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## SUMMARY STATEMENT

### Why is the research needed?

- De-escalation techniques are the recommended first-line intervention for aggression in mental health settings yet restrictive practices, with known risks, continue to be used frequently.
- There is a need to understand and modify staff, patient and environmental factors that may influence the use and effectiveness of de-escalation techniques in practice.
- Existing qualitative evidence on de-escalation techniques has neglected the patient perspective.

### What are the key findings?

- The dominant view among our participants was that staff used restrictive practices instead of de-escalation, as their first-line response to escalating aggression.
- The findings present a preliminary framework of barriers and enablers to effective use of de-escalation techniques at staff, patient and environmental level, as perceived by patients.
- De-escalation techniques are unlikely to be enhanced without first increasing accountability for misuse of restrictive practices and disrespect of patients; addressing culture and practice in relation to ward rules and reducing social distance between staff and patients.

### How should the findings be used to influence policy/practice/research/education?

- Our preliminary framework of barriers and enablers to de-escalation in practice identifies some potentially salient behavior and organizational-change targets for interventions seeking to reduce violence and restrictive practices.
- Participant descriptions of staff de-escalation provide a rich, unique source of learning for clinicians, enabling them to understand and reflect on how individual and team behaviours may be interpreted during these events.
- The patient accounts and recommended process of de-escalation represent useful training resources for Prevention and Management of Violence and Aggression training staff.

KEYWORDS

Aggression; communication; de-escalation techniques; mental health; nursing; patient and public involvement; qualitative; restrictive practices; safety; violence

ABSTRACT

**Aim**

To investigate patient perspectives on barriers and enablers to the use and effectiveness of de-escalation techniques for aggression in mental health settings.

**Background**

De-escalation techniques are the recommended first-line intervention for the management of aggression in mental health settings internationally, yet the use of higher-risk restrictive practices persists. This indicates that de-escalation techniques are not used at optimum frequency and/or that there are important factors limiting their use and effect.

**Design**

Descriptive qualitative research using semi-structured interviews and Framework Analysis.

**Methods**

26 inpatient interviews exploring staff, patient and environmental factors influencing the use and effectiveness of staff de-escalation were conducted mid-2014. Three service user researchers led the analysis.

**Results**

Data were synthesized in three deductive themes relating to staff, patient and environmental influences on the use and effectiveness of de-escalation techniques. The dominant view was

that restrictive practices, rather than de-escalation techniques, are used in response to escalating patient behavior. Under-use of de-escalation techniques was attributed to: lack of staff reflection on culture and practice and a need to retain control/dominance over patients. Ward rules, patient factors and a lack of staff respect for patients diluted their effectiveness. Participants' identified a systematic process of de-escalation, rule subversion, reduced social distance and staff authenticity as enablers of effective de-escalation use.

**Conclusion**

This study investigated staff, patient and environmental influences on use and effectiveness of de-escalation techniques, as identified from the patient perspective. Our framework of barriers and enablers provides strong indicators of organizational and behavior change targets for interventions seeking to reduce violence and restrictive practices through enhanced de-escalation techniques.

## INTRODUCTION

Meta-analyses of international literature indicate high frequencies of violence and aggression in mental health settings (Lozzino et al. 2015;Bowers et al. 2011). This causes psychological and physical harm (Renwick et al. 2016a) and costs to health services (NHS 2010). Restrictive practices (e.g. physical restraint, seclusion) are used to minimise harm from violence and aggression through restricting at-risk patients' ability to act independently (Department of Health 2014). These measures are expensive (Flood et al. 2008) and can result in unintended consequences including post-traumatic stress (Bonner et al. 2002), delayed recovery (Ashcraft and Anthony 2008) injury (Renwick et al. 2016a) and death (Paterson et al. 2003). Interventions that reduce aggression without restrictive practices are a priority for clinicians, policymakers and researchers internationally (Department of Health 2014). De-escalation techniques, verbal and non-verbal skills/strategies to reduce aggression

(NICE 2015), represent one such intervention. Despite being internationally recommended as the first-line intervention for aggression (Richmond et al. 2012;NICE 2015) recent findings indicate restrictive practices are routinely used to manage escalations of aggression/agitation in mental health settings (MIND 2013). This suggests potential barriers to the implementation and effectiveness of de-escalation techniques in practice are not yet understood.

