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Police Instruments of Restraint against Persons with Health Problems – Analysis of the Use of Expert Grips and Holds as Forms of Physical Force

Branko Gabrovec, Tilen Zupan, Srečko Felix Krope, Branko Lobnikar

Purpose:

The purpose of this article is to analyse whether police officers have sufficient expert knowledge to control a violent patient with health problems. The aim is to determine the actual capability of police officers to control such persons and analyse the competencies of police officers in controlling violent persons.

Design/Methods/Approach:

Utilising the quantitative method of research and an adapted questionnaire by Gabrovec et al. (2014) as the method of data collection, we determined the state of the capability of police officers to control violent patients.

Findings:

In order to deal with and control violent persons, police officers can make use of a wide range of powers, including the use of instruments of restraint. However, since dealing with a violent person is not the same as dealing with a violent person with health issues or a person under the influence of drugs or medications, coercive means against such persons must be used differently and adapted. The specific nature of the situation dictates the need for additional skills and training for the successful implementation of police procedures that do not jeopardise the subsequent treatment procedures with the patient. Our analysis has shown the lack of knowledge and skills of police officers in dealing with violent persons who have health issues or are under the influence of drugs or medications. Police officers are not afforded appropriate training in this field.

Research Limitations/Implications:

The research was conducted in one of the eight police administrations in Slovenia. However, the frequency of police procedures with violent persons who have health issues is similar to that in the other police administrations, so with certain reservations we may generalise the findings to cover the whole of Slovenia.

Practical Implications:

This article offers some basic information to police managers for upgrading training and education programmes in this area of exercising police powers.

Originality/Value:

The article uncovers an entirely new field of police operation for which the police force is not specifically prepared.

Keywords: violence, patient, police, assistance, physical force, means of coercion

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Uporaba strokovnih prijemov pri osebah z zdravstvenimi težavami – policijski vidik

Namen prispevka

Namen prispevka je ugotoviti, ali policisti menijo, da imajo na voljo dovolj strokovnih znanj za obvladovanje nasilnega pacienta. Cilj je ugotoviti dejansko usposobljenost policistov za obvladovanje nasilnega pacienta ter ugotoviti prednosti in slabosti pri kompetencah policistov pri obvladovanju nasilnih.

Metode

S pomočjo kvantitativne metode raziskovanja, kjer je bil za metodo zbiranja podatkov prilagojen vprašalnik Gabrovca idr. (2014), smo ugotavljali stanje usposobljenosti policistov za obvladovanje nasilnega pacienta.

Ugotovitve

Ker obravnava nasilne osebe ni enaka obravnavi nasilne osebe z zdravstveno težavo ali pod vplivom drog oziroma zdravil, je pomembno, da je obravnava takšne osebe drugačna in prilagojena. Tako zdravstveni delavci in policisti pogosto sodelujejo pri obravnavi nasilnih bolnih oseb in se medsebojno dopolnjujejo. V mnogih primerih pa se zgodi, da so policisti prvi na kraju intervencije in so sami soočeni s takšno osebo. Specifičnost situacije narekuje potrebo po dodatnem znanju in usposabljanju za uspešno izvedbo policijskega postopka na način, da ta ne bo ogrozil kasnejšega tretmajskega postopka s pacientom. V analizi smo ugotovili, da je znanje policistov za obravnavo nasilnih oseb, ki imajo zdravstvene težave ali pa so pod vplivom drog oziroma zdravil, pomanjkljivo ter da niso deležni ustreznih usposabljanj.

Omejitve/uporabnost raziskave

Raziskava je bila opravljena na območju ene izmed osmih policijskih uprav v Sloveniji. Frekvenca postopkov policistov z nasilnimi osebami, ki imajo zdravstvene težave ali pa so pod vplivom drog oziroma zdravil, je podobna kot na območju ostalih policijskih uprav, zato lahko (z zadržkom) ugotovitve posplošujemo na celotno območje Slovenije.

Praktična uporabnost

Prispevek podaja ugotovitev dejanskega stanja usposobljenosti policistov pri ukrepanju v postopkih z obravnavano kategorijo oseb in daje osnovne informacije policijskim vodjem za nadgradnjo programov usposabljanj in izobraževanj s področja izvajanja policijskih pooblastil.

Izvirnost/pomembnost prispevka

Prispevek analizira novo neraziskano področje dela policije. Gre za izvirno delo na tem področju in lahko pomeni osnovo za nadaljnje raziskovanje.

Ključne besede: nasilje, pacienti, policija, strokovno sodelovanje, telesna sila, prisilna sredstva

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1 UNDERSTANDING THE INTERACTION OF AGGRESSIVE BEHAVIOUR OF ILL PERSONS AND POLICE INSTRUMENTS OF RESTRAINT

In the healthcare sector, staff often encounter a wide range of patients and persons in their care. It is frequently the case that these persons are violent, both to health workers, other persons, those close to them and even to themselves. A few years ago, aggression in the health sector was regarded as just part of the job, but nowadays there is zero tolerance towards it (Jambrošič & Bregar, 2015). Nevertheless, healthcare workers still see violence as part of their everyday work and accept it more than people in other occupations (Kores Plesničar & Kordić Lašič, 2004). The general belief is that it is mainly staff in psychiatric hospitals who encounter violent patients, which is valid to a certain extent, for as Kobal (2009, p. 104) found, »there is no psychiatry that does not encounter violence«. Most commonly, the violence of psychiatric patients is something encountered by health workers employed in care positions. At the same time, other stakeholders in dealing with such persons are also faced with it – police officers, external security operatives, emergency service personnel, and those in old people's homes (Gabrovec, 2014).

People with mental health issues are often violent, especially those affected by substance abuse, psychotic symptoms, and comorbidities with personality disorders (Davison, 2005). The main cause of aggressive behaviour in patients with mental health issues is their illness, while it is also partly due to the negative influence of their surroundings (Duxbury & Whittington, 2005). In psychiatry, the following groups of potentially violent patients are encountered: those dependent on psychoactive substances, patients with personality disorders, psychotic patients, psycho-organic syndrome patients, those with dementia, persons with learning difficulties, patients with epilepsy and those with depression (Perne, 2005). Data on violent behaviour in psychiatric hospitals, especially closed sections, shows that it ranges from 3.9% to 37% in different parts of the world and from 6% to 7% in Slovenia. Here, staff suffer the highest number of injuries due to violent behaviour in psychiatric wards, which points to the need for adequate knowledge among all

psychiatric staff regarding timely recognition and prevention of violent behaviour in psychiatric patients (Groleger, 2009). A total of 92.6% of health professionals working in intensive psychiatric wards stated that they had experienced verbal aggression from a patient in the past year, and 84.2% had experienced physical violence from a patient. Moreover, 63.5% of such staff had already been injured by a patient, while 24.6% had experienced sexual harassment from patients (Gabrovec et al, 2014; Gabrovec & Lobnikar, 2015). Emergency and rescue services also encounter violence from patients when administering care, and Gabrovec (2015) found that 78.0% of such health professionals had experienced verbal violence from a patient, 49.6% had experienced physical violence, and 26.8% had at some time in their career been injured by a patient.

