallgatter geben an, dass kein Interessenkonflikt besteht. T. Strittmatter ist ausführender Architekt des Klinikneubaus. Funding not reported
<b>Qualitätsbemerkung</b>	aggregierte und geglättete Daten verwendet

<b>Nummer</b>	54
<b>Studie</b>	Schepelern, E. S.; Aggernaes, K. H.; Stender, A. K.; Raben, H. (1993): Use of restraints in a psychiatric department, Frederiksberg Hospital, before and after introduction of the new psychiatric law. Restraining devices. In: Ugeskrift for laeger 155 (50), S. 4091–4095.
<b>Institution</b>	Sct. Hans Hospital, Psychiatric Department/Frederiksberg Hospital
<b>Studientyp</b>	pre-post-design, prospektiv
<b>Kontrollgruppe ja/nein</b>	no
<b>Komplex ja/nein</b>	no
<b>Interventionstyp</b>	political/legislative changes
<b>n Patienten</b>	145 restrained patients (167 admissions), 58 baseline, 87 nach Gesetzesänderung
<b>Effekt ja/nein auf S/R</b>	no
<b>Beschreibung Intervention</b>	New Danish law concerning commitment and compulsory procedures in psychiatry from 1.10.1989. Das Gesetz sichert die rechtliche Stellung psychisch kranker Patienten, regelt Fixierungen und versucht diese wo möglich zu reduzieren oder zu verhindern. Es regelt Indikation und Durchführung von Fixierungen, die Anwendung körperlicher Gewalt sowie die Einrichtung einer Sitzwache und eines Patientenfürsprechers.
<b>Beschreibung Patienten</b>	stationäre psychiatrische Patientne zwisch 15 und 90 Jahren, die Zwang erlitten habe, Männer und Frauen, Diagnosen: Schizophrenie, Manie, Depression, reaktive Psychose, organische Psychose
<b>Beschreibung Outcomevariablen</b>	number and duration of restraints

<b>Beschreibung Ergebnisse</b>	Nochanges were registered in the number of restraints in connection with the law reform, but the duration of the fixations increased by 42 %.
<b>Beschreibung sekundäre Ergebnisse</b>	The number of medications given forcibly in connection with the resrtaints increased significantly.
<b>Dauer Baseline/Intervention/Follo w-up</b>	23 Monate vor und 24 Monate nach Gesetzesänderung
<b>Funding</b>	not reported

<b>Nummer</b>	55
<b>Studie</b>	Smith, S.; Jones, J. (2014): Use of a sensory room on an intensive care unit. In: Journal of psychosocial nursing and mental health services 52 (5), S. 22–30. DOI: 10.3928/02793695-20131126-06.
<b>Institution</b>	East London NHS Foundation Trust; City University
<b>Studientyp</b>	pre-post-design
<b>Kontrollgruppe ja/nein</b>	no
<b>Komplex ja/nein</b>	no
<b>Interventionstyp</b>	sensory room
<b>n Patienten</b>	(15 bed PICU; 7 patients participated in the inteviews; 19 were secluded the 3 months prior to intervention, and 18 the 3 months after)
<b>Effekt ja/nein auf S/R</b>	no
<b>Beschreibung Intervention</b>	Sensory room, 2.5x5m, light blue painted walls, laminate flooring, window with black out roller blind, equipment: foor-mounted bubble tube, optic mat, a light/image emitting projector, two lying bean bags, two sitting bean backs, cushions, iPod, iPod dock, magazines, stress release toys, chewing gum, educational materials promoting relaxation and healthy living
<b>Beschreibung Patienten</b>	males only, PICU, locked doors, average length of stay 3-4 weeks, compulsory detained, usually in secure conditions, acutely disturbed phase of a serious mental disorder with a correspondending increase in risk
<b>Beschreibung Outcomevariablen</b>	seclusions, secluded patients, seclusions per secluded patient
<b>Beschreibung Ergebnisse</b>	The number of seclusion incidents was higher after the sensory room was introduced with 27 incidents of seclusionin the three months prior to the sensory room introduction and 37 incidents in the following 3 months. 18 patients secluded prior nach 19 patients secluded after. But more repeater incidents post. (25 repeater events in 6 patients post vs. 12 repeater events in 4 patients prior)
<b>Dauer Baseline/Intervention/Follo w-up</b>	3 months baseline, 3 months post-intervention
<b>Funding</b>	Ms. Smith conducted this research as a Clinical Academic at City

	University London, a program funded by East London NHS Foundation Trust and part of the Joint Institute of Mental Health Nursing.
<b>Qualitätsbemerkung</b>	small sample

<b>Nummer</b>	56
<b>Studie</b>	Stead, Karen; Kumar, Saravana; Schultz, Timothy J.; Tiver, Sue; Pirone, Christy J.; Adams, Robert J.; Wareham, Conrad A. (2009): Teams communicating through STEPPS. In: The Medical journal of Australia 190 (11 Suppl), S128-32.
<b>Institution</b>	South Australian Department for Health; Center for Allied Health Evidence/University of South Australia; Australian Patient Safety Foundation; Cramond Clinic/Queen Elizabeth Hospital; Health Observatory/University of Adelaide; Lyell McEwin Hospital
<b>Studientyp</b>	pre-post-design // interrupted time series??
<b>Kontrollgruppe ja/nein</b>	no
<b>Komplex ja/nein</b>	no
<b>Interventionstyp</b>	staff training? Communication through STEPPS
<b>n Patienten</b>	(five sites, including the mental health site)
<b>Effekt ja/nein auf S/R</b>	yes
<b>Beschreibung Intervention</b>	Communication through STEPPS, ad hoc gatherings, structured team approach
<b>Beschreibung Patienten</b>	mental health patients???
<b>Beschreibung Outcomevariablen</b>	number of unique seclusion events per admission per month
<b>Beschreibung Ergebnisse</b>	Seclusion rates before implementation were significantly higher than after implementation.
<b>Dauer Baseline/Intervention/Follow-up</b>	26 months baseline, 12 months post intervention
<b>Funding</b>	US Department of Defense and the Agency for Healthcare Research and Quality permitted the use of TeamSTEPPS material and offered guidance during program implementation-
<b>Qualitätsbemerkung</b>	insufficient reporting about patients (mental health, what's about the other sites, were also non-mental health patients secluded...), intervention (content of training)

<b>Nummer</b>	57
<b>Studie</b>	Steinert, Tilman; Zinkler, Martin; Elsasser-Gaissmaier, Hans-Peter; Starrach, Axel; Hoppstock, Sandra; Flammer, Erich (2015): Long-Term

	Tendencies in the Use of Seclusion and Restraint in Five Psychiatric Hospitals in Germany. In: Psychiatrische Praxis 42 (7), S. 377–383. DOI: 10.1055/s-0034-1370174.
<b>Institution</b>	ZfP Südwürttemberg/Weissenau und Schussenried, Klinik für Psychiatrie und Psychotherapie I/Uni Ulm; Psychiatrische Klinik der Kliniken Landkreis Heidenheim gGmbH, Klinik an der Lindenhöhe Offenburg, Bezirkskrankenhaus Kaufbeuren
<b>Studientyp</b>	Zeitreihe
<b>Kontrollgruppe ja/nein</b>	no
<b>Komplex ja/nein</b>	no
<b>Interventionstyp</b>	Benchmarking (und komplexe interventionen)
<b>n Patienten</b>	138 580 BehandlungsfÄLLE
<b>Effekt ja/nein auf S/R</b>	Yes
<b>Beschreibung Intervention</b>	Benchmarking, Maßnahmen zur Reduktion von Zwangsmaßnahmen (klinikinterne LL, DGPPN-LL, Deseskalationstrainings, sonstige Schulungen, Hospitation in England/Festhaltetechniken/Physical restraint, strukturierte Risikovorhersage, 4-Stufen-Programm zur Deeskalation (Primat Festhalten vor Fixieren, Bezugspersonensystem, Stationsöffnung, Behandlungsvereinbarungen, klinikinterne Kriseninterventionsteams, Einführung einer verpflichtenden 1:1 Überwachung, erhöhte Anforderungen an die Dokumentation, Verkürzung der Überprüfungsintervalle, technische Alternativen in der Gerontoüsyhiatrie (geteilte Bettgitter, Klingelmatte, Niedrigbett, Hüftprotektoren), Bewegungstraining in der Gerontopsychiatrie, Vermittlung durch Patientenfürsprecher und Beschwerdestellen, spezialisierte Stationskonzepte, geeignete Architektur, Leadership
<b>Beschreibung Patienten</b>	psychiatrische Patienten F0-F4, F6
<b>Beschreibung Outcomevariablen</b>	Anteil von Zwangsmaßnahmen betroffener Fälle an allen Behandlungsfällen in %, durchschnittliche Dauer einer freiheitsbeschränkenden Maßnahme in Stunden, kumulative Dauer aller Zwangsmaßnahmen pro Fall in Stunden
<b>Beschreibung Ergebnisse</b>	Insgesamt reduzierte sich der Anteil der Betroffenen innerhalb von 8 Jahren von 8,2 % 2004 auf 6,2 % 2012. Bei einer Steigung der Regressionsgeraden von –0,2 ergab sich also ein Rückgang von durchschnittlich 0,2 Prozentpunkten pro Jahr. Die Reduktion betraf in erster Linie die Diagnosegruppe F0, während sich in den anderen Diagnosegruppen keine eindeutigen Tendenzen zeigten. Auch von 2011 nach 2012 zeigte sich keine auffällige Änderung außer einem Anstieg in der Diagnosegruppe F1 auf den höchsten bis dahin festgestellten Wert. Die Standardabweichung zwischen den Kliniken reduzierte sich stetig mit einem Koeffizienten von 0,34 /Jahr. Bei der durchschnittlichen Dauer einer Maßnahme ist kein eindeutiger Trend über die Jahre erkennbar. Zwischen 2011 und 2012 war eine Verkürzung der durchschnittlichen Dauer einer Maßnahme von 10,2

	<p>auf 7,8 Stunden feststellbar, d. h. um 23,5 %. Dies betraf weitgehend alle Diagnosegruppen gleichermaßen. Bei der durchschnittlichen kumulativen Dauer der Maßnahmen pro betroffenen Fall über alle Diagnosen hinweg sind dabei eine eindeutigen Tendenzen festzustellen. Der Koeffizient der Regressionsgeraden ergibt einen Rückgang von 0,6 Stunden/Jahr pro betroffenen Fall. Die Tendenzen in den einzelnen Diagnosegruppen sind unterschiedlich. Bei den organischen psychischen Störungen ist eine Tendenz zur Abnahme zu erkennen, bei den übrigen Diagnosegruppen fand sich kein einheitlicher Trend. Zwischen 2011 und 2012 zeigte sich bei der Diagnosegruppe F3, aber auch bei F0 und F1, ein deutlicher Anstieg, während es bei F2 zu einer leichten Abnahme kam. Zunahmen waren auch bei den Diagnosegruppen F4 und F6 zu beobachten, wo die Zahlen allerdings stark schwanken. Bezogen auf die Gesamtzahl aller Behandlungsfälle (kumulierte Dauer der Maßnahmen pro Fall x Anteil der Betroffenen) ergab sich die größte Abnahme von 2010 auf 2011 (von 3,06 Stunden pro Behandlungsfall auf 2,48 Stunden), gefolgt von einem nahezu vergleichbar großen Anstieg 2012 (auf 2,95 Stunden pro Behandlungsfall).</p>
<b>Dauer</b>	
<b>Baseline/Intervention/Follow-up</b>	Beobachtungszeitraum 9 Jahre
<b>Funding</b>	keine Interessenskonflikte
<b>Qualitätsbemerkung</b>	unklar, welche Kliniken welche Interventionen durchführen, welche Interventionen was bringen, was allein auf Benchmarking (Hawthorneffekt) zurückzuführen ist.

<b>Nummer</b>	58
<b>Studie</b>	Sullivan, Ann M.; Bezmen, Janet; Barron, Charles T.; Rivera, James; Curley-Casey, Linda; Marino, Dominic (2005): Reducing restraints: alternatives to restraints on an inpatient psychiatric service--utilizing safe and effective methods to evaluate and treat the violent patient. In: The Psychiatric quarterly 76 (1), S. 51–65.
<b>Institution</b>	Gold Coast Hospital/Spouthport/Queensland, Reserach Center for Clinical Practice Innovation/Griffith University, Department of Occupational Therapy/University of Queensland
<b>Studientyp</b>	pre-post-design, retrospective
<b>Kontrollgruppe ja/nein</b>	no
<b>Komplex ja/nein</b>	yes
<b>Interventionstyp</b>	patient-focused care (= staff rotation and risk assessment and staff training)
<b>n Patienten</b>	330 pre, 310 post intervention (48 secluded pre, 31 post intervention)
<b>Effekt ja/nein auf S/R</b>	yes (just duration decreased)
<b>Beschreibung Intervention</b>	In June of 2001 nursing began using a violence assessment tool

created to look at three specific areas. Part one of the tool detailed pertinent history and precipitants to violence such as past violence history, access to weapons, history of abuse, cognitive and physical deficits ranging from head trauma to limited intellectual functioning, and violence precipitating situations (Figure 1). In part two, the clinician defined with the patient those behaviors, which were the patient's way of manifesting agitation, aggression or violence either verbal and physical. Staff discussed specific details as to how the patient expressed his or her anger and aggression and noted for example postural movements: large movements through the torso may pose a greater threat to the staff and other patients, while those that are gestural or contained within one small body part and do not move through the torso, may pose less of a threat. In part three, the patient was then given options for interventions that he or she might find helpful when faced with a potential loss of control. Choices were made from a realistic menu that included many options such as: physical (exercise, walking, deep breathing); cognitive (reading, painting, watch TV); social (talking with friend or staff, being alone); environmental (decreasing stimulation, listening to music); spiritual (prayers, meditation, yoga). The tool did rate potential for violence as low, medium or high, but was primarily utilized as a guide for how to approach each patient in a unique way to meet his or her needs. A primary goal of the tool was to help nurses establish conversations with patients around this genuinely difficult topic for both patients and staff. When nursing staff supported patients in discussing their expressed feelings of violence and worked with them to choose realistic options of dealing with those feelings, they began to develop an effective partnership necessary to learning new behaviors. This information was then shared with the treatment team, and the plan of care reflected patient choices. In addition staff were trained in new methods of working with patients who became agitated or threatened violence. This training included several formal courses: 8-hour Crisis Intervention Course, an Alternatives to Restraint and Seclusion Course, and training in Cultural Diversity. Units regularly monitored their incidents and rates of seclusion and restraints, and on some units it became a measure of treatment success and staff pride that restraint and seclusion use was minimal. Whenever seclusion or restraint were utilized, these events were carefully reviewed by staff and patients to determine what might have been done differently.

#### Beschreibung Patienten

acute psychiatric unit, 8 bed locked unit within a large regional hospital, 78 % male, age in average 32 years, diagnosis: schizophrenia, substance related disorders, bipolar disorder (manic phase), depressive disorder, personality disorder, delirium/dementia/cognitive disorder, anxiety and dissociative disorder, LOS in average 13.5 days, 8 days in acute care area



<b>Beschreibung Outcomevariablen</b>	number of times in seclusion (median), length of time secluded (median hours)
<b>Beschreibung Ergebnisse</b>	no difference in number of seclusion (median pre and post 1.0), but length of time secluded decreased from 5.5 hours (median) to 3.5 hours (median)
<b>Beschreibung sekundäre Ergebnisse</b>	pre intervention more haloperidol was given
<b>Dauer Baseline/Intervention/Follow-up</b>	6 months baseline, 6 months post-intervention
<b>Funding</b>	conflict of interest: none

<b>Nummer</b>	59
<b>Studie</b>	Sullivan D; Wallis M; Lloyd C (2004): Effects of patient-focused care on seclusion in a psychiatric intensive care unit...including commentary by Holmes D and Perron A. In: International Journal of Therapy & Rehabilitation 11 (11), S. 503–508.
<b>Institution</b>	Elmhurst Hospital Center in Queens/mt. Sinai School of Medicine
<b>Studientyp</b>	pre-post-design // interrupted time series??
<b>Kontrollgruppe ja/nein</b>	no
<b>Komplex ja/nein</b>	yes
<b>Interventionstyp</b>	complex (violence safety program: structured risk assessment + individual crisis plan for early intervention + staff training (least restrictive alternatives, intercultural competencies))
<b>Effekt ja/nein auf S/R</b>	yes
<b>Beschreibung Intervention</b>	staff were rostered to different appts of the ward, which resulted in them working with people who were not as acutely unwell; daily nursing assessment (brief mental state component, risk of violence or harm to self or others, individual service plan for the following 24h), workshops covering topics such as verbal de-escalation
<b>Beschreibung Patienten</b>	psychiatric in-patients, US-American with special wards for Asians and Latinos
<b>Beschreibung Outcomevariablen</b>	patients confined, confinement episodes, confinement hours
<b>Beschreibung Ergebnisse</b>	Patients confined in all adult units per thousand patient days significantly declined from 5.8 in 1998 to 1.6 in 2003. The lowest rate of individuals confined per thousand patient days occurred in 2002 at 1.3 patients. Confinement events per 1000 patient days in all adult units decreased from 10.9 in 1998 to 3.2 in 2003. The lowest rate of confinement events was in 2002 at 1.7. Total Confinement hours per thousand patient days decreased from 36.6 hours in 1998 to 6.6 in 2003, with the lowest rate occurring in 2002 at 3.0 hours per thousand patient days.
<b>Beschreibung sekundäre</b>	Use of alternative methods for violence control and safety on unit

<b>Ergebnisse</b>	<p>AB-11 in 2003 showed that the most commonly used methods were: 32 % favored talking to staff; 17 % walking with staff; 12 % use of time out or a quiet room/space; 8 % decrease stimulation and 20 % others including special requests for calling specific person on the phone, movie or TV of their choice, talking to another patient with staff assistance. The average length of stay on the adult service did not vary to any large extent during the years measured: 1998 LOS 21.7 days; 1999 LOS 27.5 days; 2000 LOS 30.9 days; 2001 LOS 25.5 days; 2002 LOS 29.3 days; 2003 LOS 29.1. The length of stay on the Adult Units is high largely due to patients needing housing placement.</p>
<b>Beschreibung Nebenwirkungen</b>	<p>The number of injurious behaviors (self-inflicted gestures, and attempts) and altercations (between staff and patients) per thousand patient days on the adult units from 1998 to 2003 were as follows: a general decrease in altercations from 1998 through 2003 from 4.1 to 2.8, the lowest in 2002 at 1.9; a decrease in Adult self-injurious behaviors from 0.9 to 0.4 in 2003. There was some variation in the self-injurious behaviors, with an increase in 2000 to 1.4 and 2002 at 1.1. However, there was a significant decrease in 2003 at 0.4. The trend of decrease in altercation follow the same trend as the decrease in confinement on the Adult Services with the lowest in adult altercations in 2002, the same as the lowest confinement rates. It should be noted that the number of these events per thousand patient days was low throughout this period. The use of IM medication on Unit A between 2001 and 2003 decreased slightly in medications given per thousand patient days from 8.0 to 6.5 and increased slightly in number of patients who received IM medication from 2.3 to 4.3. There was no significant increased trend in use of IM medication for stat emergency purposes in this unit during the reduction in use of restraints and seclusion. The rate of use of special observation hours per thousand patient days decreased on the Adult Service from June 2002 to December 2003 . There was no trend upward in special observation hours with the reduction in restraint and seclusion use during this period.</p>
<b>Dauer Baseline/Intervention/Follo w-up</b>	3,5 years baseline? 2,5 years post-intervention?
<b>Funding</b>	Not reported
<b>Nummer</b>	60
<b>Studie</b>	Taxis, J. Carole (2002): Ethics and praxis: alternative strategies to physical restraint and seclusion in a psychiatric setting. In: Issues in mental health nursing 23 (2), S. 157–170.
<b>Institution</b>	University of Texas in Austin/School of Nursing
<b>Studientyp</b>	observational study??

<b>Kontrollgruppe ja/nein</b>	no
<b>Komplex ja/nein</b>	yes
<b>Interventionstyp</b>	Complex
<b>n Patienten</b>	(86-bed unit)
<b>Effekt ja/nein auf S/R</b>	yes
<b>Beschreibung Intervention</b>	A group of nurses discussed S/R, collected data on S/R incidents and developed a program to reduce S/R: The program included (1) development of an assault program, (2) expanded use of individual treatment planning -> development of nonviolent coping skills, (3) implementation of mandatory staff education (sometimes in brief sessions on the unit to make the best use of existing teams) to focus on developing alternatives to restraint and seclusion, (4) patient education to focus on empowering patients to make adaptive choices that enhance self-efficacy incl. structured individual debriefing sessions after S/R, (5) environmental alterations -> Oasis room, (6) creation of a communication feedback loop to disseminate information and progress in reducing restraints and seclusions, and (7) administrative and programmatic changes -> audit tool for nurses to check the S/R practice after every event, -> special treatment program for people with personality disorders with group therapy and staff education. There were many concerns about safety, especially from unlicensed personal, leadership and an interdisciplinary group with all clinical disciplines to implement these changes were required.
<b>Beschreibung Patienten</b>	adult unit in a state psychiatric facility, people with psychosis, personality disorders? (long term??)
<b>Beschreibung Outcomevariablen</b>	seclusion and restraint events
<b>Beschreibung Ergebnisse</b>	94 % reduction in the incidence of restraint and seclusion
<b>Beschreibung sekundäre Ergebnisse</b>	comprehensive programmatic changes <sup>1</sup>
<b>Dauer</b>	
<b>Baseline/Intervention/Follow-up</b>	42 months
<b>Funding</b>	not reported
<b>Qualitätsbemerkung</b>	insufficient reporting about patient characteristics, data for several quarters are missing, insufficient reporting about when the changes were implemented and in which order, contaminations?
<b>Nummer</b>	61
<b>Studie</b>	Teitelbaum, A.; Volpo, S.; Paran, R.; Zislin, J.; Drumer, D.; Raskin, S. et al. (2007): Multisensory environmental intervention (snoezelen) as a preventive alternative to seclusion and restraint in closed psychiatric wards. In: Harefuah 146 (1), 11-4, 79-80.
<b>Institution</b>	Jerusalem Mental Health Center/Kfar Shaul Psychiatric Hospital

	affiliated with the Hadassah Faculty of Medicine/Hebrew University
<b>Studientyp</b>	CCT, pre-post-design
<b>Kontrollgruppe ja/nein</b>	yes
<b>Komplex ja/nein</b>	no
<b>Interventionstyp</b>	sensory room
<b>n Patienten</b>	626 Männer (davon 234 gesnoezelt, 393 fixiert), 258 Frauen fixiert
<b>Effekt ja/nein auf S/R</b>	yes
<b>Beschreibung Intervention</b>	Männer sind Interventionsgruppe: Snoezelen gegen psychomotorische Unruhe, Anspannung, verbale Aggressionen (bei tätlichen Aggressionen, wenn Deeskalation und Medikation nicht hilfreich, Fixierung wegen akuter Eigen/Fremdgefährdung, muss in Israel alle 4 h durch Arzt angeordnet werden). Bei Snoezelen wählt Pat. Stimulus selbst aus, muss selbst aktiv werden, wird dabei über Mikro von einem "enableing therapist" supervidiert: Musik, Lavendelduft... Pat. ist im Raum alleine, Intervention dauert etwa 30-40 Minuten.
<b>Beschreibung Kontrolle</b>	Frauen sind Kontrollgruppe, kein Snoezelen, TAU.
<b>Beschreibung Patienten</b>	Psychiatrische Patienten mit F20, anderen Psychosen, affektiven Störungen, Persönlichkeitsstörungen, illegaler Drogenkonsum als Komorbidität. Geschlossene Abteilung. Frauen- und Männergruppe unterscheiden sich nicht wesentlich.
<b>Beschreibung Outcomevariablen</b>	Fixierungen pro Bett
<b>Beschreibung Ergebnisse</b>	Frauen haben vor der Intervention signifikant weniger Fixierungen als Männer (1,027 vs. 1,7), Männer haben nach der Intervention signifikant weniger Fixierungen als vor der Intervention (1,17 vs. 1,7). Die Fixierungen sind bei den Frauen über die Zeit extremw angestiegen (1,027 vs. 2,42), allerdings nicht signifikant wegen hoher SD (Ausreißer?).
<b>Beschreibung sekundäre Ergebnisse</b>	Im Schnitt haben 1,3 Pat pro Tag gesnoezelt, Pat. gaben in Umfrage positives Feedback für die Intervention, aggressives Verhalten ging auf Station zurück (nur in der Diskussion erwähnt)
<b>Dauer Baseline/Intervention/Follow-up</b>	6 Monate Baseline, 6 Monate post-intervention
<b>Funding</b>	not reported
<b>Qualitätsbemerkung</b>	Männer-Frauen Vergleich gerechtfertigt, Männer waren zu Beginn signifikant häufiger fixiert (aggressiver??)? Woher kommt große SD und Zunahme bei Frauen?, kein Reporting zu klinischen Daten wie Pathopsychologischen Phänomenen, medikamentöser Behandlung
<b>Nummer</b>	62
<b>Studie</b>	Templeton L; Gray S; Topping J (1998): Seclusion: changes in policy and practice on an acute psychiatric unit. In: J MENT HEALTH 7 (2), S. 199–202.

<b>Institution</b>	Wexham Park Hospital
<b>Studientyp</b>	pre-post-design, baseline retrospective, post-intervention prospective
<b>Kontrollgruppe ja/nein</b>	no
<b>Komplex ja/nein</b>	no
<b>Interventionstyp</b>	Complex, data use for an audit with consecutive changes in policies and staff education
<b>n Patienten</b>	annual admission rate of around 900
<b>Effekt ja/nein auf S/R</b>	yes
<b>Beschreibung Intervention</b>	All episodes of seclusion between July 1993 and June 1994 were studied retrospectively. Information regarding each patient's admission and seclusion dates, reason for seclusion and previous attempts to defuse the situation were sought from seclusion forms and the casenotes. The timing of reviews and the identity of staff attending these were recorded as well as the length of the episode. The results were compared to the standards in the Code of Practice and a new policy was written emphasising these standards. The results were presented at the multi-disciplinary audit meeting and staff were educated about the standards. The new policy was accepted and all nursing staff were instructed in its use by senior nurses who were present at the meeting. The audit was repeated retrospectively after a year of its use.
<b>Beschreibung Patienten</b>	open acute psychiatric unit with a lockable room for seclusion
<b>Beschreibung Outcomevariablen</b>	Number of seclusion episodes, Mean length of seclusion (hours), Mean days from admission, Percentage out of working hours
<b>Beschreibung Ergebnisse</b>	In the year 1993±94, 19 patients were involved in 29 seclusion episodes, seven patients being secluded twice and one four times. In the year 1995±96, this fell to 10 patients in 11 episodes despite a slightly increased admission rate (882 admissions in 1993±94 compared to 975 for 1995±96). This represented a 66 % reduction in seclusion use, which was statistically significant ( $p < 0.01$ ). In the 1993±94 study, was secluded four times and seven were secluded twice, whereas in the re-audit period, only one patient was secluded twice. There was also a reduction in the proportion of seclusion episodes occurring outside working hours, i.e. weekends and between 5 p.m. and 9 a.m. weekdays (45 % at re-audit compared to 82 % initially). Patients were also secluded later in their admission, mean time being 54 days, median 28 days (range zero to 323 days) compared to a mean of 20 days and a median of 2 days in the earlier audit (range zero to 276 days). The mean length of seclusion fell from 12 hours (range 1 hour 20 minutes ± 50 hours 50 minutes) to 6.5 hours (range 1 hour ± 24 hours 35 minutes). These changes were not, however, statistically significant
<b>Beschreibung sekundäre Ergebnisse</b>	Improvements in documentation were also seen as a result of the audit, with statistically significant improvement in the legibility of staff names on seclusion record. At re-audit, all indications for

	seclusion were appropriate whereas previously inappropriate reasons such as damage to property or absconding had been noted. In addition, significantly more interventions and plans for seclusion were documented. During the re-audit period, more reviews occurred within the recommended time but this difference was not statistically significant. The longest period between reviews was 6 hours, whereas in the first period of study, eight patients waited nine hours or more between reviews. During the first study period, none of the 13 patients secluded for 8 hours or more received an independent review whereas at re-audit, three of five did receive this.
<b>Dauer Baseline/Intervention/Follo w-up</b>	1 year baseline, 1 year post-intervention
<b>Funding</b>	not reported

<b>Nummer</b>	63
<b>Studie</b>	van de Sande, R.; Nijman, H. L. I.; Noorthoorn, E. O.; Wierdsma, A. I.; Hellendoorn, E.; van der Staak, C.; Mulder, C. L. (2011): Aggression and seclusion on acute psychiatric wards: effect of short-term risk assessment. In: The British journal of psychiatry : the journal of mental science 199 (6), S. 473–478. DOI: 10.1192/bjp.bp.111.095141.
<b>Institution</b>	Mental Health Centre Bavo-Europoort/University of Applied Science Utrecht; Behavioural Science Institute/Radboud University Nijmegen; Erasmus Medical Centre/Department of Psychiatry/Research Center O3
<b>Studientyp</b>	cluster randomised controlled trial
<b>Kontrollgruppe ja/nein</b>	yes
<b>Komplex ja/nein</b>	no
<b>Interventionstyp</b>	Early Interventions// Structured Risk Assessment, BVC
<b>n Patienten</b>	597 (In the 40-week study period, 617 admissions of 597 individual patients occurred on the four wards. During the 10-week preintervention period 170 patients were resident on the wards. During the intervention period 458 patients were resident on the wards, of whom 207 were admitted to an experimental ward and 251 to a control ward.)
<b>Effekt ja/nein auf S/R</b>	yes (for aggressiveness, duration of seclusion, not for number of seclusion incidents or secluded patients)
<b>Beschreibung Intervention</b>	Structured risk assessment: Patients were monitored daily by psychiatric nurses on the experimental wards by means of risk assessment scales, from the first day of admission until discharge or transfer to another ward. The item scores on the Crisis Monitor were discussed during inter- and multidisciplinary meetings. On a daily basis the Brøset Violence Checklist and the Kennedy–Axis V (short version) scale were used to identify risks of loss of control that might

	<p>result in imminent (but preventable) escalations on the ward. Once a week the Kennedy–Axis V (full version), the Brief Psychiatric Rating Scale (BPRS), the Dangerousness Scale and the Social Dysfunction and Aggression Scale were used. All psychiatric nurses and doctors on the two experimental wards were trained to use the instruments on site directly after the random allocation of the wards to either the experimental or the control cluster.</p>
<b>Beschreibung Kontrolle</b>	TAU (assessment was based purely on clinical judgement)
<b>Beschreibung Patienten</b>	<p>psychiatric inpatients on a acute psychiatric wards, male and female, mean age 38-40, diagnosis: psychosis, personality disorders, drug misuse, on interventions wards more people were involuntary admitted, more people had psychotic or personality disorders, at baseline the experimental wards had more seclusion hours (1382 vs 985, <math>p &lt; 0.001</math>)</p>
<b>Beschreibung Outcomevariablen</b>	<p>Aggression incidents (SOAS-R), Aggressive patients, seclusion incidents (Seclusion episodes were recorded using the Argus scale, which enables detailed collection and analysis of seclusion rates, in terms of both incidence and duration of the seclusion. On the Argus scale a seclusion incident is defined as a sequence of periods of seclusion separated by no more than 24 h; for example, two single hours in seclusion separated by 36 h would be counted as two seclusion incidents, whereas two single hours in seclusion separated by less than 24 h would be counted as one seclusion incident.), Secluded patients, Seclusion duration. The procedures were continuously monitored by a clinical nurse specialist to avoid underreporting of aggression incidents and seclusion use in both experimental and control arms.</p>
<b>Beschreibung Ergebnisse</b>	<p>The number of incidents of aggression decreased on the experimental wards from baseline to intervention period compared with the control wards. Relative risk ratios between the baseline and intervention period changed substantially, revealing a lower risk of aggression incidents on the experimental wards (RRR = -68 %; risk ratio at baseline 1.12, 95 % CI 0.72–1.76, at intervention 0.36, 95 % CI 0.26–0.50). When converted into number of aggression incidents per week, the rate on the experimental wards decreased from 4.9 incidents per week (i.e. 49 incidents over 10 weeks) during the baseline period to 1.7 incidents per week (52 incidents over 30 weeks) during the intervention period. On the control wards, the number of aggression incidents hardly changed, going from 3.5 incidents per week (35 incidents over 10 weeks) during baseline to 3.9 incidents per week (117 incidents over 30 weeks) during the intervention period. Otherwise, the number of patients engaged in aggression showed a (non-significant) trend towards reduction on the experimental wards during the intervention period compared with the control wards. The relative risk ratios of the number of aggressive patients between the experimental and the control</p>

