# Programme and Abstract book

**10 – 12 th. May 2018**


**Horatio European Congress in the Faroe Islands**

FPS

HORATIO European Psychiatric Nurses

RCSI

# Programme and Abstract Book

Horatio European Congress in the Faroe Islands 2018

*Tórshavn*

# Table of contents



*Nordic House*

## Welcome to the Horatio Congress in the Faroe Islands

It is with great pleasure that I welcome you to this Horatio congress in collaboration with our colleagues from the Faroese Psychiatric Nurses. It is nearly 20 years ago that I last spoke at an event on this beautiful archipelago, and at the time I remember being so impressed with the dedication, enthusiasm and motivation of the Faroese PMHNs. It is perhaps fitting that the theme of 'Safe Settings' was chosen for this event. Living and working in a small island nation has added factors that in some way increase the potential of risk to oneself and others. Safety was one of the underpinning features of the EU Framework for Action on Mental Health and Wellbeing initiative, with the EU Compass focusing on suicide reduction in 2017 and increasing community based facilities in 2018. Working in inpatient settings has always been stressful for nurses and patients alike. And, whilst most European nations report an increase in community based mental health care few are prepared to say how they protect both their patients and nurses in that environment. Our distinguished list of keynote speakers will attempt to address concerns about how to tackle a wide variety of safety issues in all mental health clinical settings and our concurrent sessions and posters will provide some practical options for practitioners, managers and educationalists. Take the time to share your ideas and experiences with others and don't be afraid to think outside the box. As the late Dr. Steven Hawkings said, "Be Creative". Enjoy your congress and I look forward to meeting with you all during the event.

Martin Ward

President, Horatio: European Psychiatric Nurses

# Welcome

Dear delegates and colleges

It is a great pleasure to welcome you all to the joint FPS and Horatio- European Psychiatric Nursing Congress in Tórshavn, Faroe Islands. The Congress is organized by FPS, Faroese Psychiatric Nurses and Horatio, European Psychiatric Nurses.

We extend warm greetings to those of you attending for the first time at the Horatio Congress and to
those loyal attendees returning. This is the first time a European Psychiatric Congress is held in the Faroes and we welcome you all to our beautiful islands.

We selected the theme Safe Settings as a multidimentional approache, both in psychiatric and mental health nursing as well as in life in general. We believe that though multidimentional, it captures the essence of what is needed for every human being, to feel safe in our inviroment. Safety to grow, thrive and give us the foundation we need to live our lives, no matter where – in schools,work places, communities, psychiatric hospitals, prisons, general hospitals, nursing homes, families, goverments, NGO's etc.

The presentations over these three days will provide participants with ideas and knowledge to connect to their everyday lives and surroundings. The topics that will be presented are varied and cut across many aspect of psychiatric and mental health nursing. The Congress gives you a great opportunity to meet colleagues from all over the world and you will have an outstanding possibility to
net-work with your new and old friends. We look forward to the discussion and the debate as we discover the acpects of relationships, settings and milieu that connect us all - as well as research and nursing practice.

Once again welcome and lets have a great time together.

Birgit Andersen, Chair of FPS and Organizing commitee and treasurer of Horatiio.


## Horatio

The aims of the Association are twofold: to advocate for the interest of the members by providing input into the decision-making processes on issues relevant to psychiatric and mental health nursing in Europe and to promote the development of psychiatric and mental health nursing practice, education, management and research.
For more information: **http://www.horatio-web.eu**

In the Spring of 2004 there were many European, International and Global Nursing Organisations. However, when it came to psychiatric nursing, unlike so many other specialist nursing groups, it was clear we lacked not just an Organisation but also a representative voice.

Two psychiatric nurses from Malta and the Netherlands sought the interest of other national psychiatric nursing organisations to start a network. This resulted in a group called the Psychiatric Nursing Work Group (PNWG) that first met October 2005 in Amsterdam.

At that meeting the decision was taken to transform the group into an association and with the name 'Horatio: European Psychiatric Nurses'. In April 2006 the Association was formally established and in May 2006 the second meeting took place in Prague. The network increased rapidly and currently has membership from most European countries.

Some members are individuals; some are representatives of an International Organisation within the field of psychiatric or mental health nursing or the psychiatric sections in their national nursing associations. We also have institutional memberships, such as libraries or universities. We liaise with organisations beyond Europe as well as mental health groups representing both carers and patients with mental health problems. We are in a collaborative partnership with the other professional mental health representative associations in Europe, coordinated by the WHO.

**Objectives of Horatio**

1. To promote and facilitate information about psychiatric and mental health nursing within Europe.
2. To represent the special interest of psychiatric and mental health nurses in Europe and collaborate with stake holder nursing organisations
3. To advance the art and science of psychiatric and mental health nursing within Europe.
4. To improve the recognition of psychiatric and mental health nursing within all fields of health care.
5. Contribute to effective co-operation between health professionals, organisations, institutes, agencies, charities and groups who have an interest in the care of people with mental health problems.
6. To inform the development of standards for education and continuing competence for psychiatric and mental health nurses.
7. To strengthen nurse leadership in mental health.
8. To provide conferences, congresses and continuing education opportunities for psychiatric and mental health nurses.
9. To link and network with similar national and international organisations, external to the European community

*Gjógv*


## FPS, Faroese Psychiatric Nurses

FPS is a interestgroup within the Faroese National Nurses organization FFS. The members of FPS are nurses, that work as psychatric nurses or have a special interest in this field of nursing. FPS was established in 1995 and has about fourty members

### Aims

The aims of the organization is to support and encourage the members, developing their professional qualifications, in order to provide the best psychiatric nursing required at any given time.

### Activities

The board has 12 annual meetings, at times even more. There are at least two annual meetings for members, in addition to the general assembly. In order to reach the aims of the organization, the board organises courses for members and other professionals, to support the development of skills and professional Psychiatric nursing.

### PSSN

FPS is a member of PSSN ( The Nordic Psychiatric Nuses Cooporation). The aim of PSSN is to strengthen psychitric nursing in the Nordic. Every third year, the memeber countries take turn organizing a Nordic congress in association with PSSN.

### Horatio

FPS is also member of Horatio (European Psychiatric Nurses). The aims of the Association are twofold: To advocate for the intrest of the members by providing input into the decision-making processes on issues relevant to psychiatric an mental helth nursing in Europe and to promote the development of psychiatric and mental health nursing practice, education, management and reserach (www.horatio-web.eu).

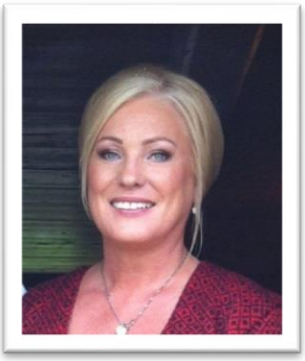
## Organizing commitee

Birgit Andersen, Chair (Faroe Islands)

Jana Mortensen (Faroe Islands)

Eydna Iversen Lindenskov (Faroe Islands)

Anna Simonsen (Faroe Islands)



Kristianna Lund Dam (Faroe Islands)

Aisling Culhane (Ireland)

## Scientific Committee

Prof. Dr.  Michael Löhr
Professor of Psychiatric Nursing Fachhochschule der Diakonie Bielefeld, Germany
Chair of the Sientific Committee of ‚Safe Setting' Congress on Faroe Islands 2018
Co-Chair of the Horatio HORATIO Expert Group

Gro Gade Haanes, RN, Phd, Assistant Professor in  Nursing, Section of Nursing, University Faroe Islands

Kristianna Dam, RN, Master of Sciense (MSc) in nursing, Phd.student
Section of Nursing, University Faroe Islands

May Brit Skoradal, RN, Master of Public Health
Section of Nursing, University Faroe Islands

Durita G. Joensen, RN, Master of Sciense (MSc) in nursing
Section of Nursing, University Faroe Islands

Hildigunn Steinhólm, RN, Master of Public HealthSection of Nursing, University Faroe Islands

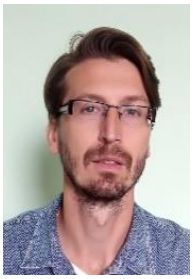
Annemi Joensen, RN, Master of Social Sciences (Ms.Sc.)
Section of Nursing, University Faroe Islands

Johild Dulavík, RN, Master of Education, Counselor
Section of Nursing, University Faroe Islands

Maria Hammer Olsen, RN, Master in edb technology
Section of Nursing, University Faroe Islands

Súsanna Mortensen, RN, Master of Education and Psychology
Section of Nursing, University Faroe Islands

Nina Kilkku, RN, MNSc, PhD, psychotherapist
Principal lecturer, School of Health Care and Social Services, Tampere University of Applied Sciences, Finland
European Psychiatric Nurses (Horatio), member of the board



Mgr.Tomas Petr, Ph.D. C Czech Republic
European Psychiatric Nurses (Horatio), member of the board

Henrika Jormfeldt
Associate professor in Nursing ScienceDepartment of Health and Welfare
Halmstad university, Sweden
European Psychiatric Nurses (Horatio), member of the board

Evanthia Sakellari
Assistant Professor, Department of Public Health and Community Health,
Athens University of Applied Sciences
European Psychiatric Nurses (Horatio), member of the board

# Generel information

**Badges:**

All participants must wear their festival name badges during all events. Admission to the sessions is restricted to registered participants wearing their name badge. The festival staff can be recognized by the colour of their name badges

**Currency**

The official currency is Danish krona (DKK)
USD 1 = 6,04 DKK
EUR 1= 7,45 DKK (april 2018)

**Electricity**

Electrical current in the Faroe Islands is 220v/50Hz. Round, European-style two –pin plugs are used. Appliances, designed to operate on 110/120/Volts need a voltage converter and a plug adapter

**Emergency Call 112**

If you are in an emergency situation and in need of immediate help: **Call 112** . 112 is the emergency number that you can call from a landline or a mobile phone all over the Faroe Islands.

If you need police assistance: Call +298 351448

**Excurision:** Staff at the regitration desk, will be happy to help and guide you on this matter.

**Insurance and Disclaimer**

All participants are highly recommended to carry a proper travel and health insurance. The Organizing committee and Green Gate Incoming accept no liabilities for any injuries/losses incurred by participants

and/or accompanying persons, nor loss of, or damage to any luggage and/or personal belongings

**Internet Access**

Internet access “NLH-Guests” will be available in the Nordic House, free of charge

**Meals:**

Coffee breaks and lunches are complimentary. These are served in the open area (forhøllin) in the Nordic house.

**Messages and other information**

A message board is placed in the registration area where the participants can exchange personal messages or share informations, such as future conferences, articles published etc.

**Mobile phones**

All mobile phones should be turned off before entering the conference sessions as a courtesy to speakers and other participants

**Poster presentation**

Posters will be displayed in the registration area througout the program. Contact the conference secretariat at the information desk if presentation service is needed.

The best posters will receive a reward. The awards will be announced at the closing ceremony

The participants can register and collect their conference documents at the informiation desk. The conference staff will be pleased to assist with your inquiries

**Speakers**

To ensure smooth running of the sessions, all speakers are requested to report to the chairs for the sessions, for downloading of the presentation, at the beginning of the conference. Bring your presentation on a memory stick

**Time zone**

The time zone in the Faroe Islands is GMT

**Working language**

The conference language is English. Simultanious interpretation will not be provided.

**Cuisine's pub's and art/history:**

The city even though it's small, has quite a number of café's, pubs and restaurants with a variety of international and traditional cuisine to offer. Art exhibition and museum of art and history are also worth to pay a visit. To see more, please check www.visittorshavn.fo & www.faroeislands.com

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## Presentation of key note speaker

**Title of presentation**: *Sexual safety: the neglected discourse in mental health*.

**Professor Agnes Higgins;** PhD; MSc; BNS; RPN; RGN; RNT, Ireland

Agnes is Professor in Mental Health at the School of Nursing and Midwifery Trinity College, Dublin Ireland where she has held key administrative positions including Head of Mental Health Nursing and Head of School. She is registered mental health nurse, general nurse and with over forty years' clinical and education experience in the areas of mental health, palliative/hospice care and general nursing. Her research interests are in the area of mental health recovery, service user and family engagement, and sexualities. She has published over 100 journal articles and book chapters in her area of research and is co-editor of the book Mental Health in Ireland: Policy Practice and Law published by Gill and Macmillan in 2014 and co-author of the book Narratives of Recovery from Mental Illness: Role of peer support which was published by Routledge earlier in the year. She is a Fellow of Trinity College, an Elected Fellow (Ad Eundem) of Royal College of Surgeons in Ireland and a fellow of the European Academy of Nursing Science. She is founding chairperson of the Irish Institute of Mental Health Nursing and is the current Chairperson of Mental Health Reform, Irelands leading service user collation campaigning to transform mental health services.

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**Title of the presentation**:

*Housing for people with mental illness: Preferences, outcomes and what mental health professionals can do about it.*

**Dirk Richter;** Head of Research and Development, Center for Psychiatric Rehabilitation, University Bern Psychiatric Services and Senior Nursing Researcher, Health Division, Bern University of Applied Sciences, Switzerland

Dirk Richter has published several books on his previous major research topic violence in mental health care, on psychiatric sociology and on mental health nursing. He has also published more than 50 peer-reviewed papers and more than 100 articles and book chapters and has talked at conferences throughout Europe and beyond. Dirk's current research covers psychiatric rehabilitation in general and housing for people with mental illness in particular. He will talk about results of his research that deals with housing preferences and with outcomes of living in different accommodations. Dirk Richter was trained as a nurse in mental health care in the 1980s in Germany and has worked mainly on acute wards. He then trained to become a sociologist (with minors in psychology and philosophy) and finished his academic education with a PhD and a post-doc degree (habilitation). After having worked for several years as a researcher and quality manager at a public mental hospital in Germany, he moved to Switzerland, to become a nursing research professor at Bern University of Applied Sciences (BUAS). Since 2015 he is head of research and development at the at the University Bern Psychiatric Hospital's Center for Psychiatric Rehabilitation and is still affiliated to BUAS

## Title of the presentation: *Safewards – user friendly culture change*?

**Geoff Brennan;** Executive Director, STAR WARDS, Ireland

Geoff is Northern Irish, did his first training as a registered nurse for Learning Disabilities and then did mental health nurse training. Geoff has now worked in, on and around mental health wards for over thirty years. In that time, he has been in just about every position a clinical nurse can have – health care assistant, staff nurse, charge nurse, practice development lead, nurse tutor and nurse consultant. Occasionally he got to work with really smart people – like professor Len Bowers. It was Len who recruited Geoff to help with the Safewards research trial. So basically, it's Len's fault. Anyway, it's all on www.safewards.net Since 2014, Geoff has worked for the UK charity "Bright" and runs the Star Wards project (www.starwards.org.uk) for acute inpatient wards. In this role he has continued to support Safewards with training, cheerleading, and assisting the international dissemination of the interventions. Geoff has presented Safewards in Australia, Brussels and many parts of the UK. He also provides the jokes for the @safewards twitter account

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## Title of the presentation:

*Using Quality Improvement across the Public Sector: Lessons from Scotland.*

**Jason Leitch;** National Clinical Director, Healthcare Quality and Improvement, Scottish Goverment, Scotland

Jason has worked for the Scottish Government since 2007 and in January 2015 was appointed as The National Clinical Director in the Health and Social Care Directorate. He is a Scottish Government Director and a member of the Health and Social Care Management Board. He is one of the senior team responsible for the NHS in Scotland. He is an Honorary Professor at the University of Dundee. Jason was the 2011 UK Clinician of the Year. He is a Senior Fellow at the Institute for Healthcare Improvement (IHI). He was a 2005-06 Quality Improvement Fellow at IHI, in Boston, sponsored by the Health Foundation. Jason is also a trustee of the UK wing of the Indian Rural Evangelical Fellowship which runs orphanages in southeast India.

He has a doctorate from the University of Glasgow, an MPH from Harvard and is a fellow of the Royal College of Surgeons of England, the Royal College of Physicians and Surgeons of Glasgow and the Royal College of Surgeons of Edinburgh. He is also a Fellow of the Higher Education Academy. Jason was appointed to NHS England review group led by Don Berwick looking into the patient safety elements of the Francis Inquiry

## **Title of the presentation**: ´The Search for being

**Katarina Nolsøe**, Actor, Faroe Islands

Katarina Nolsøe is 53 years old. She is an actor, and was committed to the psychiatric hospital in 2006 with psychosis which led to severe depression. She was staying on and off at the hospital for two years, and is still in treatment. Now, after eleven years, almost recovered, she has written an account of her process from illness to recovery. The account,

'The search for being,' is written in poetic form and is accompanied by drawings and paintings of her own.

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## **Title of the presentation:**

*Safety aspects within the scope of person – centered care and self – determination in psychiatric settings.*

**Michael Schulz** Prof. Dr. rer. medic. habil. Michael Schulz Psychiatrische Pflege Fachhochschule der Diakonie gemeinnützige GmbH University of Applied Sciences Bielefeld, Germany

In 2011, Michael Schulz became the first professor for psychiatric nursing in Germany. He has been involved in national and international research and dissemination projects for several years. As a member of the organization committee of a cross-border congress for psychiatric nursing he made a significant contribution to strengthening the network in the German-speaking countries Germany, Austria and Switzerland. Moreover, he was involved in founding HORATIO

## **Title of the presentation**: *If you see something, say something*

**Simon Tulloch** BSc, MSc, Improvement Coach and Senioradvisor, Denmark

Simon Tulloch is a senior improvement advisor (chef konsultant) at the Danish Society for Patient Safety (Dansk Selskab for Patientsikkerhed). Simon is a psychologist with a degree in psychology, an MSc in health psychology, training in solution focused therapy and is an IHI trained improvement coach. Simon has several years' experience of work with people with a range of mental health and substance misuse issues. As a researcher at the Royal College of Psychiatrists and Queen Mary University London, Simon has been lead or co-researcher on a number of national and international research projects covering a diverse range of mental health related subjects including service evaluation, service provision and measurement development. As a senior manager in the quality department and quality improvement coach at East London Foundation Trust Simon has been integral to the development, implementation and evaluation of the quality improvement program across the organisation. Simon has extensive knowledge of the UK health care system, using and coaching others in quality improvement methodology across different health settings and implementing large scale systemic change across organisations. Simon joined DSfPS in June 2016 and leads on the Safe Psychiatry (Sikker Psykiatri) and Educational (Forbedringsagentuddannelsen) programmes. Simon has experience of presenting to wide range of audiences, from health service leaders and government, to frontline healthcare staff, patients and carers. Presentations subjects include improvement science, research methodology and health service leadership. In the last four years Simon has presented at national conferences, the Ministry of Health, universities and healthcare services.

