Recognizing risky behaviour among offenders

Improving the use of a crisis prevention action plan at a forensic psychiatric facility

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Preface

The moment I write the last pages of this thesis, I am six months pregnant of my second child. I have done my Master's in Psychology at the University of Twente last year. During this year, I also bought my own house together with my husband and my 3-year-old daughter. At the same time, I work part-time as a forensic nurse at a forensic psychiatric facility, where I also did this research.

Writing this thesis was a process for me. I noticed that as I progressed, I became more attentive during work. All the reviewed literature was information that helped me doing my job better; this made the writing of this thesis two-fold. On the one hand, I had the opportunity to develop myself by doing research under the supervision of the University of Twente. On the other hand, I had the opportunity to develop myself as a staff member of a forensic psychiatric facility, both during the same project.

I want to thank first of all my husband, because he always supports me in going the extra mile. Of course I want to thank my supervisors for the cooperation and the advice while writing this thesis. I feel honoured and want to thank dr. F. A. J. Fluttert for reading this thesis and for the feedback he gave. Next to this, I want to thank my colleagues who were also interviewees in this study. It was very interesting to gather all the information and knowing that I will be using the results in the future in my daily work. Also knowing that I will be a part of implementing the recommendations, gives me a grateful and excited feeling. Last but definitely not least, I want to thank God for patiently listening to all my prayers about this thesis and the combination with my work and family. And that it all worked out for the good.

28th of February 2020,

Celina Klok

Abstract

In the last few years, research has been done regarding recognizing early warning signs of deteriorating behaviour from offenders who receive treatment in forensic clinics. The reason for this research is to prevent crises and recidivism during and after treatment and to gain a better understanding of deteriorating behaviours and thereby to maintain stability. There are different types of strategies to systematically document what personalized early warning signs are recognized in the deteriorating behaviour of forensic patients. These strategies can be used by staff members who work with forensic patients and also by patients themselves, to recognize these early warning signs and to take preventive action. Practice shows that these strategies are not always used as they should be.

Goal: The aim of this research is to improve the use of the Crisis Prevention Action Plan (CPAP) at a Forensic Psychiatric Facility (called: FPA).

Method: Through the use of semi-structured interviews with staff members (N = 21) working at a FPA, information was gathered about how to improve the use of the CPAP. This is done using three research questions about what the perceived optimal *purpose*, *content* and *procedure* should be of the CPAP, which is the foundation of this research. Through qualitative content analysis the data from the interviews were coded and analysed.

Results & Discussion: According to the *purpose*, interviewees mentioned that the early recognition of deteriorating behaviour and the early deployment of interventions to prevent crisis, most important. Regarding the *content*, findings showed that the patient and the forensic nurse together should fill out the CPAP, written down in three phases, where concise and specific personalized behaviours have to be filled out as early warning signs for deteriorating behaviour. According to the *procedure* of the CPAP, most interviewees mentioned that patients should be involved in the CPAP procedure as much as the responsible forensic nurse and the therapist. Staff members should remind each other daily to check the CPAP and the forensic nurses should reflect on it with patients during weekly conversations. The CPAP should be evaluated during the treatment plan meetings and the staff members should receive training in making and using a CPAP. When all this is implemented and staff members follow the same CPAP procedure, it will be more homogeneously.

Samenvatting

Er is de afgelopen jaren onderzoek gedaan naar het herkennen van vroege waarschuwingssignalen van gedragsescalatie bij gedetineerden in een forensische kliniek. De reden voor dit onderzoek is onder andere om crisis en recidive te voorkomen tijdens en na de behandeling en om een beter begrip te krijgen van verslechterend gedrag. Er zijn verschillende soorten strategieën die systematisch documenteren wat voor gepersonaliseerde vroege waarschuwingssignalen herkend worden in gedragsescalatie van forensische patiënten. Deze strategieën kunnen gebruikt worden door medewerkers die werken met forensische patiënten en ook door de patiënten zelf, om deze signalen te herkennen en preventief actie te ondernemen. De praktijk leert dat deze strategieën niet altijd worden gebruikt zoals zou moeten.

Doel: Het doel van dit onderzoek is om het gebruik van het Crisis Preventie Actie Plan (CPAP) te verbeteren binnen een Forensisch Psychiatrische Afdeling (FPA).

Methode: Door het gebruik van semi-gestructureerde interviews met medewerkers (N = 21) die werken binnen een FPA, is er informatie verzameld over hoe het gebruik van het CPAP verbeterd kan worden. Dit is gedaan door middel van drie onderzoeksvragen over het optimale *doel*, *inhoud* en *procedure* van het CPAP. De qualitative content analysis is gebruikt om de data van de interviews te coderen.

Resultaten & Discussie: Met betrekking tot het *doel* van het CPAP, vinden geïnterviewden de tijdige herkenning van verslechterend gedrag en de vroege inzet van interventies om crisis te voorkomen, het belangrijkst. Wat de *inhoud* betreft, toonden de bevindingen aan dat het CPAP door de patiënt en de forensisch verpleegkundige samen moet worden ingevuld, opgeschreven in drie fasen, waarbij specifiek en te observeren gedrag ingevuld moet worden. Volgens de *procedure* geven de meeste geïnterviewden aan dat de patiënt betrokken moet zijn bij de CPAP-procedure, en ook de forensisch verpleegkundige en de therapeut. Medewerkers moeten elkaar er dagelijks aan herinneren om het CPAP erbij te pakken en de forensisch verpleegkundigen moeten daar in wekelijkse gesprekken met patiënten op reflecteren. Het CPAP moet worden geëvalueerd tijdens de behandelplanbesprekingen en de medewerkers moeten training krijgen in het maken en gebruiken van een CPAP. Als dit alles geïmplementeerd is en alle medewerkers werken volgens dezelfde CPAP procedure, zal het werken met het CPAP meer homogeen zal zijn.

Introduction

In 2017 a terrible event happened in the forensic world, a delinquent staying at a Forensic Psychiatric Facility (called: FPA) recidivated and raped and killed a woman in The Netherlands who was a passenger on the street (Tieleman & Kleuver, 2018). This offense happened during the treatment of the delinquent and while he was on leave of absence with permission of the FPA. FPA's have a low to medium security level and are focused on resocialization. In weighing the risk of recidivism, the clinic is a protective factor (Douglas et al., 2014). Recidivism during leave of absence, while the delinquent is still in treatment at the clinic, does not happen very often. Every year this happens a few times in The Netherlands (GGZ Nederland, 2018). Recidivism after forensic care happens more often in The Netherlands, this is within two years on average more than 50%, with 10% very severe crimes (Drieschner, Hill & Weijters, 2018). The question arises; could this have been prevented? Were there notions from the history of the delinquent or early warning signs and indications that there was a risk for this recidivism?

At a FPA, forensic nurses work together with psychologists, psychiatrists and therapists to support the patient his return to society. Since the earlier mentioned incident, many changes occurred in forensic care facilities in The Netherlands, for instance the drugs policy, the leave of absence policy and the assessment of recidivism (Inspection Justice & Safety, 2019). The frequency of drug tests has been increased and also the amount of time has increased before delinquents can go on leave of absence unaccompanied. The Safety Investigation Board (2019) of The Netherlands did research on how this event could have happened and how this can be prevented in the future. One very important recommendation in the report of the Safety Investigation Board is that there must be even more attention for the risk of recidivism during forensic care. An important factor that can contribute to the assessment of the risk of recidivism is signalling risky behaviour that leads to violent behaviour (Hoogsteder & Bogaerts, 2018). Also according to Fluttert, Van Meijel, Grypdonck and Bartels (2005), early detection of warning signs in behaviour from patients is important in forensic care, in particular to prevent from recidivism. Although this relation should be studied more to see if there is really a decrease in recidivism when using early recognition strategies.

In forensic care, the Crisis Prevention Action Plan (CPAP) can be used during treatment of forensic patients to signal early warning signs in behaviour that leads to violent behaviour. This early warning signs can for example be verbal aggression, substance abuse or a psychosis. Several FPA's in The Netherlands are using the CPAP for early recognition. It is unknown to the researcher what other early recognition strategies are used in other FPA's.

The CPAP entails five different stages of possible violent behaviour (See Appendix A): the normal stage, the early stage, the mild stage, the severe stage and the very severe stage. Each stage is assessed by the patients' and the nurses' perspective. The CPAP has a dual purpose, that the forensic nurse recognizes deteriorating behaviour and uses risk-reducing interventions (for example offering a possibility for a conversation with a forensic nurse, listening to music that calms the patient or take a walk to unwind) and that the patient recognizes his or her own deteriorating behaviour and uses personalized best practices (for example going to forensic nurses to talk about the situation, going to their own room or ask for medical treatment to calm down). Both these purposes are to prevent a crisis during and also after treatment. Forensic patients can learn different things from working with a signalling plan: they learn about the relation between their early warning signals and their risky behaviour, they become familiar with self-reflection and they learn coping skills to prevent from risky behaviour (Fluttert et al., 2005).

For this research, a search was made for scientific substantiation of the CPAP as used in FPA's in The Netherlands. In a manual composed in 2005, the CPAP is introduced and explained. The CPAP is mainly based on scientific literature from F. Fluttert and B. Van Meijel about signalling plans (De Borg, 2005).

Problem statement

At FPA's in The Netherlands where the CPAP is used, all staff members should fill out and use this CPAP correctly. In practice, this is not always the case according to the client of this research. For example vague warning signs are filled out like 'patient is restless', which might look differently for every patient. Forensic nurses cannot signal warning signs in behaviour when it is not specific. Also patients should be aware of and familiar with their own CPAP, so they can use this in the future when they integrate into society again. However, practice shows that this is also not always

the case. For example staff members do not use the CPAP often when deteriorating behaviour is signalled and the CPAP is also not evaluated on a regular basis (personal communication K. De Carvalho). Therefore, this study focuses on improving the use of the CPAP by forensic nurses and by patients at the FPA. Signalling risky behaviour is the purpose of the CPAP, so by improving the use of CPAP there can be expected that the risk of recidivism decreases.

Research aim: To improve the use of the Crisis Prevention Action Plan (CPAP) at a Forensic Psychiatric Facility (FPA).

