PSYCHIATRIA ET NEUROLOGIA JAPONICA

Special Feature Article

Protection Program (CVPPP): From Care in the Medical Treatment and Supervision Act to General Psychiatry

Seiji SHIMOSATO
Institute of Health Science, Shinshu University
Psychiatria et Neurologia Japonica 125: 1049-1057, 2023

Abstract

The Comprehensive Violence Prevention and Protection Program (CVPPP) was developed following the implementation of the Medical Treatment and Supervision Act. It was incorporated into workers' training when the wards were opened in the early years of designated inpatient medical institutions. CVPPP was modelled after the control and restraint method adopted in security hospitals in the UK. From the outset, CVPPP included a security element even though it was described as a care technique.

CVPPP has gradually been extended to general psychiatry. Today, the Ministry of Health, Labor, and Welfare's training project for ensuring psychiatric care systems has adopted the objective of disseminating CVPPP principles.

In other countries, training programs for managing violence are collectively known as Aggression Management Training Programs (AMP). There are many different AMP models. AMPs in Europe and the US have been active since the 1980s, but much debate on the difficulties in presenting evidence, accidents caused by physical intervention, and negative psychological effects of forced intervention remain. Moreover, the need for such training continues to be recognized today; since its inception, the CVPPP has faced challenges similar to those encountered in Europe and USA. There is a dichotomous issue of whether to focus on safety management or a person-centered approach of coercive psychiatric care. Moreover, difficulty of judgement caused by the complexity of

the definition of violence persists. Furthermore, from the staff's perspective, there psychological distress from exposure to violent behavior is possible, and so is of becoming a perpetrator of abuse. For the parties concerned, they can be both victims and perpetrators. In this respect, when judging violence, it is advisable to consider the question: "From whose point of view is it violence?"

In this context, the CVPPP is moving towards a program with a recovery-oriented and person-centered philosophy. To manage violence, a problem that can easily lead to confrontational structures, both parties and medical staff should move forward with joint ownership. This article reviews the background to the development of this program, which is now widespread in general psychiatric care; outlines trends in Europe and the US; and discusses future prospects for violence management programs in psychiatry.

Keywords: aggression, violence, psychiatric nursing, CVPPP

Introduction

This paper discusses the Comprehensive Violence Prevention and Protection Program (CVPPP), developed following the Act on Medical Treatment and Observation for Persons Who Have Committed Serious Acts of Harm to Others in a State of Insanity, etc. (hereinafter referred to as the Medical Treatment and Supervision Act). CVPPP is discussed as a model for addressing violence from a care perspective. Initially developed with reference to the UK's Control and Restraint (C&R) framework, it was originally described in British English; however, it is now uniformly referred to in American English.

Violence occurring in psychiatric settings is complex and cannot be discussed in a single category. However, this paper uses the development and dissemination history of CVPPP as a guide to revisiting the changing perspectives on responding to violence in psychiatry. By referring to the current principles, methodology, and challenges of CVPPP, this paper discusses care-based response techniques for violence in general psychiatric care with a particular focus on them.

I. Violence Addressed by CVPPP

Violence permeates our surroundings; we live in an era confronting violence. Beyond the issue of violence involving numerous victims, such as war and conflict, problems like bullying and abuse exist, along with hate speech,

violent posts on social media, and issues stemming from discrimination known as microaggressions. Violence is also a significant problem in the workplace. The U.S. National Institute for Occupational Safety and Health (NIOSH) identifies four types of workplace violence: Type I: Crimes by unrelated individuals; Type II: Violence from parties involved; Type III: Violence between workers; and Type IV: Violence from workers' partners or others.[26] It also provides guidelines for countermeasures. In hospitals, concern over Type II violence is increasing, particularly in emergency departments.[38] Furthermore, violence against caregivers in dementia care and physical care settings, along with its impact on these caregivers,[41] is also receiving attention. Violence from colleagues corresponding to Type III,[32] has also come to be discussed.