**Title of presentation**: *Patient and Nurse Safety*

**Thomas Kearns** Professor; Kearns Interim Chief Executive Officer International Council of Nurses, Ireland

Thomas Kearns was appointed Interim Chief Executive Officer at the International Council of Nurses in September 2017, taking a sabbatical from his role as Executive Director of the Faculty of Nursing & Midwifery at the Royal College of Surgeons in Ireland (RSCO) which he has held since April 2014. Prior to his role at RCSI, Kearns was Education Officer and Acting Chief Education Officer in the Nursing and Midwifery Board of Ireland (formerly An Bord Altranais), where he conceptualised, scoped, developed and was responsible for managing the Board's on-line Continuing Education directory. His doctorate is in the regulation of CPD and professional competence. His focus in RCSI has been on blending an entrepreneurial and educational approach to meeting evolving service needs through meeting the education training and practice development needs of nurses and midwives and through innovative project development and research partnerships with multiple stakeholder

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**Title of presentation**: *Equality in health.*

**Sirið Stenberg**

Minister of Health and the Interior

Faroese Government

Faroe Islands

Sirið Stenberg is the Faroese Minister of Health and the Interior. Sirið has a keen interest in public health and graduated as a nurse in 1994 and continued to study and became a health visitor in 2001. This has given her a front seat view to see the important work that medical professionals do every day. Psychiatric and mental health issues have been very important to Sirið throughout her education and also later in her professional life and as well in her personal life. As a minister, Sirið has underlined the importance of portraying mental health just as important as physical health. In addition to this, she also wants to give patients with mental health issues equal rights as others. This is also the headline for the unified plan, which the Minister presents this spring. In her keynote Sirið Stenberg will focus on the concept “Equality in health”, and why this is the core and foundation for all development of mental health in the Faroe Islands both in the psychiatric hospitals, schools, the elderly care and in the family etc

# Welcome to the Congress

# "SAFE SETTINGS"

## Horatio European Congress 10-12th May 2018 in the Faroe Islands

## Congress agenda for Safe Settings

### 9 th.May - Pre Congress professial & Social event

| | |
|---|---|
| **17.00-18.30** | **World café at the University in the Faroe Islands** |
| | **Topic:** Community Mental Health |
| **20.00 -** | **Let´s say HI ! "**Jomfrúbakkin" Cocktail bar in the center of Tórshavn |


# 10 th.May

**8.00-8.45** **Registration**

**9.00-10.15** **Opening Ceremony**

**10.15-10.45** **Coffee break and poster visit**

**10.45-11.30** **Keynote 1: Sirið Stenberg, Minister of Health and Interior Faroese Goverment, Faroe Islands**: "Equality in health"
**Chair: Birgit Andersen**

**11.30-12.30** **Workshop, Symposium and Concurrent sessions**

| **Høllin – room number 1** | **Klingran – room number 2** | **Dansistovan – room number 3** |
|---|---|---|
| WORKSHOP | WORKSHOP | SYMPOSIUM |
| **Chair:** Michael Lohr | **Chair:** Anna Simonsen | **Chair:** Tomăs Petr |
| **De-escalation a social and collaborative process in mental health care settings**<br><br>First author:Lene Lauge Berring<br>Second author: Anne Winkel<br>Third author: Louise Krossing Hansen<br>Denmark | **Safe treatment of forensic MH outpatients by regular community mental health teams**<br><br>First author:Diana Polhuis,<br>Second author: Ben Lijten Netherlands | **Safe settings for "Play and creation - a way to mental health" - The practice development of a holding and empowering environment based on creative self-actualization**.<br><br>First author: Ole Wich,<br>Second author:<br>Sanne Storm<br>Faroe Islands |
| **Skálin 1– room number 4** | **Skálin 2 – room number 4** | **Norðurstova – room number 5** |
| CONCURRENT | CONCURRENT | CONCURRENT |
| Chair: Jana Mortensen | Chair: Birgit Andersen | Chair: Martin Ward |
| **Title:** The ward atmosphere and the role of nursing staff in psychiatric in-patient settings<br><br>First author: Hanna Tuvesson, Sweden | **Title:** How to Prevent Coercion in Danish Mental Health Care - A Longitudinal Cluster Study<br><br>First author:Jesper Bak<br>Second author: Jacob Hvidhjelm<br>Third author: Lene Lauge Berring<br>Denmark | **Title:** The role of the nurse in charge in the prevention and management of aggression in acute psychiatric units<br><br>First author: Christina Larkin, Ireland |

| | | | |
|---|---|---|---|
| | **Title**: Attendees perspective on the quality in community-based day centre services for people with psychiatric disabilities<br><br>First author: Lars-Olov Lundqvist<br>Second author: Agneta Schroeder<br>Sweden | **Title:** Improving Physical health for persons with schizophrenia or other long-term psychotic conditions in psychiatric outpatient services.<br><br>First author: M. Blomqvist<br>Second author. A, Ivarsson<br>Third author: I-M, Carlsson<br>A, Sandgren<br>H, Jormfeldt<br>Sweden: | **Title:** Informal coercion: a neglected form of communication in psychiatric settings<br><br>First author: Franziska Rabensclag, Switzerland |
| | **Title:** The Canadian Federation of Mental Health Nurses Standards of Practice 4th ed.<br><br>First author: Elaine Santa Mina<br>Second author: Beth McCay<br>Third author: Donald Rose<br>Canada | **Title:** Screening women for birth depression in a small-scale society - the significance of feeling safe for the outcome of the screening<br><br>First author: Anna Sofía Fjallheim<br>Second author: Kristianna Hammer<br>Third author: Elisabeth O.C. Hall<br>Faroe Islands: | **Title:** Living in a paradox: Experiences in adults, who as children, lived with at least one parent experiencing mental illness in a small-scale society<br><br>First author:Kristianna Dam<br>Second author: Durita Joensen<br>Third author: Elisabeth O.C.Hall<br>Faroe Islands |

**12.30-13.30** **Lunch and poster visit**

**13.30-14.45** 𝄞

**Keynote 2: Simon Tulloch,** If you see something, say something.
**Chair: Evanthia Sakellari**

**14.45-15.15** **Coffee break and poster visit**

**15.15-16.15** **Workshop, Symposium and Concurrent sessions**

| **Høllin – room number 1** | **Klingran – room number 2** | **Dansistovan – room number 3** |
|---|---|---|
| WORKSHOP | CONCURRENT | CONCURRENT |
| **Chair:** Aisling Culhane | **Chair:** Nina Kilkku | **Chair:** Evanthia Sakellari |
| **Moving a Rhetoric of 'Trauma Informed Practice' into Mental Health Nursing Reality**<br><br>First author: Liam Mac Gabhann, Ireland | **Title**: Benefits of collaboration in treatment of dementia disease<br><br>First author: Marjun Restorff,<br>Second author: Maria Skaalum Petersen<br>Faroe Islands<br><br>**Title:** Multiprofessional Skill- and -Grade - Mix in Forensic Psychiatry: Which Mixture is necessary to provide person centered treatment in a safe environment<br><br>First author: Claudia Loetscher:,<br>Second author: Schoppmann, Susanne<br>Switzerland<br><br>**Title:** Influence of staffing levels on the incidence of conflict and use of containment in in-patient psychiatric care<br><br>First author: Andre Nienaber<br>Second author: Michael Schulz<br>Third author: Michael Loehr<br>Germany | **Title**: Suicide Risk Assessments: Is there evidence from nurses and clients of practice that supports safety<br><br>First author: Elaine Santa Mina, Canada<br><br>**Title**: Smart Homes: Health Care Technology to Assist Recovery for Psychiatric Inpatients<br><br>First author: Cheryl Forchuk,<br>Second author: Dr. Jeffrey Reiss<br>Canada<br><br>**Title:** Witnessing Dying – The therapeutic courage of listening to people with a lived experience of mental illness who are facing death<br><br>First author: Sharon Picot, Australia. |

| Skálin 1– room number 4 | Skálin 2 – room number 4 | |
|---|---|---|
| CONCURRENT | CONCURRENT | |
| **Chair:** Michael Lohr | **Chair:** Susanna Flansburg | |
| **Title**: Examine the possible correlation between violence and compassion satisfaction and fatigue and experience with traumatic life events among mental health professionals working in a forensic department.<br><br>First author: Jacob Hvidhjelm,<br>Second author: Jesper Bak<br>Third author: Christian Delcomyn<br>Denmark<br><br>**Title**: Safewards: The Irish experience Safe treatment of forensic MH outpatients by regular community mental health teams<br><br>First author: Christina Larkin<br>Second author: Eilish Neylon<br>Ireland | **Title**: From 'Person-centered' care to 'Person-driven' care: Towards a new umbrella term for future mental health care<br><br>First author:Dirk Richter<br>Second author: Holger Hoffmann<br>Switzerland<br><br>**Title:** Sound and Music Intervention to empower patients to handle anxiety and agitation or support the improvement relaxation or sleep<br><br>First author: Sanne Storm<br>Second author: Bjørghild Nolsøe<br>Third author: Marja Lund Gjógvará<br>Faroe Islands<br><br>**Title:**<br>The clinical utility of evidence based risk evaluation combined with de-escalation interventions in emergency psychiatry.<br><br>First author:<br>Roland van de Sande | |

**16.30-17.30** **Keynote 3: Agnes Higgins,** Sexual safety: the neglected discourse in mental health
**Chair: Nina Kilkku**

**19.00 -** **Reception at City Council**

# 11 th.May

**8.00-8.45** **Registration**

**9.00-10.00** **Keynote 4: Dirk Richter** "Housing for people with mental illness: Preferences, outcomes and what mental health professionals can do about it"
**Chair: Michael Løhr**

**10.00-10.30** **Coffee Break and poster visit**

**10.30-11.30** **Workshop, Symposium and concurrent sessions**

| **Høllin – room number 1** | **Klingran – room number 2** | **Dansistovan – room number 3** |
|---|---|---|
| WORKSHOP | CONCURRENT | CONCURRENT |
| **Chair:** Eydna Iversen Lindenskov | **Chair:** Henrika Jormfeldt | **Chair:** Kristianna Lund Dam |
| **How to create Psychological Safety in your workplace**<br><br>Simon Tulloch, Denmark | **Title:** Predictors of outpatient nursing service use from people with mental health problems in Switzerland<br><br>First author:Christian Burr<br>Second author: Renato Farcher<br>Third author: Dirk Richter<br>Switzerland<br><br>**Title:** Adolescent mental well-being _ assessment and perceived supportive elements<br><br>First author: Pinja Kokkonen, Finland<br>Second author: Helena Leino-Kilpi, Finland<br>Third author: Evanthia Sakellari, Greece (presenter) | **Title**: Have you seen My PAL?' Physical Achievement Log: A physical health tool for people with severe mental illness (SMI) pilot study in collaboration with the National Forensic Mental Health Service<br><br>Second author: Teresa McDonagh (presenter)<br>First author: Sinead Hennessey<br>Third author: Peter McCrarren<br>Irland<br><br>**Title:** Recovery College: An Emancipatory Approach to Personal Growth and Community Connection<br><br>First author: Liam Mac Gabhann<br>Second author: John Kelly<br>Ireland |

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|---|---|---|
| | **Title**. Preventing Discharge of Psychiatric Inpatients into Homelessness<br><br>First author: Cheryl Forchuk,<br>Second author: Dr. Jeffrey Reiss<br>Third author: Sarah Stevens<br>Canada | **Title**: Early maladaptive schemas in psychiatric nurses and helping professions in Germany<br><br>First author: Pascal Wabnitz, Germany |
| **Skálin 1– room number 4** | **Skálin 2 – room number 4** | |
| CONCURRENT | CONCURRENT | |
| **Chair:** Martin Ward | **Chair:** Aisling Culhane | |
| **Title**: The "Sigmaringen model" to reduce seclusion and restraint in psychiatry<br><br>First author: Alex Theodor Gogolkiewicz,<br>Second author: Frank-Thomas Bopp<br>Germany<br><br>**Title:** Individual Cooperation Plan – a tool for reducing the use of coercive care<br><br>First author: Jeanette Jonsson<br>Second author: Eva Andreasson<br>Third author:Nils Sjøstrøm<br>Sweden.<br><br>**Title:** The benefits of sensory modulation on levels of distress for consumers in a mental health emergency setting<br><br>First author: Eimear Muir-Cochrane Australia | **Title**: Safe care - changes in education of psychiatric nurses in Czech Republic<br><br>First author: Tomas Petr<br>Second author: Blanka Novotna<br>Czech Republic<br><br>**Title:** What are the perceived effects of and satisfaction with clinical supervision amongst psychiatric nurses availing of clinical supervision in Saint John of God Hospital<br><br>First author:Ciaran Cuddihy, Ireland<br><br>**Title**: Nurse-patient therapeutic relationship as a cornestone for creating safety culture<br><br>First author: Aljosa Lapanja, Slovenia : | |

**11.30-12.30** **Keynote 5: Katarina Nolsøe – The search for beeing**
**Chair: Jana Mortensen**

**12.30-13.30** **Lunch and poster visit**

**13.30-14.30** **Keynote 6: Thomas Kearns – Patient and Nurse Safety**
**Chair: Aisling Culhane**

**14.30-15.00** **Fellowship Award – Martin Ward**

**15.00-15.30** **Coffee Break and poster visit**
**15.30-16.30** **Workshop, Symposium and Concurrent Sessions**

| **Høllin – room number 1** | **Klingran – room number 2** | **Dansistovan – room number 3** |
|---|---|---|
| SYMPOSIUM | CONCURRENT | CONCURRENT |
| **Chair:** Henrika Jormfeldt | **Chair:** Evanthia Sakellari | **Chair:** Susanna Flansburg |
| **The quiet superiority of the medical sickness model in mental health system cultures is a hindrance: Critiquing and co-producing peer support for safer settings in the NHS**.<br><br>First author: Nicky Lambert<br>Second author: Sarah Carr<br>England | **Title:** Experiences of people living with mental illness in Switzerland – a qualitative inquiry<br><br>First author: Peter Wolfersberger,<br>Second author: Sarah Thomas<br>Third author: Sabine Hahn<br>England<br><br>**Title**: Evil, psycho monster killers? Who do the cameras and fences that typify high sure forensic care really protect?<br><br>First author:Terez Burrow:<br>Second author: Jonathon Slater<br>United Kingdom | **Title**: Safe settings for women experiencing distress labeled as borderline personality disorder<br><br>First author:<br>Teresa McDonagh, Ireland<br><br>**Title:** Emotional safety in mental health nursing<br><br>First author: Nina Kilkku, Finland<br><br>**Title:** Secondary traumatizations among nurses working in different psychiatric settings.<br><br>First author:<br>Jacqueline Rixe<br>Germany |

| Skálin 1 – room number 4 | Skálin 2 – room number 4 | |
|---|---|---|
| CONCURRENT | CONCURRENT | |
| **Chair:** Anna Simonsen | **Chair:** Tomas Petr | |
| **Title:** The experience of safety in a world open to virtual intrusion<br><br>First author: Colman Noctor, Ireland<br><br>**Title:** Young adults living with mental illness and their family in community mental health settings.<br><br>First author: Lisbeth Kjelsrud, Second author: Hege Skundberg Kletthagen Third author: Øyfrid Larsen Moen Norway<br><br>**Title:** The experiences of family-centred care intervention from the perspectives of health professionals in a community mental health care setting in Norway<br><br>First author: Hege Skundberg-Kletthagen: Second author: Agneta Schroder Third author: Øyfrid Larsen Moen | **Title:** The experience and impact of the 1-2-3 Magic parent training programme on the family unit from mothers' perspectives: A narrative analysis.<br>First author: Stephanie Louise Allen<br><br>**Title:** Health professionals in primary mental health care, their perceptions of quality of care and attitudes towards working with families.<br><br>First author: Oeyfrid Larsen Moen<br>Second author: Agneta Schroder<br>Third author: Hege Skudberg-Kletthagen<br>Norway<br><br>**Title:** Family perceptions about the needs of people with enduring mental health problems within an inpatient setting<br><br>First authoar:Andrew Walsh<br>Second author: Ana Barrios<br>United Kingdom | |

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| **16.45-17.45** | **Keynote 7: Michael Schulz** "Safety aspects within the scope of person – centered care and self – determination in psychiatric settings"<br>**Chair**: Henrika Jormfeldt |
| **17.45-18.00** | 𝄞 |
| **18.15-20.15** | **GA Horatio** |

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# 12 th.May

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| 9.00-10.00 | **Best Poster Award**<br><br>**Keynote 8: Geoff Brennan "Safewards – user friendly culture change?"**<br>**Chair: Martin Ward** |
| 10.00-10.15 | 𝄞 with Recovery Band |
| 10.15-10.45 | Coffee Break and poster visit |
| 10.45-11.45 | **Keynote 9: Jason Leitch** "Using Quality Improvement across the Public Sector: Lessons from Scotland"<br><br>**Chair: Thomas Petr** |
| 12.00-13.00 | Ending ceremony<br>Best Poster will recieve an award |
| 13.00 - | Excursions ad libitum: https://www.greengate.fo/en/conferences-incentives/upcoming/safe-settings-10-12-may-2018/excursions/ |
| 19.00 - | Galladinner at Hotel Føroyar<br>Registration for Galla Dinner at Green Gate |

*Mindfullness*

## Poster presentation

**Living in a paradox: Experiences in adults, who as children, lived with at least one parent experiencing mental illness in a small-scale society**

First author: Kristianna Dam, RN, MScN, Assistant Professor, Nurse, Master of Science in Nursing, Phd-student,
The University of Faroe Islands, Tórshavn, Faroe Islands; kristiannad@setur.fo
Second Author: Durita Joensen
Third author: Elisabeth O.C.Hall

**Less Known Environments: Child and Adolescent Psychiatric Clinics**

First author: Nareg Dogan, Lecturer, M.Sc. and psychodramatist, Bezmialem University, EyÙp Merkez Mahallesi, Istanbul, Turkey; leylak73@yahoo.com

**International Comparisons _ A focus on Quality in Psychaitric Care**

First author: Agneta Schroeder, Norway, Professor, Psychiatric nurse, PhD, NTNU, Gjøvik, Norway; agneta.schroder@regionorebrolan.se
Second author: Lars-Olov Lundqvist

