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Changing practice by using recovery-focused care in acute mental health settings to reduce aggression: A qualitative study

ABSTRACT

Consumer aggression is common in acute mental health settings and can result in direct or vicarious psychological or physical impacts for both consumers and health professionals. Using recovery focused care, nurses can implement a range of strategies to reduce aggression and empower consumers to self-regulate their behaviour, when faced with challenging situations, such as admission to the acute care setting. Currently, there is limited literature to direct nurses in the use of recovery-focused care and how it can be used to reduce consumer aggression. Twenty-seven mental health nurses participated in this study. The constructivist grounded theory method guided data collection and analysis to identify categories that accurately described participants' experiences. Five categories emerged that described how nurses can implement recovery-focused care clinically to reduce the risk of consumer aggression: (i) Identify for the reason for the behaviour before responding; (ii) Being sensitive to the consumer's trigger for aggression; (iii) Focus on the consumer's strengths and support, not risks; (iv) Being attentive to the consumer's needs; and (v) Reconceptualise aggression as a learning opportunity. As the importance of promoting consumer recovery is now embedded in mental health policies internationally, nurses need to prioritise the application of recovery-focused care clinically. Further research to provide evidence-based outcomes supporting the use of recovery-focused care is needed.

INTRODUCTION AND BACKGROUND

Most people living with a mental illness are only hospitalised if they become acutely unwell and are in need of support to manage the acute phase of their illness (NSW Mental Health Commission 2014; WA Mental Health Commission 2014). On admission to the acute mental health setting, consumers who are distressed or highly aroused can display dysregulated behaviour which can lead to aggression (Fletcher et al. 2017; Wright et al. 2014). Aggression is common in health care settings, and it is estimated that one in five consumers admitted to an acute mental health setting will be aggressive (Lozzino et al, 2015). Aggression occurs when a person uses intentional verbal and physical behaviour with the goal of threatening or injuring self or others physically and psychologically or causes damage to property (McCann et al. 2014). Aggression has direct or vicarious psychological or physical impacts for both consumers and health professionals and it has a negative influence on the process of building trusting therapeutic relationships. Aggression can also cause financial strain on health services, for example, through the need for higher staffing levels, compensation for work-related injuries, and reduced productivity costs (Bowers et al. 2009; Dickens et al. 2013; Duxbury et al. 2013; Pulsford et al. 2013).

To minimise the potential for aggression, nurses need to regularly assess the consumer's risk for aggression and mitigate any risk using least restrictive and person-centred strategies (Lim et al. 2017). These include early intervention and de-escalation, assisting the person to learn and utilise anger management strategies or other socially acceptable ways, to support themselves to self-regulate their behaviour and not become aggressive (Kuivalainen et al. 2017). However, nurses' confidence and skills to work collaboratively with the consumer to mitigate the risk for aggression is reported to influence the choice of intervention utilised with the consumer (Happell & Koehn, 2011; McCann, Baird, & Muir-Cochrane, 2014; Meehan, de Alwis, & Stedman, 2017; Vargas, Luis, Soares, & Soares, 2015). Nurses who are

less confident to allow the consumer time to self-regulate their behaviour, may utilise more restrictive interventions such as sedative medications, closer observations, and in some instances use restraint and seclusion to resolve the escalating situation (Maguire et al. 2017; Pulsford et al. 2013).

More restrictive interventions, such as restraint and higher rates of sedative medication, are reported to be used more commonly with consumers who are perceived by health professionals as a high risk group for becoming aggressive (Barr et al. 2017; Maguire et al. 2017; McKenna et al. 2017; Usher et al. 2017). For example, clinicians often intervene and use sedation with people who have recently used methamphetamine, are intoxicated or withdrawing from illicit substances, and/or are experiencing acute and severe psychiatric symptoms. Yet, McKenna et al. (2017) found that "there was no difference in the risk of harm to self or others on admission to the acute mental health inpatient unit among people using methamphetamine and those who did not" (p. 51). Likewise, people experiencing severe and acute psychiatric symptoms or distress, do not necessarily pose an increase risks for aggression (Elbogen & Johnson 2009; Rueve & Welton 2008). Therefore, without accurate assessment and an understanding of the underlying causes of the person's behaviour, the use of restrictive practices such as sedation can exacerbate the situation and be detrimental to the consumer's recovery. When implemented too early, the use of sedation and restraint can also impact upon the therapeutic relationship, the person's ability to self-regulate their behaviour, and on the nurse's skills to practice recovery-based and trauma-informed care (Muir-Cochrane & Duxbury 2017).