Early recognition of warning signals in behaviour

At forensic psychiatric facilities, the levels of reported violence are twice as high compared to general psychiatry. A review of almost 70.000 psychiatric patients from 122 countries, found that 48% of patients in forensic facilities were violent. This is almost double compared to the reported violence for acute psychiatric wards (26%) and 22% at other less acute psychiatric settings (Ramesh, Igoumenou, Vazquez Montes & Fazela, 2018). This violent behaviour can occur spontaneous, but it often follows a pattern that is personal and idiosyncratic. Patients can react in a more or less ascending and predictable violent manner (Fluttert, Van Leeuwen, Van Meijel & Bjørkly, 2011). It is thus very important to signal this risky behaviour that leads to violent behaviour at an early stage, so that preventive action can be taken. Forensic nurses are important for this de-escalation of violent behaviour from their patients. For they have close contact with patients and have to act in the moment (Webster, Nicholls, Martin, Desmarais & Brink, 2006). Forensic nurses do not deal with patients who are committing an offense at the FPA; they often deal with milder and more general violent behaviour. The risky behaviour at the FPA rarely has the intensity of behaviour during a crime (Fluttert et al., 2005). With recognition of deteriorating behaviour in an early stage and early interventions, this violent behaviour can be prevented (Fluttert et al., 2008). In this way, patients can practice with self-reflection coping skills and preventing from risky behaviour in a controlled environment (Fluttert et al., 2005).

Such early warning signs of deteriorating behaviour are very personal and vary between individuals. Birchwood (2000) called this a personal ‘signature’; every individual patient has their own set of deteriorating behaviours leading to for instance

psychosis, or in case of forensic patients to violent behaviour. There are also recurring themes that may apply to patients more generally, like substance abuse, stressful events and psychoses (Fluttert et al., 2008). According to the process of deteriorating behaviour (see Figure 1), the baseline includes behaviour that is constant, nonviolent and predictable. When limited stress is experienced, patients can cope with this themselves and recovery of the stress level to the baseline occurs. This stress can emerge from many situations, like irritation or financial problems. This is different for every person. As the level of stress increases, support of others may be needed for further coping (Fluttert et al., 2008). When the stress level increases up to a certain point that the patient cannot cope with it anymore, early recognition and early intervention are used by forensic nurses to recover the stress level to the baseline. Like offering a conversation or indicate that it would be good to listen to music, to exercise or to take medical treatment to calm down. When this early recognition and intervention is not used, crisis and severe violence is likely to emerge and returning to baseline can take a lot of time and effort.

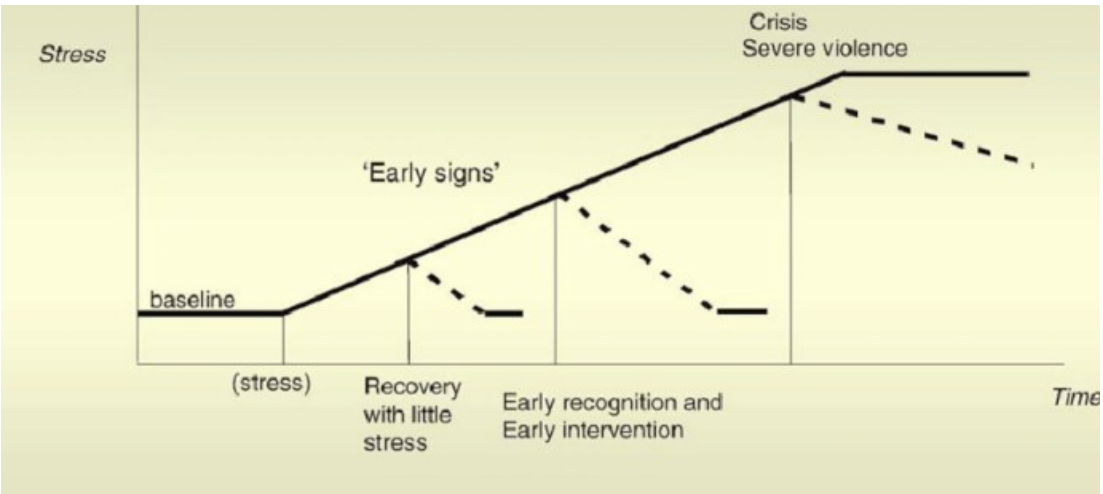

Figure 1. The process of deteriorating behaviour (Fluttert et al., 2008).

Forensic nurses can recognize this set of deteriorating behaviour from their patients with whom they work closely and learn them to recognize this themselves. When patients learn to recognize their own 'signature', they can undertake action to stabilize so this might not lead to violent behaviour during treatment.

Methods for early recognition

There are different methods used by forensic nurses to recognize deteriorating behaviour. Eidhammer, Fluttert & Bjørkly (2014) did a systematic review on cooperation between patients and forensic nurses concerning violent risk management in forensic care. There is barely any research evidence on this topic and therefore this research was conducted with the suggestion that forensic clinics may learn from positive experiences in general psychiatry and adapt them to the forensic care. Out of all the reviewed literature, Eidhammer, Fluttert & Bjørkly (2014) included three articles. The interventions discussed in these three articles are: the Early Recognition Method (ERM: Eidhammer, Knutzen & Fluttert, 2010), the Progression Ladder (ProLad: Bjørkly, 2004) and the Managing Problematic Anger (MPA: Jones & Hollin, 2008). These violence risk management strategies guide patients to self-management of their violent behaviours under the supervision of forensic nurses. Studies of the ERM and the MPA show a significant decrease in aggressive incidents (Fluttert, Van Meijel, Nijman, Bjørkly & Grypdonck, 2010; Jones & Hollin, 2008). The ProLad has been tested within one single forensic unit and only to a small group of patients with no control group, but is selected based on promising outcomes (Bjørkly, 2004).

The *ERM* is a method for early recognition of early warning signals in behaviour, to prevent behaviour with negative consequences and reduce different types of coercion in forensic settings (Eidhammer, Knutzen & Fluttert, 2010). Competent forensic nurses can use it on a daily basis, to manage risks from a particular patient (Fluttert et al., 2008). Participation of the patients during their stay at the clinic is very important so they can exercise self-management (Fluttert, 2010). The ERM contains four steps of applying this strategy:

1. Introduction of the method and expectations from forensic nurse and patient.

2. Defining early warning signs in behaviour in the patient's own words. These early warning signs are described by the patients and the mentor in three phases: 1= stable phase; patient is not stressed, 2= moderate phase; early warning signs moderately present and a little stressful, 3= serious phase; patient is very stressed and the warning signs are strongly present. In every phase, 3-5 early warning signs are chosen that the patients perceive to be the most important.

3. Patients learn to monitor their behaviour to recognize the early warning signs, during weekly conversations with a forensic nurse, which is the mentor of that patient. On a weekly base, mentor and patient together rate and evaluate the presence and meaning of the early signs, described on the three levels of severity.

4. Preventive actions are described in terms of positive self-management measures, divided into what the patient and forensic nurse can and should do and should avoid doing. For example, what a forensic nurse should avoid doing is constantly visiting the patient to see how it goes or to touch the patient physically. What patients should do, can be for example listening to music or do calming breathing exercises. The patient will be encouraged by the forensic nurse to carry out these preventive actions when early warning signs are detected (Eidhammer, Knutzen & Fluttert, 2010; Fluttert et al., 2008).

The *ProLad* is a method for including individual dynamic risk factors in a stepwise risk management procedure, which is aimed at self-management of violent behaviour (Bjørkly, 2004). Forensic nurses can use the ProLad to evaluate a patient his progress and coping according to self-control, which results in absence of violent behaviour and an increase of self-control. According to Bjørkly (2004), building a collaborative and therapeutic relationship between forensic nurse and patient is the starting point of the ProLad. The key building blocks of ProLad are:

1. A structured and stepwise approach. Success at one step in the progression ladder leads to the next step. Each ladder consist of 15 to 20 steps covering several coping domains like basic living skills, interpersonal skills and self-management of risk factors.

2. Criterion-based progression. When the criterion for successful functioning is met for two weeks, the patient is allowed to progress to the next step.

3. Individually-adopted strategy. Detailed analyses of the patients coping level, progress and special needs are documented. The forensic nurse evaluates each step and gives written feedback to the patient every evening.

The *MPA* is a structured method to formulate a personalized treatment plan for reducing anger, designed for offenders with mental disorders in a high security setting (Jones & Hollin, 2008). Forensic nurses collaborate with the patients and provide

support. It is a 36-week program that changes the cognitive, arousal and behavioural aspects of anger. It involves developing techniques to reduce arousal and it is a program that involves both individual and group based treatment.

- Group sessions: There are 2-hour skill training sessions in a group setting every week given by a group facilitator. These skills consist of appropriate behaviour in response to cues that previously evoked aggressive responses. Every session has a session plan as described by the program manual. Everything that is needed can be found in the program manual, like handouts, worksheets, homework, diaries.

- Individual sessions: There are weekly individual sessions for the duration of one hour. During the individual sessions, the patients have a mentor for the whole duration of the program. Mentors help transfer the skill training to everyday situations, with the support from a hassle log. This is a structured diary, where patients can record and monitor anger provoking situations and write down what their responses were. Mentors discuss this hassle log with their patient and talk about what went well, what went wrong and what different behaviour the patient can perform next time.

The group and individual sessions are given in three modules: Module One; Preparing for Change (6 sessions), Module Two; Recognizing and Owning Anger (16 sessions) and Module Three; Reducing Problem Anger (14 sessions).

ERM, ProLad and MPA are structured risk management strategies that provide a systematic approach to patients' violent behaviour and aggression during treatment. The CPAP as it is currently used in the FPA's in The Netherlands is based on the ERM, but not entirely the same (Eidhammer, Knutzen & Fluttert, 2010). The differences and similarities will be discussed later.

The ERM, ProLad, MPA and CPAP are all methods for early recognition of warning signals in behaviour. Forensic nurses can recognize this early warning signs and teach their patients to recognize this warning signs themselves. It is important for both forensic nurses and patients to know what this early warning signs are.

