

# Best Evidence Summaries of Topics in Mental Healthcare

**BEST in MH** *clinical question-answering service*

## Question

In medium and low secure services, what are the most effective interventions for reducing violence in service users?

## Clarification of question using *PICO* structure

*Patients:* Service users in medium/low secure services

*Intervention:* Any intervention

*Comparator:* Any other intervention

*Outcome:* Violence in service users

## Plain language summary

There is limited high quality evidence into interventions for reducing violence in service users. High quality research is needed in this area to adequately assess the effectiveness of interventions for reducing violence in service users.

## Clinical and research implications

Evidence about the effectiveness of cognitive behavioural therapy (CBT) interventions for reducing violent or aggressive behaviour in service users is inconclusive; studies do not report sufficient information to allow adequate interpretation and findings were inconsistent. There is no evidence to support the use of other psychological interventions. There is some evidence to suggest that clozapine may be more effective than olanzapine or haloperidol for reducing violent behaviour.

Further research is needed to assess longer-term and comparative effects of psychological interventions and to confirm findings about pharmacological interventions.

## What does the evidence say?

### ***Number of included studies/reviews (number of participants)***

We identified one systematic review<sup>1</sup> and two additional randomised controlled trials (RCTs)<sup>2,3</sup> which reported results that were partially relevant to this evidence summary. The systematic review assessed the effects of psychological therapies on violent behaviour in clinical and forensic settings and included ten studies, of which seven assessed cognitive behavioural therapy (CBT) interventions. One additional RCT compared the effectiveness of two atypical antipsychotics (clozapine and olanzapine) and haloperidol in, mainly male, psychiatric in-patients with schizophrenia and schizoaffective disorder and current evidence of violent behaviour.<sup>2</sup> The second additional RCT was also conducted in psychiatric in-patients and included both patients with aggressive (63%) and regressive behaviours.<sup>3</sup> All three studies reported at least one measure of violence or physically aggressive behaviour.<sup>1,2,3</sup>

### ***Main findings***

The results of studies included in the systematic review were inconsistent. One RCT included in the review found that individual CBT significantly reduced the occurrence of violent and aggressive incidents compared to social activity therapy (follow-up duration not reported) and one RCT found no difference in violent and aggressive incidents, between the CBT group and the treatment as usual group, over a 12 month follow-up period.<sup>1</sup> Similarly, two comparative observational studies of group CBT, by the same group, included in the systematic review, provided contradictory results on recidivism rates in violent offenders, however, the larger and more recent study found no significant treatment effect.<sup>1</sup> Details of studies included in the systematic review, interventions, duration and results (no numerical results reported) were poorly reported and results were not reported for all listed outcome measures. The systematic review included no comparative studies of other psychological interventions.<sup>1</sup>

The additional RCT of pharmacological interventions, conducted in people with schizophrenia and schizoaffective disorder and current evidence of violent behaviour, found that clozapine was consistently superior to olanzapine and olanzapine was consistently superior to haloperidol on all components of the modified overt aggression scale (MOAS).<sup>2</sup> The second additional RCT, conducted in psychiatric in-patients with aggressive or regressive behaviours, reported that equine animal-assisted psychotherapy was associated with a very small reduction in the mean number of violent incidents per month, however, no other significant treatment effects were observed in this study.<sup>3</sup>

## ***Authors conclusions***

Ross 2013 – The authors concluded that their findings provide tentative support for the utility of psychotherapeutic interventions in reducing aggressive behaviour in forensic and psychiatric patients with a history of violent behaviour.

Krakowski 2006 – Clozapine shows greater efficacy than olanzapine and olanzapine shows greater efficacy than haloperidol in reducing aggressive behaviour. This effect seems to be separate from the antipsychotic and sedative effects of these medications.

Nurenberg 2015 – The study authors concluded that animal assisted therapy and, perhaps uniquely, equine assisted therapy, may be an effective therapeutic modality for long-term psychiatric patients at risk of violence. These conclusions are not supported by the data presented.