	<p>wards, corrected for the number of patient days, however, did show a clear decrease (-50 %) between the baseline (risk ratio RR = 1.13, 95 % CI 0.57–3.10) and intervention period (RR = 0.62, 95 % CI 0.40–0.99), albeit with a 13 % overlapping confidence interval (P&lt;0.10). The number of hours spent in seclusion decreased significantly on the experimental wards after the introduction of the Crisis Monitor, in comparison with the control wards. A significant decrease of -45 % in the risk ratio was observed in seclusion hours per admission hours, showing no overlapping confidence intervals: baseline period RR = 1.12 (95 % CI 1.01–1.19), intervention period RR = 0.62 (95 % CI 0.58–0.66). The number of seclusion incidents showed a small but not significant decrease (-15 %) from baseline (RR = 1.19, 95 % CI 0.76–1.88) to intervention (RR = 1.01, 95 % CI 0.74–1.88). The number of individual patients exposed to seclusion also did not increase significantly (+8 %; 100 % overlapping confidence intervals) on the experimental wards during the intervention period, despite a relatively significant increase in the number of patients secluded in the control ward (RR at baseline 1.42, 95 % CI 0.83–2.48; RR at intervention 1.71, 95 % CI 1.12–2.67), but again with 100 % overlapping confidence intervals.</p>
<p><b>Beschreibung sekundäre Ergebnisse</b></p>	<p>Regression analyses controlling for patient characteristics on time spent in seclusion per number of admission days revealed significant intervention effects but in opposite directions for baseline (b = -0.71, P = 0.005) and intervention periods (b = 1.34, P &lt; 0.0001; goodness-of-fit statistics: deviance 479.419, d.f. = 131 and deviance 1596.856, d.f. = 419, respectively). In this model both short-term (b = -0.78, P &lt; 0.0001) and long-term (b = -2.25, P &lt; 0.0001) involuntary admission and psychotic disorder (b = -1.71, P &lt; 0.0001) showed a negative association with time spent in seclusion. Being aged less than 35 years also showed a positive association with time spent in seclusion (b = 0.35, P = 0.005). Various other regression analyses performed on seclusion incidents and number of secluded patients showed no effect of the intervention, but again involuntary admission as well as a psychotic disorder predicted these outcome variables. Therefore, it seems fair to conclude from these regression analyses that observed differences in patient characteristics did not explain the reduction of time spent in seclusion found on the experimental wards after implementation of the Crisis Monitor.</p>
<p><b>Dauer Baseline/Intervention/Follow-up</b></p>	<p>baseline 10 weeks, intervention/control 30 weeks</p>
<p><b>Funding</b></p>	<p>The study was funded by the Dutch Ministry of Health to investigate interventions that might contribute to the reduction of use of seclusion in The Netherlands.</p>
<p><b>Qualitätsbemerkung</b></p>	<p>Experimental wards had higher baseline measurements, RRR containing differences over time and between wards are discussed,</p>



	randomisation was not successful (-> regression analysis was done)
<b>Nummer</b>	64
<b>Studie</b>	Vruwink, F. J.; Mulder, C. L.; Noorthoorn, E. O.; Uitenbroek, D.; Nijman, H. L. (2012): The effects of a nationwide program to reduce seclusion in the Netherlands. In: BMC psychiatry 12, S. 231. DOI: 10.1186/1471-244X-12-231.
<b>Institution</b>	GGNet (Forensische Psychiatrie?); Mental Health Centre Bavo-Europoort Rotterdam/University of Applied Science Utrecht; Forensic Psychology/Behavioural Science Institute/Radboud University Nijmegen; Erasmus Medical Centre/Public Mental Health/Research Center O3; Quantitative Skills/Consultancy for Research and Statistics
<b>Studientyp</b>	interrupted time series?
<b>Kontrollgruppe ja/nein</b>	no
<b>Komplex ja/nein</b>	no
<b>Interventionstyp</b>	Legislative changes/governmental program
<b>Effekt ja/nein auf S/R</b>	yes
<b>Beschreibung Intervention</b>	From 2006 to 2009, the Dutch government provided €5 m annually for a nationwide program to reduce seclusion in psychiatric hospitals by 10 % a year. In 2006, grants were awarded to 34 Dutch psychiatric hospitals (approximately 70 % of all psychiatric hospitals), a number that had increased to 42 by 2009 (approximately 90 %). The grants were allocated only to psychiatric hospitals that had a specific plan how to reduce the number of seclusions and would also match the sum they received. The total national investment was therefore €40 m, i.e. €20 m from the government and €20 m from the hospitals. Criteria for receiving the grant included the plan having a specific target for reducing seclusion, developing psychiatric intensive care, gathering reliable data on coercive measures, and enhancing expertise of staff (e.g. using specific strategies for preventing seclusion and dealing with problematic behaviours). The projects were very varied in scope. Some sought reductions at institutional level (e.g. closing seclusion rooms), others at ward level (e.g. through new engagement strategies or aggression de-escalation training), others at patient level (e.g. through crisis plans or aggression-risk assessment), and others by combining various levels and strategies.
<b>Beschreibung Patienten</b>	psychiatric inpatients
<b>Beschreibung Outcomevariablen</b>	annual change in seclusion/involuntary medication (per involuntary hospitalization)
<b>Beschreibung Ergebnisse</b>	Whereas the number of seclusions had increased 3.2 % annually from 1998 to 2005 (logit slope = 1.032), they fell significantly between 2006 and 2009 to an annual decrease of 2.0 % (logit slope = 0.980, difference -5,2 %: $z = -8.58$ , $p < 0.001$ ). The use of involuntary

	<p>medication had increased by 8.5 % annually from 1998 to 2005 (logit slope = 1,085). Between 2006 and 2009, this increase was 8.0 % (logit slope = 1.080, difference -0,5 %: z = -0.54, not significant). A 3.3 % annual decrease in the number of seclusions per involuntary hospitalization from 1998 to 2005 (logit slope = 0.967) was followed between 2006 and 2009 by a significantly greater annual decrease of 4.7 % (logit slope = 0.953, difference -1,4 %: z = -2.37, p = 0.018). A 1.8 % annual increase in the number of involuntary medications per involuntary hospitalization from 1998 to 2005 (logit slope = 1.018) became a significantly greater annual increase of 5.1 % between 2006 and 2009 (logit slope = 1.051, difference 3,3 %: z = 3.16, p = 0.002).</p>
<b>Dauer Baseline/Intervention/Follo w-up</b>	baseline 8 years, observation during intervention 4 years
<b>Funding</b>	no conflicts of interest, data provided by Dutch Health Care Inspectorate, funding not reported

<b>Nummer</b>	65
<b>Studie</b>	Wale, Joyce B.; Belkin, Gary S.; Moon, Robert (2011): Reducing the use of seclusion and restraint in psychiatric emergency and adult inpatient services- improving patient-centered care. In: The Permanente journal 15 (2), S. 57–62.
<b>Institution</b>	Office of Behavioural Health for the New York City Health and Hospitals Cooperation
<b>Studientyp</b>	pre-post-design
<b>Kontrollgruppe ja/nein</b>	no
<b>Komplex ja/nein</b>	yes
<b>Interventionstyp</b>	complex, 6CS, Seclusion and Restraint Reduction Initiative, patient--centered, trauma-informed
<b>Effekt ja/nein auf S/R</b>	yes
<b>Beschreibung Intervention</b>	Seclusion and Restraint Reduction Initiative: interdisciplinary change teams are in charge of the initiative at each facility; education about rehabilitation and recovery in a discussion and dialogue format, corporate culture change training ("Creating Violence Free and Coercion Free Mental Health Treatment Environments for the Reduction of Seclusion and Restraint" a training from the National Association of State Mental Health Program Directors' Office of Technical Assistance (OTA)), crises de-escalation training; OTA-

	<p>Consultation; Peer Counselor Program; data transparency: monthly data submission to the corporate office was required and a competition was announced with a prize for the facility with the greatest improvement per year; sensorymodulaiton tools and approaches; Managing agitated patients Work group, implementing emergency response teams and a new job called Behavioral Health Associate (receives extensive crises prevention and de-escalation training) perform some duties that had been assumed by hospital police, trining modules for hospital police; corporate guidelines on S/R e.g. two-hour-maximum limit on an S/R order for adults; Trauma assessment including effective calming measures, triggers for agitation and preferences regarding S/R</p>
<b>Beschreibung Patienten</b>	Psychiatric Emergency and Adult Inpatient Services (unclear if long term facilities are included)
<b>Beschreibung Outcomevariablen</b>	frequency of S/R per 1000 patient hours, mean duration (minutes) of S/R, patient injuries in pyschiatric emergency services
<b>Beschreibung Ergebnisse</b>	<p>Data captures mechanical as well as manual restraints. The frequency of S/R use per 1000 patients dropped markedly during the project. The total duration of restraint episodes rate per 1000 patient hours dropped by 28 %, and the total duration of seclusion episodes decreased 27 %. In addition, there was a decrease in patient injuries in our PES settings by 56 %. Also, the duration per episode of restraint went from a mean of 246.81 minutes to 57.62 minutes between 2007 to June 30, 2009, a 77 % reduction and the mean duration per episode of seclusion decreased from 88.78 minutes to 50.50 minutes, a 43 % reduction. A one-way analysis of variance (ANOVA) of the mean differences between 2007, 2008, and 2009 was conducted. The overall change in inpatient restraint rate did not achieve statistical significance. However, the patterns of use of these methods did change significantly reflecting more targeted and safer use, and significant reduction in the most acute treatment areas. For the adult inpatient service, reductions in frequency of seclusion, mean duration per restraint and mean duration per seclusion were significant at 0.04. Patient injury (restraint) reduction was significant at 0.05. In the PES settings, frequency of restraints was significant at 0.02 and patient injury was significant at 0.03. Given that at the outset of the Seclusion and Restraint Reduction Initiative some facility leadership and staff were concerned that further reductions in S/R use would be difficult especially with the advent of including counts of manual restraints in the S/R data, these declines strongly speak to the success of the initiative. Unfortunately, staff injuries have remained generally level, which could reflect that despite fewer restraints, those patients that are restrained represent a core of significantly violent or agitated patients that contribute to injury.</p>
<b>Dauer</b>	3 years of observation (2007-2009), mentioned baseline year 2006

<b>Baseline/Intervention/Follow-up</b>	not reported
<b>Funding</b>	No conflicts of interest, funding not reported
<b>Qualitätsbemerkung</b>	baseline missing, insufficient reporting about patient characteristics

<b>Nummer</b>	66
<b>Studie</b>	Whitecross, Fiona; Seear, Amy; Lee, Stuart (2013): Measuring the impacts of seclusion on psychiatry inpatients and the effectiveness of a pilot single-session post-seclusion counselling intervention. In: INT J MENT HEALTH NURS 22 (6), S. 512–521. DOI: 10.1111/inm.12023.
<b>Institution</b>	Alfred Psychiatry, Monash Alfred Psychiatry Research Centre
<b>Studientyp</b>	CCT, retrospective?
<b>Kontrollgruppe ja/nein</b>	yes
<b>Komplex ja/nein</b>	no
<b>Interventionstyp</b>	debriefing// post-seclusion debriefing
<b>n Patienten</b>	31 patients
<b>Effekt ja/nein auf S/R</b>	yes
<b>Beschreibung Intervention</b>	Structured debriefing: In developing the content of the intervention, a review of the debriefing published work was conducted with a study by Needham and Sands (2010) particularly influential. They identified five areas that they argued were appropriate for inclusion in postseclusion counselling: (i) counselling; (ii) ventilation; (iii) support and reassurance; (iv) screening for physical adverse effects; and (v) psychoeducation. An emphasis was also on exploring in a discussion between clinician and patient, the patient, staff, and environmental factors that contributed to the occurrence of the seclusion episode, as well as how similar situations in future could be avoided.
<b>Beschreibung Kontrolle</b>	informal debriefing only on patient's request or when a need was identified by clinician
<b>Beschreibung Patienten</b>	patients admitted to the acute inpatient service (58 beds on 2 wards), wards divided in a high-dependency unit (behavioural problems, harming self or others) or low-dependency unit, 14,6 % of 508 patients were secluded on ground floor and 14,8 % of 567 patients on the first floor (baseline?); Participants were mostly male and had a primary diagnosis of a psychotic illness or schizoaffective disorder with the remaining patients having a primary diagnosis of a unipolar or bipolar affective disorder or borderline personality disorder. Highlighting the potential complexity of treating this population, the admission lengths of stay were more than double those of the overall inpatient psychiatry unit during the study period.
<b>Beschreibung Outcomevariablen</b>	Seclusion Register: the number of seclusion episodes across the admission, the number of hours in seclusion across the admission; 22-item Impact of Event Scale-Revised
<b>Beschreibung Ergebnisse</b>	The difference in number of episodes of seclusion for the two groups

	was not significant ( $t(15.6) = 0.95, P = 0.36$ ), whereas participants on the first floor ward (intervention ward) had significantly fewer hours of seclusion ( $t(29) = 2.70, P = 0.01$ ) (Fig. 3). Of additional interest, for patients who experienced more than one episode of seclusion (ground floor ward, five; first floor ward, eight), the mean number of seclusion episodes was far higher for patients on the ground floor (mean = 5.20; standard deviation (SD) = 3.83) than the first floor (mean = 2.50; SD = 1.07).
<b>Beschreibung sekundäre Ergebnisse</b>	No differences were found between the groups on ISE-R scale.
<b>Dauer Baseline/Intervention/Follow-up</b>	10 months of recruiting?
<b>Funding</b>	Alfred research trust

<b>Nummer</b>	67
<b>Studie</b>	Wieman, Dow A.; Camacho-Gonsalves, Teresita; Huckshorn, Kevin Ann; Leff, Stephen (2014): Multisite study of an evidence-based practice to reduce seclusion and restraint in psychiatric inpatient facilities. In: PSYCHIATR SERV 65 (3), S. 345–351. DOI: 10.1176/appi.ps.201300210.
<b>Institution</b>	Human Services Research Institute; Department of Psychiatry/Harvard Medical School/at the Cambridge Health Alliance; Division of Substance Abuse and Mental Health/Delaware Health and Social Services
<b>Studientyp</b>	CCT ?? Case-control-study?
<b>Kontrollgruppe ja/nein</b>	yes
<b>Komplex ja/nein</b>	yes
<b>Interventionstyp</b>	Complex, Six Core Strategies
<b>Untersuchungseinheit</b>	individual psychiatric facility
<b>n Patienten</b>	43 psychiatric facilities
<b>Effekt ja/nein auf S/R</b>	yes
<b>Beschreibung Intervention</b>	6CS implementation stabilized, passing the 20 % threshold then reaching a steady state of an ISRRI score that did not increase or decrease by more than 10 points over a four-month period (N=28)
<b>Beschreibung Intervention II</b>	6CS implementation continuing, passing the threshold then continuing to increase fidelity by adding components throughout the time frame (N=7), Intervention 3: 6 CS implementation decreasing, passing the threshold to reach a plateau and then subsequently declining by more than 10 % (N=5)
<b>Beschreibung Kontrolle</b>	6CS implementation discontinuing, passing the threshold but then subsequently falling below it (N=1); OR 6 CS never implemented, never reaching the threshold score (N=2)
<b>Beschreibung Patienten</b>	psychiatric inpatients including residential programs and psychiatric units in hospitals

<b>Beschreibung Outcomevariablen</b>	<p>Patient-level seclusion and restraint events: S/R rates are specified as the percentage of clients secluded or restrained at least once during the report period, duration of S/R events are specified as hours of S/R per total inpatient hours. Implementation and fidelity was measured with the "Inventory of Seclusion and Restraint Reduction Interventions" (ISRRRI) twice (2004 and 07). The ISRRRI, which was completed by facility staff knowledgeable about their reduction program, required respondents to indicate retrospectively whether and when a particular activity had been implemented. In the second administration, they were also required to identify any activities that had been discontinued and when this occurred.</p>
<b>Beschreibung Ergebnisse</b>	<p>Nine of the 28 facilities that reached stable implementation achieved reductions in the percentage of the overall population secluded, with an average reduction of 17 % (<math>p=.002</math>). Fifteen reduced the amount of seclusion hours per 1,000 treatment hours, with an average reduction of 19 % (<math>p=.001</math>). Nine facilities achieved reductions in the percentage of patients who were restrained, with an average reduction of 30 % (<math>p=.027</math>). Twelve facilities achieved reductions in the hours of restraint, with an average of 55 %, although the change was not significant.</p>
<b>Beschreibung sekundäre Ergebnisse</b>	<p>The dose-effect analysis tested the hypothesis that facilities in the stabilized implementation category (<math>N=28</math>) would have sharper declines in seclusion and restraint rates than facilities in the other implementation categories. The results shown in Figure 3 indicate that the hypothesis was supported with respect to two of the four outcome measures—those related to average duration of seclusion and restraint events—but not to the proportion of the population secluded or restrained. Facilities in the stable implementation group had the greatest mean change in seclusion hours per 1,000 treatment hours (<math>r=.88</math>, <math>p=.02</math>) and in restraint hours per 1,000 treatment hours (<math>r=.46</math>, <math>p=.05</math>). The greatest reduction in percentage secluded, however, was achieved by facilities in the implementation continuing group. Group differences in the change in the percentage of patients restrained were nonsignificant. It is also noteworthy that the order of the implementation categories in relative degree of change varied with respect to the four outcomes.</p>
<b>Dauer Baseline/Intervention/Follo w-up</b>	<p>4 years observation?</p>
<b>Funding</b>	<p>Data collection for this study was funded under task order 280-04-0103 from the Center for Mental Health Services (CMHS) of the Substance Abuse and Mental Health Services Administration (SAMHSA) to the National Association of State Mental Health Program Directors (NASMHPD). Measures from the Behavioral Health Performance Measurement System were licensed for this study by the NASMHPD Research Institute.</p>

<b>Qualitätsbemerkung</b>	not reported which strategies were adopted?
---------------------------	---

<b>Nummer</b>	68
<b>Studie</b>	Yang, Chin-Po Paul; Hargreaves, William A.; Bostrom, Alan (2014): Association of empathy of nursing staff with reduction of seclusion and restraint in psychiatric inpatient care. In: PSYCHIATR SERV 65 (2), S. 251–254. DOI: 10.1176/appi.ps.201200531.
<b>Institution</b>	Department of Psychiatry and Department of Epidemiology and Biostatistics, University of California, San Francisco
<b>Studientyp</b>	pre-post-design
<b>Kontrollgruppe ja/nein</b>	no
<b>Komplex ja/nein</b>	no
<b>Interventionstyp</b>	staff training, empathy training
<b>n Patienten</b>	1098 nursing shifts
<b>Effekt ja/nein auf S/R</b>	no
<b>Beschreibung Intervention</b>	mindfulness-based empathy training
<b>Beschreibung Patienten</b>	inpatient psychiatric unit in a general hospital
<b>Beschreibung Outcomevariablen</b>	binary: any vs. no entry of a patients into S/R in each day or evening shift
<b>Beschreibung Ergebnisse</b>	With controls for shift, patient, and other staffing variables, analyses showed that the presence of more nursing staff with above-average empathy ratings was strongly associated with reduced use of seclusion and restraint but empathy training showed no further benefit.
<b>Dauer Baseline/Intervention/Follow-up</b>	6 months baseline, 6 months post-intervention one year apart
<b>Funding</b>	This project was supported by a University of California, San Francisco, REAC grant.

<b>Nummer</b>	69
<b>Studie</b>	Ashcraft, Lori; Anthony, William (2008): Eliminating seclusion and restraint in recovery-oriented crisis services. In: Psychiatric services (Washington, D.C.) 59 (10), S. 1198–1202. DOI: 10.1176/appi.ps.59.10.1198.
<b>Institution</b>	Recovery Opportunity Center/Recovery Innovations/Phoenix, Arizona, Center for Psychiatric Rehabilitation/Boston University
<b>Studientyp</b>	Time series?
<b>Kontrollgruppe ja/nein</b>	no
<b>Komplex ja/nein</b>	yes
<b>Interventionstyp</b>	Complex, recovery-oriented
<b>n Patienten</b>	14.500 people per year (12000 in the small, 2500 in the large center)
<b>Effekt ja/nein auf S/R</b>	yes
<b>Beschreibung Intervention</b>	Seclusion and restraint elimination strategies included strong leadership direction (CEO informing staff that S/R is not used)

	anymore), policy and procedural change, 4x3-hours recovery-based staff training (esp. about trauma, substance abuse strength-based communication, building resilience, giving responsibility back to consumers, avoiding crises rather than managing them, telling stories of recovery and inviting peers to training), consumer debriefing (what should (have been) done to avoid crisis, staff should be more service orientated) and regular feedback on progress.
<b>Beschreibung Patienten</b>	Involuntarily admitted clients (32 % of the total admissions) were brought by police and others who believed them to be a danger to themselves or others. People admitted voluntarily came because they were frightened by their own thoughts and feelings and needed reassurance, support, or medication. Some of the voluntary clients came because they didn't know what else to do. Some were homeless, were hungry, and had no other alternatives. Many were self-medicating with street drugs and alcohol. Primary Diagnosis: Schizophrenia 27 %, Major depression or mood disorder 31.8 %, Bipolar disorder 15.7 %, Substance abuse 15.1 %, ANxiety disorder 2.3 %. When both primary and secondary axis I data were considered, 44.5 % of the individuals seen had a diagnosis of substance abuse. Fifty-five percent were male. LOS was up to 24h in larger unit and up to 5 days in the smaller one.
<b>Beschreibung Outcomevariablen</b>	restraint and seclusions events per month
<b>Beschreibung Ergebnisse</b>	The larger crisis center took ten months until a month registered zero seclusions and 31 months until a month recorded zero restraints. The smaller crisis center achieved these same goals in two months and 15 months, respectively.
<b>Beschreibung Nebenwirkungen</b>	Over the course of the evaluation, the smaller center decreased its yearly staff injuries from 15 to five, whereas the larger center essentially stayed the same (nine to eight).
<b>Dauer Baseline/Intervention/Follow-up</b>	58 months observation after intervention
<b>Funding</b>	The development of this article was supported in part by the National Institute on Disability and Rehabilitation Research (NIDRR) within the Department of Education and the Center for Mental Health Services (CMHS), a division of the Substance Abuse and Mental Health Services Administration.
<b>Qualitätsbemerkung</b>	baseline is missing
<b>Nummer</b>	70
<b>Studie</b>	Corrigan P, Holmes PE, Luchins D, Basit A, Buican B. (1995): The effects of interactive staff training on staff programming and patient aggression in a psychiatric inpatient ward. In: Behavioral Interventions 10 (1), 17-32.



<b>Institution</b>	Center of Psychiatric Rehabilitation/University of Chicago, Tinely Park Mental Health Center
<b>Studientyp</b>	interrupted time series
<b>Kontrollgruppe ja/nein</b>	no
<b>Komplex ja/nein</b>	no
<b>Interventionstyp</b>	staff training -> social learning program
<b>n Patienten</b>	Two physically seperated housing facilities with 30-32 patients each (one for males, one for females)
<b>Effekt ja/nein auf S/R</b>	yes
<b>Beschreibung Intervention</b>	"Interactive Staff Training (IST)" uses principles of organizational psychology to help line-level staff members design and implement social learning programs for severely mentally ill inpatients. IST is a training package that includes assessment of staff perceptions regarding programatic needs, selection of appropriate social learning strategies to meet these needs (here: token economy, social skills trianing), appointment of a program committee from within the ward to champion development of the social learning strategy, and participative decision making about aspects of the social learning strategy. Weekly meetings for one hour.
<b>Beschreibung Patienten</b>	extended care wards at a state hospital, Patients had diagnoses of severe mental illness (e.g., schizophrenia and manic depression) but, for the most part, not developmental disability; they had typically been hospitalized at least 60 days on acute wards prior to transfer to the extended care ward.
<b>Beschreibung Outcomevariablen</b>	The average number of aggressive incidents (operationalized as patient injury, staff injury, fire, theft, damage to property, and unauthorized absences) and physical restraints per quarter.
<b>Beschreibung Ergebnisse</b>	Number of restraints per quarter prior to implementing the token economy averaged 19.0 (SD = 1.7). This average decreased to 11.3 (SD = 0.6) during the period in which the token economy was implemented, a 41 .OYO reduction. The change in aggression-related incidents as a result of the token economy program was not as dramatic; 69.0 incidents were reported per quarter during baseline (SD = 9.3) while only 60.3 incidents (SD = 9.3) were reported during the token economy condition, only a 12.6 % decrement. Data showed that number or physical restraints remained low after introducing the skills training program; 10.0 (SD = 1 .O) restraints were reported per quarter when the skills training modules were operative. Aggression-related incidents per quarter for the tokens plus skills training condition diminished markedly from the token economy alone to 5 1.2 (SD = 1.9), a 26.8 % reduction from baseline.
<b>Dauer Baseline/Intervention/Follo w-up</b>	3 quaters baseline, 3 quaters post intervention token economy, 2 quateres post-intervention token + skills
<b>Funding</b>	grant from the Illinois Department of Mental Health and

	Developmental Disabilities to the University of Chicago to establish the Illinois State Staff Training Institute
<b>Qualitätsbemerkung</b>	unclear reporting: which quarter belongs to which months on the time axis

<b>Nummer</b>	71
<b>Studie</b>	Craig, C.; Ray, F.; Hix, C. (1989): Seclusion and restraint: decreasing the discomfort. In: Journal of psychosocial nursing and mental health services 27 (7), S. 17–19.
<b>Studientyp</b>	interrupted time series?
<b>Kontrollgruppe ja/nein</b>	no
<b>Komplex ja/nein</b>	yes
<b>Interventionstyp</b>	Complex
<b>Effekt ja/nein auf S/R</b>	Yes
<b>Beschreibung Intervention</b>	unit space for seclusion and restraint was renovated, an anteroom was added for continuous observation during S/R, minimum one RN per shift, at least one person for the patients in S/R - this staff is free from all other unit duties, staff education (crises theory, early recognition, prior interventions), interdisciplinary team for decision making, automatic notification of Medical Director/Hospital Administrator when S/R > 12 h
<b>Beschreibung Patienten</b>	acute care, state-operated hospital
<b>Beschreibung Outcomevariablen</b>	total restraint hours per month
<b>Beschreibung Ergebnisse</b>	Restraint hours per month declined from 1030 in the year prior to the intervention to 408 in the year after
<b>Beschreibung Nebenwirkungen</b>	average monthly seclusion hours initially increased from 231 to 260 hours, but fell to the lowest totals since record-keeping began after about 10 months
<b>Dauer Baseline/Intervention/Follow-up</b>	12 months baseline, 12 months post-intervention
<b>Funding</b>	not reported
<b>Qualitätsbemerkung</b>	insufficient reporting about patient characteristics, no statistical measures (SD, p etc.)

<b>Nummer</b>	72
<b>Studie</b>	Currier, Glenn W.; Farley-Toombs, Carole (2002): Datapoints: use of restraint before and after implementation of the new HCFA rules. In: Psychiatric services (Washington, D.C.) 53 (2), S. 138. DOI: 10.1176/appi.ps.53.2.138.
<b>Institution</b>	department of psychiatry at the University of Rochester School of Medicine in Rochester, New York
<b>Studientyp</b>	pre-post-design
<b>Kontrollgruppe ja/nein</b>	no

<b>Komplex ja/nein</b>	no
<b>Interventionstyp</b>	Legislative change
<b>n Patienten</b>	4 psychiatric units with a total of 80 beds
<b>Effekt ja/nein auf S/R</b>	yes
<b>Beschreibung Intervention</b>	The rules require that a physician or a licensed independent practitioner make a face-to-face assessment of a patient within one hour of the initiation of restraint or seclusion. The rules also shorten the interval between mandatory renewal orders, codify requirements for staff training, and create more stringent requirements for documentation.
<b>Beschreibung Patienten</b>	The medical center has four specialty units—a child and adolescent unit (not relevant for this review), a general adult unit, a unit for medically ill chemical-abusing patients, and a unit for neurogeriatric patients (not relevant for this review).
<b>Beschreibung Outcomevariablen</b>	number and mean duration of episodes of restraint
<b>Beschreibung Ergebnisse</b>	The overall number of episodes decreased by more than 50 percent after the new rules went into effect (adult unit 20 -> 3 episodes, medically ill chemical abusing unit 15 -> 22). Reductions in the use of restraint were seen on all units except the unit for chemical-abusing patients, where a 46.7 percent increase occurred. The mean duration of an episode declined by 40.8 percent overall and 72.1 percent on the general adult unit (adult unit 8.6h -> 2.4h, medically ill chemical-abusing unit 11h -> 8.3h). The higher rate of restraint on the unit for chemical-abusing patients may reflect the large number of delirious patients in drug and alcohol withdrawal who were served on the unit.
<b>Beschreibung sekundäre Ergebnisse</b>	The use and duration of seclusion decreased at similar rates.
<b>Dauer Baseline/Intervention/Follow-up</b>	3 months before the new rules, 3 months after
<b>Funding</b>	not reported
<b>Qualitätsbemerkung</b>	insufficient reporting on seclusion, no statistical measures (SD, p etc.)

<b>Nummer</b>	75
<b>Studie</b>	Goodness, Kelly R.; Renfro, Nancy S. (2002): Changing a culture: a brief program analysis of a social learning program on a maximum-security forensic unit. In: Behavioral sciences & the law 20 (5), S. 495–506. DOI: 10.1002/bsl.489.
<b>Institution</b>	North Texas State Hospital
<b>Studientyp</b>	time-series??//pre-posttest design
<b>Kontrollgruppe ja/nein</b>	no
<b>Komplex ja/nein</b>	no
<b>Interventionstyp</b>	Behavioral therapy// social learning program

<b>Effekt ja/nein auf S/R</b>	yes
<b>Beschreibung Intervention</b>	The essence of the Behavior Management Treatment Program's (BMTP's) Social Learning Diagnostic Program that social learning principles are applied during staff-patient interactions and that all patient activities are utilized as diagnostic evaluations aimed at identifying both the patient's engagement problems and effective dangerousness management strategies. In addition, there are five key behavioral concepts that have been incorporated into the core of the BMTP Social Learning Diagnostic Program: modeling, reinforcement, shaping, overlearning, and generalization. A major thrust of the program is the use of positive reinforcement through contingent points (e.g., tokens), differentiated privilege levels, and social reinforcement to shape and maintain adaptive pro-social behaviors. Moreover, the common denominator for all BMTP programming efforts is the focus on developing a Dangerousness Management Plan that is individual specific and capable of assisting all concerned parties in managing the factors that contribute to a particular patient's dangerousness.
<b>Beschreibung Patienten</b>	extremely challenging, treatment resistive patient population on a maximum-security forensic setting (also civilly committed patients)
<b>Beschreibung Outcomevariablen</b>	incidents and hours of emergency interventions (S/R), average no. of hours and incidents per patient served
<b>Beschreibung Ergebnisse</b>	In fact, in less than two years since changing the program, the average number of incidents of restraint and seclusion dropped by more than 50 %, with FY 1999 (pre-SLDP) having an average of 4.78 incidents per patient served and FY 2001 (post-SLDP) having an average of 2.32. Likewise, the average number of hours that patients spent in restraint and seclusion for each incident absolutely decreased between FY 1999 (pre-SLDP) which saw an 11.20 hour average restraint and seclusion time per patient served and 2000 (post-SLDP) which saw a 10.35 hour average restraint and seclusion time. Even more impressive is that the average number of hours per incident plummeted to 5.75 in FY 2001 (post-SLDP).
<b>Dauer Baseline/Intervention/Follow-up</b>	1 year baseline, 1 year implementation, 1 year post-intervention
<b>Funding</b>	not reported

<b>Nummer</b>	76
<b>Studie</b>	Kostecka, M.; Zardecka, M. (1999): The use of physical restraints in Polish psychiatric hospitals in 1989 and 1996. In: Psychiatric services (Washington, D.C.) 50 (12), S. 1637-1638. DOI: 10.1176/ps.50.12.1637.
<b>Institution</b>	department of psychiatry at the Medical University of Warsaw
<b>Studientyp</b>	pre post

<b>Kontrollgruppe ja/nein</b>	no
<b>Komplex ja/nein</b>	no
<b>Interventionstyp</b>	Legislative changes and political transformations
<b>Untersuchungseinheit</b>	
<b>n Patienten</b>	In 1989 a total of 452 patients were hospitalized on the 11 wards, 207 men and 245 women. In 1996 a total of 414 patients were hospitalized, 163 women and 251 men.
<b>Effekt ja/nein auf S/R</b>	no ??
<b>Beschreibung Intervention</b>	Political transformation from a totalitarian to a democratic system, implementation of the Mental Health Act in 1995
<b>Beschreibung Patienten</b>	11 locked wards (7 in two large psychiatric hospitals, 4 were run by a scientific institute one of the latter in a general hospital), average age of patients 43, all Caucasian, restrained patients mostly suffered from endogenous psychosis/schizophrenia, alcohol dependence
<b>Beschreibung Outcomevariablen</b>	no of patients restrained, no of restraint episodes, no. Of episodes divided by total no. Of patients, no of episodes due to aggression, no. Of episodes due to aggression divided by total number of episodes, mean and SD duration of episodes
<b>Beschreibung Ergebnisse</b>	Significantly more episodes of restraint occurred in 1996 than in 1989; the number of episodes increased in each of the wards studied. However, the number of episodes per patient fell, as did the average duration of each episode. In addition the proportion of episodes that were due to patient aggression increased.
<b>Beschreibung sekundäre Ergebnisse</b>	Wards with high global pathology levels as measured by the Kellam's index had higher rates on three measures— the frequency of restraint episodes, the percentage of patients restrained, and the percentage of episodes due to aggression. The Pearson's correlation coefficients were .66 ( $p=.05$ ), .69 ( $p=.02$ ), and .54 ( $p=.1$ ), respectively. The duration of restraint was correlated with the patient-staff ratio. On wards with more patients per staff member, episodes of restraint were longer ( $r=.7$ , $p=.02$ ).
<b>Dauer Baseline/Intervention/Follow-up</b>	1 year baseline (1989), 1 year post intervention (1995)
<b>Funding</b>	Helsinki Human Rights Foundation
<b>Qualitätsbemerkung</b>	Effects of political transformation and new law cannot be distinguished