Early warning signs

As indicated above, early warning signs can be different for every patient, because every patient has a specific set of deteriorating behaviours (Birchwood, 2000). For

most forensic patients, the central problem is aggression (Nicholls, Brink, Greaves, Lussier & Verdun-Jones, 2009). In forensic care, the Brøset Violence Checklist (BVC) is used on a daily basis to assess warning signs in behaviour that lead to aggression (Almvik & Woods, 1999). The BVC is a short-term violence prediction instrument and it can assist in preventing deteriorating behaviour. This BVC contains the following six items: irritability, physically threatening, verbally threatening, boisterous, confusion and attacking objects. Some of these signs are universal signs of aggression, like physically threatening, verbally threatening and attacking objects. These items can be scored every day, absence of behaviour is a score of 0 and presence of behaviour is a score of 1. Maximum score is thus 6 and only an increase in behaviour is scored. So when a patient is always confused, only an increase in his confusion is scored (Almvik & Woods, 1999). Violent behaviour often starts with verbal threats and it can escalate to physical harm. When forensic nurses measure these early warning signs, preventive action can be taken.

It is possible that violent behaviour does not start with clear and obvious verbal threats, but with other more indirect early warning signs, which can also lead to physical harm eventually. Fluttert (2010) developed the Forensic Early Warning Signs of Aggression Inventory (FESAI) to assist forensic nurses in using the ERM and to define early warning signs systematically (see Appendix E). The FESAI is a validated list of early warning signs in the behaviour of forensic patients. With the support of the FESAI, forensic nurses and patients can get to know the early warning signs that apply for a specific patient. The FESAI is developed through research among signalling plans in the forensic care, 167 signalling plans from forensic patients were studied and 3768 early warning signals were categorized. 44 early warning signals were coded in 15 categories, almost 50% of all the early warning signals from forensic patients are in these four categories: anger, social isolation, reduction in social contact and changing day activities. According to the FESAI, significant but less notable behaviour changes are also scored as early warning signs of aggression, such as isolation, withdrawal and superficial contact. These are less common, less noticeable and thus more unique early warning signs, but nevertheless very important because they can lead to the same violent behaviour as the universal warning signs (Fluttert, Van Meijel, Bjørkly, Van Leeuwen, & Grypdonck, 2012). When using the

FESAI together with the ERM, it is important that forensic nurses and patients will be educated about this to use it in a professional way (Fluttert, 2010).

Another unique early warning sign not considered explicitly in the above approaches might be dual harm. Research of Slade (2019) concluded that assessments of early signs in behaviour should cover both self-harm and violent behaviour towards a person, with a possible link between these two signs. This dual harm occurs often in forensic settings, where around 50% of those who harm themselves also commit violence to others. Self-harm can thus be a potential early warning sign for violent behaviour. Slade (2019) states that patients with dual harm are responsible for a major part of the incidents in forensic facilities.

These universal and unique early warning signs in behaviour can possibly lead to physical harm of others or other behaviour with negative consequences and are important to keep in mind, while filling out the CPAP of a patient.

CPAP

The discussed literature about early recognition, the methods and the early warning signs can be used to improve the use of the CPAP. What is important for the CPAP is that the forensic nurses plays a central role in making the CPAP together with the patient. They are the closest to the patient compared to other disciplines that see the patient only a few times a week. They can teach the patients how to recognize early warning signs for themselves, so they can hold on to stability when re-integrating in society (Fluttert et al., 2005). Forensic nurses use the CPAP to recognize observed early warning signs and to deploy interventions to calm the patient down. Patients use the CPAP by recognizing detected early warning signs and use personalized best practices to calm down.

The CPAP is based on the ERM, as mentioned before. In both the ERM and the CPAP there is a description of early warning signs of deteriorating behaviour of a particular patient. These are described in a plan with different phases. Also positive self-management measures are described and divided into what the patient and forensic nurse can and should do. The difference between the CPAP and the ERM is that the ERM contains of step one and two, which are: 1. Introduction of the method and expectations from forensic nurse and patient and 2. Defining early warning signs

in behaviour in the patient's own words. Also the ERM contains a choice of 3-5 early warning signs that the patients perceive to be the most important. These things are not included in the CPAP, but seem nevertheless very important to involve the patient in the process.

This research has shown that there are early warning signs in behaviour that can also be used in the CPAP. These are the six items from the BVC, but also the 44 signs in 15 categories from the FESAI (Appendix E). Finally the warning signs about dual harm from the research of Slade (2019) can be added.

From this literature review and in collaboration with the client, three research questions follow. In these three research questions, the perspective of forensic professionals working at a FPA is examined. The perspective of the staff members will be researched to see if this corresponds with literature and what practical recommendations can be given. It is important to investigate the perspective of the staff members of a FPA, because they have insight in what goes wrong and they will probably have the best ideas to improve the use of the CPAP in daily work. Their perceived usefulness is of great value for this research. Also they have to use the CPAP in the future and benefit the most from a correct use.

Research Questions

a. Purpose: For what purpose should the CPAP be used?

b. Content: What is the correct way to fill out a CPAP?

c. Procedure: How could the CPAP be used more often?

Method

Given the insights from the literature about early warning signals in risky behaviour, steps are undertaken to improve the use of the CPAP. For this research there has been given permission from the ethics committee from the Faculty of Behavioural, Management and Social sciences (BMS) at the University of Twente.

First, interviews were held with the staff members of the FPA to investigate how the use of the CPAP can be improved. The aim was to interview a wide variety of staff members (i.e., with different tasks and responsibilities) to elicit a multidisciplinary perspective. This is important, because every staff member contributes to the CPAP in different ways. During the interviews, the earlier mentioned research questions were used as conversation topics.

Organization description

To give an impression of the type of organization, FPA is a name for a Forensic Psychiatric Facility in the Netherlands. Patients are treated there with behavioural problems that have a psychiatric cause. These psychiatric problems have put the patients in contact with the judiciary. Admission to a FPA takes place with a criminal measure; the judge decides whether an offender will be admitted to a FPA. Treatment within a FPA is aimed at allowing patients to return to society safely and successfully. There are three main goals during treatment: resolving the psychiatric problems, preventing future crime and supporting in problem areas (financial problems or unemployment for example) that can lead to criminal behaviour. The treatment at a FPA is mostly terminated when the criminal measure expires.

Design

This research has a qualitative approach with semi-structured interviews. Semi-structured (vs. fully structured or standardized) interviews are taken to leave some room to ask further for opinions and ideas from the staff members. The researcher is interested in the answers on the research questions and with a semi-structured interview it is possible to ask further by using in-depth questions. This is necessary to get a good and complete view of what the staff member think what is important in using the CPAP correctly (Baarda, 2013). The three research questions about the purpose, content and the procedure are the fundament of the interviews, these

questions were asked first. To deepen the conversation in case the three research questions did not provide enough information, there were other questions formulated (See Appendix B). These in-depth questions worked as probes and their function was to stimulate the conversation. By using the three RQs as main questions and the rest of the questions as probes, an attempt is made to get a complete picture of the thoughts and ideas of interviewees. All questions were created through consultation between the researcher, the supervisor and the contact person from the FPA. Together they formulated the questions to stimulate the thinking process of the interviewees.

The method that was used to code the data from the interviews is the qualitative content analysis from Zhang and Wildemuth (2009). This method examines meanings, themes and patterns in a written text and it aims to understand social reality in a subjective and also scientific manner. It also reduces the multitude of written text into manageable data. For the purpose of this qualitative content analysis, the data was first transcribed. The transcribed data was searched for themes and categories and coding schemes were developed – see Data analysis below.

Research population

The interviewees were staff members working at the FPA (See Table 1). From the 21 interviewees, 15 were women and 6 were men. This difference can be explained by the fact that more women work in the FPA. In total 146 staff members work at the FPA, from which 92 are women and 54 are men. The response rate is approximately 14%. The mean age of all the interviewees is 38 years (SD = 11.6); the youngest interviewee was 24 years and the oldest 62 years. The mean experience is 11 years (SD = 7.9), with 2 years as the least experience and 30 years as the most experience.

To get a clear view of the opinions and ideas of the staff members, interviews were held with staff members from different disciplines. It is important that all disciplines were covered from the FPA, to gather enough information from different viewpoints about the correct use of the CPAP. Inclusion criteria were that all interviewed staff members work at the FPA and that they know what the CPAP entails. It is also important that they all have agreed to the conditions described in the informed consent (See Appendix C). All interviewees received an invitation on their e-mail address from the FPA, so it was certain that they were working there. In this e-mail (see Appendix D) was mentioned that to be interviewed, one must know what a CPAP

entails. All interviewees signed the informed consent and thus agreed with the conditions mentioned there.

In Table 1 the different disciplines working at a FPA are described. Forensic nurses are mentioned before; they work in a team 24 hours a day and seven days a week closely with the patients. Evironmental Department Coordinators are also forensic nurses with additional tasks, like coordinating the work processes and coaching colleagues. The psychologist is responsible for the psychological treatment of the patients and the psychiatrist for the medical treatment. Social workers keep in touch with external organizations such as probation service. Therapists can be specialized in sports therapy or drama therapy, but also in aggression regulation therapy or behavioural therapy. General staff members are teammanagers of forensic nurses, safety coaches or other administrative functions that are not directly in contact with the patients.

Table 1. *Disciplines in which interviewees worked at a FPA*

Position in the organization	**Number of interviewees**
Forensic Nurse (FN)	7
Environmental Department Coordinator (EDC)	3
Psychologist (P)	2
Psychiatrist (Psychia)	2
Social Worker (SW)	2
Therapist (T)	2
General Staff Member (GSM)	3
Total	21

Procedure

To start the interview process, an e-mail was sent to all staff members of the FPA with the purpose of this research and the invitation for an interview (See Appendix D). When staff members responded, an interview moment was planned. After sending the earlier mentioned e-mail, 15 staff members responded immediately that they were willing to participate. A reminder e-mail was sent to relevant disciplines that were not well represented in the sample of the 15 responding staff members. After this 6 more staff members responded and these in total 21 interviewees were interviewed for this research. This means that there are 21 interviewees from a population of 146; from which there are approximately 100 forensic nurses and the rest are other disciplines. It is possible that participating staff members who reacted on the e-mail are more

interested in the use of the CPAP compared to other staff members. This can be a response bias, because the participating staff members may have had the idea that something had to change. The interviews took place at the FPA at one of the meeting rooms. 21 interviews were held with the researcher as interviewer, all the interviews were recorded with recording equipment and interviewees signed up for this in the informed consent. It was important for the interviewees to know that the interview was voluntary and anonymous, that the results will be used for research and that the interviewee can stop the interview at all times. They could read all this in the informed consent, which was present on paper and signed by all interviewees (see Appendix C). After this, the interview and the recording started. The mean duration of the recordings was 21 minutes (SD = 3.7), with the shortest recording 17 minutes and the longest 28 minutes. The three research questions were asked to the staff members and there was some room to ask further in-depth questions, as mentioned before.