Zeller et al. (2009) noted the frequency of violence suffered by health staff providing care in older adults' homes. Similarly, Gabrovec, and Eržen (2016) found that in the previous year care staff in older adults' homes most often encountered verbal violence (71.7%), physical violence (63.8%) and sexual violence (35.5%). A total of 35.5% of those surveyed had suffered injuries due to such violence. Staff most often experience verbal abuse from patients, but frequently also physical abuse and sexual harassment, with the levels of violence especially high in psychiatric care, older adults' homes, and in-home care (Gabrovec, 2017).

The purpose of this article is to present a review of the available literature, legislative regulations and research conducted on a sample of police officers in determining whether they consider that they have at their disposal sufficient expert knowledge to control a violent patient. The aim is to determine the actual capability of police officers to control a violent patient, and their strengths and weaknesses in this regard.

In article we will present terms and specific regulations and refer to police powers that relate to instruments of restraint and assistance, which are defined in detail in the Police Tasks and Powers Act (»Zakon o nalogah in pooblastilih policije [ZNPPol]«, 2013).

1.3 Violence, aggression, and aggressiveness

Violence should not be confused with aggression, nor should aggression be equated with aggressiveness, although they are similar and related concepts. Aggression is any form of behaviour intended to hurt someone and demonstrate dominance over them (Šolc, 2001). Aggressiveness is a lasting characteristic of an individual and is defined as an originally non-destructive and non-affective energy expressed in the desire to establish one's position through some activity and enterprise (Škrila Čuš, 2005). However, as a behavioural characteristic it can be seen in overbearing, violent or attacking actions towards other people. In the broader sense, it is a form of behaviour aimed at impacting or wounding another living being that wishes to avoid such behaviour. People are aggressive principally because, based on past experience, they have learned that they can be rewarded for such behaviour, or see specific reactions and aggressive behaviours as rewards in themselves. Their immediate environment also often directly encourages them towards violence (Pačnik, 1989). Aggressiveness has been observed both among

people and animals, where for animals it is necessary for survival, while people use it to attain mastery over individual conflicts and difficulties (Kores Plesničar, 2006).

Violence involves an expression of loss of control over one's actions, and in many respects, it thus becomes a normal part of everyday life that we often no longer even notice. Common to all forms of violence is that they disregard the freedom of the individual to decide for themselves. Violence means using physical force, grievous threats, insults, and power. The use of power by the strong over the weak adversely affects the dignity and integrity of the affected individuals (Močnik, 2009). The essential difference between violence and aggression is that aggression does not always end in violence involving physical force, grievous threats, insults, and power (Šolc, 2001). Violence is just one of form of aggression and is aggression that includes physical force and the causing of damage or injury to persons or property. Aggression also involves threatening, hateful or harmful behaviour in non-physical ways (Škrila Čuš, 2005).

We can observe various forms of violence: physical violence, psychological violence, sexual violence, verbal violence, economic, legal, ideological, and political violence. In the broadest sense, physical violence is the use of physical force or power against another person or group of persons that has a physical, sexual or psychological impact (Cvetežar & Pretnar Kunstek, 2005). We count the following as physical violence or abuse: striking (with or without an object), lashing out, beating, shoving, pushing, shaking, slapping, kicking, pinching and causing burns. It can also include the unjustified administering of medications, physical restriction, forced feeding and various physical punishments. Physical violence can be seen for the most part in outward signs, such as scratches, bruises, contusions, lacerations, grazes, breaks, wounds, cuts, puncture wounds, sprains, internal injuries, bleeding (Močnik, 2009).

The most refined and non-provable violence, and at the same time the most widespread, is psychological violence (Šolc, 2001). It is characterised by the causing of suffering, emotional pain, or sadness resulting from various verbal attacks, insults, threats, shaming, denigration, and harassment. Psychological violence is evident in emotional disturbance or agitation, extreme closure within oneself, being uncommunicative or unresponsive, being quick to anger, sadness, tearfulness, self-criticism, loss of self-respect, and poor self-image. Most physical violence begins with verbal violence, usually with an outbreak of anger (Močnik, 2009). Sexual violence usually begins with verbal harassment, which frequently crosses over into actual violence. It is present in both sexes and is a form of violence that the victims are less likely to talk about, since they are ashamed of it, which further emboldens the perpetrator. It relates to any involuntary sexual contact with a person who cannot give their consent to such behaviour, such as undesired groping, rape, sodomy, forced nudity and photographing for sexual stimulation. The outward signs are scratches and grazes in the area of the breasts and genitals, unexpected venereal diseases, anal and vaginal bleeding, and torn, dirty or bloody underwear (Močnik, 2009).

1.3 Violent ill persons and special protective measures

The concept of special protective measures (hereinafter referred to as SPM) is defined in Article 29 of the Mental Health Act (»Zakon o duševnem zdravju [ZDZdr]«, 2008). These are urgent measures whose use is intended to enable the treatment of a person or neutralise or control the dangerous behaviour of a person in cases where their own life or the lives of others are in danger, their health or the health of others is seriously endangered, or where such behaviour causes grave damage to themselves or others, and these dangers cannot be prevented with other, gentler measures. SPM accompanies emergencies in psychiatry – in other words, any situation of urgency where there is a need for immediate treatment to prevent the advance of a deteriorated state and heteroaggressive or autoaggressive behaviour (Pregelj & Kobentar, 2009 in Gabrovec, 2014).

SPM is used by psychiatric care staff only in cases where it is truly necessary, since their work mode is oriented towards applying other methods before this. The type of coercive protective measure that will be used is prescribed by a physician (Dernovšek & Novak Grubič, 2001). In cases of severe violent behaviour both internal and external security services are required, since, in line with ethical criteria, their education and training, medical staff are not professionally required to control such behaviour (Novak Grubič et al., 2018). The use of SPM is not limited just to psychiatric institutions, and reasons for their use also arise outside the hospital treatment of patients and in other types of institution or social protection institutions. Healthcare institutions are bound in terms of spatial conditions, the number of health staff and appropriate training to ensure the professional and most humane possible implementation of SPM (Novak Grubič et al., 2018). SPM represent a major encroachment on the patient's integrity and liberty. We may observe two groups of measures, with the first being intended to deal with patients, and the second to eliminate a patient's dangerous behaviour (self-injury, threatening others, destruction of property) (Možgan, 2009). The »ZDZdr« (2008) prescribes as SPM physical restraint and confinement to one space or room.

In addition to these, some would add various degrees of more or less invasive forms of control, the use of an enclosure bed, and restraint in a wheelchair, armchair or ordinary chair (Možgan, 2009). In terms of the method imposing these, according to Možgan (2009) we may differentiate (a) the use of medications (receiving antipsychotics, benzodiazepine, or a combination of both); (b) physical measures (discrete control, constant control, the use of an enclosure bed for prone patients, standard restraints using special belts, restraining upper and lower extremities and restraint in a wheelchair), and (c) a combination of both.

The indications for physical restraint are the prevention of direct threat of injury for the patient, other patients in the ward and staff. They are also used to prevent serious disruption in the therapeutic programme (agitated patient whose behaviour significantly hinders normal activities in the ward) and serious damage to the inventory, by reducing stimulation from the environment that harms the patient (for a manic or delirious patient who cannot become calm in the normal ward environment). Physical restraint can also be carried out at the patient's request, when they can envision not being able to control their behaviour clearly. Contraindications for physical restraint include the use of this approach

as a substitute for treatment using a medication, as a punishment for a patient's disagreeable behaviour that is not dangerous, when physical restraint cannot be imposed without significantly endangering the safety of the patient and staff, and when physical restraint could have a severe adverse effect on the patient's physical condition. Caution should thus be used when applying physical restraint, especially with children, the elderly or patients with severe physical impairments (Novak Grubič et al., 2018).