**Regulation of medical treatment as a group course for adolescents diagnosed with ADHD**

First author: Sanne Lemcke, Clinical Nurse Specialist
RN, MPH, PhD
Aarhus University Hospital, Centre for Child and Adolescent Psychiatry
Risskov, Danmark; sanne.lemcke@ps.rm.dk
Second author: Sanne Hermansen

**Education programme in Psychiatric Nursing in Denmark. Education that makes a difference in practice**

First author: Ina Mie Rasmssen, Education Manager, Master in clinical nursing. Master of educational Management, Region Hovedstadens Psykiatri, Copenhagen, Denmark; ina.mie.rasmussen@regionh.dk
Second author: Gitte Nørreskov Vase
Third author: Jane Lorentzen

**Equine-assisted therapeutic interventions among individuals diagnosed with schizophrenia**

First author: Henrika Jormfeldt, Senior lecturer, Associate professor in Nursing Science, School of health and welfare, Halmstad. Sverige; henrika.jormfeldt@hh.se

Second author: Ing-Marie Carlsson

**The antecedents of violence and suicide on inpatient mental health units: A literature review**

First author: Neil Crowhurst, Senior Staff Nurse and Postgraduate Research Student, RMN, BSc (hons), PG Dip, Research MSc candidate , Health Service Executive, Waterford Mental Health Services / Waterford Institute Technology, Waterford, Irland; neil.crowhurst@hse.ie

**The effect of psycho-education techniques in self-esteem and in patients' quality of life following long-term injection treatment**

First author: Evanthia Sakellari, assistant professor, Technological educational institution of Athens, Greece; Sakellari@teiath.gr

Second author: Eleutheria Bougonikolou,

Third author: Katerina Pikouli

**The role of peer support in mental health care**

First author: Wendy Van Londersele, Lector, RN, MScN, Erasmushogeschool, Brussels, Belgia wendy.van.londersele@ehb.be

Second author: Ann Claeys

**What are the experiences of the relatives with regard to being partners in the cooperation with the Psychiatric department, and what are the significant factors that would contribute to them having an active role in the recovery of their family members?**

First author: Óluva Poulsen, RN, BSc,Out-patients nurse, Cognitive treatment

National hospital, Psychiatric center, Tórshavn, Faroe Islands; lsolupo@ls.fo

Second author: Birgit Andersen

Third author: Elsebeth Andreassen

**Psychiatric nursing in Slovakia**

First author: Martina Dubovcova, Principal nurse, Mgr., PhD., University Hospital in Martin, Psychiatric clinic, Slovakia; m.dubovcova@gmail.com

Second author: Julia Molnarova

**The Quiet Room at Acute Psychiatry Unit 1: Patients« experiences**

First author: Hanna Rajala-Koenkytö, Ward manager, RN, M.Sc., PSHP, TAYS, PitkŠniemen sairaala, Finland; hanna.rajala-koenkyto@pshp.fi

**Regular contact prevents suicide**

First author: Randi Borðoy, RN, BSc Out-patients nurse, intensive follow-up nurse, Nationalhospital, Psychiatric center, Tórshavn, Farore Islands; lsranbo@ls.fo

Second author: Morid Johannesen

**Defining the genetic etiology of Alzheimer«s disease in the Faroe Islands**

First author: Marjun Restorff, Leader of Dementia Clinic, RN BSc, Landsjúkrahúsið, Tórshavn, Faroe Islands; lsmaire@ls.fo

Second author: Maria Skaalum Petersen

**The implementation of the Safewards Model in the Acute Psychiatric Ward**

First author: Teija Tynjälä, Specialist Nurse, Master of Health Care, Pirkanmaa Hospital District, PO BOX 2000, Tampere, FI-33521; teija.tynjala@pshp.fi

**Implementation of EWS (Early Warning Score) at the ward and in the community care**

First author: Eydna Iversen Lindenskov; eydna.lindenskov@ls.fo

Second author: Lisbeth Vang ; Third author: Jana Mortensen, Birgit Andersen og Ingun Durhuus.

# Abstracts (Authors in alphabetical order)

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### The experience and impact of the 1-2-3 Magic parent training programme on the family unit from mothers' perspectives: A narrative analysis

Stephanie Louise Allen, Child and Adolescent Mental Health Nurse, BSC Honours Mental Health Nursing, Dr H H Stewart Medical Scholarship in Psychiatric Nursing,MSC by Research, Rocherstown Rise, Cork, Ireland; 109667075@umail.ucc.ie

**Abstract:** The aim of the study was to explore the perspectives and experiences of parents who participated in a parent training programme including its impact on the family unit. Methods: A purposive sample of 6 mothers over the age of 18 years of children with ADHD who completed a 1-2-3 Magic parent training programme were invited to take part in this qualitative study utilising a narrative inquiry approach. Data were collected by means of individual in-depth, semi-structured interviews, which were audio recorded and transcribed. The interviews were conducted approximately one year following the commencement of the programme. A narrative inquiry approach further informed analysis of the interview data. The findings from this study reveal two major narrative constructions of experience: 'parent training as more heroic in the story' and 'parent training as less heroic in the story'. Overall, mothers viewed the parent training as an intervention which was variable in that the implementation of parent training techniques appeared to impact the family and relationships with one another, both positively and negatively at various and contrasting stages throughout the process. In general, mothers described the parent training as a beneficial intervention, but it was not without its flaws. They described it as helpful for their family when used in conjunction with other parent training courses and mediations such as psychotherapy. Conclusion and Implications: Insights from this study are anticipated to contribute to a better understanding of what can be done to develop a comprehensive treatment approach to allow all families to avail from parent training programmes, whilst also ensuring that there are no undesirable/ unintended consequences for family members. This client centred insight will provide future researchers/nurses with the opportunity to put in place measures recommended directly from service users.

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### How to Prevent Coercion in Danish Mental Health Care - A Longitudinal Cluster Study

Jesper Bak, Research manager, RN, SD, MPH, PHD, Mental Health Center Sct. Hans, Roskilde, Danmark; jesper.bak@regionh.dk; Second author: Jacob Hvidhjelm; Third author: Lene Lauge Berring

**Abstracts:** Background: The use of physical coercive measures, e.g. mechanical restraint (MR), in mental health care, is a major infringement on the psychiatric patients autonomy. MR can cause physical and mental harm but may be necessary to avoid putting an individuals health at risk. The nursing staff is tasked with protecting the life and health of, not only the individual patient, but also other patients, and relatives. A situation can occur in which staff is obligated to use concurrent force, and occasionally MR, if a patient is very aggressive, violent, self-destructive, or suicidal. Although MR is legal, the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment concluded, in three reports from 2002, 2008, and 2014 that no medical justification exists for applying instruments of physical restraint to psychiatric patients for days, and that doing so amounts to ill treatment. Following, the Government in Denmark decided in 2014, that the number of MR should be halved before 2020. This decision lead to development, and implementation of an array of more or less, evidence based preventive initiatives. In some regions, the development has been positive, reducing the numbers of MR episodes, but we do not know which initiatives has created this development. Aim: To examine which MR preventive factors/initiatives reduces the number of MR episodes. Methods: This study is designed as a nationwide, longitudinal, cluster, cross-sectional survey of preventive initiatives implemented in psychiatric units and the corresponding numbers of coercive episodes. Questionnaires will be used to gather data on preventive initiatives from the unitsÍ once a year, over a period of three years, and data on coercive episodes will be accessed from the national database on coercion. A linear mixed-method model will be used to estimate the longitudinal effect of implementing the specific preventive initiatives. Results: The only data collected at the time of the conference will be from 2016, so descriptive data will be presented, together with data on coercive episodes. Conclusions: Will be presented at the conference

## De-escalation a social and collaborative process in mental health care settings

Lene Lauge Berring, Leader of Center of Relation and de-escalation, Post.doc., RN, MSCn, Ph.D. Mental Health Services Region Zealand, Slagelse, Danmark; lelb@regionsjaelland.dk; second author: Anne Winkel; Third author: Louise Krossing Hansen

**Abstract:** Background: Coping with and understanding violent and threatening behaviour in mental health care settings is a challenging, but integral part of a caregivers job. If not handled well, such situations can result in staff and patient injuries, and they can lead to stereotype representations of patients as divergent, unpredictable and dangerous. Therefor there is a need to avoid violence and implement de-escalation approaches. Aim This interactional workshop discusses and reflects upon how sustainable de-escalation practices can be implemented in mental health care settings and to how increased knowledge about de-escalation can create safe settings and reduce violence and use of coercive measures. Methods: The workshop includes a presentation of how four studies contributed in developing a de-escalation strategy: 1) an integrative literature review on de-escalation, 2) a critical discourse analysis, examining how mental health workers constructs accounts of aggressive events, 3) a multiple case study, exploring threatening and violent situations resolved without the use of coercive measures, and 4) a co-operative inquiry that investigated how practical knowledge about de-escalation was achieved and transformed in a psychiatric intensive care unit. The research methods used were ethnographic, including focus group interviews, participant observation ethnographic field notes and our process notes and summaries.Findings: The workshop exemplifies the study findings such as how mental health workers in collaboration with each other, generated knowledge about how to break the vicious circle, and instead help the patients to solve the problem by means of a structured de-escalation process including two phases: The acute phase (crisis) and the re-establishing trustworthiness phase. They transformed this knowledge through role-play in action learning sessions and they developed a sustainable learning program which included the patients as active participants .Conclusion: A social and collaborative understanding of de-escalation practises can foster shared problem solving in violent and threatening situations. This approach offers a turning point in violence management: instead of blaming each other, members of staff will look at their experiences with curiosity. They lift de-escalation to a professional level where they understand their experiences theoretically and thus become aware of avoiding power struggles. The workshop contains: *A short introduction to the de-escalation strategy and the research behind: *Implementing de-escalation - challenges: *A presentation of the learning program: *Participants is divided into groups. Each group discuss the de-escalation strategy and the transferability

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## Safe settings for persons with schizophrenia or other long-term psychotic conditions by improving physical health

Marjut Blomqvist, RN, Doctoral student, RN, MSc, Halmstad University, School of Health and Wellfare, Halmstad, Sweden marjut.blomqvist@hh.seConcurrent

**Abstract:** It has been shown that people with schizophrenia and other long-term psychotic conditions have poor physical health outcomes. Several years reduced life expectancy compared to the general population has been documented. People with schizophrenia have higher risk for lifestyle-related diseases such as cardiovascular diseases and Type 2 diabetes and have also a large number of physical health needs that affect their everyday life and be not recognized in health care settings. The causes of poor physical health are complex and have been shown to be due to unhealthy habits, related to the psychiatric disease itself, medication and to organizational shortcomings. A high mortality rate among people with schizophrenia of all age groups has been demonstrated, and argued that people with schizophrenia have not been able to make the same advances in longer lifespan as the rest of the population has done. Also lower levels of well-being and quality of life have been showed. It is important to change this and provide safe setting so that the lifespan of people with schizophrenia would not stay shorter that the rest of the population. Our first qualitative study enabling healthy living among people with severe mental illness in outpatient services described some of the factors that persons with schizophrenia (N=16) experienced as supporting their health. Such important factors that can support healthy living were for example everyday structure, it was important for participants that they had reflected on the life events that gave motivation to healthy living. Support from others was essential for participants. Our second study was quantitative and aimed to explore the relationship between self-rated health, sense of coherence, cardiovascular disease risk and BMI among people with schizophrenia. This study did not found any

correlation between these subjective and objective measurements, but a strong correlation between self-rated health instrument SHIS and sense of coherence instrument SOC 13. This sample showed alarmingly high BMI and over half of the participants were exposed to moderate to high risk of CVD

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### Regular contact prevents suicide

Randi Borðoy, RN, BSc Out-patients nurse, intensive follow-up nurse, Nationalhospital, Psychiatric center Tórshavn, Farore Islands lsranbo@ls.fo; Second author: Morid Johannesen

**Abstract**: Research shows that there is a need for suicide preventive measures to reduce the number of suicides. The number of suicide attempts is multiple times that of committed suicides and preventive measures might change this trend. The purpose of this dissertation is to study whether regular contact with patients at risk of attempting suicide will prevent committed suicides or suicide attempts. Measures taken in other countries were studied and compared to the Faroese society.In order to test the hypothesis, a literature review was conducted using a hermeneutical methodology. Four articles were chosen, three of which were studies about suicide prevention using home visits, phone conversations and text-messages, and one that only studied phone conversations with patients. The results were analysed using a meta-analysis, which is often used for quantitative studies.It was concluded that preventive measures that involve contacting the patient immediately after the suicide attempt reduce the number of patients that repeat suicide attempts. The studies all suggest that taken measures must seek out and follow up on patients and persist in their attempts to do so. In addition, it is important that steps taken are flexible, offer individual treatment and is focused on solving problems.

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### Predictors of outpatient nursing service use from people with mental health problems in Switzerland

Christian Burr, Clinical Nurse Specialist, research fellow, MScN, RN, University Hospital of Psychiatry, Berne, Berne 60, Switzerland christian.burr@upd.ch; Second author: Renato Farcher; Third author: Dirk Richter

**Abstract:** Introduction: Despite the high social and economic costs and the increasing use of psychiatric health services, people with a mental illness often do not receive the appropriate treatment. To understand the use of mental health services, research about predicting factors represents an important step. Since social factors play a very important role in recovery from mental illness, outpatient care should be a key component of the psychiatric health system. Many studies indicate its positive influence on patients recovery processes. Nursing plays a major role in these services. However, there is a gap of research focusing on nursing in community mental health services in general, and more specifically in the Swiss health system. The aim of this study is to identify predictors to the use of community nursing services by people with mental health problems in Switzerland and will be the first to deal specifically with the use of the nursing services in Switzerland. Method and material. For this study, we used the data from the Swiss Health Survey (SHS) 2012 from the Federal Statistical Office (FSO). The sample consists of those who indicated during the survey that they had used psychiatric treatment in the last 12 months. The dependent variable is the utilization of community nursing services over the past 12 months. The selection of predisposing factors takes place in two steps. The first theorized selection step was inspired by Andersen's Behavioral Model of Health Services Use. It is a widely-used theory concept for determining the factors of the use of health care. In a second statistical step, the variables identified in the first selection step were selected with logistic regression models and the application of the AIC backward selection method according to statistical characteristics. In the end, we calculated the significance and the effect size of the selected variables with a multivariate logistic regression model. Results.The first selection step resulted in the selection of 32 variables. Eleven of them rested after the logistic regression selection. Preliminary results show the following factors influencing the community nursing service use: Age, female as gender, unemployed, chronic disease, taking psy-medication, frequency of doctor visits, informal help use and some aspects of social support. At the conference, we will present the final results and an in-depth discussion and conclusions

## Evil, psycho monster killers? Who do the cameras and fences that typify high sure forensic care really protect?

Terez Burrow, Deputy Modern, Matron, MSc NHS Leadership, Nottinghamshire Healthcare NHS Foundation Trust, Rampton Hospital, Notts, United Kingdom terez.burrows@nottshc.nhs.uk; Second author: Jonathon Slater

**Abstract:** Within the popular and mainstream press high secure patients are often perceived as sick, evil monsters and are invariably referred to as ïpsycho-killers (News UK, 2017). The external image of HS contexts does little to challenge these perspectives with multiple layers of physical security evident to the outside eye (Tilt et al., 2000). Widely reported independent inquiries into high secure care failings further serve to perpetuate and popularise stigma, emphasising dangerousness (Fallon et al 1999) Yet what is it like to provide nursing care in high secure contexts? Are the popular representations and perspectives deserved? Who is it whom the fences and security really keep safe? What are the challenges nurses in high secure care contexts experience and which skills and abilities best equip them to meet these challenges? Deeper scrutiny of content within independent reports reveals myth busting data establishing high secure patients as some of our society most vulnerable people, persecuted by an ignorant society and invariably rejected by an uncaring health service, factors inextricably linked to any subsequent offence. Indeed, the latest Care Quality Commission report into UK high secure care provision identified that the most pressing systemic recovery need stated by high secure patients was to feel safe and that it was nursing staff who most engendered this feeling (CQC, 2017). This included feeling safe from a persecutory and rejecting public. Yet little is written academically or anecdotally about the capabilities, roles, responsibilities and impact of the high secure mental health nurse (Timmons, 2010) or what it is that they do that so ably engenders a sense of safety in people who may never have previously felt safe (Byrt at al., 2008). In this session two experienced high secure psychiatric nurses demystify high secure healthcare using case examples, independent inquiry outcomes and their own reflections. They then offer a summary of the literature on the role of mental health nurses in high secure care settings before offering a framework of competencies derived from their own observations and practices.

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## The benefits of sensory modulation on levels of distress for consumers in a mental health emergency setting

Eimear Muir-Cochrane Chair of Nursing (Mental Health) BSc Hons RN (University of London), Grad Dip Adult Ed. (UniSa), MNS (Deakin), PhD (RMIT) FACMHN, Credentialled Mental Health Nurse. Professor. College of Nursing and Health Sciences Flinders University, Adelaide, Australia eimear.muircochrane@flinders.edu.au

**Abstract:** This paper reports a quality improvement research project exploring the benefits ofoffering sensory modulation (SM) within a mental health emergency setting for consumersexperiencing distress during a psychiatric presentation.Method: Seventy-four consumers with a mental-health presentation reported on their sensorymodulation use experiences during their stay in a South Australian tertiary teaching hospitalemergency department. An evaluation form was used to document use of SM items, self-reporteddistress pre- and post-sensory modulation use, and other consumer experiences.Results: Consumers used between one and five sensory items for a median duration of ~49minutes. There was a statistically significant reduction (at $p < .001$) in self-reported distress postsensory modulation use, and consumers also reported that use was helpful, distracting, calmingand assisted in managing negative emotions and thoughts.Conclusions: The research demonstrates the potential value of sensory-based interventions inreducing behavioural and emotional dysregulation in an emergency setting whilst also promoting consumer self-management strategies.