Consumers who are at higher risk for aggression have often experienced previous abuse and/or other traumatic experiences (Flannery et al. 2011; Grenyer et al. 2013; Vandecasteele et al. 2015). Bruce and Laporte (2015) found that this group were almost three times more likely to become aggressive during hospitalisation, as they felt unsafe or were unable to

establish a trusting connection with other people (Macinnes, et al. 2016). Hence, on admission, this at risk group requires additional support and a safe environment, to allow them to engage therapeutically and be given opportunities to self-regulate their emotions and respond appropriately (Salzmann-Erikson et al. 2016). The use of restrictive practices while hospitalised can reinforce their feelings of vulnerability, all of which can increase the risk of aggression (Fletcher et al. 2017; Kuivalainen et al. 2017; Maguire et al. 2017).

Recovery-focused care (RFC) may assist nurses to reduce the consumer's potential for aggression and empower the person to take responsibility for their personal well-being (Lim et al. 2017). RFC encompasses the knowledge of trauma informed care, clinical and personal recovery principles, and recognising the individual's lived experience along with its impact on the individual when hospitalised. Nurses practising RFC actively involve the person in decision making and care planning (McKenna et al. 2014a). This allows nurses to assist the person to actualise their potential and strengths to cope with life challenges (Wilson et al. 2017). It also focuses on supporting the person to increase their level of self-esteem and confidence and instils hope for the future (Walsh & Boyle 2009).

While the importance of using RFC is now well-established in mental health policy in many countries (Slade 2013), current research suggests nurses' working in the area of acute mental health struggle to implement RFC into their clinical practice (Aston & Coffey 2012; McKenna et al. 2014a). This paper reports the findings of a qualitative exploratory study, to obtain an increased understanding of nurses' knowledge of the components of RFC, and how it can be utilised to reduce aggression in the acute mental health setting.

METHOD

Ethics approval to conduct the research was obtained from Curtin University in Western Australia. The constructivist grounded theory method guided data collection, participant

sampling procedures, analysis of data and write up of identified categories (Willig, 2013). Grounded theory was chosen as the method guiding the research process because of the emphasis placed on identifying social and psychological aspects of emerging categories (Charmaz, 2014; Meabh & Robert, 2015; Willig, 2013). This was viewed as particularly important to researching the area of RFC and reducing aggression. Constructivist grounded theory was chosen due to the researcher's knowledge of this particular method.

Participants and recruitment strategy

A convenience sample of nurses who are members of the Australian College of Mental Health Nurses (ACMHN) participated in this study. Participants came from all states and territories in Australia. Recruitment of the participants was via an email advertisement sent by the Australian College of Mental Health Nurses to their members. Those who were interested in this study contacted the researchers and were provided with an information sheet outlining the purpose of the study and what their involvement would entail.

Data collection

Data were collected by the first author using semi-structured interviews with mental health nurses across Australia from January to June 2017. Participants were asked to sign a consent form, and complete a demographic data survey. An interview guide was used to guide each data collection. Initially, purposeful sampling was used to recruit participants who had: 1) at least 12 months post registration clinical experience in working in the acute mental health setting; and, 2) experience in the management and prevention of aggression. Theoretical sampling was then employed to capture participants experiences that were different to those identified during purposeful sampling as categories started to emerge through concurrent data collection and analysis (Crossetti & Goes 2016). For example, nurses

with only one year of experience in the area of mental health. The constant comparative method of analysis, central to grounded theory, was utilised during the coding of each interview (Charmaz 2014). Grounded theory sampling techniques ensured that data from participants was "information rich" (Onwuegbuzie & Leech 2007, p. 111) and maximised the understanding of the phenomenon under study (Lewis 2003; Polit & Beck 2012; Ritchie et al. 2003). Data saturation occurred at 27 participants. At this time no new information was being obtained during interviews and categories were well developed and rich in descriptions from participants.. (Polit & Beck 2008).