#### ***Reliability of conclusions/Strength of evidence***

The available evidence was limited. The systematic review of psychological therapies was poorly reported and did not provide sufficient details of the included studies (specifically in relation to interventions, study and follow-up duration and numerical results for all outcomes assessed) to allow adequate interpretation. Two additional small RCTs, both with methodological weaknesses, provided some evidence about the relative effectiveness of three pharmacotherapies and the effectiveness of animal assisted psychotherapies. The study of animal assisted psychotherapies included a mixture of patients with aggressive and regressive behaviours and may therefore have limited applicability to this evidence summary.

#### **What do guidelines say?**

Neither NICE nor SIGN guidelines comment specifically on interventions for reducing violence in service users, however NICE guidelines (NG10) do make the following recommendations on general principles in managing short term violence and aggression:

- Establish a close working relationship with service users at the earliest opportunity and sensitively monitor changes in their mood or composure that may lead to aggression or violence.
- Separate agitated service users from others (using quiet areas of the ward, bedrooms, comfort rooms, gardens or other available spaces) to aid de-escalation, ensuring that staff do not become isolated.
- Use a wide range of verbal and non-verbal skills and interactional techniques to avoid or manage known 'flashpoint' situations (such as refusing a service user's request, asking them to stop doing something they wish to do or asking that they do something they don't wish to do) without provoking aggression.
- Encourage service users to recognise their own triggers and early warning signs of violence and aggression and other vulnerabilities, and to discuss and negotiate their wishes should they become agitated. Include this information in care plans and advance statements and give a copy to the service user.
- Communicate respect for and empathy with the service user at all stages of de-escalation.

**Date question received:** 12/09/2016  
**Date searches conducted:** 03/10/2016  
**Date answer completed:** 11/10/2016

## References

### ***Systematic reviews***

1. Ross, J., Quayle, E., Newman, E., Tansey, L. (2013) The Impact of Psychological Therapies on Violent Behaviour in Clinical and Forensic Settings: A Systematic Review. *Aggression and Violent Behavior* 18(6): pp761-773.

### ***Randomised controlled trials***

2. Krakowski, MI., Czobor, P., Citrome, L., Bark, N., Cooper, TB. (2006) Atypical Antipsychotic Agents in the Treatment of Violent Patients with Schizophrenia and Schizoaffective Disorder. *Archives of General Psychiatry* 63(6): pp622-629.
3. Nurenberg, JR., Schleifer, SJ., Shaffer, TM., Yellin, M., Desai, PJ., Amin, R., Bouchard, A., Montalvo, C. (2015) Animal-Assisted Therapy with Chronic Psychiatric Inpatients: Equine-Assisted Psychotherapy and Aggressive Behavior. *Psychiatric Services* 66(1): pp80-86.

### ***Guidelines***

National Institute for Health and Care Excellence (2015) Violence and Aggression: Short-term Management in Mental Health, Health and Community Settings: NG10. Nice: London

<https://www.nice.org.uk/guidance/ng10/resources/violence-and-aggression-shortterm-management-in-mental-health-health-and-community-settings-1837264712389>