**The antecedents of violence and suicide on inpatient mental health units - A literature review**

Neil Crowhurst, Senior Staff Nurse and Postgraduate Research Student RMN, BSc (hons), PG Dip, Research MSc candidate Health Service Executive, Waterford Mental Health Services / Waterford Institute Technology Waterford, Irland neil.crowhurst@hse.ieor neil.crowhurst@yahoo.com;

**Abstract:** Instances of violence and suicide/attempted suicide within inpatient mental health services are commonly seen as a simple manifestation of mental illness. Research evidence would also suggest, however, that these incidents can occur in the absence of mental health problems or are at least partly influenced by other contextual factors such as environment or clinical intervention. Although varying elements may be identified as the root cause/s in each case of violence or suicide, it is clear that the experience and aftermath of these events can have an overwhelming impact on the future health and wellbeing of patients, families and professionals alike. Reducing the occurrence and impact of these frequently traumatic events therefore remains a key objective for mental health services, who for some considerable time have tried to control the risk of violence and suicide through maintaining safe inpatient unit environments and identifying the sources of such incidents. Despite these ongoing efforts internationally there does not appear to be any abatement in the frequency and seriousness of reported events. This narrative literature review examines and discusses the multi-factorial nature of violence and suicide antecedents on mental health inpatient units. The review categorises antecedents under four main headings namely patient-related factors; staff-related factors; organisation/environment related factors and externally related factors, raising a number of themes for further discussion. These themes incorporate the main review findings including the strong interplay between each category and the sub-categories within each area; the difficulties in designing research to pinpoint the causes of violence and suicide; the extent of violence/self-violence as a concept on inpatient units and the potential for negative counter-effects in controlling risk, often stemming from efforts to care and manage increasingly diverse patient groups.Reducing the frequency and impact of violence and suicide requires nurses, other professionals and organisations to reflect on and continually modify the services they provide. There is also scope for wider collaboration within communities to address the risks of mental health violence and suicide, alternatives to inpatient treatment and the continuing recovery approach in mental health care.

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**What are the perceived effects of and satisfaction with clinical supervision amongst psychiatric nurses availing of clinical supervision in Saint John of God Hospital?**

Ciaran Cuddihy, Clinical Supervisor, Msc Acute Mental Health/Diploma Clinical Supervision/Diploma Dementia, Saint John of God Hospital, Stillorgan, Dublin, Irland ciaran.cuddihy2@sjog.ie

**Abstract**: Clinical supervision is generally viewed as being supportive of psychiatric nurses and has been associated with reducing stress, preventing burnout, affording time for reflection and thereby improving patient care. Benefits have been described as being formative (enabling professional development), normative (permitting self-evaluation and comparison with others) and restorative (supportive) (Proctor, 1987).In 2017 Saint John of God Hospital Nursing Department implemented clinical supervision by appointing a clinical-supervision supervisor. The objectives are to support nurses in their professional roles.This proposed quantitative study seeks to statistically evaluate the effectiveness of and satisfaction with clinical supervision of those nurses receiving clinical supervision in the Hospital in its current 2017 iteration. The study will use the Manchester Clinical Supervision Scale (MCSS-26) a tool with established psychometric properties designed to measure satisfaction with and effectiveness of clinical supervision. Data returned will be analysed statistically (descriptive and inferential) using SPSS Version 24 a statistical software tool. Participants will be recruited from a convenience sample of qualified permanent nurses working in Saint John of God Hospital. They will be contacted by e-mail by the departmental secretary on behalf of the Principal Investigator with a Letter of Information explaining the study. Questionnaires will be made available one week later at numerous locations. Participants may then opt to complete questionnaires and drop them into sealed boxes. Complete anonymity is assured.The study evaluates the perceived satisfaction with and effectiveness of clinical supervision in the nursing department and will be of interest to hospital management, to other services considering clinical supervision for nurses and to the Order in appraising this innovation.

**Living in a paradox: Experiences in adults, who as children, lived with at least one parent experiencing mental illness in a small-scale society**

Kristianna Dam,RN, MScN, Assistant Professor, Nurse, Master of Science in Nursing, Phd-student, The University of Faroe Islands, Tórshavn, Faroe Islands Kristiannad@setur.fo; Second author: Durita Joensen; Third author: Elisabeth O.C.Hall

**Abstract**: Estimated 23 % of children live with at least one parent experiencing mental illness. These children are exposed of different degrees of emotional, physical and psychosocial challenges. They need health care professionalÍs attention and care. The children are carrying a caring burden, concealing the parental illness, they are stigmatized, bullied and take special attention to parental health and well-being. Aim: To explore adult childrenÇs experiences (n=11) living with a parent experiencing mental illness mentally ill parent in the small-scale society Faroe Islands. Method: The approach is qualitative; data were collected by individual interviews and analyzed using content analysis. Result: Being a child of a parent experiencing severe mental illness in a small scale society was found to be a paradox enlightened in three categories: intergenerational help and caring, barriers understanding parental illness and everybody knows everybody. Discussion: The study findings are discussed in the context of caring theories, gossiping and suffering. Children who live with a parent experiencing mental illness in the small scale society as well as their families are indispensable carers for the parents. But because everyone knows everyone in the small scale society, the families are exposed to the prejudice and gossip of others regarding mental illness, which results in that they conceal the illness as an effort to protect the ill member. Because of the prejudices and lack of openness in the small scale society the childrensÇ situation are invisible to others, and they doÇnt get the nessecary support and they are sad, lonely and suffering. Thus, not only the family but also the mental healthcare providers did not take care of the children of parents experiencing mental illness.

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**Less Known Environments: Child and Adolescent Psychiatric Clinics**

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**Abstract:** Beyond just ensuring patients safety by protecting them from all internal and external adversities, psychiatric clinics are environments that meet patients psychiatric and basic self-care needs and aim to deal with their problems by determining these problems nature. They are influential on the therapeutic effects of treatment modalities, development and satisfaction of patients. Patients' perceptions and experiences about treatment setting can negatively affect their participation in treatment process. Some of the patients hospitalized in acute psychiatric clinics have negative thoughts and feelings due to nurses' non-therapeutic approaches. The separation of children and adolescents from their primary caregivers in hospitalization period can make them more sensitive. Therefore, the ability to establish a trust relationship with them is of great importance for the effectiveness of psychiatric care and treatment. Caregiver professionals should be more sensitive to prevent negative effects of treatment applications leading to re-traumatize patients, so that their improvement and recovery are not adversely affected during the hospitalization period. There are few studies regarding the perceptions and experiences of children and adolescent psychiatric patients regarding psychiatric clinics. In a study of children aged 15-17 in Australia conducted to examine their hospitalization experiences in psychiatric clinic; it was found that children had both negative and positive feelings for their hospitalization experiences and demanded more interaction with the clinical nurses. They also emphasized that they wanted to be more informed about the hospitalization process, and felt they needed more space and activity in the clinic. Hospitalization experiences of adult psychiatric patients has been extensively researched in the literature. However, there is a very limited number of studies on the experiences of children and adolescent psychiatric patients hospitalized in psychiatric clinics. Further, no relevant study on the subject was observed in Turkey. Treatment, evaluation and approach to diseases in children and adolescents significantly differ from adults. It is believed that studies on understanding the experiences and perceptions of child and adolescent psychiatric patients about the clinical environment, treatment and care will enable us to understand the factors affecting their treatment adherence and to develop the most appropriate care models for them.

## Psychiatric nursing in Slovakia

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**Abstract:** The healthcare system in Slovakia falls under the competence of the Ministry of Health. In Slovakia there are state and private health care providers.Everybody can choose a GP who usually provides basic health care and can refer a patient to an appropriate specialist for further medical examination.There are two types of health insurance: public health insurance (statutory or voluntary) and individual health insurance. Public health insurance covers the following benefits in full or to a partial extent, depending on specific conditions: diagnostics, treatment and preventative care, outpatient and inpatient care including rehabilitation, compulsory vaccination, provision of drugs, medical aid and dietetic food, spa treatment can be provided upon the recommendation of a doctor, where such care is an inevitable component of the treatment procedure. Psychiatric nursing is cinderella between medical disciplines and takes lack of interest from politicians and public. Slovak Chamber of Nurses and Midwives in Slovakia has 49 000 members dividend inti 58 regional chambers. Memebship is voluntary. Psychiatric section has about 420 members and since 2010 is full memeber of HORATIO. Main activities of psychiatric section are organizing conferences, congresses, workshops, working on clinical guidelines, participating in clinical research and publishing study materials. In the future create more participation with other countries from middle and eastern Europe in psychiatric nursing

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## Screening women for birth depression in a small-scale society - the significance of feeling safe for the outcome of the screening

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**Abstract:** Birth depression is a common condition following childbirth. If untreated, birth depression can leave women and their children at risk of a wide range of unfortunate consequences. Many women, however, go untreated partly because the health care system lacks the ability to detect them, and partly because the women themselves do not seek help. They feel ashamed and fear the moral condemnation of others. In an attempt to increase identification rates, screening has been proposed as a method. Screening has the potential to identify people at an early stage of illness and in several countries, including the Faroe Islands, screening is now offered to all women in the early postpartum period. However, an International debate concerning the appropriateness of screening as a detection strategy has been going on for some time, initiated by a certain study, that explored womenÍs acceptability with screening. The study revealed unfortunate results, as the women expressed feelings of being overexposed by the screening and feeling unsure, what the screening results were going to be used for. Therefore, some women deliberately lied when filling out the screening test, to make results look better. The aim of this study was therefore to explore how women in the Faroe Islands experience to be screened for birth depression, taking into account the multiplex relational structure that characterizes the Faroe Islands as a small-scale society, with people linked together in a huge network of overlapping connections, making women potentially more vulnerable to disclosure than in large-scale societies, and thus more reluctant to tell the truth on the screening scale. An interview study was carried out with 12 Faroese speaking women, who had been screened for postnatal depression 2 months prior to the interview. Purposeful sampling was used selecting participants based on differences in screening scores, geographic location and age. The collected data was analysed using deductive content analysis, making it possible to compare findings from the Faroe Islands with findings elsewhere. All women and especially women with high scores or vulnerable issues preferred the screening to take place in their own homes. The home was described as a safe environment to reveal personal issues. None of the women felt too exposed by the screening. Rather, they felt relieved to be given the opportunity to discuss personal issues with a health professional in a safe environment.

### Preventing Discharge of Psychiatric Inpatients into Homelessness

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**Abstract:** The hospital discharge of psychiatric patients into homelessness remains a prevalent issue despite detriments to the individual and community (Forchuk et al., 2008; Gaetz, 2012). Lack of stable housing can result in long-term consequences including exacerbated health problems, costly health care service use and hospital readmission (Munn-Rivard, 2014). Finding safe housing for these individuals is imperative to their recovery and transition back to the community. The ñNo Fixed Addressî version 2 (NFA v.2) tests the efficacy of a potential best practice program that finds safe housing for inpatients, preventing discharge into homelessness. Forchuk et al. (2006, 2008) developed a system that streamlines housing and social supports using on-site access. Housing Stability Workers and Ontario Works are brought directly into hospital settings, allowing inpatient access via drop-in or by appointment. The program allows Canadian Mental Health Association Housing Workers on-site access to a database of available rental units, and Ontario Works staff are given access to an income support database. A 4 time-point (discharge, 1 month, 6, month, 12 month), repeated measures design will be conducted. Descriptive and statistical analysis will be sought where necessary. Data will be collected from administrative sources through the Institute of Clinical Evaluative Sciences, local hospitals, and shelters. Qualitative data will be obtained from participants and staff via interviews and focus groups. Preliminary findings of the NFA v.2 project will be discussed. In a previous pilot project (Forchuk et al., 2006) found that all 7 participants randomly assigned to the intervention remained housed at 3 and 6 monthsÍ follow-up, while individuals in usual care were unhoused or had entered the sex trade. In a following scaled-up phase of the project involving 219 acute psychiatric clients and 32 tertiary care clients (Forchuk et. al, 2008), 92.5% of those who accessed the service and were at risk of homelessness were connected with affordable accommodation. If successful, this strategy could be implemented to address the provincial priority of preventing homeless discharge. Locating safe housing for psychiatric patients may have a positive impact on treatment, rehabilitation, and the system as a whole. The findings of this project may offer safe policy alternatives for the prevention of homelessness for at risk individuals

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### Smart Homes: Health Care Technology to Assist Recovery for Psychiatric Inpatients

Cheryl Forchuk, Beryl & Richard Ivey Research Chair in Aging, Mental Health, Rehabilitation and Recovery, RN, PhD, Parkwood Institute, London, Canada cforchuk@uwo.ca; Second author: Dr. Jeffrey Reiss

**Abstract:** The hospital discharge of psychiatric patients into homelessness remains a prevalent issue despite detriments to the individual and community (Forchuk et al., 2008; Gaetz, 2012). Lack of stable housing can result in long-term consequences including exacerbated health problems, costly health care service use and hospital readmission (Munn-Rivard, 2014). Finding safe housing for these individuals is imperative to their recovery and transition back to the community. The No Fixed Address version 2 (NFA v.2) tests the efficacy of a potential best practice program that finds safe housing for inpatients, preventing discharge into homelessness. Forchuk et al. (2006, 2008) developed a system that streamlines housing and social supports using on-site access. Housing Stability Workers and Ontario Works are brought directly into hospital settings, allowing inpatient access via drop-in or by appointment. The program allows Canadian Mental Health Association Housing Workers on-site access to a database of available rental units, and Ontario Works staff are given access to an income support database. A 4 time-point (discharge, 1 month, 6, month, 12 month), repeated measures design will be conducted. Descriptive and statistical analysis will be sought where necessary. Data will be collected from administrative sources through the Institute of Clinical Evaluative Sciences, local hospitals, and shelters. Qualitative data will be obtained from participants and staff via interviews and focus groups. Preliminary findings of the NFA v.2 project will be discussed. In a previous pilot project (Forchuk et al., 2006) found that all 7 participants randomly assigned to the intervention remained housed at 3 and 6 monthsÍ follow-up, while individuals in usual care were unhoused or had entered the sex trade. In a following scaled-up phase of the project involving 219 acute psychiatric clients and 32 tertiary care clients (Forchuk et. al, 2008), 92.5% of those

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### Moving a Rhetoric of 'Trauma Informed Practice' into Mental Health Nursing Reality

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Abstract: When we think of safe settings one would think that mental health services provide suchsanctuary for people with mental health problems and indeed professionals working in thesesettings. Many services users and mental health nurses have for generations argued that on thecontrary, mental health services often equate with unsafe settings. Contemporary evidence supports those experiences, arguing that mental health settings and in particular approaches tocare increase the likelihood that service users will experience re traumatisation and nursesthemselves are at risk of experiencing vicarious trauma (Read 2013; Mac Gabhann et al. 2017).A fast emerging discourse in mental health literature, policy and practice aspirations provides anew impetus for nurses to reconsider the effect of their practice on selves and service users, anddevelop ways of implementing trauma informed practice (Sweeney et al. 2016). Policydepartments and professional bodies are beginning to take positions on trauma, with nursing noless imagining relating to others in safer more therapeutic ways than traditional approaches indanger of perpetuating trauma.This workshop having explored the rationale for taking a trauma informed approach will examinethe principles of Trauma Informed Practice as they relate to nursing. Participants will thenengage in a facilitated exercise that draws out how these principles can be incorporated intoevery day practice.

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### An Emancipatory Approach to Personal Growth and Community Connection

Liam Mac Gabhann, Associate Professor, Mental Health Practice DrNSci, MSc, BSc, RPN. Dublin City University Dublin, Irland Recovery College; liam.macgabhann@dcu.ie; Second author: John Kelly

**Abstract**: In February 2016 Ireland, a small group of partners from service user, Dublin City University & mental health services backgrounds successfully bid for seed funding from the regional Office ofthe Nursing & Midwifery Services Directorate to establish a regional Recovery College over a twoyear period. The Region included North Dublin and counties Louth and Meath. This was aresponse to what has been a persistent drive in Irish Mental Health Services to createorganisational change towards recovery orientated service delivery (HSE 2016). Pilot sites in Ireland have been guided by The Centre for Mental Health (Perkins et al., 2012a) guidelines oneffective organisational change. Core to the required outcomes of such change has been thedevelopment of regional recovery colleges (Perkins et al., 2012b).The Dublin North, North East Recovery College (DNNERC) has been providing college education tothe community for a year and a half now. The Recovery College provides empowering andtransformative recovery-based education to anyone with an interest in Mental Health Recoveryin the community. Taking a co-production approach, the work of the recovery college isinformed by a combination of recovery, adult learning, and community development principles.The purpose of DNNERC is to provide an emancipatory recovery process outside of mental healthservices, yet in partnership with them and other community stakeholders.Whilst recovery education is being rolled out in mental health services, it does so within aninfrastructure governed by health services institutional norms that are in contrast to anemancipatory educational philosophy. Therefore the college provides a transcendent space forpeople to explore possibilities around recovery, not necessary enabled within a services culture.This presentation having located Recovery Colleges in the overall scheme of mental healthservice provision and compared DNNERC to recovery colleges governed still by mental healthservices; will demonstrate diversity and synergy between mental health services and the collegethat enhance the recovery experiences of students. The college has undergone its first yearevaluation and a summary of the findings will demonstrate the effectiveness of this college inimproving personal and social recovery experiences of college participant

## The Sigmaringen model to reduce seclusion and restraint in psychiatry

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**Abstract:** During the past years, a number of activities both in research and clinical practice to reduce seclusion and restraint in psychiatry can be noted. Numerous interventions have been described in the literature and were tested in psychiatric hospitals. Nevertheless, it has been shown that the sole unsystematic propagation of these successful solitary interventions undoubtedly does not show through in the clinical practices and the measureable effects still remain low. Based on this background the idea of creating a practically relevant manual came up to combine already successful concepts in reducing seclusion and restraint in psychiatry. Based on this background, the idea of creating a practical relevant manual combined the already successful concepts in reducing seclusion and restraint in psychiatry. A multimodal intervention program was developed that has been evaluated in the Clinic of Psychiatry, Psychotherapy and Psychosomatic Medicine at the SRH Hospital at Sigmaringen from August 2016 to July 2017. The Sigmaringen model connects the scaffolding of six core strategies (US) with the safewards model (UK) as well as the DGPPN guidelines regarding measurements concerning aggressive behavior (GER). These concepts were adapted to the conditions of a psychiatric clinic at a general hospital in Germany. The primary goal is to reduce the frequency and duration of mechanical restraint and seclusion. Interventions at the levels of clinical administration and organization, continuous analysis of data, talent management of the staff in terms of a central team spirit, the implementation and continuous policing of preventative measurements as well as structured debriefing techniques at various levels were implemented. During the intervention period from August 2016 to July 2017, a significant reduction in cases of seclusion and restraint were observed. Altogether, 565 cases were treated at the acute psychiatric ward of which only 14,4% compared to the previous 20.4% of the cases had undergone restraint or seclusion. An analysis of the intervention was conducted in which the frequency and duration of restraint and seclusion before and after the intervention was evaluated. In addition, an analysis about aggressive assaults was conducted. The results of our study that is considered a pilot study shall be presented in a concurrent session / oral presentation

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## Have you seen My PAL? Physical Achievement Log: A physical health tool for people with severe mental illness (SMI) pilot study in collaboration with the National Forenssic Mental Health Service

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**Abstract:** A physical health tool for people with severe mental illness (SMI) pilot study in collaboration with the National Forensic Mental Health Service The physical health of individuals with severe mental illness (SMI) is a cause for growing concern. Individuals with a SMI have a reduced life expectancy of up to 10-15 years due to physical ill health, in comparison to the general population. The physical health care of this cohort has been described by Gray (2012) as a Ôsilent scandalÕ. My Physical Achievement Log (My PAL) has been introduced as a collaborative project, on a pilot study basis, in a residence within the National Forensic Mental Health Service. My PAL is a service user-held empowerment tool which is conveniently pocket-sized. My PAL is an adapted physical healthcare passport specifically designed for individuals with SMI. It acts as a prompt to the individual for attending the GP or other health related appointments. It includes a checklist of the physical health markers which if neglected may contribute to declining physical health for this cohort. This checklist is completed by the individual with support provided by the primary nurse. An action planning section is included wherein issues identified pertaining to physical health can be addressed by the individual in collaboration with the key nurse. This plan is incorporated into their individual care pathway. My PAL is an educational tool used in partnership with the service user to promote active participation and personal responsibility for physical health. It is recovery orientated and embraces service user involvement. It may help improve the physical outcomes of these individuals.Aims/Objectives: The aim of My PAL is to improve the physical health outcomes of those with SMI and to empower individuals with SMI in their physical health care. A further aim is to develop My PAL as a tool to assist mental health nurses in physical health promotion.- Utilise HSE Model of Change (2008) to introduce MY PAL into clinical practice- Empower individuals with SMI to become active participants within their physical health care.- Improve the Ôhealth literacyÕ of mental health nurses and individuals with SMI in the forensic mental health serviceDescription of the initiative: Key stakeholders were

identified to facilitate the introduction of My PAL. The project lead made a presentation to forensic mental health nurses. 12 week pilot study was commenced.Outcomes/Results: This initiative has recently commenced, audit results and evaluation will available in May 2018.