## BACKGROUND

A recent concept analysis defined de-escalation as 'a range of interwoven staff-delivered components comprising communication, self-regulation, assessment, actions, and safety maintenance, which aim to extinguish or reduce aggression/agitation irrespective of its cause, and improve staff-patient relationships while eliminating or minimising coercion or restriction' (p16) (Hallett and Dickens 2017). Qualitative evidence-syntheses on de-escalation (Price and Baker 2012;Bowers 2014a) indicate the key components involve manipulating environmental conditions to optimise communication and safety (Berring et al. 2016ab), removing uninvolved patients/un-required staff (Johnson and Hauser 2001), removing objects with utility as weapons and ensuring clear exit routes (Duperouzel 2008). Attempts should be made to clarify then resolve the problem causing the aggression (Berring et al. 2016ab; Duperouzel 2008; Johnson and Delaney 2007;Cowin et al. 2003). Empathy and respect should be conveyed (Delaney and Johnson 2006;Carlsson et al. 2000) and negative emotional responses inhibited (Virkki 2002;Lowe 1992).

Event-sequencing studies indicate de-escalation effectively disrupts the trajectory of verbal aggression to violence and restrictive practices in approximately 80% of events when used (Lavelle et al. 2016;Bowers et al. 2013). However, study designs limit findings to binary outcomes (i.e. de-escalation success or failure) and they do not reveal factors contributing to either outcome (Bowers et al. 2013;Lavelle et al. 2016). Qualitative research investigating the

range of staff, patient and environmental factors contributing to de-escalation outcome has been recommended (Lavelle et al. 2016;Price and Baker 2012).

This study was part of a project exploring staff and patient perspectives on barriers and enablers to the implementation (factors influencing staff use) and effectiveness (successful reduction of aggression without restrictive practices) of de-escalation techniques for aggression in mental health settings. This paper presents the patient perspectives.

## Theoretical framework

Evidence indicates a multi-factorial model of aggression in mental health settings (Bowers 2014b;Duxbury 2002;Duxbury and Whittington 2005;Nijman et al. 1999;Nijman et al. 1997). Rates are subject to: staff modifiers (individual staff/team attributes influencing interactions with patients) (Bowers 2014b;Duxbury and Whittington 2005); patient modifiers (nature of mental health problems and demographics) and environmental modifiers (quality and safety of physical environments and extent organisations protect patient rights) (Bowers 2014b;Nijman 2002). When conceptualised as an intervention to manage aggression, it follows that the use and effectiveness of de-escalation techniques may be subject to these same modifiers. This study adopted the a priori assumption that use and effectiveness is subject to staff, patient and environmental modifiers.

# THE STUDY

## Aim

Investigate patient perspectives on barriers and enablers to the use and effectiveness of de-escalation techniques for managing aggression in mental health settings.

## Design

Descriptive qualitative methodology (Sandelowski 2000) was adopted using semi-structured interviews and Framework Analysis (Ritchie and Spencer 1994). Descriptive qualitative research seeks understanding of phenomena, processes and perspectives of involved populations and enables direct application to health services design, delivery and impact (Caelli et al. 2003).

**Sample**

Purposive sampling (Teddlie and Yu 2007) was adopted ensuring the sample reflected in-patient population diversity. Accordingly a sample was sought varying by: gender, age, ethnicity, Mental Health Act status, substance misuse, diagnosis, experience of restrictive practices.

Inclusion criteria:

- Adult acute mental health inpatient admission in past year
- Involved in incident of escalating behavior requiring staff intervention in past year
- Informed consent
- English-speaking

Of 14 wards approached, seven wards across four hospitals in three UK mental Health Trusts in North-West England participated including: three female, two mixed and one male acute wards and 1 PICU. 26 current inpatients (sample description **Table 1**) were interviewed (duration: 03m-1h:50m M33m). Unsuccessful attempts were made to recruit from two community mental health teams.