## Results

### *Systematic reviews*

Author (year)	Search date	Inclusion criteria	Number of included studies	Summary of results	Risk of bias
Ross et al. (2013)	11/2012	<p><b>Participants:</b> Adults aged 16+ with a history or current presentation of violent behaviour. Those in prison, forensic inpatient hospitals or being managed in the community as forensic outpatients were included. Studies with participants whose primary reason for detention was a sexual offence or domestic violence and studies conducted in people with learning disabilities were excluded.</p> <p><b>Intervention:</b> Any psychological intervention, including CBT-based interventions delivered in groups (3 studies) or individually (3 studies); CBT-informed anger management (1 study); Aggression replacement training (ART) (1 study); dramatherapy (1 study); Motivation and engagement (1 study).</p> <p><b>Comparator:</b> In RCTs (2 studies): Social activity therapy (SAT) (1 study); treatment as usual (1 study) In Pre-post intervention studies (6 studies):</p>	n=10 studies (n=769 participants; study size 3 to 418)	<p>This review aimed to assess the effects of psychological therapies on violent behaviour in clinical and forensic settings; studies of any psychological therapy, including CBT, were eligible for inclusion.</p> <p>The majority of included studies evaluated a CBT intervention and most were conducted in male in-patients/violent offenders.</p> <p><i>Individual CBT</i> The two RCTs included in the review both assessed individual CBT. The details and duration of the CBT intervention were not reported for either study. One study was conducted in majority (87%) male inpatients and outpatients with a diagnosis of schizophrenia and a history of violence. This study compared individual CBT to social activity therapy and found that there were</p>	<p>The review addressed a clearly stated objective and defined appropriately broad inclusion criteria.</p> <p>Six bibliographic databases were searched and a simple search strategy was reported.</p> <p>Electronic searches were supplemented by hand searching of selected journals and contact with</p>

	<p>Matched non-completers or no comparator-In case series studies (2 studies): No comparator</p> <p><b>Outcome:</b></p> <p>Psychometric outcome measures and reporting of violent incidents: study: Aggression and offending (MacArthur Community Violence Screening Instrument; MCVSI); Drug use (Drug Abuse Screening Test; DAST); Alcohol use (Alcohol Use Disorders Identification Test; AUDIT); Anxiety and depression (Hospital Anxiety and Depression Rating Scale; HADS); Anger (Novaco Anger Scale and Provocation Inventory; NAS-PI); Social functioning (Social Functioning Questionnaire; SFQ); Evaluation of self and others (Brief Core Schema Scales; BCSS); Anger (Ward Anger Rating; WARS; and Novaco Anger Scale and Provocation Inventory; NAS-PI); Psychotic symptoms (Psychotic Symptom Rating Scales; PSYRATS; and (Positive and Negative Syndrome Schedule; PANSS).</p> <p><b>Study design:</b></p> <p>There were no restrictions on study design; RCTs, controlled trials, cohort studies and case-series were eligible for inclusion: RCTs (2 studies); Pre-post interventions (6 studies); case series (2 studies)</p>	<p>fewer incidents of physical aggression during treatment and follow-up (duration not reported) in the CBT group. However, results were not reported for the four psychometric outcome measures listed and the authors stated that there were no significant changes in anger in either group. The second RCT included only community dwelling violent male participants with antisocial personality disorder and compared individual CBT to treatment as usual (not described). This study found no between group differences in incidences of verbal and physical aggression over the 12 month follow-up period; results were not reported for all outcomes listed including NAS-PI-anger.</p> <p>One additional case series (n=3) reported that CBT reduced post-treatment anger and aggression in all three cases (detailed results and duration of intervention not reported), however, the effect was not maintained at follow-up (duration not reported).</p> <p><i>Group CBT</i></p> <p>Two studies from the same group assessed the effects on recidivism of a group CBT intervention (details and duration not</p>	<p>study authors.</p> <p>Two reviewers independently assessed studies for inclusion and extracted data.</p> <p>The methodological quality of included studies was assessed and reported.</p> <p>The use of a narrative synthesis was appropriate, given the different interventions, comparators and study designs included. However, included studies were not described in sufficient detail (e.g. follow-up periods were described as varying between</p>
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			<p>reported) in violent offenders, compared to a matched group of violent offenders who had not received the intervention. The initial small study (n=22) found no between group difference in non-violent reconvictions, but 31% fewer violent interventions in the CBT group. However, the subsequent larger study (n=112) found no difference in re-offending rates. Follow-up periods were not reported for either study. One observational 'before and after' study assessed the effects of a two-day drama-based CBT intervention in 62 male violent offenders in three high security hospitals; the study did not include a comparator group. This study reported reductions in anger (STAXI-2) pre- to post-intervention and reductions in self-reported anger at three month follow-up. The remaining study was a small (n=12) observational study assessing a brief (two-session) CBT-based intervention in patients on a psychiatric ward who had a history of anger and violence; the study did not include a comparator group. This study found a significant decrease in the numbers of violent and aggressive incidents in the two weeks post-intervention compared to the two weeks prior to the intervention (no</p> <p>studies, but were not reported for all studies, durations of interventions not reported), and results were not reported for all outcomes listed.</p>
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			<p>further details reported.</p> <p><i>Other psychological interventions</i></p> <p>One observational ‘before and after’ study assessed the effects of Aggression control therapy based on Aggression replacement training (ART) in male forensic in-patients and outpatients (no further details reported). Outcome measures of hostility and aggression were developed by the study authors (no details reported); the study found that therapy reduced levels of aggression, particularly amongst those with a low psychopathy score. One further ‘before and after’ study assessed the effects of a two day psychodynamic drama therapy intervention in 12 mentally disordered offenders, in three high security hospitals. This study reported significant reductions in self-reported anger at three months follow-up and some reductions across the anger scales within the STAXI. The final study reported a case series of five male prisoners (violent offenders with psychopathic personality traits) who participated in the Chromis Programme (motivation and engagement, good lives model and schema therapy). A reduction in self-reported anger</p> <td></td>	
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			<p>and expected incidences of physical aggression were observed, although a higher than expected incidence of verbal aggression following programme completion was also found.</p> <p>Numerical results (e.g. absolute numbers of violent incidents) were not reported for any of the included studies.</p>	
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### *Randomised controlled trials*