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**Examine the possible correlation between violence and compassion satisfaction and fatigue and experience with traumatic life events among mental health professionals working in a forensic department**.

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**Abstract:** Violence and threats of violence is a widely recognized problem, particularly in Mental Health services. No research is available investigating the possible relationship between compassion satisfaction, compassion fatigue and experience with traumatic life events with experienced violence and threats of violence. A better understanding of these complex relationships may offer insight into a way to reduce violence and threats of violence on forensic psychiatric wards. Aim: This study aimed to assess the possible correlation between violence and compassion satisfaction and fatigue and experience with traumatic events in life.Methods: A Cross-sectional design was used to survey health professionals at a mental health center in Denmark. The survey included questions regarding exposure to violence and threats, demographic questions, the Professional Quality of Life: Compassion Satisfaction and Fatigue v. 5 tool (Stamm, 2010) measured compassion satisfaction, and compassion fatigue (secondary traumatic stress and burnout) and Brief Trauma Questionnaire (BTQ) (National Center for PTSD, 1999).Results: Two hundred and seventeen mental health professionals (nurses, nurses-aid, psychiatrist, psychologist, social works, physiotherapist and occupational therapist) returned their questionnaires giving rise to a response rate of 74.8%. Sixty-seven percent of the respondents were females and 25.8% reported to have been exposed to violence during the last 12 months and 71% have been exposed to threats of violence. Descriptive statistics demonstrate that 33.2% of the staff showed low Compassion satisfaction, 30.4% high Burnout, and 28.1% high Secondary traumatic stress. There were no significantly differences between sex and age in regards to be exposed to violence and threats of violence. Compassion satisfaction were significantly lower among nurses (p=.036) and nurses-aid (p=.034) compared to the two other groups (the group of psychiatrist, psychologist, and the group of social works, physiotherapist and occupational therapist), there were no significantly differences on Burn-out and Secondary traumatic stress. Implications: Mental health professionals working in a forensic setting experience a considerable amount of stress suggesting psychological risk to the staffÍs wellbeing and possible impairments to patientsÇ care. Our results pointes in a direction, but more research need to be done on this matter

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**Individual Cooperation Plan - a tool for reducing the use of coercive care**

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**Abstract**: To be treated with coercive measures is often experienced as frightening, traumatizing and stigmatizing. An Individual Cooperation Plan (ICP) has been developed based on an earlier study investigating patientsÕ experiences from involuntary care (Andreasson & Skerseter, 2012). Method: Development work that aims at implementing the ICP and evaluating the patients experience of it. ICP contains an assessment of the coercive care the patient has been submitted to, an Early Warning Signs Action Plan and Participation in psychiatric hospital care. (PPHC) (The instrument will be described in detail during the presentation). The collection of data began at the Department of Psychotic Disorders in Gothenburg, Sweden, and is still going on. Results: The results so far show that 143 patients have assessed the coercive care and that 54 % of them thought that it would have been possible to avoid coercion. They also give examples of how this could be done. 84 patients have worked out a PPHC. 445 patients made an agreement based on the Early Warning Signs Plan. It has been activated 36 times. Admission to hospital has been avoided in 19 cases. Conclusion: The results suggest that by making the patient into a co-worker the ICP contributes to less coercive care.Keywords: Coercive care, participation, Individual Cooperation Plan.

**Equine-assisted therapeutic interventions among individuals diagnosed with schizophrenia**

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**Abstract:** Persons diagnosed with schizophrenia are not sufficiently offered health promotion interventions, notwithstanding their increased risk of bodily ill health. Physical activity is found to improve health and decrease psychiatric symptoms although, there is a challenge to motivate and increase physical activity in people with schizophrenia and innovative evidence-based treatment interventions are needed. The aim was to systematically review studies concerning equine assisted interventions among individuals diagnosed with schizophrenia. The findings of the six included articles indicate that therapeutic equine assisted interventions could be beneficial for individuals with severe mental illness such as schizophrenia or schizophrenia like disorders.

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**Emotional safety in mental health nursing In different health care settings, practitioners are often facing emotionally burdening situations**

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**Abstract:** This is even more common in mental health nursing since practitioners are working in close relationships with patients and clients using their own personality. To be able to understand other one's experiences and to be able to help practitioners need to be empathetic and responsive. However, at the same time this provides a risk for practitioners' own wellbeing emotionally and physically. Risk of compassion fatigue and secondary traumatization is high especially in long-term therapeutic relationships and in the situations where person is exposed to emotionally traumatic experiences. Today in mental health care settings one specific patient group are the forced immigrants who often describe severe traumatic experiences. These kind of experiences might not be familiar to practitioner before and they could be hard to hear and comprehend -and yet at the same time it is extremely important to be able to listen these experiences. Concept of resilience is often used to describe the psychological flexibility and possibilities to survive in extreme and challenging situations, a concept which is used more and more also in mental health nursing. Resilience could be seen as one of the characteristics needed from practitioners to cope with their own emotional and physical responses and ensure their own wellbeing. In this presentation, preliminary findings of a review literature on the subject are described and discussed to give some ideas also for audience to support their own emotional safety and wellbeing Đand by that also supporting the wellbeing of the clients with traumatic backgrounds.

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**Young adults living with mental illness and their family in community mental health settings.**

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**Abstract**: Young adults (18-25) living with mental illness may be less prepared to care for themselves, because of their mental illness and need support from family in everyday life. Family care in most community mental health settings focuses on the person living with mental illness or their families separately. Community mental health settings must shift from deficit- or dysfunction-based family assessments to strengths- and resiliency based family intervention. The theoretical framework of the Family Centered Support Conversation Intervention (FCSCI) tested in this study originates from the Calgary Family Assessment and Intervention Model and Illness Belief Model. Three family-centred support conversations between young adults living with mental illness, their family and health care professionals in a community mental health setting intend to increase support in everyday life by creating a context of change, facilitate new beliefs, meanings, and opportunities in relation to the family`s present concerns. Aim: To describe young adults living with mental illness in Norway and their familyÍs variety of experiences regarding participation in FCSCI. Method: A qualitative descriptive and explorative design with a phenomenographic approach. Family interviews (n=10) post-intervention will be carried out in February 2018. Analyzed with phenomenography to investigate qualitatively different ways families perceive, understand, experience or think about FCSCI. The families will be offered participation in the intervention December 2017/January 2018. Inclusion criteria patient: young adults between 18-25 years old living with mental illness

in 9 community mental health settings. Exclusion criteria: cognitive impairment, psychotic state, alcohol or drug dependence. Inclusion criteria family members: adults who are defined by the young adult to be in the family. Exclusion criteria cognitive impairment, psychotic state, alcohol or drug dependence. Family members will be asked verbally and in writing to participate in the interview. Approval given by the Data Protection Official of Research (NSD),June 2017, Ref: 54696.Preliminary findings on families living with mental illness in community mental health settings in Norway, and their experience of participating in the Family Centered Support Conversation Intervention (FCSCI), will be presented at the conference.

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### The experiences of family-centred care intervention from the perspectives of health professionals in a community mental health care setting in Norway

Hege Skundberg-Kletthagen, ass. professor, PhD,RNT, Mental health nurse, Faculty Medicine and Health Science, University of Science and Technology (NTNU) Gjøvik, Norway; Hege.kletthagen@ntnu.no; Second author: Agneta Schrøder; Third author: Øyfrid Larsen Moen.

**Abstract:** In Norway, young adults living with mental illness who are in need of outpatient mental health care are by law entitled to professional support by mental health services in the municipalities. Mental illness not only affects the young adult, but also family members' everyday lives. A family-centred care focus may involve and acknowledge family members as a resource in treatment and care, and acknowledge the reciprocal relationships. The aim of the study is to describe health professionalsÍ experiences of having conducted Family Centred Support Conversation Intervention (FCSCI) in a community mental health care setting.Method: A qualitative descriptive and explorative design with a phenomenographic approach. Individual interviews with health professionals (n=20) will be carried out in January and February 2018. Inclusion criteria are: minimum three years bachelor degree in health or social science, working in municipalities and minimum one year of work experience, working with young adults from 18.25 years suffering from mental health problems. Autumn 2017, the health professionals participated in a two-day education programme on the Family Centred Support Conversation Intervention (FCSCI) and thereafter conducted three conversations with families, using this. The health professionals will be asked verbally and in writing about participation in the interview. Approval was given by the Data Protection Official for Research (NSD), August 2017. Ref: 54962 Findings: The FCSCI has not previously been used in Norway. Preliminary findings on the health professionalsÍ experiences of having conducted FCSCI, will be presented at the conference.

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### The Quiet Room at Acute Psychiatry Unit 1: Patients« experiences

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**Abstract**: The Acute Psychiatry Unit 1 in Pitkniemi Hospital (Nokia, Finland) has 14 beds for adult psychiatric patients. The Unit treats and examines patients with mood disorders. For many of the patients, anxiety, depression and self-injurious behavior are core symptoms. Many of the patients have a trauma history. The duration of hospital treatment at the Unit is usually between two and three weeks. The idea to The Quiet Room was inspired by the Sensory Rooms and by the Safe Wards Model. In the Safe Wards Model one of the interventions is the Calm Down Methods. The Calm Down Methods can be used in the Quiet Room. The Quiet Room is always open and the use is voluntary. The aim is to offer patients tools that they can apply in their self-treatment to relieve their anxiety and easy distress. The room is decorated with half-wall-sized nature photos on the wall, comfortable armchairs and a fatboy. The lights in the room are dimmable. In the room patients can for example listen to music (classical music, nature sounds, relaxation tapes), make relaxing exercises, use a weight blanket, use a massage chair, use a stress ball, read, watch pictures or just be in silence. Patients can make choices of what they want to do during they stay in the room. In the Unit there has been collected data via a questionnaire the patients can fill after using the room. 92 % (n=23) of the patients who used the Quiet Room and answered the questionnaire found the room to be helpful and easy distress. In the room the patients found the most helpful massage chair, foam roller, listening to music, a fatboy and relaxing exercises. Before using the Quiet Room 44% (n=11) of patients had moderate anxiety and 36% (n=9) had severe anxiety. After using the Quiet Room 16% (n=4) of patients had no anxiety and 52%(n=13)

had mild anxiety. Based on patients« experiences The Quiet Room helps patients coping with anxiety. The Quiet Room and items within the Quiet Room can be used in teaching patients strategies for coping with anxiety. Patient«s feedback will be obtained to continue exploring ways to further develop of the Quiet Room within the unit.

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### Adolescent mental well-being - assessment and perceived supportive elements

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**Abstract**: Assessment and support of mental well-being is integral for promoting mental health, rather than focusing merely on mental illness or absence of it. Moreover, the elements that support mental well-being should be known in order to promote mental well-being and a fulfilling and safe life of all adolescents. The aim of the study is to describe secondary school pupilsÍ mental well-being and factors related to their mental well-being, and further to describe adolescentsÍ perceptions about the elements they find supportive to their mental health. The ultimate goal is to draw the attention to mental health professionals on planning and implementing empowerment interventions among adolescents for a safe school setting. The sample (n=114) consisted of secondary school pupilsÍ aged 12-17 (mean age 14.22). The Warwick-Edinburgh Mental Well-Being Scale (WEMWBS) was used to measure mental well-being. Adolescents perceptions of the elements supporting their mental health were explored by conducting a content analysis of their responses to an open-ended question. Results show that the mean score of WEMWBS was 47.51 with 13.2% of the adolescents scoring high on mental well-being and 70.2% reaching the middle level. A statistically significant positive relation was found between mental well-being and perception of family relationships. Mothers educational level was related to adolescents mental well-being also. In regards to what adolescents perceive as supportive elements for their mental health, these included: loved ones, feeling of security and certainty, enjoyable and relaxing leisure time, good physical status, expectations from the society (such as good education) and specialized care. To conclude, mental health professionals need to plan and implement mental health promotion interventions in order to empower adolescents and ultimately support a safe school setting. The present study found several elements that can have an impact on adolescents mental well-being which should be taken into account when planning mental health promotion interventions. Further research is needed on the impact of empowering health education interventions aiming at mental well-being which promote school safe settings

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### The quiet superiority of the medical sickness model in mental health system cultures is a hindrance

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**Abstract:** Critiquing and co-producing peer support for safer settings in the NHS. "Peer support programmes are becoming ubiquitous in mental health with specific approaches to peer support arising from the service user and survivor movement, such as advocacy, focusing on aspects of risk and safety by supporting individuals to speak up and challenge poor care or harmful practice. Peer support is also key to effective Open Dialogue teams which consist of practitioner and peer therapists and need staff to work co-productively as allies and as equals.Output from the conference offers insights from service users and survivors working in peer support provision and research, along with their practitioner colleagues, progressing the debate about the role of experiential knowledge alongside practice knowledge in delivering innovations in support and questioning the efficacy of the traditional psychiatric system. This presentation will give highlights from the conference proceedings relevant to the theme of peer support and co-production for safer settings. Co-production in mental health is about the transformation of power and control. It is about facilitating not fixing; doing with, not doing do and it requires new roles and relationships which challenge traditional, institutional role boundaries in mental health. It entails using expertise and experience not just relating to your relative position in the mental health services. This can result in difficulties and tensions, particularly for staff, when working co-productively in teams with peer support workers. Research shows that sharing experiences and finding common ground, identifying

and defining problems and exploring and designing solutions together is how co-production between frontline practitioners and service users can work.It is vital to consider practice lessons and steps towards transformative co-production in mental health to address some of the challenges both peer workers and practitioner workers face in working as allies to develop safer settings.

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## The role of the nurse in charge in the prevention and management of aggression in acute psychiatric units

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**Abstract:** Aim: To determine the role played by the nurse in charge (NIC) in the prevention and management of aggression specific to the acute mental health setting.Description:A mixed methods approach, specifically an exploratory sequential design of two phases was used. Phase 1 used the leaders shift report to collect quantitative data over a sixty day period on the level of activity in each unit, such as rule breaking, use of containment and nurse in charge responses to aggression. The attitudes towards containment questionnaire (Bowers et al. 2004) used to ascertain the attitudes of the NICs towards psychiatric containment measures. Phase 2, involved qualitative group interviews with a sub sample from phase 1, a sample of junior nurses and a sample of senior nurses from each unit to augment and contextualise data obtained in phase 1. Outcomes/Results: Overall the study supports the fact that aversive staff attitudes and interaction styles can contribute to aggression and subsequently containment. Positive staff attitudes intertwined with a preventative approach to aggression can result in reduced levels of aggression containment. However, these findings are contingent on the role of the NIC who effectively creates the climate within which staff and patients reside together in the acute psychiatric unit. Values are important. The NIC creates norms that can encourage or discourage maladaptive practices, containment measures and empathic responsible nursing practice. The role is challenging, requires an organisational connection and requires resilience in those who undertake it. Implications for psychiatric/mental health nursing: The NIC must have a core set of attributes for them to be effective in their role The findings of this study have significant implications for the organisation of care in acute psychiatric wards, development of staff and most importantly the promotion of care that connects with patients on a human level. Furthermore, engaging with this staff group may offer real possibilities at the front line of care delivery for reductions in seclusion and restraint practices

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## Safewards: The Irish experience

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**Abstract:** Safewards is a contemporary theoretical framework which aims to reduce conflict and containment in acute mental health care. The model is a consolidation of a substantial research programme undertaken by Prof Len Bowers and colleagues in London. Originating in the City Model which was described by Bjorkdahl et al 2013 (p.401) as an important and influential theoretical nursing framework, the Safewards model has been implemented in acute mental health services across the globe. Recently the model has been shown to be effective in reducing seclusion rates in Australia (Fletcher et al 2017). This presentation shares the experiences and evaluation of the first area in Ireland to implement the model. Aims/Objectives of the project: To implement the Safewards Model in acute psychiatry of a discreet health board area in Ireland in a phased way. To evaluate the experience of implementing the model in practice from the following perspectives: Containment- Patient perspectives - Staff perspectives. Description of the initiative and associated research: The model is currently being introduced in a phased way to acute inpatient psychiatric services of a discreet health board area in Ireland. An inclusive change management approach has been adopted with ownership of the initiative remaining with the unit. A qualitative research project is underway to capture the staff and patient experience of the introduction of the model- data will be available for the conference- currently going through ethics processes. This presentation will outline the Safewards Journey for the Mid West, the implementation process to date, the challenges experienced and the practice and research outcomes to date. In particular the presentation will highlight how the model contributed to the therapeutic environment following implementation

## Nurse-patient therapeutic relationship as a cornestone for creating safety culture

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**Abstract:** Creating and improving a safety culture is one of the fundamental guidelines of any healthcare organization. Developing and maintaining a culture of safety in psychiatric nursing has a very important role in all nursing interventions in which a nurse needs to have a wide range of knowledge and ethical norms. The creating a culture of safety involves the interweaving of architectural, technological, organizational, systematic, professional and personality factors. The main tool in the hands of a psychiatric nurse is therapeutic communication with which nurse creates a field of trust in which the therapeutic relationship grows and develops and thus acts therapeutically in the true sense of the word. The intensive psychiatric care unit is an environment that nurses together with colleagues co-create and strive to be a positive therapeutic milieu in which patients as well as employees will feel safe. When discussing the (un)safety of the treatment of an aggressive patient, the use of de-escalation communication techniques is a therapeutic approach that directly ensures safety in urgent situations, so it is very important that nurses are continually educated in that direction. Analysis of incident reports and analysis of predicting scales for aggressive behavioural (OAS / BVC) at the University Psychiatric Clinic Ljubljana show a high level of safety culture in which the intervention of a therapeutic communication is the most common intervention in the area of prevention and nursing intervention after the incident. The safety culture of the organization must spread vertically and horizontally, with all employees having to add their share to a complex mosaic of constructing a proactive safety culture, in which it works towards the timely identification of risk factors and the implementation of preventive safety interventions. The basic prerequisite for internalising the organization's safety culture is their personal sense of work safety, which the state and the organization must provide at the system level with a policy of open reporting of incidents, impunity, systemic analysis of incidents, providing adequate human resources, continuous education and, above all, encouraging positive and open communication among employees, which is a cornerstone of good interpersonal relations and consequently a positive work and safety milieu at the level of individual departments, units, centres and organizations as a whole.