**Data collection**

An interview schedule guided participant discussion of staff, patient and environmental factors perceived to impact successful use of de-escalation techniques. These concepts required clarification for participants. 'De-escalation techniques' were defined as 'verbal and non-verbal skills or strategies to reduce aggression without methods like physical restraint, medication or seclusion.' A priori category (staff, patient, environment) questions were asked in lay terms, for example, patients were asked: 'Please tell us about what staff do help you to feel calmer when you are feeling angry, aggressive or violent.' Participants were encouraged to describe experiences in-depth and additional topics were pursued when raised.

To ensure currency, participants were asked to discuss experiences in the past year. Data collection continued to saturation point (Francis et al. 2010). A questionnaire collected (self-reported) data on demographics, diagnoses and experience of restrictive practices. Interviews were: conducted mid-2014, digitally recorded and transcribed verbatim.

**Ethical considerations**

Ward nurses distributed study information packs to all eligible patients. Interested patients returned 'consent-to-contact' forms to ward staff. No patient was approached/interviewed until consent-to-contact had been received and capacity had been assessed by the nurse-in-charge. Participants consented to: participate; be recorded and have direct quotes used in reporting of results. NHS ethics favourable opinion was received 02/2014 (ref: 14/NW/0033).

**Data analysis**

Three Service User Researchers (SURs) (AG, DB, AS) were involved in data analysis. The SURs are current secondary mental healthcare users and trained researchers with prior research experience including use of Framework methodology. A revision session on the Framework approach was provided. Service users were involved in the analysis because a)

qualitative evidence on de-escalation is weighted in favour of the professional view (Price and Baker 2012) and b) research has shown that service users code data differently to academics; the former tending to code emotional, the latter, procedural aspects of in-patient experiences (Gillard et al. 2010).

Analysis used the three Framework Analysis stages: indexing, summarising and mapping and interpretation (Ritchie and Spencer 1994). Indexing involved 6 days' face-to-face meetings with SURs and the lead author. SURs read each transcript in the lead author's absence identifying themes and sub-themes with reference to staff, patient and environmental influences on de-escalation use and quality. The lead author returned to document feedback, avoiding influencing interpretations but clarifying understanding if needed. No consensus attempt was made, divergent perspectives were included in the developing index. This process identified the important themes in the data from the SUR perspective.

'Summarising' and 'mapping and interpretation' were conducted remotely between SURS and other authors due to practical difficulties meeting over extended periods. Summarizing used QSR NVivo10 ©. A thematic framework was generated with columns representing the three a priori categories (staff, patient, environment) and sub-themes identified at indexing stage, and rows representing cases. Line-by-line analysis of transcripts was then conducted and framework cells populated with summarized data (Ritchie and Spencer 1994).

Mapping and interpretation involved defining concepts and refining categories (Ritchie and Spencer 1994). New columns were generated for additional themes emerging from analysis of summarized data. Once the framework represented a complete account of the phenomena described in the data, the analysis was shared with SURs who provided feedback and requested amendments where required. Finally, cases were ordered by sample variables (e.g. age, gender) to examine their influence in each theme.

### Validity, reliability and rigour

Processes for ensuring data trustworthiness met COREQ criteria (Tong et al. 2007). Multiple analysts were involved in data analysis (Tong et al. 2007). A reflexive approach (Mays and Pope 2000) to study design and conduct was adopted involving ongoing reflection on relationships between the researchers and the participants/ the investigation topic. A purposive sample with sufficient diversity and data collection to saturation point (Tong et al. 2007) ensured a complete range of issues were explored.

## FINDINGS

Findings are presented in three overarching themes consistent with the research objectives. Theme 1 describes staff practices and behaviors, Theme 2 describes patient contexts and behaviors, and Theme 3 describes environmental and cultural factors, influencing the use and effectiveness of de-escalation techniques. Table 2 provides a framework of barriers and enablers identified across the three themes.

### Theme 1: Staff practices and behaviors that influence the use and effectiveness of de-escalation techniques

Seven subthemes present the staff factors identified as influential to the use and effectiveness of de-escalation techniques. The first three describe factors perceived to preclude use and/or reduce de-escalation effectiveness including: Lack of reflection on practice; Power and control, and Disrespect. The latter four sub-themes relate to staff behaviors and practices that may enhance greater and more effective use of de-escalation techniques including: A recommended process of de-escalation; Rule subversion, Reducing social distance, and Authenticity.