The use and specific features of SPM are approved by the relevant physician, but the entire medical team is involved in the actual decision-making. Where the use of SPM is needed, the measure selected is the one that is most effective and least restrictive in the given situation. If the selected SPM does not suffice, a more restrictive method of applying SPM can then be employed. It is possible right from the outset to opt for the most restrictive SPM, if the assessment is that this is the only possibility of ensuring safety. The use of SPM should last only for as long as is necessary with regard to the reason for imposing it, but in any case no longer than four hours for the measure of restraining with belts or no longer than 12 hours for the measure of restricting freedom of movement within a single space or room (Možgan, 2009). In cases where a physician is not present, SPM may also be implemented by another health worker in a psychiatric hospital or professional worker in a social protection institution. However, they must immediately notify the physician, who will assess the justification for imposing the measure. If the physician does not order the measure, it is immediately ceased (»ZDZdr«, 2008).

Throughout the duration of the SPM, the person who has been subjected to it is supervised, their vital functions are monitored, and they are dealt with professionally. Equally, the precise details of the reason, purpose, duration and supervision of the implementation of the SPM are entered in the medical records of the patient. Records are kept of SPM, and with regard to the actual ordering and implementation such measures the physician must within 12 hours of ordering the measure notify in writing the director of the psychiatric hospital or social protection institution, the next of kin, lawyer and authorised representative of the patient (»ZDZdr«, 2008).

a. Legal basis for special protective measures

In Slovenia, the primary legal document defining the use of SPM is the Mental Health Act (»ZDZdr«, 2008), which applies only to psychiatric hospitals and social protection institutions. The Act defines SPM as just two measures: physical restraint and confinement within one space or room. The Act lays down that SPM should be used under special supervision and in secure wards. Equally, the Act lays down who may order SPM and in what cases, who needs to be notified of such measures, how much time the measure can last, and the supervision of the person during the imposition of the measure (Bregar et al., 2012). Since the Act permits such measures only within psychiatric hospitals or social protection institutions and not in other hospitals or public health institutions, a consideration arises as to the use of SPM or similar measures in non-psychiatric hospitals (Bregar et al., 2012). In 2012 the Nurses and Midwives Association of Slovenia adopted a Protocol on the physical restraint of patients in hospitals using belts (Bregar et

al., 2012). The Protocol, with which staff must be familiar and which they must observe consistently, is intended to standardise the approach and steer action in cases where a patient needs to be restrained using physical protective measures. It precisely defines the methods of ensuring safety and enabling treatment by means of restraining and tools of restraint (Bregar et al., 2012). In 2018 the Association of Psychiatrists at the Slovenian Medical Association adopted Recommendations and guidelines for the use of special protective measures in psychiatry (Novak Grubič et al., 2018). These are necessary in order to ensure the appropriate handling of emergencies in patients with mental disturbances. They contain a review of SPM, their criteria, when they can and must be used, and their implementation and methods of documentation. These guidelines, which emphasise the need for professionalism and continuous training of personnel, are also necessary to protect and respect the integrity and rights of the patient (Novak Grubič et al., 2018).

b. Physical restraint with belts

As Marinič (1999) states, physical restraint is one of the most stressful events for patients and staff. In Slovenia staff use Segufix belts and straps to physically restrain the patient in a hospital bed, for the purpose of enabling treatment, and neutralising or controlling their behaviour (Marinič, 1999). The belts are felt-lined and connected to each other with a magnetic locking system. Their application requires the participation of at least five properly trained health professionals. Most often medication measures are applied simultaneously with the use of belts. While the measure is being carried out, continuous monitoring of the patient is needed with the direct presence of staff or observation from a neighbouring room. Every four hours the patient must be examined by a physician, who will make a judgement as to ending and substituting the restraint with less restrictive measures (Novak Grubič et al., 2018). The special protective measure of physical restraint should not last more than four hours. After four hours have elapsed, the physician then checks the justification for repeated use of SPM (»ZDZdr«, 2008). A set of belts and straps for SPM comprises (Bregar et al., 2012):

- body strap (abdominal strap) – 1 pc,
- cuff strap for hands with felt – 2 pcs,
- cuff strap for feet with felt – 2 pcs,
- strap for securing legs to the bed – 1 pc,
- magnetic lock buttons – 8 pcs, and
- magnet – 2 pcs (red).

The following details of carrying out the measure are summarised from the Protocol for Physical Restraint of Patients in Hospitals (Bregar et al., 2012).

Implementers:

- measure prescribed by physician,
- SPM may be applied by a graduate nurse, graduate midwife, healthcare technician or physician.

Number of implementers:

- at least two persons for a patient that is cooperating,

- for an aggressive patient, at least five persons (psychiatric practice specifies five persons – one at each extremity and the leader at the patient's head).

Materials and tools:
- standardised belts, which are always clean, ready and in a set,
- bed enclosure.

Preparation of patient:
- the need for the measure and the method of carrying it out must be explained to the patient.

Cause of implementing special protective measures:
- protection during the use of therapeutic tools,
- behavioural changes in the patient.

Execution of measure:
- selection of the appropriate size of the belt,
- preparation of selected equipment,
- the bed is raised to an appropriate height and prepared so that it can be accessed from all sides,
- removal from the patient's immediate environment of objects that could be a danger to them or their surroundings (e.g. lighter, knife, scissors, razor or other such items),
- the belts are then secured (Bregar et al., 2012).

c. Confinement within one space or room

Confinement within one space or room is defined as SPM by the »ZDZdr« (2008), but at present this measure is not applied in Slovenian psychiatric hospitals. This is the confinement of an individual patient in a small, safe space for the purpose of mitigating agitation and aggression (Novak Grubič et al., 2018). The measure is ordered and signed by a physician, except in urgent cases where a physician is not present when it can be imposed by another health worker or professional associate, who immediately notifies the physician, who in turn approves or terminates the measure. Such confinement may only last as long as needed, depending on the reason for imposing it, but in any case no longer than 12 hours. After that time has elapsed the physician must confirm the justification for repeated use of the measure (Zbornica zdravstvene in babiške nege Slovenije, 2018). This type of confinement involves being kept in a special space or room with padding made of pleasant, soft materials that can be easily sanitised. The space has visual and audio monitoring via a video system. A patient alone in such a space can still be contacted via a loudspeaker (Zbornica zdravstvene in babiške nege Slovenije, 2018).