<b>Nummer</b>	77
<b>Studie</b>	Lloyd C, King R, Machingura T. (2014): An investigation into the effectiveness of sensory modulation in reducing seclusion within a acute mental health unit. In: Advances in Mental Health 12, S. 93–100.
<b>Institution</b>	Behavioural Basis of Health, Gold Coast Campus, Griffith University; Queensland University of Technology; Gold Coast Health Service

	District.
<b>Studientyp</b>	CCT and pre-post-design
<b>Kontrollgruppe ja/nein</b>	yes
<b>Komplex ja/nein</b>	no
<b>Interventionstyp</b>	Sensory modulation
<b>n Patienten</b>	all patient admitted to intervention or control ward in 1 year (2011)
<b>Effekt ja/nein auf S/R</b>	yes
<b>Beschreibung Intervention</b>	Implementing a sensory modulation room
<b>Beschreibung Patienten</b>	acute mental health inpatient unit, 237 of the seclusion episodes male, 99 female, nothin reported on age, diagnosis of the patients
<b>Beschreibung Outcomevariablen</b>	seclusion episodes per year
<b>Beschreibung Ergebnisse</b>	intervention ward 157 -> 53, effect size 0.24, but duration of seclusion did not change, control ward 46 -> 81
<b>Dauer Baseline/Intervention/Follow-up</b>	1 year baseline, 1 year intervention
<b>Funding</b>	not reported
<b>Qualitätsbemerkung</b>	no randomization and highly increasing number on controll wards, wenig Daten, da von Anfang an auf Jahr aggregiert

<b>Nummer</b>	<b>78</b>
<b>Studie</b>	Moore D. (2010): The least restrictive continuum. In: Inst Nurs News 6, 2-6.
<b>Institution</b>	Mental Health Services South Jersey Healthcare
<b>Studientyp</b>	interrupted time series
<b>Kontrollgruppe ja/nein</b>	yes
<b>Komplex ja/nein</b>	no
<b>Interventionstyp</b>	staff training -> NVCIP (non-violent crisis intervention program)
<b>Effekt ja/nein auf S/R</b>	yes
<b>Beschreibung Intervention</b>	Six employees became CPI (Crisis Prevention Institute) certified instructor, three of them attended advanced team training, all inpatient nursing employees were certified in NVCIP, code teams respond to silent codes.
<b>Beschreibung Patienten</b>	short term inpatient units (14 beds for children/ados, 28 for adults)
<b>Beschreibung Outcomevariablen</b>	The Moore Safety Code Team Performance/Analyses Tool (the lower the TOOL scores the less restrictive was the intervention de-escalation -> S ->R), injuries, Minutes of restraint Utilization over Patient Care Days
<b>Beschreibung Ergebnisse</b>	The TOOL Score on the adult unit fell from 271 in 2008 (2005: 300, 2006: 392, 2007:431) to 122 in 2009. Minutes of Restraint Utilization over Patient Care Days on the adult unit fell from 0.98 in 2008 (2005: 0.65, 2006: 0.94, 2007: 0.67) to 0.45 in 2009. Just one Injury occurred on the adult unit in 2007.
<b>Dauer Baseline/Intervention/Follow-up</b>	3 (?) years baseline 1 year in which intervention was implemented (all retrospective?) 1 year follow up, another year was not completed
<b>Funding</b>	not reported
<b>Qualitätsbemerkung</b>	retrospective, uncomplete data, willkürlicher Vergleich von Jahren (bspw. 2006 - weil da hoher restraint? Mit Ergebnisejahr 2009), hohe Variabilität in der Baseline

<b>Nummer</b>	<b>79</b>
<b>Studie</b>	Morales, E.; Duphorne, P. L. (1995): Least restrictive measures: alternatives to four-point restraints and seclusion. In: Journal of psychosocial nursing and mental health services 33 (10), S. 13–16.
<b>Institution</b>	Veterans Administrative Center/Albuquerque, Ft. Lyon Veterans Administrative Center/Ft Lyon, College of Nursing/University of New Mexico
<b>Studientyp</b>	pre-post-design, retrospective
<b>Kontrollgruppe ja/nein</b>	no
<b>Komplex ja/nein</b>	yes
<b>Interventionstyp</b>	complex
<b>n Patienten</b>	25
<b>Effekt ja/nein auf S/R</b>	yes
<b>Beschreibung Intervention</b>	Team meetings for discussing patients, alternative measures, early

	signs and symptoms; information for staff (6 articles about Alzheimer, violence and assaultiveness, managing the difficult patient, the use of restraint and seclusion, and staff responsibilities); idea of offering patients two alternative choices was supported (choices: one-to-one verbal interaction with staff member, quiet time, beating on a pillow, warm milk or cold drink, provision of limited exercise, listening to soft music or relaxation tapes)
<b>Beschreibung Patienten</b>	acute psychiatric unit, 30 beds, majority of patients were chronically mentally ill with diagnoses of schizophrenia, organic brain syndrome, bipolar affective disorder, and depression, Primarily men, aged 27-69. Average length of stay 2 weeks.
<b>Beschreibung Outcomevariablen</b>	??
<b>Beschreibung Ergebnisse</b>	By the end of the project, the total time spent by patients in restraints and seclusion was ESTIMATED(?) to have been reduced by approximately 50 %.
<b>Dauer</b>	
<b>Baseline/Intervention/Follow-up</b>	3 months during the project, compared with the same 3-month period in the previous 2 years
<b>Funding</b>	not reported
<b>Qualitätsbemerkung</b>	baseline retrospective (Hawthorne effect?), measuring instruments not mentioned, documentation of coercive measures not described

<b>Nummer</b>		80
<b>Studie</b>	O'Malley J, Frampton C, Wijnveld AM et al. (2007): Factors influencing seclusion rates in an adult psychiatric intensive care unit. In: Journal of Psychiatric Intensive Care 3 (2), S. 93-100.	
<b>Institution</b>	Department of Psychological Medicine/Christchurch School of Medicine and Health Science	
<b>Studientyp</b>	pre-post-design, retrospective, multivariate analysis	
<b>Kontrollgruppe ja/nein</b>	no	
<b>Komplex ja/nein</b>	yes	
<b>Interventionstyp</b>	split (=downsize) unit	
<b>n Patienten</b>	(21 shifts baseline, 21 shifts post-intervention, 126 shifts follow up; 1x20 bed unit at baseline, 2x10 bed unit post-intervention/follow up)	
<b>Effekt ja/nein auf S/R</b>	Yes	
<b>Beschreibung Intervention</b>	Splitting the PICU from a 20 bed unit to two 10 bed units	
<b>Beschreibung Patienten</b>	PICU, locked all times, high levels of observation, patients: 18-64 years, require 24 h acute psychiatric care, average LOS 17-20 days, at significant risk of harm to self or others	
<b>Beschreibung Outcomevariablen</b>	Seclusion room entry and exit times, unit admission and discharge times were used to calculate hours in seclusion and patient hours in the unit. From this, total patient hours in seclusion as a percentage of the total patient hours in the unit (from which the secluded patients came) was calculated per shift.	



<b>Beschreibung Ergebnisse</b>	Univariate analysis of variance revealed a significant reduction in the rates from 8,2 % in the first period to 4,4 % in the second and 3,6 % in the third. Multivariant analysis: Period, shift and nurse hours all showed independent statistically significant association with seclusion rates and explained 23 % of seclusion while period alone explained 15 %.
<b>Dauer</b> <b>Baseline/Intervention/Follow-up</b>	12 weeks baseline (retrospective), 12 weeks post intervention (retrospective), after a year 6 months follow-up (prospective)
<b>Funding</b>	A Canterbury (New Zealand) District Health Board Research grant of \$11,000 supported data collection.
<b>Qualitätsbemerkung</b>	retrospective.

<b>Nummer</b>	<b>81</b>
<b>Studie</b>	Smith, Gregory M.; Davis, Robert H.; Bixler, Edward O.; Lin, Hung-Mo; Altendor, Aidan; Altendor, Roberta J. et al. (2005): Pennsylvania State Hospital system's seclusion and restraint reduction program. In: Psychiatric services (Washington, D.C.) 56 (9), S. 1115–1122. DOI: 10.1176/appi.ps.56.9.1115.
<b>Institution</b>	Office of Mental Health and Substance Abuse Services of the Commonwealth of Pennsylvania in Harrisburg, Pennsylvania State University School of Medicine in Hershey
<b>Studientyp</b>	time-series, multivariate analysis
<b>Kontrollgruppe ja/nein</b>	no
<b>Komplex ja/nein</b>	yes
<b>Interventionstyp</b>	Complex
<b>n Patienten</b>	(The annual census for the hospital system during this 11-year period decreased 56 percent, from about 6,300 to about 2,800)
<b>Effekt ja/nein auf S/R</b>	yes
<b>Beschreibung Intervention</b>	advocacy efforts (By 1995 the state government had independent advocates assigned to each hospital, who provided a needed layer of protection for patients on a day-to-day basis), leadership (e.g. defining seclusion as a treatment failure), state policy change (defining S/R, limit use of S/R to emergency situations, defining and prohibiting chemical restraint), improved patient-staff ratios and reduction of unit-size, psychiatric emergency response teams (PERT), incident management system (tracking S/R, PRN and STAT medications, making 35 performance indicators available on unit level) and second-generation antipsychotics, increase on the quantity and quality of treatment especially training programs to prepare people for discharge, recovery-based approaches and group therapy
<b>Beschreibung Patienten</b>	records of patients older than 18 years who were civilly committed to one of the nine state hospitals in Pennsylvania were included, patients had severe and persistent mental illness, 53 % were men

<b>Beschreibung Outcomevariablen</b>	Two databases were used in each of the nine hospitals: one identified date, time, duration, and justification for each episode of seclusion or restraint and the other identified when a patient was hospitalized and the demographic characteristics and the diagnosis of the patient. Rate and duration of seclusion and restraint were calculated. Reports from compensation claims were used to determine staff injuries from patient assaults.
<b>Beschreibung Ergebnisse</b>	The rate and duration of seclusion and mechanical restraint decreased dramatically during this period. From 1990 to 2000, the rate of seclusion decreased from 4.2 to .3 episodes per 1,000 patient-days. The average duration of seclusion decreased from 10.8 to 1.3 hours. The rate of restraint decreased from 3.5 to 1.2 episodes per 1,000 patient-days. The average duration of restraint decreased from 11.9 to 1.9 hours.
<b>Beschreibung sekundäre Ergebnisse</b>	No significant changes were seen in rates of staff injuries from 1998 to 2000.
<b>Dauer Baseline/Intervention/Follow-up</b>	11 years observation
<b>Funding</b>	This research project was funded, in part, by an award from the Ford Foundation in conjunction with Harvard University's John F. Kennedy School of Government and the Council for Excellence in Government through an Innovations in American Government Award.
<b>Qualitätsbemerkung</b>	Patient population changing to a less acute one (During most of its history the hospital system provided direct admission service. However, during the study period, the admission of civilly committed patients was limited to referrals from local psychiatric acute care settings for individuals who were unable to be stabilized within a 30-day acute care stay)?; No clear intervention, many changes over time, unclear what helped.

<b>Nummer</b>	<b>82</b>
<b>Studie</b>	Steinert T, Eisele F, Göser U, Tschöke S, Solmaz S, Falk S. (2009): Quality of Process and Results in Psychiatry: Decreasing Coercive Interventions and Violence among Patients with Personality Disorder by Implementation of a Crisis Intervention Ward. In: Gesundheitsökonomie und Qualitätsmanagement 14, S. 44–48.
<b>Institution</b>	Abteilung Psychiatrie I der Universität Ulm, Zentrum für Psychiatrie Die Weissenau
<b>Kontrollgruppe ja/nein</b>	no
<b>Komplex ja/nein</b>	no
<b>Interventionstyp</b>	Specialized therapy for personality disorders// Diagnosespezifische Spezialstation
<b>Effekt ja/nein auf S/R</b>	yes
<b>Beschreibung Intervention</b>	Während bis dahin alle in Krisensituationen aufgenommenen

	<p>Patienten mit Persönlichkeitsstörungen (ICD-10: F6) auf eine der vier allgemeinpsychiatrischen, überwiegend geschlossen geführten Aufnahmestationen der Klinik aufgenommen worden waren und die Verteilung nach dem Wohnort erfolgte (Sektorprinzip), wurde eine dieser Stationen ab 1.11.2005 zur Kriseninterventionsstation umfunktioniert, auf die seitdem alle Patienten mit einer Hauptdiagnose F6 oder F4 (Anpassungs- und Belastungsstörungen) aufgenommen werden.</p>
<p><b>Beschreibung Patienten</b></p>	<p>Es handelt sich weiterhin um eine Akutstation, d. h. Patienten werden zu jeder Zeit aufgenommen, kommen überwiegend als Notfall, sind bei der Aufnahme häufig suizidal oder auch fremdaggressiv, nicht selten auch intoxikiert bei begleitendem Substanzmissbrauch. Zwangsmaßnahmen können auf dieser Station durchgeführt werden, die Patienten werden zu diesem Zweck nicht verlegt. Bei Patienten mit der Hauptdiagnose F4 handelt es sich überwiegend um Patienten mit suizidalen Krisen oder Zustand nach Suizidversuch, die Zuweisung erfolgt von vorbehandelnden Allgemeinkrankenhäusern oder direkt von außen. Diese Patientengruppe ist strukturell ähnlich wie die hier im Fokus des Interesses stehende Gruppe mit Persönlichkeitsstörungen (F6), selbstverletzende und fremdaggressive Verhaltensweisen sind aber seltener und Zwangsmaßnahmen kommen deshalb auch vergleichsweise selten zur Anwendung. Patienten mit primärer Substanzabhängigkeit (ICD-10: F1), psychotischen oder affektiven Störungen (ICD-10: F2, F3) werden nicht auf der Kriseninterventionsstation aufgenommen.</p>
<p><b>Beschreibung Outcomevariablen</b></p>	<p>Behandlungsepisoden, Anteil von Fixierung/Isolierung betroffen, mittlere Dauer einer Fixierung/Isolierung, durchschnittliche Anzahl Maßnahmen pro betroffenem Pat, Gesamtzahl freiheitsbeschränkende Maßnahmen, Suizidversuch, gewalttätige Drohung, Gewalt gegen Gegenstände/Personen, gerichtliche Untebringung (BGB, UBG)</p>
<p><b>Beschreibung Ergebnisse</b></p>	<p>Die Gesamtzahl der Zwangsmaßnahmen konnte von 120 bei allen in der Gesamtklinik behandelten Fällen mit der Diagnose einer Persönlichkeitsstörung auf 17 reduziert werden, auch der Anteil der von solchen Maßnahmen betroffenen Patienten reduzierte sich um über die Hälfte. In allen untersuchten Maßen ergab sich eine fast einheitlich gleichgerichtete günstige Tendenz, wenn auch statistische Signifikanz aufgrund der zum Teil kleinen Fallzahlen entsprechender Vorkommnisse nicht immer erreicht (signifikant: Anteil von Isolierung betroffenen 15 % -&gt; 2,7 % <math>p &lt; 0,001</math>). Einzig die durchschnittliche Dauer einer Fixierung war deutlich angestiegen, was aber in Anbetracht der sehr geringen Fallzahl von Fixierungen nicht als systematischer Effekt interpretiert werden sollte. Auch aggressive Tötlichkeiten konnten um nahezu die Hälfte reduziert werden. Der Anteil unfreiwillig untergebrachter Patienten reduzierte</p>

	sich von 11,0 auf 3,8 % und damit um zwei Drittel ( $p < 0,05$ ).
<b>Dauer</b>	
<b>Baseline/Intervention/Follow-up</b>	1 Jahr vor und 1 Jahr nach Eröffnung der Station
<b>Funding</b>	not reported
<b>Qualitätsbemerkung</b>	kleine Stichprobe, Signifikanz häufig nicht erreicht

## Deeskalation und Mitarbeitertrainings

<b>Nummer</b>	1
<b>Autoren</b>	Allen, D.; McDonald, L.; Dunn, C.; Doyle, T.
<b>Jahr</b>	1997
<b>Studie</b>	Changing care staff approaches to the prevention and management of aggressive behaviour in a residential treatment unit for persons with mental retardation and challenging behaviour. In: Research in developmental disabilities 18 (2), S. 101–112.
<b>Studientyp</b>	Prä/Post-Intervention
<b>Dauer Intervention</b>	Bei Stellenantritt, dann Refresher Training alle 6 Monate
<b>Dauer Follow up</b>	5 Jahre
<b>Kontrollgruppe ja/nein</b>	nein
<b>Ort der Datenerhebung</b>	Residential Treatment Unit for Persons With Mental Retardation and Challenging Behaviour. The unit contained six beds and was located on the campus of a large institution for people with mental retardation
<b>Land</b>	UK
<b>Charakterisierung der Zielgruppe der Trainingsmaßnahme</b>	New staff, All staff
<b>Anzahl Patienten</b>	7 Patienten
<b>Beschreibung Patienten</b>	people with mental retardation and challenging behaviour 7 residents accounting for 90.8 % of possible inpatient days. average age 28years; 4 were male. 6 had been formally detained in institutional care at least once under the powers of the Mental Health Act (1983) as a consequence of the behavioural challenges they posed; 5 had offended against the criminal or civil law, 1 had been in prison on remand; 4 had at some time been placed in private out-of-county facilities because local services felt unable to cope with them.
<b>Beschreibung Intervention</b>	Training: Understanding aggressive incidents, Primary prevention, Secondary prevention, Reactive strategies, Post-incident support for clients and caregivers
<b>Detaillierte Beschreibung der Intervention</b>	# Understanding aggressive incidents: a brief introduction to the nature of aggressive incidents which was based on the time-intensity model developed by Smith and cited in Rowett and Breakwell (1992).S4 # Primary prevention: instruction in modifying or removing known environmental or individual setting conditions or triggers associated with the production of challenging behaviour.N1 # Secondary prevention: instruction in responding safely to early indicators that behaviour is moving away from baseline via verbal and non-verbal defusion/distraction strategies. # Reactive strategies: instruction in safe, efficient, effective responses to critical incidents (including self-defensive strategies and minimal physical restraint procedures).

	<p># Post-incident support for clients and caregivers: training to sensitise caregivers to the emotional consequences of aggressive incidents.  --&gt; Teaching methods included classroom instruction, role play (for developing interpersonal defusion and distraction skills), and repeated practice of physical interventions.</p>
<b>Beschreibung Outcomevariablen</b>	behavioral incidents, overall rate of major reactive strategy use, reduced injuries to both residents and caregivers
<b>Beschreibung Ergebnisse</b>	<p># overall decreasing trend in total behavioural incidents, there were major outlying peaks in 3 middle years. More serious behavioural incidents were essentially stable, but showed a slightly increasing trend towards the end of the phase. The outlying data points on the graph were largely explained by the fact that one person accounted for 37 % of total recorded incidents in 1992 and 50 % in 1993. The person concerned had Prader-Willi syndrome and a dual diagnosis; Excluding this person's data from the analysis indicated a clearer decreasing trend in overall behavioural incidents for the group over time (<math>r = -.74</math>, significant at .05 level for a one-tailed test)</p> <p># The use of the three major reactive strategies of physical restraint, emergency medication, and seclusion was consistently low in relation to total behavioural incidents and showed little variation over time.</p> <p># Rates of staff client injuries over time, expressed as a percentage of severe behavioural incidents. Once again, clear trends are evident toward decreasing rates of both staff and client injury over time (<math>r</math> values being <math>-.93</math> and <math>-.75</math>); the relationship between staff injury and time was significant beyond the .05 level for a one-tailed test.</p>
<b>Qualitätsbemerkung</b>	Sehr geringe Patientenzahl

<b>Nummer</b>	<b>2</b>
<b>Autoren</b>	Baker PA; Bissmire D.
<b>Jahr</b>	2000
<b>Studie</b>	A Pilot Study of the Use of Physical Intervention in the Crisis Management of People with Intellectual Disabilities who present Challenging Behaviour. In: Journal of applied research in intellectual disabilities : JARID (13), S. 38–45.
<b>Studientyp</b>	Prä/Post-Intervention
<b>Dauer Baseline</b>	5 Monate
<b>Dauer Intervention</b>	2 Tage
<b>Dauer Follow up</b>	2 Monate
<b>Kontrollgruppe ja/nein</b>	nein
<b>Ort der Datenerhebung</b>	Wohnanlage für Menschen mit Verhaltensauffälligkeit und Lernbehinderung
<b>Land</b>	UK
<b>Charakterisierung der Zielgruppe der Trainingsmaßnahme</b>	Staff without formally qualification
<b>Anzahl Teilnehmer Interventionsgruppe</b>	17
<b>Anzahl Patienten</b>	10 Patienten
<b>Beschreibung Patienten</b>	people with learning disabilities and challenging behaviour
<b>Beschreibung Intervention</b>	SCIP-Training course (Strategies for Crisis Intervention and Prevention)
<b>Detaillierte Beschreibung der Intervention</b>	Topics: Service Values, Understanding Challenging Behaviour, Prevention, Early Intervention, Health & Safety and the Legal Framework; 25 % of the time was devoted to demonstration and training of physical intervention
<b>Beschreibung Outcomevariablen</b>	1. Fragebogen vor und 3 Monate nach der Intervention bezüglich: Crisis management, Prevention of challenging behavior, supported by organization 2. Messung der Anzahl der Ereignisse und die Reaktion des Personals darauf (verbal, physikal, ignorierend)
<b>Beschreibung Ergebnisse</b>	the number of responses to incidents pre- and post-training indicated that there was a highly significantly increased tendency to respond physically

<b>Nummer</b>	<b>3</b>
<b>Autoren</b>	Barton SA, Johnson MR, Price LV
<b>Jahr</b>	2009
<b>Studie</b>	Achieving Restraint-Free on an inpatient behavioral Health Unit
<b>Studientyp</b>	Prä/Post-Intervention
<b>Dauer Baseline</b>	1 Jahr
<b>Dauer Intervention</b>	regelmässig über ca. 18 Monate,
<b>Dauer Follow up</b>	1 Jahr
<b>Kontrollgruppe ja/nein</b>	nein

<b>Ort der Datenerhebung</b>	Geschlossene Psychiatrische Station
<b>Land</b>	US
<b>Charakterisierung der Zielgruppe der Trainingsmaßnahme</b>	Front Line Staff
<b>Anzahl Patienten</b>	26 Betten
<b>Beschreibung Patienten</b>	14 Jahre und älter, freiwillige und unfreiwillige Aufnahme, Hauptdiagnosen: Schwere rezidivierende Depression, Bipolare Störung und Schizoaffektive Störung; Mittlere Verweildauer 5-7 Tage
<b>Beschreibung Intervention</b>	Training basierend auf dem "National Executive Training Institute programm 2005 (NETI)
<b>Detaillierte Beschreibung der Intervention</b>	Zusammenfassung: 1. Sensibilisierung des Personals durch Edukation in Traumatherapie, 2. Präventive Massnahmen "olfaktorisch und situativ" "Comfort room", 3. Culture Change: Patienten werden mit Namen angesprochen, ausführliche Besprechung von Restraints, Restraints waren als letzte Möglichkeit stets verfügbar Medien: Handbuch, Film, 3 Tage Präsentationen z.T. interaktiv, Inhalte: 1. Trauma Theorie ("Learning about trauma theory was a major eyeopener.", Many staff react with fear, voicing concern for their safety, as well as patient safety. These concerns must be addressed. Und wie steht nirgends..; The restraint elimination vision had to be kept constantly in the forefront. As a key component in achieving culture change, restraint elimination was constantly addressed, alluded to, promoted, and "talked up" in staff meetings and impromptu gatherings. Staff safety concerns were discussed repeatedly.
<b>Beschreibung Outcomevariablen</b>	1. Messung von Restraints 2004 und 2007 2. Messung Verabreichung Sedativer Medikamente
<b>Detaillierte Beschreibung Outcomevariablen</b>	2. Lorazepam, Haldol, Fluphenazin, Chlorpromazine, Olanzapin
<b>Beschreibung Ergebnisse</b>	1. Ab 2007 keine Restraints mehr 2. kein Anstieg an Verabreichung sedativer Medikamente, diese gingen um 22 % zurück.

<b>Nummer</b>	5
<b>Autoren</b>	Bowers, Len; Nijman, Henk; Allan, Teresa; Simpson, Alan; Warren, Jonathan; Turner, Lynny
<b>Jahr</b>	2006
<b>Studie</b>	Prevention and management of aggression training and violent incidents on U.K. Acute psychiatric wards. In: Psychiatric services (Washington, D.C.) 57 (7), S. 1022–1026. DOI: 10.1176/ps.2006.57.7.1022.
<b>Studientyp</b>	Prä/Post-Intervention
<b>Dauer Intervention</b>	five-day foundation course or a one day annual update course
<b>Dauer Follow up</b>	two-and-a-half years (April 2002 to November 2004)



<b>Kontrollgruppe ja/nein</b>	nein
<b>Ort der Datenerhebung</b>	Acute Psychiatric Wards (14 acute admission psychiatric wards at three hospital sites) (One was a female-only ward, a second served as an assessment ward, the remainder were mixed-gender wards serving specific localities.)
<b>Land</b>	UK
<b>Charakterisierung der Zielgruppe der Trainingsmaßnahme</b>	Nursing Staff
<b>Anzahl Teilnehmer Interventionsgruppe</b>	312 course attendances (144 ward staff attended five-day PMVA courses, and 168 attended updates)
<b>Anzahl Patienten</b>	5,384 admissions
<b>Beschreibung Patienten</b>	14 acute admission psychiatric wards at three hospital sites: One was a female-only ward, a second served as an assessment ward, the remainder were mixed-gender wards serving specific localities.
<b>Beschreibung Intervention</b>	PMVA- Training courses in the Prevention and Management of Violence and Aggression Courses consisted of either a five-day foundation course or a one day annual update course.
<b>Detaillierte Beschreibung der Intervention</b>	courses content: theoretical material on factors influencing aggression and signs of imminent violence; discussions pertaining to when restraint can be legally used; teaching breakaway techniques; and teaching manual restraint techniques performed by a three-person team, utilizing pain-free holds based on leverage # 5- day course: prediction, anticipation, and prevention of violence; reporting requirements; the role of personal, environmental, and organizational factors in violence reduction; responses to aggression, involving deescalation, communication skills, problem solving, and negotiation; and the principles and practice of breakaway and manual-restraint skills. # Update course: manual-restraint skills only
<b>Beschreibung Outcomevariablen</b>	violent incident rates
<b>Beschreibung Ergebnisse</b>	# 684 incidents (226 incidents of verbal aggression, 88 incidents of property damage, and 370 incidents of physical aggression ) # positive association was found between training and rates of violent incidents # weak evidence that increased rates of aggressive incidents prompted course attendance # no evidence that course attendance reduced violence # some evidence that attendance of briefer update courses triggered small short-term rises in rates of physical aggression # Course attendance was associated with a rise in physical and verbal aggression while staff were away from the ward.
<b>Beschreibung sekundäre</b>	Associations within four-week periods: The relationship between

<b>Ergebnisse</b>	<p>training and aggression was explored by examining the association of aggression to training in the months after the incident and the relationship between training and aggression in the months after the training course.</p> <p>For every one incident of property damage in the month before the course, there was a 38 percent increase in course attendances; for every one incident of physical violence during the month of the course, the rate of course attendance increased by 16 percent, and for every incident of physical violence three months before the course, the attendance rate decreased by 22 percent.</p>
-------------------	---

<b>Nummer</b>	6
<b>Autoren</b>	Bybel, Barbara-Ann
<b>Jahr</b>	2011
<b>Studie</b>	Does education of alternative measures decrease the use of physical restraints and seclusion? In: Does Education of Alternative Measures Decrease the Use of Physical Restraints & Seclusion? (D.H.A), 109 p-109 p.
<b>Ort der Datenerhebung</b>	Psychiatrisches Krankenhaus (akut9
<b>Land</b>	US
<b>Charakterisierung der Zielgruppe der Trainingsmaßnahme</b>	Front Line Staff
<b>Anzahl Teilnehmer Interventionsgruppe</b>	450
<b>Beschreibung Outcomevariablen</b>	the dependent variable is the use of seclusion and physical restraints and the independent variable is the number of staff educated on restraint reduction strategies.

<b>Nummer</b>	7
<b>Autoren</b>	Calabro, Karen; Mackey, Thomas A.; Williams, Steven
<b>Jahr</b>	2002
<b>Studie</b>	Evaluation of training designed to prevent and manage patient violence. In: Issues in mental health nursing 23 (1), S. 3–15.
<b>Studientyp</b>	Prä/Post-Intervention
<b>Dauer Intervention</b>	12-hour training
<b>Kontrollgruppe ja/nein</b>	nein
<b>Ort der Datenerhebung</b>	Akut - psychiatrisches Krankenhaus
<b>Land</b>	US
<b>Charakterisierung der Zielgruppe der Trainingsmaßnahme</b>	Nursing staff/Mental health care workers (registered nurses (one third), hospital aides (about one half), and activity therapists, social workers and individuals who admit patients (less than ten percent for each of these respective categories).)
<b>Anzahl Teilnehmer Interventionsgruppe</b>	118

<b>Beschreibung Patienten</b>	12 inpatient units. The units housed both male and female patients in either adult, geriatric, child, adolescent, or substance abuse units.
<b>Beschreibung Intervention</b>	The Nonviolent Crisis Intervention® R (CPI), (National Crisis Prevention Institute, Inc, Brookfield, WI) and Handle with Care (Handle with Care Behavioral Management System, Old Bridge, NJ)
<b>Detaillierte Beschreibung der Intervention</b>	<p># The Nonviolent Crisis Intervention: to increase staff knowledge and self-efficacy about defusing potentially violent incidents and preventing assaults, methods to identify nonverbal and verbal behaviors and the use of techniques for managing people whose behaviors could escalate to physical aggression, help staff manage their fear and anxiety in a crisis situation. Practicing the techniques demonstrated during the training helps to provide staff safety and quality care for clients. The basic program consisted of participative lecture, role-plays, a posttest, and self-study as participants work through a study manual supplied by the developers. The hospital training staff customized the intervention for use in the psychiatric setting. Patients with mental illness can be psychotic, agitated, or confused, and their ability to process information may be impaired. As a result, staff were instructed to set clear and simple limits with the patients when communicating both verbally and nonverbally. Staff were taught about hospital policies and procedures and about rights for patients mandated by the state. The training focused on preventing acting-out behaviors through the use of techniques such as reducing environmental stressors, setting consistent limits across shifts, and teaching clients to recognize and cope with anxiety.</p> <p># Handle with Care” was a lecture about team dynamics for managing aggressive patients and included specific hospital policies and procedures for physical interventions. To pass this section of the training, staff demonstrated the required self-defense and restraint skills.</p>
<b>Beschreibung Outcomevariablen</b>	Four variables (knowledge, attitude, self-efficacy, and behavioral intention to use the training techniques)
<b>Beschreibung Ergebnisse</b>	<p># the staff’s knowledge increased from 6.1 pretest to 7.3 posttest, (<math>t[109] = 7.29, p &lt; 0.001</math>).</p> <p># For attitude about using the techniques presented in the program, the results showed a significant change at posttest (<math>t[109] = - 5.68, p &lt; 0.001</math>). The attitude score showed a positive indication of change as measured by the mean score improvement from 18.6 pretest to 16.8 posttest.</p> <p># For self-efficacy, there was significant positive improvement, (<math>t[114] = - 2.82, p &lt; 0.01</math>). Respondents indicated that their confidence levels and perception about the ease or difficulty about using the training techniques changed with a pretest mean of 15.0 to 14.3 posttest. This change indicated that respondents chose responses that displayed enhanced self-efficacy.</p>