Data analysis

The interviews were recorded, transcribed and coded. The completely transcribed interviews (verbalizations from the interviewer and the interviewees were transcribed literally) were analysed with the software Atlas.ti, a coding programme. The method used for making coding schemes is the earlier mentioned qualitative content analysis. What was important first of all, according to Zhang & Wildemuth (2009), was defining the coding units. The three research questions were used as main categories and these were defined first. After this, the transcriptions were examined for themes. According to the qualitative content analysis, when using themes as coding units, a theme can be assigned to a text chunk of any size that represents this theme (Zhang & Wildemuth, 2009). This was done by assigning themes to different chunks of text in Atlas.ti. This process is called inductive reasoning; through the researcher's examination and comparison, themes emerge from the data. During this coding process, themes emerged and these were added to a table with coding results, which consists of category names, definitions and examples (Zhang & Wildemuth, 2009). To reach coding consistency, the interpreted data was discussed with the supervisor and inter-coder agreement has been examined. During discussion some changes were made, for instance some subcategories were also divided into labels to make the themes more clearly for the reader. A coding example is that in one of the transcripts, the interviewer is asking about the main category *procedure*: 'How could the CPAP

be used more often'. The interviewee answers: 'discuss early warning signs on a daily basis and look at the CPAP together, preferably a printed version of the CPAP so it is close and easy'. The subcategory chosen here is 'daily work', because it is an example of using the CPAP on daily basis by the forensic nurses. Because 'daily work' is a very broad category, it is divided in labels and the label chosen for the previous example is 'ease of use'.

Results

Table 3 shows the three main categories, which represent the research questions. Table 3 also shows the different subcategories that were derived directly from the raw data. Where necessary Table 3 also shows labels to make the subcategories more clear. These subcategories are themes that are assigned to a text chunk that represents this theme. For every subcategory or label there is a description and an example.

Main categories

According to the qualitative content analysis from Zhang & Wildemuth (2009), defining the coding units is the first step. The main categories are the coding units in this research, they are the three research questions and these are defined below.

Purpose: For what purpose should the CPAP be used?

According to the literature, the purpose of early recognition strategies is to recognize early warning signals in behaviour and to timely undertake preventive action when deteriorating behaviour is recognized. Forensic nurses or patients themselves can reduce stress and so prevent crisis by early intervention and early recognition.

Content: What should be the content of the CPAP?

According to the ERM, early recognition contains of four steps that must be completed by the patient and the forensic nurse. Regarding the content, step two to four are important, step one is part of the procedure. Step 2: Defining early warning signs in behaviour (early warning signs are described in three phases; in every phase, 3-5 early warning signs are chosen), step 3: Patients learn to monitor their behaviour and to recognize these early warning signs, through weekly conversations with their personal mentor and step 4: Preventive actions are described in terms of positive self-management measures.

Procedure: How could the CPAP be used more often?

According to the ERM step one; the forensic nurse should introduce the method to the patient. The ERM also states that it is important to use early recognition on a daily basis, because of timely recognition of early warning signs in behaviour. Also it is important to evaluate on a weekly basis in mentor and patient conversations.

Table 3.1 *Coding results*

Main category	Subcategory	Labels	Description of subcategory/label	Example of quote
Purpose The purpose for which the CPAP is used	*Interventions*		According to the interviewees, one of the goals of the CPAP is the timely use of interventions. Such as what can forensic nurses do to reduce stress from their patients.	FN: 'That you use an intervention that the patient likes and that fits well' Psychia: 'Immediately take action so you avoid a more severe phase'
	Recognizing stress		To be able to use interventions, increasing levels of stress must be recognized first. This increasing stress can be recognized more readily and in time when the CPAP is used.	GSM: 'To recognize as quickly as possible if there is increasing stress in a patient'
	Preventing crises		Recognizing deteriorating behaviour and deploying interventions can prevent crisis.	Psychia: 'So in order to prevent a real crisis, it is important that you can recognize deteriorating behaviour early'
Content The correct way to fill out a CPAP	*Specific behaviours*		When completing the CPAP, specific behaviours must be written down in a short, concrete and concise manner.	FN: 'You must describe real behaviour, properly describe the concrete behaviour of how the patients behaves and what they need'
	Improvement of the Design of the CPAP	Ease of use	Thoughts and ideas to change the design of the CPAP, with regard to the classification of the phases or regarding reducing the quantity of the CPAP.	EDC: 'It would be handy if you had the early warning signs short and concise, that you could see the whole plan in 1 A4' P: 'It is fine to have just 3 phases instead of 5'
		Standardization	Design a standard CPAP as a starting point.	SW: 'It would be useful to use standard questions to also provide the staff member with tools to inquire about specific topics'
		Other improvements	Some additional ideas are mentioned to expand or change the design of the CPAP. For example adding something to the CPAP, making more CPAPs or make small cards.	FN: 'Give them a small crisis card that patients can carry with them' GSM: 'Therefore add also a kind of treatment in it, like what can others do'

	Early warning signs		Broad categories of early warning signs of deteriorating behaviour, that can be described per category, based on the phases of the CPAP.	FN: 'It is good to have a number of standard things in it such as emotions, becoming psychotic, aggression, suicidality, addiction'
	Completion process	Fill out together with patient	The best way to fill out a CPAP according to interviewees is to do it together with a patient.	FN: 'As a personal mentor, together with a patient I look at what the signals are and what we have to fill out there'
		Short and concrete	When writing the CPAP, it needs to be short, concrete and concise.	T: 'That you write it down in short clear sentences'
		History	Be aware of the history of the patient when completing a CPAP.	GSM: 'Make sure you are aware of the history of the patient so that you already have prior knowledge'
		Tools	The tools that forensic nurses and other disciplines need to properly complete the CPAP. For instance an example list of behaviours and interventions.	T: 'For the more inexperienced employees, make a list with examples of behaviours and interventions, to get inspiration from it and help them on their way'
Procedure How the CPAP should be used	*User involvement*		That the patient gets involved with their own CPAP, so that when they leave the FPA they know what they can do to prevent their own deteriorating behaviour.	GSM: 'Because I want the patients to take the CPAP with them when they resign and that they can use it by themselves'
	Multidisciplinary involvement		That most disciplines get involved with the CPAP from a patient, because it should be considered from different perspectives.	FN: 'A moment when you ask all the disciplines that are involved, this is the CPAP for a specific patient and then you get interaction and everyone can respond' SW: 'In fact, anyone who provides therapy could have an input'
	Daily work	Reminding each other	To draw more attention to the CPAP, staff members can remind each other about it daily.	FN: 'Making each other aware of, pointing out to each other, it must come to the attention'
		Mentor conversations	Discuss the CPAP on a regular basis during the mentor conversations.	EDC: 'In your mentorship you discuss certain topics every week, like leave of absence, why not discuss the CPAP every week'

		Reporting	Use headings in the daily reporting to remind staff members that they have to report about the CPAP.	FN: 'You should put that in the reporting system, we now have a 'BVC' heading, that you also add a 'CPAP' heading'
		Printing on paper	To print the CPAP on paper, so it is closer and more at hand.	EDC: 'Printing the CPAP that would be really cool' SW: 'Print it out, put it in a folder at the office'
	Responsibility		Assignment of a person responsible for filling out the CPAP, keeping it up-to-date and that the CPAP is substantively useful.	Psychia: 'Personal mentor and the psychologist are responsible, they know the CPAP best and they make the design and are most involved'
	Evaluation		Which moments are suitable for evaluation of the CPAP.	FN: 'Update or review at least 2 or 3 times a year, because the behaviour changes after a while and you should definitely do something with that'
	Implementation		Greater implementation through training and making a staff member responsible for checking the CPAP.	EDC: 'I also think a little training on how to make a CPAP' FN: 'An environmental department coordinator who monitors the entire process and check if everything is correct'

The results as shown in Table 3 will be elaborated below. An overview will be given of the differences and similarities between the opinions and ideas from interviewees for every sub category. Also an overview of the suggestions and ideas of the interviewees according to several issues will be shown. More quotes than mentioned in Table 3 will be attached to substantiate the results.

Purpose

Interventions

Interviewees (18; 86%) mentioned that the deployment of interventions should be one of the goals from the CPAP. More specifically, that staff members should consult the CPAP to look for personalized interventions that reduce stress in patients. Examples of quotes in this respect are:

> 'How can we guide patients as well as possible in a moment of increasing stress' (FN).
>
> 'Headings with 'interventions that others can do', for the forensic nurses and 'interventions that you can do yourself', for the patients' (GSM)

So, according to the interviewees, the CPAP must include interventions that can be implemented by the staff members and by patients themselves. Interviewees mention various examples of such interventions, for example:

> 'Things like medication should also be there' (Psychia).
>
> 'To increase contact moments' (GSM).
>
> 'Take a walk, a time-out, a cigarette or coffee, sometimes medication' (FN).
>
> 'Also a list of pleasant things, what you can use to stabilize someone' (EDC).

Recognizing stress

The recognition of deteriorating behaviour precedes the deployment of interventions. Interviewees (16; 76%) mentioned that by consulting the CPAP, behaviours that indicate increasing stress could be recognized. Example of a quote that supports this:

> 'I think it is important that you can recognize the phase that someone is in' (T).

The CPAP should also include early warning signals in deteriorating behaviour that can easily be recognized.

> 'Certain behaviour so that you know whether or not it is going well' (EDC)

‘Being able to remove stress and de-escalate by being able to pick up early warning signals timely’ (FN).