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## Regulation of medical treatment as a group course for adolescents diagnosed with ADHD

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Abstract: There are positive experiences with conducting regulation of medical treatment as a group course for adults with ADHD, whereas there is only very limited experience with similar initiatives among adolescents with ADHD. Many studies have shown that group counselling and treatment of adolescent patients with other chronic diseases is an effective way to help them focus on their own coping with the disease. Adolescents are in a process of detachment from the parents, and a medication group can be a forum where they are given the opportunity to practise being responsible for own treatment. A project has therefore been initiated with the aim: "To investigate whether young patients with ADHD can benefit from inclusion in a patient group with peers, where regulation of medical treatment is in focus". Method: A group course is offered to adolescents 14 and 18 years old newly diagnosed with ADHD / ADD. Following the diagnosis and initiation of medical treatment where parents participate, the adolescent is included in a group. The group meets every other week for one and a half hours, and approximately six patients attend each group. The groups are run by nurses, who have experience with young people and the specialty. The sessions in the group include a round where the young people tell about the current status of their medical treatment and have the possibility to get comments from their fellow patients and guidance from the nurses. Each session is followed by individual control of blood pressure, heart rate, and weight. The adolescents join the group six times, and one month after the last session, the course ends with an individual consultation.Contact with the parents is maintained by their participation in an individual consultation halfway through and at the end of the course. They are also kept up to date on changes in the medical treatment via e-mail, as well as they are able to contact the group leaders throughout the course.The project is evaluated using questionnaires that measure the effect on ADHD symptoms, quality of life, and the experience of participating in the group course. The young people and the parents are all asked to evaluate the course.Results: The project is on-going, and the first results from the

project are expected to be presented at the Horatio conference in May. Already after the first meetings, we have received positive comments from parents about the impact of the course on their children.

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### Implementation of EWS (Early Warning Score) at the ward and in the community care

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Abstract: It is known that people with severe mental health illnesses, have a life-ecxpectancy span that is 15-20 years shorter than other people. It is found that 60 % of this excess mortality is because of physical health co-mobidity. It is primarily cardiovascular diseases and certain metabolic diseases. The "Patient Safety Program for Mental Health" involves working with several clinical bundles, but in the following we focus on the physical health bundle, more precisely on the implementation of Early Warning Score at the wards and in the community. Assesment of porblem and analysis of its causes: Involvement of staff on the wards: doctor teaching how to use EWS at the ward and the importance of it being done. Teammembers of the Quality Improvement team, working on the ward, constantly reminding their colleagues to conduct EWS both on admittance of every patient and every Monday as planned. Ward leaders consistently asking staff to remember to conduct EWS and working on resistance in the staff group.Feedback from the patients and carers. Building a system for EWS screening in the homes of the patients and working on the resistance of the frontline nurses. Data collection is an important part of the improvement work. At the board meetings, ongoing data-analysis is presented to follow the process in order to make improvement. Interventio: Ensure patientfeedback and carers feedback. Building and continousiously improving the system. Involvement of the staff both in terms of ideas of how to implement the EWS tool and to make PDSA´s in order to refine the system and speed the implementation. A multi-professional improvement team has been established, including users, carers, frontline staff and management. The project uses the "Model for Improvement" (MFI), which is a powerful tool for improving patient safety. There are three seperate processes: 1) On admission to the ward – from september 2015. 2) Follow up every week during admittance – 1) On admission to the ward. Effect of changes: We can see the impact of the implementation of EWS in several aspects of the treatment and care. There is a increased focus on somatic problems and it has helped us identify several smaller and some serious problems that we otherwise might have overseen

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### Multiprofessional Skill- and -Grade - Mix in Forensic Psychiatry: Which Mixture is necessary to provide person centered treatment in a safe environment?

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**Abstract:** Multidisciplinary teamwork is the basis for almost all psychiatric work. In Switzerland we don`t have any framework for stuffing in forensic psychiatry. Therefore it seems useful to know which professional group fulfills which task and to which extend. Aim: In order to achieve a safe and person centered treatment in forensic psychiatry a clear multidisciplinary framework should be developed.Methods. A Multi Moment Analysis (MMA) was conducted whose data reflect the real work situation. The results are matched against international treatment guidelines and their inherent stuffing requirements. In doing so gaps are made visible and therefore allow finding creative solutions for bridging these gaps.Results. Preliminary results of the MMA show that nurses play a pivotal role in providing a safe and trustworthy environment for the patients. The full results will be available until Spring and will be presented at the conference.Discussion Based on the results of the MMA and the analysis of the guidelines it will be discussed if, how and to which extend guidelines inform the necessary multidisciplinary stuffing and what kind of research is further needs

## The role of peer support in mental health care

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**Abstract**: Together with the evolution of recovery-oriented mental health care, there is an increasing interest to include peer support. This study aims to answer the following questions: (1) How is peer support in mental health care organised at micro-level in Flanders and (2) which peer-supported interventions at micro-level are useful and acceptable according to healthcare providers? Methods: To provide quantitative results about which kind of activities are useful for peer support, a questionnaire based on concepts of recovery-oriented models, was completed by 98 healthcare providers from three psychiatric hospitals in Flanders. Qualitative data on the current role of the peer workers were provided via semi-structured interviews with twelve head nurses of three psychiatric hospitals. Results: Sharing their experience was found to be the most useful activity of the peer workers. In addition, activities that contribute to a better coping, self-image and social integration, listening to psychological problems and discussing the patients psychological condition were perceived as useful. Currently, peer support is used within the whole hospital, with peer workers not being linked to a specific ward. During group sessions patients talk about their problems and ask questions to the peer workers. In addition to providing information and advice, peer workers teach the module recovery to patients. Hence, they are not part of the multidisciplinary team but are assigned an advisory role outside the team. On the other hand, the liaison between the healthcare worker and the patient was found to improve via peer support. Discussion: None of the 29 activities was found acceptable and useful by more than 75% of the respondents, suggesting some resistance towards peer support from healthcare providers.The practical implementation of peer support in the hospital raises questions on workload of the peer workers. Conclusions: In daily practice peer support is mainly employed during group sessions. Sharing their experience, supporting coping, self-image and social integration are perceived als acceptable and useful. Based on these results, it is recommended that a peer worker is assigned to each hospitalization ward, with a specific defined role and in consultation with all partners involved. Future studies could include additional activities as well as argumentation why a certain activity is assigned acceptable and useful or not.

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## Attendees perspective on the quality in community-based day centre services for people with psychiatric disabilities

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**Abstract**: Community-based day centres in Sweden are well-established arenas for psychiatric rehabilitation. Little is, however, known of the attendees perception of the quality of the service provided. Therefore, the aim of the study was to describe and investigate the quality of community-based day centre services for people with psychiatric disabilities. A sample of 218 attendees (44% females) between 18 and 71 years old in 14 community-based day centre services in Sweden completed the Quality in Psychiatric Care Daily Activities (QPC-DA) instrument. The results showed that people with psychiatric disabilities perceived the quality of community-based day centre services as high and 87% perceived the overall quality as satisfactory. The highest ratings were found in Encounter followed by Support, Daily Activity-Specific, Secure Environment, Participation, and the lowest quality was found in Secluded Environment dimensions of the QPC-DA. Most notably, quality of service was rated higher by those with lower educational level, had waited shorter time to attend the centre, and had better mental and physical health. However, particularly aspects of a secluded environment and participation (information) may be areas with potential for improvement. In conclusion, the results adhere to the importance of occupational balance, with periods of rest/privacy during the time at the centre.

## Safe settings for women experiencing distress labeled as borderline personality disorder

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**Abstract:** As we move into a new era of trauma-informed mental health service provision we, as nurses, ought to consider our role in working to ensure the psychological and emotional safety of service users within the therapeutic relationship. Understanding the individuals lived experience, having empathy, building trust, demonstrating unconditional positive regard, being self-aware and practising in a person-centered way are key elements in establishing and maintaining a therapeutic relationship that offers safety and containment for individuals in distress (Dziopa and Ahern, 2008). For women who experience distress labeled as borderline personality disorder (BPD) the literature reveals, from both the perspectives of service users and of nurses, a multiplicity of issues that potentially impact upon the therapeutic relationship. Adopting a feminist lens three key issues are explored here (i) diagnosis and stigma (ii) lack of acknowledgement of trauma context and (iii) attitudes of mental health practitioners. Since BPD was first introduced into the Diagnostic and Statistical Manual of Mental Disorders (DSM-III) in 1980 the DSM perpetuates the notion that BPD is more common, by a ratio of 3:1, in women than in men. However, research points to an equal prevalence of BPD in men and women in the general population (Grant et al. 2008). Shaw and Proctor (2005) argue that BPD is a gendered diagnosis and that symptoms attributed to BPD pathology could be more helpfully understood as a survival strategy for traumatized women.Health professionals have a critical role in working with individuals experiencing distress labeled as BPD whether in a hospital, forensic setting, outpatient clinic, primary healthcare or community setting. However, published literature reveals prevailing negative attitudes, lack of empathy, stigma, reluctance to engage and low levels of optimism for recovery among health professionals related to people diagnosed with BPD. Bonnington and Rose (2014) found two categories of stigma and discrimination endured by people labeled as having BPD; stigma surrounding diagnosis and the BPD label and that related to negative attitudes of staff. They describe incidences of stereotyping, psychological abuse and withholding of diagnosis resulting in exclusion from treatment. Against this background the presenter is prompted to explore and critique the notion of safe settings' in mental health services for women experiencing distress labeled as BPD.

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## Suicide Risk Assessments: Is there evidence from nurses and clients of practice that supports safety?

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**Abstract**: Nursing suicide risk assessments are evidence-based and include key practice guideline recommendations that promote patient safety, by protecting against self-destructive behaviours. Yet research is lacking regarding nursesÍ knowledge of, and care in accordance with, best practices for safe practice settings vis-a-vie risk for suicide. Nor is there evidence of clients experiences of safety in the context of nurses' assessments of suicide risk. Objective: This study investigated evidence of nurses congruence with and patients experience of suicide risk assessment, that supports safe practice, as articulated in recommendations within the Registered Nurses Association of Ontario (RNAO) best practice guideline: Assessment and Care of Adults at Risk for Suicidal Ideation and Behaviour (2009) at a Provincial Centre for Mental Health Care. Method: Post guideline implementation, researchers utilized a cross-sectional, mixed method design. A quantitative, chart audit instrument, developed for this study, measured evidence of congruence within nursing documentation (n = 33). Two qualitative approaches investigated nurses perspectives (n = 13) and patients (n= 9) experiences of nursing practice in suicide risk assessment. Results: Data triangulation revealed practice congruence with and divergence from recommendations specific to suicide risk assessment, and mobilization of resources for safety. Nurses documented assessments of suicide risk and resources mobilized for safe care more frequently (65%) than documentation about cultural safety in relation to suicide risk (10%). Thematic analysis of narratives complemented the quantitative results of inconsistent practice that would support a milieu of safety, as per guideline recommendations. Most enlightening was that both clients and nurses described a dance between them in the decision made by either, to approach the other, regarding suicidality. Client and nurse hesitancy to explore risk may hinder suicide risk assessments and undermine the provision of a safe environment.

Discussion: This presentation highlights the importance of including the clients voices in addition to the clinicians perspectives to expand upon the traditional, objective metrics in understanding the complexity of safe practice settings for suicidal clients.

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### The Canadian Federation of Mental Health Nurses Standards of Practice 4th ed

Elaine Santa Mina Associate Professor, RN, PhD, Ryerson University, 350 Victoria Street, Toronto, Canada esantami@ryerson.ca; Second author: Beth McCay, RN., PhD; Donald Rose, RN., PhD .

**Abstracts**: Provide Practice Competencies for Safe Settings"The Canadian Federation of Mental Health Nurses (CFMHN) scoping study (2014) supported the 4th revision of the standards of nursing practice. The CFMHN standards revision utilized Levac, Colquhoun, and OBriens (2010) scoping framework to guide the revision process. The CFMHN standards committee conducted an extensive review of the academic and grey literature with consultation from mental health nurse, educator, and researcher stakeholders across Canada, via surveys and focus groups. Empirical evidence and mental health nursing expertise informed standard revisions for the current issues, beliefs and values, and the 7 standard statements. Evidence from nurse stakeholder surveys (N = 295) and focus group narratives (N = 2) confirmed grey literature (N = 10) findings that promote safety in the traditional interpretation of settings, as well as the broadest understanding. The beliefs and values that ground the standards of practice were revised to support nurses, as advocates of safe practice environments. In addition, six indicators, across four of the standard statements that direct safe settings, are presented with the supporting references from policy documents, best practice guidelines, standards of practice documents from other jurisdictions, and stakeholder surveys and narratives. Gaps in the empirical literature to direct future research are identified and knowledge mobilization strategies for the revised indicators to improve safety are discussed.

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### Health professionals in primary mental health care, their perceptions of quality of care and attitudes towards working with families

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Abstract: Mental health problems among young people constitute a growing public health problem requiring knowledge and assessable services. Health authorities point out that service users will contribute to more customized health care by being involved in service design, and involvement will also have an intrinsic value. Young adults may need support and involvement from family members to manage the transition and achieve recovery. Mental illness not only affects the ill person, but also family members' everyday lives, health and quality of life. Being in the family of a person with mental illness can accommodate both empathy, love, kindness and support for that person, but also extensive difficulties. Family-centred care conversations may increase coping in everyday family life. Previous research has described health personnel attitudes of involvement of families in psychiatric care as being scares. Quality of care in psychiatric care is described in five dimensions by SchrÀder (2006): the patient`s dignity, sense of security with regard to care, participation in the care, recovery and patient care environment. The quality of psychiatric care in primary health care has scarcely been described previously in Norway. The aim of the presentation is to explore and describe the attitudes of health personnel working with young adults with mental illness towards quality of care and health, and familiesÍ importance in care. Method: Descriptive and comparative quantitative design with 300 health personnel in municipalities across Norway. Instruments used are: The Quality of Psychiatric Care in community health services health professionals (QPC-OPSC) consisting of 30 items and based on the QPC-outpatient instrument by Schrøder et al.(2011), with the items reworded to fit the context of the community outpatient staff. The Families Importance in Nursing Care Nurses attitudes (FINC) measures nurses attitudes towards the importance of including families in nursing care. The data material will be analyzed using both descriptive and comparative statistics. Results: The study will reveal new knowledge of quality of care and health personnels attitudes when working with families. Preliminary results will be presented at the conference

## Influence of staffing levels on the incidence of conflict and use of containment in in-patient psychiatric care

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**Abstract:** Psychiatric wards are an important element in the mental health care of people with risk for acute harm or self harm. Unfortunately, aggression, violence (conflict) and the use of coercion (containment) are still part of psychiatric care. The decisive factor for the proper handling of these situations is the quantity as well as the quality of the employees. Therefore the present study deals with the care situation at acute psychiatric wards in Germay. The hypothesis is that both the number of beds on the acute psychiatric ward and the number of caregivers have an impact on the occurrence of conflict and containment. For this purpose data has been collected in 6 clinics on a total of 12 psychiatric acute wards for 90 days. The Patient Staff Conflict Checklist Ð Shift Report (PCC-SR) was used as the data entry tool. A total of 2026 shifts (early, late and night shifts) were recorded and evaluated (n=2026). That corresponds to a return of 62.5%. The staffing of the stations with nursing staff varied considerably. The results show that both the size of the ward and also the number of caregivers at acute psychiatric wards have a significant impact on the occurrence of conflicts. The results also show that the incidence of conflicting behavior of patients differs both in terms of the wards of the hospitals involved and in the type of service considered. In addition, it can be seen that the extent of closure of an acute ward (i. e. the closed ward or entrance door) and the size of a ward (i. e. the number of beds) have a negative impact on the incidence of inpatient acute psychiatric contexts. The occurrence of conflicting behavior can lead to alien or self-endangerment and to a variety of de-escalating and containment measures. This requires appropriate human resources

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## The experience of safety in a world open to virtual intrusion

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Technology has improved our lives in many ways. There are obvious advances in terms of the ease of access, convenience and mobilization. The technological evolution has been described as the greatest social experiment of our time of which we have very little insight into the potential outcomes, especially from a mental health perspective. In light of the ubiquitous influence of technology on our everyday lives it is reasonable to assume that this evolution is having an impact on our mental lives too. This paper explores the evolution of the technological era and explores ways in which it impacts on how we communicate with our family members, colleagues, peers and ourselves. This paper examines the literature detailing the impact of technology on our lives and identifies areas in which we need to be vigilant when it comes to mental wellbeing.This paper will explore the motivations for why we are drawn to 'check' and share personal information on online social media forums. The paper aims to create a better understanding of how we can stay safe in a virtual world that involves many new and challenging dynamics. The conclusions of this paper are thought provoking not only for mental health nurses, but also service users and the general population.