### Lack of reflection on practice

The dominant view among participants was that restrictive practices and not de-escalation techniques are primarily used in response to escalated behavior. These were perceived to be applied uniformly, irrespective of risk or aggression context i.e. whether arising from an unmet need, bullying within the patient community or symptoms of illness. Staff practices in response to aggression were often characterized as 'robotic' and numerous participants drew on the observation that rapid tranquilization seemed to 'just come with' physical restraint (without reference to illness or aggression context) to emphasize this point. There was a strong view that to promote use of de-escalation, greater staff reflection on the morality and proportionality of their practice, and the potential for important contextual differences in the causes of escalating aggression was required.

'They (staff) just come and grab you. They don't know what happened before, they don't need to know, they're not interested. They're like robots... you know, irobots... don't feel? (laughter)… they have their own techniques to rush through. They're not there for you, they think talking is a waste of time' (female patient A, acute ward)

**Power and control**

Many participants felt de-escalation techniques are not used because staff rely on restrictive practices to retain dominance over the boundaries of acceptable behavior. Participants drew on a range of experiences to support this view including the use of physical restraint in the context of punishment, revenge and refusals to comply with staff instruction. Many drew specific attention to a marked resistance among staff to revise the need for staff-initiated PRN, irrespective of subsequent changes in the patient's presentation and when the patient had offered to voluntarily de-escalate:

'Once they (staff) say they're going to do it (medicate), they do it. You're saying 'look, I don't need this, I'll go away if that's what you're wanting, suffer in silence in a little corner,

take myself for the time out and keep quiet.' Well, no, once they've said you're going to get it, you get it, even though you've talked yourself round, you're going to calm down and you're prepared to take yourself away…. it's not used as an alternative, it's used as a definite.' (female patient B, acute ward)

Others described the rigid requirement to accept PRN only being relinquished once the patient had made threats of further aggression. Many simultaneously described difficulty accessing PRN for self-reported feelings of agitation/aggression. These observations tended to support the view that these interventions are sometimes used to retain control within the staff team, rather than immediate risk or clinical need. Participants emphasized that greater use of de-escalation is unlikely without firstly addressing the power dynamics they described around current use of restrictive practices.

**Disrespect**

Disrespect was identified as a barrier to effective de-escalation. Three disrespect types were identified in staff's verbal responses to escalating aggression: hierarchical, biopsychiatric and affective. Hierarchical disrespect, most overtly, referred to the widely-held view that some staff considered themselves, as a social group, superior to patients resulting in patronizing responses to aggression. Its more subtle form was communicated in bland and value-laden, standard responses to aggression such as 'Stop getting aggressive' 'You're getting agitated' 'It's inappropriate.' These statements' function was perceived to be to shut down aggression without having to engage with underlying causes whilst communicating that anger and aggression toward nurses was unconditionally illegitimate. Biopsychiatric disrespect referred to statements in response to aggression expressing skepticism about its function. Many accounts described staff reference to patient aggression as 'behavioural issues' or 'it's just behaviors' relating to a dichotomy drawn by staff between deserving ('illness-related') and

undeserving (‘non-illness-related’) aggression. These statements were often accompanied by comments questioning the validity of personality disorder as a diagnosis:

‘The staff member said 'We’ll get you discharged, nothing much wrong with you. It seems to me you’ve got plenty of behavioural issues’… by behavioural, they mean if you scream and shout about something you’re not mentally ill, you just can’t control your behaviour…And she (the patient) went, 'I’ve had a diagnosis, what are you talking about?’ And she went, ‘Yes, yes, I know what kind of diagnosis you’ve had’… just who are you talking to? Who do you think you are?’ (female patient C, acute ward)

Affective disrespect referred to staff failure to inhibit angry, frustrated or aggressive responses to patient aggression. Examples included: angrily-delivered instructions to stop behaviour; retaliation; standing over or sitting under the patient (the latter emasculating the patient through communicating a lack of concern in response to aggression); intentional failure to retreat in response to aggression cues and invading of personal space.

**A recommended process of de-escalation**

Desirable approaches promoted patient autonomy during escalated behavior. Participants conceptualized de-escalation as a process of creating the conditions in which the patient could draw on their own resources to regain control. De-escalation was therefore regarded a process of facilitation involving passive as much as active interventions. Participants described three steps: ‘providing time and space’, ‘impartial investigation of aggression causes’ and ‘emphasizing decisional control.’ Knowledge of the patient was considered useful but not a prerequisite for these processes.