Violence occurring in psychiatric settings has been a major global concern for many years. Within nursing science, violence remains a significant research focus to this day, primarily addressed through two approaches. One involves discussions on professional care responses to violence in psychiatric settings,[6] while the other examines workplace violence from an occupational health perspective, exploring methods to protect staff by addressing employees' experiences of violence. This paper addresses the former. However, violence occurring in general psychiatric care sometimes requires police intervention, as in the latter case, demanding a firm response to violence from an occupational safety perspective. For establishing necessary systems, including reporting procedures, support protocols, and documentation frameworks, it is advisable to refer to guidelines provided by professional organizations.

Regarding violence in psychiatric settings, it has increasingly become impossible to discuss the issue without addressing the trauma it causes.[41] The trauma experienced by individuals themselves, exposed to various forms of violence, can manifest as intense aggression toward staff. We seek ways to escape situations where both individuals and staff are harmed. However, the ongoing issue of abuse against persons with disabilities extends beyond that which is visible. It is also a problem regarding the inherent violence perpetrated by healthcare providers exercising coercive force against individuals to enforce treatment plans or rules; the very act of imposing medical care. Furthermore, what constitutes violence is ambiguous. Even if we tentatively define it simply as “aggressive actions that threaten people or property,” violence represents a state where the equilibrium of forces,

intertwined power dynamics, desires, frustrations, hatred, and more, becomes marked. In each instance, that force disrupts the public sphere.

Moreover, violence is a complex issue determined by the varying degrees and layers of concepts such as responsibility, intent, harmfulness, and legitimacy coexisting within it.[12] This complexity makes it difficult to clearly distinguish between "violence," "things bearing violence," and "things that are not violence," complicating care for violence.

II. The History of Violence Management in Psychiatric Hospitals and Beginnings of CVPPP: Lessons Learned from the UK's C&R

In Japan, intervention against violence in psychiatric hospitals has been entrusted primarily to nursing staff, particularly (physically strong) male nurses. The 1901 textbook "Psychiatric Nursing in Insane Asylums," considered Japan's earliest psychiatric nursing textbook, states: "When it is unavoidable to use physical restraint, the nurse must do so with a heart of compassion toward the patient."[28] This passage conveys the fundamental attitude toward physical intervention. However, in reality, "responding to violence" was not discussed,[20][27] and was instead passed down orally among male nurses. Here too, there were positions: one demanding nurses act as security personnel, and another seeking care-based response methods. In practice, male nurses were expected to fulfill the former role. Such differences in perspective are also observed globally. Björkdahl, A. et al.[3] use metaphors: the ballet dancer approach, emphasizing artistic sensitivity and nonverbal messages in care delivery, and the bulldozer approach, prioritizing ward safety over individual patients and using force as a shield to protect the ward. The former emphasizes person-centered care, while the latter focuses on eliminating and managing violence. However, the former often faces criticism, questioning "What about staff rights?," and the latter tends to foster an adversarial stance toward patients.

Amidst this context, following enactment of the Medical Treatment and Supervision Act, the author had an opportunity in 2002 to study in the UK for six months as part of the Ministry of Health, Labour and Welfare's training program for specialists in acute psychiatric care. At that time, only the nursing course included a one-week training program called C&R (Containment and Restraint), a violence management program. C&R was adapted from C&R Prison Service used in prisons.[29] While time was allocated for literature review and discussion, the majority of the training involved

practicing physical interventions. One procedure involved saying: “Thank you for your cooperation,” to the individual during each step of the physical intervention. For the author, who had previously lacked systematic knowledge of such techniques, this aspect felt particularly significant. Although initially shared in Japan, this concept did not seem to gain sufficient awareness. Nevertheless, the systematic approach to violence management practiced in Europe and America became the model for Japan's CVPPP.