Preventing crisis

When by consulting the CPAP deteriorating behaviour is recognized and interventions have been successfully deployed, crisis can be prevented. Just over half of the interviewees (12; 57%) mentioned that further deteriorating behaviour can be prevented and a patient's stress level can be decreased by using the CPAP.

> 'When a patient thinks or you think something is wrong, someone is restless, that then the CPAP is used, to make sure that there will be no crisis' (SW).

Thus, not all interviewees mentioned all three sub-categories, but the majority of the interviewees mentioned one or more. There can be stated that the different disciplines working at the FPA have the same purpose regarding to the CPAP, recognizing deteriorating behaviour and deploying interventions to prevent crisis. This corresponds to the literature studied in this research and thus to the definition of the main category '*purpose'*.

Content

Specific behaviours

Interviewees (9; 43%) mentioned that when completing the CPAP it is important to write down short, concrete and concise behaviours that you can literally observe.

> 'What kind of gaze does someone have, what kind of posture, really that you know that it is specifically about that patient' (EDC).
>
> 'Simply concrete behaviour, short but powerful, not whole sentences' (FN).

Improvement of the Design of the CPAP

There were many ideas among all interviewees (21; 100%) regarding the improvement of the design of the CPAP. In Appendix A there is seen how a CPAP looks like in its current design at the FPA. The opinions and ideas about the design of the CPAP are subdivided into labels because there were many examples.

- Ease of use: Most of the interviewees (17; 81%) mentioned that they would like to have a more concise version of the CPAP, because it should be able to be used quickly when deteriorating behaviour is recognized. For forensic nurses and also for patients.

> 'A concise version, easily readable' (FN).

> ‘At most it would have to be 2 A4 pages on the front and back, which makes it manageable, especially when the stress level is raised, the patient should be able to understand it’ (GSM).

Also most of the interviewees (15; 71%) mentioned that they would like to see a different design regarding the phases from the CPAP. This is in line with the previous example with regard to the concise version, because those 15 interviewees want an adjustment in the phases so that the CPAP is more manageable. What they are saying is that they want to have three phases instead of the now five phases, because there is often not so much difference between different phases of deteriorating behaviour. Interviewees mention this must be the ‘normal’, the ‘mild’ and the ‘severe’ phase.

> ‘I would favour a normal phase, a mild phase and a severe phase and then these as 3 headings in the CPAP’ (GSM).

Most of them (12; 57%) are suggesting to add colours to increase clarity. These interviewees mention the colours green, orange and red, as a kind of traffic light.

> ‘It is more concise, three phases: it goes well, it goes less, it goes bad’ (FN).
>
> ‘Colours behind the phases, I thought that is pretty useful, a bit childish as a traffic light, but clear; green orange and red’ (FN).

A minority of interviewees (3; 14%) suggested changing the last phase of the current CPAP, the very severe phase, into a plan for when coercion is needed and what the best way is to place the patient in isolation.

> ‘Some sort of separation plan, how would you like to be placed in isolation if this is needed, what is the least traumatic way for you, I think that this is good to add to the very severe phase of the CPAP’ (GSM).

- Standardization: What was also mentioned by almost half of the interviewees (9; 43%) was to make a standard CPAP with for example the same topics in every CPAP or based on diagnostics.

> ‘A kind of basic CPAP based on the clinical picture, so that you have a kind of start’ (FN).
>
> ‘I think you should have a standard CPAP, you can do so by addressing the same topics or questions for everybody’ (T).

Some examples of this last quote are also given:

> ‘The same topics must come back, that if you talk about day and night rhythm, you describe that in phase 0 and you also describe this in other phases, certain early warning signs that are important for that person’ (T).

> ‘For example, phase 1, 2 and 3 standard sentences: ‘How am I doing’, ‘I notice this’, ‘How do I feel’, ‘What do I do’’ (FN)

- Other improvements: Furthermore some examples for expanding or changing the CPAP are given: 1. add a piece of text to the CPAP about treatment of the patient in general, 2. adding items from the Brøset Violence Checklist (BVC) to the CPAP, 3. make more CPAPs for several risks and 4. give patients their own summarized CPAP in the form of a card. The first two examples are mentioned by 7 interviewees (33%) and the last two examples are mentioned by 5 interviewees (24%). Below for every example an appropriate quote.

> 1. Treatment: ‘A very small piece of treatment that I just miss in the CPAP, in general how do you want to be treated, what are your trigger points’ (FN)
> 2. BVC: ‘Linking to a BVC, actually the BVCs should also be in a CPAP, for example that you have a BVC 1 in phase 1 or moderate phase’ (FN).
> 3. More CPAPs: ‘To have multiple CPAPs, I do miss how we distinguish how to act in case of aggression or someone who has cravings for drugs or alcohol, sometimes there is really a different kind of intervention needed’ (FN).
> 4. Card: ‘On a card very globally, a flashcard that you can put in your wallet that a patient can also give to a family member like this is my crisis plan’ (T).

Early warning signs

The majority of the interviewees (15; 71%) mentioned broad categories of early warning signs that can be included in the CPAP. Specific early warning signs cannot be mentioned, because this is very individual and differs per patient. Broad categories of early warning signs that were mentioned: aggression, substance abuse or craving, suicidality, withdrawal, psychosis and psychological state of mind. Interviewees believe that these early warning signs are important to add to the CPAP, because crises often takes place in one of these categories. For example, one interviewee mentioned:

> ‘Psychotic decompensation, aggression, suicidality, craving, I think those things are the main signals for the CPAP’ (Psychia).

Another interviewee indicated:

> ‘In forensic care you are often aiming to reduce aggression or craving and aiming for stress regulation, so I think those warning signs are important’ (P).

Aggression, substance abuse or craving, psychosis and psychological state of mind are mentioned most often. Aggression and substance abuse were mentioned by 12 interviewees (57%). Eight interviewees (38%) mentioned psychosis and psychological state of mind. Suicidality follows with five interviewees (24%) who mention this and withdrawal is mentioned least often, only by two interviewees (10%). Also an example is given about the potential use of these broad categories of early warning signs:

> ‘Compile a whole list with possible early warning signals, these have to be of course very concrete things’ (EDC).

Completion process

All interviewees (21; 100%) had an opinion how to correctly fill out a CPAP. These opinions and ideas are subdivided into labels because there were many examples.

- Fill out together: There are differences and similarities in the opinions of the interviewees. A great similarity is that more than half of the interviewees (13; 62%) mentioned that the best way to fill out a CPAP is together with the patient.

> ‘The most ideal thing is to do it together with the patient’ (GSM).
>
> ‘Make the CPAP together with the patient in a one on one conversation’ (FN).

- Short and concrete: Also a similarity is that interviewees (9; 43%) mentioned that the CPAP needs to be filled out short, concrete and concise. To make it clear for everyone.

> ‘Must be completed briefly and concretely and as clearly as possible’ (FN).
>
> ‘Describe phase 1 standard: ‘how am I doing, I notice this, I feel this, I do this’, very concrete’ (FN).

- History: Some interviewees (8; 38%) mentioned that being aware of the history of the patient is important. For example asking family or previous institutions if they know behaviour or interventions that can be added to the CPAP, with permission of the patient of course.

> ‘For example, ask the patient if it's good if I ask your mother because mothers know things like that’ (EDC).
>
> ‘Family should be involved wherever possible’ (T).
>
> ‘Call the previous institution and ask for their signalling plan so we can place this in our own CPAP’ (EDC)

Also that you have read into the file and the history of the patient and that you are informed about the offense and the clinical picture is mentioned as useful before filling out the CPAP.

> 'Take a week to observe and read all reports' (FN.)

- Tools: Regarding the completion of the CPAP, there are some differences in the opinions of the interviewees. Some interviewees (6; 29%) mention that you just have to get started, ask colleagues for help and for feedback.

> 'Send an e-mail to your team and say the CPAP is finished, would everyone look at it and give feedback?' (FN).

But others (9; 43%) say something different, like that it is useful to have some starting points for staff members and help them on their way.

> 'It may be useful to have some tools, actually what we explain to new staff members but then written on paper' (EDC)
>
> 'For example that you can start the conversation with that the patient commits a crime, what are the signals and symptoms and what precedes this, and you do this until the first phase' (Psychia).

Concluding, interviewees have many ideas, some corresponding to literature and some 'new' ideas. According to interviewees, to improve the CPAP some changes could be made. Most interviewees mention that the CPAP should be filled out by the patient and the forensic nurse together, this should be done in three phases, where concise and specific behaviours have to be filled out as early warning signs for aggression and substance abuse. This corresponds partly to the literature studied in this research and thus to the definition of the main category '*content'*.

Procedure

User involvement

Regarding the use of the CPAP, it is important that the patients also get involved. That they not only fill out the CPAP, but also use it themselves. Most of the interviewees (17; 80%) think that the CPAP is useful for patients to help them recognize their own deteriorating behaviour. So they can use this in the future when they are back in society and no longer have the protection of the clinic and the forensic nurses.

‘The best thing would be if patients started using the CPAP themselves, I think that this is one of the main goals’ (FN).

‘Create problem awareness and problem insight in patients, so that they gain more insight into their own stress levels’ (P)

An idea of an interviewee regarding the involvement of the patients with the CPAP:

‘Because I want them to take the CPAP with them when they resign from the clinic’ (GSM)

Multidisciplinary involvement

It is also important that different disciplines get involved in the process of using and making the CPAP. The forensic nurse and the psychologist, but also the therapists, the psychiatrist and other disciplines that are involved in the treatment of a patient.

‘I think it must be an obligation for all disciplines involved in the treatment of a patient, that everyone has viewed and added to the CPAP, and that this must be checked’ (Psychia)

All interviewees (21; 100%) agree that more disciplines need to be involved, but there are differences in opinions about which disciplines and how they should be involved. Most interviewees (20; 95%) think that the therapists need to be involved, because they have substantive and deep personal contact with the patient.

‘Therapists can definitely be involved, not at the start, but later they can be of great value if they know the patient for a while and if they notice that something works that they used, then that can be added to the CPAP’ (P)

Other interviewees (8; 38%) think that the forensic nurses and the psychologists need to be involved, some others (5; 24%) think that social workers and environmental department coordinators should be involved and only a few interviewees (3; 4%) believe that general staff members and psychiatrists need to get involved.