Providing time and space

Drawing on the view staff intervention was often too active, participants recommended greater time and space be offered and greater tolerance of escalated behavior, including threats of violence and aggression toward property:

'Give them (patients) time. If they're going to attack someone, you've got to restrain them, apart from that let them have their tantrum, everyone's got a child in them. If I'm shouting down the corridor, I'm just on one, leave me alone. If I punch the wall I'm only going to hurt my wrist, no-one else.' (male patient B, PICU ward).

Impartial investigation of aggression causes

There was agreement the first verbal component should be to ask about the reason for the aggression, adopting a gently enquiring style whilst inhibiting assumptions and preconceptions about causes and individuals involved:

'Judge each incident on its merits, rather than believing one person over another. That happens a lot, they (staff) take too much on-board according to what someone else said. It's good to have evidence, you know, ask the patients 'what happened?' (male patient A, PICU ward).

Emphasizing decisional control

There was common support for greater patient involvement in finding solutions during escalations. Participants recommended: asking the patient to identify the solution, listening more than speaking, avoiding interruption, suggesting rather than instructing, and offering choices and options to resolve or distract (emphasizing voluntariness of these).

**Rule subversion**

Participants identified two staff types: those conceptualising their role as chiefly about dogmatic and inflexible rule enforcement, and those willing to exercise more reasonable flexibility. Staff willing to subvert rigidly-applied rules to facilitate access to coping strategies during distress were valued e.g.:

'They (effective de-escalators) let you have cigarettes out of the timescale. They don't threaten or pressure, they let you have more leeway and freedom, even going against the rules sometimes.' (female patient B, acute ward)

**Reducing social distance**

The value of reducing social distance was central to participant descriptions of effective de-escalators and involved fostering a sense of equality with the aggressive patient. A useful tool in this respect, described by numerous participants, was inviting the patient into normally staff-limited areas (nursing offices, medication clinics) for de-escalation, breaking down hierarchical and physical barriers to communication, promoting an atmosphere of respect. Expression of staff humility and reciprocal behaviours revealing a shared humanity such as humour, self-disclosure and physical affection (touch was only reported of value by female participants) were also valued. The need for staff to reveal their humanity was further evident in discussion of desirable emotional expression during de-escalation. Notably, whilst staff anger and frustration were widely regarded unhelpful, staff anxiety was rarely identified as problematic and, in one instance, was beneficial through engendering protective feelings in the aggressive patient:

'I'm not bothered whether they come across nervous, I'll calm down to that because I see them as a vulnerable person. I'm not a bully… if they're passive, that's fine.' (Female patient D, acute ward)

**Authenticity**

Anxiety was problematic where staff were perceived to be masking it through an artificial persona of authority. Moreover, patient acceptance of de-escalation was dependent on how consistent staff behaviour was perceived to be with a) their true thoughts, feelings, intentions and b) their previous behaviour. Again, this referred to adopting unconvincing authoritative styles but also excessive friendliness at odds with the patient's previous experience of the staff member. Participants repeatedly affirmed the value of talking to the patient 'naturally', 'normally' or 'on the level;' consistently conceptualised as a human-to-human, as opposed to nurse-to-patient, basis for dialogue. It was important that patients perceived staff members as genuinely wanting to help them feel calmer:

'You can tell which ones genuinely want to help you calm down. If no one's about, they act different, but if there's other staff about, they'll come over dead nice and caring, but really they're not.' (female patient E, acute ward)

Although empathy was not a prominent feature of the data, its effectiveness was again dependent on its perceived authenticity, which was reinforced by staff disclosure of own/a family member's experience of personal distress:

'Speaking from experience is good, having an understanding of their (staff's) own problems and how it relates to patients. Bring your experience to work, then you can say 'I know what it's like, I've been in these situations too…' Then you feel they (staff) understand… Speaking to someone that used to have a bad behaviour but knows how to control it… that's what's lacking.' (male patient A, PICU ward)