III. Flow of the Aggression Management Training Program

1. Aggression management training program

Training programs like CVPPP are sometimes collectively referred to as Aggression Management Training Programs (AMPs).[15] Numerous programs exist worldwide, many managed as commercial entities with undisclosed specifics. They are considered to include prevention, de-escalation, physical intervention, crisis management, reporting, debriefing, trauma, self-control, and facility protocols. CVPPP is a rare program in that it is published as a book (although it has many points needing revision). Most programs focus more on crisis management than prevention, and include breakaway techniques and physical intervention methods.[2] Effectiveness studies of AMPs use incident and coercive intervention rates as outcomes, but the evidence is unclear. Other indicators, such as changes in nurses' attitudes and confidence, have been examined,[4] and many reports indicate that at least changes in attitudes and confidence are achieved.

In the UK, the National Institute for Health and Care Excellence (National Institute for Health and Care Excellence: NICE) has issued guidelines on violence in psychiatric settings. The latest version is the 2015 edition,[24] but the previous 2005 edition[23] stated that 50% of training courses in England at that time taught the use of pain (methods to intentionally inflict pain on the individual). It also stated that when using physical intervention as a last resort, “every effort should be made to avoid causing pain.” “Intentionally inflicting pain has no therapeutic value and is justified only to immediately rescue staff, service users, or others.” While the need for person-centered care is mentioned, the impression at this time was that the focus was on the methodology of physical intervention. In the C&R training the author attended, the techniques were used confidentially, with the rationale that “if the individual learns this technique, they will counter it, so it must remain unknown to them.”

This reflected an approach of secretly acquiring security restraint techniques.

However, the 2015 update edition,[25] mentions that physical intervention can lead to negative attitudes and trauma for the individual, such as fear, pain, and anger, and also describes how it can generate negative emotions in staff. While there is no specific mention of using pain in manual restraint, it is stated that pain should not be used as a part of restrictive interventions overall. Conducting risk assessments with the individual and respecting advance decisions (pre-instructions regarding restrictive interventions the individual wishes to refuse) and advance statements (expressions of the individual's wishes, feelings, beliefs, and values) are called for, strengthening the stance of participant involvement. While physical interventions and their training remain necessary, overall emphasis has shifted toward strengthening preventive methods for restrictive interventions, such as assessment and de-escalation.

Within this trend, the existence of an authoritarian culture in psychiatry is recognized as a significant risk factor for patient aggression and violence.[3] Consequently, AMPs emphasize trauma-informed care and person-centeredness,[4][5] recovery-oriented approaches,[8] and incorporation of the individual's perspective. NICE guidelines were also revised in 2019 in line with this trend. In the UK, Safewards,[11] which emphasizes getting to know each other well, and RESPECT,[18] which advocates a stance of caring rather than controlling, have also gained recommendations. These are points similarly emphasized by CVPPP, and I believe CVPPP's approach is consistent with this global trend.

2. CVPPP as AMP

CVPPP itself has vacillated since its inception in 2005 within the dichotomy of care versus safety management. While care was the intended goal, there was a tendency to lean toward strategic descriptions primarily for healthcare providers. Even while stating it was “for care,” it often became practice for how to respond when a person acted violently, reinforcing the image of the person not as someone “who can only resort to violence,” but as a “person who is an aggressor.” When the first CVPPP text was published, Mukaiyachi[19] offered this advice: “Engage in large numbers, restrain, and provide care. Intensive care perpetuates the cycle of violence. What is needed is the posture of reinforcements arriving to help.” Even so, the focus remained on physical intervention as crisis management, and the perception of CVPPP as a technique for subduing grew stronger.

Nakai[21] remarked on CVPPP: "That's why we tend to end up feeling like we're confronting the patient. Now, for the first time, a textbook on violence (Comprehensive Violence Prevention Program for Healthcare Professionals, Igaku-Shoin) has been published, but even this initially had a bit of that feeling." I believe his use of "initially" stems from deep compassion for Japan's first initiative, and that what he truly wanted to say was "even now, it's still far from ideal."