Author (year)	Inclusion criteria	Number of participants	Summary of results	Risk of bias
Krakowski et al (2006)	<p><b>Participants:</b> Aged 18-60, diagnosed with schizophrenia or schizoaffective disorder (DSM-IV). Patients were required to have a clearly confirmed episode of physical assault during the current hospitalisation and some persistence of aggression.</p> <p>Exclusion criteria: history of non-response or intolerance to any of the three study medications; any of the three study medications contraindicated; receipt of depot antipsychotic within 30 days before randomisation.</p> <p><b>Intervention:</b> Clozapine(500mg/d)</p>	n=110 (clozapine=37, olanzapine=37 haloperidol=36)	<p>This study aimed to compare the effectiveness of two atypical antipsychotics and haloperidol for the management of aggressive behaviours in people with schizophrenia and schizoaffective disorder and current evidence of violent behaviour.</p> <p>Most study participants (approximately 80%) were male. The mean age of participants was approximately 35 years and their mean duration of illness was approximately 15 years, with a mean of 11 previous psychiatric hospitalisations. There were no significant differences between the three treatment groups in demographic characteristics, psychiatric history, baseline outcome measures, pre-study medications or</p>	<p>No details of randomisation or allocation concealment procedures were reported.</p> <p>Study participants, personnel and outcome assessors</p>