	<p># For behavioral intention, there was positive improvement with a mean 10.8 pretest to 10.3 posttest (<math>t[114] = -1.99, p &lt; 0.05</math>). Respondents chose responses that were stronger for intention to use the techniques learned in the program.</p>
<b>Nummer</b>	8
<b>Autoren</b>	Carmel, Herold; Hunter, Mel
<b>Jahr</b>	1990
<b>Studie</b>	Compliance with training in managing assaultive behavior and injuries from inpatient violence. In: Hospital & community psychiatry 41 (5), S. 558–560.
<b>Studientyp</b>	Fall- Kontroll-Studie
<b>Dauer Intervention</b>	16Stunden einmal + 6h alle 2 Jahre
<b>Dauer Follow up</b>	Erhebungszeitraum 1 Jahr (1986)
<b>Kontrollgruppe ja/nein</b>	ja
<b>Charakterisierung der Kontrollgruppe</b>	The 27 wards were divided into two groups: 18 wards with low compliance with the requirement for training in management of assaultive behavior (less than 60 percent of the staff in compliance) and nine wards with high compliance (more than 60 percent of the staff in compliance).
<b>Ort der Datenerhebung</b>	Forensisches Krankenhaus
<b>Land</b>	US
<b>Charakterisierung der Zielgruppe der Trainingsmaßnahme</b>	Nursing staff
<b>Anzahl Teilnehmer Interventionsgruppe</b>	244 (High Compliance)
<b>Anzahl Teilnehmer Kontrollgruppe</b>	500 (Low Compliance)
<b>Anzahl Patienten</b>	Low compliance n=643 beds, High compliance n=330 beds
<b>Beschreibung Patienten</b>	Forensic hospital
<b>Beschreibung Intervention</b>	Training program in the management of assaultive behaviour for state hospital of the California Department of mental health
<b>Detaillierte Beschreibung der Intervention</b>	training, which includes attention to interpersonal skills as well as didactic and practical instruction in the management of violent patients.
<b>Beschreibung Outcomevariablen</b>	compliance with the training requirements for management of assaultive behavior and for cardiopulmonary resuscitation (CPR), the rate of employee injury from patient violence, and the number of aggressive incidents per bed.
<b>Beschreibung Ergebnisse</b>	<ol style="list-style-type: none"> <li>1. There was no evidence of a relationship between staff compliance with training in management of assaultive behavior by ward and incidents of patient aggression in the ward.</li> <li>2. The rate of staff injury from patient violence in the wards with low</li> </ol>

	compliance with training in managing assaultive behavior was almost three times the rate in the wards with high compliance
<b>Nummer</b>	9
<b>Autoren</b>	Colenda, C. C.; Hamer, R. M.
<b>Jahr</b>	1991
<b>Studie</b>	Antecedents and interventions for aggressive behavior of patients at a geropsychiatric state hospital. In: Hospital & community psychiatry 42 (3), S. 287–292.
<b>Studientyp</b>	Prä/Post Intervention
<b>Dauer Baseline</b>	16 consecutive days in August 1987
<b>Dauer Follow up</b>	15 consecutive days in January 1988
<b>Kontrollgruppe ja/nein</b>	nein
<b>Ort der Datenerhebung</b>	Gerontopsychiatrische Klinik, a 210-bed state facility providing long term care. The hospital has a 24-bed admission unit and five long-term care units
<b>Land</b>	US
<b>Charakterisierung der Zielgruppe der Trainingsmaßnahme</b>	Staff
<b>Anzahl Patienten</b>	118 voluntary and in voluntary admissions a year
<b>Beschreibung Patienten</b>	<p>Patients must be 65 years of age or older, have a primary diagnosis of mental illness or dementia, and reside within the designated 8,833-square mile catchment area in central Virginia.</p> <p>Hospital census data for 1988 showed: 42.1 per cent of the patient population had dementia (all types), schizophrenia (all types), 22.2 percent; major affective disorder (mania and depression), 11.8 percent; organic psychosis, 10.8 percent; and alcohol-related disorders (excluding alcohol-related dementia), 4.4 percent.</p>
<b>Beschreibung Intervention</b>	<p>two kinds of inservice training:</p> <ol style="list-style-type: none"> <li>1. training in agenda behavior modification</li> <li>2. training: series of three clinical case conferences on psychotropic drug use in the elderly.</li> </ol>
<b>Detaillierte Beschreibung der Intervention</b>	<ol style="list-style-type: none"> <li>1. training in agenda behavior modification, which is based on the premise that for patients with dementia, wandering and aggression often stem from loneliness and separation. The assumption is that staff can modify or prevent such behaviors by helping patients feel safe and "connected" in their present environment, using such techniques as reality orientation and reassurance. The agenda behavior modification training was presented to the direct care staff by the clinical nurse specialists in small group sessions. The training was on going.</li> <li>2. training: series of three clinical case conferences on psychotropic drug use in the elderly, conducted by the senior author for the prescribing physicians. The physicians were encouraged to use low-</li> </ol>

	dose neuroleptics for dementia patients who were psychotic; to minimize polypharmacy; and to intervene with p.r.n. medications when potentially violent patients begin to telegraph aggressive behavior.
<b>Beschreibung Outcomevariablen</b>	<p># All aggressive events committed by patients</p> <p># the kind of event that triggered them</p> <p># the kind of staff interventions, based on an instrument designed by the senior author.</p>
<b>Detaillierte Beschreibung Outcomevariablen</b>	<p># The instrument listed five kinds of aggressive events: patient-patient exchange, patient-staff exchange, yelling or threatening behavior, physical and vocal behavior, and property damage. Patient-patient exchange and patient-staff exchange were defined as physically aggressive behavior "such as hitting, pushing, or biting" between patients or between patient and staff, respectively. Yelling or threatening behavior referred to patients' cursing, yelling, or making verbal threats at staff or patients. Physical and vocal behavior was defined as both physical and vocal aggression toward staff or patients.</p> <p># Four categories of triggering events were documented: unknown or not observed, patient-patient exchange, patient-staff exchange, and group activity (such as congregate dining or a group outing).</p> <p># Interventions were documented in six categories: no intervention, removal of patient from the stimulus (but without intensive supervision), one-to one supervision, seclusion or restraint, p.r.n. medication, and p.r.n. medication plus seclusion or restraint.</p>
<b>Beschreibung Ergebnisse</b>	<p>1st survey: n=48 agitated or aggressive patients with and without dementia, between 66 to 93 years who committed 199 aggressive events. 2nd survey: n=40 agitated or aggressive patients with and without dementia, between 65 to 87 years who committed 119 aggressive events.</p> <p># Patient behaviors: total rate of aggression was stable across both study periods, at 1.49 and 1.36. Both surveys found dementia patients to have a higher rate of aggression than nondementia patients (.99 compared with .50 in the first survey period, and .85 compared with .51 in the second). Dementia patients also had a higher rate of aggressive events in both survey periods. Based on the formula for calculating change between surveys, the total aggressive event rate for all patients dropped by 23.6 percent across surveys.</p> <p># Triggering events: In both surveys, the triggering event most often listed was "unknown or not observed", especially for yelling or threatening behavior. Patient staff exchange was listed as the second most frequent triggering event, especially for dementia patients, and was most frequently associated with physical aggression between staff and patients. It was also the category in which the largest reduction of triggering events for both dementia and nondementia patients was recorded between surveys.</p> <p># Staff interventions: During the first survey, for both dementia and</p>

	nondementia patients the most frequent staff intervention for aggression was one-to-one supervision, followed by removal of the patient from the situation. P.r.n. medication, seclusion or restraint, and a combination of the two were used much less frequently.
<b>Beschreibung sekundäre Ergebnisse</b>	<p># Both surveys found dementia patients to have a higher rate of aggression than nondementia patients.</p> <p># Both surveys found that most aggressive events occurred during the day shift.</p> <p># Based on the formula for calculating change between surveys, the total aggressive event rate for all patients dropped by 23.6 percent across surveys.</p>

<b>Nummer</b>	10
<b>Autoren</b>	Cowin, Leanne; Davies, Rhian; Estall, Graham; Berlin, Theresa; Fitzgerald, Maria; Hoot, Sandra
<b>Jahr</b>	2003
<b>Studie</b>	De-escalating aggression and violence in the mental health setting. In: International journal of mental health nursing 12 (1), S. 64–73.
<b>Studientyp</b>	Prä/Post Intervention
<b>Dauer Follow up</b>	3 Monate
<b>Kontrollgruppe ja/nein</b>	nein
<b>Ort der Datenerhebung</b>	Acute mental health-care unit (MHU) and the emergency department (ED) at Liverpool Hospital, Sydney
<b>Land</b>	AUS
<b>Charakterisierung der Zielgruppe der Trainingsmaßnahme</b>	Nursing Staff MHU und Nursing Staff ED
<b>Beschreibung Intervention</b>	<p>de-escalation kit: educative and informative package (kit) on de-escalation.</p> <p>The kit include the de-escalation poster, a nursing staff survey to test pre- and post-knowledge and awareness of de-escalation, an in-service education session that explored the important processes involved in successful de-escalation using case studies for group discussions and a literature discussion paper.</p>
<b>Detaillierte Beschreibung der Intervention</b>	The goals of the de-escalation project were to develop an informative poster for use in an ED and MHU that could serve as a useful reminder to nurses of the processes and skills involved in de-escalation. The in-service education lecture supported the introduction of the poster by offering nurses an opportunity to discuss and examine their current knowledge while improving their understanding within a group of their peers. The use of a pre- and post-test survey provided the de-escalation development group with an excellent opportunity to test nurses' knowledge and awareness and examine any changes over time.

<b>Beschreibung Outcomevariablen</b>	increase in de-escalation knowledge and awareness
<b>Beschreibung Ergebnisse</b>	<p># Mental health-care unit within-group differences over time: Overall, the results revealed an increase in de-escalation knowledge and awareness for the nursing staff of the MHU although there were no significant changes noted in an analysis of variance. While the total mean scores from T1 to T2 were non-significant for the small sample size, the total scale mean score increased from 48.07 to 49.73 thereby demonstrating a positive effect from the intervention (de-escalation poster and in-service education).</p> <p># Emergency department within-group differences over time: An overall non-significant increase in de-escalation knowledge and awareness was also apparent for the nursing staff of the ED. There was a rise in total mean scores from T1 to T2 (41.18–42.43). a number of non-significant rises in individual item scores as well as a number of falls from pre-intervention to post-intervention. The differences between scores from T1 to T2 were less than those of the MHU, indicating less change (Table 1). The fall in mean score for item 3 from 3.39 at T1 to 3.27 at T2 may have been the result of staff changes in the ED. For example, shortly after the administration of the survey at T1 a fulltime security guard was employed to work within the ED thereby making it easier for the nursing staff to gain security help at any time throughout their shift.</p>

<b>Nummer</b>	11
<b>Autoren</b>	Dickens, G.; Rogers, G.; Rooney, C.; Mc Guinness, A.; Doyle, D.
<b>Jahr</b>	2009
<b>Studie</b>	An audit of the use of breakaway techniques in a large psychiatric hospital. A replication study. In: Journal of psychiatric and mental health nursing 16 (9), S. 777–783. DOI: 10.1111/j.1365-2850.2009.01449.x.
<b>Studientyp</b>	Prä/Post Intervention
<b>Dauer Intervention</b>	initial induction and refresher updates are provided annually
<b>Kontrollgruppe ja/nein</b>	nein
<b>Ort der Datenerhebung</b>	St Andrew's Hospital, Northampton
<b>Land</b>	UK
<b>Charakterisierung der Zielgruppe der Trainingsmaßnahme</b>	all Staff (any members of clinical or nonclinical staff, ward-based or otherwise). Sampling was opportunistic.
<b>Anzahl Teilnehmer Interventionsgruppe</b>	147
<b>Anzahl Patienten</b>	0
<b>Beschreibung Patienten</b>	inpatient services for approximately 500 adults and adolescents with mental disorder, learning disability or acquired brain injury. Many



	patients have challenging behaviours
<b>Beschreibung Intervention</b>	break away from simulations of potentially life-threatening scenarios in a timely manner, and using the techniques taught in annual breakaway or refresher training. Breakaway techniques comprise a set of physical skills to help separate or break away from an aggressor in a safe manner, but do not involve the use of restraint.
<b>Detaillierte Beschreibung der Intervention</b>	The audit team = three conflict management advisors; One of the three, the lead auditor, was assigned to play the role of violent assailant while the other two independently assessed the participant's use of breakaway techniques to escape from the hold. Participants were requested to randomly select one of five unmarked envelopes. Each envelope contained one of the following scenarios: <ul style="list-style-type: none"> <li>• a straight arm strangle hold from the front;</li> <li>• a hair pull from the front;</li> <li>• neck lock;</li> <li>• bar neck lock; and</li> <li>• a bear hug with arms trapped.</li> </ul> The lead auditor read aloud the scenario and gave the participant 5 s to think about the situation before the simulation commenced. If the participant had not escaped within 10 s the simulation was halted. The two independent raters completed the audit measures during the scenario. Participants were given a chance to discuss the experience afterwards.
<b>Beschreibung Outcomevariablen</b>	"used taught technique" "successful breakaway" within an appropriate time frame (10 s)
<b>Detaillierte Beschreibung Outcomevariablen</b>	# correctly recalled and implemented the techniques taught to them to 'break away' from a simulated life-threatening situation # and did so within an appropriate time frame (10 s)
<b>Beschreibung Ergebnisse</b>	# Only 21/147 (14.3 %) of participants correctly used the taught techniques to break away within 10 s. However, 117 (79.6 %) of people were able to break away from the scenarios within 10 s but did not use the techniques taught to them.

<b>Nummer</b>	12
<b>Autoren</b>	Fitzwater, Evelyn L.; Gates, Donna M.
<b>Jahr</b>	2002
<b>Studie</b>	Testing an intervention to reduce assaults on nursing assistants in nursing homes. A pilot study. In: Geriatric nursing (New York, N.Y.) 23 (1), S. 18–23.
<b>Studientyp</b>	Randomisierte-kontrollierte Studie (Prä/Post Intervention)
<b>Dauer Baseline</b>	2 Wochen
<b>Dauer Intervention</b>	4 Stunden

<b>Dauer Follow up</b>	2 Wochen
<b>Kontrollgruppe ja/nein</b>	ja
<b>Charakterisierung der Kontrollgruppe</b>	Jeweils 10 certified nurse assistants (CNAs) in 2 nursing homes: Interventionsgruppe (120 Betten), Kontrollgruppe (100 Betten)
<b>Ort der Datenerhebung</b>	Pflegeheim
<b>Land</b>	US
<b>Charakterisierung der Zielgruppe der Trainingsmaßnahme</b>	Certified nursing assistants (CNA)
<b>Anzahl Teilnehmer Interventionsgruppe</b>	10
<b>Anzahl Teilnehmer Kontrollgruppe</b>	10
<b>Anzahl Patienten</b>	Intervention (120 Betten), Kontrollgruppe (100 Betten)
<b>Beschreibung Intervention</b>	Multifaceted, multisite intervention program
<b>Detaillierte Beschreibung der Intervention</b>	The workshops involved roleplaying, simulation, discussion, lecture, videotapes, and return demonstration of self-protection techniques. Zudem gab es eine Checkliste zur Prävention von Vorfällen
<b>Beschreibung Outcomevariablen</b>	Assault Incidents, Daily Log-Selfreport
<b>Detaillierte Beschreibung Outcomevariablen</b>	Assault included any sudden physical attack, such as biting, kicking, hitting with the body or other object, pinching, spitting, scratching, or pushing. The log is a daily self-report tool that includes five data categories: caregiver demographics, gender of resident who assaulted caregiver, type of physical assault, injury, and type of caregiving activity at the time of assault
<b>Beschreibung Ergebnisse</b>	an educational intervention can effectively decrease assaults against caregivers and increase the confidence level of staff

<b>Nummer</b>	13
<b>Autoren</b>	Ford, Paul
<b>Jahr</b>	2012
<b>Studie</b>	Patient Care Provider Safety. Examining a Training Intervention to Reduce Hospital Violence. In: Patient Care Provider Safety: Examining a Training Intervention to Reduce Hospital Violence (Ph.D), 107 p-107 p.
<b>Dauer Baseline</b>	12 Monate
<b>Dauer Intervention</b>	1 Stunde
<b>Dauer Follow up</b>	12 Monate
<b>Kontrollgruppe ja/nein</b>	ja
<b>Ort der Datenerhebung</b>	Akutkrankenhaus (incl. Psychiatrie)
<b>Land</b>	US
<b>Charakterisierung der Zielgruppe der</b>	Caring staff

<b>Trainingsmaßnahme</b>	
<b>Beschreibung Patienten</b>	Geriatrische und Kardiologische Stationen vs. Kontrollen
<b>Beschreibung Intervention</b>	One-hour de-escalation and selfdefense training
<b>Detaillierte Beschreibung der Intervention</b>	De-escalation taught both nonverbal and verbal methods to calm, display respect, and encourage continual dialog. The self-defence portion provided basic techniques of escaping the most common forms of physical contact by patients and visitors, beginning with methods to seek assistance and understanding the importance of identified escape routes. Next was demonstration of and practicing escapes from arm grabs, clothing grabs, hair pulls, and blocking punches.
<b>Beschreibung Outcomevariablen</b>	1. Number of calls to security for assistance from patient care staff
<b>Beschreibung Ergebnisse</b>	1. Signifikant weniger "Code grey", d.h. Alarmierungen des Sicherheitsdienstes 2. Weniger physische Gewalt dafür mehr verbale Gewalt

<b>Nummer</b>	14
<b>Autoren</b>	Forster, P. L.; Cavness, C.; Phelps, M. A.
<b>Jahr</b>	1999
<b>Studie</b>	Staff training decreases use of seclusion and restraint in an acute psychiatric hospital. In: Archives of psychiatric nursing 13 (5), S. 269–271.
<b>Studientyp</b>	Prä/Post Intervention
<b>Dauer Baseline</b>	12 Monate
<b>Dauer Intervention</b>	annual 2-hour review course and weekly discussions
<b>Dauer Follow up</b>	12 Monate
<b>Kontrollgruppe ja/nein</b>	nein
<b>Ort der Datenerhebung</b>	San Francisco Country Community Mental Health Services, John George Psychiatry Pavillon, Gateway Psychiatric Services
<b>Land</b>	US
<b>Charakterisierung der Zielgruppe der Trainingsmaßnahme</b>	all staff members with any patient contact
<b>Anzahl Patienten</b>	?? (Approximately 6,500 patients are evaluated in the Psychiatric Emergency Service annually, and nearly 2,000 are admitted for inpatient treatment.
<b>Beschreibung Patienten</b>	acute-psychiatric hospital: 4 locked wards, 1 emergency service
<b>Beschreibung Intervention</b>	Interventions included a mandatory staff training session on the management of assaultive behavior, weekly discussion items during team meetings for each local ward, and hospital-wide publicity charting the ongoing progress of the effort
<b>Detaillierte Beschreibung der Intervention</b>	The multidisciplinary committee met biweekly during paid work time and only nursing and occupational therapy staff to attend an annual 2-hour review course: 1.to increase awareness of the factors leading to

	<p>patient agitation and violence; 2. to promote the knowledge and use of less restrictive measures, such as seclusion without restraint; 3. to increase safe staff reactions to violence</p> <p># The program emphasized a hands-on approach. Each staff member experienced 5-point restraints first-hand, and many cited that experience as pivotal in their decision whether or not to restrain a patient in a state of agitation when queried 1 year after the course.</p> <p># Hands-on self-defense training was taught and optimal "containment" techniques were practiced to minimize the risk of patient or staff injury. Inappropriate uses of restraint (for staff convenience or because of irritation) were discussed, and participants role-played verbal interventions that may be used as less restrictive alternatives to physical containment.</p> <p>The intervention also included weekly discussion items about S&amp;R during team meetings for each local ward and hospital-wide publicity charting the ongoing progress of the effort.</p>
<b>Beschreibung Outcomevariablen</b>	Rates of the use and duration of seclusion and restraint episodes, and number of staff injuries incurred during physical containment
<b>Beschreibung Ergebnisse</b>	The total annual rate of restraint decreased 13.8 % overall, from 2,379 episodes per 2,560 admissions in 1995, to 2,380 episodes per 3,010 admissions in 1996. The average duration of seclusion or seclusion and restraint per episode was reduced 54.6 %, from 13.9 hours/episode in 1995 to 6.3 hours/episode in 1996. Staff injuries were reduced 18.8 % from 48 incidents in 1995 to 39 in 1996
<b>Funding</b>	Not reported
<b>Qualitätsbemerkung</b>	Contamination due to other changes (LOS decreases, admissions increase), all staff injuries should have been counted, not just those linked to containment

<b>Nummer</b>	15
<b>Autoren</b>	Geoffrion, Steve; Goncalves, Jane; Giguere, Charles-Edouard; Guay, Stephane
<b>Jahr</b>	2017
<b>Studie</b>	Impact of a Program for the Management of Aggressive Behaviors on Seclusion and Restraint Use in Two High-Risk Units of a Mental Health Institute. In: The Psychiatric quarterly. DOI: 10.1007/s11126-017-9519-6.
<b>Studientyp</b>	Prä/Post Intervention
<b>Dauer Baseline</b>	Pre-training data (April 2010–December 2011)
<b>Dauer Intervention</b>	4 Days training
<b>Dauer Follow up</b>	data during training (January 2012–October 2012) posttraining data (November 2012–July 2014)
<b>Kontrollgruppe ja/nein</b>	nein
<b>Ort der Datenerhebung</b>	emergency unit and the intensive care unit, which each have a 12-bed

	capacity
<b>Land</b>	CAN
<b>Anzahl Patienten</b>	The yearly average number of admissions for this period is 210 patients in the intensive care unit and 1041 patients in the emergency unit
<b>Beschreibung Intervention</b>	Omega training
<b>Detaillierte Beschreibung der Intervention</b>	The training is delivered by peer trainers (security agents) on a four-day period and seeks to teach participants the skills and intervention methods necessary to ensure their safety and that of their patients in situations of aggression. Participants are taught the fundamental values (i.e., respect, professionalism, accountability, and security) and principles (i.e., to protect oneself, to assess the situation, to predict behavior, to take the time needed, and to focus on the person) of Omega. Participants are also taught a pacification approach and the use of a grid for classifying behaviors and levels of dangerousness of potentially aggressive individuals. Levels of dangerousness include emotional tension, conditional cooperation, refractory behavior, destructive behavior, psychological intimidation, active resistance, physical aggression, serious assaults, and exceptional threats. Seven levels of interventions are classified in an intervention pyramid ranging from mitigation (i.e., resolving the aggressive crisis situation or the acute crisis with an approach focused on the safety of the patient) to physical intervention (i.e., last resort intervention, used when the patient or client has imposed an act of protection or control). The training also provides the necessary tools to complete a post-incident report.
<b>Beschreibung Outcomevariablen</b>	number and duration of S/R
<b>Detaillierte Beschreibung Outcomevariablen</b>	number and duration of S/R --> reducing potential emotional and physical harm patients may cause to themselves and staff, as well as in maintaining a positive and trustful atmosphere between the patients and the staff in the unit
<b>Beschreibung Ergebnisse</b>	A total of 6933 S/R were registered in the Intensive care unit between April 1st 2010 and July 31st 2014. For the same period, a total of 880 S/R were registered in the Emergency unit. # Intensive care unit: increase of both mean daily number and duration of S/R pre-training followed by a decrease during the training and post-training. # Emergency unit, no statistically significant differences were observed. A decrease had already started prior to the Omega training program
<b>Funding</b>	This study was funded by the Canadian Institutes of Health Research

<b>Nummer</b>	16
---------------	----

<b>Autoren</b>	Gertz, B.
<b>Jahr</b>	1980
<b>Studie</b>	Training for prevention of assaultive behavior in a psychiatric setting. In: Hospital & community psychiatry 31 (9), S. 628–630.
<b>Studientyp</b>	Prä/Post-Intervention
<b>Dauer Baseline</b>	1 Jahr
<b>Dauer Intervention</b>	2-tägiger Workshop
<b>Dauer Follow up</b>	1 Jahr
<b>Kontrollgruppe ja/nein</b>	nein
<b>Ort der Datenerhebung</b>	Psychiatrisches Krankenhaus in Denver
<b>Land</b>	US
<b>Charakterisierung der Zielgruppe der Trainingsmaßnahme</b>	Alle Berufsgruppen
<b>Anzahl Teilnehmer Interventionsgruppe</b>	317
<b>Beschreibung Intervention</b>	Two-day workshop: goals: to increase their skills in defusing or de-escalating potentially violent behavior, to learn to apply both defensive and restraining techniques, and to develop plans for improving the prevention of assaultive incidents
<b>Beschreibung Outcomevariablen</b>	Anzahl der Vorfälle
<b>Beschreibung Ergebnisse</b>	center's staff and administration: increased confidence by giving all a valuable set of guidelines for managing assaultive behavior. A study to assess any reduction in patient-related accidents as a result of the workshop showed that in calendar year 1979 there were 117 such incidents compared with 174 in 1978. A one-day workshop has been designed to teach nonclinical staff members similar methods for the management of disturbed patient behavior.

<b>Nummer</b>	17
<b>Autoren</b>	Huizing, Anna R.; Hamers, Jan P. H.; Gulpers, Math J. M.; Berger, Martijn P. F.
<b>Jahr</b>	2006
<b>Studie</b>	Short-term effects of an educational intervention on physical restraint use. A cluster randomized trial. In: BMC geriatrics 6, S. 17. DOI: 10.1186/1471-2318-6-17.
<b>Studientyp</b>	Cluster-randomisierte kontrollierte Studie
<b>Dauer Intervention</b>	5x 2-stündige Meetings in insgesamt 2 Monaten für 23 ausgewählte Nurses 1x 1,5 Stunden Plenarsitzung für alle Nurses der Interventionsstationen
<b>Dauer Follow up</b>	1 Monat
<b>Kontrollgruppe ja/nein</b>	ja

<b>Charakterisierung der Kontrollgruppe</b>	3 Wards mit Intervention, 2 Wards ohne Intervention als Kontrollgruppe
<b>Ort der Datenerhebung</b>	Psycho-geriatrisches Wohnheim (5 Stationen)
<b>Land</b>	NL
<b>Charakterisierung der Zielgruppe der Trainingsmaßnahme</b>	Nursing staff
<b>Anzahl Teilnehmer Interventionsgruppe</b>	23 Nursing staff from Interventions wards
<b>Anzahl Teilnehmer Kontrollgruppe</b>	0
<b>Anzahl Patienten</b>	145 (Insgesamt 5 Stationen: intervention (3 wards) or control status (2 wards)) Ursprünglich 167, aber einige verstorben
<b>Beschreibung Patienten</b>	Patienten mit Demenz
<b>Beschreibung Intervention</b>	educational programme combined with consultation with a nurse specialist
<b>Detaillierte Beschreibung der Intervention</b>	# educational programme: decision-making process towards restraint use, the effects and consequences of restraint use, strategies to analyse risk behaviour of residents and alternatives for restraints. discussion of real-life cases during the educational meetings. small-scale meetings with an active learning environment for the nurses. # The consultation with the nurse specialist focused on supporting nurses in achieving restraint-free care and complying with the decision-making process concerning restraint use
<b>Beschreibung Outcomevariablen</b>	1. restraint prevalence and intensity of use 2. Effect on multiple restraint use 3. Effect on different restraint types
<b>Detaillierte Beschreibung Outcomevariablen</b>	Datensammlung mittels Fragebögen (Baseline und 1 Monat nach Intervention) und "Beobachten" zu 1. Restraint prevalence was defined as the percentage of residents observed restrained at any time during the 24-hour period. Restraint intensity indicated the number of times in four observations that a particular resident was restrained. zu 2. Multiple restraints indicated the number of different restraint types used per resident recorded during the four observations. zu 3. Restraint types were also recorded in order to gain insight into the types of restraint used with residents. Any device with limitation on an individual's freedom of movement was regarded as a restraint. Examples of restraint types are chairs with tables, belts tied to a chair or bed, bilateral bed rails, sleep suits, special sheets (a fitted sheet including a coat that encloses a mattress), chairs with a board (a chair with chair legs fixed to a board), infrared systems, safe seats, and deep or overturned chairs.

<b>Beschreibung Ergebnisse</b>	<p>Interventionsgruppe: Restraint use did not change significantly over time in the experimental group (55 %–56 %)</p> <p>Kontrollgruppe: significant increased use (<math>P &lt; 0.05</math>) in the control group (56 %–70 %).</p> <p>The mean restraint intensity and mean multiple restraint use in residents increased in the control group but no changes were shown in the experimental group. Logistic regression analysis showed that residents in the control group were more likely to experience increased restraint use than residents in the experimental group</p>
<b>Beschreibung sekundäre Ergebnisse</b>	<p># Restraint prevalence: Restraint prevalence in the experimental group did not change significantly. Restraint prevalence during the morning, afternoon, evening and at night did also not change over time. However, restraint prevalence in the control group increased significantly from 56 % to 70 % (<math>P = 0.021</math>), and there was a statistically significant increase in restraint use in the morning and at night.</p> <p># Restraint intensity: Comparison of restraint intensity and the average score of restraint intensity at both measurements showed no statistically significant differences between the experimental and control groups. There was a significant increase in the mean score of restraint intensity over time in the control group from 1.41 to 1.89. The mean restraint intensity did not change over time in the experimental group. Although the mean score in the control group increased more (gain score = 0.48) compared to the experimental group (gain score = 0.13), the gain score difference was not statistically significant (<math>P = 0.133</math>).</p> <p># Multiple restraints: The control group had a significantly higher mean score of multiple restraint use at post-intervention compared to the experimental group (<math>P = 0.033</math>).</p> <p># Restraint types: 12 different restraint types were found to be used with nursing home residents. The most frequently used restraints at baseline were bilateral bed rails (57 %), sleep suits (14 %), belts in bed (11 %), belts in chairs (8 %), and chairs with a table (8 %).</p> <p>Comparison in the use of different restraint types at baseline between the control and experimental groups showed that more sleep suits were used with the control group (23 %) compared to the experimental group (7 %) (<math>P = 0.008</math>). At post-intervention, even more sleep suits were used with the control group (36 %) compared to the experimental group (12 %) (<math>P \leq 0.001</math>). The use of sleep suits in the control group increased significantly over time from 22 % to 38.9 % (<math>P = 0.012</math>). The increased use of belts in bed with the control group, from 9 % to 19 %, nearly reached the level of statistical significance (<math>P = 0.063</math>). No significant changes occurred over time in the experimental group (Table 4).</p>
<b>Nummer</b>	18



Autoren	Hurlebaus, A. E.; Link, S.
Jahr	1997
Studie	The effects of an aggressive behavior management program on nurses' levels of knowledge, confidence, and safety. In: Journal of nursing staff development : JNSD 13 (5), S. 260–265.
Studientyp	Randomisierte-kontrollierte Studie (Prä/Post Intervention)
Dauer Intervention	4 Stunden
Kontrollgruppe ja/nein	ja
Charakterisierung der Kontrollgruppe	Entsprechend der Interventionsgruppe wurde eine Kontrollgruppe mit ähnlichen Qualifikationen und Berufserfahrung zusammengestellt
Ort der Datenerhebung	Krankenhaus
Land	US
Charakterisierung der Zielgruppe der Trainingsmaßnahme	Nursing staff
Anzahl Teilnehmer Interventionsgruppe	13
Anzahl Teilnehmer Kontrollgruppe	10
Beschreibung Intervention	Workshop: "Managing Aggressive Behavior"
Detaillierte Beschreibung der Intervention	Introduction, Discussion about general crime and crime specific of the institution, Verbal and nonverbal signs of increasing agitation, Communication skills, Body Language, Tone of voice, Eye contact, nonphysical interventions as preferred method, use of physical defense techniques discussed and demonstraed, supervised practice of self-defence and breake away techniques
Beschreibung Outcomevariablen	1. Objektiver Wissenszuwachs 2. Messung der Sicherheit des Personals im Umgang mit der Sitation und bezüglich des subjektiven Bewältigungsvermögens
Detaillierte Beschreibung Outcomevariablen	1. Schriftlicher Test prä/post Intervention zur objektiven Wissenkontrolle mittels 15 Fragen (Ja/Nein und Multiple Choice) 2. Messung der Sicherheit und des subjektiven Bewältigungsvermögen mittels einer visuellen Analogskala
Beschreibung Ergebnisse	1. Significant differences in knowlege, no significant changes in safety or confidence

<b>Nummer</b>	19
<b>Autoren</b>	Ilkiw-Lavalle, Olga; Grenyer, Brin F. S.; Graham, Linda
<b>Jahr</b>	2002
<b>Studie</b>	Does prior training and staff occupation influence knowledge acquisition from an aggression management training program? In: International journal of mental health nursing 11 (4), S. 233–239.
<b>Studientyp</b>	Prä/Post-Intervention
<b>Dauer Intervention</b>	2 Tage
<b>Kontrollgruppe ja/nein</b>	nein

<b>Ort der Datenerhebung</b>	Multizentrische Psychiatrische Stationen (Geschlossen, Offen, Akut, Subakut)
<b>Land</b>	AUS
<b>Charakterisierung der Zielgruppe der Trainingsmaßnahme</b>	Nursing staff, Medical health staff (Psychologen, Sozialarbeiter, Ärzte), sonstige Beschäftigte (Administrativ, Hauswirtschaft usw)
<b>Anzahl Teilnehmer Interventionsgruppe</b>	103 (42 Nursing, 18 Medical health, 37 Ancillary Staff)
<b>Beschreibung Patienten</b>	Psychiatrische Stationen (Geschlossen, Offen, Akut, Subakut)
<b>Beschreibung Intervention</b>	INTACT Aggression Management Program (Graham 1999)
<b>Detaillierte Beschreibung der Intervention</b>	Gruppengröße 13 Teilnehmer, Aushändigung Kursbuch, Gruppenarbeit, Rollenspiele, Übung von Selbstverteidigungstechniken, Unterricht in Legalen Aspekten, Charakteristika von Aggression, Vorhersehbarkeit von Aggression, Management von Aggression und Selbstschutz
<b>Beschreibung Outcomevariablen</b>	1. INTACT knowledge evaluation (Schriftlicher Wissenstest) 2. Program evaluations Fragebogen bezüglich, Zielsetzung, Verständlichkeit des Kursbuches und des Kursleiters, Unterrichtsmaterials, Praktischen Kursanteile und Kursdauer
<b>Detaillierte Beschreibung Outcomevariablen</b>	1. Schriftlicher Test (14 Punkte) prä/post intervention bezüglich Charakteristika, Erkennungsmerkmale, Management und Legale Aspekte im Bezug zu aggressivem Verhalten 2. Evaluationsfragebogen
<b>Beschreibung Ergebnisse</b>	1. Alle Gruppen profitierten signifikant im Wissenszuwachs, am meisten die mit der schlechtesten Vorbildung 2. Insgesamt war die Belegschaft mit dem INTACT Programm zufrieden.