Some interviewees mentioned that some disciplines could have the task of bringing the CPAP to the attention of others:

‘To bring it to attention, the psychologists and the environmental department coordinators can play a role in this’ (FN)

‘Checking the CPAP together, ask others do you recognize this’ (T)

Daily work

All interviewees (21; 100%) mentioned the use of the CPAP on a daily basis. These ideas are subdivided into labels because there were many examples.

- Reminding each other: Interviewees (16; 76%) mentioned reminding each other in different ways to use the CPAP on a daily basis.

> 'That everyone is attentive and that they say to each other in different situations; take a look at the CPAP' (EDC).
>
> 'Mention it during transfers of forensic nurses and in the multidisciplinary briefings in the morning' (GSM).

- Mentor conversations: Other interviewees (9; 43%) think that it is useful to integrate the CPAP in the conversations between forensic nurse, who is a mentor, and patient.

> 'You can integrate it into your mentor conversations, you can say: shall we look at you CPAP?' (EDC).

- Reporting: A few interviewees (3; 14%) think that is useful to add the CPAP as a heading for reporting, reporting needs to be done every day so then it is inevitable to think about it.

> 'I think in the reporting a heading 'CPAP signals?', for instance' (FN)

- Printing on paper: Something striking that 71% of the interviewees (14) mentioned, is printing the CPAP on paper. This is striking, because so many interviewees mentioned this and it is a very specific solution. Then the CPAP is more physically close during the daily work, staff members can grab it during transfers or briefings.

> 'Very simple, close on paper, or nobody will learn' (Psychia)

One interviewee (5%) talked about the CPAP as an application for a smartphone or tablet, which can be seen by forensic nurse and patient.

> 'To make the CPAP in an application form because you always have your smartphone with you and that the app would synchronize with the reporting system from the forensic nurses, that they and the patient can see this' (GSM)

Responsibility

Almost every interviewee (20; 95%) agrees that first the personal mentor and also the psychologists are both responsible for completing the CPAP and keeping it up-to-date. One interviewee did not agree, because the forensic nurse should not be responsible for such an important document:

> ‘In the end the psychologist is responsible, I have never understood that it is also the personal mentor, I do not think this is right’ (T).

But the rest of the interviewees agreed that the personal mentor, who is a forensic nurse, and the psychologist are responsible, with both different tasks.

> ‘Responsibility should be shared between psychologist and personal mentor, who is a forensic nurse, in which the personal mentor takes a more active approach to it but the psychologist also provides feedback on the CPAP’ (T).
>
> ‘That the personal mentor completes the CPAP and that the psychologist can make an addition to it by being able to add something from the diagnostic level and things that they have read in treatment interviews or from files’ (FN).

Evaluation

All interviewees (21; 100%) had ideas about when to evaluate a CPAP, because they stated that the CPAP is a dynamic document and it must be updated on a regular basis. There are different ideas among interviewees, these are discussed below:

1. Treatment plan: Most interviewees (15; 71%) mentioned that the CPAP needs to be evaluated during the official conference about the treatment plan where all involved disciplines are present.

> ‘Evaluation moment can be added to the treatment plan because there is a learning goal for every patient about stress regulation’ (EDC).

2. After crises: More than half of the interviewees (12; 57%) mentioned that the CPAP needs to be evaluated after an incident.

> ‘It is good to evaluate the plan after an incident’ (P).

A few interviewees (3; 14%) mentioned evaluating the CPAP specific during ‘zinloop’, which is the weekly meeting where the reported incidents are discussed at the FPA.

3. Case study: Some interviewees (7; 33%) mentioned that the CPAP could be evaluated during the weekly case studies that are every week about a different patient.

> ‘There is a case study every week, that you discuss a patients CPAP there’(T).

4. Leave request: Very few interviewees (3; 14%) mentioned evaluating the CPAP during the weekly meeting (called: ‘VGB’) where the requests for leave of absence are discussed.

> ‘During the VGB, if they request the next phase for leave of absence’ (GSM).

Implementation

What is mentioned by almost all interviewees (20; 95%) is that there is a need for more explanation and training about how to make and use a CPAP.

> 'What matters is that the personal mentors have the feeling that they can do it and that they are also trained in this where necessary' (T).
>
> 'There just needs to be sufficient explanation and guidance' (EDC).

Other interviewees (9; 43%) say that it is important to make somebody responsible for checking if it is correctly made and used. Most of them (7; 33%) think that the environmental department coordinators should be made responsible.

> 'Environmental department coordinators, they are busy with the common thread in the treatment and then they can check whether CPAPs are correct and make personal mentors aware of this' (FN).

In conclusion, according to this research question concerning '*procedure'*, interviewees have many ideas. The aim of this research question was to investigate how the CPAP should be used more often. Most interviewees mention that the patient should be involved in the CPAP procedure. What is also mentioned, is that the responsible forensic nurse and the therapist needs to be involved. When more staff members are involved, the CPAP will probably be used more often. During daily work, staff members should remind each other to check the CPAP and the forensic nurses should reflect on it with patients during weekly conversations. The CPAP should be evaluated during the treatment plan meeting and the staff members should receive training in making and using a CPAP. This corresponds to some literature studied in this research.

Discussion

The research aim of this study was, to improve the use of the CPAP at a FPA facility in The Netherlands. Overall, the most important findings from the data fit the expectations from the literature from Fluttert (Fluttert et al., 2008; Fluttert, 2010; Eidhammer, Knutzen & Fluttert, 2010). According to the interviewees, the *purpose* of recognizing early warning signals in behaviour is to prevent crisis by early intervention and early recognition. The *content* of the CPAP should be regarding the majority of the interviewees, filled out concisely with specific behaviours. Some changes in the design are suggested, a few early warning signs are mentioned and also some ideas about the completion process. Regarding the *procedure* of using the CPAP, interviewees indicated that patients, responsible forensic nurses and therapists need to be involved in the process. Also that the CPAP should be used daily and that there needs to be an evaluation moment. To implement all of this at the FPA, interviewees mentioned that staff members should be trained in this.

Only the most important findings will be discussed, these are the findings that are mentioned by 50% or more of the interviewees and findings that clearly correspond with literature.

Theoretical reflection

There are several differences and similarities between literature and findings in this research, although the similarities are more prevalent. First similarities about the main category *purpose* will be discussed; findings have shown the importance of early recognition to prevent crises and the use of risk-reducing interventions to decrease the stress level of patients. There can be stated that there are almost no discrepancies between the purpose literature gives and the purpose interviewees give to the CPAP. A minor difference is that Fluttert et al. (2005) states that a purpose of early recognition is that patients can practice with coping skills, self-reflection and preventing themselves from risky behaviour in a controlled environment. Interviewees (17; 80%) did mention the importance of user involvement, but the reasons they gave were generally focused on the patient reintegrating in society. It is not clear whether patients practicing coping skills, self-reflection and preventing themselves from risky behaviour did not come to the minds of the interviewees or that they think this is not important. A possible explanation can be the broad research questions that have been

asked to the interviewees and that no specific questions were asked about this particular topic.

Findings in data have shown that according to the *content,* interviewees (13; 62%) mentioned that forensic nurses and patients should fill out a CPAP together. The CPAP should be easy to use with specific and concrete early warning signs. This relates to the literature about the method of Fluttert et al. (2008): the ERM. The ERM also corresponds to the findings in the data about the design of the CPAP and the completion process. There are interviewees (15; 71%) who also want three phases, like there are in the ERM. A difference is that almost all interviewees (12; 57%) mentioned that these three phases should be in colours: green, orange and red. Some other differences are, that the ERM is focused on preventing all behaviour with negative consequences (Eidhammer, Knutzen & Fluttert, 2010). However interviewees (12; 57%) think that the focus from the CPAP should be mostly on preventing aggression and substance abuse that leads to aggression. Although at odds with the ERM approach, this finding does relate to the literature from Nicholls et al. (2009) about aggression as the central problem of forensic patients.

A possible explanation for the discrepancy is that interviewees often deal with aggressive behaviour and thus think that this should be the main focus of the CPAP. This can be important, because using the CPAP is all about preventing crises and recidivism, it does not only have to be due to aggression. The ERM enlarges this and states that it is about early warning signs of all behaviour with negative consequences, which are combined in the FESAI (Fluttert et al., 2012). This is also mentioned by one interviewee (1; 5%), who mentions that there should be a list of early warning signs to support forensic nurse and patient in making the CPAP.

In addition, what is not often mentioned by interviewees are preventive actions described in terms of positive self-management measures, which can be used by forensic nurse and patient. According to the ERM, preventive actions should be described in terms of positive self-management measures, which can be used by forensic nurse and patient (Fluttert et al., 2008). Only a few interviewees (2; 10%) mentioned this, they say that there should be a list of pleasant things what the patient can do to decrease stress. A possible explanation that this is not often mentioned could be, that interviewees were thinking about what they can do about deteriorating

behaviour from a patient and not about what the patient can do. But because of the broad research questions that have been asked to the interviewees, no specific questions were asked about this particular topic. Almost all interviewees (17; 80%) mentioned the importance of user involvement from the patients, but putting this into practice and describe interventions, as positive self-management measures for patients could be difficult. No interviewees mentioned dual harm from Slade (2019), a possible explanation for this could be that it is a fairly recent phenomenon.

Some similarities that have emerged from literature and also from the findings concerning *procedure*, is the need for active involvement of patients and responsible forensic nurses. The CPAP should be used in daily work; it should be evaluated regularly and implemented correctly in the organization. According to literature, forensic nurses can use the ERM on a daily basis and they are first responsible, using weekly mentor conversations to teach patients to monitor their behaviour (Fluttert et al., 2008). This corresponds to the findings in the data about daily work and responsibility. There are interviewees (9; 43%) who think that the CPAP should be a part of weekly mentor conversations and there are interviewees (20; 95%) who believe that the forensic nurse is responsible for filling out and teach patients about the CPAP. Contrasting, Bjørkly (2004) states that ProLad must be evaluated every evening. This is not feasible for forensic nurses who are mentor, because they don't work every day and certainly not every evening. The MPA from Jones and Hollin (2008) offers a 36-week during program and it is a prerequisite to have the same mentor throughout the entire program. This is not feasible, because the duration of the admission at the FPA can be longer or shorter than 36 weeks. Also having a mentor for this amount of time is not feasible, because there is a flow of patients within the departments and when patients are transferred also their mentor changes. On the other hand, the ProLad and the MPA are very structured and complete methods; they provide customized care because of the stepwise approach and so they are worth considering.