As physical intervention techniques gained attention, while the official stance was that "CVPPP is a method of care," expressions like "CVPPP is for martial artists," "training is a brawl," and "in the field, you just have to restrain them" were frequently seen on social media. Indeed, similar processes occurred in Europe and America. Paterson et al.[30] expressed concern that "the term C&R itself came to mean physical restraint." While there were attempts to rebrand C&R from "Control and Restraint" to "Care and Responsibility," no marked change occurred.[13] CVPPP is also commonly referred to as "CV." When used in phrases like "We're about to apply CV now," it signifies physical intervention = CV, unconsciously referring to manual restraint techniques.

However, physical intervention methods inherently involve exercising force within a power gradient, which can lead to violent behavior toward minorities. Therefore, we must constantly confront the question of how to resist this. The author has addressed this by working on "how to approach this issue together with those directly involved." CVPPP has been advanced so that it may serve as a tool enabling people from all positions to think together about the complex and sensitive issue of violence.[34-36][43] In 2019, a new text was published,[34] describing the experiences of three individuals who have been directly affected. It has been reported that gaining confidence in managing aggression reduces negative attitudes toward those affected,[33] and that CVPPP reduces negative attitudes toward aggression from affected individuals.[15] Nevertheless, I believe it is essential to sincerely address the potential for wanting to resort to physical intervention,[9] and the risk of justifying intervention in the name of care.[10] The author intends to continue reflecting on whether the program should include methods for physical intervention.

IV. CVPPP as a Method to Care for Violent Individuals

1. The current state of CVPPP and philosophy of caring for violent individuals

1) Development of CVPPP

CVPPP was incorporated into staff training when the Medical Treatment and Supervision Act was established. The core component is the CVPPP Trainer Training Course, a 4-day, 24-hour program. Graduates are certified as CVPPP Trainers (following the Western model, individuals who are able to implement the program within their own facilities). Currently, certification is administered by the Japan Society for Mental Health and Care. Initially, CVPPP Instructors capable of facilitating this course were primarily staff from designated inpatient medical institutions. Furthermore, as the Japan Psychiatric Nurses Association incorporated it into their training, over 13,000 individuals had completed the trainer development program by 2021. Approximately 10,000 of these individuals participated in training conducted at designated inpatient medical institutions (including those co-hosted with branches of the Japan Psychiatric Nurses Association).

Furthermore, the Ministry of Health, Labour and Welfare's "Training Program for Ensuring Psychiatric Medical Care Systems (Training to Provide Safe and Secure Medical Care in Psychiatric Hospitals)" states: "Recognizing the achievements of the Comprehensive Violence Prevention Program, which has spread primarily among hospitals with medical observation wards, it aims to disseminate the fundamental concepts of the program to a wide range of professionals working in psychiatric hospitals and similar facilities. It also seeks to further promote and advance efforts to ensure a safe and secure medical environment in psychiatric hospitals."

The current CVPPP training is positioned solely as means to examine care methods. In all exercises, the goal is not merely to learn procedures but also consider the necessary care elements within those procedures. Therefore, exercises constantly focus on determining what care is needed. We consider how to support rather than restrain, focusing on the message conveyed through the touch of a hand. It is not suppressing by force but the warmth that is conveyed,[16] that reduces risk. Indeed, this new CVPPP style faced marked resistance. Some reacted with concerns, such as: "Are healthcare providers not protected?" or "To protect the individual, techniques are necessary; we can't talk about care until we learn them." However, if the individual feels secure, the risk of violence should decrease. Insisting that restraint methods are more important is akin to saying: "When physically restraining someone, we cannot afford

to be considerate until they are safely restrained."

2) The philosophy of CVPPP

The perspectives of those focused on managing violence and prioritizing operational efficiency naturally differ (Table). The CVPPP philosophy holds that "both the individual concerned and helper are equally 'persons' (persona)-centered,"[22] deserving mutual respect and protection. Becoming an ally to the distressed individual and acting to reinforce their care most effectively reduces the risk of aggression or violent behavior.[34] While the term "ally" may be debatable, it signifies the position described by Sullivan, H.S. as "members of the same community,"[22] differing from mere customer service. It suggests not just completing tasks, but being present and navigating through the uncertainty together.