<b>Nummer</b>	20
<b>Autoren</b>	Infantino, J. A., JR; Musingo, S. Y.
<b>Jahr</b>	1985
<b>Studie</b>	Assaults and injuries among staff with and without training in aggression control techniques. In: Hospital & community psychiatry 36 (12), S. 1312–1314.
<b>Studientyp</b>	Fall- Kontroll-Studie
<b>Dauer Intervention</b>	3 Tage zu 8h
<b>Dauer Follow up</b>	Erhebungszeitraum 9 Monate
<b>Kontrollgruppe ja/nein</b>	ja
<b>Charakterisierung der Kontrollgruppe</b>	Angestellte ohne ACT Training
<b>Ort der Datenerhebung</b>	State Hospital
<b>Land</b>	US
<b>Charakterisierung der Zielgruppe der Trainingsmaßnahme</b>	Angestellte mit direktem Patientenkontakt

<b>Anzahl Teilnehmer Interventionsgruppe</b>	31
<b>Anzahl Teilnehmer Kontrollgruppe</b>	65
<b>Beschreibung Intervention</b>	Training in Aggression Control Techniques (ACT) Florida
<b>Detaillierte Beschreibung der Intervention</b>	3 Trainingsphasen zu Verbale Deeskalation, Selbstverteidigungsmassnahmen bei Tötlichkeiten. Phae 1: Vorgehensmassnahmen entsprechend der Patientenrechte und Verbale Deeskalation mit Rollenspielen, verschiedenen Interventionsmodelle mit Schwerpunkt auf dem helping relationship stressed by Egan, 2. Phase: Selbstverteidigungsmassnahmen, Befreiungstechniken, 3. Phase: Instruktionen zu Zwangsmaßnahmen
<b>Beschreibung Outcomevariablen</b>	1. Auftreten von Vorfällen; 2. Anzahl an Verletzungen von Mitarbeitern,
<b>Beschreibung Ergebnisse</b>	1.+2. Signifikant weniger tätliche Angriffe mit signifikant weniger Verletzungen für das Personal

<b>Nummer</b>	21
<b>Autoren</b>	Khadivi AN, Patel RC, Atkinson AR, Levine JM
<b>Jahr</b>	2004
<b>Studie</b>	Association between Seclusion and Restraint and Patient-Related Violence
<b>Studientyp</b>	Prä/Post-Intervention
<b>Dauer Baseline</b>	12 Monate
<b>Dauer Follow up</b>	12 Monate
<b>Kontrollgruppe ja/nein</b>	nein
<b>Ort der Datenerhebung</b>	Psychiatrisches Krankenhaus Akutstation, fürsorgliche Unterbringung
<b>Land</b>	US
<b>Charakterisierung der Zielgruppe der Trainingsmaßnahme</b>	Staff, wahrscheinlich nur Pflege
<b>Anzahl Patienten</b>	1,766 preintervention and 1,602 postintervention
<b>Beschreibung Patienten</b>	Stationär Psychiatrisch, unfreiwillige Einweisung
<b>Beschreibung Intervention</b>	Trainingsprogramm
<b>Detaillierte Beschreibung der Intervention</b>	The intervention centered on early recognition of signs of agitation among patients and early clinical intervention. All staff members had previously been trained on assault prevention measures; however, this training varied and specific training on violence prevention was not given during the study period.
<b>Beschreibung Outcomevariablen</b>	1. total number of episodes of seclusion and restraint 2. episodes of assault on patients and staff 3. Anzahl der behandelten Patienten und Patiententagen
<b>Detaillierte Beschreibung Outcomevariablen</b>	central nursing log books of the department of psychiatry. Episodes of violence against patients and staff and episodes of self-destructive behavior

	were determined from incident report files.
<b>Beschreibung Ergebnisse</b>	<ol style="list-style-type: none"> <li>1. Signifikant weniger Zwangsmaßnahmen (310 zu 148)</li> <li>2. Signifikant mehr Vorfälle von Aggressivem Verhalten gegenüber dem Personal (31 zu 83) und gegenüber von Patienten (67 zu 85)</li> <li>3. Die Gruppen sind vergleichbar</li> </ol>

<b>Nummer</b>	22
<b>Autoren</b>	Lee S, Wright S, Sayer J, Parr AM, Gray R, Gournay K
<b>Jahr</b>	2001
<b>Studie</b>	Physical restraint training for nurses in English and Welsh psychiatric intensive care and regional secure units
<b>Studientyp</b>	Deskriptiv Retrospektiv
<b>Kontrollgruppe ja/nein</b>	nein
<b>Ort der Datenerhebung</b>	Psychiatrische Intensivstation und Forensische Stationen (Secure Units)
<b>Land</b>	UK
<b>Charakterisierung der Zielgruppe der Trainingsmaßnahme</b>	Pflegepersonal
<b>Anzahl Teilnehmer Interventionsgruppe</b>	338
<b>Beschreibung Patienten</b>	Psychiatrisch Intensiv und Forensisch (PICU/RSU)
<b>Beschreibung Intervention</b>	Überregionale Untersuchung, in wie weit das Pflegepersonal ausgebildet ist und welche Ausbildung es bekommen hat und wo
<b>Detaillierte Beschreibung der Intervention</b>	Fragebogen an 63 Stationen (von Insgesamt 112 Stationen in England und Wales)
<b>Beschreibung Outcomevariablen</b>	<ol style="list-style-type: none"> <li>1. Untersuchung welches Training stattgefunden hat</li> <li>2. Dauer des Trainings</li> <li>3. Inhalte des Trainings</li> <li>4. Bewertung des Trainings</li> </ol>
<b>Beschreibung Ergebnisse</b>	<ol style="list-style-type: none"> <li>1. Die meisten Teilnehmer konnten nicht angeben welches Training sie bekommen haben. Am Häufigsten waren "Control &amp; Restraint" (Broadmoor and Rampton hospital and C&amp;R Services) und "Care and Responsibility" (Ashworth Hospital)</li> <li>2. Das Training dauerte durchschnittlich 5 Tage</li> <li>3. Die Inhalte siehe Tabelle Paper welche Techniken gelehrt wurden, verbale Deeskalation 50 %, restraining hold 49 %, use of three person team 47 %)</li> <li>4.</li> </ol>

<b>Nummer</b>	23
<b>Autoren</b>	Lehmann, L. S.; Padilla, M.; Clark, S.; Loucks, S.
<b>Jahr</b>	1983
<b>Studie</b>	Training personnel in the prevention and management of violent behavior. In: Hospital & community psychiatry 34 (1), S. 40–43.
<b>Studientyp</b>	Prä/Post-Intervention

<b>Dauer Intervention</b>	5 Stunden
<b>Kontrollgruppe ja/nein</b>	nein
<b>Ort der Datenerhebung</b>	Veteranenkrankenhaus
<b>Land</b>	US
<b>Charakterisierung der Zielgruppe der Trainingsmaßnahme</b>	Sämtliche Angestellte mit Patientenkontakt in einem Krankenhauses
<b>Anzahl Teilnehmer Interventionsgruppe</b>	144
<b>Beschreibung Intervention</b>	Training program for the personnel of the Audie L. Murphy Memorial Veterans Hospital
<b>Detaillierte Beschreibung der Intervention</b>	Kurze Einführung, Vorstellung der Gründe für Aggressives Verhalten: Gewalttätige Patienten werden als ängstlich vor ihrer eigenen Feindseeligkeit betrachtet sowie als ängstlich vor einem Kontrollverlust trotz der Tatsache dass sie Gewalt als Bewältigungsstrategie für Hilflosigkeitsgefühle und für Kontrolle über andere verwenden.; Präventionsmassnahmen zur Abwendung von gewalttätigem Verhalten; Management von gewalttätigem Verhalten; Verbale Intervention, Legale Aspekte von Gewaltanwendung, Demonstration und Übung von Selbstverteidigungstechniken sowie Haltegriffe, Rollenspiele zu verbalen und Selbstverteidigungstechniken
<b>Beschreibung Outcomevariablen</b>	1. Wissen zur Thematik 2. subjektives Bewältigungsvermögen
<b>Detaillierte Beschreibung Outcomevariablen</b>	1. prä/post MC-Test zu 10 Punkten 2. Strukturiertes Interview Formular bei tatsächlichen Vorfällen
<b>Beschreibung Ergebnisse</b>	1. Der MC Test zeigte einen objektiven Wissenszuwachs nach Absolvieren des Kurses 2. Trainingsteilnehmer hatten ein signifikant höheres Selbstvertrauen und subjektives Bewältigungsvermögen, Teilnehmer waren zudem signifikat besser in der Lage die auslösenden Umstände zu erfassen.

<b>Nummer</b>	24
<b>Autoren</b>	Long CG, West R, Afford M, Collins L, Dollex O
<b>Jahr</b>	2015
<b>Studie</b>	Reducing the use of seclusion in a secure service for women
<b>Studientyp</b>	Prä/Post-Intervention
<b>Dauer Baseline</b>	1 Jahr
<b>Dauer Intervention</b>	1h / Woche über 4 Monate
<b>Dauer Follow up</b>	1 Jahr
<b>Kontrollgruppe ja/nein</b>	nein
<b>Ort der Datenerhebung</b>	Secure service for women
<b>Land</b>	UK
<b>Charakterisierung der Zielgruppe der Trainingsmaßnahme</b>	Staff

<b>Anzahl Patienten</b>	38 (19 prä / 19 post-Intervention)
<b>Beschreibung Patienten</b>	Frauen, alle Forensisch oder fürsorglich untergebracht, Hauptdiagnosen: Emotionale instabile Persönlichkeitsstörung oder Schizophrenie, Die ersten 19 Patienten mit einer Liegedauer von 1 Jahr wurden mit 19 Patienten vor der Intervention verglichen. (Zuteilung auf der Basis von Alter, Diagnose, Herkunft (Krankenhaus oder Gefängnis))
<b>Beschreibung Intervention</b>	<ol style="list-style-type: none"> <li>1. RAID (Reinforce Appropriate Implode Disruptive; Davies, 2004) milieu therapeutic approach to the management of extreme behaviour</li> <li>2. Training in Relational Security (Allen, 2010)</li> <li>3. Einbeziehung der Patientensicht in die Prävention und Management von aggressin und Gewalt</li> <li>4. Training auf Station</li> <li>5. Präventionsmassnahmen</li> </ol>
<b>Detaillierte Beschreibung der Intervention</b>	<ol style="list-style-type: none"> <li>1. RAID: staff training; . the use of a recovery approach to patient care; post-incident use of Behaviour Chain Analysis (Linehan, 1993); .the use of structured risk assessment tools and scenario-planning to inform risk management and Intervention (Douglas et al. 2013) and the use of a risk stage system (Long et al. 2014)</li> <li>2. 1-Stündiges Einführungsprogramm für Personal und wöchentliche Besprechungen zur Kontrolle der Compliane</li> <li>4.. 1-Stündiges wöchentliches Training in Deeskalations-Techniken anhand von Fallbeispielen (nicht physikalisch)</li> <li>5. Präventionsmassnahmen wie Gewichte um Arousal zu senken, Sport am Wochenende</li> </ol>
<b>Beschreibung Outcomevariablen</b>	<ol style="list-style-type: none"> <li>1. Ereignisse für Isolationsmassnahmen</li> <li>2. Vorfälle von riskantem Verhalten</li> <li>3. Behavior rating scale</li> <li>4. Anwesenheit bei Therapiesitzungen</li> <li>5. Seclusion questionnaire</li> </ol>
<b>Detaillierte Beschreibung Outcomevariablen</b>	<ol style="list-style-type: none"> <li>3. Bewertungssystem (0-3 Punkte) für folgende Punkte: self-harm; suicide ideation; appropriate behaviour; verbal aggression; physical aggression; property care, participation in ward/hospital programmes; compliance with drug treatment; responsibility for own behaviour; insight into disorder; insight into risk; relationship with primary nurse; and relationship with staff</li> <li>5. Fragebogen an Belegschaft und Patienten über die beste mglichkeit Isolationsmassnahmen zu umgehen (training in de-escalation; timetabled BCA sessions; patient consultation about risk management plans; sensory integration treatment; increased activity sessions at weekends; and Relational Security items: increased levels of engagement with patients by staff (team) and initiatives to reduce bullying, harassment and discrimination (other patients).)</li> </ol>
<b>Beschreibung Ergebnisse</b>	1. Signifikant weniger Seclusion (Isolationsmassnahmen) und

	<p>signifikant weniger Zeit der Patienten in der Isolationsmassnahme</p> <p>2. Am Häufigsten war Selbstgefährdung der Grund für die Isolationsmassnahmen</p> <p>3. Signifikant weniger Risikoverhalten</p> <p>4. Höhere Rate an Teilnahmen an Therapiesitzungen</p> <p>5. Staff findet deeskalationstechnik am effektivsten, patienten finden Relational Security team initiative item am besten</p>
--	--

<b>Nummer</b>	25
<b>Autoren</b>	Martin, K. H.
<b>Jahr</b>	1995
<b>Studie</b>	Improving staff safety through an aggression management program. In: Archives of psychiatric nursing 9 (4), S. 211–215.
<b>Studientyp</b>	Prä/Post-Intervention
<b>Dauer Baseline</b>	1 Jahr
<b>Dauer Intervention</b>	1 Tag Workshop, danach wöchentliches Hands-on Training für 2 Monate
<b>Dauer Follow up</b>	2 Jahre
<b>Kontrollgruppe ja/nein</b>	nein
<b>Ort der Datenerhebung</b>	Psychiatrie einer Universitätsklinik
<b>Land</b>	US
<b>Charakterisierung der Zielgruppe der Trainingsmaßnahme</b>	Begleitschaft zweier psychiatrischer Stationen (Pflege, Ärzte, Beschäftigungstherapeuten, Sozialarbeiter, Sekretariat)
<b>Beschreibung Patienten</b>	Inpatient Psychiatric
<b>Beschreibung Intervention</b>	Aggression Management Program: Workshop
<b>Detaillierte Beschreibung der Intervention</b>	1) A mandatory Aggression Management Workshop, was attended by all inpatient staff, which provided both theory and practice: The morning session, primarily theory, focused on overall review of the psychiatric emergency protocol with emphasis on assessment and interventions for level I and II. Staffs' behaviors, attitudes and perceptions in dealing with aggressive and/or potentially aggressive patients were also discussed. The afternoon session offered hands-on training with emphasis on personal safety techniques, individual and team takedowns, as well as the use of seclusion and restraints, all part of level II! interventions in the psychiatric emergency protocol., 2) a video on verbal deescalation techniques, was viewed by all staff, 3) a competence assessment, through return demonstration of learned skills, was required by all staff within 2 months of the workshop, and 4) annual certification in each of the three areas was required for all staff.
<b>Beschreibung Outcomevariablen</b>	1) number of aggressive incidents, 2) level of aggression, 3) type of injury, 4) Number of missed work days, and 5) cost to the Department of Psychiatric Nursing as a result of injury.
<b>Beschreibung Ergebnisse</b>	1+2) The level of actual aggression began to drop after the

	implementation of the program, despite an increase in total number of aggressive incidents 3) The occurrence of staff injuries improved only the second year after the program development. 4) The number of injuries resulting in missed work time stayed the same over all 3 years.
<b>Beschreibung sekundäre Ergebnisse</b>	Schriftliche Evaluation nach 1 Jahr zeigte eine gesteigerte Zufriedenheit und Selbstvertrauen im Management mit Aggressiven Patienten

<b>Nummer</b>	26
<b>Autoren</b>	McDonnell, Andrew
<b>Jahr</b>	1997
<b>Studie</b>	Training Care Staff to manage challenging behaviour: an evaluation of a three day training course. In: The British Journal of Development Disabilities 43 (85), S. 156–162. DOI: 10.1179/bjdd.1997.015.
<b>Studientyp</b>	Prä/Post-Intervention
<b>Dauer Intervention</b>	3 Tage
<b>Kontrollgruppe ja/nein</b>	nein
<b>Land</b>	UK
<b>Charakterisierung der Zielgruppe der Trainingsmaßnahme</b>	Pflegepersonal
<b>Anzahl Teilnehmer Interventionsgruppe</b>	21
<b>Beschreibung Intervention</b>	3-tägiger Trainingskurs
<b>Detaillierte Beschreibung der Intervention</b>	Tag 1: Understanding the law, Ursachen für auffälliges Verhalten, Unterschiede in Gewalt und Aggression, Tag 2: Nicht-gewalttätige Methoden zum Management von auffälligem Verhalten, incl Selbstverteidigung ohne das Verdrehen von Gelenken Tag 3: Nichtgewalttätige freiheitsentziehende Massnahmen
<b>Beschreibung Outcomevariablen</b>	1. MC-Test mit 20 Fragen prä/post, 2. Managign Challenging Behavior Confidence Scale mit 15 Punkten prä/post 3. Restraint Role Play Test
<b>Detaillierte Beschreibung Outcomevariablen</b>	1. MC Fragen zum Abfragen von Wissen 2. Selbsteinschätzung zum Umgang mit aggressiven Patienten und zur Anwendung von freiheitsentziehenden Massnahmen 3. Videoanalyse der Rollenspiele durh 2 unabhängige Bewerter, Analyse anhand eines 9-Stufen Bewertungssystems
<b>Beschreibung Ergebnisse</b>	1. Wissenszuwachs durch die Massnahme (nicht signifikant) 2. Signifikant gesteigertes Selbstvertrauen im Umgang mit aggressivem Verhalten und mit freiheitsentziehendenMassnahmen 3. Alle Teilnehmer bestanden den Role-Play test mit mindestens 8 von 9 Stufen
<b>Beschreibung sekundäre</b>	Die älteren Teilnehmern haben schlechter im Rollenspiel



<b>Ergebnisse</b>	abgeschlossen
<b>Nummer</b>	27
<b>Autoren</b>	McGowan, S.; Wynaden, D.; Harding, N.; Yassine, A.; Parker, J.
<b>Jahr</b>	1999
<b>Studie</b>	Staff confidence in dealing with aggressive patients. A benchmarking exercise. In: The Australian and New Zealand journal of mental health nursing 8 (3), S. 104–108.
<b>Studientyp</b>	(nicht randomisierte) Fall-Kontroll-Studie mit Prä/Post-Intervention
<b>Dauer Intervention</b>	Kontroll-Gruppe: 1-Tages-Trainingsprogramm bei Stellenantritt, alle 6 Monate 1,5 -ständiger Refresher-Kurs Interventionsgruppe: 6 Module mit insgesamt 22,5 Stunden
<b>Dauer Follow up</b>	6 Monate (Interventionsgruppe)
<b>Kontrollgruppe ja/nein</b>	ja
<b>Charakterisierung der Kontrollgruppe</b>	Kontroll-Krankenhaus mit bereits vorher bestehendem Aggressionsmanagement-Programm
<b>Ort der Datenerhebung</b>	Multizentrisch (2 Psychiatrische Intensivstationen in 2 verschiedenen Krankenhäusern)
<b>Land</b>	AUS
<b>Charakterisierung der Zielgruppe der Trainingsmaßnahme</b>	Nursing Staff
<b>Anzahl Teilnehmer Interventionsgruppe</b>	ursprünglich 28, aber nur 15 haben den 2. Fragebogen ausgefüllt
<b>Anzahl Teilnehmer Kontrollgruppe</b>	42
<b>Beschreibung Intervention</b>	Kontrollgruppe: "Restraint and Manual Handling." Interventionsgruppe: Safe physical restraint module + 5 weitere Module
<b>Detaillierte Beschreibung der Intervention</b>	1. Kontrollgruppe: 'Restraint and Manual Handling' . *New staff undertake a one day training program that includes legal and ethical issues, managing challenging incidents, communicating effectively with aggressive patients, recognition and management of antecedent behaviour and physical restraint techniques including breakaway strategies. All staff undertake a one and a half-hour annual refresher training workshop. --> This explains the significantly higher confidence levels reported by staff at Graylands Hospital (Kontrollgruppe) for every item on the questionnaire when compared with Fremantle Hospital staff (Interventionsgruppe) prior to implementation of the safe physical restraint module. The safe physical restraint module was introduced at Fremantle Hospital (Interventionsgruppe) in May 1997. In addition, five other modules that cover legal and ethical issues, multicultural issues, management of aggressive behaviour, self-

	<p>defence techniques, and management of aggression in the community form the basis for a comprehensive management of aggression program. The total hours for all six modules in the program is 22 and a half.</p> <p>The safe physical restraint-module is seven and half-hours in length. It is designed for health professionals working in the mental health area and includes training in defusing and debriefing of both patients and staff following a critical incident. The module teaches a structured sequential process of dealing with physical aggression and the importance of team work and role assignment during the restraint process. The module follows a strict set of guidelines that ensure standards of safety for both staff and patients are met. Trainings focuses on early recognition and management of antecedent behaviours and the empowerment of the patients to take control of their behaviour. Six monthly updates and clinical drills are conducted</p>
<b>Beschreibung Outcomevariablen</b>	Messung des Selbstvertrauens (Confidence) im Umgang mit aggressivem Verhalten von Patienten
<b>Detaillierte Beschreibung Outcomevariablen</b>	<ol style="list-style-type: none"> <li>1. Selbstbewertungsfragebogen (mit 10 Punkten) zu Selbstvertrauen vor Intervention</li> <li>2. Wiederholung des Fragebogens 6 Monate nach Trainingsprogramm</li> </ol>
<b>Beschreibung Ergebnisse</b>	<ol style="list-style-type: none"> <li>(1) Confidence level. (how comfortable they felt working with an aggressive patient). --&gt; Signifikant erhöht.</li> <li>(2) Training for handling psychological aggression. (how good their present level of training was for handling psychological aggression). --&gt; Signifikant erhöht.</li> <li>(3) Ability to physically intervene. (views on their ability to intervene physically with an aggressive patient). --&gt; Signifikant erhöht.</li> <li>(4) Self assurance. (how self-assured they felt in the presence of an aggressive patient). --&gt; Signifikant erhöht.</li> <li>(5) Ability to intervene psychologically. (how able they are to intervene psychologically with an aggressive patient). --&gt; Signifikant erhöht.</li> <li>(6) Training for handling physical aggression. (indicate their present level of training for handling physical aggression). --&gt; Signifikant erhöht.</li> <li>(7) Safety. (how safe they felt around an aggressive patient). --&gt; Signifikant erhöht.</li> <li>(8) Techniques for dealing with aggression. (indicate the effectiveness of techniques they knew for dealing with aggression). --&gt; Signifikant erhöht.</li> <li>(9) Meeting needs. (how able they were to meet the needs of an aggressive patient). --&gt; Signifikant erhöht.</li> <li>(10) Protection. (how able they were to protect themselves from aggressive patients). --&gt; Signifikant erhöht.</li> </ol>

<b>Nummer</b>	28
<b>Autoren</b>	Needham I.; Abderhalden C.; Meer R.; Dassen T.; Haug H. J.; Halfens R.J.G.; Fischer J.E.
<b>Jahr</b>	2004
<b>Studie</b>	The effectiveness of two Interventions in the management of patient violence in acute mental inpatient settings: report on a pilot study. In: Journal of Psychiatric and Mental Health Nursing 11, S. 595-601.
<b>Studientyp</b>	Prä/Post-Intervention (Prospektive nicht- randomisierte Studie)
<b>Dauer Baseline</b>	3 Monate
<b>Dauer Intervention</b>	Gesamtdauer der Studie: 10 Monate Nach 3 Monaten (= Baseline) nur Kurs "Risikovorhersage" Im 7. Monat 5- tägiger Trainingskurs zu Aggressionsmanagement Die letzten 3 Monate Risikovorhersage und Trainingsprogramm parallel
<b>Kontrollgruppe ja/nein</b>	nein
<b>Ort der Datenerhebung</b>	Multizentrisch (1 Städtische psychiatrische Station, 1 ländliche psychiatrische Station mit jeweils 12 Betten)
<b>Land</b>	CH
<b>Charakterisierung der Zielgruppe der Trainingsmaßnahme</b>	Nursing Staff
<b>Anzahl Patienten</b>	576 Patienten
<b>Beschreibung Patienten</b>	576 patients (41.3 % females, mean age 38 years, range 15–88 years) accounted for 721 admissions to the two acute psychiatric wards. hospitalizations comprised 38.5 % voluntary and 61.5 % involuntary admissions, giving rise to a total of 7 732 hospitalization days. Diagnosen: schizophrenia, schizo-type 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 %).
<b>Beschreibung Intervention</b>	1. Systematische Risikovorhersage mit BVC-R 2. Standardisiertes Trainingsprogramm zu Management von Aggressionen
<b>Detaillierte Beschreibung der Intervention</b>	1. Risikovorhersage mittels extended version of the Brøset Violence Checklist (BVC-R) . Einschätzung von "six patient behaviours (confused, irritable, boisterous, verbally threatening, physically threatening and attacking objects)" --> anschliessend Bewertung "of the risk for imminent violence using a slide-rule-VAS. These combined ratings produce a score between 0 (very low risk) and 12 (high risk). --> Alle Patienten wurden so bei Aufnahme und die nächsten 3 Tage (2x tgl) bewertet 2. Trainingsprogramm zu Management von Aggressionen (devised by (N.E. Oud unpublished) in the Netherlands). 5-tägiger Kurs mit 35 Einheiten " is a skilloriented, action-centred, and problem-centred educational programme incorporating

	<p>experiential- and knowledgebased elements such as 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." Weiterer Bestandteil des Kurses: "practical 'hands-on' skills such as holding methods, breakaway techniques, and control and restraint"</p>
<b>Beschreibung Outcomevariablen</b>	<ol style="list-style-type: none"> <li>1. Anzahl der aggressiven Ereignisse</li> <li>2. Schwere der aggressiven Ereignisse</li> <li>3. Anzahl der Zwangsmaßnahmen</li> </ol>
<b>Detaillierte Beschreibung Outcomevariablen</b>	<ol style="list-style-type: none"> <li>1. Aggressive Ereignisse = verbal aggression, physical attacks against persons, or coercive measures. Dokumentiert mittels Staff Observation Aggression Scale (SOAS-R). The SOAS-R allows the registration of the provoking factor, the means used by the patient, the target of aggression, the consequence for the victims, and the measures to terminate aggression.</li> <li>2. Zwangsmaßnahmen: recorded on a form developed on the basis of existing formats in general use in the area. Coercive measures were further categorized as: (1) coercive measures without prior aggression, and (2) coercive measures following an aggressive incident. Incidence rates were expressed as events per 100 hospitalization days (unit of analysis = occupied beds) and as days with event per ward (unit of analysis = ward). Secondary outcomes were the severity of aggressive events as measured by the SOAS-R and by a visual analogue scale.</li> </ol>
<b>Beschreibung Ergebnisse</b>	<ol style="list-style-type: none"> <li>1. Anzahl der aggressiven Ereignisse unverändert</li> <li>2. Schwere der aggressiven Ereignisse etwa unverändert</li> <li>3. Signifikante Abnahme der Zwangsmaßnahmen</li> </ol>
<b>Beschreibung sekundäre Ergebnisse</b>	<p>A 'ward effect' was detected with one ward showing a decline in attacks with unchanged incidence rates of coercion and the other ward showing the opposite. The severity of the incidents remained unchanged whilst the subjective severity declined after the training course.</p>
<b>Funding</b>	<p>This study was supported by research grant BK 361/01 of the Swiss Academy of Medical Science.</p>
<b>Qualitätsbemerkung</b>	<p>"ward effect"</p>

<b>Autoren</b>	Needham, I.; Abderhalden, C.; Halfens, R. J. G.; Dassen, T.; Haug, H. J.; Fischer, J. E.
<b>Jahr</b>	2005
<b>Studie</b>	The effect of a training course in aggression management on mental health nurses' perceptions of aggression. A cluster randomised controlled trial. In: International journal of nursing studies 42 (6), S. 649–655. DOI: 10.1016/j.ijnurstu.2004.10.003.
<b>Studientyp</b>	Randomisierte-kontrollierte Studie (Prä/Post Intervention)
<b>Dauer Intervention</b>	5 Tage
<b>Dauer Follow up</b>	90 Tage
<b>Kontrollgruppe ja/nein</b>	ja
<b>Charakterisierung der Kontrollgruppe</b>	ohne Trainingsmaßnahme
<b>Ort der Datenerhebung</b>	Multizentrisch
<b>Land</b>	CH
<b>Charakterisierung der Zielgruppe der Trainingsmaßnahme</b>	Pflegepersonal auf Psychiatrische Station
<b>Anzahl Teilnehmer Interventionsgruppe</b>	30
<b>Anzahl Teilnehmer Kontrollgruppe</b>	28
<b>Beschreibung Patienten</b>	Stationär Psychiatrisch
<b>Beschreibung Intervention</b>	Trainingsprogramm im Management von Aggressionen nach Nico Oud
<b>Beschreibung Outcomevariablen</b>	1. Fragebogen zur sozio-biographischen Datenerhebung und Fragen zu persönlichen Erfahrungen mit aggressivem Verhalten 2. Perception of Aggression Scale (POAS-S) 3. Tolerance Scale 4. Impact of Patient Aggression on Carers Scale (IMPACTS)
<b>Detaillierte Beschreibung Outcomevariablen</b>	#####
<b>Beschreibung Ergebnisse</b>	1. Beide Versuchsgruppen sind gleichwertig. 2. +3)+4) Alle Vergleiche zwischen der Kontrollgruppe und der Interventionsgruppe sind nicht signifikant unterschiedlich. Evtl war die Nachuntersuchungszeit zu kurz.

<b>Nummer</b>	30
---------------	----

Autoren	Nijman, H. L.; Merckelbach, H. L.; Allertz, W. F.; a Campo, J. M.
Jahr	1997
Studie	Prevention of aggressive incidents on a closed psychiatric ward. In: Psychiatric services (Washington, D.C.) 48 (5), S. 694–698. DOI: 10.1176/ps.48.5.694.
Studientyp	Prä/Post-Intervention
Dauer Baseline	3 Monate
Dauer Follow up	3 Monate
Kontrollgruppe ja/nein	ja
Charakterisierung der Kontrollgruppe	Stationen ohne Intervention
Ort der Datenerhebung	Psychiatrisches Krankenhaus
Land	NL
Charakterisierung der Zielgruppe der Trainingsmaßnahme	Staff
Anzahl Patienten	3 Stationen a 20 Betten
Beschreibung Patienten	Akute geschlossene Psychiatrische Station
Beschreibung Intervention	Managment von Patienten
Detaillierte Beschreibung der Intervention	Interventions included a protocol for talking to patients who exhibited aggressive behavior, discussing treatment goals with the patient shortly after admission, explaining why the ward's door was locked and the exit rules, providing a schedule of staff meetings to explain staff members' absence from the ward, and clarifying the procedure for making an appointment with the psychiatrists. R
Beschreibung Outcomevariablen	1. Messung der aggressiven Vorfälle mittels Staff Observation Aggression Scale (SOAS)
Beschreibung Ergebnisse	Kein Unterschied Signifikant weniger "Incidents of physical aggression" im Post-Interventionszeitraum auch auf den Control Wards. Wahrscheinlich wurde im Laufe der Zeit exakter durch das Personal differenziert (systematischer Fehler)

<b>Autoren</b>	Parkes, Jon
<b>Jahr</b>	1996
<b>Studie</b>	Control and restraint training. A study of its effectiveness in a medium secure psychiatric unit. In: The Journal of Forensic Psychiatry 7 (3), S. 525–534. DOI: 10.1080/09585189608415035.
<b>Studientyp</b>	Prä/Post-Intervention
<b>Dauer Baseline</b>	18 Monate
<b>Dauer Intervention</b>	4 Tage
<b>Dauer Follow up</b>	12 Monate
<b>Kontrollgruppe ja/nein</b>	nein
<b>Ort der Datenerhebung</b>	Forensische Pyachatrie
<b>Land</b>	UK
<b>Charakterisierung der Zielgruppe der Trainingsmaßnahme</b>	Nursing staff
<b>Beschreibung Patienten</b>	Psychiatrische Stataion mittlerer Sicherheit
<b>Beschreibung Intervention</b>	Control and Restraint (C&R) Training
<b>Detaillierte Beschreibung der Intervention</b>	It involved non-touch training, break-away, techniques and the use of a team of three staff to restrain a person
<b>Beschreibung Outcomevariablen</b>	Data consisted of information on the nature of the incident, the number of staff involved, the number of injuries occurring and the staff's feelings.
<b>Beschreibung Ergebnisse</b>	Es gab einen leichten nicht-signifikanten Anstieg von Verletzungen beim Personal (post training), Das Personal stufte die Vorfälle als gleich Schwierig wie vor dem Programm ein. Break away techniken wurden nicht benutzt.
<b>Beschreibung sekundäre Ergebnisse</b>	Am häufigsten waren Schläge gegen den Kopf des Personals 149 incidents involving restraint

<b>Nummer</b>	32
<b>Autoren</b>	Paterson, B.; Turnbull, J.; Aitken, I.
<b>Jahr</b>	1992
<b>Studie</b>	An evaluation of a training course in the short-term management of violence. In: Nurse education today 12 (5), S. 368–375.
<b>Studientyp</b>	Prä/Post-Intervention
<b>Dauer Intervention</b>	10 Tage
<b>Kontrollgruppe ja/nein</b>	nein
<b>Ort der Datenerhebung</b>	Psychiatrisches Krankenhaus
<b>Land</b>	UK
<b>Charakterisierung der Zielgruppe der Trainingsmaßnahme</b>	Nursing staff
<b>Anzahl Teilnehmer</b>	25

<b>Interventionsgruppe</b>	
<b>Beschreibung Intervention</b>	De-escalation Methode nach (Turnbull et al 1990)
<b>Detaillierte Beschreibung der Intervention</b>	Inhalte: Participants are first introduced to the theoretical issues surrounding violence and are encouraged to examine their current practice, particularly in relation to its legal basis and the safety of the client and themselves. Secondly, instruction is given in verbal and non-verbal techniques which might prevent assault and participants are afforded opportunities to practice their new skills in video role-play situations. Thirdly, participants are shown a comprehensive set of physical skills which would enable them to 'escape' from situations where a client has initiated an assault by grabbing clothing, pulling hair and so on. Fourthly, participants are instructed in techniques of control and restraint. Übungen wurden durchgeführt in De-escalation role plays, Instrucion in almost 100 separate break away techniques, davon 10 Haupt-Techniken wurden gelehrt.
<b>Beschreibung Outcomevariablen</b>	1. Fragebogen 2. Situationsmanagement 3. Befreiung aus Haltegriffen
<b>Detaillierte Beschreibung Outcomevariablen</b>	1. Zu (Wissen, General health questionnaire (GHQ), Job satisfaction questionnaire ,Role conflict/ambiguity scale) 2. Video Bewertung von Rollenspielen durch unabhängige, nicht in die Weiterbildungsmaßnahme involvierte Experten. Bewertung Hinsichtlich: Personalises self, Mood matching, Negotiating options, Distraction, Non-verbal communication, Use of non-provocative phrases 3. Bewertung durch Instruktoren bezüglich Effektivität, Geschwindigkeit, Technik, Sicherheit des Aggressors und des Personals
<b>Beschreibung Ergebnisse</b>	1. Signifikanger Wissenszuwachs, 2. Signifikant weniger Stress, 3. Höhere Job-Zufriedenheit (nicht signifikant), 4. Signifikant weniger Rollenkonflikt, 5. Signifikant bessere Fähigkeiten in Deeskalation, 5. Signifikant grössere Kompetenz bezüglich Praktischer Verteidigungstechniken
<b>Beschreibung sekundäre Ergebnisse</b>	Nach dem Kurs waren die Teilnehmer strukturierter und effektiver im Umgang mit schwierigen Situationen.