Something that is not mentioned in literature, but what interviewees (14; 67%) state as important, is printing out the CPAPs on paper. To have it more close so that staff members could remind each other more often. Reminding each other about the CPAP during daily work was something that interviewees (16; 76%) mentioned quite often. Concerning specific evaluation moments and training for staff members, not

much is found in the reviewed literature. However, interviewees (15; 71%) mention the treatment plan meeting as an appropriate moment to evaluate the CPAP. Also to implement everything that is mentioned at a FPA, interviewees (20; 95%) believe that staff members need training to fill out and use the CPAP. Only in research about the ERM, Fluttert (2010) mentioned that forensic nurses should have professional education to use the ERM.

Limitations

There is not much literature about signalling plans (like the CPAP) for early warning signals in deteriorating behaviour in forensic care. The reviewed literature shows a general approach to this subject, but not very much specific information. For example, literature shows that forensic nurses should fill out and use the CPAP together with their patients, but not how and when. What makes this research unique is that it examines the opinions from staff members working at forensic care and how they would like to use the CPAP. This provides specific information with tools to implement the use of the CPAP at an organization. Therefore a number of recommendations are set up in the following.

One of the limitations in this research is the response bias; this is also mentioned in method. The interviewees represent a large group of staff members working at the FPA (21 interviewees out of 156 staff members). It is possible that participating staff members who reacted on the e-mail are more interested in the use of the CPAP than compared to other staff members. This can be a response bias, because the participating staff members may already have had the idea that something had to change. So it is possible that all the opinions mentioned during the interviews are not a good representation of the general opinion of staff members working at the FPA. Another limitation is that the researcher that conducted this thesis works at the FPA and is thus a colleague of the interviewees. It could be possible that interviewees tell fewer details about their dissatisfaction of the organization, because the researcher knows all the staff members and works also for the organization. On the other hand, this can also be an advantage, because interviewees might tell more details to someone they know and who also knows the organization. According to the intergroup sensitivity effect of Hornsey & Imani (2016), it is found that an ingroup member is more trusted with criticism and evokes less defensiveness compared to

outgroupmembers. Based upon this, there can be stated that because the researcher is an ingroupmember, interviewees will tell more details.

As expected, not all the interviews preceded the same. The interviews did follow the same questions, but this did not mean that they had the same sequence. This depended on the amount of information provided by the interviewee and how much the interviewer had to ask further for more in-depth information. Some had no opinion about a certain question or they just did not mention it. This could explain why interviewees do not mention some concepts, which came forward from literature. Examples of this are described above, see ‘Theoretical reflection.

Generalizability of the current study to all forensic care needs to be further investigated. The research was conducted in a FPA and there can be assumed that it is also applicable for other FPA’s who work with the CPAP.

Implications

The results of this research can be used in practice. Staff members working at a FPA can be helped with this information. This can be important for many more organizations in forensic care that are working with offenders. These organizations can improve the use of their CPAP, based on this research. For all the practical implications and also recommendations, see ‘Recommendations’ below.

Recommendations

There is not much known yet about how to fill out and use a signalling plan. Where this research could be used for, is as a base for further research. From this research, ideas have emerged from interviewees about the use of the traffic light colours in the CPAP. There is not much research about the use of traffic light colours in forensic care. Exploratory research about the use of traffic light colours in the forensic care has found that it can be effective in the treatment of forensic patients and in particular in the application of signalling plans. Adding colours can thus be supportive, but further research into the application in for example signalling plans, is necessary (Fluttert, Fonteijn, Van der Sleen & Van der Meulen, 2011). It would be interesting for further research to see to what extent patients could benefit from this when added to the CPAP, for scientific substantiation. Other interesting information is the importance of preventive actions described in terms of positive self-management measures. It would

be interesting for further research to investigate what these preventive actions could or should look like with concrete examples. Findings and literature mention that forensic nurses should discuss the CPAP with patients during weekly mentor conversations. However, how forensic nurses should do this is not mentioned in literature or in findings. It would be interesting for further research to see how forensic nurses could do this exactly in a systematic way.

Below, some practical recommendations are given to the FPA based on the findings of this study that can be implemented in the organization to improve the use of the CPAP. According to *purpose,* no recommendations are given. The purpose that the interviewees gave to the CPAP is very similar to the purpose that literature gives. All practical recommendations are based on the findings and literature from the *content* and the *procedure.*

Practical recommendations

From the interviews and literature, data and results have followed that can be used to set up an improved CPAP procedure. For this procedure, some practical recommendations are given as an advice for the FPA.

- Use three phases for the CPAP and add colours to the phases. The first phase is the normal phase with the colour green, the second phase is the mild phase where the first early warning signs are recognized and early interventions can be deployed (colour orange) and the last phase is the severe phase where the early warning signs are severe and preventive action must be taken to prevent crisis (colour red). This is a major change in the instrument the CPAP. The reason that this change is included in the recommendations is because using three phases is mentioned in the ERM (Fluttert et al., 2010). Also next to the three phases, adding colours is mentioned by the majority of the interviewees (15; 71%).

- Forensic nurse and patient fill out the CPAP together.

- Fill out concrete and specific behaviours as early warning signs. Forensic nurses can use the FESAI to discuss and identify the most relevant early warning signs in behaviour (about 3 to 5 signs). It should be focused on all behaviour with negative consequences.

- Involve patients in the use of the CPAP. This can be done for instance during weekly mentor conversations to help the patients monitor their own behaviour. In this way the patients are aware of their CPAP and what their early warning signs are.

- Remind each other daily about using the CPAP. Printing out the CPAP on paper can support this.

- Provide training in making and using the CPAP for staff members.

- Involve therapists in making and using the CPAP. They can for instance join the weekly mentor conversations or follow the training.

- The evaluation moment should be during the treatment plan meeting. This is a systematically recurring meeting and then there is assurance that the CPAP will be evaluated.

Regarding all suggestions and improvements the interviewees gave in this research, it seems like that the CPAP was not used properly. When these practical recommendations are implemented at the FPA, it is likely that the use of the CPAP will be improved. Staff members will work more homogeneously with the CPAP, because they all use the same procedures. Also patients will be able to maintain themselves better in society, because they have different tools to manage themselves (Eidhammer, Knutzen & Fluttert, 2010). Using the CPAP can also lead to a decrease in recidivism, through signalling early warning signs in behaviour of forensic patients and taking preventive action (Fluttert et al., 2005; Hoogsteder & Bogaerts, 2018). Through these improvements, there will probably be a decrease in the number of incidents and thus better working conditions for the staff members. This is likely, because a significant decrease in the number of incidents was found when introducing the ERM (Fluttert et al., 2010). A critical sidenote from Dr. F. Fluttert about the CPAP, is that he is not enthusiast how institutes develop from ERM their own strategies without sound research. According to his opinion, the CPAP should first be tested in its current state. From a scientific point of view there is ‘program integrity’, a strategy cannot just be changed. Research is needed in order to avoid false expectations, or unwanted side effects (Fluttert, e-mail communication). To reach ‘program integrity’ according to Dr. Fluttert his opinion, the ERM can be used as instrument and procedure for signalling early warning signs in behaviour.

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Appendix A

CPAP zoals gebruikt binnen de FPA

FASE 0	**Normale fase**
Wat merk ik zelf	
Wat merken anderen	
Wat doe ik zelf	
Wat kunnen anderen doen	
FASE 1	**Vroege fase**
Wat merk ik zelf	
Wat merken anderen	
Wat doe ik zelf	
Wat kunnen anderen doen	
FASE 2	**Milde fase**
Wat merk ik zelf	
Wat merken anderen	
Wat doe ik zelf	
Wat kunnen anderen doen	

FASE 3	**Ernstige fase**
Wat merk ik zelf	
Wat merken anderen	
Wat doe ik zelf	
Wat kunnen anderen doen	
FASE 4	**Zeer ernstige fase**
Wat merk ik zelf	
Wat merken anderen	
Wat doe ik zelf	
Wat kunnen anderen doen	

CPAP as used at the FPA

PHASE 0	**Normal phase**
What do I notice myself	
What others notice	
What can I do myself	
What can others do	
PHASE 1	**Early phase**
What do I notice myself	
What others notice	
What can I do myself	
What can others do	
PHASE 2	**Mild phase**
What do I notice myself	
What others notice	
What can I do myself	
What can others do	

PHASE 3	**Severe phase**
What do I notice myself	
What others notice	
What can I do myself	
What can others do	
PHASE 4	**Very severe phase**
What do I notice myself	
What others notice	
What can I do myself	
What can others do	

Appendix B

Vragenlijst (Nederlands)

a. Doel: Voor welk doel zou het CPAP gebruikt moeten worden?

- Wat heb je geleerd in je inwerkperiode over vroegsignalering en een CPAP?
- Maak je nu regelmatig gebruik van CPAP van patienten? Waarom niet/wel?
- Waar gebruik je een CPAP voor?
- Wat vind jij het belang en de meerwaarde van een CPAP?
- Wat zou je ervan vinden als er diagnostiek gebruikt zou worden om de CPAP vorm te geven?
- Hoe kan het CPAP het beste gebruikt worden op de afdeling?

b. Inhoud: Wat is de correcte manier om het CPAP in te vullen?

- Heb je wel eens een CPAP ingevuld? Zo ja, hoe deed je dit dan en waarom?
- Heb je hierbij hulp gehad van collega's?
- Wat vul je dan in?
- Wat moet de inhoud van een CPAP zijn?
- Welke vragen moeten er gesteld worden bij het invullen van een CPAP?
- Welke onderwerpen of risicofactoren moeten absoluut in het CPAP?
- Hoe ziet een CPAP eruit dat jij prettig zou vinden om te gebruiken in je dagelijkse werk?

c. Procedure: Op wat voor manier zou het CPAP vaker gebruikt kunnen worden?