Data analysis

All interview data were digitally recorded and transcribed verbatim to ensure that the data was maintained and fully captured. The coding and analysis outlined by Charmaz (2006) was used and consisted of initial coding and focused coding to build categories and identify links to sub-categories. In initial coding, data from the interview were fragmented line-by-line and in segments and given labels to build initial codes (Holten 2007). In focused coding, the initial codes which were most significant were used as provisional categories for checking with new interview data to finalise categories (Crossetti & Goes 2016; Meabh & Robert 2015). This iterative process allowed the researcher to refine the data into categories at a higher level of abstraction (Charmaz 2014; Willig 2013). Throughout the analysis, the researcher kept a record of the comparison and connections to recognise patterns that aided in the construction of analytical categories (Dey 2007) (see Figure 1).

[Insert Figure 1 here]

The process of coding and construction of categories occurred in consultation with the second author who is experienced in qualitative research to ensure the credibility of constructed categories. Trustworthiness of the analysis and findings were therefore augmented by constant data comparison and confirmation with peers (Leung, 2015).

RESULTS

Twenty-seven interviews were conducted for this study. Nine males and eighteen females provided written informed consent to participate in the interview and to have their interview digitally recorded. Twelve face-to-face interviews and 15 telephone interviews were completed. The mean interview time was 31 minutes.

The majority of participants spoke about the principles of mental health recovery in the interviews and reported that they have used RFC with consumers. Ten participants were able to provide clear examples of the provision of RFC, but 17 described the use of restrictive practices as being part of RFC when a consumer loses control of his or her behaviour. However, most participants were able to visualise the ability to reduce the risk of aggression if nurses are equipped with the knowledge and skills to facilitate RFC for people who were highly aroused or distressed. Five categories emerged during data analysis that encompassed participants' descriptions of RFC, and how they would utilise these to reduce consumer aggression in the acute mental health setting.

Category 1: Identify the reason for the behaviour before responding

Participants reported there is usually a reason why consumers become aggressive when hospitalised. However, as nurses are pressured to maintain safety in the acute care environment, at times they may respond to challenging/escalating behaviours with interventions directed at controlling or reducing that behaviour. Yet, the nurse's response

may not identify, acknowledge, or address why the consumer's challenging/escalating behaviours occurred or how to prevent it from re-occurring. Practising RFC ensured the nurse gave *"the person a chance to talk and get to know them, work with what they feel is most important, the most pressing things in their life"* (P1), *"work with them [the consumers] to identify some stressors, triggers, why they become aggressive, then all of that [needs to be] coordinated back to [assessing the cause of their presenting] behaviour"* (P13). Having knowledge and understanding of common triggers for aggression assisted nurses, to identify timely and appropriate interventions and support the consumer to mitigate the risk of aggression: *"it is really important because the more information you get [about them], the better the decision you can make. [You need to] talk to them and ask them what their point of view is?"* (P16).

Participants explained that prior to responding, nurses should seek to identify the reasons for the escalating behaviour, for example, previous personal trauma or use of restraint during hospitalisation: *"they see the person with [lived experience] rather than just a person who is verbally abusing them"* (P12). This knowledge can motivate nurses to show more appreciation of the causes of the behaviour and provide time for the person to try and self-regulate their behaviour, rather than intervening to manage the situation. This approach allowed nurses to:

> *"Break [down] barriers [in communications] and misunderstandings of what's going on exactly at the time. If you know they are in personal crisis or have a decompensation in mental or emotional state, being locked in a small area with fourteen or fifteen other people who are very unwell, and you are saying "no" to all their requests, I mean obviously all those things can lead to aggression as well"* (P13).