<b>Nummer</b>	33
<b>Autoren</b>	Phillips, Douglas; Rudestam, Kjell Erik
<b>Jahr</b>	1995
<b>Studie</b>	Effect of Nonviolent Self-Defense Training on Male Psychiatric taff Members' Aggression and Fear. In: In: PSYCHIATR SERV 46 (2), S. 164-168.
<b>Studientyp</b>	Randomisierte Fall-Kontroll-Studie
<b>Dauer Intervention</b>	1. Gruppe: Didaktisches Training in 2 Einheiten: Gesamtdauer 4 Stunden und 20 Min 2. Gruppe: Didaktisches und Physical skills Training in 2 Einheiten: Gesamtdauer 4h und 20 min
<b>Dauer Follow up</b>	2 Wochen



<b>Kontrollgruppe ja/nein</b>	ja
<b>Charakterisierung der Kontrollgruppe</b>	Three groups of male staff: 1. didactic training 2. didactic and physical skills training 3. no training in the nonviolent self-defense skills (= Kontrollgruppe)
<b>Ort der Datenerhebung</b>	Multizentrisch (2 Psychiatrische Krankenhäuser)
<b>Land</b>	US
<b>Charakterisierung der Zielgruppe der Trainingsmaßnahme</b>	Male psychiatric staff members Three groups of male staff: 1. didactic training 2. didactic and physical skills training 3. no training in the nonviolent self-defense skills
<b>Anzahl Teilnehmer Interventionsgruppe</b>	Gruppe 1: 8 (Didaktisches Training) Gruppe 2: 8 (Didaktisches Training und Physikal skills Training)
<b>Anzahl Teilnehmer Kontrollgruppe</b>	8
<b>Beschreibung Intervention</b>	Three groups of male staff received didactic training, didactic and physical skills training, or no training in the nonviolent self-defense skills of protective profile, repel, and push-off, as well as in evasive movement.
<b>Detaillierte Beschreibung der Intervention</b>	<p>Am Anfang der ersten Einheit simulierter Angriff als Rollenspiel für alle Teilnehmer, wurde per Video aufgezeichnet, anschliessend self-report questionnaire.</p> <p>The role-plays were videotaped and later reviewed by two judges who had received two hours of training in use of the assessment instruments and who were teaching violence management in other settings using the skills employed in this study. The judges were trained to rate levels of physical competence and levels of behaviorally expressed aggression and fear.</p> <p>Group 1 met with the first author for presentation and discussion of the following didactic material: nature and dynamics of violence, including psychoanalytic and social learning theories; the effects of nonverbal communications; warning signs of violence; intervention strategies; and legal and institutional issues.</p> <p>Group 2 followed an identical course, with the addition of training in the core physical skills of protective profile, repel, and push-off to evasion. The concepts of nonviolent self-defense and stress inoculation training were explained. The crucial factors of interpersonal distance and threat perception were discussed and illustrated with the protective profile. The protective profile is an upright posture with the knees very slightly bent and with the body at an oblique angle to the attacker. The hands are held crossed in front of the chest, held at the sides, or held up in front of the body.</p> <p>After training, subjects engaged in the same role-play as before training. The role-play was videotaped. The judges reevaluated the subjects for achieved physical competence using the evaluation of physical skill</p>

	<p>instrument. The Buss-Durkee Inventory was readministered. The subjects then participated in another videotaped role-play and were evaluated for physical competence and behaviorally expressed aggression and fear. After the role-play, subjects completed the self-report questionnaire.</p>
<b>Beschreibung Outcomevariablen</b>	<p>1. Level der Aggression und Angst des Personals gegenüber aggressiven Patienten (1. Bewertung durch Jury, 2. Eigenbewertung)</p> <p>2. Anzahl der Angriffe</p> <p>3. Episoden der Zwangsmaßnahmen</p> <p>4. Verletzungen Mitarbeiter</p>
<b>Detaillierte Beschreibung Outcomevariablen</b>	<p>Messung der Effektivität mithilfe von:</p> <p>1. Buss-Durkee Hostility-Guilt inventory (Messung von Feindseligkeit und Schuldgefühlen)</p> <p># a demographic questionnaire</p> <p># an instrument used for evaluation of level of physical skill (clinical experience and sports training)</p> <p># a scale evaluating aggression and fear</p> <p># a self-report questionnaire</p> <p># a follow-up questionnaire about posttraining assaults.</p>
<b>Beschreibung Ergebnisse</b>	<p>1. Buss-Durkee measures:.. Keine signifikanten Unterschiede zwischen den Gruppen</p> <p>2 Judges' ratings: Two judges rated three measures from the videotapes. The three measures were physical competency, fear, and aggression.</p> <p># competency: From pre- to posttraining, group 2 improved in competency by 32 percent, while group 1 improved by 2 percent and group 3 decreased by 2 percent.</p> <p># fear: group 2 reduced their fear by 38 percent, while group 1 subjects reduced their fear by 5 percent and group 3 by 3 percent.</p> <p># aggression: Subjects in group 2 reduced their aggression by 50 percent, while group 1 subjects reduced their aggression by 1 percent and group 3 by 5 percent.</p> <p>3. Self-ratings. The subjects rated themselves pre- and posttraining on the variables of the value of nonaggressive responses and outcomes and on fear and aggression.</p> <p># The three groups differed significantly from each other in posttraining self-ratings of the value of nonaggressive response. group 2 was significantly different from those for group 1 and group 3 at the .05 level but that the mean ratings for group 1 and group 3 were not different from one another.</p> <p># No significant differences were found between the groups in the degree of change in self-ratings of fear or aggression; that is, the three groups experienced similar levels of change from pretraining to posttraining.</p> <p>4. Follow-up measures. Follow-up questionnaires were solicited from the subjects two weeks after the final training exposure.</p> <p>Group 1: 18 assaultive encounters, resulting in ten episodes of restraint and three minor staff injuries.</p>

	<p>Group 2: 13 assaults, resulting in five episodes of restraint and no injuries. Group 3: 15 assaults, leading to eight episodes of restraint and one staff injury.</p> <p>--&gt; Gruppe 2 involved in 23 percent fewer assaults than those who received only didactic training and 20 percent fewer assaults than the control group. They reported no injuries and 50 percent fewer episodes of restraint than the didactic group and 30 percent fewer than the control group.</p>
<b>Beschreibung sekundäre Ergebnisse</b>	<p>Relationships between physical competency and other variables.</p> <p>The judges' ratings of change in physical competency were significantly correlated with judged change in fear (<math>r=.77</math>, <math>p&lt;.001</math>) and in aggression (<math>r=.83</math>, <math>p &lt; .001</math>). Subjects with increased physical competency were judged to have had reductions in fear and aggression.</p> <p>Judged change in physical competency was also significantly correlated with self-reports of value of a nonaggressive response (<math>r = .46</math>, <math>p &lt;.01</math>), indicating that increased physical competency was accompanied by increased belief in the value of a nonaggressive response.</p> <p>Finally, judged change in physical competency was not significantly related to self-reports of fear or aggression.</p>

<b>Nummer</b>	34
<b>Autoren</b>	Shah, A.; De, Tamal
<b>Jahr</b>	1998
<b>Studie</b>	The effect of an educational intervention package about aggressive behaviour directed at the nursing staff on a continuing care psychogeriatric ward. In: International journal of geriatric psychiatry 13 (1), S. 35–40.
<b>Studientyp</b>	Prä/Post-Intervention
<b>Dauer Baseline</b>	6 Wochen
<b>Dauer Intervention</b>	2x45 Min/Woche über 6 Wochen
<b>Dauer Follow up</b>	6 Wochen
<b>Kontrollgruppe ja/nein</b>	nein
<b>Ort der Datenerhebung</b>	Gerontopsychiatrie
<b>Land</b>	UK
<b>Charakterisierung der Zielgruppe der Trainingsmaßnahme</b>	Nursing staff
<b>Anzahl Teilnehmer Interventionsgruppe</b>	15
<b>Anzahl Patienten</b>	26
<b>Beschreibung Patienten</b>	26 Patienten mit Hohem RAGE und SOAS Score Patientengut: Geriatrische Psychiatrische Station, Only patients with persistently severe behavioural disturbance, despite assessment and treatment on the acute admission ward, were admitted to the continuing care ward
<b>Beschreibung</b>	Educational package by consultant psychiatrist

<b>Intervention</b>	
<b>Detaillierte Beschreibung der Intervention</b>	Inhalte: support, opportunity for the nursing staff to ventilate their feelings, sharing of knowledge about aggressive behaviour in the elderly based on an up-to-date literature review. Themen: The literature review included discussion on the definitions, prevalences, precipitants, outcomes, clinical correlates, social correlates, demographic correlates, biological correlates, timing, site and management of aggressive behaviour. The influence of staffing factors, including staff training, and the sensitive pharmacokinetics and pharmacodynamics in the elderly were also discussed.
<b>Beschreibung Outcomevariablen</b>	Messung aggressiven Verhaltens mittels RAGE and SOAS scales.
<b>Detaillierte Beschreibung Outcomevariablen</b>	The RAGE scale (Patel and Hope, 1992a) measures the quantity and severity of aggressive behaviour, and gives a score on a three-point scale (0±3) for each of the 21 items and a total score. The RAGE scale was completed once a week for each patient by the nursing manager of the ward for the entire study duration of 18 weeks. The original RAGE scale was designed to measure aggressive behaviour for the preceding 3 days. The Staff Observation Aggression Scale (SOAS) (Palmstierna and Wistedt, 1987) measures individual episodes of aggressive behaviour and gives a total score (0±12) and subscores for the means (the method of aggression used), aims (the actual target of the aggression) and results (the outcome of aggression) of an individual episode of aggressive behaviour on a four-point scale (0±4). Individual nurses, across all shifts, completed the SOAS scale every time they observed an individual episode of aggressive behaviour.
<b>Beschreibung Ergebnisse</b>	RAGE UND SOAS -Score waren signifikant abnehmend durch die Bildungsmaßnahme
<b>Beschreibung sekundäre Ergebnisse</b>	RAGE und SOAS korrelieren gut

<b>Nummer</b>	35
<b>Autoren</b>	Singh NN, Lancioni GE, Winton ASW, Singh AN, Adkins AD, Singh J
<b>Jahr</b>	2008
<b>Studie</b>	Mindful Staff Can Reduce the Use of Physical Restraints when Providing Care to Individuals with Intellectual Disabilities
<b>Studientyp</b>	Prä/Post-Intervention
<b>Dauer Baseline</b>	3-5 Wochen
<b>Dauer Intervention</b>	2h/Woche über 12 Wochen (=24h)
<b>Dauer Follow up</b>	22-24 Wochen
<b>Kontrollgruppe ja/nein</b>	nein
<b>Ort der Datenerhebung</b>	Wohnheim für Geistig Behinderte
<b>Land</b>	US
<b>Charakterisierung der Zielgruppe der</b>	Staff

<b>Trainingsmaßnahme</b>	
<b>Anzahl Teilnehmer Interventionsgruppe</b>	23
<b>Anzahl Patienten</b>	20
<b>Beschreibung Patienten</b>	Geistige Retardierung
<b>Beschreibung Intervention</b>	Mindfulness training, Anweisung bezüglich Umgang mit Patientengewalt blieb unverändert
<b>Detaillierte Beschreibung der Intervention</b>	All received basic training in behaviour management based on the Miller (1997) text. This was provided 2 years before the mindfulness training and was similar to that reported by Singh et al. (2006a) The staff was taught meditation methods and given exercises to enhance mindfulness.
<b>Beschreibung Outcomevariablen</b>	1. Anzahl Ereignisse 2. Beobachtungen von Verbalen Ereignissen 3. Physical Restraints 4. Verschreibung Medikamente gegen aggressives Verhalten 5. Verletzungen des Personals 6. Verletzungen der Patienten
<b>Detaillierte Beschreibung Outcomevariablen</b>	1. Eine Episode von physikalischer (gegen Sachen oder Personen) oder verbaler Aggression ist ein Ereignis 2. Beobachtungen von verbalem Austausch der zu physikalischer Gewalt führen konnte mit und ohne Einschreiten des Personals 3. kurze Physikalische Restraints ohne mechanische restraints
<b>Beschreibung Ergebnisse</b>	systematic decreases in incidents, verbal redirections and injuries to staff and peers and an increase in observations. The use of restraints and Stat medications decreased during mindfulness training and more substantially (to almost zero levels) during mindfulness practice.

<b>Nummer</b>	36
<b>Autoren</b>	Sjöström, N.; Eder, D. N.; Malm, U.; Beskow, J.
<b>Jahr</b>	2001
<b>Studie</b>	Violence and its prediction at a psychiatric hospital. In: European psychiatry : the journal of the Association of European Psychiatrists 16 (8), S. 459–465.
<b>Studientyp</b>	Prä/Post-Intervention
<b>Dauer Baseline</b>	6 Wochen
<b>Dauer Intervention</b>	35h während 2 Monaten
<b>Dauer Follow up</b>	6 Wochen
<b>Kontrollgruppe ja/nein</b>	nein
<b>Ort der Datenerhebung</b>	Psychiatrische Universitätsklinik Göteborg
<b>Land</b>	S
<b>Charakterisierung der</b>	Nursing staff

<b>Zielgruppe der Trainingsmaßnahme</b>	
<b>Anzahl Teilnehmer Interventionsgruppe</b>	185/144 (prä/post)
<b>Anzahl Patienten</b>	211/175 (prä/post)
<b>Beschreibung Patienten</b>	Stationäre psychiatrische Patienten
<b>Beschreibung Intervention</b>	35-Stündiger Trainingskurs auf verschiedenen Ebenen
<b>Detaillierte Beschreibung der Intervention</b>	Improve staff competence, understand the aggressive process and how aggression arises, be able to predict aggressive events and dangerous situations, be able to defend oneself with psychological and physical techniques and routinely, follow up assaults to gain experience.
<b>Beschreibung Outcomevariablen</b>	1. SDAS - Scale 2. SOAS-Scale 3. Erfassung der Krankheitstage des Personals
<b>Detaillierte Beschreibung Outcomevariablen</b>	Social Dysfunction Aggression Scale (SDAS) was used to report and assess aggressive behaviour over time, and the Staff Observation Aggression Scale (SOAS) to report and assess single aggressive incidents
<b>Beschreibung Ergebnisse</b>	1+2 Es gab keine signifikante Reduktion in aggressiven Vorfällen 3. Die Krankheitstage waren unverändert

<b>Nummer</b>	37
<b>Autoren</b>	Smoot, S. L.; Gonzales, J. L.
<b>Jahr</b>	1995
<b>Studie</b>	Cost-effective communication skills training for state hospital employees. In: Psychiatric services (Washington, D.C.) 46 (8), S. 819–822. DOI: 10.1176/ps.46.8.819.
<b>Studientyp</b>	Prä/Post-Intervention
<b>Dauer Baseline</b>	6 Monate
<b>Dauer Intervention</b>	8h/Woche für 4 Wochen (Insgesamt 32h)
<b>Dauer Follow up</b>	6 Monate
<b>Kontrollgruppe ja/nein</b>	ja
<b>Charakterisierung der Kontrollgruppe</b>	Zusammenstellung einer Gruppe ohne Training, Annähernd gleiche Bettenzahl (45 statt 43)
<b>Ort der Datenerhebung</b>	Psychiatrische Klinik eines Regionalkrankenhauses in Atlanta
<b>Land</b>	US
<b>Charakterisierung der Zielgruppe der Trainingsmaßnahme</b>	Direct care staff
<b>Anzahl Teilnehmer Interventionsgruppe</b>	35
<b>Anzahl Teilnehmer Kontrollgruppe</b>	37

<b>Beschreibung Patienten</b>	Akut psychiatrisch Stationär, Rückfall innerhalb eines Jahres
<b>Beschreibung Intervention</b>	32-stündiges :specific empathy-based human resources program.
<b>Detaillierte Beschreibung der Intervention</b>	Hauptlernziel: Akkurate Empathie erlernen in dem man die Bedeutung der Botschaft zurück auf den Sprecher gibt. emotional components of interpersonal communication, Körpersprache, Ablauf: Theoretischer überblick, Videos, Rollenspiele, Deesalationskommunikation
<b>Beschreibung Outcomevariablen</b>	1. Erfassung von Daten der Teilnehmer, 2. Maslach Burnout Inventory (13) 3. Ward Atmosphere Scale 4. Kostenanalyse
<b>Detaillierte Beschreibung Outcomevariablen</b>	Kostenanalyse: 1 Stunde Arbeitsausfall: \$13; Untersuchung einer Patientenbeschwerden: \$615; Kosten eine Registered Nurse zu ersetzen: \$3255 (Einstellungs- und Einarbeitungskosten);
<b>Beschreibung Ergebnisse</b>	-30 % Restraints and Seclusion, bessere Kosteneffizienz (-52 %) Ersparnis von 62000\$!, weniger Staff-Turnover (-63,6 %), weniger Fehlzeiten (-73 %), Weniger Patientenbeschwerden (-66 %),

<b>Nummer</b>	38
<b>Autoren</b>	St. Thomas Psychiatric Hospital Ontario, Canada
<b>Jahr</b>	1976
<b>Studie</b>	A program for the prevention and management of disturbed behavior. In: Hospital & community psychiatry 27 (10), S. 724–727.
<b>Studientyp</b>	Prä/Post-Intervention
<b>Dauer Baseline</b>	1 Jahr
<b>Dauer Intervention</b>	5x2h Training
<b>Dauer Follow up</b>	1 Jahr
<b>Kontrollgruppe ja/nein</b>	nein
<b>Ort der Datenerhebung</b>	Psychiatrisches Krankenhaus
<b>Land</b>	CAN
<b>Charakterisierung der Zielgruppe der Trainingsmaßnahme</b>	Gesamte Belegschaft (klinisch und nicht-klinisch)
<b>Beschreibung Patienten</b>	Akutes Psychiatrisches Krankenhaus
<b>Beschreibung Intervention</b>	Theoretischer Vortrag mit Handbuch und Video und praktische Übung von Befreiungsgriffen
<b>Detaillierte Beschreibung der Intervention</b>	Video: A 45-minute, color, audiovisual tape mit Schritt zu Schritt Anleitungen I)are(I a workbook to be used in the teaching prograiiii. 'I'lic First part of the workbook identifies various behaviors that will predictahl lead to aggressive behavior an(I UletlB)(IS of intervention that inight prevent inappropriate behavior from occurring. The second Part of the workbook describes and illustrates methods of physical intervention if disturbed behavior occurs.2. teaching appropriate physical intervention for those situations that were not predictable and preventable and hat occurred spontaneously, Emphasis

	was placed on intervening physically only when no other methods were effective and on using methods that would not injure either the staff or the patient. he movements are part of the Korean style of karate,
<b>Beschreibung Outcomevariablen</b>	number of incidents of disturbed behavior, number of patient injuries, and number of staff injuries and manhours lost from work.
<b>Beschreibung Ergebnisse</b>	1. Anzahl der Ereignisse ging zurück (-9 % 222 zu 201), 2. Weniger Verletzte Patienten (-12 %, 415zu365), 3. Die Anzahl verletzter Mitarbeiter ging zurück (-10.4 %, 87zu78), Die Abwesenheitszeit ging zurück (-31 %, 15128h zu 10444h)

<b>Nummer</b>	39
<b>Autoren</b>	Testad I, Aasland AM, Aarsland D
<b>Jahr</b>	2005
<b>Studie</b>	The effect of staff training n the use of restraint in a single-blind randomised controlled trial
<b>Studientyp</b>	Randomisierte-kontrollierte single Blind Studie
<b>Dauer Baseline</b>	( min. 1 Woche)
<b>Dauer Intervention</b>	1 Tag + 1h/Monat über 6 Monate
<b>Dauer Follow up</b>	(min. 1 Woche)
<b>Kontrollgruppe ja/nein</b>	ja
<b>Charakterisierung der Kontrollgruppe</b>	gleiches Patientengut, gleiche grösse
<b>Ort der Datenerhebung</b>	4 Pflegeheime
<b>Land</b>	N
<b>Charakterisierung der Zielgruppe der Trainingsmaßnahme</b>	Pflegepersonal
<b>Anzahl Teilnehmer Interventionsgruppe</b>	14
<b>Anzahl Teilnehmer Kontrollgruppe</b>	22
<b>Anzahl Patienten</b>	151 (55 Intervention 96 Kontrolle)
<b>Beschreibung Patienten</b>	Geriatrische Patienten mit Demenu
<b>Beschreibung Intervention</b>	The content of the educational program focused on the decision making process in the use of restraint and alternatives to restraint consistent with professional practice and quality care.
<b>Detaillierte Beschreibung der Intervention</b>	A six-hour seminar focusing on dementia, aggression, problem behaviour, decision making process and alternatives towards use of restraint was presented to the entire staff.
<b>Beschreibung Outcomevariablen</b>	The primary outcome measures were number of restraints per patient in the nursing homes in one week and agitation as measured with the Brief



	Agitation Rating Scale (BARS). Demographic and clinical information über a standardised interview of the nurse,
<b>Beschreibung Ergebnisse</b>	1. Die beiden Vergleichsgruppen sind gleichwertig. 2. Die Anzahl der Einsätze von Fixierungsmaßnahmen ging signifikant zurück (-54 % in Interventionsgruppe; -18 % in der Kontrollgruppe) 3. Das Level der Aggressivität war gleichbleibend bzw leicht ansteigend

<b>Nummer</b>	40
<b>Autoren</b>	Ward A, Keeley S, Warr J
<b>Jahr</b>	2012
<b>Studie</b>	Physical interventions training and organisational management in mental health: an integrated approach to promote patient safety
<b>Studientyp</b>	Prä/Post-Intervention
<b>Dauer Baseline</b>	3 Monate/ 1 Jahr
<b>Dauer Intervention</b>	5 Tage
<b>Dauer Follow up</b>	3 Monate/1Jahr
<b>Kontrollgruppe ja/nein</b>	nein
<b>Ort der Datenerhebung</b>	Mental health care trust
<b>Land</b>	UK
<b>Charakterisierung der Zielgruppe der Trainingsmaßnahme</b>	Staff
<b>Beschreibung Patienten</b>	Akut Psychiatrisch Stationär und Ambulant
<b>Beschreibung Intervention</b>	Physical Intervention Training Programme
<b>Detaillierte Beschreibung der Intervention</b>	Seven step model for promoting patient safety (National Patient Safety Agency, 2008) Inhalte: Kontrolle über einzelner Körperteile, Häusliche Gewalt, Bericht von Vorfällen, Legale Aspekte, Restraints im Stuhl und Sitzsack, Seclusion, Deeskalationstechniken, Rollenspiele
<b>Beschreibung Outcomevariablen</b>	1. Anzahl der Schwerwiegenden Vorfälle 2. Anzahl an Vorfällen 3. Verletzungen der Mitarbeiter
<b>Detaillierte Beschreibung Outcomevariablen</b>	1. Trust routinely collects 'serious incident' data
<b>Beschreibung Ergebnisse</b>	1. Reduction in the number of reported situations where physical restraint was required 2. dramatic reduction across the in-patient wards in the number of recorded incidents where aggressive behaviour had required the team to consider the possible use of restraint to contain a situation; for example there were 134 incidents in the three months following the programme compared with 261 in the corresponding period of the previous year.

3. Angriffe aufs Personal halbiert (41 post vs 75 prä)	
<b>Nummer</b>	41
<b>Autoren</b>	Whittington, R.; Wykes, T.
<b>Jahr</b>	1996
<b>Studie</b>	An evaluation of staff training in psychological techniques for the management of patient aggression. In: Journal of clinical nursing 5 (4), S. 257–261.
<b>Studientyp</b>	Prä/Post-Intervention
<b>Dauer Baseline</b>	28 Tage
<b>Dauer Intervention</b>	1 Tag (7h)
<b>Dauer Follow up</b>	28 Tage
<b>Kontrollgruppe ja/nein</b>	ja
<b>Charakterisierung der Kontrollgruppe</b>	Interventionsgruppe und Kontrollgruppe wurden je nach Dienstplan von der Stationsleitung bestimmt
<b>Ort der Datenerhebung</b>	Psychiatrisches Krankenhaus
<b>Land</b>	UK
<b>Charakterisierung der Zielgruppe der Trainingsmaßnahme</b>	Nurse
<b>Anzahl Teilnehmer Interventionsgruppe</b>	47
<b>Anzahl Teilnehmer Kontrollgruppe</b>	108
<b>Beschreibung Patienten</b>	Akutes Psychiatrisches Krankenhaus
<b>Beschreibung Intervention</b>	Trainingspaket (Whittington & Wykes, 1994), leading cognitive stress theory Lazarus & Folkman 1984
<b>Detaillierte Beschreibung der Intervention</b>	1. Teil: Prävention von aufkeimender Gewalt 2. Verarbeitung der psychologischen Folgen von Angriffen Rollenspiele über Gewalttätige Situationen und Deeskalationstechniken, keine Physikalischen Techniken.
<b>Beschreibung Outcomevariablen</b>	1. Gewalttätige Angriffe auf das Personal
<b>Detaillierte Beschreibung Outcomevariablen</b>	Als Gewalttätiger Angriff war jeder physikalisch-aggressive Kontakt eines Patienten zu einer Pflegekraft unabhängig von der Schwere
<b>Beschreibung Ergebnisse</b>	1. Anzahl der Vorfälle war -31 % signifikant weniger (58 zu 40 Vorfällen)
<b>Beschreibung sekundäre Ergebnisse</b>	vor der Trainingsmaßnahme wurden 22 % der Interventionsgruppe und nur 13 % der Kontrollgruppe Opfer von gewalttätigen Vorfällen. - d.h. Gruppen sind nur bedingt vergleichbar

Gewalt gegen Angehörige

## Studien, die Prädiktoren beschreiben:

Year NAME COUNTRY population (N=) method	p r e d i c t o r s o f v i o l e n c e [ 2 3 5 ] a g a i n s t f a m i l y c a r e g i v e r s		
	perpetrator	victim	interaction
<p>S</p> <p><b>2017 LABRUM</b></p> <p><b>USA</b></p> <p>persons who report having an adult relative with PD (N=243)</p> <p><i>Sekundäranalyse!</i></p> <p>➔ Mit anderen Studien und v.a der Hauptstudie ergänzen!</p>	<p><u>Financial abuse:</u></p> <p>... have used illegal drugs in the past 6 months</p>	<p><u>Physical abuse:</u></p> <p>... greater levels of limit-setting practices towards relatives with PD</p> <p><u>Financial abuse:</u></p> <p>... representative payees for relatives with PD;</p> <p>greater levels of limit-setting practices towards relatives with PD</p> <p><u>Psychological abuse:</u></p> <p>... more frequent financial assistance; greater levels of limit-setting practices towards relatives with PD</p>	<p><u>Physical abuse:</u></p> <p>... co-resided with relatives with PD</p> <p><u>Psychological abuse:</u></p> <p>.. co-resided with relatives with PD</p>
<p>S</p> <p><b>2016 VARGHESE</b></p> <p><b>INDIA</b></p> <p>caregivers of patients with severe mental illness (N= 100/63)</p> <p><i>cross sectional study</i></p>	<ul style="list-style-type: none"> <li>- mere sight of medicines (30)</li> <li>- perceived hostility (20)</li> <li>- lack of sleep (10)</li> <li>-hearing loud noise (10)</li> <li>- not able to meet sexual needs (5)</li> </ul>	<p><u>Not fulfilling patients demands:</u></p> <ul style="list-style-type: none"> <li>- not giving money for consumption alcohol (10)</li> <li>- not allowing to smoke (10)</li> <li>- not allowing to go out at midnight (2)</li> </ul>	<p><u>Non-adherence to caregiver instructions:</u></p> <ul style="list-style-type: none"> <li>- refusal to take medicines (40)</li> <li>- refusal to</li> </ul>

		<u>Other responses obtained:</u> - talking to others regarding patient's illness (30) - listening or talking to the patient (15)	do household chores (20) - refusal to get up in morning (5)
<b>S</b> <b>2016 KAGEYAMA</b> <b>JAPAN</b> parents of patients with schizophrenia (N=400) <i>questionnaire</i>	... patients who were female, were not competitively employed, were hospitalized three or more times since the onset of the illness, did not use rehabilitation services, and had fewer days of talking to others per month.	... 2/3 were mothers, primary caregivers, and most lived with the patient; have a lower household income.	... parents who experienced violence were more likely to have higher hostility and criticism scores on the EE measures and to manage the patient's money.
<b>S</b> <b>2016 KIVISTO</b> <b>USA</b> patients (SMI) and a nominated informant who best knew what was going on in his or her life: 47 % family and 24 % friends (N=1136) <i>Interview with both and records</i>	<b>perpetrator:</b> ... female gender (family violence in general, as well as intimate partner violence (IPV) specifically; ... highest during the first 10 weeks following discharge		
<b>S</b> <b>2015 KONTIO</b> <b>FINLAND</b> focus groups including relatives (N=8) <i>qualitative design: focus groups interviews</i>	<b>perpetrator:</b> <i>"The relative described examples of how psychiatric symptoms, such as serious psychotic hallucinations, restlessness, suspiciousness, and fear, affected patients' violent behavior or were signals before a violent episode. "</i> <i>"Differences in patients' daily routines, [...] might also indicate imminent violence."</i>		

	<p><i>“Decline of the patients’ mental health”</i></p> <p><i>“Although the patients trusted the relative, sometimes the relatives felt that the patient was not him- or herself and was capable of doing anything against them.”</i></p> <p>Patienten erhalten eine nicht-gewalttätige Fassade nach außen hin aufrecht. Zuhause spielt sich dann das Gegenteil ab: <i>„My husband would not have behaved that way in hospital, threatening and aggressive as he did at home at his worst. “</i></p> <p><i>“He was able to behave very nicely at the doctors’ so the doctor only prescribed sleeping pills...”</i></p> <p><i>“Idle days caused patients frustration and could contribute to violent behavior (on the wards)”</i></p>		
<p><b>S</b></p> <p><b>2015 KAGEYAMA</b></p> <p><b>JAPAN</b></p> <p>caregivers of patients with schizophrenia (N=302)</p> <p><i>mail survey questionnaires</i></p>		<p><u>Physical violence:</u></p> <p>... main targets were mothers, fathers, and younger sisters.</p>	<p><u>Physical violence:</u></p> <p>... fathers and older brothers in lifetime were targeted more by male patients.</p>
<p><b>S</b></p> <p><b>2014 ONWUMERE</b></p> <p><b>UK</b></p> <p>caregivers of patients with psychosis (N= 72)</p> <p><i>RCT</i></p>	<p>... younger, male, single being an inpatient at the time of recruitment into the study</p>	<p>... hostility towards the patient;</p> <p>... low self-esteem;</p> <p>... being on its own caring for a patient</p>	
<p><b>S</b></p> <p><b>2014 HSU</b></p> <p><b>TAIWAN</b></p> <p>patients with schizophrenia and their parent (N=14 dyads)</p> <p><i>qualitative study design: phenomenology, individual in-depth interviews</i></p>	<p>... psychotic symptoms and impulse control appeared to be important factors of the violent behavior:</p> <p><i>“Some parents felt that in some cases,</i></p>	<p><i>“Some patients complained that parents distrusted or rejected them, lacked flexibility and were stubborn.”</i></p>	<p><i>“Repetitive violent episodes and tension made parents and patients feel uncontrollable, with a loss</i></p>

	<p><i>violence was the weapon of choice for the purpose of retaking supremacy when making decisions.”</i></p> <p><i>“The parents felt that the patient often tried to compensate for their unmet needs and perceived lack of power by using violence.”</i></p> <p>... emotional stress and fluctuation (precursors and causes of catalysts of violence) ... result of an irritable mood, frequent emotional or behavioral overreactions or intense mood changes.</p>	<p><i>of self-control, and even feeling powerless to stop after a violence episode or a threat of violence.”</i></p> <p>... ineffective communication; monologue was reported, they did not dialogue.</p> <p><i>“Most patients and parents agree that a combination of psychodynamic and situational factors plays a role in precipitation violence and aggression.”</i></p>
<p><b>S</b></p> <p><b>RAVEENDRANATHAN 2012</b></p> <p><b>INDIA</b></p> <p>100 family members of inpatients (focus on caregiver) (N= 100) <i>interview</i></p>	<p>... in 70 %, a family member was the target of the violence;</p> <p>... 78 % history of violence in the previous month;</p> <p>... about 70 % of incidents were preceded by a clear threat made by the patient, which comprised verbal threats (72 %) and physical threats (28 %)</p> <p><u>Behavior 1 - day prior to violent incident:</u></p>	<p><u>Perceived cause of violence:</u></p> <ul style="list-style-type: none"> <li>- prevented from leaving the ward 43 (57 %)</li> <li>- patient’s resistance to treatment 4</li> </ul>