2. Methods to care for violent individuals

1) Risk assessment

CVPPP establishes momentary risk assessment as a distinctive approach. This determines whether healthcare providers can engage within a safe range, enabling them to extend a helping hand with confidence. Next, to prevent healthcare providers from making unilateral judgments, mutual understanding is emphasized. For example, expressions like "unresponsive" or "unwilling to listen" suggest a one-sided judgment that the individual is not complying with the provider. Mutual understanding helps identify discrepancies[14] in protective factors as understood by both the individual and provider.

2) De-escalation

De-escalation is defined as "a technique (including verbal and nonverbal communication skills) aimed at reducing anger and avoiding aggression. While medication can be used as part of a de-escalation strategy, this alone does not constitute de-escalation."[24] It encompasses all strategies, not merely communication. In CVPPP, in addition to "engaging calmly using risk assessment techniques," the verbal aspect emphasizes "being mindful of the 'power' inherent in speech acts,[1] while demonstrating sincerity through expressions of gratitude or apology, and focusing on the illocutionary act," while the nonverbal aspect stresses: "receiving and responding to all messages" and "sincerity rather than prepared answers."[44] This creates a calm and reassuring environment for the individual, exploring the applicability of the concept of collaborative commitment.

3) Physical intervention

CVPPP incorporates physical intervention techniques. Physical

intervention methods prioritize de-escalation during the intervention above all else. Therefore, practice focuses not on "memorizing procedures" but solely on considering "methods that reassure the individual." However, some countries prohibit practices like prone positioning or placing one's hands behind the back,[31] necessitating continued review. Additionally, the author has modified the traditional nursing practice known as "escort," where individuals are supported from both sides, by incorporating CVPPP theory. This modified approach is currently being validated through experimental research. It should be noted that this technique is also considered a form of physical restraint and must not be misused as a convenient method.

4) Breakaway

Breakaway is a technique with self-defense implications, used to evade attacks such as being struck or grabbed (which may be why it has been accepted by healthcare providers). However, current practice emphasizes structuring exercises within breakaway that focus on how to find the next care method, thereby differentiating it from mere self-defense.

5) Reflection

Reflection often occurs after an actual violent incident, which can inadvertently lead to demanding self-reflection from the individual involved. CVPPP takes care not to force reflection or compel individuals to "look back" in order to help them regain a peaceful daily life. While individuals carry trauma from their life experiences and stigma, caregivers can also experience significant stress when exposed to intense aggression from the individual. To prevent the support provider's own trauma from perpetuating the cycle of violence, CVPPP prioritizes a firm grasp of its core principles. It aims to foster natural peer support networks and continues to explore methods for developing pathways that prevent surrendering to violent impulses.

3. Current initiatives and challenges: Creating together with those affected – Collaborative action theory care –

Programs like CVPPP, which involve physical intervention, risk oppressing individuals and inflicting trauma if healthcare providers are unaware of their own power. CVPPP aims to avoid falling into Eichmann-like thoughtlessness,[42] by focusing on the structure of surveillance and punishment as described by Foucault, M.,[7] and consider violence outside the oppositional structure of superior-inferior. When considering this, we must also look at the power inherent within the hospital organization itself, much like Foucault identified power

dynamics in education and hospitals, or Sullivan's "divine power of the nursing department."

Because CVPPP imposes restrictions on human behavior, it requires constant philosophical reflection. Currently, the author is engaged in a Grant-in-Aid for Scientific Research (C) project, entitled: "Improved CVPPP for Creating Safe Spaces with Those Affected." Within this project, while examining philosophical concepts surrounding violence and organizing theories on communication from a linguistic philosophy perspective, the author aims to create CVPPP developed with the involvement of persons with lived experience. This includes having Mr. Neteru Masukawa, a WRAP® Advanced Facilitator, participate in CVPPP trainer development training,[16] and exchanging opinions with Mr. Yuhei Yamada of Porque, the Organization of Persons with Psychosocial Disabilities.[37] Mr. Masukawa shared the perspective: "There are times when I feel like I might lash out. At such times, I want someone to stop me with a gentle hand." He proposed positioning CVPPP as one option within a crisis plan. Mr. Yamada emphasized the need to consider theory while paying attention to the power gradient structures inherent in general psychiatric care. From these efforts, I believe the path CVPPP should pursue is to explore care methods that foster mutual respect through mutual commitment, even in response to violence.