Category 2: Being sensitive to the consumer's triggers for aggression

The second category was being sensitive to the consumer's triggers for aggression. Participants noticed that when consumers are first admitted to hospital they are often experiencing negative thoughts and feelings which may increase their risk for aggression:

> *"The main causes for aggression are [when the consumers] haven't been in a hospital before, and when they [are] locked up they are scared, they are anxious. They don't know what is going on, they think they are locked up in jail, they think they can't get out, they don't know what's happening. So I think the triggering factors are usually more to do with staff not being on guard to see what's happening not giving [the person] enough attention [and] time to explain what's going on"* (P14)

Participants explained that this group of consumers had often experienced previous trauma, such as *"childhood sexual assault or adult abuse"* (P3), *"domestic violence, and a lot of other stressors that they had not talked about, so they can take a long time for them to trust us"* (P1). Due to their previous trauma, they experienced difficulties in expressing themselves because it is *"re-traumatising having them tell their story over and over again"* (P12), resulting in emotional dysregulation and a *"lowering of their frustration tolerance, especially when they are in situational crisis or have a decompensated mental state"* (P13). Practising RFC made nurses more sensitive to the person's triggers and to take time to assist them to feel safe within the unfamiliar hospital environment: *"obviously, they [the consumers] feel that they are not in control, they get scared if they have trauma in the past. [So if we intervene the wrong way and] restrain and sedate somebody, we can actually make them quite agitated and paranoid"* (P12).

Category 3: Focus on the consumer's strengths and support, not risks

Participants stated that most consumers have acquired personal strengths, coping mechanisms, and established families and carers' support to manage their mental illness and

life challenges. There was a consensus that even during the acute phase of their illness, the person was still able to utilise their resources to self-regulate their behaviours.

> *"Work on a strength-based approach, assess what they [the consumers] are good at, what they like, or what lights them up and what motivates them. Even if they don't have anything [at present] because they are depressed, there is always something in the past [lived experience]. You could use it to collaborate with the person to find ways to resolve the problem"* (P1)

Participants highlighted that when practising RFC the nurse needed to focus on the consumer's strengths and support, not their risks, and encourage them to self-manage their behaviour thus reducing their potential for aggression: *"give the power all back to the person so that they will experience respect and [regard for their] human rights. Sometimes what [the person] needs is just for you to give them one or two minutes and a little bit of attention [encouragement]. They can often de-escalate properly on their own* (P5), *"If you can instil trust and hope [for the person], then the crisis [potential for aggression] can be managed in a positive way that is empowering and helps the person get back to being in control of their own behaviour"* (P11).

Category 4: Being attentive to the consumer's needs

Participants described that when people are highly aroused or distressed following admission, they often became preoccupied with personal issues, and these increased their level of distress. They described how the consumers' static risk factors, such as having a past experience of trauma, sexual abuse, exposure to violence, or treatment in the community and hospital, could intensify their potential for aggression. This was important as practising RFC could possibly address these static risks when the consumer was *"under the influenced or withdrawing [from drugs and/or alcohol] admitted involuntarily or brought in by the police"* (P5) or *"highly paranoid or extremely manic"* (P8). Addressing the person's needs allowed

the risk to be mitigated and "*to come to that win-win resolution"* (P13) of reducing aggression and at the same time, making the person feel supported was a critical focus of RFC. These needs varied and *"could be [something like] asking for a cup of tea, asking for a phone call, or asking to go out for a cigarette, asking for a different meal to what they ordered… making the environment more conducive for them, rather than trying to control the person"* (P11). Another participant provided this example:

> *"In the ward, [consumers] will be knocking on the window, they will be knocking on the door. They have obviously got issues that need resolving and I think we need to ask questions: What can I do to help you? What can I do to make you feel safer? What can I do to make you feel better because this is a really bad situation that you are in? Getting them to come and have a discussion about where to from there, and actually getting them to discuss from a whole admission perspective what we can do to assist them and support them to get discharge into the community [is important]"* (P12).