1.3 Instruments of restraint of the police

The use of instruments of restraint is just one of several police powers with which police tasks are carried out. The »ZNPPol« (2013) states that police tasks are to be performed by observation, patrolling, intervention, ambush, heightened control,

and security action. Police officers are enabled to perform their official tasks by legally defined measures, i.e., police powers. These are measures defined by law that generally involve an encroachment on human rights and fundamental freedoms, and other rights of the individual. Since the execution of police powers involves encroachments on specific human rights or fundamental freedoms, the legislators have entrusted these powers solely to police officers. Other citizens must obey the demands of police officers, and they may not exercise police powers since they would thereby be committing a crime (Celestina & Hudrič, 2014). Police powers are a tool for successfully and effectively carrying out tasks specified in law and implementing regulations. They represent a mandate that the police require for successfully carrying out tasks and entitlements provided by law, and no other bodies or citizens have such tasks and entitlements. This does not just relate to the rights of police officers, but also to the duty whereby in legally specified cases they may carry out against persons certain measures in the manner laid down by law and implementing regulations (Žaberl, 2006). As already mentioned at the beginning, the use of instruments of restraint is one of a number of lawful police powers. Police officers employ them for physical coercion or in order to force someone to do something. There are various means of coercion, such as the use of one's own physical force or the force of animals (police dog, mounted police officer), and there are various implements that can be used in this context (baton, handcuffs and means of restraint, gas agents, means of forcing vehicles to stop, water cannon, special motor vehicles and firearms) (Žaberl, 2006). However, their use is resorted to only when a police officer cannot, through a warning, order or another exercise of authority, prevent or avert danger and, consequently, carry out a police task. Through their use, the individual is coerced into doing or not doing something. Means of coercion are set out in law and categorised by type, meaning that police officers may not use means other than those specified. Other means and methods, while not prescribed in law or categorised, may be used by police officers only for restraining and handcuffing persons, for forcible stopping of vehicles or when police officers' lives or the lives of others are directly threatened. These means and methods may be used if they are comparable and appropriate in terms of the expected consequences of their use (Celestina & Hudrič, 2014).

The use of instruments of restraint is regulated in point two of the third section of the »ZNPPol« (2013), and their manner of application is defined in the Rules on Police Powers. Given the topic in question, when we talk about instruments of restraint it is also essential to mention police assistance, as defined by the »ZNPPol« (2013). It is important precisely because it is a key link in cooperation between health workers and the police, most commonly in dealing with the very persons who are the subject of our study. Police assistance is defined in Article 12 of the »ZNPPol« (2013), where it states that the police shall provide help to state authorities and self-governing local communities and to the holders of public authorisation only when they are carrying out public authorisations based on legally defined tasks and competences, if in implementing their tasks they encounter resistance or threats or if these may be justifiably anticipated. The duty of the police to cooperate and offer assistance to health workers is also defined

and regulated by the »ZDZdr« (2008) and the Rules on the cooperation between medical staff and rescue service and police (»Pravilnik o načinu sodelovanja med zdravstvenim osebjem in reševalno službo ter policijo«, 2009), which lay down that in cases where violence is anticipated in advance from a patient, and it is likely that the health workers will not be able to control it, the physician may request in advance the assistance of the police. In this case, the police are bound to cooperate with the health workers and emergency medical services and offer them the necessary assistance for as long as medical measures cannot contain the person's threat. Equally, the police are bound to provide assistance in carrying out the holding of a person without their consent and in carrying out emergency transport in an ambulance without the person's consent.

As stated by the Rules on the cooperation between medical staff and rescue service and police (»Pravilnik o načinu sodelovanja med zdravstvenim osebjem in reševalno službo ter policijo«, 2009), the assistance of the police may be requested when, due to the nature of the mental disturbance of the person, it is essential for the person's movement or contact with their surroundings to be prevented even before the procedure is carried out for receiving treatment without consent, and if the legal conditions for receiving such treatment without consent are met. Upon fulfilment of the stated conditions, the physician may request the assistance of the police in holding the person and in ordering their transport to the hospital in an ambulance without their consent. Prior to receiving assistance, the physician must brief the police on all information that is important in the specific case. The physician is the one who assesses when police assistance is no longer needed, and the threat can be contained through medical measures.

1.4 Therapeutic process and proportionality in the use of force

As Gabrovec (2014) has found, the receiving and treatment of a psychiatric patient is a therapeutic process that begins with the reception or referral for reception. The successful treatment of mental disturbances requires that the individual cooperates and accepts the help of professional staff and their close family and friends (Fergola, 2007). Since the hospitalisation of a patient is usually urgent and is only rarely the patient's own wish, the hospitalisation of such a patient is fear-inducing and traumatic. However, the hospitalisation process can also be encouraging for the patient, something that depends on the institution itself, the family relations, friends, the reaction of health workers and the method of reception. Upon being received, patients are often frightened, untrusting, tense and even verbally and physically violent, which may be a consequence of their past experiences or ideas of what might happen next, which the patients create and are fuelled by the media (Komazec, 2000).

Nowadays, psychiatry applies ways of handling patients that are the most patient-friendly, non-traumatic and effective. Such handling must observe all the principles and laws with regard to not encroaching on human integrity and not violating human rights and freedoms. Account must always be taken of a patient's dangerous behaviour in the past, the diagnosis of the illness for which they are being treated, and their current behaviour. To foresee and prevent the

potentially dangerous behaviour of a patient, health workers need to be skilled in observing, with both theoretical and practical knowledge, and able to assess the situation correctly (Možgan, 2009). With sufficiently early recognition of the risk of aggressive behaviour and appropriate action, health workers can prevent later complications, including injuries to patients and staff (Groleger, 2009). To avoid the possible consequences of the patient's violent behaviour, it is all the more important to foresee well in advance such a development. To this end, a range of questionnaires and scales are in use, including the currently most revised, simplified and increasingly used around the world, the BVC – Brøset violence checklist (Perne, 2005). Equally, to prevent outbreaks of aggressiveness and ensure the safety of patients and employees, it is vital to be familiar with the procedures for managing aggressiveness, the best known of which are de-escalation techniques (Jambrošič & Bregar, 2015). Attention must also be paid to behaviour that points to the potential for aggression to arise (Andrejek Grabar, 2009). If heightened aggressiveness is recognised and efforts are made early enough to reduce it, it is often possible to avoid more restrictive measures that are unpleasant both for the patient and staff (Groleger, 2009). Nevertheless, it is often impossible to avoid a patient's dangerous behaviour, for which reason special protective measures must be employed, and these are stressful for everyone involved (Možgan, 2009). Since SPM are highly traumatic, special attention needs to be paid to the principle of proportionality, meaning that the measures must be in proportion to the risk level and may not be substituted for less coercive measures. Depending on the individual case, a decision needs to be made as to which measure for a given person is least traumatic, and an assessment must be made about whether the expected benefits outweigh the possible drawbacks. SPM must be selected based on the latest findings and adjusted in terms of duration to the circumstances. Equally, account must be taken that physical or psychological harm may be done during their application. The guiding principle must always be the protection of rights and dignity, and the selected SPM may not serve to shame the patient or give them the feeling that it is some form of punishment (Bregar et al., 2012). Even when health workers opt for police assistance, it is important that the scope of measures used to avert the threat posed by the person is not greater than absolutely necessary (»Pravilnik o načinu sodelovanja med zdravstvenim osebjem in reševalno službo ter policijo«, 2009).

2 METHOD USED, SAMPLE AND QUESTIONNAIRE

From 2 September to 2 November 2019, we surveyed male and female police officers employed at the Novo Mesto Police Administration. We used an adapted questionnaire developed by Gabrovec et al (2014), divided into seven sets of questions.