Conversely, where staff life experience was perceived so far removed from the patient's that their ability to identify was considered suspect; a false sense of empathy could escalate aggression:

'One young nurse said 'I know how you feel,' I said 'Why, do you hear voices, do you want to cut yourself or does someone tell you your mum killed herself because of you?' She said, 'No,' I said, 'Well you don't understand me then so don't say you do.' I hate people saying, 'I understand'... that makes a person angry… they don't understand, they've not got mental health.' (female patient F, acute ward)

Although more authoritative verbal techniques such as instructions and deterrents were widely perceived patronising or threatening, acceptance depended on the person using them and whether benevolent intent was construed. Therefore, it was often not what was said but who was saying it and how. Benevolent intent was expressed through: emphasising ongoing availability to the patient; reinforcing interventions with acts of kindness and, specifically when issuing deterrents, being clear and honest, while emphasising the mutual undesirability of consequences of continued aggression to staff as well as patients. Authenticity of staff behaviour depended most upon the patient's prior experience with them. The interest taken in the patient, the helpfulness, kindness and reliability they demonstrate and pre-emptive rather than reactive responses to patient emotions. These skills were rarely distinguished from the innate qualities of the nurse or person generally, numerous patients described simply the presence of a trusted nurse sufficient to reduce all feeling of aggression:

'Nurse X is just a really good person, she can calm people down just by the way she is… she's just a nice person.' (female patient E acute ward).

**Theme 2: Patient behaviors and contexts that influence the use and effectiveness of de-escalation techniques**

Participants were divided between the view it was always possible to de-escalate aggression without restrictive practices and those identifying patient-related barriers. A minority felt that, for themselves, escalations between trigger and violent responses were so rapid that verbal intervention was ineffective. Others felt it was difficult for staff to calm them during hypomanic episodes, and several described difficulty for staff in de-escalating aggression associated with psychosis. One participant spoke about difficulty responding to staff de-escalation whilst experiencing command hallucinations:

'Sometimes… it (de-escalation) doesn't work. I just lose it… there's no talking down. I'll kick out and there's nothing anyone can do because I get voices telling me I'm going to be killed and… to kill myself and I want to get out to do it' (female patient G, acute ward).

More rarely a history of violence and lack of discharge motivation were identified as indicators of unsuccessful de-escalation:

'Some people kick off so they can be in hospital and be sectioned. They're not going to calm down, they want to be here.' (female patient E, acute ward)

**Theme 3: Environmental and cultural factors influencing the use and effectiveness of de-escalation techniques**

5 sub-themes present the environmental and cultural factors perceived to influence the use and effectiveness of de-escalation techniques including: Organizational resourcing, Cultural conditioning to use of restrictive practices, Organizational culture and disrespect of patients, Rule-bound cultures, and Social distance and nursing culture.

**Organizational resourcing**

A commonly-identified barrier to de-escalation use was a lack of staff time caused by under-resourcing and excessive bureaucracy. Participants felt this reduced available staff to identify

causes of escalations and inform more timely, just and proportionate intervention. These explanations were not universally agreed with and were regarded by some as excuses for staff preference for spending time in nursing offices and using restrictive practices on the basis of convenience:

'The auxillaries spend as much time in the office to get away from the patients… and anything could be happening and, sometimes, it does.' (female patient B, acute ward)

**Cultural conditioning to use of restrictive practices**

A minority felt individual staff may want to use de-escalation but feel influenced to practice restrictively by prevailing staff culture:

'It's because of your (staff's) procedures, what you have to do when a problem is provoked. You know… you're supposed to Acuphase them, get the person down on the ground…Where I believe you shouldn't have that approach when people get emotional or upset. They're occupied by procedures. It's like a distraction from how they would like to address a problem. Some staff may want to address a problem patiently but feel like they have to control the problem first…' (male patient A, PICU ward)

**Organizational culture and disrespect of patients**

Participants felt disrespect of patients, identified as a key barrier to effective de-escalation, was reinforced at ward and organization level through maintenance of a gross power deficit between patients and staff. Factors contributing to this included: an absence of mutuality in expected standards of conduct; lack of consequences for disrespectful staff behavior, lack of confidence in the complaints system and intolerance of dissent against the regime:

'It's like a dictatorship. They expect you to do what they say, to be quiet, whether it makes sense or not, there ain't no negotiation. They're very narrow-minded, they come across like

'I'm the boss, I know what I'm doing, I'm doing my job, I'm right'… they're not always right.' (female patient A, acute ward).