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## Safe care - changes in education of psychiatric nurses in Czech Republic

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**Abstract:** The process of psychiatric reform in the Czech republic has started in 2013 when Ministry of health signed a Strategy of reform of psychiatric care. This Strategy is a core document which contains the main principles and goals and describes necessary changes in the future. There are many projects regarding the psychiatric reform with different aims and focuses: Deinstitutionalization Multidisciplinary cooperation- New services- Information structure and support These projects are funded from EU. The reform aims to contribute to change the mental health care system from institutional model to community model. Change of the services has to be accompanied by changes in education of professionals. Nurses will need totally different range of

skills and knowledge as well as changed attitudes to provide good quality and safe care to their clients. During the session, we would like to share and discuss our plans for changes in education of psychiatric nurses and analyse some obstacles and threats. We are convinced, that there is no good mental health care without well trained mental health nurses.

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### Witnessing Dying - The therapeutic courage of listening people with a lived experience of mental ilness who are facing death

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**Abstract**: People with a lived experience of mental illness are dying at a much younger age than the general population due to poor physical health. Sadly, litterature exploring their experience of dying is scarce. In addition, dying at a younger age and not fulfilling one´s dreams is a clar indicator for an individual to suffer from `death anxiety´and existential despair. Facing death can also lead to major depressive disorder and increased suicide risk. However, this population of individuals are less likely to be seen in either the mental healht setting or a palliative setting. As mental health nurses what is useful in keeping this vulnerable population safe from despair, isolation and increased risk of suicide? How do we use core skills as mental health nurses to assist the individeal who is facing death? This pater will present the author´s experience as a Nurse Practioner and her PhD research on the benefits of using the mental health nursing skill fo the Therapeutic use of Self and the "Human to Human´relationship in caring for this population. The author has used the combined qualitative methodologies of focuses ethnography and autoethnography to gain a greater understanding of the experience and need of individuals with a lived experience of mental illness who are facing death from a life limiting illness such as cancer of severe heart disease.

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### Workshop Safe treatment of forensic

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**Abstract:** MH outpatients by regular community mental health teams In western countries community mental health teams are increasing (Burns, Fioritti, Holloway, Malm, & Rossler, 2001; Catty et al., 2002; Firn & Brenton, 2015; Killaspy et al., 2006; Vugt, 2015). In the Netherlands for example we see an increase of intensive home treatment teams and flexible assertive community treatment teams. At the same time we are facing a reduction of mental health beds. The duration of admissions has decreased over the last decades as well as the total admissions. This development is in a sense a good one, because people with mental health problems are more able to recover at home and encounter fewer stigmas. But now we are starting to face other problems. In the Netherlands we also see a reduction in mandatory forensic psychiatric inpatient treatment and a reduction in incarcerations. National financial cuts lead to cuts in the police force, cuts in sheltered housing, cuts in supported employment and cuts in day care. Social benefits decreased and rents increased. All together society experiences an increase in people with visible behavioral problems, many times due to social problems and in 50 percent of the cases due to mental health problems (Planije & Hoof, 2016). This all leads to extra workload and extra complex cases for the community mental health teams. To prevent every patient with behavioral problems needs forensic treatment, we think it is necessary to empower the community mental health teams by providing forensic consultation. Working in a forensic assertive community team we developed in cooperation with MH teams a systemical way for forensic consultation in order to empower our colleagues is several community mental health teams. The consultation is based on the principles of the Risk-Need-Responsivity model (Andrews, Bonta & Wormith, 2011; Prins, Skeem, Mauro, & Link, 2015) and can be seen as best practice. During the presentation we will illustrate the consultation for which we use the Short Term Assessment of Risk and Treatability (START; Webster, Nicholls, Martin, Desmarais & Brink, 2006).We show how to organize the forensic consultation systemically, and present some of our results.

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**What are the experiences of the relatives with regard to being partners in the cooperation with the Psychiatric department, and what are the significant factors that would contribute to them having an active role in the recovery of their family members?**

Óluva Poulsen, RN, BSc,Out-patients nurse, Cognitive treatment National hospital, Psychiatric center, Tórshavn, Faroe Islands; lsolupo@ls.fo; Second author: Birgit Andersen; Third author: Elsebeth Andreassen

**Abstract**: Studies indicate that the cooperation with the relatives of psychiatric patients is a significant key factor in the recovery of the patient. Relatives are of the opinion that it is crucial to have this cooperation in patient care and treatment. Therefore, the aim of our dissertation is to study how relatives experience this cooperation with the Psychiatric Department. This has led to the following research questions: What are the experiences of the relatives with regard to being partners in the cooperation with the Psychiatric department, and what are the significant factors that would contribute to them having an active role in the recovery of their family members.To answer the research questions, we have conducted a qualitative study, a focus group interview and used the hermeneutical approach propounded by Paul Ricoeur. We have identified the following themes: *It is significant for the relatives to be seen, heard, valued and have the relevant knowledge: *Relatives often have feelings of insecurity and anxiety: *It is pivotal to view the patient as more than his medical condition viz., as one with resources, strengths, competencies and abilities. We have analysed the results using the theory of W. Antony on Recovery and Rehabilitation, Responsibility and Trust, The Human to Human Relationship Model of Nursing as developed by J. Travelbee, Sense of coherence in the theory stated by A. Antonovsky and the CFAM theory of L.M. Wright & M. Leahey as tools to ensure cooperation with relatives. In conclusion, relatives experience their cooperation with the Psychiatric Department in two ways: some see themselves as having an active cooperation and others claim otherwise. It is significant for families that nurses take responsibility for the cooperation with them, are aware of active roles and responsibilities and create trust in their contact with them. Moreover, it is of pivotal importance that much emphasis is placed on the patients healthy side, resources and opportunities. It is crucial to meet the families where they are, and give families every chance to discuss their insecurities and fears with regard to their family member who is the patient.

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**Informal coercion: a neglected form of communication in psychiatric settings**

Franziska Rabensclag, Scientific Nurse, Dr. Phil, Psychiatric Universities Clinics; Basel. Switzerland; franziska.rabenschlag@upkbs.ch

**Abstract**: Informal coercion is a frequently used form of communication of mental health professionals to influence treatment outcomes. This study investigates the recognition, attitude, and application of different forms of informal coercion by mental health professionals.Method: Mental health professionals of five psychiatric institutions in Germany and Switzerland (N=424) took part in an online survey assessing the recognition of, attitudes towards, and application of different forms of informal coercion.Results

Mental health professionals did not recognize the extent of informal coercion adequately; especially stronger forms were underestimated. Recognition and application of informal coercion was predicted by attitudes toward coercion. Furthermore, there were differences between profession of participants regarding the recognition and application of informal coercion. Conclusions

It is important to realize that the extent of applied informal coercion in therapeutic communication is often not recognized by practitioners, although it might interfere with a sound therapeutic relationship.

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**Education programme in Psychiatric Nursing in Denmark**

Ina Mie Rasmussen, Education Manager Master in clinical nursing. Master of educational Management Region Hovedstadens Psykiatri Copenhagen, Denmark; ina.mie.rasmussen@regionh.dk; Second author: Gitte Nørreskov Vase; Third author: Jane Lorentzen

**Abstract:** Education that makes a difference in practice Education programme in Psychiatric Nursing in Denmark- A Practical higher Education. The education has been under development for the last couple of years, and a new direction has now been set, where the focus of the education is to train postgraduate mental health nurses into practice, not out of practice. The education has a particular focus on strengthening clinical skills

for the benefit of patients and relatives in psychiatry The education is offered in close cooperation with the clinic and management throughout the process. Both in relation to the selection, preparation and implementation of the program. The close collaboration with the clinic helps to ensure that nurses work to develop patient-nursing care for the benefit of the practice they are working on daily. The strengthening of the clinical focus is also of great importance for nurses training a new role as a postgraduate mental health nurse, and the hope is that it helps to maintain the nurses in their department after graduation. You can read more about the new education: www.specpsyksygeplejerske.dk Education program in psychiatric nursing in Denmark Practical higher education The need for specialist nurses in Denmark is increasing, because of the national focus on avoiding coercion. It speaks for a louder amount of nurses with higher psychiatric skills, to handle and be around the patients and to handle the cooperating with relatives and collaborators. The education for nurses in psychiatric nursing has experienced a larger amount of nurses who shows interest in the education

### Defining the genetic etiology of Alzheimer«s disease in the Faroe Islands

Marjun Restorf, leader of Dementia Clinic, RN BSc, Landsjúkrahúsið, Tórshavn, Faroe Islands lsmaire@ls.fo; Second author: Maria Skaalum

**Abstract:** The Dementia Clinic at the National Hospital was established in 2007. This is the only dementia clinic in the country and gets all referral for diagnostic evaluation of dementia.The clinic occupies a consultant in psychiatry, three specially trained nurses and one health care assistant.The diagnoses are established based on the ICD-10 criteria and rely on psysical and psychiatric examination, laboratory test results and CT scan. To check for signs of intellectual impairment the Mini-Menthal State Examination (MMSE) and the Clock Drawing Test is being used while depression is assessed with geriatric depression scale (GDS-15)Method: Data is manly retrieved from the electronic patient journal system, COSMIC but some data was obtained from paper journals, Data reported from 2010-2016. The data collection, leading to dementia database, has been approved by the Faroese Data Protection Agency . Conclusion: Alzheimer«s disease is the most common type of dementia in the Faroe Islands. Women are at higher risk than men. The incidence and prevalence seems to be lower compaired with European contries.

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### Benefits of collaboration in treatment of dementia disease

Marjun Restorf, Leader of Dementia Clinic, RN BSc, Landsjúkrahúsið, Tórshavn, Faroe Islands; lsmaire@ls.fo; Second author: Maria Skaalum Petersen

**Abstract:**The Dementia Clinic at the National Hospital was established in 2007. This is the only dementia clinic in the country and gets all referrald for diagnostic evaluation of dementia.The clinic occupies a consultant in psychiatry, three specially trained nurses and one health care assistant.The diagnoses are established based on the ICD-10 criteria and rely on psysical and psychiatric examination, laboratory test results and CT scan. To check for signs of intellectual impairment the Mini-Menthal State Examination (MMSE) and the Clock Drawing Test is being used while depression is assessed with geriatric depression scale (GDS-15)Method: Data is manly retrieved from the electronic patient journal system, COSMIC but some data was obtained from paper journals, Data reported from 2010-2016.The data collection, leading to dementia database, has been approved by the Faroese Data Protection AgencyConclusion: Alzheimer«s disease is the most common type of dementia in the Faroe IslandsWomen are at higher risk than menThe incidence and prevalence seems to be lower compaired with European contries.

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### From 'Person-centered' care to 'Person-driven' care: Towards a new umbrella term for future mental health care

Dirk Richter, Head of Research and Development, PhD, RN, University Bern Psychiatric Services, Center for Rehabilitation, Bern, Switzerland; dirk.richter@upd.unibe.ch; Second author: Holger Hoffmann

**Abstract:** In many western health care systems, person-centered care was seen as a solution to the massive human rights problems and to the shortcomings of the institution-centered care that dominated post-world war

II care systems. In lieu of institution-centeredness, person-centeredness focused on the service usersÍ needs and moved large parts of the care systems from intramural to extramural settings. In the German-speaking region, the main slogan of person-centered care was Negotiating instead of treatingî (Verhandeln statt Behandeln). Service users were supposed to be partners on what was negotiated, and this approach was the basis for what became known in the wider medical field as Shared decision-making. However, there still is lots of resistance against being treated for mental illness. Many service users acknowledge the changes, but they do not feel to be in charge of their lives when mental health professionals are involved. Rather than receiving care that really satisfies their needs and is in accordance with their preferences, many feel that their needs are defined by professionals and preferences are oftentimes massively ignored. We propose that the terminus ïPerson-centered care needs to be replaced by the terminus ïPerson-driven care. Person-driven care is a much better umbrella term for the most recent developments in the politics and theory of mental health care. Driven by the Recovery approach and by the UN Convention on the Rights of People with Disabilities, it is more and more acknowledged that service users not only should be partners in negotiations on matters of their one life and health but should be decision-makers. Thus, Shared decision-making has to be replaced by Supported decision-making. The notion of professional support for service users life and treatment plans has been outlined in a variety of concepts in psychiatric rehabilitation. ïSupported housing is increasingly seen as an alternative to traditional residential care. ïSupported employment is more and more replacing conventional occupational settings, while Supported education becomes the starting point of preventing social exclusion for people with mental illness. Related concepts are Positive risk taking or user-led medication reduction or withdrawal. In this presentation we will review the state of research on service user preferences and will outline the differences between Person-centered car and ïPerson-driven care in detail.

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### Secondary traumatizations among nurses working in different psychiatric settings

Jacqueline Rixe, Nursing Sientist, M.Sc. Health and Nursing Sciences, B.A. Psychiatric Nursing, PMHN Research Department, Clinic for Psychiatry and Psychotherapy, Ev. Klinikum Bethel, Germany; jajcqueline.rixe@evkb.de

**Abstract**:Safety is an important issue in the context of psychiatric care and includes safety for patients and for staff. Apart from difficult situations which need to be handled by psychiatric nurses (e.g. aggression, violence) and which could lead to primary traumatizations, there is another cause of work-related stress which could endager staffs´safety: secondary traumatizations. These are caused by listening to patients´resports of traumatic evednts and are accompanied by effects which show high similarity to effects caused by primary traumatizations. While this phenomenon was examined globally among various professions anda mong nurses in various working fields ( oncology, hospice etc., Beck 2011), there was only one study focusing on nurses working in psychiatric settings (Magnoulia et al. 2015). Because of potential disrortion and national differences concerning qualifications and occupational characteristics, in 2016 a further study was conducted in Germany. This study examined the prevalence in different psychiatric settings as the majority of identified risk factors (Hensel et al. 2015) cannot be transferred to the work situation of nurses. Methods: The prevalence study utilized a standardized interview which contained sociodemographic questions, an evaluated questionnaire (FST, Daniels 2006) for assessing stress levels referred to secondary traumatizations and questions focusing on different psychiatric setting. With permission of staffs´councils and approval of an appropriate ethics committee participants were recruited all over Germany using a mixed mode desing (online-variant spread all other Germany and a pater & pencil-variant used for selected psychiatric settings). Results: In Total, 1789 PMHNs participated in the study. According to the previously determined inclusion and analysis criteria 1284 data records were analayzed. 74,6 % for all participants (n=1284)hjad suffered from emotional stress caused by listening to trauma details at least once in their work life. 21,3% (n=1284) reached stress levels which were associated with moderate or severe secondary traumatization. Secondary traumatic stress was reported in all psychiatric setting. The study shows some starting points for specific prevention. Study limitations need to be considered (Rixe & Luderer 2017). Conclusins:As safety and patients´health maiantenance is one essential task of nursing, caring for nurses´health regarding secondary traumatizations should be discusses as one essential task for employers. Moreover, the topic should be intergrated in the curriculum of nursing training.

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## The effect of psycho-education techniques in self-esteem and in patients' quality of life following long-term injection treatment

Evanthia Sakellari, ass. Professor, Technological Educarional, Institution of Athens, Greece; Sakellari@teiath.gr

**Abstract:** Impairment in diseases process and fragmentation in patients of schizophrenia spectrum lives are caused by two crucial factors, poor quality of life and low self-esteem. Assistance to meet families needs and prediction of patients mental illness and quality of life are addressed by the Ian RH Falloons model of psycho-education techniques (education and problem solving). The significance of the present study is the fulfillment of the literature gap, exploring the effectiveness of psycho-education techniques in self-esteem and in patients injection treatment quality of life. Forty one patients of long-term injection treatment, between the ages of 23 to 72, replied the Rosenbergs self-esteem scale and the WHOQOL scale, before and after monitoring the psycho-education techniques. The analysis determined in patients self-esteem improvement. As far as quality of life is concerned, patients reported stability of their environment and their health and psychological status, while there were not stated noteworthy differences in their social interactions. The psycho-education practices constitute an effective clinical tool for the patients self-esteem and quality of life enhancement, included also as a necessary condition of patients monitoring during the injection treatment. Key words: psycho-education, long-term injection treatment, self-esteem, quality of life, schizophrenia.

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## The clinical utility of evidence based risk evaluation combined with de-escalation interventions in emergency psychiatry

Roland von der Sande, HU University of Applied Sciences, Utrecht, Parnassia Psychiatric Institute, Rotterdam, Holland; roland.vandesande@hu.nl

**Absract**: Early recognition of alarming signs associated with the risk of severe escalations are crucial for caring patients that have to rely on emergency psychiatric services. However combining individualized structured riskassesment with tailored de-escalations can be difficult to manage effectively in hectic clinical environments. Over the past few years robust scientific evaluations reveal several useful evidence based approaches in this area. Time has arrived to link these dynamic and frequent risk evaluation modalities with tailored psychosocial de-escalation interventions to enhance stabilization and recovery. This workshop will address to the clinical utility of frequent short term risk evaluations (Crisis Monitor approach) combined with a tailored set of research informed de-escalation (Safewards) interventions. Pairing these interventions in a dynamic and personalized way will be demonstrated in five typical crisis scenario's. The implications for training, implementation, sustainability and future research will be discussed with the participants. The learning objectives of this workshop will be focused on understanding and managing the basic principles of the two research based approaches in five different realistic crisis scenario's in day to day practice

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## International Comparisons: A focus on Quality in Psychaitric Care

Agneta Schroeder, Professor, Psychiatric nurse, PhD, NTNU, Gjøvik, Norway; agneta.schroder@regionorebrolan.se; Second author: Lars-Olov Lundqvist

**Abstract:** There is a lack of cross-cultural comparison of patients and staff perceptions of quality of care in the psychiatric care. One reason is the absence of standardized instruments. The international project Quality in Psychiatric Care (QPC) is a large research programme aiming at adapting the versions of the QPC instrument for patients and staff to different international settings. Method: The QPC is a family of instruments based on a definition of quality of psychiatric care from the patients perspective with a common core including the dimensions: Environment (secure and secluded), Encounter, Participation, Discharge, Support and Context-dependent dimensions. The QPC family covers six areas of psychiatric care: in-patient (QPC-IP), forensic in-patient care (QPC-FIP), out-patient (QPC-OP), addiction out-patient care (QPC-AOP), Housing support (QPC-H) and Daily Activities (QPC_DA). Four of the QPC-versions are available in adapted versions for staff. Six of the versions are available in Swedish, Danish, Norwegian, Finnish, English, Persian, Portuguese, Spanish, Indonesian, French and Faroese. Results. Comparisons of quality of in-patient care from the perspectives of patient (QPC-IP) and staff(QPC-IPS) in Indonesia show that patients rated lower quality than staff and lowest in the discharge dimension followed by the participation dimension. In the versions for forensic in-patient care (QPC-FIP and

QPC- FIPS) in both Denmark and Sweden show that staff were generally more positive on the quality of care provided and that patients were more critical of the care they received. Staff and patients were similar in their perceptions of the low quality of participation. Several studies in Indonesia are still ongoing as well as in Brazil, Spain, Norway and Faroe Islands. Conclusions. So far in this international project it shows that patients and staff in different cultures and health care systems may have different views on some aspects of quality of care, but most of all that they have many views in common, particularly the low ratings on participation. The psychometric test and validations of the instrument QPC in different language and country versions will assist countries to compare quality of care, quality improvement and permits benchmarking. Currently there are few standardized instruments for measuring quality of care in the psychiatric care and the QPC is expected to make an important contribution to the development in this field.