The questionnaire contained questions (a) on the frequency of encountering various forms of violence at work and how many times those surveyed had experienced such behaviour on the part of persons with health issues or under the influence of medications or drugs, followed by (b) a set of questions where we sought to identify what emotions the respondents encountered while carrying

out tasks with an aggressive person with health issues or under the influence of drugs. Respondents were offered nine different emotions, where they assessed to what extent they faced the described emotion, using a scale from 1 (not at all) to 5 (very much); the rate of internal consistency of this part of the questionnaire, measured using Cronbach α, amounted to .941. This was followed by seven statements with which we measured the level of empowerment of respondents from the organisation (police force) to effectively face situations where they had to carry out tasks with an aggressive person with health issues or under the influence of drugs; the responses were measured by means of a scale from 1 (not at all) to 5 (very much); the rate of internal consistency of this part of the questionnaire, measured using Cronbach α, amounted to .973. In the next set, we used eight statements to measure the influence of certain factors on the safety and quality of handling of the user upon an outbreak of violent behaviour; a five-level scale from 1 (not at all) to 5 (very much) was used; the rate of internal consistency of this part of the questionnaire, measured using Cronbach α, amounted to .949. In the final set of questions, we used four statements to measure the assessment of respondents about the education or training provided to police officers for working with aggressive persons with health issues or under the influence of drugs. A five-level scale from 1 (not at all) to 5 (very much) was used; the rate of internal consistency of this part of the questionnaire, measured using Cronbach α, amounted to .959. For all the substantive sets used in the questionnaire, we may conclude that they are internally highly consistent and useful for further analysis.

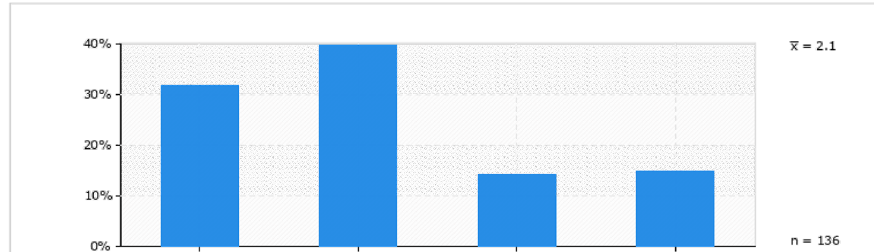
We conducted the survey by placing the questionnaire in the web environment 1ka, and we invited the participation of police officers from the Novo Mesto Administration who perform work in the field and may be sent on an intervention assignment where they could encounter aggressive persons with health or drug issues.

In total, the questionnaire was correctly completed by 281 police officers performing field or intervention work, although 20 did not answer all the items. Of the 261 respondents who answered the questions used to gather their demographic data, 81% of the officers were male and 19% female, with an average age of 40.7 years and an average length of service of 18.8 years. The largest number of respondents had a secondary education (41%), followed by those with post-secondary education (30%), one fifth had a higher education and one-tenth had an academic university education. Participation in the survey was voluntary, with respondents being guaranteed anonymity and confidentiality for their responses.

3 RESULTS

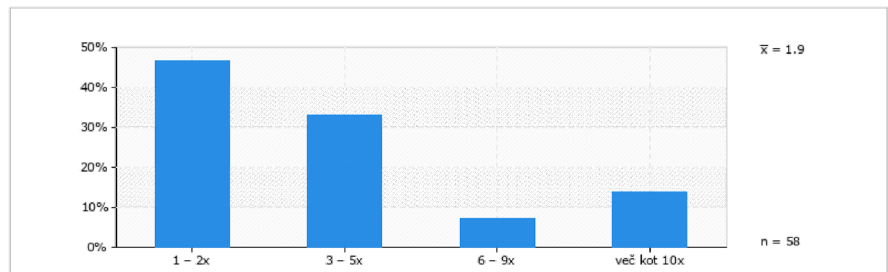
The respondents were first asked if and how frequently they had encountered verbal and physical violence in the past year at work and if they had ever been injured at work. Out of 278 respondents, 136 (49%) answered in the affirmative, meaning that nearly half of them had faced verbal violence in the past year. Of these, 43 (32%) had encountered verbal violence at work once or twice, 54 (40%) had encountered it three to five times, 19 (14%) six to nine times and 20 (15%) respondents had encountered it more than ten times.

Figure 1: Frequency of police encountering verbal violence at work in the past year



In the past year, 58 out of 276 respondents (or 21%) encountered physical violence at work. The largest number of respondents encountered physical violence at work in the past year once or twice (27 or 47%), 19 (33%) had encountered this three to five times, 4 (7%) six to nine times, and eight (14%) respondents had encountered this more than ten times. Injuries at work had already been suffered by 110 (40%) of the respondents, of which 37 had suffered such injuries once, 35 twice, 24 three times, eight four times and six as many as five times.

Figure 2: Frequency of police encountering physical violence at work in the past year



We then sought to find out if and how many times respondents had encountered verbal and physical violence in the past year at work from persons with health issues or under the influence of drugs/medications, and how many times such persons at work had injured them. Out of 277 respondents, this form of violence was encountered by 110 (40%) in the past year. Those who answered yes to this question were then asked how many times this had happened. Half of them (55, or 50%) responded that they had encountered verbal violence from such persons once or twice in the past year. Slightly fewer (39, or 35%) responded that they had encountered this form of violence three to five times in the past year. Then eight (7%) responded that they had encountered verbal violence from such persons six to nine times or more than ten times in the past year. Physical violence from persons with health issues or under the influence of drugs/medications was encountered at work in the past year by 49 (18%) out of 274 respondents, of whom more than half (28, or 57%) experienced this one or two times. Slightly fewer (18, or 37%) had encountered this form of violence three to five times, two respondents (4%) six to nine times, and one respondent (2%) had encountered this more than ten times in the past year. Injuries caused by persons with health issues or under the influence of drugs/medications were suffered at work by 35 (13%) respondents, of whom 28 suffered injuries once, four twice, two suffered them three times and one four times.

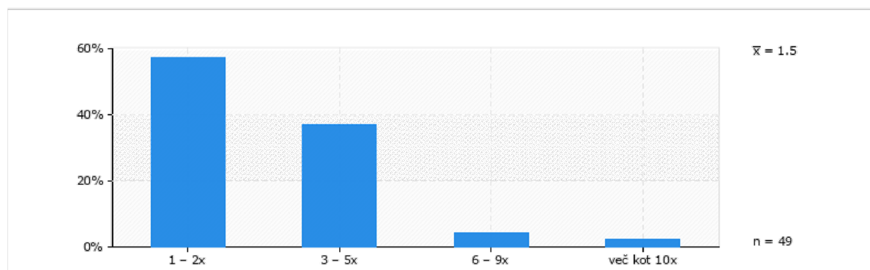


Figure 3: Frequency of police encountering physical violence at work in the past year from persons with health issues or under the influence of drugs/medications

We also wished to know what emotions and states are experienced by the respondents when encountering an aggressive person. Emotions and states foreseen in advance, such as fear, uncertainty, impotence, lack of knowledge, anger, despair, a feeling of threat, and a lack of understanding from colleagues and superiors, were assessed by respondents using a five-level scale from 1 (completely disagree) to 5 (agree very much). The responses are shown in Table 1 below.