Another dimension of this category was the disruption to familiar routines or lifestyle that people experienced when hospitalised: "*They [the consumers] might have a cat or a dog something at home, they might be quite worried and quite distressed and quite agitated. They don't know who is going to feed the cat or the dog. I think [the cause of aggression] is about how we engage with people"* (P3). Using RFC meant that:

> *"Aggression management is really based on what the particular individual need, there is no blanket rules, there is nothing. It really is what that individual needs at that time and lots of individual's express a lot of different behaviours. It is about knowing the [consumer], knowing what can indicate aggression, intervene early, communicate and making sure that they have the information that they need, making sure that they are aware of who they can come to when they need help"* (P15)

Category 5: Reconceptualise aggression as a learning opportunity

The last category identified was reconceptualise aggression as a learning opportunity. Some participants recognised that while aggression is unwelcomed in the acute care

environment, it contributed to *"a great learning opportunity"* (P11) for the consumer to improve the *"understanding their own ability, strengths and vulnerabilities"* (P20). It allowed them to self-regulate their behaviour and lessen the risk of future aggression. When using RFC nurses reflected on and provided feedback to consumers regarding *"their strengths, positive things, useful things, their success and triumphs*" (P23), *"help them [the consumer] remember the positive strategies to deal with the anger before it escalate into an episode of aggression"* (P16). Nurses who reconceptualise aggression as a learning opportunity assisted the person *"to regain hope and find meaningful and purpose in life" (P 21).*

> *"It is validating [for the person]. I think you [nurses] will help build a stepping stone for that person's ongoing recovery because afterwards you can reflect with them and say look, that was some crisis but with a bit of support you will be able to get it [self-regulation] back. We can end it with a positive outcome."* (P11)

DISCUSSION

Participants in this research contributed to increasing the knowledge and understanding of how nurses utilise RFC in acute mental health settings, and how this care can reduce aggression. While some participants were unable to provide clear examples of using RFC to intervene with consumers who were aggressive, they were knowledgeable about the positive impact of facilitating self-determination, shared-decision making, being strength-focused, consumer choice and empowerment could have on the person's well being and mental health recovery (Davidson et al. 2009; Pilgrim 2008; Rabenschlag et al. 2014). This finding is supported by McKenna et al. (2014a) who claimed that nurses are challenged more by how they use the concepts of recovery in their clinical practice, than by their comprehension of its components. Two supporting components, namely effective communication and taking time for the exploration of issues with consumers, were identified by participants as vital vehicles for nurses to effectively use RFC.

While nurses do not accept repeated exposure to aggression as an inevitable consequence of working in acute mental health settings (Baby et al. 2014), they believed it is often unavoidable because people are highly aroused and/or distressed on admission (Bigwood & Crowe 2008). This belief may have resulted in some participants identifying the use of restrictive practices as a component of recovery-focused that is used when the consumer is unable to control their behaviour. The literature highlights that nurses associate aggression with consumers' internal related factors (e.g. symptom severity, drug use, previous trauma or personality traits), and may therefore utilise more PRN medications, restriants, and seclusion more frequently when these factors are present (Cornaggia et al. 2011; Duxbury & Whittington 2005; Meehan et al. 2006; Pulsford et al. 2013). However, people who have past or current experience of abuse and trauma can also have higher risk for aggression if they developed feelings of helplessness, vulnerability, frustration, and anxiety about their future (Muir-Cochrane, Barkway, & Nizette, 2014; Thibeault, Trudeau, d'Entremont, & Brown, 2010). Therefore, these preconceptions of predicted consumer behaviour impact on nurses' attitude and responses to people in the acute phase of their illness.

If all mental health professionals take on equal responsibility for managing adverse behaviours such as aggression, this will enhance nurses' ability to work therapeutically with consumers who are acutely unwell (Bowers et al. 2009) and promote the use of RFC at the clinical level. It would also reduce the pressure on nurses to keep people safe (Aston & Coffey 2012) and lessen the current responsibility placed upon them to manage risk (Cashin et al. 2010; Happell & Harrow 2010; McKenna et al. 2014b). Practising RFC enhance nurses' ability to promote consumer empowerment and utilise co-production in decision making with consumers (Beckett et al. 2013). The challenge remains to change these perceptions of others about the role of nurses in relation to managing adverse events such as aggression in acute mental health settings (Dickens et al. 2013; Marynowski-Traczyk et al. 2015). Yet, this