Violence presents a complex picture where both the individual experiencing it and healthcare provider, as well as those around them, can become both victims and perpetrators. We aim for everyone to consider this problem and its response methods as shared actions, with shared agency. However, it is also natural that no one can forgive the person who was the direct agent of a traumatic experience they suffered in the past. Through the nursing dilemmas discussed within the Medical Treatment and Supervision Act, CVPPP aims to address this complex issue within general psychiatric care as well.

Conclusion

Moving forward, CVPPP must also consider approaches to care for violent behavior associated with dementia or severe behavioral disorders (although careful consideration should also be given to whether it ought to be called violence), as well as responses to violence in the community.

When nurses take action to respond to violence, those around them might comment: "Oh, they're restraining and taking them away again." CVPPP should aim to develop intervention methods that make bystanders perceive the action as "going to help."

Editor's Note: This special feature article is based on the symposium held at the 118th Annual Meeting of the Japanese Society of Psychiatry and Neurology, with Hisako Taguchi (Kanagawa Psychiatric Center) as the representative.

No conflicts of interest related to this paper exist.

References

1) Austin, J. L.: How to Things with Words: The Willliam James Lectures Delivered in Harvard University in 1955 (ed by Urmson, J. O.). Clarendon Press, Oxford, 1962 (飯野勝己訳: 言語と行為—いかにして言葉でものごとを行うか—. 講談社, 東京, 2019)

2) Baby, M., Gale, C., Swain, M.: Communication skills training in the management of patient aggression and violence in healthcare. Aggress Violent Behav, 39; 67-82, 2018

3) Björkdahl, A., Palmstierna, T., Hansebo, G.: The bulldozer and the ballet dancer: aspects of nurses' caring approaches in acute psychiatric intensive care. J Psychiatr Ment Health Nurs, 17 (6); 510-518, 2010

4) Björkdahl, A., Hansebo, G., Palmstierna, T.: The influence of staff training on the violence prevention and management climate in psychiatric inpatient unit. J Psychiatr Ment Health Nurs, 20 (5); 396-404, 2013

5) Duxbury, J. A.: The Eileen Skellern Lecture 2014: physical restraint: in defence of the indefensible? J Psychiatr Ment Health Nurs, 22 (2); 92-101, 2015

6) Foster, C., Bowers, L., Nijman, H.: Aggressive behaviour on acute psychiatric wards: prevalence, severity and management. J Adv Nurs, 58 (2); 140-149, 2007

7) Foucault,, M.: Surveiller et Punir: Naissance de la Prison. Gallimard, Paris, 1975 (田村 俶訳: 監獄の誕生—監視と処罰—. 新潮社, 東京, 2020)

8) Guha, M. D., Cutler, N. A., Heffernan, T., et al.: Developing a trauma-informed and recovery-oriented alternative to 'aggression management' training for a metropolitan and rural mental health service. Issues Ment Health Nurs, 43 (12); 1114-1120, 2022

9) 長谷川利夫: 隔離と身体拘束. すべての人の社会, 36 (5); 1-10, 2016 (in Japanese)

10) 長谷川 唯: 行動制限は医療安全に資するのか. 病院・地域精神医学, 62 (2); 127-129, 2022 (in Japanese)

11) Higgins, N., Meehan, T., Dart, N., et al.: Implementation of the Safewards model in public mental health facilities: a qualitative evaluation of staff perceptions. Int J Nurs Stud, 88; 114-120, 2018