	<p><b>Comparator:</b> Olanzapine (20mg/d) or haloperidol (20mg/d)</p> <p><b>Outcome:</b> Number and severity of physical assaults (MOAS), physical aggression score, severity of all aggressive events, and psychiatric symptoms (PANSS); outcomes were measured at baseline and at endpoint (12 weeks), and at intervals throughout the study.</p>	<p>length of hospitalisation, or number of physical assaults during the four week pre-study period.</p> <p>The 12 week trial comprised a six week dose escalation and fixed dose period (pre-study antipsychotic medication was gradually discontinued whilst study medications were escalated to their target levels) followed by a six week variable dose period (study medication dose was allowed to vary within the following ranges: clozapine 200 to 800 mg/d; olanzapine 10 to 35 mg/d; haloperidol 10 to 30 mg/d). Patients who were receiving mood stabilisers or antidepressants prior to study entry continued these medications, and treatments for extrapyramidal adverse effects, restlessness, agitation and insomnia were prescribed as needed. At the end of the study period the mean dose of clozapine was 565.5 mg/d, the mean dose of olanzapine was 24.7 mg/d and the mean dose of haloperidol was 23.3 mg/d. There were no significant differences between the groups in the use of 'treat as needed' medications.</p> <p>Overall MOAS scores and MOAS physical aggression scores indicated that clozapine was superior to both olanzapine and haloperidol and that olanzapine was superior to haloperidol. Odds ratios (odds of a lower total MOAS score at any point during the study) were: 1.69 (95% CI: 1.60 to 1.80) for clozapine vs. haloperidol; 1.30 (95% CI: 1.20 to 1.40) for clozapine vs. olanzapine; 1.30 (95% CI: 1.20 to 1.40) for olanzapine vs. haloperidol. For the MOAS physical aggression</p>	<p>were blind to treatment group.</p> <p>Results were reported for all specified outcome measures.</p> <p>Intention-to-treat analyses were presented, however drop-out rates were high (13/37 in the clozapine group, 11/37 in the olanzapine group, and 16/36 in the haloperidol group)</p>
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			<p>scale, odds ratios were: 2.04 (95% CI: 1.80 to 2.30) for clozapine vs. haloperidol; 1.33 (95% CI: 1.20 to 1.50) for clozapine vs. olanzapine; 1.54 (95% CI: 1.40 to 1.70) for olanzapine vs. haloperidol. Analysis of the MOAS aggression against property and verbal aggression scales found similar results, however, for the aggression against property scale the clozapine vs. olanzapine comparison did not reach statistical significance and for the verbal aggression scale the olanzapine vs. haloperidol comparison did not reach statistical significance.</p> <p>There were no statistically significant differences between the groups in changes in psychotic symptoms (PANSS) over time.</p>	
Nurenberg et al (2015)	<p><b>Participants:</b> Inpatients at a state Psychiatric Hospital, aged 18 to 65 years, with aggressive or regressed behaviour (defined as three or more violent incidents in the preceding 12 months or two incidents plus clinically perceived active risk), or regressed behaviour (defined as persistent social isolation and difficulty in engaging in discharge-related activities). Exclusion criteria: impaired ambulation; cognitive impairment; medical conditions that may be exacerbated by animal</p>	n=90 (EAP=24, CAP=25, ESS=23, RHC=18)	<p>This study aimed to compare the effects, on violent behaviour, of equine and canine versions of animal assisted therapy (AAT) with standard care, in psychiatric in-patients. The majority (63%) of study participants were male and their mean age was 44 years. The mean duration of hospitalisation was 5.4 years, 76% of participants had a diagnosis of schizophrenia or schizoaffective disorder and 56% were committed on a civil or criminal basis. Aggressive behaviour was the primary criteria for study entry in 63% of participants. There were no significant baseline differences among the four intervention groups in age, sex, racial-ethnic</p>	<p>No details of randomisation or allocation concealment procedures were reported.</p> <p>The nature of the interventions precluded</p>