**Rule-bound cultures**

Accounts, near universally, described regimes characterized by myriad, apparently arbitrary rules which reduced de-escalation effectiveness in two ways. Firstly, the enforcement of rules perceived petty or unnecessary was perceived to have such a corrosive effect on staff-patient relationships that de-escalation, when attempted, was not accepted. Relationship-damaging rules consistently referred to included: bans on physical affection between patients; access to water coolers at night; smoking restrictions; patients lying on, sleeping on, or having their feet on, furniture and, finally, bedtime and when the television was switched off:

'Some are 'that's the rule, that's the way it is.' The girls were watching a film… Nurse X came in and switched it off at dead on midnight. The film finished at quarter past twelve. She went 'that's the rule, it goes off at twelve'… so she had three people ready to strangle her.' (female patient C, acute ward)

Secondly, by restricting options for de-escalation once escalations occurred. Physical environments that facilitated options for de-escalation through a range of accessible areas and activities to use during times of distress were highly valued by participants. When these areas/activities were blocked by ward rules, this represented a barrier to effective de-escalation:

'In that state… screaming and shouting… I just desperately needed a cigarette, I was overwhelmed. Instead of being told 'such and such a time,' maybe they (staff) could make an allowance and help the patient get away from the ward for a moment… that time-out, that

one-to-one time with staff, might just...they shouldn't be so strict on that.' (female patient H, acute ward)

**Social distance and nursing culture**

Participant accounts indicated beliefs in staff teams about the impermissibility of intimacy in staff-patient relationships could limit potentially useful de-escalation strategies. For example, some patients were conflicted between their knowledge of 'professional boundaries' (imparted to them by staff) and their experiential knowledge of the helpfulness of staff who approached them 'like a friend' and used physical affection in response to aggression. This conflict is revealed in the following two examples:

'(Effective de-escalators) act more like a friend…. I know that shouldn't be allowed but I feel that is better for the patient.' (female patient I, acute ward)

'Certain staff, they'll tell them to go to their room, have time out instead of sitting down and giving them a hug. They can't give them a hug because it's inappropriate behaviour because I used to get told off for doing that but there's a certain girl and I, personally, think she needs a lot of cuddling.' (female patient J, acute ward)

DISCUSSION

This study investigated patient perspectives on staff, patient and environmental barriers and enablers to the effective use of de-escalation techniques. Our findings indicate de-escalation techniques are unlikely to be enhanced without addressing the structural disempowerment of patients in these settings. This requires increased accountability for poor practice in relation to restrictive practices and disrespect of patients.

The de-humanization and ill-treatment of the disempowered by those in custodial authority is an established psychological phenomenon that has situational rather than dispositional

explanatory causes (Zimbardo 2008). Our data indicate de-escalation attempts are more likely to be accepted in the context of respectful staff-patient relationships within organizations that have safeguards against the development of malignant nursing cultures. Such safeguards were apparently absent from the descriptions participants provided, with a view that disrespectful responses to aggression were reinforced by complaints systems that failed to foster patient confidence, absence of prescribed standards of conduct for staff as well as patients, and a culture of intolerance of patient dissent. Paterson's (2012) analysis of corrupted nursing cultures and physical restraint notes that the 19th century psychiatric reformer, Samuel Tuke, observed that a 'system which, by limiting the power of the attendant' made 'it his interest to obtain the good opinion of those under his care' and provided more 'effectually for the safety of the keeper as well as of the patient' (Tuke 1813 p 54). Our research indicates such systems remain aspirational in parts of contemporary mental health services but are likely essential to more effective use of de-escalation techniques. Personalized patient feedback on professional performance has been found effective in reducing perceived power-differentials (Rise et al. 2012) and represents one potential means of enhancing de-escalation through deterring disrespect of patients.