12) 飯野勝己, 坪井雅史, 上石 学:「暴力の哲学」に向けて—暴力とは何か, いかにして回避されうるか—. 東北哲学会年報, 35; 69-84, 2019 (in Japanese)

13) Isherwood, T.: Restraint and seclusion in services for people with mental health problems and learning disabilities: a literature review. Mental Health Learn Disabil Res Pract, 3 (2); 127-141, 2006

14) Kashiwagi, H., Yamada, Y., Umegaki, Y., et al.: The perspective of forensic inpatients with psychotic disorders on protective factors against risk of violent behavior. Front Psychiatry, 11; 575529, 2020

15) Kinoshita, A., Shimosato, S.: Effectiveness of an aggression management training program in Japan: a quasi-experimental study. Issues Ment Health Nurs, 43 (6); 543-551, 2022

16) 増川ねてる:「CVPPP」ってなんですか? 精神科看護, 49 (7); 35-40, 2022 (in Japanese)

17) 三木那由ほか: 話し手の意味の心理性と公共性—コミュニケーションの哲学へ—. 勁草書房, 東京, 2019 (in Japanese)

18) Mind: Mental health crisis care: physical restraint in crisis: a report on physical restraint in hospital settings in England. 2013 (https://www.mind.org.uk/media-a/4378/physical_restraint_final_web_version.pdf) (参照 2022-10-20)

19) 向谷地生良: 暴力に対して援助者はどこに立つべきか—『医療職のための包括的暴力防止プログラム』の発行に際して—. 精神看護, 8 (4); 60-67, 2005 (in Japanese)

20) 村上 優: 医療における暴力. 医療職のための包括的暴力防止プログラム (包括的暴力防止プログラム認定委員会編). 医学書院, 東京, p.10-13, 2005 (in Japanese)

21) 中井久夫: こんなとき私はどうしてきたか. 医学書院, 東京, p.54-62, 2007 (in Japanese)

22) 中井久夫: サリヴァン, アメリカの精神科医. みすず書房, 東京, p.80, 2012 (in Japanese)

23) National Institute for Clinical Excellence: Clinical Practice Guidelines for: Violence: The short-term management of disturbed/violent behaviour in in-patient psychiatric settings and emergency departments. 2005 (https://www.ncbi.nlm.nih.gov/books/NBK55521/pdf/Bookshelf_NBK55521.pdf) (参照 2022-10-01)

24) National Institute for Health and Care Excellence: Violence and aggression: short-term management in mental health, health and community settings (NICE guideline [NG10]). 2015 (https://www.nice.org.uk/guidance/ng10) (参照 2022-10-10)

25) National Collaborating Centre for Mental Health commissioned by the National Institute for Health and Care Excellence: Violence and Aggression Short-term management in mental health, health and community settings (NICE Guideline NG102015), Updated edition. British Psychological Society, London, 2015

26) National Institute for Occupational Safety and Health (NIOSH): Workplace Violence Overview, Resources, Guidelines, and Prevention Strategies for Healthcare Employers (NIOSH and OSHA Resources). (https://ihainsurancesolutions.com/IHAInsuranceSolutions/media/Insurance-Solutions/files/ICT/Symposium/Aa_Dan-Hartley-Presentation.pdf) (参照 2022-10-19)

27) 西谷博則: 看護と暴力. 医療職のための包括的暴力防止プログラム (包括的暴力防止プログラム認定委員会編). 医学書院, 東京, p.14-22, 2005 (in Japanese)

28) 岡田靖雄, 小峯和茂ほか編: 精神障害者問題資料集成, 戦前編第 5 巻 六花出版, 東京, p.209-222, 2013 (in Japanese)

29) Paterson, B., Leadbetter, D.: Managing Physical Violence. Aggression and Violence: Approaches to Effective Management (ed by Turnbull, J., Paterson, B.). Palgrave, London, p.124-147, 1999

30) Paterson, B., Bradley, P., Robertson, M., et al.: Control and restraint: changing thinking, practice and policy. Ment Health Pract, 13 (2); 16-20, 2009