change in perception is critical as the current pressure on nurses to ensure safety and manage risk encourages the continued use of restrictive practices even though it is not always the nurse's choice of intervention (Happell & Harrow 2010). For example, in the forensic mental health setting, Barr et al. (2017) identified that there is an ongoing reliance on medication as a treatment option to reduce aggression, which precludes other strategies such as de-escalation through the use of effective communication. Furthermore, the use of restrictive practices can reduce the consumer's power and responsibility to self regulate hindering their mental health recovery (Kuivalainen et al. 2017). This has long been recognised as a major barrier to achieve a recovery orientated care culture in acute mental health settings (Happell 2008; Wright et al. 2014).

Currently there appears to be insufficient resources and practice guidelines to assist nurses to practise RFC, making it harder for them to conceptualise how it can be incorporated into daily practice (Cleary et al. 2013). Hungerford and Fox (2014) claimed that without these resources, most nurses will continue with the traditional models of practice. Yet, these resources are essential to contemporary nursing practice internationally as the pressure from a human rights perspective to eliminate the use of restrictive practices in the mental health setting, including the use of chemical restraint is increasing (McSherry 2014; World Health Organization 2017).

Nurses practising RFC foster collaborative partnership with consumers and establish a strong nurse-patient therapeutic relationship built on trust (Lim et al. 2017; Wilson et al. 2017). This is consistent with Happell and Koehn (2011) findings that nurses' choice of intervention to reduce aggression was often influenced by the level of trust and developed rapport with the consumer. RFC can support the consumer to experience self-growth and build confidence to face their life challenges (Slade 2013). It can also decrease the intensity of their emotions and minimise the risk for aggression (Barton et al. 2009; Eidhammer et al.

2014; McCann et al. 2014). The results of this study endorse previous research (McKenna et al. 2014) about the need to identify pragmatic strategies of how nurses can use RFC in the acute mental health settings and extends its application to improve the management of aggression in acute mental health settings.

LIMITATION

Several limitations are acknowledged in this research. Firstly, the recruitment of participants was conducted through the ACMHN and this may have potentially created a participant group with a greater understanding of recovery, as well as a higher level of therapeutic optimism for consumers who are most at risk of becoming aggressive. Transferability of findings may therefore only be possible with mental health nurses who have knowledge and experience of using RFC in acute mental health settings (Leung, 2015). Secondly, the first author is a mental health nurse who has 12 years of experience in mental health nursing and came to the study with both experiential and personal knowledge about the phenomena of interest, and this may have potentially introduced bias into this study (Anderson 2010). However, researcher checks during all stages of data analysis, adherence to the grounded theory method and memoing, and reflections prior to commencing the study by the researchers reduced the risk of bias. Lastly, developing a substantive theory was not an objective of this research and this is viewed as a limitation of the study when using grounded theory methodology. Yet, the five categories identified in this research were robust and well described and add knowledge and understanding of how nurses can deliver RFC in acute mental health settings.

CONCLUSION

Nurses working in acute mental health settings will continue to be involved in risk assessment and management of aggression due to their direct care role (Happell & Harrow 2010). However, the nurses' level of confidence to work with people who have the potential for aggression and their choice of approach to mitigate identified risks impacts on the therapeutic process and both consumers and nurses' level of wellbeing. RFC can support nurses to reduce aggression and maintain a safe and recovery-oriented environment in the acute mental health setting.

RELEVANCE TO CLINICAL PRACTICE

The presence of aggression in the acute mental health setting is common. However, nurses' ability to utilise RFC can reduce this risk and support consumers to self-regulate their behaviours as part of their recovery process. Yet, while most nurses have the theoretical understanding of RFC and its impact on the consumers, they struggle with how to implement RFC clinically. The five categories identified in this study are pragmatic approaches that assist nurses to implement RFC to reduce aggression. They provide guidelines for education and training for nurses on the use of RFC in acute mental health settings.

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