Table 1: Level of agreement or disagreement with the statement: "When you encounter a person who is aggressive, you experience the following emotions and states"

	N	Average	Standard deviation	Difference between male/ female police officers
Feeling of threat	268	3.04	1.04	none
Fear	269	2.85	.98	none
Uncertainty	269	2.80	.99	$t = -2.12; p = .035$
Anger	267	2.55	1.07	none
Lack of understanding from superiors	270	2.55	1.03	none
Lack of understanding from colleagues	266	2.26	.98	none
Impotence	269	2.16	.90	none
Lack of knowledge	268	2.04	.91	$t = -2.42; p = .016$
Despair	266	1.85	.80	none

from 1 – completely disagree to 5 – agree very much

The results show that it is hard to pinpoint a specific emotion or state that the respondents experience more distinctly upon encountering an aggressive person. Most commonly, they experience feelings of threat, fear, and uncertainty. A total of 7% agreed very much that they experienced a feeling of threat, 25% agreed and 41% of respondents agreed partly. A total of 4% agreed very much with the feeling of fear, 18% agreed and 45% of respondents agreed partly. A total of 3% agreed very much with the feeling of uncertainty, 20% agreed and 40% of respondents agreed partly. The respondents least frequent experiences are feelings of despair, lack of knowledge and impotence. A total of 43% did not agree with the feeling of despair, and 38% of respondents did not agree at all. A total of 43% did not agree that they experienced a feeling of lack of knowledge, and 31% of respondents did

not agree at all with this statement. A total of 44% did not agree with the feeling of impotence, and 25% of respondents did not agree at all. We then used a t-test to verify whether these feelings are differentiated between male and female police officers. We found statistically significant differences in the sensing of uncertainty and lack of knowledge; female officers reported that they experienced both these emotions more frequently than male officers. We also checked the link between these emotions and the level of education, and determined that education has no statistically significant link with any of the emotions described. Younger respondents more frequently feel threatened ($r = -.115$; $p = .010$), while for the other emotions the participants' age or length of work experience had no statistically significant links (measured using the Pearson correlation coefficient).

In the next set of questions, we sought to obtain from the police officers surveyed an assessment of whether they were provided with all the means for dealing with violent persons, if their chiefs had a clear picture of the risks regarding provisions for violent persons, if their chiefs were familiar with the errors that arise in the area of ensuring safety, if their chiefs work to ensure conditions that support the safety of users and staff, if the safety of employees and users has the greatest importance in the organisation, if the organisation responds to outbreaks of violence, and if the organisation ensures supervision over the subduing of a violent user.

Table 2: Assessment of empowerment from the organisation for effective handling of persons with health issues or under the influence of drugs

	N	Average	Standard deviation
I have all means available for the safe handling of violent users.	266	3.31	.98
The work organisation responds to outbreaks of violence.	264	3.28	.93
The safety of employees and users is of the greatest importance in our organisation.	264	3.22	1.07
The heads of the work organisation are properly familiarised with the types of errors that actually arise in the area of ensuring safety.	264	3.12	.89
The work organisation ensures supervision over the subduing of a violent user.	265	3.11	.89
The heads of the work organisation work to ensure conditions that support the safety of users and staff.	264	3.09	.88
The heads of the work organisation have a clear picture of the risks regarding provisions for violent persons and safety of staff.	265	2.98	.89

from 1 – completely disagree to 5 – agree very much

We found that the respondents have all means available for the safe handling of violent users, that the work organisation responds to outbreaks of violence and that the safety of employees and users is of the greatest importance in the organisation. A total of 44% agreed (very much) with the first statement, and 38% of respondents agreed partly. A total of 41% agreed (very much) with the

second statement, and 44% of respondents agreed partly. A total of 36% agreed (very much) with the third statement, and 44% of respondents agreed partly. The lowest level of agreement was observed in the statement that the heads of the work organisation have a clear picture of the risks regarding provisions for violent persons and the safety of staff. A total of 27% agreed (very much) with the statement, and 46% of respondents agreed partly. Using a t-test, we sought to determine whether there were any statistically significant differences between male and female police officers in their assessments in the above table, but we found no such differences. The statement that the "Heads of the work organisation have a clear picture of the risks regarding provisions for violent persons and safety of staff" found more agreement among older ($r = .169$; $p = .006$) and more experienced ($r = .144$; $p = .019$) respondents, while we found no other correlations, measured using the Pearson correlation coefficient, with regard to the education, age or work experience of respondents.

In the next set of questions, we determined how certain factors affect the safety and quality of dealing with users upon the outbreak of violent behaviour. Respondents were given statements as set out in Table 3 below.

Table 3: The effect of certain factors on the safety and quality of dealing with users upon the outbreak of violent behaviour

	N	Average	Standard deviation
Conflicts between members of the team affect the safety and quality of work with violent persons.	263	3.63	.96
A record is made of any unfortunate event (outbreak of violence, other incidents).	262	3.28	1.10
Employees have precise instructions and protocols for how to act upon an outbreak of violence (what to do, who to call, etc.)	261	3.07	.86
After an outbreak of violence or an incident, decisions are taken to improve work in the future.	262	2.89	.970
In your work you rely on "luck" for everything to be OK, for nothing bad to happen.	263	2.73	1.08
After an outbreak of violence or an incident, we are offered team consideration and support.	261	2.67	.95
We are sufficiently motivated and rewarded for high quality and safe work.	263	2.51	.93
The number of employees in each shift is sufficient.	262	1.76	.90

from 1 – completely disagree to 5 – agree very much

We found that respondents agree most with the statement that conflicts between team members affect the safety and quality of work with violent persons. A total of 55% agreed (very much) with this statement, and 34% of respondents agreed partly. There was also greater agreement with the statement that a record is kept of any unfortunate event, where a total of 43% agreed (very much)

with the statement, and 34% of respondents agreed partly. The highest level of disagreement was observed for the statement that the number of employees in each shift is sufficient, where nearly half of respondents (48%) did not agree at all, 32% did not agree and just 15% partly agreed. We also observed disagreement with the statement that respondents are sufficiently motivated and rewarded for high quality and safe work. A total of 48% did not agree (at all) with this statement, and 40% of respondents agreed partly. The gender of respondents did not have any statistical significance with regard to the responses shown in the table above, but older ($r = .146$; $p = 0.18$) and more experienced ($r = .130$; $p = .036$) respondents agree more with the statement that they are sufficiently motivated for high quality and safe work, while younger respondents rely more than their older colleagues on luck for everything to be OK and for nothing to happen to them ($r = -.123$; $p = .045$). We did not detect any other links, and we found that education was not linked to any differences in responses to the statements shown in the above table.

In the final set of questions we determined whether the respondents, in their opinion, have sufficient knowledge to control violent persons and violent persons with health issues or under the influence of medications/drugs, and if they can access appropriate training to deal with such persons. The results are shown in Table 4 below.