### Sound and Music Intervention to empower patients to handle anxiety and agitation or support the improvement, relaxation or sleep

Sanne Storm, Music Therapist, PhD Psychiatric Center, National Hospital, Faroe Islands; sanne.storm@ls.fo; Second author: Bjørghild Nolsøe; Third author: Marja Lund Gjógvará

**Abstract:** This presentation will describe a newly begun pilot study focusing on research into music intervention (a concept covering music therapy as well as music medicine). Music intervention in clinical settings takes important steps towards recognition as evidence-based practice and is part of multidisciplinary clinical practice at Psychiatric Center, National Hospital of the Faroe Islands. The nurses involved have gained clinical experience in offering music to patients resulting in new practices where music listening is considered an effective coping strategy to regulate affect, to reduce stress and anxiety and improve relaxation and sleep quality. The aim of the pilot project is to empower patients to choose music suited to their needs here and now, and enable the patient to develop coping strategies during hospitalisation, which the patient may continue to use at home after being discharged. (Lund, Bertelsen & Bonde, 2016)The project has derived from the national project "Reduction of Restraint in Psychiatry" initiated by the Danish National Board of Health from 2011 to 2014. The aim of this project is to offer music pillows (pillows with small built-in speakers) and special deigned music programmes as a non-medical alternative to tranquilising medicine in two psychiatric adult in-patient units at Psychiatric Center, National Hospital of the Faroe Islands.Hospitalisation challenge that the individual is not taken away from daily routines and activities leaving the patient in a passive position that is not helpful for the recovery process. Psychiatric Center has focus on patient-centred treatment and the importance of helping the patient take responsibility for and control over his or her own treatment and recovery. The presenation will give exambles from the number of playlists developed, which incorporate a combination of musical parameters characterised as relaxing and supportive (WŠrja & Bonde, 2014), and with the potential of lowering arousal have been developed, based on theoretical and empirical research in music medicine and music therapy (Lund, Bertelsen & Bonde, 2016).Furthermore the special developed software and hardware design Đ "The Music Star" Đ will be presented as well as the many safety requirements which must be met when introducing sound systems into psychiatric intensive care units will be described.

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### If you see something, say something

Simon Tulloch, Chefkonsulent, BSc, MSc, Improvment Coach, Dansk Selskab for Patientsikkerhed, Kobenhaven, Danmark; simon.tulloch@patientsikkerhed.dk

**Abstract:** To outline the importance of psychological safety in creating safe space Learning outcomes: Understand what psychological safety is. Why psychological safety is crucial for effective teams and learning Organisations How to develop a culture of psychological safety with your team

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### How to create Psychological Safety in your workplace

Simon Tulloch, Chefkonsulent, BSc, MSc, Improvment Coach, Dansk Selskab for Patientsikkerhed, Frederiksberg Hospital, København st@patientsikkerhed.dk

**Abstract**: The concept of 'psychological safety' relates to the sense that members of a group feel comfortable taking interpersonal risks without fear of negative professional or social consequences. Interpersonal risks in healthcare include situations such as speaking up when you see a problem, or making a suggestion for improvement. As a result of low psychological safety, our healthcare services may be missing out of four critical outcomes; learning, risk management, innovation and job satisfaction. In this one-hour workshop we will take a deep dive into the factors that contribute to developing psychological safety in your team, including a summary of the research evidence supporting the concept and some practical steps to create psychological safety in your workplace. This will be an interactive session; therefore participants will be expected to contribute to the content of the workshop by sharing their experiences and knowledge

### The ward atmosphere and the role of nursing staff in psychiatric in-patient settings

Hanna Tuvesson Senior Lecturer, PhD, Psychiatric nurse, Department of health and caring sciences, Sweden; hanna.tuvesson@lnu.se

**Abstarct:** Although much of todays mental health care has moved from hospital care to care and treatment in the community, psychiatric in-patient care still has an important role. The importance of the ward milieu and atmosphere in psychiatric care settings has been demonstrated in numerous studies, primarily from the perspectives of patients. Fewer studies have focused on the staff and their perceptions. A couple of studies indicate that the staff might be the main contributors for the characteristics of the ward atmosphere. The psychosocial work environment, staff general stress, stress of conscience, and individual characteristics of the staff might be factors of importance to the ward atmosphere in psychiatric in-patient care. The main aim of the presentation is to describe how the nursing staff, their work environment and stress levels are related to the ward atmosphere as perceived and experienced by nursing staff in psychiatric in-patient care. Methods: The presentation is based on previous and on-going quantitative and qualitative studies, focusing on the nursing staff in psychiatric in-patient wards. Individual interviews with 10 nursing staff and 93 questionnaires comprising questions about the ward atmosphere, psychosocial work environment, general stress, stress of conscience, moral sensitivity, mastery and demographic information (age, sex, occupation, form of employment, length of experience) were used for the analysis. Results and conclusion: Non-parametric statistical analysis showed that the psychosocial work environment, nursing staff general stress and stress of conscience are of importance for the ward atmosphere in psychiatric in-patient wards. For example, staff with high scores of stress of conscience, in terms of internal demands, also had higher odds of perceiving high levels of anger and aggressive behaviors. Preliminary qualitative analysis indicate that the meaning of the ward atmosphere, as experienced by the nursing staff, was that the ward atmosphere could be understood as a reflection of the staff and their work situation. The function of the team or the work group could, for example, ñinfectî the ward atmosphere. Nursing staff stress spread like a contagious wind, influencing the characteristics of the ward atmosphere on the wards.

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### The implementation of the Safewards Model in the Acute Psychiatric Ward

Teija Tynjala, Specialist Nurse, Master of Health Care, Pirkanmaa Hospital District, Tampere, Finland; Teija.tynjala@pshp.fo;

**Abstract:** With the Safewards model, developed for psychiatric wards, the aim is to increase the sense of security and the interaction between patients and staff. This development will make psychiatric wards safer places for all and reduce the use of coercive measurements. The purpose of the study was to support the implementation process of the Safewards model in one acute psychiatric ward. Action research method was adapted to support this process. During the study, six interventions of the Safewards model were implemented and the process was followed and reported with the data from interviews of the staff and statistics. Results of these data sets show the importance of both qualitative and quantitative information when following the implementation process.
Results of the study will be presented to give one example of the implementation process. Similar process could beadapted also in other psychiatric hospitals when implementing Safewards model in their everyday practices. After

the study, the implementation process has continued in the participating ward as well as in the other psychiatric wards of the hospital

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### Early maladaptive schemas in psychiatric nurses and helping professions in Germany

Pascal Wabnitz, Prof. Dr. Psychologist (Diploma), licenced psychotherapist, Diaconic University of Applied Science Bielefeld, Germany; pascal.wabnitz@fhdd.de;

**Abstract**: Helping professions in the field of psychiatry (e.g. medical, psychological or nursing staff) are prone to job related stress and burnout. Research shows high prevalences of related disorders and the burden of working in this field. However, little is known about personal factors that contribute to an increase vulnerability to job related burnout and stress among psychiatric nurses and other helping professions in Germany. Especially the role of early maladaptive schemas (EMS) has been underestimated in the literature so far. Our study aims at exploring the role and prevalence of EMS in a sample of helping professions esp. psychiatric nurses in Germany. Data has been gathered by a online survey throughout Germany addressing helping professions working in inpatient and outpatient settings. The predictive value of EMS in the prediction of job related burnout and stress as well as differences between professions will be presented and discussed.

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### Family perceptions about the needs of people with enduring mental health problems within an inpatient setting

Andrew Walsh, Senior lecturer, RNMH, EdD,MA,Bsc. (Hons), Birmingham City, University Edgbaston, Birmingham, United Kingdom; andrew.walsh@bcu.ac.; Second author: Ana Barrios

**Abstract**: This study set out to develop understanding of carer perceptions about the needs of service users with enduring mental health problems. Methodology: Transcripts from semi-structured interviews conducted with six carers were analysed using an interpretive phenomenological approach Findings: Five themes were identified, Carers perceptions of changes made to hospital, Clinical and family perspectives differ, Measures of wellness differ, Significant interactions, Stress and upset Research limitations/implications: The paper describes a small qualitative study and conclusions may not be directly relevant elsewhere. However, study findings might inspire discussion and reflection in similar environments. Implications for practice are that services might promote better understanding between carers and clinical teams. Consider more informal gatherings to develop relationships. Clinicians need to try and understand family perspectives recognising that clinical formulations differ from long held family views. Whilst the institution has a duty to adhere to statutory requirements it might also consider how to mitigate the effect of these on spontaneous family contact. Finally, services need to be sensitive to possible stress amongst carers and should reflect on how best they can provide support Originality/ value- Literature suggests that carers frequently feel excluded from the care of service users with enduring mental health problems. This paper provides some evidence that understanding carer perspectives and developing better communication with them could help services provide better care. Finally, many people the carer role stressful and services should respond sensitively

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### Safe settings for "Play and creation - a way to mental health

Ole Wich, Conceptual Artist and Grafic designer, Masters a wide range of different approaches and medias of artistic expressions. Wich has worked and teached in many different settings involving both children, teenagers and adults. Psychiatric Center, National Hospital, Faroe Islands; wichole@gmail.com; Second author: Sanne Storm, music therapist and PhD -

**Abstract:** The practice development of a holding and empowering environment based on creative self-actualization. The topics for this symposium will be the multi-disciplinary team-work between different artists, a music therapist, and the nursing staff, the practice development of a holding and empowering environment based on creative self-actualization. Two papers will address this topic. The first paper will present the research

and theory underpinning the approach and creation of a so called field-of-play based on multi-disciplinary team-work, as well as a theoretical understanding of the empowering process of creativity as an ingredient for self-actualization and recovery. The second paper will describe the artist's approach, providing practical examples and considerations in creating a holding and empowering environment based on creative self-actualization. Finally the audience will be invited to an open discussion and reflection upon the topic and themes addressed. Art may be considered a way of telling without talking, and art-work a medium for self-actualization and recovery by a creative force within. When a person's severe sufferings are diagnosed the person partly loose his or her identify, and as a severe consequence the person's self-esteem and self-confidence diminish. However, in the meeting, between the artist and the creator (the patient), lies an opportunity to empower one self, discover new sides and qualities of your self, and re-define your self-identification. Within this view is a trust that a healing potential lies within ourselves when activating our creativity. The practice development is about how the multi-disciplinary team-work aim to establish conditions that foster an individual inner experience of flow in creativity. In order to do so the many different ways of expressing your self creatively is aimed to be free of expectations towards material and choice of artistic medium. The practice development is therefore also about applying a frame and a setting, different materials and artistic mediums, and not least about how the focus stays with the art-work and the creative space in the process. An exhibition provides an opportunity to tell a story and partly to meet the outside world beyond the identified sufferings and the individual self-identification. This symposium will all together present the model applied in clinical practice within psychiatry on the Faroe Islands, as well as the product of this work. This include pictures and music from an exhibition.

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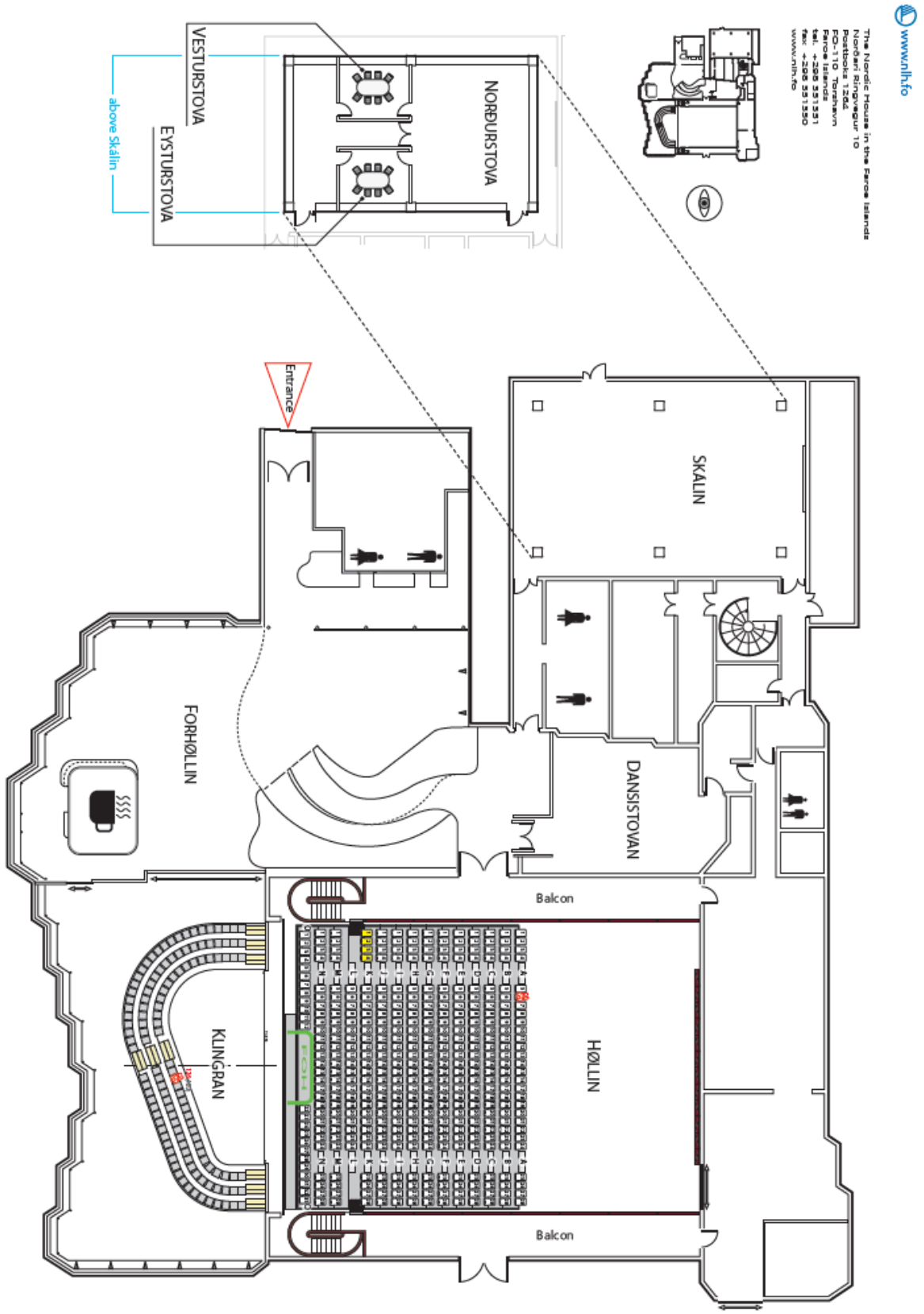
### Experiences of people living with mental illness in Switzerland - a qualitative inquiry

Peter Wolfersberger , RN, MScN, cand. PhD , Bournemouth University, Faculty , of Health & Social Sciences , Christchurch Road, Royal London House, , Bournemouth, England; pwolfensberger@bournemouth.ac.uk; Second author: Sarah Thomas; Third author: Sabine Hahn

**Abstract:** Recovery refers to the lived experiences of people living with mental illness and to their adaptation process to life and illness (Slade, 2009). This process is deeply personal and unique for everyone as it includes the development of new meaning and purpose in one's life (Anthony, 1993). For professionals, various models of care have been developed (Mahler et al., 2014, Barker & Buchanan-Barker, 2005) and advice has been given on how to promote recovery in clinical practice (Trenoweth, 2017). This is all very useful, however, how does it relate to the experiences of people living with mental illness? Aim of study The research project aims to explore and evaluate the personal experiences of people living with mental illness in Switzerland using a lifeworld approach (Galvin & Todres, 2013). The findings will help to create a unique understanding of the adaptation process to mental illness from a patients perspective. What are the issues most relevant to these people and how do they relate to the personal recovery process? Methodology A constructivist and reflective approach to Grounded Theory (Charmaz, 2014) has been chosen to analyse the ten open interviews with participants from various backgrounds and with different mental illnesses. The methodology appreciates that the researcher himself is subject and person within the context of the social-scientific discovery (Breuer, 2010). Results The analytical and interpretive process has not yet been finished. However, the current results show a variety of topics, that are relevant and meaningful for the people living with mental illness. They cover areas such as on how symptoms are experienced and dealt with or what role family, friends or health professionals play in the adaptation process to illness. Overall consistent seems the search for meaning or the making sense of what is or was happening. However, the answers to that are as varied and diverse as the lifeworld of each of the participants. Discussion & Conclusion The results are still partial. However, there are already insights that encourage us as health professionals to reflect on our own practice and care. We tend to think of ourselves as extremely important in the lives of people living with mental illness, which might not be that true. Creating safe spaces often simply means being human ourselves and seeing the human instead of the patient.

# Location in Nordic House



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**FUGLAFJARÐAR KOMMUNA**

**KIRVI**

**P/F North Pelagic**

**SPEKT – løggildir grannskoðarar**

**TÓRSHAVNAR KOMMUNA**