The process of de-escalation recommended by participants makes intuitive sense but is also supported by current empirical understanding. For example, verbal aggression and aggression toward property are known to occur frequently in mental health settings, yet transitions to more serious conflict and containment are known to vary greatly, even within data related to the same patient (Renwick et al. 2016b). Rates of 'no management consequences' in response to aggression are known to vary substantially between different wards (Renwick et al. 2016b) plausibly indicating that how active or passive staff intervention is, mediates these event transitions. Qualitative evidence indicates a non-linear pattern of escalation in mental health settings, in which many escalations of aggression are not witnessed by staff and result in no

further aggression (Bowers et al. 2013;Johnson and Delaney 2007), providing support for the more tolerant approaches participants recommended.

The view that de-escalation interventions should emphasize decisional control is consistent with trauma-informed therapy which seeks to enhance cognition following exposure to triggers by offering choices and alternatives to fight/flight responses (Substance Abuse and Mental Health Services Administration 2014). Related, was the finding indicating staff view patient aggression via a biopsychiatric formulation of deserving (illness-related) and undeserving (non-illness-related) aggression. This was evident in staff use of the term 'behavioural issues' in response to aggression, implying the patient was in control of, and to blame for, the behaviour. Shaming behavior is likely to trigger fight/flight responses in patients with traumatic histories (Hodas 2006) which applies to up to 91% of inpatients (Floen and Elklit 2007). There is a need for further training in the relationship between traumatic history and current behavior. Inability to regulate anger/frustration in response to aggression was another effectiveness barrier. Evaluated de-escalation training programmes have evidenced limited impact on staff capacity for emotional regulation (Price et al. 2015). Thus, there is a need to review mechanisms through which enhanced regulation has previously been proposed.

Patient-related barriers were consistent with evidence on aggression in mental health settings (Bowers 2014b). Findings indicate environments conducive to effective de-escalation should be well-resourced and facilitate use of options through ranges of accessible locations and activities for de-escalation. Accounts reflect a need for culture change in the extent and application of ward rules and in promoting more authentically caring relationships. Broader literature confirms the therapeutic value of touch (Salzmann-Erikson and Eriksson 2005) (critical to promoting human resilience and recovery from trauma (Burleson and Davis 2014)), self-disclosure (Welch 2005) and reciprocity (Finfgeld-Connett 2009). This study

revealed cultural stigmatisation of these fundamental caring behaviours, consistent with recent evidence of staff resistance to sharing, on safety grounds, even non-intrusive information such as favourite films (Price et al. 2016). Our data indicate interventions that humanise staff through increasing disclosure and reducing social distance are likely to enhance effectiveness of de-escalation techniques, thereby, increasing safety.

## Limitations

We sought participants with direct experience of de-escalation, so only included patients involved in an incident of escalated behavior requiring staff intervention. To explore barriers as well as enablers of de-escalation, we sought a sample varying in experience of restrictive practices. Both decisions may have created an unduly negative impression of staff practice. However, we identified no obvious difference in views between participants who had experienced low level, high level or no restrictive practices, suggesting neither extent of disturbed behavior nor extent of coercion had an obvious role in modifying perspectives. Our failure to recruit community-based patients may have resulted in negative in-patient perspectives that may have changed post-discharge. However, we spoke with patients with a range of admission durations, all spoke with great clarity and conviction regarding their experiences. We further note that the MIND physical restraint report (MIND 2013) spoke with community-based patients about their experiences as inpatients and found very similar findings, suggesting perspectives on these issues do not change post-discharge.

There was an imbalance between female (16) and male (8) participants but eight males provided good coverage. There were no important gender differences in perspectives emerging warranting further recruitment. Mean interview duration was 33 minutes (range 3minutes – 1 hour 50 minutes) but there were three short interviews of <10 minutes. This was

understandable given the context in which participants provided their time. All interviews contributed to the analysis.

## CONCLUSION

This study examined patient perspectives on staff, patient and environmental factors influencing the implementation and effectiveness of de-escalation techniques in mental health settings. Participants identified barriers and enablers at staff, patient and environmental level, indicating the theoretically-informed design represented an appropriate conceptual model. Aligned with recent findings, the dominant view among participants was that restrictive practices and not de-escalation techniques are used in response to escalating aggression. Our findings indicate greater and more effective use of de-escalation may require: increasing accountability for misuse of restrictive practices and disrespect of patients; addressing ward rule culture and reducing social distance between staff and patients.

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