Table 4: Training to control violent persons with health issues

	N	Average	Standard deviation	Difference between male/ female police officers
The knowledge I possess is sufficient for controlling violent persons.	263	3.18	.84	$t = 2.239$; $p = .017$
The knowledge I possess is sufficient for controlling violent persons with health issues or under the influence of medications/drugs.	263	2.88	.86	$t = 3.129$; $p = .002$
Adequate training is available to personnel for the safe care of violent persons.	263	2.69	.88	None
Adequate training is available to personnel for the safe care of violent persons with health issues or under the influence of medications/drugs.	263	2.44	.88	None

from 1 – completely disagree to 5 – agree very much

We can state that nearly half (48%) of respondents at least partly agree that their knowledge is sufficient for controlling violent persons. There was slightly more disagreement than agreement with the statement that the knowledge respondents possess is sufficient for controlling violent persons with health issues or under the influence of medications/drugs. A total of 30% did not agree

(at all) with this statement, 46% of respondents agreed partly, and 25% agreed. Disagreement was noted for the statement that adequate training is available to respondents for the safe care of violent persons. A total of 41% did not agree (at all) with this statement, and 42% of respondents agreed partly. The respondents disagreed most strongly with the statement that adequate training is available to personnel for the safe care of violent persons with health issues or under the influence of medications/drugs. A total of 54% did not agree (at all) with this statement, and 35% of respondents agreed partly. There was also a statistically significant higher frequency of agreement from male police officers than female officers with the statements that their knowledge of controlling violent persons is sufficient and that they are sufficiently skilled in controlling violent persons with health issues or under the influence of medications/drugs. Age, length of service or education had no statistically significant connection with the statements in the above table.

4 DISCUSSION

The results of the analysis point to a fair number of issues which should be considered in further work, particularly in terms of educating police officers. As is well known, police officers have standards for police procedures, but we can find no particular procedures in these standards for persons with health issues (in the health sector they would be termed patients). The fact is that acting against the stated categories of person is a specific field of action and cannot be equated with procedures for dealing with intoxicated persons. Although they are similar to a certain extent, especially in terms of the use of expert grips/holds, ultimately these procedures cannot be the same. Upon the first contact with the parties involved, police officers have a hard job identifying which category of person they are dealing with. Of the police officers who in the past year had encountered physical violence from persons who were suffering from health problems or were under the influence of drugs/medications (49, or 18% of respondents), most encountered this form of violence up to five times. The proportion of police officers who had encountered this form of violence in the past year represents as much as 94% of respondents. In dealing with and subduing such persons, police officers can make use of the same powers as when they deal with persons who do not have health issues. They have access to a wide variety of instruments of restraint to control them, depending on the intensity of resistance or attack, and these means can also be proportionally enhanced. At the same time, there are laws, guidelines and protocols setting out grips/holds and forms of cooperation between police officers and health professionals when they encounter such persons (Pravilnik o načinu sodelovanja med zdravstvenim osebjem in reševalno službo ter policijo, 2009).

The results of this study indicate that the total share of surveyed police officers who do not agree with the statement that they possess sufficient knowledge to control such persons is just under a third, which may later affect the course of treatment effectiveness (Gabrovec, 2014). Looking at the results, we can see that the share of those who agree that they have sufficient knowledge for these procedures is equal to the share of surveyed police officers who view that they do

not possess this knowledge. More than half of the surveyed police officers believe that there is not adequate training available for the controlling and safe care of violent persons with health issues or under the influence of medications/drugs. It should be especially noted that female police officers report that they lack such knowledge. We have found that most police officers believe that they lack appropriate knowledge for controlling such persons, and this lack is even greater in terms of adequate training. They do indeed have a more positive opinion regarding having sufficient knowledge and training to control violent persons without health issues, but they are also aware that dealing with and controlling such persons is a specific kind of activity that requires a different kind of approach. Given the awareness among police officers that they lack sufficient knowledge to control such persons, we may conclude that they would be willing to supplement this through appropriate training. Training should include health workers who are in regular contact with such persons and who could familiarise police officers with their methods and courses of action (»Pravilnik o načinu sodelovanja med zdravstvenim osebjem in reševalno službo ter policijo«, 2009; Žaberl, 2006). Even some basic knowledge would make it easier for police officers to deal with and control such persons, and thereby facilitate more effective treatment of the patient later on (Gabrovec, 2014). We also anticipate that with additional knowledge and the right approach both the number of times and intensity of using means of coercion against persons with health issues would diminish.

REFERENCES

Andrejek Grabar, E. (2009). Terapevtski ukrepi pri agresivnem pacientu [Therapeutic measures toward a violent patient]. In S. Čelan Stropnik (Ed.), *Funkcionalno izobraževanje iz psihiatrične zdravstvene nege in psihiatrije* (pp. 119–128). Univerzitetni klinični center Maribor.

Bregar, B., Kadivec, S., Kramar, Z., Marinšek, N., & Naka, S. (2012). *Protokol fizičnega oviranja s pasovi pacientov v bolnišnicah* [The protocol of usage of physical restraint over patients in hospitals using belts]. Zbornica zdravstvene in babiške nege Slovenije, Zveza strokovnih društev medicinskih sester, babic in zdravstvenih tehnikov Slovenije. https://www.zbornica-zveza.si/wp-content/uploads/2019/09/Protokol-fizi%C4%8Dnega-oviranja-s-pasovi-pacientov-v-bolni%C5%A1nicah-.pdf

Celestina, I., & Hudrič, G. (2014). *Kaj moramo vedeti o policijskih postopkih?*[What we need to know about the police procedures]. Ministrstvo za notranje zadeve Republike Slovenije.

Cvetežar, I. Š., & Pretnar Kunstek, V. (Eds.). (2005). *Okvirne smernice za obravnavanje nasilja na delovnem mestu v zdravstvu* [Framework guidelines for addressing workplace violence in the health sector]. Delovna skupina za nenasilje v zdravstveni negi, Zbornica zdravstvene in babiške nege Slovenije – Zveza društev medicinskih sester, babic in zdravstvenih tehnikov Slovenije.

Davison, S. E. (2005). The management of violence in general psychiatry. *Advances in Psyciatric Treatment*, *5*(11), 362–370. https://www.cambridge.org/core/services/aop-cambridge-core/content/view/EF671B6513F53315E0B46A7656B064DA/

S1355514600002509a.pdf/management_of_violence_in_general_psychiatry.pdf

Dernovšek, M. Z., & Novak Grubič, V. (2001). *Priporočila in smernice za uporabo posebnih ukrepov v psihiatriji* [The recommendations and guidelines for the use of special measures in psychiatry]. Viceversa.

Duxbury, J., & Whittington, R. (2005). Causes and management of patient aggression and violence: Staff and patient perspectives. *Journal of Advanced Nursing, 50*(5), 469–478. http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.472.339&rep=rep1&type=pdf

Fergola, B. (2007). *Sprejem proti volji pri bolniku z duševno motnjo* [Diplomsko delo] [The admission against the will of the mental health disordered patient into the hospital [Diploma thesis]]. Fakulteta za zdravstvene vede.

Gabrovec, B. (2014). *Organizacijski model zagotavljanja varnosti in kakovosti pri obravnavi psihiatričnega bolnika z vidika različnih deležnikov* [Doktorska disertacija] [Organizational model of safety and quality assurance in psychiatric patient treatment in terms of diverse participants [Doctoral dissertation]]. Fakulteta za organizacijske vede.

Gabrovec, B. (2015). The prevalence of violence directed at paramedic services personnel. *Obzornik zdravstvene nege, 49*(4), 284–294. https://doi.org/10.14528/snr.2015.49.4.60

Gabrovec, B. (2017). Violence towards nursing employees in Slovenia. *Varstvoslovje, 19*(2), 151–166.

Gabrovec, B., & Eržen, I. (2016). Prevalence of violence towards nursing staff in Slovenian nursing homes. *Zdravstveno varstvo, 55*(3), 212–217.