	<ul style="list-style-type: none"> <li>- irritable 50 (67 %)</li> <li>- irritable to family member 4 (5 %)</li> <li>- irritable and suspicious 6 (8 %)</li> <li>- quiet 15 (20 %)</li> </ul> <p><u>Behavior 2 - hours prior to violent incident:</u></p> <ul style="list-style-type: none"> <li>- irritable 57 (76 %)</li> <li>- irritable to family member 2 (3 %)</li> <li>- irritable and suspicious 4 (5 %)</li> <li>- quiet 12 (16 %)</li> </ul> <p><u>Behavior just before the violent incident:</u></p> <ul style="list-style-type: none"> <li>- irritable 57 (76 %)</li> <li>- irritable to family member 2 (3 %)</li> <li>- irritable and suspicious 4 (5 %)</li> <li>- quiet 12 (16 %)</li> </ul>	<p>(5 %)</p> <ul style="list-style-type: none"> <li>- arguments with family member 10 (13 %)</li> <li>- attempts during family member's assistance with activities of daily living 2 (3 %)</li> <li>- family member's report to ward staff regarding patient's violent behavior 6 (8 %)</li> <li>- suspicious thoughts 5 (7 %)</li> <li>(perpetrator)</li> <li>- do not know 5 (7 %)</li> </ul>	
<p><b>D</b>  <b>2012 MORGAN USA</b>          patients with dementia and caregivers (N=171)  <i>longitudinal study design</i></p> <p>→ part of a longitudinal study, ok?!</p>	<p><b>aggression:</b> defined as any physical or verbal behavior that has the effect of harming or repelling others and includes behaviors such as hitting, kicking, and verbal threats.</p> <p>... worst pain over 4 weeks</p> <p>... the Relationship between depression and the time to aggression onset appeared to be mediated by pain...;</p> <p>... both baseline</p>	<p><b>aggression or rather time to onset of aggression:</b></p> <p>Risk factors:</p> <p>... higher levels of baseline caregiver burden</p> <p>... and caregiver burden, whereas the relationship between baseline dementia severity and the time to aggression onset appeared partially</p>	<p><b>aggression:</b></p> <p>Risk factors:</p> <p>... decline in mutuality over time</p> <p>... <i>Schaubild direkte und indirekte Beziehungen zwischen psychosozialen Faktoren</i></p>

	physical agitation and change in physical agitation significantly predicted the time to aggression onset; ... to lesser extent change in nonaggressive physical agitation (p<0,1)	mediated by caregiver burden, (although the direct relationship between dementia severity and time to aggression onset remained marginally significant; ... the relationship between baseline nonaggressive physical agitation and time to aggression onset appeared mediated by caregiver burden (p<0,001) and...	<i>und Aggression und caregiver burden</i>
<b>D</b> <b>2010 BALL</b> <b>USA</b> Patients with dementia and their caregivers (N= 171) <i>part of a larger study</i>	<b>changes in mutuality over time:</b> ... increases (ie, improvement) in total mutuality over 4-month periods were significantly associated with increased number and frequency of pleasant events and decreased caregiver burden (p< 0,0001) and patient aggression (p< 0,04) over the same 4-month periods.		
<b>D</b> <b>2010 COOPER</b> <b>UK</b> family dementia carers (N= 220) <i>part of a larger cross-sectional study</i> <i>EINSCHLUSS?</i>	<b>abusive behavior: perpetrator:</b> ... male gender, non-white ethnicity, more ADL impairments <b>victim:</b> ...using dysfunctional coping strategies, finding their current and past relationship with CR less rewarding. <b>interaction:</b> “Those who experienced more abuse were also more likely to report acting abusively towards the CR.”		
<b>S</b> <b>2009 LOUGHLAND</b> <b>AUSTRALIA</b> carer relatives of people with psychosis (N= 106)	<b>aggression:</b> ... the moderate/severe aggression group were rated as having	<b>abusive behavior:</b> ... using more dysfunctional coping strategies; ... experiencing the	<b>abusive behavior:</b> ... those who experienced more abuse



<p><i>questionnaire</i></p>	<p>greater affective (p&lt;0,045), antisocial (p&lt;0,001), negative (p&lt;0,001) and psychotic (p&lt;0,007) symptoms, compared with the none/mild aggression subgroup.</p>	<p>relationship less rewarding</p>	<p>were also more likely to report acting abusively towards the care recipient; ... carers reported finding their current and past relationship with the CR less rewarding; cares abusive behavior was associated with the carer reporting fewer current rewards from their dyadic relation</p> <p>ship/ a greater deterioration in their relationship</p>
<p><b>S</b>  <b>2008 CHAN CANADA</b>  caregivers (N= 61) and their relatives with schizophrenia (N= 51)  <i>survey kontrollieren!</i></p>	<p><b>intensity of threat/control-override symptoms:</b>  ... significant factor that contributed to the incidence of <u>physical assault</u> against caregivers and to the incidence of <u>psychological aggression</u> against caregivers</p> <p><b>caregivers' critical comments:</b>  ... significant factor that contributed to the incidence of <u>psychological aggression</u> against caregivers</p>		

	<i>PLUS: GUTE SCHAUBILDER; EVTL HILFREICH: FIGURE 1+2</i>																								
<p><b>S</b> <b>2005 ELLBOGEN</b> <b>USA</b> persons with severe mental illness (SMI) (N= 245) <i>Interviews for a randomized study (The effectiveness of outpatient commitment for persons with SMI)</i></p>	<p><b>family violence</b> <b>perpetrator:</b> ... substance abuse (bivariate association <math>p &lt; 0,04</math>, multivariate analysis <math>p &lt; 0,009</math>), ... history of violence (multi.a. <math>p &lt; 0,05</math>)</p> <p><b>interaction:</b> ... family representative Payee ship (FRP) (bivariate association <math>p &lt; 0,05</math>, multi. a <math>p &lt; 0,04</math>), high family contact (multi.a. <math>p &lt; 0,05</math>) ... individuals in the “FRP + High Family Contact” Group were over four times more likely to indicate family violence relative to the comparison group (<math>p &lt; 0,003</math>).</p>																								
<p><b>S</b> <b>2004 JOYAL</b> <b>CANADA</b> men with schizophrenia (N= 58) and schizoaffective psychosis (N= 4) <i>interviews</i></p>	<p><b>homicide:</b> ... 60 % followed delusions and/or hallucinations directly related to them.</p> <p><b>interaction:</b> ... poor access to, or insufficient time in, psychiatric hospitals ... simple social conditions: because patients often live with their parents, parents are likely to be “victim of convenience” or to be in a “zone of danger” when something goes awry. ... mothers may press their sons or daughters to take their medications, frustrate their impulses to do something, or simply be in the wrong place at the wrong time. ... demanded money for cigarettes, his mother refused</p>																								
<p><b>S</b> <b>2003 WEIZMANN-HENELIUS</b> <b>FINLAND</b> violent female offenders (N= 61) <i>semi-structured interview</i></p>	<p><b>perpetrator:</b></p> <table border="1"> <thead> <tr> <th>Motive/ Circumstance</th> <th>Close ( %)</th> <th>Acquaintance ( %)</th> <th>Stranger ( %)</th> </tr> </thead> <tbody> <tr> <td>Quarrel while drinking alcohol</td> <td>18,9 %</td> <td>26,9 %</td> <td>33,3 %</td> </tr> <tr> <td>Deep conflicts in relation</td> <td>8,1 %</td> <td>0,0 %</td> <td>0,0 %</td> </tr> <tr> <td>Defense in violent situation</td> <td>10,8 %</td> <td>3,8 %</td> <td>0,0 %</td> </tr> <tr> <td>Long-term psychological abuse</td> <td>10,8 %</td> <td>0,0 %</td> <td>0,0 %</td> </tr> <tr> <td>Solving some other problem</td> <td>13,5 %</td> <td>11,5 %</td> <td>22,2 %</td> </tr> </tbody> </table>	Motive/ Circumstance	Close ( %)	Acquaintance ( %)	Stranger ( %)	Quarrel while drinking alcohol	18,9 %	26,9 %	33,3 %	Deep conflicts in relation	8,1 %	0,0 %	0,0 %	Defense in violent situation	10,8 %	3,8 %	0,0 %	Long-term psychological abuse	10,8 %	0,0 %	0,0 %	Solving some other problem	13,5 %	11,5 %	22,2 %
Motive/ Circumstance	Close ( %)	Acquaintance ( %)	Stranger ( %)																						
Quarrel while drinking alcohol	18,9 %	26,9 %	33,3 %																						
Deep conflicts in relation	8,1 %	0,0 %	0,0 %																						
Defense in violent situation	10,8 %	3,8 %	0,0 %																						
Long-term psychological abuse	10,8 %	0,0 %	0,0 %																						
Solving some other problem	13,5 %	11,5 %	22,2 %																						

	<p>Mental health problems 13,5 % 3,8 % 16,7 %</p> <p><u>Women in the close-group were/had...</u> usually married,-children, a higher degree of education, more often employed <u>a personality disorder</u> (N= 24) paranoid 12,5 %, histrionic 12,5 %, narcissistic 12,5 %, borderline 20,8 % antisocial 25,0 %</p> <p><u>Homicide:</u> Significantly more offenders with a dual diagnosis (34 %) than offenders without an antisocial personality disorder (APD) had an argument or a fight not related to psychotic symptoms prior to the homicidal act. ... in each case of altercation, the offender had used alcohol, often with the victim</p>
<p><b>S</b> <b>2003 ROBBINS</b> <b>USA</b> patients in acute psychiatric wards (men N= 667, women N= 469) <i>part of the "MacArthur Violence Risk Assessment Study"(Steadman et al, 1998), interviews after discharge</i></p>	<p><b>perpetrator:</b> <u>Gender</u> ... violent acts by women were less likely to have been preceded by alcohol or drug consumption and more likely to occur while psychiatric medications were being taken; ... men were more likely to have a co-occurring substance abuse diagnosis (52,2 %) than were women (34,0 %). <u>Co-occurring substance abuse diagnosis</u> ... patients were usually more likely to be violent. These findings suggest that the effect of gender on violence is in part explained by the increased likelihood of males to possess co-occurring abuse substance disorders, compared to females.</p>
<p><b>S</b> <b>2001 DORE</b> <b>NEW ZEALAND</b> caregivers of patients with bipolar disorder (N= 41) <i>face-to-face interviews</i></p>	<p><b>violence:</b> ... the patient was experienced as more irritable when unwell (80 %) and this frequently led to arguments that did not occur other times; ... episodes of mania and hypomania; ... patient was unwell</p>
<p><b>S</b> <b>1997 VADDADI</b> <b>AUSTRALIA</b> patients and their relatives (N= 101)</p>	<p><b>perpetrator:</b> ... patients with schizophrenia or schizoaffective disorder were more likely to lose their temper or hit or strike their carer, and were significantly more likely to cause a serious injury to their</p>

<p><i>semi-structured interview</i></p>	<p>carer</p> <p><u>Overall level of abuse:</u></p> <p>... schizophrenic and bipolar psychosis patient sample &gt; depressed and other non-psychotic sample</p> <p>... heavy consumption of alcohol increases the probability of the carer reporting having been struck or hit by the patient</p> <p>... use of cannabis associated with the most aspects of abuse</p> <p>... younger age</p> <p>... pre-illness-episode relationship</p>		
<p><b>S</b></p> <p><b>1997 TARDIFF</b></p> <p><b>USA</b></p> <p>psychiatric patients after hospital discharge (N= 430)</p> <p><i>prospective study, interview about violence before admission, via telephone: asking about violence after discharge</i></p>	<p><b>history of violence before admission:</b></p> <p>... 9x more likely to be violent in the two weeks after discharge;</p> <p>... for 69,2 % of those patients, the target of past violence was the same person.</p> <p><b>axis II disorder; personality disorder:</b></p> <p>... 4x more likely to be violent</p> <p><b>borderline or antisocial personality disorders:</b></p> <p>... 4x more likely to be violent</p> <p><b>other types:</b></p> <p>... 2,3x more likely to be violent</p>		
<p><b>?</b></p> <p><b>1994 ASNIS</b></p> <p><b>USA</b></p> <p>outpatients (N= 517)</p> <p><i>survey</i></p> <p><i>Einschluss ?</i></p>	<p><b>SCL-90-R subscales/ symptom checklist-90</b></p> <p><b>no homicidal behavior: (403)</b></p> <ul style="list-style-type: none"> <li>- obsessive-compulsive</li> <li>- depression</li> <li>- anxiety</li> </ul> <p><b>homicidal ideation: (92)</b></p> <ul style="list-style-type: none"> <li>- depression</li> <li>- interpersonal sensitivity</li> <li>- psychoticism</li> </ul> <p><b>homicide attempts: (22)</b></p> <ul style="list-style-type: none"> <li>- interpersonal sensitivity</li> <li>- hostility</li> <li>- paranoid ideation</li> </ul>		
<p><b>D</b></p> <p><b>1990 HAMEL</b></p> <p><b>CANADA</b></p> <p>caregivers and care receivers with</p>	<p><b>aggressive behavior:</b></p> <p>... premorbid aggressive behaviors were reported for only</p>	<p><b>aggressive behavior:</b></p> <p>... the situation most often found to elicit patient aggression</p>	<p><b>aggressive behavior:</b></p> <p>... whereas the typical</p>

<p>dementia (N= 213) <i>interviews</i></p>	<p>9,6 % of the patients;</p> <p><u>Patient variables:</u> Age, sex, aggression before onset of dementia, level of cognitive impairment, behavior and memory problems</p>	<p>was when he or she was told to do something;</p> <p><u>Caregiver variables:</u> Sex, income, relation to patient, NEO neuroticism score, reaction to patient problem behavior, length of caregiving, past social interaction</p>	<p>caregiver reaction to aggression was to retreat, ignore, or accept such behavior. Feeling angry, but not responding aggressively, was reported by 10,1 % of the caregivers, whereas aggressive reactions to patient aggression were reported by 10,6 % of the caregivers. ... a more troubled premorbid relationship between the caregiver and receiver, higher levels of premorbid patient aggression, and greater number of patient problems were</p>
--	---	---	--

			significant predictors of current patient aggression.
	<p><b>objective burden:</b>  ... past social interactions with their patients as being of poorer quality, patients having greater number of behavior and memory problems  ... living together at the time of the assault</p>	<p><b>subjective burden:</b>  ... being less healthy (caregiver), being more distressed by these problems, spending less time in pleasurable activities</p>	

### Studien, die negative Folgen von Gewalt beschreiben

Year NAME

COUNTRY

population (N=)

method

o u t c o m e o f a g g r e s s i v e  
b e h a v i o r a g a i n s t f a m i l y  
c a r e g i v e r s [ 2 4 6 ]

<p><b>S</b></p> <p><b>LABRUM 2017</b></p> <p><b>USA</b></p> <p>persons who report having an adult relative with PD (N=243)</p> <p>Survey</p> <p>→ Ergänzen mit Haupt und Nebenstudien!</p> <p>PD= psychiatric disorders</p>	<p><b>violence:</b></p> <p>In the past 6 months...</p> <p><u>36 (15 %) of respondents reported physical abuse:</u>  16 (6,6 %) reported "one type of physically abusive act",  20 (8,2 %) "multiple types of physically abusive acts" or that "specific act was committed multiple times"  -&gt;Co-occurrence of abuse:17 (47 %) also experienced financial abuse, 29 (81 %) psychological abuse.</p> <p><u>47 (19 %) reported financial abuse:</u>  10 (4,1 %) were financially abuse "once",  23 (9,5 %) were abused "between 2 and 4 times", and  14 (5,8 %) were abused "5 ore more times".  -&gt;Co-occurrence of abuse:17 (36 %) also experienced physical abuse, 39 (83 %) psychological abuse.</p> <p><u>99 (41 %) psychological abuse against them,</u></p>
---	--

	<p>Median summed score for psychological abuse is eight (M= 8,77, SD= 3,44)</p> <p>-&gt;Co-occurrence of abuse: 29 (29 %) experienced physical abuse, 39 (39 %) financial abuse.</p> <p><b>burden:</b></p> <p><u>Violence at home:</u>  <u>Feeling:</u> concern, guilt, fear, grief</p>
<p><b>D</b>  <b>2017 LANGE</b>  <b>USA</b>  caregivers of US military service members with TBI  (N= 214)  <i>study</i>  EINSCHUSS??</p>	<p><b>burden:</b></p> <p>... high caregiver burden was associated with a service members symptom of [...] and verbal and physical expressions of irritability, anger, and aggression.</p>
<p><b>S</b>  <b>2016 VARGHESE</b>  <b>INDIA</b>  caregivers of patients with severe mental illness  (N= 100)  <i>cross sectional study</i></p>	<p><b>violence:</b></p> <p><u>Verbal aggression:</u> 95 %</p> <ul style="list-style-type: none"> <li>- makes loud noises, shouts angrily: 85 %</li> <li>- makes personal insults (e.g. "You're stupid!"): 76 %</li> <li>- curses viciously, uses foul language, makes moderate threats to others or self: 62 %</li> <li>- makes clear threats of violence toward others or self (I'm going to kill you.):38 %</li> <li>- requests to help to control self: 13 %</li> </ul> <p><u>Severity of aggressive behavior:</u></p> <ul style="list-style-type: none"> <li>- slight/ mild: 14 %</li> <li>- moderate/moderately severe: 53 %</li> <li>- severe/extreme: 33 %</li> </ul> <p><b>burden:</b></p> <p><u>Impact of patient aggression on the caregiver:</u></p> <ul style="list-style-type: none"> <li>- impairment of relationship between patient and carer: 42 %</li> <li>- adverse moral emotions: 91 %</li> <li>- adverse feelings to external sources: 30 %</li> </ul>
<p><b>2016 KAGEYAMA</b>  <b>JAPAN</b></p>	<p><b>violence:</b></p>

<p>parents of patients with schizophrenia (N=400) <i>questionnaire</i></p>	<p>... of 400 parents, 263 (65,8 %) „no physical violence“and 137 (34,4 %) „physical violence“. 35 (8,8 %) erlebten “acts of violence”, 136 (34,0 %) berichteten “other aggressive acts” im letzten Jahr. Letztere teilten sich noch auf in 34 Eltern, die zusätzlich auch „acts of violence“ erfuhren und 102 Teilnehmer mit „other aggressive acts only“. <i>Tabelle einfügen!</i></p> <p>... acts of violence: visited physician for injury, injured with knife, threatening with knife, beating with a physical object, choking</p> <p>... other aggressive acts: destroyed property, pushing, punching and kicking, throwing an object</p>
<p><b>S</b> <b>2016 KIVISTO</b> <b>USA</b> patients and a nominated informant who best knew what was going on in his or her life: 47 % family and 24 % friends (N=1136) <i>Interview with both and records</i></p>	<p><b>violence:</b></p> <p>... the rates of violence toward any family member by patients with schizophrenia were 60,9 % (lifetime) and 27,2 % (past year).</p>
<p><b>D</b> <b>2015 RATTINGER</b> <b>USA</b> patients with dementia and their unpaid caregivers (N= 306) <i>progression study</i></p>	<p><b>burden:</b></p> <ul style="list-style-type: none"> <li>- NPI: Neuropsychiatric Inventory</li> <li>- CGNPM: Number of caregiver non-psychotropic medications</li> <li>- CGPM: Number of caregiver psychotropic medications</li> <li>- CGHC: Number of caregiver health conditions</li> </ul> <p>... greater CGHC and CGNPM were associated with NPI-agitation/aggression, although over time, higher NPI-agitation/aggression predicted lower CGNPM.</p> <p>... NPI-agitation/aggression were associated with higher caregiver depression scores over time.</p> <p>... significantly associations of agitation/aggression with CGNPM.</p> <p>... CGNPM remained after controlling for dementia severity.</p> <p>... neuropsychiatric symptoms are associated with negative caregiver psychiatric and health outcomes over time, particularly affective, psychotic and agitation/aggression are associated with more severe depressive symptoms in caregivers.</p>
<p><b>S</b> <b>2015 KONTIO</b></p>	<p><b>violence:</b></p>



<p><b>FINLAND</b></p> <p>focus groups including relatives (N=8)</p> <p><i>Qualitative design: focus groups interviews</i></p>	<p>12-Month Prevalence of Family Violence Perpetration:</p> <p>... 4 in 10 discharged patients committed at least one violent act following discharge, similar rated across male and female patients.</p> <p>... prevalence rates for IPV (Intime Partner Violence) perpetration is more than twice as high among discharged female patients (13,9 % vs 29,4 %)</p>
<p><b>D</b></p> <p><b>2015 FINLAYSON</b></p> <p><b>UK</b></p> <p>adults with mild to profound ID (Intellectual Disabilities) and their carers: 218/446 patients /carers (N=511)</p> <p><i>face-to face interviews</i></p>	<p><b>violence:</b></p> <p>... 44 (9,8 %) of the 446 carers experienced at least one injury that required medical or nursing attention and treatment in the previous 12 months (four of the 44 experienced two incidents of injury).</p> <p>... the family carers (17, 7,8 %) were significantly more likely to have experienced falls, trips, or slips than the paid carers (7, 3,1 %).</p> <p>... the family carers (7, 3,2 %) were significantly more likely to experience bone fractures than the care/support workers (1, 0,4 %).</p> <p>... 57 (12,8 %) carers reported that they were exposed to challenging behaviors of adults with ID through their caring/support role (16, 7,3 % unpaid carers). The term challenging behavior included but was not exclusive to physical aggression. 17 (3,3 %) carers were specifically exposed to physical aggression through their caring/support role, but only one (0,2 %) experienced an injury in the 12-month period.</p>
<p><b>S</b></p> <p><b>2014 ONWUMERE</b></p> <p><b>UK</b></p> <p>caregivers of patients with psychosis (N= 72)</p> <p><i>interview</i></p>	<p><b>violence:</b></p> <p>... 52, 9 % of the caregivers reported at least 1 incident of patient-initiated violence during their CFI interview.</p> <p>... 62, 2 % reported personal violence, 5, 4 % of the violence was toward other family members.</p> <p><u>Examples of caregiver reports of patient violence from the Camberwell Family Interview: (Violence toward caregiver)</u></p> <ul style="list-style-type: none"> <li>- "He used to give you the odd punch and kick as he was walking by, but his mind was so confused and muddled."</li> <li>- "She did hit me a few times when we used to live together. "</li> <li>- "He started to slap me, threaten me, and push me. This went on</li> </ul>

	<p>for a couple of days and I couldn't get anyone out to assess him. "</p> <p>- "I have passed him money in the past he squeezed it in my hand that made it bleed. He twisted my hands as if I have done something wrong and that does really get to me. "</p> <p>- "He only ever lashed out at me at once. "</p> <p>- "She hit me yesterday because she wanted me to come up here every day like I used to. "</p> <p>- "He punched me in the face and threatened to kill me. I had a fractured rib."</p> <p>- "There was a period when he was violent every day. "</p> <p>- "The day she hit me I was going to ring child line. This wasn't my mum. This is because she had escaped from hospital. "</p> <p>- "Only been aggressive to me once, years ago. I said if you do that again I will hit you in the balls when you are fast asleep----he has never touched me since. He has got physical with my eldest daughter-he transferred it over to her."</p>
<p><b>S</b>  <b>2014 HSU</b>  <b>TAIWAN</b>  patients with schizophrenia and their parent (N=14)  <i>qualitative study design: phenomenology, individual in-depth interviews</i></p>	<p><b>violence:</b></p> <p>... most violent episodes were verbal (e.g. abusive language, yelling to parent, blaming, ridicule and criticism),  ... followed by damage to property, violent threats of harm and physical violence towards objects and families (e.g. hitting, shoving, throwing objects, punching walls or doors)</p>
<p><b>D</b>  <b>2013 UEI</b>  <b>TAIWAN</b>  people with dementia and their primary caregivers (N= 162)  <i>Cross-sectional study</i></p>	<p><b>violence:</b></p> <p><u>DBD (dementia behavior disturbance)</u>  ... the most frequent behavior types were [...] agitation (2,38 in a range of 0-4), [...] aggressiveness (1,77); and inappropriate sexual behavior (1,1).</p> <p><b>burden:</b></p> <p>... the results of multiple regression analyses showed that the frequency of DBD of people with dementia, [...] were significantly positively associated with increased care burden.</p>
<p><b>S</b>  <b>2013 HANZAWA</b></p>	<p><b>violence:</b></p>

<p><b>JAPAN</b> caregivers of individuals with schizophrenia (N= 116) <i>questionnaire</i></p>	<p>... 56 (48,3 %) family members experienced patients' abusive language and violent behavior toward family members or others.</p> <p><b>burden:</b></p> <p>... with violence behavior (N= 56) vs without violence behavior (N= 56)</p> <p>IES-R (psychological impact) total score: 31,21 vs 21, 83 (mean)</p> <ul style="list-style-type: none"> <li>- Intrusion: 11,21 vs 7,58 (mean)</li> <li>- Avoidance: 11,96 vs 8,56 (mean)</li> <li>- Hyperarousal: 8,04 vs 5,69 (mean)</li> </ul> <p>... Zarit Caregiver Burden Interview total score: 17, 21 vs 11,67 (mean)</p> <p>... there was a significant difference in mean IES-R total scores between caregiver families who had experienced a patient's violent behavior and those who had not (P&lt;0,01). ... however, the IES-R total score was not significantly associated with patients' abusive language and violent behavior using multiple regression analysis.</p>
<p><b>D</b> <b>2012 HUANG</b> <b>TAIWAN</b> patients with dementia (N= 88) and caregivers (N= 88) <i>cross-sectional study</i></p>	<p><b>burden:</b></p> <p>... for individual BPSD ... NPI-D score (caregiver burden): ... agitation/aggression (mean 3,0), irritability/lability (mean 2,6) ... agitation/aggression showed a statistically significant positive correlation between symptom frequency and NPI-D score.</p> <p>... agitation/aggression and irritability/lability showed a statistically significant correlation between symptom severity and NPI-D scores and showed a significant correlation between the product of frequency and severity and NPI-D score.</p>
<p><b>D</b> <b>2012 MORGAN</b> <b>USA</b> PwD and caregivers (N=171) <i>Longitudinal study design</i></p>	<p><b>burden:</b></p> <p>... both depression and dementia severity were also indirectly related to caregiver burden through their relationships with our baseline measures of agitation (p&lt;0,03 with depression and p&lt;0,001 with dementia severity).</p> <p>... the relationship between baseline nonaggressive physical</p>

	<p>agitation and time to aggression onset appeared mediated by caregiver burden (<math>p &lt; 0,001</math>) and to a lesser extent change in nonaggressive physical agitation (<math>p &lt; 0,10</math>).</p> <p>SCHAUBILD DIREKTE UND INDIREKTE BEZIEHUNGEN ZWISCHEN PSYCHOSOZIALEN FAKTOREN UND AGGRESSION UND CAREGIVER BURDEN</p>
<p><b>D</b> <b>2011 UNWIN</b> <b>UK</b> family caregiver of people with intellectual disabilities (ID) (N= 44) <i>part of a longitudinal explorative study</i> EINSCHLUSS?</p>	<p><b>violence:</b></p> <p><u>Types of aggressive behavior:</u> (N= 44)</p> <ul style="list-style-type: none"> <li>- verbal aggression: 34 (79, 1 %)</li> <li>- physical aggression to others: 16 (37, 2 %)</li> <li>- SIB (against the self): 18 (41, 9 %)</li> <li>- physical aggression toward objects: 25 (58, 1 %)</li> <li>- all four types of aggressive behavior: 4 (9, 3 %)</li> </ul> <p><b>burden:</b></p> <p>... in terms of the ABC-I measure for severity of aggression, caregiver burden was strongly positively associated. Conversely, caregiver uplift was negatively correlated.</p> <p>... caregiver burden was significantly higher in those caring for people who showed physical aggression in the week preceding assessment compared with those who did not show physical aggression.</p>
<p><b>D</b> <b>2010 COOPER</b> <b>UK</b> family dementia carers (N= 220) <i>part of a larger cross-sectional study</i></p>	<p>... proportion of family carers who reported that each abusive behavior was happening “at least sometimes” in 3 months (from large to small percentage):</p> <ul style="list-style-type: none"> <li>- used harsh tone of voice, insulted or swore at carer</li> <li>- screamed or yelled at carer</li> <li>- accused carer of neglecting or abandoning them</li> <li>- threatened to use physical force on carer</li> <li>- threatened to leave, live elsewhere or evict you</li> <li>- carer afraid CR might hit or hurt them</li> <li>- hit or slapped carer</li> <li>- otherwise behaved roughly towards carer</li> <li>- shaken carer</li> <li>- not allowing carer to eat</li> </ul> <p>BALKENDIAGRAMM</p>
<p><b>S</b> <b>2009 LOUGHLAND</b> <b>AUSTRALIA</b> carer-relatives of people</p>	<p><b>violence:</b></p> <p>... overall, verbal aggression was reported to occur with the</p>

<p>with psychosis (N= 106) <i>questionnaire</i></p>	<p>greatest frequency, followed by physical, then self-directed and sexual aggression.</p> <p><b>burden:</b></p> <p>... IES-R score (was used to measure PTSD symptoms after exposure to levels of aggression): 34 (51,5 %) reported an IES-R score of 33 or more and were assigned to the “high likelihood of PTSD” subgroup.</p> <p>... exposure to verbal aggression, but not physical, self-directed or sexual aggression, was significantly higher in the high likelihood of PTSD subgroup.</p>
<p><b>2009 JACKSON UK</b> family carers of adults with Acquired brain injury (ABI) (N= 222) <i>questionnaire, comparison with patients with dementia</i> -&gt;from two studies: ABI study and Dementia study- secondary analysis</p>	<p><b>Violence/ Burden:</b></p> <p>... aggressive problems significantly predicted greater burden, poor quality-of-life and poor mental health in ABI carers, (whereas passivity/low mood significantly predicted greater burden and worse quality-of-life in dementia carers.)</p> <p>... aggressive behaviours were more likely to occur in people with head injuries than other groups with ABI (p&lt;0,05).</p> <p>... overall frequency of behavioural problems was similar across groups, negative carer reactions to problems were greater overall in the ABI group.</p> <p>Associations were found between the extent of behavioural problems, both overall and in subscales, and carer burden, quality-of-life and mental health.</p>
<p><b>S</b> <b>2008 CHAN CANADA</b> caregivers (N= 61) and their relatives with schizophrenia (N= 51) <i>survey</i></p>	<p><b>violence:</b></p> <p>... prevalence of Violence and Injury Against Caregivers in Families Providing Care to Relatives with Schizophrenia (N= 61) in the last 12 months</p> <p><u>Physical assault</u> Severe 26,2 % Minor 31,1 %</p> <p><u>Psychological aggression</u> Severe 44,3 % Minor 63,9 %</p> <p><u>Any incident of violence</u> 63,9 %</p> <p><u>Injury</u></p>

	Severe 9,8 % Minor 18,0 %																											
<b>D</b> <b>2008 ORENGO</b> <b>USA</b> patients with dementia (N= 385) <i>telephone screening</i>	<b>violence:</b> ... 75/385 participants (19, 5 %) were aggressive at the initial telephone screening. <ul style="list-style-type: none"> <li>- 23 (31 %) verbally aggressive</li> <li>- 9 (12 %) physically aggressive</li> <li>- 24 (32 %) both, verbally and physically aggressive</li> <li>- 19 (25 %) unspecified aggressive behavior</li> </ul>																											
<b>S</b> <b>2007 THOMPSON</b> <b>USA</b> caregiver of patients with severe mental illness (SMI) (N= 189) <i>part of the Duke Mental Health Study (RCT): "The effectiveness of involuntary outpatient commitment and..." (Swartz et al. 1995)</i>	<b>burden:</b> ... caring for persons with SMI who engage in violence is associated with a greater number of financial contributions and more perceived financial strain. <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th>Caregiver Burden</th> <th>Financial Contributions</th> <th>Perceived</th> </tr> <tr> <th>Financial Strain</th> <th>Violence Effects</th> <th>Violence</th> </tr> <tr> <th>Stressor</th> <th></th> <th></th> </tr> <tr> <th>Effects</th> <th></th> <th></th> </tr> </thead> <tbody> <tr> <td colspan="3">Moderator variable</td> </tr> <tr> <td colspan="3">Perceived disruptive behavior*</td> </tr> <tr> <td>-low</td> <td>2,225</td> <td>2,138</td> </tr> <tr> <td>-moderate</td> <td>3,379</td> <td>2,984</td> </tr> <tr> <td>-high</td> <td>4,533</td> <td>3,785</td> </tr> </tbody> </table> <p>*= included problems sleeping, verbal abuse, stealing, inappropriate sexual behaviors, hallucinations, suspicions, delusions, temper tantrums, carelessness with safety, pacing aimlessly, running away, social withdrawal, eating too little or overeating</p>	Caregiver Burden	Financial Contributions	Perceived	Financial Strain	Violence Effects	Violence	Stressor			Effects			Moderator variable			Perceived disruptive behavior*			-low	2,225	2,138	-moderate	3,379	2,984	-high	4,533	3,785
Caregiver Burden	Financial Contributions	Perceived																										
Financial Strain	Violence Effects	Violence																										
Stressor																												
Effects																												
Moderator variable																												
Perceived disruptive behavior*																												
-low	2,225	2,138																										
-moderate	3,379	2,984																										
-high	4,533	3,785																										
<b>D</b> <b>2007 MATSUMOTO</b> <b>JAPAN</b> participants with dementia and their caregivers (each N= 67) <i>second analyses of a study, analysis of three</i>	<b>violence:</b> ... the most common symptom [...], followed by agitation/aggression (39 %) and irritability/lability (34 %).  <b>burden:</b> ... agitation/aggression had the highest mean NPI-D score																											