	<p>contact; behaviour judged to pose a substantive risk to the animals in the study</p> <p><b>Intervention:</b> equine-assisted psychotherapy (EAP) canine-assisted psychotherapy (CAP)</p> <p><b>Comparator:</b> Active control - enhanced social skills psychotherapy (ESS), or regular hospital care (RHC)</p> <p><b>Outcome:</b> frequency of aggressive behaviour through incident reports, frequency of clinical observation or seclusion or restraint, verbal and physical aggression, brief psychiatric rating scale, life skills profile, in-house intrusiveness measure, patients propensity to violate others personal space, pet attitude scale. Outcomes were assessed at baseline or over the two month pre-study period and at three month follow-up.</p>	<p>background, diagnosis, days from hospital admission to study intake, recruitment for aggressive versus regressed behaviour, or aggressive incidents in the two months preceding intake.</p> <p>AAT interventions and the active control were provided in ten 40 to 60 minute weekly group sessions. Sessions were conducted at dedicated sites in the hospital grounds by certified pet therapists, hospital staff and hospital rehabilitation staff. The EAP intervention did not include riding.</p> <p>There was a small, but statistically significant (<math>p=0.035</math>) difference between the groups in the number of violent incidents in the three months after study intake compared to the number in the two months prior to intake. Participants in the EAP group had a small mean reduction in the number of incidents per month from <math>1.33 \pm 2.04</math> to <math>0.77 \pm 0.87</math>; all other groups showed an increase in the mean number of incidents per month.</p> <p>All other outcome measures, including the Overt Aggression Scale item for assault of others and number of instances of one-to-one observation or use of seclusions or restraints, showed no statistically significant between group differences.</p>	<p>blinding of study participants and personnel.</p> <p>Outcome assessors were blind to group allocations. However, staff members interviewed at follow-up were not blind to group allocation.</p> <p>Participants who attended at least one treatment session were included in the analyses; 15/105 (14%) participants</p>
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				initially recruited were excluded.  Results were reported for all specified outcome measures.
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## Risk of bias

### *Systematic reviews*

Author (year)	RISK OF BIAS				
	Inclusion criteria	Searches	Review process	Quality assessment	Synthesis
Ross (2013)	😊	😊	😊	😊	😢

### *Randomised controlled trials*

Study	RISK OF BIAS					
	Random allocation	Allocation concealment	Blinding of participants and personnel	Blinding of outcome assessment	Incomplete outcome data	Selective Reporting
Krakowski et al (2006)	?	?	😊	😊	😢	😊
Nurenberg et al (2015)	?	?	😢	😢	😊	😊

😊 Low risk

😢 High risk

? Unclear risk

## Search details

Source	Search Strategy	Number of hits	Relevant evidence identified
<i>Guidelines</i>			
NICE	Violence, Aggression		
MEDLINE	19. Medline; ((low OR medium) adj2 secur*).ti,ab; 643 results. 20. Medline; ((secur* OR forensic) adj2 (service* OR unit* OR facilit* OR prison* OR setting* OR institution*)).ti,ab; 3713 results. 21. Medline; ((correction* OR mental* OR psychiatric* OR forensic) adj2 (institution* OR unit* OR facilit* OR service*)).ti,ab; 30986 results. 22. Medline; ((secur* adj2 psychia* adj2 care)).ti,ab; 26 results. 23. Medline; (forensic adj2 psych*).ti,ab; 1404 results. 24. Medline; exp FORENSIC PSYCHIATRY/; 60219 results. 25. Medline; ((mental* adj2 ill* adj2 (offender* OR prisoner*))).ti,ab; 333 results. 26. Medline; ((forensic OR secur*) adj2 (mental adj2 health)).ti,ab; 489 results. 27. Medline; exp VIOLENCE/; 74241 results. 28. Medline; exp AGGRESSION/; 31356 results. 29. Medline; ((aggress* OR viole*)).ti,ab; 198490 results. 30. Medline; exp PRISONERS/; 13971 results. 31. Medline; 19 OR 20 OR 21 OR 22 OR 23 OR 24 OR 25 OR 26 OR 30; 104098 results. 32. Medline; 27 OR 28 OR 29; 258522 results. 33. Medline; 31 AND 32; 9367 results. 34. Medline; 33 [Limit to: (Document type Clinical Trial or Controlled Clinical Trial or Meta-analysis or Randomized Controlled Trial or Scientific Integrity Review)]; 195 results.		
EMBASE	1. EMBASE; ((low OR medium) adj2 secur*).ti,ab; 861 results. 2. EMBASE; ((secur* OR forensic) adj2 (service* OR unit* OR facilit* OR prison* OR setting* OR institution*)).ti,ab; 4277 results. 3. EMBASE; ((correction* OR mental* OR psychiatric* OR forensic) adj2 (institution* OR unit* OR facilit* OR		