Gabrovec, B., & Lobnikar, B. (2015). The analysis of the role of an institution in providing safety and quality in psychiatric health care. *Anadolu Psikiyatri Dergisi, 16*(6), 420–425.

Gabrovec, B., Eržen, I., & Lobnikar, B. (2014). The prevalence and the nature of violence directed at the medical staff in psychiatric health care in Slovenia. *HealthMed, 8*(2), 228–234.

Groleger, U. (2009). Agresivnost [Aggressiveness]. In P. Pregelj, & R. Kobentar (Eds.), *Zdravstvena nega in zdravljenje motenj v duševnem zdravju* (pp. 288–294). Rokus Klett.

Jambrošič, I., & Bregar, B. (2015). Nasilje pacientov do zaposlenih v zdravstveni negi [Aggressiveness of patients against health staff]. In S. Majcen Dvoršak, T. Štemberger Kolnik, & D. Klemenc (Eds.), *Z optimalnimi viri do učinkovite zdravstvene in babiške nege: Zbornik predavanj z recenzijo* (pp. 208–215). Zbornica zdravstvene in babiške nege Slovenije – Zveza strokovnih društev medicinskih sester, babic in zdravstvenih tehnikov Slovenije, Nacionalni center za strokovni, karierni in osebnostni razvoj medicinskih sester in babic.

Kobal, M. F. (2009). *Psihopatologija za varnostno in pravno področje*. Fakulteta za varnostne vede.

Komazec, S. (2000). Nasilje nad negovalnim timom [Violence against nursing teams]. In D. Klemenc, & M. Pahor (Eds.), *Nasilje in spolno nadlegovanje na delovnih mestih medicinskih sester v Sloveniji* (pp. 93–97). Društvo medicinskih sester in zdravstvenih tehnikov.

Kores Plesničar, B. (2006). Pomen agresije v zdravstvenih ustanovah [The meaning of aggression in health care institutions]. In V. Čuk (Ed.), *Raziskovanje, izobraževanje in razvoj v psihiatrični zdravstveni negi: Pravice bolnikov in zaposlenih* (pp. 27–30). Zbornica zdravstvene in babiške nege – Zveza društev medicinskih sester, babic in zdravstvenih tehnikov Slovenije, Sekcija medicinskih sester in zdravstvenih tehnikov v psihiatriji.

Kores Plesničar, B. in Kordić Lasič, J. (2004). Nasilje bolnikov in njihovih svojcev v zdravstvenih ustanovah [Violent behaviour of patients and their relatives in health care institutions]. *Zdravstveno varstvo, 43*(3), 179–183.

Marinič, M. (1999). Izolacija pacientov s pasovi Segufix [Isolation of patients with Segufix belts]. In B. Kogovšek, & R. Kobentar (Eds.), *Priročnik psihiatrične zdravstvene nege in psihiatrije* (pp. 169–175). Rokus Klett.

Močnik, M. (2009). Zloraba in nasilje varovancev v posebnem socialnovarstvenem zavodu Lukavci z vidika dela medicinske sestre [Abuse and violence of protégés in the special social welfare institution Lukavci from the nurses point of view]. In U. Poček (Ed.), *Zbornik prispevkov: Nasilno vedenje v duhu novih praks* (pp. 17–25). Zbornica zdravstvene in babiške nege – Zveza društev medicinskih sester, babic in zdravstvenih tehnikov Slovenije, Sekcija medicinskih sester in zdravstvenih tehnikov v psihiatriji.

Možgan, B. (2009). Posebni varovalni ukrepi [Special precautionary measures]. In P. Pregelj, & R. Kobentar (Eds.), *Zdravstvena nega in zdravljenje motenj v duševnem razvoju* (pp. 439–443). Rokus Klett

Novak Grubič, V., Bon, J., & Novak Šarotar, B. (Eds.). (2018). *Priporočila in smernice za uporabo posebnih varovalnih ukrepov v psihiatriji* [Recommendations and guidelines for the use of special protective measures in psychiatry]. Viceversa. http://www.zpsih.si/media/documents/PVU2018.pdf

Pačnik, T. (1989). Socialni vidiki agresivnosti [The social aspects of aggressiveness]. *Obzornik zdravstvene nege*, *23*(1/2), 73–79. https://obzornik.zbornica-zveza.si/index.php/ObzorZdravNeg/article/view/1809

Perne, D. (2005). Uporaba Brosetove lestvice za napoved nasilnega pacienta [Brøset violence checklist – presentation and practical use]. In A. Bručan, M. Gričar, & R. Vajd (Eds.), *Urgentna medicina: Izbrana poglavja* (pp. 67–72). Slovensko združenje za urgentno medicino.

Pravilnik o načinu sodelovanja med zdravstvenim osebjem in reševalno službo ter policijo [Rules on the cooperation between medical staff and rescue service and police]. (2009). *Uradni list RS*, (44/09).

Škrila Čuš, D. (2005). Alkohol, agresija in nasilje [Alcohol, aggression, and violence]. *Zdravniški vestnik*, *74*(9), 535–537. https://www.dlib.si/details/URN:NBN:SI:doc-RNQUXRGA

Šolc, S. (2001). Agresija in nasilje [Aggression and violence]. *Utrip*, *9*(1), 32–35.

Zakon o duševnem zdravju (ZDZdr) [Mental Health Act]. (2008, 2015, 2019). *Uradni list RS*, (77/08, 46/15, 44/2019).

Zakon o nalogah in pooblastilih policije (ZNPPol) [Police Tasks and Powers Act]. (2013, 2015, 2017, 2019, 2021). *Uradni list RS*, (15/13, 23/15, 10/17, 46/19, 47/19, 153/21).

Zbornica zdravstvene in babiške nege Slovenije. (2018). *Nacionalni protokoli*

aktivnosti zdravstvene in babiške nege: Posebni varovalni ukrep – omejitev gibanja znotraj enega prostora na področju psihiatrije [National protocols of nursing and midwifes activities: Special protective measure – restriction of movement within one place in psychiatry]. https://www.zbornica-zveza.si/wp-content/uploads/2019/09/NP-omejitev-gibanja-znotraj-enega-prostora.pdf

Zeller, A., Hahn, S., Needham, I., Kok, G., Dassen, T., & Halfens, R. J. G. (2009). Aggressive behavior of nursing home residents toward caregivers: a systematic literature review. *Geriatric Nursing*, *30*(3), 174–187.

Žaberl, M. (2006). *Temelji policijskih pooblastil* [Legal foundations of police powers]. Fakulteta za policijsko – varnostne vede.

ABOUT THE AUTHORS:

Branko Gabrovec, PhD, assist. professor in public health at the University of Ljubljana, National Institute of Public Health and Faculty of Health Sciences at the University of Maribor. E-mail: branko.gabrovec@nijz.si

Tilen Zupan, BA in security sciences, employed at the Novo Mesto Police Administration. E-mail: tilen.zupan@policija.si

Srečko Felix Krope, PhD, assist. professor of security studies at the Faculty of Criminal Justice and Security, University of Maribor. E-mail: srecko.krope@siol.net

Branko Lobnikar, PhD, professor of security studies at the Faculty of Criminal Justice and Security, University of Maribor. E-mail: branko.lobnikar@fvv.uni-mb.si