- Wanneer vul je het beste een CPAP in volgens jou?
- Wie vult een CPAP in? Wie niet? Waarom?
- Hoe vul je een CPAP het beste in volgens jou?
- Wanneer en hoe vaak moet het CPAP geëvalueerd worden?
- Wie is er verantwoordelijk voor het invullen en up-to-date houden van het CPAP? Waarom?
- Hoe kunnen meerdere disciplines samen een CPAP voor een patient maken?

Questionnaire (English)

a. Purpose: For what purpose should the CPAP be used?

- What did you learn in your training period about early warning signals and a CPAP?
- Do you use the CPAP on a daily basis right now? Why (not)?
- For what do you use a CPAP?
- What do you think is the importance and added value of a CPAP?
- What do you think about using diagnostics to form a CPAP?
- How can the CPAP be used best at a department?

b. Content: What is the correct way to fill out a CPAP?

- Have you ever filled out a CPAP? When yes, how and why?
- Did you receive help from colleagues?
- What do you fill out?
- What should the content of a CPAP be?
- Which questions should be asked while filling out a CPAP?
- Which subjects or risk factors must definitely be addressed in a CPAP?
- How does a CPAP looks like which you would like to use in your daily work?

c. Procedure: How could the CPAP be used more often?

- When is the best moment to fill out a CPAP?
- Who fills out a CPAP? Who does not?
- Where and when does a CPAP need to be evaluated?
- Who is responsible for filling out and keeping the CPAP up-to-date? Why?
- How can other disciplines be involved in completing the CPAP?

Appendix C

Informed Consent (Nederlands)

Het herkennen van risicovol gedrag bij forensische patienten
Het CPAP verbeteren binnen de FPA

Onderzoeker: Celina Klok
Begeleiders: Kiki de Carvalho & Carlijn Baarsen

Doel van het onderzoek
Het doel van dit onderzoek is het verbeteren van het CPAP binnen de FPA. De meningen en ideeën van de medewerkers worden onderzocht om een procedure voor het CPAP vorm te geven en te kijken hoe dit het beste geïmplementeerd kan worden. Dit alles zal beschreven worden in een masterthesis aan de Universiteit Twente.

Interview
Voor dit interview is maximaal 30 minuten ingepland. Het interview is semi-gestructureerd aan de hand van een aantal thema's. Uw deelname is geheel vrijwillig. U kunt zich op elk gewenst moment terugtrekken van dit interview zonder dat u daar een uitleg bij hoeft te geven.

Hoe wordt omgegaan met de informatie
De data die volgt uit dit interview zal gebruikt worden voor het vormgeven van een CPAP procedure en een implementatieproces. Uw persoonlijke gegevens zullen vertrouwelijk worden behandeld, uw identiteit zal niet bekend worden gemaakt of gedeeld met derden. Het interview wordt met audioapparatuur opgenomen zodat de onderzoeker er een verslag van kan maken. Dit verslag wordt zonder vermelding van naam van de geïnterviewde en met zo min mogelijk herleidbare gegevens opgeslagen. Uw naam wordt apart van het interviewverslag opgeslagen en zal alleen bekend zijn bij de onderzoeker.

Voor verdere vragen kunt u mailen naar: celinaklok@outlook.com (u mag ook mailen als u een samenvatting wilt van de onderzoeksresultaten)

In te vullen door de deelnemer
Ik verklaar op een voor mij duidelijke wijze te zijn ingelicht over de aard van het onderzoek. Mijn (eventuele) vragen zijn naar tevredenheid beantwoord.

Naam deelnemer:
……..

Datum: …… Handtekening deelnemer: …..…….

Informed Consent (English)

Recognizing risky behaviour among offenders
Improving the use of the CPAP at the FPA

Researcher: Celina Klok
Supervisors: Kiki de Carvalho & Carlijn Baarsen

Purpose of this research
The purpose of this research is improving the use of the CPAP at the FPA. Opinions and ideas from staff members will be investigated to form a procedure for the CPAP and to implement this at the FPA. The outcomes will be described in a masterthesis at the University of Twente.

Interview
For this interview a maximum of 30 minutes is planned. The interview is semi-structured by a few themes. Your participation is completely voluntary. You can withdraw from this interview at any time without having to provide an explanation.

How is the information handled?
The data that follows from this interview will be used to form the CPAP procedure and an implementation process. Your personal information will be treated confidentially; your identity will not be announced or shared with third parties. The interview will be recorded with audio equipment, so the researcher can investigate the data and write a report. This recording and report will be saved without mentioning the naam of the interviewee and with as little traceable data as possible. Your name on this document will be saved separate from the report and will only be know to the researcher.

For further questions you can mail to: celinaklok@outlook.com (you can also mail if you want a summary of the research results)

To be completed by the interviewee
I declare that I have been informed in a clear manner about the nature of this research. My (possible) questions have been answered satisfactorily.

Name interviewee: ……

Date: ……. Signature interviewee: …..…….

Appendix D

E-mail aan medewerkers (Nederlands)

Beste collega,

Mijn naam is Celina Klok en ik werk als begeleider op ST Besloten. Naast mijn werk bij de FPA studeer ik psychologie aan de Universiteit Twente. Mijn afstudeeronderzoek voer ik uit binnen de kliniek. Hier ben ik erg enthousiast over.

Onder begeleiding van Kiki de Carvalho en Carlijn van Baarsen onderzoek ik hoe het Crisis Preventie Actie Plan (CPAP) het beste gebruikt kan worden binnen de FPA. Bijvoorbeeld, hoe kan je een CPAP het beste invullen en welk doel moet het CPAP dienen?

Als medewerker van de FPA zijn jouw ideeën hierover erg belangrijk. Ik zou je daarom graag uitnodigen voor een interview. Het is een één-op-één interview en duurt ongeveer 30 minuten. Je deelname is vertrouwelijk en uiteraard geheel vrijwillig. Zou je mij—bij interesse—willen mailen om een afspraak te maken?

Mijn vraag aan iedereen is om na te denken over het belang en gebruik van het CPAP.

Alvast hartelijk dank voor je medewerking,

Vriendelijke groeten,
Celina Klok
Begeleider – ST Besloten

E-mail to staff members (English)

Dear colleague,

My name is Celina Klok and I work as a forensic nurse at the department ST Besloten. Next to my work at the FPA I study psychology at the University of Twente. I perform my Masterthesis within the FPA and I am very enthusiastic about this.

Under supervision of Kiki de Carvalho and Carlijn van Baarsen I investigate how the Crisis Prevention Action Plan (CPAP) should be used at the Forensic Psychiatric Facility (FPA). For example, how should you fill out a CPAP and what purpose should it serve?

As an staff member of the FPA, your ideas about this are very important. I would like to invite you for an interview, this is a one to one conversation and it will take approximately 30 minutes. Your participation is completely confidentially and ofcourse entirely voluntary. Would you –when interested- send me an e-mail to make an appointment?

My question to everybody is to think about the importance and the use of the CPAP.

Thank you in advance for your cooperation,

Regards,
Celina Klok
Forensic nurse – ST Besloten

Appendix E

FESAI

		Early warning signs The change described in the individual item below can be perceived by the patient or observed by others.	Score yes/no
Change in daily activities	a)	Change in day-night rhythm	a) _
	b)	Decreased activity	b) _
	c)	Increasing boredom	c) _
	d)	Difficulties complying with agreements, daily structure	d) _
Social isolation, decreased social contact	a)	Increasingly superficial contact	a) _
	b)	Avoidance of eye contact	b) _
	c)	Increasing isolation, withdrawal	c) _
	d)	Walks away from conversation or other activities	d) _
Change of selfmanagement	a)	Declining self-care and/or care for surroundings	a) _
	b)	Decreased problem solving skills	b) _
	c)	Increasing financial problems	c) _
Physical changes	a)	Increasing physical complaints	a) _
Changed substance needs (alcohol, drugs, medication)	a)	Decreasing medication compliance	a) _
	b)	Increasing substance abuse (alcohol and/or drugs)	b) _
Cognitive changes	a)	Increasing difficulties in thinking, recalling, concentrating	a) _
	b)	Increasing associative disturbances or chaotic thinking	b) _
Dejection and anxiety	a)	Increasing worries	a) _
	b)	Increasing loneliness	b) _
	c)	Increasing low self-esteem	c) _
	d)	Increasing feelings of sadness and/or desperateness	d) _
	e)	Increasing feelings of,being hurt, offended and/or rejected	e) _
	f)	Increasing behaviours of self-harm or considering it	f) _
	g)	Increasing anxiety	g) _
	h)	Increased nightmares	h) _
Tension, agitation, anger	a)	Less open to other's ideas, thoughts or ways of behaving	a) _
	b)	Increased experience of stress	b) _
	c)	Increased anger, frustrations and/or tensions.	c) _
	d)	Increasingly responding in a verbally/physically aggressive manner	d) _
	e)	Increased suppression of emotions	e) _
Antisocial behaviour	a)	Increasingly breaking other's boundaries, humiliating and/or cynicism/sarcasm	a) _
	b)	Increased failure to take responsibility	b) _
	c)	Increasingly being unreliable or lying.	c) _
	d)	Increased splitting behaviour, setting people up against each other	d) _
	e)	Provoking conflict(s), coercive, demanding	e) _
Disinhibition and impulsivity	a)	Increasingly chaotic, restless and/or impulsive	a) _
More (extreme) sexual fantasies, needs, behaviour	a)	Increasingly having extreme sexual fantasies, needs and/or behaviour.	a) _
Criminal behaviour	a)	Absconding or considering it	a) _
	b)	Criminal contacts and/or criminal activities	b) _
Irrational ideas, perceptions	a)	Increased paranoid thoughts or feeling threatened.	a) _
	b)	Hallucinations.	b) _
	c)	Delusions, irrational convictions.	c) _
Very specific changes of behaviours	a)	Idiosyncratic behaviour	a) _
	b)	Changing eating/drinking habits, patterns	b) _
	c)	Speaking in a different manner.	c) _
Other early warning signs	a)	...	a) _