	<p>service*)).ti,ab; 35611 results.</p> <p>4. EMBASE; ((secur* adj2 psychia* adj2 care)).ti,ab; 43 results.</p> <p>5. EMBASE; (forensic adj2 psych*).ti,ab; 4408 results.</p> <p>6. EMBASE; exp OFFENDER/; 16572 results.</p> <p>7. EMBASE; exp FORENSIC PSYCHIATRY/; 12590 results.</p> <p>8. EMBASE; exp PRISON/; 15227 results.</p> <p>9. EMBASE; ((mental* adj2 ill* adj2 (offender* OR prisoner*))).ti,ab; 413 results.</p> <p>10. EMBASE; ((forensic OR secur*) adj2 (mental adj2 health)).ti,ab; 577 results.</p> <p>11. EMBASE; 1 OR 2 OR 3 OR 4 OR 5 OR 6 OR 7 OR 8 OR 9 OR 10; 76341 results.</p> <p>12. EMBASE; exp VIOLENCE/; 121791 results.</p> <p>13. EMBASE; exp AGGRESSION/; 94356 results.</p> <p>14. EMBASE; ((aggress* OR viole*)).ti,ab; 280628 results.</p> <p>15. EMBASE; 12 OR 13 OR 14; 400273 results.</p> <p>16. EMBASE; 11 AND 15; 15596 results.</p> <p>17. EMBASE; 16 [Limit to: (EBM-Evidence Based Medicine Evidence Based Medicine or Meta Analysis or Systematic Review)]; 328 results.</p> <p>18. EMBASE; 16 [Limit to: (Clinical Trials Clinical Trial or Randomized Controlled Trial or Controlled Clinical Trial)]; 344 results.</p>		
PsycINFO/CINAHL	<p>35. PsycInfo; ((low OR medium) adj2 secur*).ti,ab; 1080 results.</p> <p>36. PsycInfo; ((secur* OR forensic) adj2 (service* OR unit* OR facilit* OR prison* OR setting* OR institution*)).ti,ab; 5099 results.</p> <p>37. PsycInfo; ((correction* OR mental* OR psychiatric* OR forensic) adj2 (institution* OR unit* OR facilit* OR service*)).ti,ab; 42610 results.</p> <p>38. PsycInfo; ((secur* adj2 psychia* adj2 care)).ti,ab; 65 results.</p> <p>39. PsycInfo; (forensic adj2 psych*).ti,ab; 2931 results.</p> <p>40. PsycInfo; exp FORENSIC PSYCHIATRY/; 4013 results.</p> <p>41. PsycInfo; ((mental* adj2 ill* adj2 (offender* OR prisoner*))).ti,ab; 660 results.</p> <p>42. PsycInfo; ((forensic OR secur*) adj2 (mental adj2 health)).ti,ab; 1296 results.</p> <p>43. PsycInfo; exp VIOLENCE/; 64718 results.</p> <p>44. PsycInfo; ((aggress* OR viole*)).ti,ab; 128441 results.</p> <p>45. PsycInfo; exp MENTALLY ILL OFFENDERS/; 3383 results.</p>		

	46. PsycInfo; exp AGGRESSIVE BEHAVIOR/ OR exp AGGRESSIVENESS/; 138032 results. 47. PsycInfo; 35 OR 36 OR 37 OR 38 OR 39 OR 40 OR 41 OR 42 OR 45; 53143 results. 48. PsycInfo; 43 OR 44 OR 46; 193923 results. 49. PsycInfo; 47 AND 48; 5838 results. 50. PsycInfo; 49 [Limit to: (Methodology Meta Analysis or Systematic Review or Treatment Outcome/Clinical Trial)]; 39 results.		
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