<p><i>studys</i></p>	<p>(caregiver distress) (mean 2,3) followed by irritability/labability (mean 2,1). ... across all subjects, the symptoms most frequently reported to be severely distressing to caregivers were agitation/aggression, delusions and irritability/labability.</p>
<p><b>D</b> <b>2005 MEILAND</b> <b>NETHERLAND</b> partners of patients with dementia (N= 58) <i>Interview, cross sectional design -&gt; part of a larger multicenter study (IMO-project)</i></p>	<p><b>burden:</b></p> <ul style="list-style-type: none"> <li>- NPI-D score (emotional impact)</li> <li>- Agitation/Aggression (N= 41) -&gt; 3,3 mean</li> <li>- Disinhibition (N= 34) -&gt; 3,1 mean</li> <li>- Irritability (N= 38) -&gt; 3,3 mean</li> </ul>
<p><b>S</b> <b>2005 ELBOGEN</b> <b>USA</b> persons with severe mental illness (SMI) (N= 245) <i>Interviews for a randomized study</i></p>	<p>... 1/5 of the sample (N= 47, 19,2 %) reported either engaging in physical fights or making verbal threats using a deadly weapon with a family member during the year of the study.</p>
<p><b>S</b> <b>2004 JOYAL</b> <b>CANADA</b> men with Schizophrenia (N= 58) and schizoaffective psychosis (N= 4) <i>interviews</i></p>	<p>... nearly half (47 %) of the offenders assaulted someone from their own household, including parents and roommates. ... violence and aggression displayed by individuals with schizophrenia, family members, acquaintances, friends, or health care providers are more likely to be targeted than strangers, even when homicide and antisocial personality disorder (APD) are considered.</p>
<p><b>S</b> <b>2003 ROBBINS</b> <b>USA</b> patients in acute psychiatric wards (men N= 667, women N= 469) <i>part of the "MacArthur Violence Risk Assessment Study"</i></p>	<p><b>violence:</b></p> <p><u>Prevalence during 1-year follow-up:</u> <u>"Act of violence"</u>: 29,7 % for men, 24,6 % for women (differences between men and women only at the first follow-up period) <u>"At least one other aggressive act only"</u>: 30,1 % for men, 37,0 % for women <u>"Violence or other aggressive acts"</u>: 59,8 % for men, 61,6 % for women</p>

	<p><u>Types, targets, and locations of violence:</u>  <u>“Act of violence”</u>: kick/bite/hit-beat up, weapon threat/weapon use -&gt; especially men  <u>“Other aggressive acts”</u>: throwing objects/ push/ grab/ shove/slap -&gt; especially women  <u>Target:</u>  family members with women (69,5 % violence/74,6 % other aggressive acts)&gt; men (39,9 %/ 48,8 %)  <u>Locations:</u>  Subject’s home with women (55,8 %/ 68,2 %) &gt; men (35,8 %/ 53,1 %)  <u>Time:</u>  on the first 20 weeks with men (21,4 % violence) &gt; women (15,2 % violence)  but with women (35,2 % other aggressive acts- and no violent act) &gt; men (27,1 %)</p>
<p><b>S</b>  <b>2003 LAUBER</b>  <b>SWITZERLAND</b>  relative of schizophrenic patients (N= 64)  <i>semi-structured Interview</i></p>	<p><b>violence:</b>  ... more than half of the relatives had to deal with irritability, anger, and serious conflicts. More than one third of the affected were physically aggressive.  ... disturbing behavior of the affected (N= 64): a selection of items and respective percentages:  <u>Aggression (frequency)</u></p> <ul style="list-style-type: none"> <li>- irritability and anger 78 %</li> <li>- serious conflicts 55 %</li> <li>- impoliteness, rudeness, disrespect 48 %</li> <li>- destruction of objects 45 %</li> <li>- physical aggression 38 %</li> <li>- threatening behavior 31 %</li> </ul> <p><u>Nuisances and threats (frequency)</u></p> <ul style="list-style-type: none"> <li>- towards the informant 58 %</li> <li>- towards those living in the same house 44 %</li> </ul> <p><b>burden:</b>  <u>Burden in the relationship:</u>  ... disturbing or restricting behavior of the affected 95 %  ... both total burden scores are related to the aggressive behavior of individuals with schizophrenia.</p>



<p><b>2002 VADDADI AUSTRALIA</b>  Clients* of a community mental health service and their family carers (N= 101) <i>interviews</i></p> <p><i>*: majority: schizophrenia or schizoaffective disorder</i></p>	<p><b>violence:</b></p> <p><u>Prevalence of abuse experienced by carers (at any point during patient's illness/ in the last year)</u></p> <p><u>Verbal aggression:</u></p> <ul style="list-style-type: none"> <li>- regular loss of temper: 66 %/47 %</li> <li>- regular shouting and swearing: 64 %/42 %</li> <li>- threats of violence (ever): 40 %/22 %</li> </ul> <p><u>Physical aggression:</u></p> <ul style="list-style-type: none"> <li>- hit or struck (ever): 40 %/24 %</li> <li>- physical injury (ever): 17 %/4 %</li> <li>- destroyed property (ever): 41 %/22 %</li> </ul> <p><u>Correlates of severity of reported abuse:</u>  <u>Variable:</u> Patient's self-report on pre-episode relationship, Carer's self-report on pre-episode relationship, Number of reported offences with <math>p &lt; 0,05/0,01</math></p> <p><b>burden:</b></p> <p>... in both cases there was a highly significant correlation (GHQ and abuse, total burden and abuse).</p> <p><u>Comparison between the admission sample vs. the current community sample:</u> (both N= 101)  Carers' burden score: 12,2 vs. 9,9  Carers' GHQ total score (level of emotional distress): 11,1 vs. 9,3  ... levels of abuse were generally higher in the acute sample, whose level of clinical symptomatology was greater.</p>
<p><b>D</b>  <b>2002 FOGEL USA</b>  family caregivers of care recipients with dementia (N= 18, 17 % from the larger study) <i>post-hoc study</i>  <i>Einschluss?</i></p>	<p><b>burden:</b></p> <p>... correlational analyses showed significant <u>relationships between</u> certain behavioral symptoms (<u>aggression</u>, delusions, hallucinations, sleep disturbance, and depressed mood) <u>and higher levels of caregiver burden and depression.</u></p> <p>Also, longitudinal analysis revealed that <u>higher levels of caregiver depression</u> were significantly <u>associated with</u> the onset of depressed mood and <u>verbal aggression by....???</u></p>
<p><b>S</b>  <b>2002 MACINNES</b></p>	<p><b>violence:</b></p>

<p><b>UK</b>  caregivers of clients suffering from schizophrenia with a forensic history (N= 79) and caregivers of non-offenders (N= 28)  <i>In-depth interviews, Survey design (cross sectional)</i></p>	<p>... a great number of participants expressed concerns about violence with 177 events detailed. Approximately two third of those related to violent threats or actions directed towards the caregiver with the forensic group describing significantly more events of this type than the non-forensic group.  ... nearly half of the violent burdens recounted (42,5 %) were rated as severe; they included attacks with weapons and injuries that required hospitalization. In addition, threats of violence often accompanied requests for money.</p> <p><b>burden:</b></p> <p>... the three most described burdens were those related to (annoyance), symptomatology and violence. Forensic caregivers were most likely to note burdens relating to (annoyance), symptomatology and violence [...].  ... there were slightly more severe burdens in the forensic group which may be related to the greater reported number of violent incidents.</p>
<p><b>D</b>  <b>2002 CALHOUN</b>  <b>USA</b>  partners of vietnam war combat veterans, with PTSD vs without PTSD (N= 51 vs N= 20)  <i>interviews</i></p>	<p><b>burden:</b></p> <p>... association between caregiver burden and symptom variables including (PTSD severity), level of interpersonal violence, [...], among those veterans diagnosed with PTSD.  ... PTSD symptom severity and both veteran-reported and partner-reported acts of interpersonal violence committed by the veterans were significantly associated with caregiver burden among partner of patients with PTSD.</p> <ul style="list-style-type: none"> <li>- Partners caring for veterans with more severe levels of PTSD symptoms and higher levels of interpersonal violence tended to experience higher levels of caregiver burden.</li> </ul> <p>... both PTSD symptoms severity and level of interpersonal violence independently contributed to the variance in caregiver burden.  ... interpersonal violence was also significantly associated with partner psychological adjustment.</p> <ul style="list-style-type: none"> <li>- greater levels of interpersonal violence were associated with poorer psychological adjustment.</li> </ul>
<p><b>#s</b></p>	

<p><b>2001 Dore</b> <b>NEW ZEALAND</b> caregivers of patients with bipolar disorder (N= 41) <i>face-to-face interview</i></p>	<p><b>violence:</b></p> <p><i>“Once he threw me on the floor and tried to butt my head. “</i> <i>“He threatened me with a chain saw once.”</i> <i>“She was about to stab me with a kitchen knife so I knocked her out.”</i> <i>“His hostility and threatening attitude to me personally is upsetting and at times frightening (during mania).”</i></p> <p><b>burden:</b></p> <p><u>Caregiver relationship with the patient:</u> ... most caregivers (81 %) were distressed by the way the patient related to them when unwell; 64 % described the level of personal distress as “severe”.</p> <p><u>Caregiver experience of stress:</u> ... for 44 % this was primarily when the patient was ill, while another 27 % felt this stress even when the patient was well. ... stress as major (partners 85 % vs parents 87 %)</p> <p><u>Problem behaviours:</u> ... most commonly, caregivers found aggressive and violent behaviours to be most disturbing (17 %).</p>																					
<p><b>D</b> <b>1998 MARSH</b> <b>NEW ZEALAND</b> caregivers of adults with a severe traumatic brain injury (TBI) (N= 69) <i>questionnaires, 6 months and 1-year post-injury part of the Waikato Traumatic Brain Injury Study</i></p>	<p><b>violence/burden:</b></p> <p><u>6 months following severe traumatic brain injury:</u></p> <table border="1" data-bbox="534 1355 1181 1668"> <thead> <tr> <th><u>Problem area</u></th> <th><u>Frequency</u></th> <th><u>Mean distress:</u></th> </tr> </thead> <tbody> <tr> <td>Behavioural</td> <td></td> <td>4-point scale</td> </tr> <tr> <td>-impulsive</td> <td>35/ 52 %</td> <td>2, 23</td> </tr> <tr> <td>-mood changes</td> <td>34/ 50 %</td> <td>2, 74</td> </tr> <tr> <td>-<u>anger</u></td> <td>34/ 50 %</td> <td>2, 68</td> </tr> <tr> <td>-Irritable</td> <td>34/ 50 %</td> <td>2, 68</td> </tr> <tr> <td>-<u>aggression</u></td> <td>19/ 28 %</td> <td>2, 79</td> </tr> </tbody> </table> <p>...Aggression: low frequency, but causing the greatest degree of distress for caregivers!!</p> <p>... caregiver reports of the number of behavioural problems displayed by the TBI patient were related to all aspects of caregiver functioning:</p> <p><u>Objective burden:</u></p> <ul style="list-style-type: none"> <li>- depression</li> <li>- anxiety</li> <li>- social adjustment</li> </ul>	<u>Problem area</u>	<u>Frequency</u>	<u>Mean distress:</u>	Behavioural		4-point scale	-impulsive	35/ 52 %	2, 23	-mood changes	34/ 50 %	2, 74	- <u>anger</u>	34/ 50 %	2, 68	-Irritable	34/ 50 %	2, 68	- <u>aggression</u>	19/ 28 %	2, 79
<u>Problem area</u>	<u>Frequency</u>	<u>Mean distress:</u>																				
Behavioural		4-point scale																				
-impulsive	35/ 52 %	2, 23																				
-mood changes	34/ 50 %	2, 74																				
- <u>anger</u>	34/ 50 %	2, 68																				
-Irritable	34/ 50 %	2, 68																				
- <u>aggression</u>	19/ 28 %	2, 79																				

	<ul style="list-style-type: none"> <li>- subjective burden</li> </ul> <p>... summary of simultaneous regression analysis for TBI patient variables</p> <p><u>(behavioural) predicting caregiver functioning:</u></p> <ul style="list-style-type: none"> <li>- -objective burden</li> <li>- -anxiety</li> <li>- -social adjustment</li> <li>- <u>-subjective burden</u></li> </ul> <p><u>1 year following severe traumatic brain injury:</u></p> <table border="1" data-bbox="534 577 1181 974"> <thead> <tr> <th>Problem area</th> <th>Frequency</th> <th>Mean distress:</th> </tr> </thead> <tbody> <tr> <td>behavioural</td> <td></td> <td>4-point scale</td> </tr> <tr> <td>-impatient</td> <td>51/ 74 %</td> <td>2, 61</td> </tr> <tr> <td>-overly sensitive</td> <td>42/ 61 %</td> <td>2, 31</td> </tr> <tr> <td>-impulsive</td> <td>42/ 61 %</td> <td>2, 17</td> </tr> <tr> <td>-<u>anger</u></td> <td>38/ 55 %</td> <td><u>2, 76</u></td> </tr> <tr> <td>-irritable</td> <td>33/ 48 %</td> <td>2, 49</td> </tr> <tr> <td>-mood changes</td> <td>31/ 45 %</td> <td>2, 65</td> </tr> <tr> <td>-aggression</td> <td>22/ 32 %</td> <td>2, 50</td> </tr> </tbody> </table> <p>... the number of behavioural problems reported for the person with TBI was significantly related to caregiver levels of...</p> <ul style="list-style-type: none"> <li>- objective burden</li> <li>- anxiety</li> <li>- social adjustment</li> <li>- subjective burden</li> </ul> <p>... summary of simultaneous regression analysis for patient with TBI variables (behavioural) predicting caregiver functioning: objective burden, subjective burden</p>	Problem area	Frequency	Mean distress:	behavioural		4-point scale	-impatient	51/ 74 %	2, 61	-overly sensitive	42/ 61 %	2, 31	-impulsive	42/ 61 %	2, 17	- <u>anger</u>	38/ 55 %	<u>2, 76</u>	-irritable	33/ 48 %	2, 49	-mood changes	31/ 45 %	2, 65	-aggression	22/ 32 %	2, 50
Problem area	Frequency	Mean distress:																										
behavioural		4-point scale																										
-impatient	51/ 74 %	2, 61																										
-overly sensitive	42/ 61 %	2, 31																										
-impulsive	42/ 61 %	2, 17																										
- <u>anger</u>	38/ 55 %	<u>2, 76</u>																										
-irritable	33/ 48 %	2, 49																										
-mood changes	31/ 45 %	2, 65																										
-aggression	22/ 32 %	2, 50																										
<p><b>D</b></p> <p><b>1998 VICTOROFF</b></p> <p><b>USA</b></p> <p>Patient with dementia-caregiver pairs (N= 35) <i>interviews</i></p>	<p><b>burden:</b></p> <p>... there were highly significant correlations between patient agitation and both caregiver burden and depression.</p> <p>... agitation, particularly physical aggression, may impact caregivers even more than does the cognitive status of the demented patient.</p> <p>... the presence of violence was significantly correlated with caregiver burden.</p>																											

<p><b>D</b>  <b>1998 NAGARATMAN</b>  <b>AUSTRLIA</b>  patients with dementia and their caregivers (N= 90)  <i>Study, interview with the caregiver + tests with the patient</i></p>	<p><b>violence:</b></p> <p>... the most common behavioral change was aggression (59 %), [...].</p> <p>... most disturbing was the uncontrollable bouts of aggression seen in 59 % of the dementia patients that were mostly directed to the caregiver.</p> <p>... the behavioral problems perceived by the caregivers of those with moderate-severe dementia included a higher incidence of wandering and incontinence and a lower incidence of verbal aggression than among those with mild dementia.</p> <p>mild Dementia: verbal aggression 30/43  (N= 43)                    physical violence 7/43</p> <p>moderate-severe dementia: verbal aggression 23/47  (N= 47)                    physical violence 3/47</p> <p><b>burden:</b></p> <p>... aggression caused the most distress to the caregiver</p>
<p><b>?</b>  <b>1997 VADDADI</b>  <b>AUSTRALIA</b>  patients and their relatives (N= 101)  <i>semi-structured interview</i></p>	<p><b>violence:</b></p> <p><u>Prevalence of abuse of carers by patients</u></p> <p><u>Type of abuse                    Percentage frequency (N= 101)</u></p> <p><u>Shouting and swearing</u></p> <ul style="list-style-type: none"> <li>- never: 40 %</li> <li>- often: 43 %</li> <li>- most of the time: 18 %</li> </ul> <p><u>Temper outbursts</u></p> <ul style="list-style-type: none"> <li>- never: 29 %</li> <li>- often: 48 %</li> <li>- most of the time: 24 %</li> </ul> <p><u>Physical threats</u></p> <ul style="list-style-type: none"> <li>- never: 55 %</li> <li>- on one or two occasions: 13 %</li> <li>- several/many times: 33 %</li> </ul> <p><u>Hitting and striking</u></p> <ul style="list-style-type: none"> <li>- never: 68 %</li> <li>- on one or two occasions: 15 %</li> <li>- several/many times: 17 %</li> </ul> <p><u>Causing physical injury</u></p>

	<ul style="list-style-type: none"> <li>- NO: 80 %</li> <li>- YES: 20 %</li> </ul> <p><b>burden:</b></p> <p>... 15 % of the carers reported living in fear of their relative, all of these carers having experienced threats of or actual physical harm.</p> <p>... 79 % of the carers had scores of &gt;4 (GHQ), indicating a significant level of emotional/psychiatric disorder.</p> <p>... the total amount of abuse experienced correlated positively with relatives' GHQ score, as did the number of types of abuse.</p> <p>... the correlation between the total burden score and the total amount of personal abuse was highly significant.</p>
<p><b>S</b> <b>1997 TARDIFF</b> <b>USA</b> psychiatric patients after hospital discharge (N= 430) <i>prospective study</i></p>	<p><b>violence:</b></p> <p><u>One or more violent acts toward persons within two weeks after discharge:</u> 16 of 430 (3, 7 %)</p> <p><u>Types:</u> most of the attacks involved punching or scratching and left bruises or scratches</p> <p><u>Target:</u> most were directed toward spouses, other intimates, or other family members</p>
<p><b>S</b> <b>1994 ASNIS</b> <b>USA</b> outpatients (N= 517) <i>survey</i></p>	<p><b>violence:</b></p> <p>... <u>patients with a diagnosis of alcohol and substance abuse</u> had the greatest frequency of <u>past homicidal ideation</u> and <u>patients with schizophrenia</u> had the <u>greatest frequency of past homicide attempts.</u></p> <p><u>The targets of the homicide attempts were:</u></p> <ul style="list-style-type: none"> <li>- father (18 %)</li> <li>- brother (9 %)</li> <li>- spouse or girlfriend or boyfriend (27 %)</li> <li>- strangers (18 %).</li> </ul> <p><u>Type:</u></p> <p>... knife was the most common weapon, used in 45 percent of the attempts</p>
<p><b>?</b> <b>1994 REIS</b> <b>CANADA</b> caregiver-</p>	<p><b>burden:</b></p> <p>... female caregivers [...] who were caring for more aggressive and</p>

carereceiver participant pairs (N= 213) <i>interview</i>	more impaired dependents found caregiving more burdensome.
<b>D</b> <b>1990 HAMEL</b> <b>CANADA</b> caregivers and care receivers with dementia (N= 213) <i>interviews</i>	... caregivers reported some form of aggression for 119 (57,2 %) of the dementia patients. <u>Verbal aggression</u> in 106 (52 %) of cases <u>Physical aggression</u> in 71 (34,1 %) of cases: the most common form, 21 % threatening gestures <u>Sexual aggression</u> only in 17 (7,2 %) of the care receivers: persistent hugging and kissing, each less than 7 % ... the actual frequency was low ... hostile and accusatory language, the most frequently occurring form of aggressive act, was observed in 44,7 % of the patients. ... daily occurrence for only 10,6 %

#### **In die aktuelle Leitlinie aufgenommene Studien:**

Chan, Billy Wing-Yum (2008): Violence against caregivers by relatives with schizophrenia. In: The International Journal of Forensic Mental Health 7(1), S. 65–81.

Elbogen, E. B.; Swanson, J. W.; Swartz, M. S.; Van, DornR. (2005): Family representative payeeship and violence risk in severe mental illness. In: Law and Human Behavior 29 (5), S. 563–574.

Finlayson, Janet; Jackson, Alison; Mantry, Dipali; Morrison, Jillian; Cooper, Sally-Ann (2015): Types and causes of injuries of carers of adults with intellectual disabilities. Observational study. In: Journal of Policy and Practice in Intellectual Disabilities 12 (3), S. 181–189.

Hanzawa, S.; Bae, J. K.; Bae, Y. J.; Chae, M. H.; Tanaka, H.; Nakane, H. et al. (2013): Psychological impact on caregivers traumatized by the violent behavior of a family member with schizophrenia. In: Asian Journal of Psychiatry 6 (1), S. 46–51.

Hsu, M. C.; Tu, C. H. (2014): Adult patients with schizophrenia using violence towards their parents. A phenomenological study of views and experiences of violence in parent-child dyads. In: Journal of advanced nursing 70 (2), S. 336–349.

Huang, S.-S.; Lee, M.-C.; Liao, Y.-C.; Wang, W.-F.; Lai, T.-J. (2012): Caregiver burden associated with behavioral and psychological symptoms of dementia (BPSD) in Taiwanese elderly. In: Archives of Gerontology and Geriatrics 55 (1), S. 55–59.

Jackson, D.; Turner-Stokes, L.; Murray, J.; Leese, M.; McPherson, K. M. (2009): Acquired brain injury and dementia. A comparison of carer experiences. In: *Brain Injury* 23 (5), S. 433–444.

Kageyama, Masako; Solomon, Phyllis; Kita, Sachiko; Nagata, Satoko; Yokoyama, Keiko; Nakamura, Yukako et al. (2016): Factors related to physical violence experienced by parents of persons with schizophrenia in Japan. In: *Psychiatry Research* 243, S. 439–445.

Kageyama, Masako; Yokoyama, Keiko; Nagata, Satoko; Kita, Sachiko; Nakamura, Yukako; Kobayashi, Sayaka; Solomon, Phyllis (2015): Rate of family violence among patients with schizophrenia in Japan. In: *Asia Pacific Journal of Public Health* 27 (6), S. 652–660.

Khalifeh H, Oram S, Osborn D, Howard LM, Johnson S (2016): Recent physical and sexual violence against adults with severe mental illness: a systematic review and meta-analysis. *Int Rev Psychiatry* 28(5):433-451.

Kivisto, Aaron J.; Watson, Malorie E. (2016): 12-month prevalence, trends, gender differences, and the impact of mental health services on intimate partner violence perpetration among discharged psychiatric inpatients. In: *Journal of Family Violence* 31 (3), S. 379–385.

Kontio, Raija; Lantta, Tella; Anttila, Minna; Kauppi, Kaisa; Valimaki, Maritta (2017): Family involvement in managing violence of mental health patients. In: *Perspectives in Psychiatric Care* 53 (1), S. 55–66.

Labrum, T. (2017): Factors related to abuse of older persons by relatives with psychiatric disorders. In: *Archives of Gerontology & Geriatrics* 68, S. 126–134.

Lange, R.; Brickell, T.; French, L.; Lippa, S. (2017): Factors affecting burden in family caregivers of military service members with traumatic brain injury. In: *Brain Injury Conference 12th World Congress on Brain Injury of the International Brain Injury Association*. United States. 31, S. 893–894.

Loughland, C. M.; Lawrence, G.; Allen, J.; Hunter, M.; Lewin, T. J.; Oud, N. E.; Carr, V. J. (2009): Aggression and trauma experiences among carer-relatives of people with psychosis. In: *Social Psychiatry and Psychiatric Epidemiology* 44 (12), S. 1031–1040.

Mcgrath, M.; Oyebode, F. (2005): Characteristics of perpetrators of homicide in independent inquiries. In: *Medicine, Science and the Law* 45 (3), S. 233–243.

Meiland, F.J.M.; Kat, M. G.; Van, TilburgW.; Jonker, C.; Droes, R.-M. (2005): The emotional impact of psychiatric symptoms in dementia on partner caregivers. Do caregiver, patient,



and situation characteristics make a difference? In: *Alzheimer Disease and Associated Disorders* 19 (4), S. 195–201.

Mori, T.; Ueno, S.-I. (2011): Support provided to dementia patients by caregivers and the community. In: *Japan Medical Association Journal* 54 (5), S. 301–304.

Onwumere, J.; Grice, S.; Garety, P.; Bebbington, P.; Dunn, G.; Freeman, D. et al. (2014): Caregiver reports of patient-initiated violence in psychosis. In: *Canadian Journal of Psychiatry / Revue Canadienne de Psychiatrie* 59 (7), S. 376–384.

Oram, S.; Flynn, S. M.; Shaw, J.; Appleby, L.; Howard, L. M. (2013): Mental illness and domestic homicide. A population-based descriptive study. In: *Psychiatric Services* 64 (10), S. 1006–1011.

Orengo, C. A.; Khan, J.; Kunik, M. E.; Snow, A. L.; Morgan, R.; Steele, A. et al. (2008): Aggression in individuals newly diagnosed with dementia. In: *American Journal of Alzheimer's Disease and other Dementias* 23 (3), S. 227–232.

Rattinger, G. B.; Behrens, S.; Schwartz, S.; Corcoran, C.; Piercy, K. W.; Norton, M. C. et al. (2015): How do neuropsychiatric symptoms in persons with dementia affect caregiver physical and mental health over time? the cache county dementia progression study. In: *Alzheimer's and Dementia Conference Alzheimer's Association International Conference 2015*. Washington, DC United States. Conference Publication, P450.

Raveendranathan, D.; Chandra, P. S.; Chaturvedi, S. K. (2012): Violence among psychiatric inpatients. A victim's perspective. In: *East Asian Archives of Psychiatry* 22 (4), S. 141–145.

Uei, Shu-Lin; Sung, Huei-Chuan; Yang, Mei-Sang (2013): Caregiver's self efficacy and burden of managing behavioral problems in Taiwanese aged 65 and over with dementia. In: *Social Behavior and Personality* 41 (9), S. 1487–1496.

Unwin, Gemma; Deb, Shoumitro (2011): Family caregiver uplift and burden. Associations with aggressive behavior in adults with intellectual disability. In: *Journal of Mental Health Research in Intellectual Disabilities* 4(3), S. 186–205.

Uribe, F. L.; Heinrich, S.; Griske, J.; Wubbel, M.; Wolf-Ostermann, K.; Thyrian, J. R. et al. (2014): Dementia care networks in Germany. Care arrangements and caregiver burden at the demnet-D study baseline. In: *Alzheimer's and Dementia Conference Alzheimer's Association International Conference 2014*. Copenhagen Denmark. Conference Publication, P224.

Varghese, A.; Khakha, D. C.; Chadda, R. K. (2016): Pattern and Type of Aggressive Behavior in Patients with Severe Mental Illness as Perceived by the Caregivers and the Coping Strategies Used by Them in a Tertiary Care Hospital. In: Archives of psychiatric nursing 30 (1), S. 62–69.

### Abkürzungsverzeichnis zum Anhang

ABS	Agitated Behavior Scale
ACES	Agitation-Calmness Evaluations Scale
AEs	Adverse Effects
BARS	Barnes Akathisia Rating Scale
BPRS	Brief Psychiatric Rating Scale
CABS	Corrigan Agitated Behaviour Scale
CGI-I	Clinical Global Impression-Severity of Illness Scale
CGI-S	Clinical Global Impression-Improvement Scale
CI	Confidence Interval
EEG	Electroencephalogram
IM	Intramuscular
MBPRS	modified Brief Psychiatric Rating Scale
NNT	Number Needed to Treat
PANSS	The positive and negative syndrome scale
PEC	PANSS Excited Component
OAS	Overt Aggression Scale
RCT	Randomized controlled trial
RR	Relative Risk
SAS	Simpson-Angus Scale
YMRS	YoungMania Rating Scale

## Offener Brief des Bundesverbandes der Psychiatrie-Erfahrenen (BPE)

Sehr geehrter Herr Steinert,  
sehr geehrte Damen und Herren,

der Bundesverband Psychiatrie-Erfahrener lehnt diese Leitlinie ab.

Wir möchten, dass unsere Ablehnung klar erkennbar in der Leitlinie verschriftlicht bzw. festgehalten wird. Da ich mit den Abläufen von Leitlinienerstellungen nicht im Detail vertraut bin, muss ich Ihnen überlassen, an welcher Stelle dies geschieht. Ich bitte aber um eine Rückmeldung und Versand der weiteren Emails an den geschäftsführenden Vorstand unter [vorstand@bpe-online.de](mailto:vorstand@bpe-online.de) statt nur an Ruth Fricke. Frau Fricke ist selbstverständlich Teil des Vorstandsverteilers.

Leitlinien sollen den aktuellen Stand der Wissenschaft zusammenfassen und dienen der Profession als Grundlage ihres Handelns. Leitlinienkonformes Handeln kann sogar als Argumentationsgrundlage herangezogen werden, um sich bei zweifelhaftem Vorgehen aus der Verantwortung zu ziehen. Diese Gefahr ist hier gegeben. Gerade deswegen ist unsere /fristgerechte /Ablehnung wichtig und richtig.

Die Gründe für unsere Ablehnung sind /vielschichtig/, ich möchte Ihre Zeit aber nicht über Gebühr in Anspruch nehmen. Deshalb beschränke ich mich auf einige im Verlauf unserer internen Diskussionen angesprochenen Aspekte.

Sie als Kollektiv unternehmen den Versuch mit dieser Leitlinie Zwang und Gewalt gegen Psychiatrie-Erfahrene zu rechtfertigen und zu legitimieren. Dabei bleibt unerwähnt, dass extensiv Gewalt gegen als "schwierig" bezeichnete, /nicht /"aggressive" Insassen der häufigste Fall an psychiatrischer Gewalt ist.

Wie eigenartig wirkt eigentlich schon die Präambel, in der regelrecht die Behauptung aufgestellt wird, dass aggressives Verhalten einer psychischen Erkrankung gleichzusetzen ist? Ebenso kühn behaupten Sie, dass Zwangsmaßnahmen eine Folge aggressiven Verhaltens von Patienten seien. Zwangsmaßnahmen führen häufig zu mehr oder weniger starken psychischen oder physischem Traumata. In der Leitlinie wird Gewalt als zentraler Bestandteil der Behandlung auf- und ausgebaut. Wie ist Satz in der Präambel zu verstehen: "Eingedenk der Gewalt und des Unrechts, die psychisch erkrankten Menschen im Namen der Psychiatrie und durch in der Psychiatrie Tätige in der Vergangenheit angetan worden sind, muss dem professionellen Umgang mit aggressivem Verhalten heute unsere besondere Aufmerksamkeit und Sorgfalt gelten, ... ."?

Wir bezweifeln stark, dass die Leitlinie tatsächlich dem Stand der aktuellen Forschung/Wissenschaft entspricht. Stattdessen steht die Psychiatrie in einer Tradition der Gewalt. Beispielsweise Elektroschocks, die bekanntermaßen zu Zeiten des 2. Weltkrieges durch einen Italienischen Psychiater vom Schweineschlachthof in die Psychiatrie importiert wurden, erleben derzeit eine Wiederbelebung. Euphemistisch werden sie als Elektrokonvulsionstherapie beschrieben und nötigenfalls ohne Zustimmung mit Zwang durchgeführt.

Erniedrigende und menschenunwürdige Behandlung gegenüber den Patienten ist alltäglich und strukturell. Patienten haben kaum Möglichkeiten sich zu wehren. Sie müssen beim geringsten Widerstand Restriktionen befürchten. Gewalt als ein massives Ungleichgewicht von Macht wird verschwiegen. Stattdessen redet man von chemischem Ungleichgewicht im Gehirn. Einfachste menschliche Urprinzipien wie "Gewalt erzeugt Gegengewalt" und "Therapie kann nur freiwillig stattfinden" stehen in komischem Verhältnis zu Ihrer Leitlinie, die Insassen zu Tätern machen will.

Es fehlt ein Hinweis darauf, wie häufig prozentual eingesperrt wird. 20% der Insassinnen sind es laut Bundesjustizministerium seit Jahrzehnten. Es fehlt auch völlig, dass ein nicht unbedeutender Teil durch geschickte psychiatrische Verhandlungsführung untergebracht ist: "Wenn sie nicht freiwillig hierbleiben, dann holen wir den Richter". Auch hier erkennbar: Ein massives Ungleichgewicht an Macht.

Es könnte sicherlich noch an einigen Stellen detaillierter auf dieses Papier eingegangen werden. Uns bleibt vorerst ein weiterer wichtiger Punkt anzumerken: Wir sehen die Empfehlungen zu Psychopharmaka einfach nur als Frechheit an.

Vielen Dank für Ihre Aufmerksamkeit.

Martin Lindheimer  
im Namen und für den geschäftsführenden Vorstand