31) Raveesh, B. N., Lepping, P.: Restraint guidelines for mental health services in India. Indian J Psychiatry, 61 (Suppl 4); S698-S705, 2019

32) Sanner-Stiehr, E., Ward-Smith, P.: Lateral violence in nursing: implications and strategies for nurse

educators. J Prof Nurs, 33 (2); 113-118, 2017

33) Shimosato, S., Kinoshita, A.: Degree of anger during anger-generating situations among psychiatric staff nurses: association between nurses' attitudes toward service users' aggression and confidence in intervening in aggressive situations. J Psychosoc Nurs Ment Health Serv, 56 (9); 51-59, 2018

34) 下里誠二編著, 日本こころの安全とケア学会監, 最新 CVPPP トレーニングマニュアル. 中央法規出版, 東京, 2019 (in Japanese)

35) 下里誠二, 木下愛未: 包括的暴力防止プログラム（CVPPP）の取り組みと病院でのリカバリーの推進. こころの元気+, 7; 18-19, 2019 (in Japanese)

36) 下里誠二: CVPPP は虐待を止められるか. 日本こころの安全とケア学会誌, 3 (1); 35-41, 2021 (in Japanese)

37) 下里誠二: 理想論が実効性をもつために—精神科領域で当事者と共に安心の場を創る改良型包括的暴力防止プログラムの作成—. 精神科看護, 49 (5); 4-11, 2022 (in Japanese)

38) Spelten, E., Thomas, B., O'Meara, P., et al.: Violence against emergency department nurses; can we identify the perpetrators? PLoS One, 15 (4); e0230793, 2020

39) Sullivan, H. S.: Schizophrenia as a Human Process. Norton, New York, 1962 (中井久夫, 安 克昌, 岩井圭司ほか訳: 分裂病は人間的過程である. みすず書房, 東京, 1995)

40) 高木俊介: 対人支援のダイアローグ—オープンダイアローグ, 未来語りのダイアローグ, そして民主主義—. 金剛出版, 東京, p.121-136, 2022 (in Japanese)

41) 高橋慎一: 障害者介助と暴力についての試論. 賃金と社会保障, 1687-1688; 12-23, 2017 (in Japanese)

42) 戸谷洋志: スマートな悪—技術と暴力について—. 講談社, 東京, 2022 (in Japanese)

43) 宇田川 健: 第 1 回日本こころの安全とケア学会学術集会, 学会長企画パネルディスカッション, 緊急時のケアも見える化しよう. 日本こころの安全とケア学会誌, 1 (1); 23-29, 2019 (in Japanese)

44) 横田 泉: 精神医療のゆらぎとひらめき. 日本評論社, 東京, p.148-149, 2019 (in Japanese)

表　ケアと安全管理

ケアとしての考え方		安全管理
安心 一緒にいる	目的	効率的な目的達成 連れていく
人 Care 対話	対象	患者 Cure 説得
人中心 理想	性格	労働安全 現場（現実）
ケアの倫理	倫理	正義の倫理（制度の遵守）
感情性	優先	合理性
サポート，支える	身体介入	固定，取り押さえる
その瞬間に上下がない	地位	優位か劣位か
感じる，考えてする	実行	手順（マニュアル）を遂行
暴力をケアする	暴力対応	暴力は許さず制圧する

Table: Care and safety management

Approach to care		Safety management
Reassurance Being present	Purpose	Efficient goal achievement Taking them away
Person Care Dialogue	Object	Patient Cure Persuasion
Person-centered Ideal	Characteristic	Work safety Scene (reality)
Care ethics	Ethics	Ethics of justice (compliance with systems)
Emotionality	Priority	Rationality
Support	Physical Intervention	Restraint, Restrain
No hierarchy in that moment	Status	Superior or inferior
Feel, Think and act	Execution	Execute procedure (manual)
Care for violent individual	Response to violence	Violence is not permitted and suppressed